A SUMMARY

OF

MENTAL HEALTH CASELAW

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BACKGROUND

In December 2011 the Mental Heath Tribunal for Scotland ("MHTS") published an excellent Digest of Cases covering the work of the MHTS until around the summer of 2011. The Digest was principally concerned with appeal decisions.

Inspired by this I thought there might be merit in offering up a further contribution to this area. I have included cases decided since the Digest was published and have also included cases not mentioned in the Digest.

For what they are worth I have offered my comments on these cases based on both my experience as an advocate in legal practice but also as a Convener of the MHTS. The MHTS has been with us for some time now and there is now a fair body of case law. This is my own contribution to a growing recognition of the need for collections of case law which are accessible and as up to date as possible in this field of Scots law.

It is fair to say that the Scottish section of this paper would not have been possible but for the efforts of Valerie Mays at MHTS who led the way with the Digest which made my own task one where I was not starting from a "standing start". The Scottish section follows a similar format to the Digest. That is deliberate. The approach taken in the Digest is excellent and makes the task of the reader an easy one. I acknowledge my profound debt to her for her earlier work.

In the Scottish section, unless the context suggests otherwise, references to the Act, the 2003 Act or a Section are to be taken to be references to the Mental Health (Care and Treatment)(Scotland) Act 2003.

In the second part of the Summary I cover some recent English (and one Northern Irish case) decisions which I consider might be of interest to Scottish readers. The legislation for England and Wales is of course different as is the appeals structure. Scotland does not operate her mental health jurisdiction within the First and Upper Tier system of the Unified Tribunal system introduced under the Tribunals, Courts and Enforcement Act 2007. However there are broad similarities in the legislation and the principles which underpin their system. I believe that given the greater output of decisions from this larger jurisdiction, absent a Scottish authority on a point, those involved in mental health law in Scotland may need to look at developments in England and Wales for possible solutions to the problem.

In the English and Welsh section, unless the context suggests otherwise, references to the Act, the 1983 Act or a Section are references to the Mental Health Act 1983 as amended by the Mental Health Act 2007.

Each of these sections will cover areas such as errors of reasoning; errors of substantive law; exercise of discretion; natural justice and procedural failures. There is some consideration of some domestic cases which turned on issues under the Human Rights Act 1998. These cases will set the scene for the last part of the Summary-the European dimension.

The last part of the Summary will look at the general principles which underpin the European Convention on Human Rights where it addresses itself to mental health matters. I have tried to provide a summary of the main cases decided since the late 1970s. It covers Article 5 (the right to liberty and security), but it also examines other rights which might be of relevance in the mental health field such as Article 3 and Article 8.

About Scott Blair-

Scott is an Advocate. He is a member of the Murray Stable. He can be contacted via (www.murraystable.com

Scott worked as a solicitor in private practice before becoming an advocate in 2000. He specialises in public law. He is or has been instructed in cases in the European Court of Human Rights, Supreme Court, Judicial Committee of the Privy Council, House of Lords, Court of Session, High Court of Justiciary, Sheriff Court and before various tribunals.

He is an Immigration Judge of the First- Tier Tribunal (Asylum and Immigration Chamber) and a Legal Convener of the Mental Health Tribunal for Scotland. He has a particular interest in mental health matters and has acted in a number of cases in this field and in the related field of adults with incapacity.

He is widely published in the public law field and has a particular interest in human rights matters. He is currently external examiner in Human Rights the LLB Honours and Diploma in Legal Practice courses at Glasgow University.

PART 1-SCOTLAND

REASONING

REASONS-DECISION TO BE READ AS A WHOLE

Robbins v Mitchell [2007] Scot SC 19

Judgment of Sheriff Principal B.A. Lockhart, 4 May 2007

Facts In this case the patient applied under Section 99 seeking revocation of a Section 86 determination. This was refused by the Tribunal. It was appealed on the basis that the Tribunal had failed to give adequate reasons for the decision and also the decision was not supported by evidence.

The argument was that the decision did not record in any real detail the content of the evidence of the parties who appeared and although an independent social work report had been submitted the decision did not give adequate weight to that.

Held The appeal was refused. It was important to look at the decision as a whole. It was clear what evidence the Tribunal had relied on and broadly speaking applying the test in *Wordie v Secretary of State for Scotland* 1984 SLT 345 the informed reader – that is someone who knows something about the proceedings in the case – would realize the evidence had been considered. Some aspects of the evidence outweighed others and proper reasons had been given for preferring the view of the RMO and care team to that of the patient and the independent social worker.

Issues arising This is a clear example of the court focusing on the decision as whole rather than particular areas of the decision. The question is whether the decision leaves the informed reader and the court 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 – see *Wordie* 1984 SLT 345 at 348. It should be noted it is not necessary to narrate the evidence at any length in its decision. The requirement is to make findings on the crucial matters.

The statutory basis for the duty to give reasons is established by Schedule 2, paragraph 13(3) of the Act. Failure to give adequate reasons is an error of law (and can make the hearing procedurally unfair-see *Koca v Secretary of State for the Home Department* 2005 SC 487) and is a classic basis for an attack on a decision.

Reasons serve to concentrate the decision-maker's mind on the right questions; show the recipient that this is so; show that the issues have been addressed in a conscientious way and how the result was reached or in the alternative to show the recipient there is a potentially challengeable flaw in the process.

Reasons are addressed to the informed reader and the Court. In the mental health context a patient might not have a good grasp of what the evidence was at a hearing. Subsequent readers of a decision at a later Tribunal may not know much about the earlier decision or why it was reached. There is arguably a need for a somewhat fuller narration of the evidence that was before a Tribunal than might otherwise be the case in other administrative law contexts-see for example *R(On the application of H) v Ashworth Hospital Authority* [2002] MHLR 314 at paragraph 39 per Dyson LJ .

Adequate reasons need to address what the material issues were. There must be reasoned findings on the conclusions on the material issues that the Tribunal has to decide. There must be a clearly defined distinction between the evidence that was before the Tribunal and the findings on that evidence. A narration of evidence is not enough.

The findings have to be adequately reasoned. Why did the Tribunal place weight on document A but discount document B? Why did it accept the evidence of the RMO on risk but not that of the independent expert?

Where there is a real dispute about the facts the reasons will need to be particularly cogent. It will be necessary to explain why evidence was accepted or rejected.

Further it is not enough to make findings in fact and give reasons for those findings. The findings must justify any conclusion as to the legal decision that must be made. Do these facts as found justify the conclusion that a patient has a mental disorder? Do they justify the view that the patient will present a significant risk of harm to their health, safety or welfare or to the safety of any other person?

On appeal the issue will be whether the material was sufficient. Although in general the approach on appeal is not whether the appeal judge would have reached a different view on the facts found, because of the over riding requirement that a Tribunal must act reasonably, the appeal court will still need to be satisfied that the facts found can reasonably support the conclusion on the legal decision that was reached.

Scottish Ministers v MHTS (JK) 2009 SLT 273 also deals with reasons and in particular at paragraphs 52 and 53 where Lord Wheatley said this:-

" [52] We consider that the way the Tribunal treated the evidence, particularly that of Dr Dewar, was not satisfactory. It is, of course, 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 the 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. There are unconditional statements by Dr Dewar in his reports as well as in his evidence that the restriction order was necessary and should not be revoked. This is repeated in his CORO 1 form. In these circumstances the Tribunal ought to have given clear and intelligible reasons for the rejection of that part of his evidence, particularly as the witness was the responsible medical officer for the patient and had many years experience of working with him. The role of the responsible medical officer in the statutory scheme is plainly of the highest importance (see for example sections 182, 183 and 184 of the 2003 Act). The Tribunal therefore required to pay close attention to all parts of the responsible medical officer's evidence. The Tribunal's decision is all the more problematic against the background of the reports and reviews in the case, all emphasising the unpredictable and aggressive behaviour of the patient over many years. It is therefore difficult to understand why the Tribunal concentrated only on the incident involving the stabbing of a nurse with a pen, in considering the question of the risk posed by the patient, when there were many more such incidents to which they could have referred. Accordingly, there were unquestionably substantial areas of significant and relevant evidence before the Tribunal, the absence of which in the tribunal's justification of its decision were simply not explained.

[53] A decision on the second and third grounds of appeal is not required for the purposes of this opinion, the principal concern of which is with the question of the proper statutory interpretation of the legislation, raised in the first ground of appeal. We therefore confine ourselves at this stage to recording our concern that there does appear to be a failure on the part of the Tribunal to deal at all with large parts of the evidence and, in particular, to address the unequivocal and significant evidence of Dr Dewar, the responsible medical officer, that the serious risk test was met in the case of this patient."

REASONS-SECTION 195 AND INADEQUATE REASONS FOR DISCHARGE

Scottish Ministers v Mental Health Tribunal for Scotland (SW) [2007] CSIH 57

Facts This was another restriction case. Here the Tribunal decided that a patient should be discharged on a conditional basis. The Tribunal had to determine whether the discharge should be immediate or whether it should be deferred under Section 195.

The Tribunal issued the decision on the issue of conditional discharge and the appointed parties were to be heard at a later date in relation to whether it should be deferred.

Following an adjournment the Tribunal convener stated orally that the discharge should be immediately effective but nothing was recorded in writing by the Tribunal in relation to facts found or reasons for the decision.

The revised version of the original decision did not include any statement of the factual basis upon which the Tribunal had reached that such a discharge was appropriate. The Ministers argued that this was contrary to their contention that further steps required to be taken before an order should take effect. They appealed to the Court of Session.

Held The Court held that the appeal fell within Section 324(2) (b) of the Act. There had been a procedural impropriety on the part of the Tribunal in the conduct of the hearing. In a case involving a restriction of liberty it was clearly important that the Tribunal should comply with important procedural obligations and in particular to provide factual foundations and reasons for its decision and this had not been done and the appeal was allowed and remitted to the Tribunal for reconsideration.

In the *JK* case the Court made it clear that the Tribunal has to reach a decision based on evidence and that clear reasons must be given for making or failing to make findings that are central to the key issues. In that case the Tribunal did not accept the statements made by the RMO in relation to the necessity of a restriction order. Again the Court held that the Tribunal had failed to give clear and intelligible reasons for rejecting that part of the evidence which was material to a central issue in the case.

Scottish Ministers v Mental Health Tribunal for Scotland and MM 2010 SC 56; 2009 SLT 1093

Facts This was another adequacy of reasons case. Here the Ministers appealed against the decision of the Tribunal revoking a restriction order. Reports from the RMO and an independent expert on behalf of the patient both recommended retention of the compulsion and restriction orders. The Court held that the Tribunal had to explain why the views of the psychiatrist were not accepted. The Tribunal decision said that it had not been explained what risk existed if the order was lifted.

Held Appeal allowed. The Court was not satisfied this decision was borne out of the material before the Tribunal and various reports. Again in this case it was not clear whether the Tribunal had addressed itself to the question of the test under Section 193(5) (b) (ii)-whether the restriction order was necessary. Again following upon from *JK* there was little indication the Tribunal had addressed itself to the factors in question.

REASONS-DISAGREEMENT ON THE FACTS NOT A VALID CRITICISM

D v Mental Health Tribunal for Scotland

Judgment of Sheriff Principal E.F. Bowen Q.C. , 6 May 2008

Facts Here an application for revocation of the CTO was made by the named person under Section 102(2) (a). It was refused and there was an appeal. It was refused. Basically this was a case where the argument mounted for the appellant was that the Tribunal should have reached a different view on the evidence.

Held Appeal dismissed. This was a classic example of a challenge being brought to the decision of a Tribunal which amounted to no more than a disagreement as to the facts as found by the Tribunal. The grounds of appeal amounted in essence to an assertion that the appellant did not agree with the stated facts. It was a well established principle of administrative law that challenge on the basis of error of law does not lie where the substance of the challenge is a basic disagreement on the facts found.

Issues arising This is different from where the reasons given for the finding of certain facts are inadequate. If it is not clear why one body of evidence was preferred over another that would be an error in the reasoning underlying the fact finding process.

It is also different from cases where it is plain there is a plain error as to material fact or an inference from a fact is an unreasonable one.

The Sheriff Principal also made it clear that simply because the Tribunal took a different view from an appellant that does not indicate bias. That is an obvious point.

Underlying this was the fact that the appellant was a party litigant. There was a wealth of material to support the conclusion of the Tribunal and the position of the named person was entirely unsupported by any medical opinion. This particular appellant also appealed to the Court of Session – that was refused – and she sought to appeal to the Supreme Court.

One point the case does make clear is that the named person can choose to appeal even if the patient does not – as he did not in this case.

REASONS-SUPPLEMENTING REASONS GIVEN

T. v Mental Health Tribunal for Scotland

Judgment of Sheriff Principal B.A. Lockhart, 28 July 2008

Facts In this case the Tribunal held a hearing to review a decision to extend a compulsion order under Section 165(2) (b). The decision was to confirm the determination to extend. This ran to a mere two paragraphs and stated the Tribunal concluded that the patient remained unwell and the criteria were met. There was an appeal against this.

Held Appeal dismissed. The initial view of the Court was that the Tribunal did not provide full findings on which Tribunal based its decision or reasons for the decision and the Court sought an amended statement to give fuller specification. This was done and in response the patient submitted further grounds of appeal.

In the supplementary reasons the Tribunal explained that it had only provided brief reasons on the view that this would cause the patient minimal distress. Even so the Court took the view that the decision did not constitute adequate full findings and reasons for the decision. On the basis of the amended statement of reasons the Court took the view that the appeal had to be dismissed as there was a wealth of material to support the conclusion reached.

Issues arising This is a rare example of the opportunity to provide supplementary reasons being afforded. In general terms in administrative law the courts are reluctant to allow decision makers to supplement the reasons for their decision lest there is an element of seeking to justify a decision after it is made by reference to reasons which were not the reasons for the original decision. There is a greater use of such a procedure in English administrative law but it is relatively uncommon in Scotland. Even the English cases are fairly strict on when additional reasons can be given.

The leading English case is *R v Westminster City Council, ex p Ermakov* [1996] 2 All ER 302. There the applicant, having moved here from Greece, applied for emergency housing. The Council received no reply to its requests for corroboration sent to Greece. Housing was refused, but the officer later suggested that the real reason was that the applicant had accommodation available in Greece. The court considered an affidavit on behalf of the decision-maker explaining that the true reasons for the decision where not those expressed in the decision letter but different reasons set out in the affidavit. The Court held that a local authority cannot later change the reasons given for a finding of intentional homelessness.

The courts are not receptive to *ex post facto* justification of decisions. Hutchinson LJ considered the circumstances in which it was appropriate to admit and rely upon evidence adduced for the purpose of explaining or adding to the reasons for a decision made by a decision-maker.

He said:-

'The Court can and, in appropriate cases, should admit evidence to elucidate or, exceptionally, correct or add to the reasons; but should, consistently with Steyn LJ's observations in ex p Graham, be very cautious about doing so. I have in mind cases where, for example, an error has been made in transcription or expression, or a word or words inadvertently omitted, or where the language used may be in some way lack in clarity. These examples are not intended to the exhaustive, but rather to reflect my view that the function of such evidence should generally be elucidation not fundamental alteration, confirmation not contradiction.'

There has now been further consideration of the position in Scots law. For a review of the practice and the circumstances in which reasons might properly be given after the original decision see Lord Reed in *Paddy Tomkins v Chief Constable* 2005 SLT 315. His judgment is worth setting out in some detail, not least because he analyses both the consequence in law of failing to give adequate reasons but also the extent to which a Court might accept additional reasons after the initial decision is issued.

Until *Tomkins* analysis of the Scottish case-law appears to contain relatively little discussion of the legal consequences of a failure to comply with a duty to give reasons. In some of the reported cases concerned with a statutory duty to give reasons, the Court was dealing with a statutory appeal, rather than an application for judicial review, under provisions which themselves had a bearing on the manner in which the Court dealt with the case. For example, in *Wordie Property Co Ltd v Secretary of State for Scotland* 1984 SLT 345, the Court was dealing with an appeal under planning legislation which directed it to quash the decision appealed against, where

there had been a failure to comply with statutory requirements to the prejudice of the appellant; and in *Di Ciacca v Lorn, Mid Argyll, Kintyre and Islay Divisional Licensing Board* 1994 SLT 1150 the court construed the licensing legislation under which the appeal was brought as requiring it to order that a licence should be granted where inadequate reasons had been given for refusal. These, and many other decisions, depend on the particular appeal provisions and offer no general guidance.

Lord Reed undertook that analysis. His decision is characteristically thorough.

" [37] Of greater relevance are cases where the court was dealing with an application for judicial review based upon a failure to comply with a statutory duty to give reasons. In almost all such cases the result of a successful application for judicial review has been the quashing of the decision, but there has been little discussion of whether alternative remedies might be competent or appropriate. There are a small number of cases which require to be noted.

[38] First, in MacLeod v Housing Benefit Review Board for Banff and Buchan District the board had failed to comply with a statutory duty expressed in the following terms:

> *"The review board shall record in writing every decision which it makes on further review and shall include in every such record a statement of the reasons for its decision and its findings on material questions of fact".*

Lord Weir held that the board had failed to give intelligible reasons for the decision in question, and that it was impossible to tell whether the board had been entitled to reach the conclusion which it did. In those circumstances, Lord Weir considered that the proper course was to reduce the decision and to remit the matter to the board for reconsideration. In the course of his opinion, Lord Weir observed (at page 167):

> *"It will not suffice if the board attempts (as it has done in this case) to explain or elaborate its reasons by way of answers to the petition [for judicial review]".*

It is of course common for a decision-maker, when its decision is challenged as unreasonable, or motivated by an improper purpose, or influenced by an irrelevant consideration, to put forward an explanation of its reasoning in answers to the petition for judicial review, or in affidavits, or occasionally in oral evidence. The court has even, on occasion, ordered the decision-maker to provide such an explanation, or to expand upon an explanation already provided (eg in Robb v School Board of Logiealmond (1875) 2R 698). The different approach which was taken in MacLeod reflected the fact that the decision-maker in that case was under a statutory duty to give its reasons in the record of its decision but had failed to do so, that failure being itself a ground on which its actings were challenged. It is apparent from Lord Weir's decision that he did not consider it appropriate merely to order that proper reasons be given, or to have regard to evidence as to the board's reasons which was sought to be put forward in the course of the judicial review proceedings. This is a case in which the failure to give reasons at the proper time led to the

quashing of the decision, not on the basis that the decision had been shown to be unreasonable or erroneous in law, but on the basis that the breach of the duty to give reasons in itself warranted the quashing of the decision. That result could be explained on the basis that the effect of the statutory provision imposing the duty to give reasons (whereby the reasons were to be included in the record of the decision) was that the decision, to be legally effective, had to be recorded in a document which included a statement of the reasons for the decision.

[39] The second case which requires to be considered is Safeway Stores plc v National Appeal Panel, where the decision of the panel was challenged on a number of grounds, one of which was that they had failed to give reasons for their decision. The relevant statutory provision required the panel to determine an appeal, and within five days thereafter to give written notification of its decision with reasons for it to the health board to whom the original application had been made. The health board then had, within a further five days, to intimate that decision, and the reasons for it, to the applicant. The court was satisfied that there had been a failure to give reasons, and remitted to the panel for reasons to be given. In that regard, Lord Justice-Clerk Ross, delivering the opinion of the court, said (at page 41):

> *"In the petition the petitioners seek reduction of the panel's decision and their entry on to the pharmaceutical list of the Lanarkshire Health Board. In their second plea in law, however, by way of alternative remedy, the petitioners seek an order from the court ordaining the panel forthwith to provide a proper and adequate statement of reasons. Counsel for the petitioners explained that the petitioners were anxious to know the reasons for the panel's decision so that they could consider what their future action should be. He accordingly accepted that at this stage it might be appropriate to remit to the panel in order that they should provide a proper and adequate statement of reasons. Counsel for the panel did not accept that the panel had failed to give sufficient reason for their decision, and emphasised that the panel did not require to give reasons for reasons. Ultimately, however, he did not oppose a remit being made to the panel so that they could give further elaboration of their reasons. In the circumstances, we have come to the conclusion that it would be appropriate at this stage to remit to the panel so that they can provide a complete and adequate statement of the reasons for their decision, and in particular to state what material factors they considered in arriving at their decision, and what conclusions they reached on these material factors. Until that has been done, the court will not be able to dispose of this reclaiming motion."*

It appears from that passage that the order was made, unopposed, on the motion of the petitioners. In those circumstances, although it can be said that the court did not demur to making the order, the decision is of little value as a precedent.

[40] The decision in Brechin Golf and Squash Club v Angus District Licensing Board is also of limited assistance. The case concerned a failure by a licensing board to comply with its statutory duty to give reasons when requested to do so within 48 hours of the decision being made. In the course of his opinion, Lord Caplan said (at page 551):

> *"The respondents have not chosen to amplify their reasons in any way in their answers and their counsel frankly conceded that he had no reason to suppose that the respondents were in a position to add to their reasons... In the circumstances I doubt if anything could be gained by remitting to the respondents for further amplification of their reasons. The court cannot be satisfied that the respondents acted properly within their statutory powers..."*

In those circumstances, Lord Caplan granted decree of reduction. It appears from what his Lordship said that he might have been willing to consider evidence from the board amplifying their reasons if such evidence had been available, or to remit to the board for amplification of their reasons if that had been a practical possibility. On that basis, it would appear, therefore, that his Lordship did not consider that the failure to comply with the statutory provision imposing the duty to give reasons necessarily invalidated the decision. Such an approach would be consistent with the terms in which the duty was framed: since reasons were to be provided only if requested some time after the decision had been made, it is plain that whether a decision was or was not validly made could not depend on whether or not reasons were subsequently requested and provided. At the same time, in a case where the duty to give reasons has not been complied with, and can no longer be complied with, and where it is in consequence impossible for the person affected, or for the court, to know whether the decision-maker reached its decision on a proper basis, the purpose of the duty (as explained in Glasgow Heritable Trust Ltd v Donald and in Albyn Properties Ltd v Knox) will be defeated, and a potential injustice will result, if the decision is allowed to stand. In these circumstances, it is understandable that the court should consider it appropriate to quash the decision, notwithstanding, first, that the decision has not been shown to be unreasonable, erroneous in law or otherwise ultra vires, and secondly, that the breach of statutory duty did not, at the time when it occurred, necessarily invalidate the decision.

[41] Thus, whereas MacLeod can be regarded as an illustration of the possibility that the terms in which a statutory duty to give reasons is expressed can have the consequence that compliance with the statutory provision is essential if the decision is to be effective, Brechin Golf and Squash Club can be taken as an illustration of another possibility: that, even where a statutory duty does not have the former consequence, it may nevertheless have the effect that unless adequate reasons can be given, albeit late, the decision will have to be quashed in order to prevent Parliament's purpose in imposing the duty from being defeated.

[42] This discussion indicates that the consequences of a failure to comply with a statutory duty to give reasons depend, like those of other failures to comply with procedural requirements imposed by statute, upon the terms of the relevant provision and upon the context. The leading authority in Scots law on these matters is the decision of the House of Lords in London and Clydeside Estates Ltd v Aberdeen District Council 1980 SC (HL) 1. In that case the council had issued a certificate of alternative development, for the purpose of enabling compensation to be assessed for the compulsory purchase of land. The certificate omitted any mention of the applicants' right to appeal to the Secretary of State. There was a statutory requirement that such a certificate should include a statement of the right to appeal.

[43] Lord Keith of Kinkel, with whose opinion Lord Hailsham of St Marylebone LC, Lord Wilberforce and Lord Russell of Killowen expressed their agreement, began by considering (at pages 41 to 42) an argument which bore some similarity to that of the respondents in the present case:

> *"It was argued for the respondents initially that the notice as to rights of appeal required by article 3(3) of the 1959 Order was something severable from the certificate itself. The certificate, so it was maintained, constituted a decision of the local planning authority which had a force and validity of its own unaffected by any failure to give the statutory required notice about rights of appeal. Reference was made to the decision of the Court of Appeal in Brayhead (Ascot) Ltd v Berkshire County Council, where it was held that the failure of a local planning authority, when granting planning permission subject to a condition, to give reasons in writing for the imposition of the condition as required by article 5(9) of the Town and Country Planning (General Development) Order 1950 did not render the condition void. This was upon the ground, as stated by Winn J at pp.313-314, that while the requirement was mandatory in the sense that compliance with it could be enforced by mandamus, non-compliance did not render the condition void because that result was not required for the effective achievement of the purpose of the statute under which the requirement was imposed, and not intended by Parliament on a proper construction of that statute. In my opinion the argument is not assisted by the case referred to and is unsound. Article 3(3) of the 1959 Order specifically states that any certificate issued under section 25(4)(b) of the Act 'shall include' a statement in writing of rights of appeal. This is entirely contrary to any idea of severability, and the provision is clearly necessary for effectively achieving the obvious purpose that the applicant receiving the certificate should know what his rights are. The consequences of failure to inform him of these rights may be irretrievable, unlike the consequences of failure to state reasons in writing, which can always be put right at a later date without anything more serious than some inconvenience."*

Having considered the Scottish cases and English case law, including *Ermakov* Lord Reed summarised the position in these terms:

" [70] It appears to me that the authorities which I have discussed support a number of general propositions. First, the stringency with which the court requires a statutory duty to give reasons to be complied with will depend on the court's view of the intention of the particular statute, which it will infer from the language of the statute and the context (see eg London and Clydeside Estates). In that regard, one relevant question will be whether the purpose of the duty is solely to provide information about the reasons for the decision, or whether it has other purposes, such as to affect the decision-making process, or to maintain public confidence in that process. Secondly, where there is a statutory duty to provide reasons as part of the notification of the decision to the parties, the court will normally interpret the legislation as having made the provision of adequate reasons with the decision a condition of the validity of

the decision (see eg Ex parte Khan; Ex parte Shield; Ex parte Graham; Ex parte Ermakov; Ex parte Nortrop; MacLeod v Housing Benefit Review Board). In effect, in such a case a just and legitimate decision cannot be given without the provision of adequate reasons. Thirdly, in other cases the court may, in principle, be willing to regard the provision of late reasons (either voluntarily, or in response to an order) as sufficient compliance with the statutory duty, and will not therefore, in such a case, necessarily quash a decision by reason of the earlier failure in compliance (see eg Brayhead (Ascot) Ltd v Berkshire County Council; Ex parte W; R (Richardson) v North Yorkshire Council; R (Jackson) v The Parole Board). In such a case, however, the court will be cautious about accepting late reasons, and will take account of a number of overlapping factors, including whether the late reasons are consistent with any earlier reasons, whether it is clear that the late reasons are indeed the genuine reasons, whether there is a real risk that the late reasons are a retrospective justification of the decision, and the delay before the late reasons were put forward (see eg Ex parte Ermakov; Ex parte W; R (Richardson) v North Yorkshire Council). In a case of this kind, if the court cannot be satisfied that substantial compliance with the statutory duty can be secured by the provision of late reasons, then whether the failure in compliance will invalidate the decision will again depend on the construction of the legislation in question. Fourthly, since the jurisdiction to grant decree of reduction of administrative decisions is inherently discretionary, the court may in its discretion decline to quash a decision by reason of a failure to comply with a duty to give reasons, for example where the person seeking reduction has no substantial interest in having the decision set aside (see eg London and Clydeside Estates; Ex parte Khan; King v East Ayrshire Council). Fifthly, in the event that the court quashes a decision as the result of a failure to comply with a duty to give reasons, it follows that the matter must be reconsidered. Depending on the context, the matter may have to be reconsidered by the original decision maker, or the court may have a discretion to direct that the matter should be dealt with by a differently constituted body. In the latter situation, the court will make such a direction if it is considered appropriate in the circumstances (see eg Ex parte Khan; Stefan v General Medical Council).”

There has been at least one appeal to the Court of Session where that court allowed additional reasons to be provided. This related to a restricted patient subject to a conditional discharge. The Ministers appealed on the basis that the conditions proposed had not all been accepted by the Tribunal. The reasons given did not deal with the question of conditions but further reasons were given.

There was no argument as to the competency of these reasons and it is interesting to note that the court did not consider that the provisions of such reasons breached Article 6 ECHR. This was on the footing that the reasons that were given in addition related only to the evidence and arguments at the original hearing. Given the underlying issue of protection of liberty one might think that applying *Tomkins*, that the duty to give reasons should be handled with particular care and a Court should be particularly wary of attempts to bolster reasons after the event.

REASONS-USE OF THE SECTION 1 PRINCIPLES

Di Mascio v Mental Health Tribunal for Scotland 2008 GWD 37-559

Judgment of Sheriff Principal J.A. Taylor, 4 August 2008

Facts This was a case where a mental health officer appealed against the decision of the Tribunal which varied measures in a CTO to the effect the patient should live with his mother rather than being detained in hospital. The argument for the appellant was that there had been an error of law on the basis that the Tribunal did not apply the test in Section 64(4) which was whether it was necessary for the patient to be in hospital. It was argued that the Tribunal had failed to take account of relevant matters and had taken into account irrelevant matters. There was a complaint that the Tribunal had proceeded on the basis that they thought the local authority was simply fudging matters and that the Tribunal wanted the patient to be cared for in the community. It was argued that the decision was unsupported by the facts. Finally there had been an error of law in varying the order without there being a community care assessment and care plan prepared by the local authority.

Held Appeal dismissed. The Sheriff Principal made a ruling on a range of important issues.

First, the correct test had been applied. The first issue was to decide if an order was justified at all and then to decide the form of the order. Section 1 of the 2003 Act had to be taken into account and it was entirely correct for the Tribunal to say it had to carry out a balancing exercise. The MHO had argued that there was no balance as between the interests of the patient or public safety to be struck. On the contrary the Sheriff Principal made the point the Tribunal had to consider the safety of others and the safety of the patient and also the benefit to the patient of the order and then come to a decision on what was "minimum restriction on the freedom of the patient that is necessary in the circumstances" as required by Section 1(4).

On the relevancy point, that was misconceived. There was sufficient material which was relevant and credible to support the view that the patient could be cared for in the community and in accordance with Section 1 the community based order had to be granted. There was a clear analysis of the competing merits of the different proposals for the care of the patient.

The Court also did not consider there was any merit in the argument that what the Tribunal had said in the part of its decision under the heading "reasons" and "discussion of the evidence" could not be looked for in order to find the facts to support the decision to vary the CTO. There was a separate section headed "facts found" and the appellant argued that it was only there that the facts to support the decision could be found and that these facts were not sufficient. Again the Sheriff Principal took the approach that the substance rather than form was what was important. The decision needed to be read as a whole and that the facts found in other parts of the decision could also be looked at.

There was no error in varying the CTO in the absence of a care assessment and care plan. There had been a variation on an interim basis to allow the local authority to prepare a community care assessment and care plan but the authority had failed to do that and this in effect had defeated the aim of the interim order. Against that background the Tribunal was entitled to reach the decision given the findings it had made in the terms of the social work reassessment. Of note here was that the Tribunal had heard nine days of evidence and submissions and the Sheriff Principal stressed the point the Tribunal was best placed to make the decision in question. The appeal to the Sheriff Principal was not an appeal at large on the facts.

It should be noted that this was the second case brought for the same patient. The other case was the appeal brought by the named person in *Laurie*.

Issues arising The main lesson to be taken from this decision is that there must be a clear statement that the Tribunal had regard to the Section 1 principles when deciding the form which an order should take.

I do not think it would be necessary for the Tribunal to state in terms that it is regard to Section 1 provided it is clear from the substance of the decision that it has carried out a balancing exercise on the question of whether hospital or community was the less restrictive option.

GENERAL ERRORS OF SUBSTANTIVE LAW AND REASONABLENESS

ONUS OF PROOF AND SECTION 264

Lothian Health Board v M 2007 SCLR 478; 2007 GWD 17-309

Judgment of Sheriff Principal BA Lockhart , 27 April 2007

Facts In this case the Tribunal made an order under Section 264(2) declaring that a patient was detained in conditions of excessive security. They specified a period of three months within which the Board required to carry out its duties under Section 264(3) to (5). The Board appealed against the decision on the basis that the Tribunal had erred as to where the onus of proof lay in respect of this matter as the Tribunal had found that the onus of proof lay on the RMO. It was also argued that the Tribunal erred in law in its interpretation of Section 264(2). Finally it was argued that the Tribunal also acted unreasonably as it did not make any finding or take into account any of the evidence regarding suitability and availability of other accommodation.

Held Sheriff Principal Lockhart held that the Tribunal was wrong to hold that the onus lay with the RMO to demonstrate that the patient required conditions of special security which could only be provided in the state hospital. The onus is on the patient to lead evidence in order that the Tribunal might pronounce an order. Even so in this case because the Tribunal had stated that the question of onus did not effect their

decision this was not a material error of law. It was clear that the Tribunal did consider the whole evidence on a balance of probabilities.

The Tribunal had been right to restrict consideration of whether the patient required special security which could only be found in a state hospital. It was correct not to consider whether there was another hospital where the patient could be detained. A decision had to be made according to the condition of the patient. Other available resources were irrelevant.

After an order had been made under 264 the Health Board has to consider (1) whether there is a hospital place available with conditions of appropriate security; (2) if no such place is available other resources can be altered to make such a place available; and (3) finally whether such a placement would be adverse to the welfare of the patient.

If the Board considered that no place was available or could even become available and the only place a patient could be placed was the state hospital the appropriate course for the Board is to use Section 267 and make an application to the Tribunal to recall any order made under Section 264(2).

Finally the Tribunal had not acted unreasonably in exercising discretion under Section 264(2). Under that provision it was intended that an order be made and then the search for a place be carried out. Where the Board considers that it cannot comply for any reason with an order declaring a patient is detained in conditions in excess of security the proper course is for the Board to make an application for recall.

ERROR OF LAW/UNREASONABLENESS-RECORDED MATTERS

MP v JL, Doctor T.H. Mental Health Tribunal for Scotland

Judgment of Temporary Sheriff Principal C.N. Stoddart , 7 April 2011

Facts In this case the issue was about the Tribunal deciding not to make a recorded matter. This was a Section 100 application where variation from a hospital to a community based order was sought. The solicitor for the patient asked the Tribunal to revoke the order completely or to vary it by modifying the order to include the recorded matter under Section 100 (2) (b) (ii). Section 64(4)(a)(ii) provided the Tribunal may make an order "specifying such medical treatment, community care services, relevant services, other treatment, car or services 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'."

Here the proposed recorded matter that was requested required "up to date reports from occupational therapy, social work, housing and a responsible medical officer as to what progress has been achieved in advancing the patient's care pathway towards a community placement".

The Tribunal decided not to revoke the order and also not to make a recorded matter and the argument on appeal was the Tribunal had erred in law and acted unreasonably.

Held Appeal dismissed. The Sheriff Principal had no difficulty in holding that what was sought was not a recorded matter. He held that a recorded matter is an order specifying that certain treatment or services must be provided as part of a CTO. It is not a means for obtaining reports, which is what the patient sought. It would have been incompetent to agree to what the patient sought.

In the alternative even if it had been competent to make a recorded matter which consisted of obtaining a series of reports the refusal to do so did not amount to an error of law. It would be a question of the exercise of discretion and on the approach the Sheriff Principal applied the well known test in the House of Lords decision of *G v G (Minors: Custody Appeal)* [1985] 1 WLR 647.

The decision that was reached was not "plainly wrong". The Tribunal decided that the treatment that the patient required was hospital support and she was not capable of living in the community. Against that background it was difficult to see what purpose would be achieved by obtaining a series of reports showing what progress had been made in moving her to the community.

ERROR OF LAW-VARIATION OF CONDITIONS ON CONDITIONAL DISCHARGE-EXCEEDING THE JURISDICTION

Scottish Ministers v MHTS (NG and P) 2009 SC 510; 2000 SLT 650

Facts Here the patients were subject to a deemed compulsion and restriction orders under Section 57(2)(a) and (b) Criminal Procedure (Scotland) Act 1995 as amended by the 2003 Act. The issue in this case was whether it was competent for a Tribunal to make a further order for a conditional discharge and the varying of the conditions of discharge when dealing with a reference under Section 189(2) that is a two year review when the patient was already subject to an order for conditional discharge with conditions.

Held In this case the appeal brought by the Ministers was allowed. The words in Section 193(7) made it clear to the Court that Parliament intended that the power to impose conditions in respect of the discharged patient arose only at the time the Tribunal made an order for discharge. In this case the Tribunal had appeared to revoke the original orders to substitute new orders of conditional discharge. This was a plain excess of powers on the part of the Tribunal.

Issues arising It should be noted that Sections 200 and 201 of the Act do give power to vary conditions on a conditional discharge to give a right of appeal against that variation. Sections 202 and 204 also deal with recall of a patient from a conditional discharge. The Court took this into account in coming to the view that Section 193(7) could not contain the power that the Tribunal purported to rely on.

ERROR IN LAW-SECTION 193(2) FAILURE TO ADDRESS TEST; ROLE OF MHTS AS SPECIALIST TRIBUNAL

Scottish Ministers v MHTS 2009 SC 398; 2009 SLT 273

Facts This was an appeal by the Ministers against the decision of the Tribunal to revoke a restriction order. The Court of Session upheld the appeal on a number of grounds.

First, there had been a legal error. Section 193(2) of the 2003 Act had to be considered by the Tribunal in every case. It was necessary for the Tribunal to reach a clear and reasoned finding on this before moving on to consider the rest of the case. Here the Tribunal had failed to do that. In particular the Tribunal had failed to consider the initial mental disorder test and also the separate test of risk of serious harm requiring detention in hospital. They had to do that before going on to consider any other provision in Section 193. The Tribunal also failed to make any finding on the question of whether the ongoing detention of the patient was necessary.

In approaching the question of continuing necessity the Tribunal had to look at the nature of the offence, general background of the patient and of the risk of other offences being committed. The Tribunal had to reach rational and intelligible conclusions on each of the these considerations and having done so the Tribunal should go on to consider the nature of the effect of the order on the patient's present circumstances and determine whether the order is necessary. Because there was nothing to suggest that the Tribunal had addressed the continued necessity test this too was an error in law.

The decision also clarifies what a restriction order is meant to be about. The Court noted at paragraph 6 that it was to "provide ***additional safeguards*** in the decision making process concerned with the management of possible release of a restricted patient" (emphasis added).

The case is important as to what will be expected in terms of what will be a clear statement of adequate reasons. In this case there had been a serious failing on the part of the Tribunal.

In particular the Court was critical because it was unable to establish why the Tribunal did not accept part of the evidence of one of the medical witnesses who was in fact the RMO with many years experience of working with the patient. The Court emphasised the need of the Tribunal to pay close attention in particular to the evidence of the RMO. There was a lack of adequate reasons on why the evidence from the RMO was not accepted. In this case the Tribunal accepted his evidence in part but rejected other parts of his evidence. They gave no reasons for the latter.

Issues arising The case is also important because it makes it clear that the Tribunal is a specialist body and is entitled to apply specialist knowledge. In other words that

knowledge can be used to support the findings it makes and to supplement the evidence which is before it.

This is different from an ordinary court where the personal knowledge of the judge – unless it is of course judicial knowledge – can play no part in decision making. An ordinary judge cannot apply specialist knowledge but must work only on the basis of the evidence before the court or by drawing inferences from that evidence. The MHTS is entitled to apply specialist knowledge as well as the evidence which is before the Tribunal.

ERROR OF LAW-SECTION 193(5); REVOCATION OF RESTRICTION ORDER; FAILURE TO ADDRESS VARIATION IN COMPULSION ORDER

Scottish Ministers v Mental Health Tribunal for Scotland and JMM [2012] CSIH 18

Facts This was an appeal by Scottish Ministers under Section 322 of the 2003 Act against a decision of the Tribunal whereby, following Section 193(5) of the 2003 Act, the Tribunal revoked a restriction order. The appeal was opposed by the Tribunal and by the patient in question, "JMM".

After sundry procedure and evidence over an extended period when it came to take the decision the Tribunal had before it unanimity of opinion among the expert psychiatric witnesses, including the RMO and expert instructed by the Scottish Ministers, that the continuance of the restriction order was no longer justified. There was nothing in the other evidence before the Tribunal to any contrary effect. The patient's mental heath officer was similarly of the view that the patient no longer met the serious harm test for the maintenance of a restriction order. The community psychiatric nurse gave evidence favourable to the patient and the revocation of the restriction order.

In the written decision which it delivered the Tribunal sets out its findings in fact. These embrace, among other things, the history which we have already summarised. In findings 6 to 10 the Tribunal then finds, in summary, that the patient was in good health; was aware that matters had improved since his illness was medicated with the clozapine; had a good history of compliance with that medication and with appointments with his medical care team; was very settled and engaged in a charity shop five days per week; and had insight into his condition. Having summarised the evidence of the various witnesses and the submissions of the parties, the Tribunal then gives an exposition of the basis of its decision. It sets out the relevant statutory provisions, including the terms of Section 193 of the 2003 Act. It also considered and sought to follow the guidance given by this court in *Scottish Ministers* v *Mental Tribunal* 2009 SC398 - *"JK"* - and in *Scottish Ministers* v *Mental Tribunal* 2010 SC 56 - *"MM"*. The Tribunal then identified the questions which it had to consider as follows:

> "(a) Does the Patient have a mental disorder?

(b) As a result of the Patient's mental disorder, is it 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?
(c) Do the conditions mentioned in section 182(4)(a), (b) and (c) [of the 2003 Act], continue to apply to the Patient?
(d) Is it necessary for the Patient to be subject to the Compulsion Order?
(e) Does it continue to be necessary for the Patient to be subject to the Restriction Order?"

To the first and third of those questions the Tribunal gave a positive answer. To the second it gave a negative answer. None of those answers gave rise to any element of dispute in the proceedings before the Tribunal. As to the fourth question - whether the compulsion order was necessary - the Tribunal gave this answer:

> *"The Tribunal makes reference to section 193(4)(b)(ii)(B). The Tribunal were satisfied that it continues to be necessary for the patient to be subject to the Compulsion Order, especially as this provided the necessary structure for the Patient to receive the treatment which alleviated his condition and allowed him to be maintained within the community through a robust and extensive care package. From the evidence the Tribunal was satisfied that the Patient would be at risk of non-compliance if the order was not in place. The Compulsion Order therefore continues to be necessary."*

The final question identified by the Tribunal - namely whether there was any proper need for continuing the restriction order - was the principal matter put in issue by the Scottish Ministers in their reference and that issue thereafter receives detailed consideration.

In approaching that issue, and in light of what of what had been said by Lord Carloway at paragraph 44 in the Opinion which he gave in *MM*, the Tribunal then refers to, and sets out, Section 59(1) of the 1995 Act. Further reference is then made to what Lord Carloway said at paragraph 37 of his Opinion in *MM* and to what was said in paragraph 39 in the Opinion of the Court, delivered by Lord Wheatley, in *JK*.

Two broad criticisms were made of the decision by counsel for the Scottish Ministers.

First, while the Tribunal had set out the guidance given at paragraph 39 of the opinion of the court in *JK* (namely that the Tribunal should consider the nature of the offence, the antecedents of the patient and the risk of his committing further offences if at large), the Tribunal, it was submitted, had not properly addressed those criteria.

First, the decision made no reference to the patient's antecedents in the shape of his offending prior to the imposition of the hospital order in 1991.

Secondly, the Tribunal did not properly address antecedents in the shape of the patient's history after 1991 but prior to 2008 of cyclical grant of conditional discharge followed by recall, the patient having resumed consumption of drugs or the abuse of alcohol. In particular the Tribunal had not made detailed reference to the threats or incidents of violence which, among other things, had led to recall.

Thirdly, the Tribunal did not address the fact that the patient had a liver condition which might mean that at some point in the future he might not be able to continue with clozapine. Further, the Tribunal had not properly addressed the effects of the restriction order on the patient; in particular in the absence of a restriction order the patient would not be covered by arrangements under Sections 10 and 11 of the Management of Offenders etc. (Scotland) Act 2005, which enabled co-ordination and co-operation among various public agencies in the provision of care and services. Accordingly, so ran the submission, the Tribunal had not properly addressed the continuing necessity test in Section 193(5) (b) (ii).

The second criticism was that Tribunal having concluded under Section 193(5) of the 2003 Act that the restriction order should be revoked, the Tribunal ought to have gone on to consider whether, under Section 193(6), the compulsion order - which it had concluded should be kept in place - should yet be varied. In the Opinion of the Court delivered in *JK* the court had referred to the terms of Section 193 of the 2003 Act as setting up a "sequential" list of tests to be applied.

So the Tribunal was bound to proceed from its decision under Section 193(5), whereby it revoked the restriction order to consider, in light of that revocation and in terms of Section 193(6), whether the compulsion order should be varied. Further, whether that decision is for or against variation, reasons ought to be given for it.

Counsel for Scottish Ministers went on to point out that, notwithstanding the general principle enunciated in Section 1(4) of the 2003 Act, the Tribunal had left in place a compulsion order which required the patient to be detained in hospital. It had not considered any variation of the compulsion order to reflect the fact that JMM was in fact living in the community and had been living there for some time.

While a compulsion order could provide for the subject of the order to be resident in the community, the terms of Section 57(8) of the 1995 Act did not permit complete replication of the conditions to which JMM's current discharge from hospital was subject. It was therefore appropriate that the Tribunal should have gone on to consider the terms of the compulsion order and whether or not the compulsion order should be varied. There was however nothing in the Tribunal's decision suggesting that the Tribunal had considered Section 193(6) of the 2003 Act; nor, if the Tribunal had considered that provision, what matters it had taken into account in such consideration or what reasons it had found for resolving not to alter the terms of the compulsion order.

Held Appeal allowed and matter remitted back to the Tribunal.

On the first criticism the Court did not agree that it had substance. It was correct that the Tribunal did not make reference to the criminal convictions of the patient incurred prior to the making of the 1991 hospital order. However that was understandable since those previous convictions were very minor in nature and thus essentially irrelevant to a consideration of matters some three decades later.

It is clear that the Tribunal was wholly informed of the serious nature of the index offence which led to the making of the original hospital order. The Tribunal was

aware of the history of the patient after the making of the hospital order in 1991. It is fully detailed in the various reports before it and it was acknowledged in the reasons for their decision.

However, as the Tribunal observes, since 2008 things had changed. The patient's liver condition was also put before the Tribunal and the experts but, in a matter peculiarly within the expertise of the professional witnesses, was not seen by those witnesses as a problem of significance. Nor did any of the witnesses consider the continuing application of the Management of Offenders etc. (Scotland) Act 2005 to the patient to be necessary.

The Court was of the view that no legal error arose. The criticisms really related to the weight to be given to those matters by the Tribunal in its consideration of all the evidence and materials before it and, secondly, that the Tribunal has given adequate reasons for its view of that evidence and those materials.

The expert evidence before the Tribunal was to the unanimous effect that continuing the restriction order was not necessary. There is no suggestion in the submission advanced on behalf of the Scottish Ministers that those experts were in any way ignorant of any of the matters to which that submission refers. While, of course, ultimately the Tribunal is not bound by the expert evidence and must reach its own view, in reaching a view contrary to that unanimously held by the expert evidence a Tribunal must have a proper evidential basis for doing so.

However on the second branch of the argument the Court considered that the Tribunal had fallen into error.

Counsel for the Tribunal accepted in response to questions from the Bench that, having reached a conclusion under Section 193(5) to revoke the restriction order, the Tribunal was enjoined to proceed to Section 193(6) and consider whether the terms of the compulsion order should varied. Counsel for the Tribunal equally accepted that having proceeded to that question there would be an obligation on the Tribunal to say how that question was considered and answered and to give reasons for the view which the Tribunal had reached.

Since the Tribunal did not proceed to do either of those things in reaching its final decision the Court concluded that the decision was flawed.

ERROR OF LAW/REASONABLENESS-SECTION 264 CONDITIONS OF EXCESSIVE SECURITY ESTABLISHED BUT NO ORDER REQUIRING HEALTH BOARD TO FIND ALTERNATE HOSPITAL

G v Mental Health Tribunal for Scotland 2001 GWD 29-638

Decision of Second Division of the Inner House, 23 August 2011

Facts This case considered the discretion of the Tribunal to make no order when it was satisfied that a patient did not require to be obtained under conditions of special security which can only be provided in a State Hospital.

The patient had been acquitted by reason of insanity of certain serious offences and was subject to a compulsion and restriction order. He was detained in the State Hospital and he applied under Section 264 seeking an order declaring he was being detained in conditions of excessive security and sought a period of three months for the Health Board to identify a hospital where he could be removed to.

At the hearing before the Tribunal there was evidence from a number of experts but there was a difference of opinion on whether he required psychological sex offending work. Although all agreed some work was needed there was a dispute as to whether the work was needed before he could move to conditions of lower security.

The Tribunal agreed that he did not require to be detained under conditions of special security but it decided not to exercise discretion declaring that he was being detained in conditions of excessive security or identifying any period under which duties under Section 264(3) to (5) should be carried out by the Health Board. The Tribunal explained why it considered the patient required undergoing psychological work before he could make further progress and that it remained a maximum benefit to him that such work was carried out where he was.

The basis of the appeal was that the Tribunal failed to have regard to the purpose of Section 264 of the Act; they had taken into account an irrelevant consideration in terms of resources; that it failed to have regard to the obligations and the principles set out in Section 1(3)(a) and (g) of the Act.

Held Appeal refused. There were two aspects to the test. Firstly whether under Section 264 the patient required to be detained under conditions of special security that could only be provided in the State Hospital. However the second part of the test was whether an order should be made and the Tribunal had discretion in that regard to make an order to declare that the patient was detained in conditions of excessive security and thereafter specifying a period during which the relevant duties had to be performed.

As for the question of resources the argument was advanced under reference to the case of *Lothian Health Board v M* 2007 SCLR 478 where the Sheriff Principal took the view that the treatment of resources and facilities in hospitals with different levels of security was not relevant. The Court considered that the issue of availability and quality of resources arose in a different way from that case. In particular the availability of treatment in a State Hospital and a medium secure hospital and the security arrangements at both were factors relevant to whether an order should be made and the core question of risk that the patient posed.

In relation to the Section 1 argument the court held that a patient in the State Hospital subject to a compulsion and restriction order was not in the same position as an individual with full mental capacity exercising freedom of choice and who was entitled to make a poor decision about his own wellbeing. Here all the experts were agreed that a course of action should be followed which the patient did not wish. The patient's wishes were taken into account but they had to be balanced against the risk he presented and the need to address that risk.

ERROR OF LAW-REVOCATION OF SHORT TERM DETENTION CERTIFICATE

M v Mental Health Tribunal for Scotland 2010 SLT (Sh Ct) 235; 2010 GWD 31-652

Judgment of Sheriff Principal J.A. Taylor, 31 August 2010

Facts This was an appeal against the decision of the Tribunal to refuse an application to revoke a short-term detention certificate.

Here the certificate was granted on 26 January 2010. It was due to expire on 18 February and on that date an approved medical practitioner granted an extension under section 47. Parties were agreed that certificate was unlawful. There had been no change in the mental health of the patient, one of the criteria under section 47 for the grant of an extension. Even so on 19 February an application for a CTO was made but it was withdrawn six days later. For some reason although the patient was told it had been withdrawn she was not told that she was free to leave hospital and on the same day a second short-term detention certificate was granted which was then appealed to the Tribunal.

Held Appeal dismissed. The Sheriff Principal held that an order for a Tribunal to exercise its powers under section 50(4) to revoke a certificate it must not be satisfied on the matters specified in section 54(a) and (b). There was no argument that the Tribunal could not be satisfied in these matters and accordingly the Tribunal did not have power to revoke the certificate. The argument here had been that because the patient had been unlawfully detained from 18 to 25 February the second certificate was unlawful. The Court noted that Article 5(4) of the ECHR requires there to be a means to challenge the lawfulness of detention and there was such provision under section 291 of the Act. If the Tribunal was satisfied there had been an unlawful detention an order could be made.

Issues arising It is of note that when a short-term detention certificate is challenged, this case supports the view that arguments relating to the validity of the certificate cannot be looked at in an application under section 50. Any remedy would have to be an application under section 291 in relation to unlawful detention.

It also seems to be the case that the section 47 certificate although unlawful and invalid, it was not a complete nullity. In law for there to be a nullity there requires to be a reduction of the challenged matter and that is only a matter for the Court of Session. On that footing when the second certificate was granted, the patient was not able to fall within the category set out in section 44(2) and the certificate granted on that date was perfectly valid and there was no unlawful detention at that point. The decision was appealed to the Court of Session but abandoned.

ERROR OF LAW-WHETHER CTO "NECESSARY" WHEN STDC STILL TO RUN

AB v Mental Health Tribunal for Scotland and Mrs Margaret Cooper and Dr Sally Winning

Judgment of Sir Stephen Young Bt QC, 11 October 2011

Facts An MHO applied to the Tribunal under section 63 of the 2003 Act for a CTO to be made in respect of the appellant. At the conclusion of a hearing on 8 July 2011 the Tribunal granted the application and made a CTO for a period of 6 months beginning with that day the detention of the appellant in the Royal Cornhill Hospital, Aberdeen, and the giving to him, in accordance with Part 16 of the Act, of medical treatment. The appellant appealed on the basis that there had been an error of law.

The background to this appeal is that on 17 June 2011 the appellant's then responsible medical officer granted a short-term detention certificate in respect of the appellant under section 44(1) of the Act. This authorised the detention of the appellant in hospital for a period of 28 days beginning with that day and the giving to him, in accordance with Part 16 of the Act, of medical treatment - see section 44(1) and (5)(b)(ii) and (c). The appellant was already in hospital when the certificate was granted. In the normal course of events therefore, unless it was revoked or extended, the certificate would have expired at midnight on 14 July 2011. But in this case, since the application under section 63 of the Act was made by the RMO before 14 July 2011, the effect of section 68 of the Act was to authorise the appellant's detention for a further period of 5 days, beginning with the expiry of the period of detention authorised by the short-term detention certificate, and the giving to the appellant, in accordance with Part 16 of the Act, of medical treatment - see section 68(1) and (2). In terms of section 68(3), in reckoning this period of 5 days there was to be left out of account any day which was not a working day, and it was not in dispute that the effect of this would have been to authorise the appellant's detention in hospital until midnight on 21 July 2011 had the short-term detention certificate not been revoked on the making of the compulsory treatment order on 8 July 2011.

For the appellant it was argued that the legal error arose in this way. It was said in short that the Tribunal had erred in law in its interpretation of the word "necessary" where it appeared in section 64(5)(e) of the Act and that the making of a compulsory treatment order in respect of the appellant had not been necessary since the short-term detention certificate, and thereafter the extension of time authorised by section 68, meant that the appellant could continue to be detained in hospital and treated in accordance with Part 16 of the Act for a further period of 13 days after 8 July 2011. It was pointed out that the appellant had responded well to treatment in the past and it was said that the Tribunal had had no evidence before it to the effect that the treatment which he was then receiving would not be successful within the next 10 to

13 days. It was submitted that by the time that period had expired he might have been treated successfully, and hence that it had not been necessary to grant the compulsory treatment order on 8 July 2011. It was said too that the Tribunal had erred in law by failing to consider whether the appellant's need for treatment at that time could be met by other less restrictive means such as a continuation of the hearing with the appellant continuing to be detained under the short-term detention certificate and thereafter the extension authorised by Section 68.

Held The Sheriff Principal agreed there was merit in this line but decided to ask the Convener to clarify the reasons given before coming to determine the appeal.

Before making such an order the Tribunal had to be satisfied that this was necessary - see Section 64(5) (e) - and that it would involve the minimum restriction on the freedom of the appellant that was necessary in the circumstances - see Section 1(4). According to its written decision, the Tribunal rejected the appellant's solicitor's submission that it should either adjourn the hearing and continue consideration of the application for up to 10 (or it may have been 13) days or else refuse it for two reasons. These were (i) that "necessity related to the need to treat the patient other than informally", and (ii) that "in granting an order in terms of Section 63, the Section 44 certificate would cease to have effect".

The second reason could not be understood. While it is true that, upon the making of a compulsory treatment order in respect of a patient who is then in hospital under the authority of a short-term detention certificate, the certificate is revoked - see Section 70. But the Sheriff Principal did not see how it can be said that this of itself supports either the contention that the making of a compulsory treatment order in respect of the appellant was necessary in the circumstances or the rejection of the submission of the appellant's solicitor.

Turning to the first reason advanced by the Tribunal, the Sheriff Principal agreed that in order to satisfy the test of necessity in Sections 1(4) and 64(5)(e) of the Act it has to be shown that it is necessary that a patient should be treated, as the Tribunal put it, "other than informally", in other words compulsorily. But the compulsory element is present in both a short-term detention certificate and a compulsory treatment order. In order to demonstrate that the making of a compulsory treatment order is necessary it has to be shown, not merely that the patient needs to be treated compulsorily (which can be achieved as well by a short-term detention certificate as by a compulsory treatment order), but also that he or she needs to be treated compulsorily either (a) for a period longer than that allowed by a short-term detention certificate and any extension authorised under Section 68 or (b) subject to measures which can be authorised in pursuance of a compulsory treatment order but not in pursuance of a short-term detention certificate - or of course on the basis of both (a) and (b).

It followed that it was not enough that the Tribunal in this case should have been satisfied that it was necessary to treat the appellant "other than informally", that is on a compulsory basis. The possibility of such compulsory treatment was already assured until midnight on 21 July 2011 by virtue of the existing short-term detention certificate and the extension authorised by Section 68. It was not suggested in this case that any measures were necessary over and above those which could be

authorised in pursuance of a short-term detention certificate, in other words detention in hospital and the giving of medical treatment in accordance with Part 16 of the Act.

The only advantage of making a CTO in this case was that the appellant could be compelled to submit to these measures after 21 July 2011. So what the Tribunal had to ask itself was whether the making of a compulsory treatment order was necessary in order to secure that compulsory treatment continued to be authorised after 21 July 2011. In other words, was it necessary that the appellant should be detained in hospital and given medical treatment in accordance with Part 16 of the Act after 21 July 2011?

The Sheriff Principal was not satisfied that the Tribunal did ask this question. It was implicit in the submission made by the appellant's solicitor to the Tribunal on 8 July 2011 that the appellant might so far recover by midnight on 21 July 2011 as no longer to be in need of compulsory treatment thereafter. If that were to have been the case, then the making of a CTO would not have involved the minimum restriction on the freedom of the appellant that was necessary in the circumstances since such an order would have authorised compulsory treatment for a period of up to 6 months when all that was required was compulsory treatment until, at the latest, 21 July 2011 (which would have been secured by the short-term detention certificate and the extension authorised by Section 68).

An answer to this submission would have been that the Tribunal was satisfied, not merely that it was necessary that the appellant should receive compulsory treatment, but that it was necessary also that he should receive such treatment for a period of time after 21 July 2011. The Tribunal was evidently satisfied on the first of these matters. But the omission of any explicit statement in the written decision, in response to the appellant's solicitor's submission, that it was satisfied on the second suggested that the Tribunal did not address this point. Had it done so, it would surely have said so in order to explain why the submission of the appellant's solicitor had been rejected.

The Sheriff Principal took an unusual step in relation to disposal. In the normal case the issue might have resolved this uncertainty by concluding that the Tribunal had not addressed this particular issue and that the appeal was allowed and remitted the case to the Tribunal for consideration anew with a direction that the Tribunal be differently constituted from when it made the original decision.

However it was pointed that, if this were done then the basis upon which the appellant could be required to submit to compulsory treatment would immediately fall notwithstanding that it might be in his interests that he should continue to be subject to such treatment.

The fact that these proceedings are conceived as much for the benefit of the patient as for any other person was an important consideration and justified the taking of a more informal and pragmatic approach to the resolution of this uncertainty. As the appeal took the form of a summary application, and rule 2.31 of the Summary Applications and Appeals etc Rules 1999 allowed the Court to make such order as it thought fit for the progress of a summary application in so far as this is not inconsistent with Section 50 of the Sheriff Courts (Scotland) Act 1907.

Against that background the decision of the Court was to direct the Convener of the Tribunal who presided at the hearing on 8 July 2011 in respect of the appellant to submit a report to this court within 21 days stating (1) whether or not, before making a compulsory treatment order in respect of the appellant on 8 July 2011, the Tribunal considered the question whether it was necessary that the appellant should be detained in hospital and given medical treatment in accordance with Part 16 of the Act after 21 July 2011 and, if so, (2) what answer it gave to this question. Thereafter, depending on what answers were given by the Convener, the Sheriff Principal could decide the appeal.

PROCEDURAL ISSUES INCLUDING NATURAL JUSTICE

ADJOURNMENT

Byrne v Mental Health Tribunal for Scotland [2007] MHLR 2; 2006 GWD 10-179

Judgment of Sheriff Principal J.A. Taylor, 13 February 2006

Facts This was an appeal against a decision to extend and vary a CTO. There was a refusal of a motion to adjourn to obtain an independent medical report. Here the patient in question was unable to meet with her solicitor until the morning of the hearing. The solicitor asked for an adjournment on the basis of that and that further time was needed to familiarize her of the case to obtain an independent report. The solicitor explained that the patient would consent to the making of an interim order in the meantime. The application for an adjournment was refused and the CTO was granted.

Held The Sheriff Principal held that no Tribunal properly directing itself to the issue could do other than come to the view that insufficient notice had been given to the patient and there was no alternative but to grant the patient's motion for an adjournment. It was only three days before the hearing that the patient had been told that there would be a hearing in her case. The Sheriff Principal made the point that the solicitor was best placed to know where the patient's interests lay in terms of adequate representation although there might be cases where an adjournment could properly be refused because of the patient's own actions. Here the patient was denied meaningful participation in the Tribunal proceedings so breaching one of the general principles in Section 1 of the Act because, in particular, the views of the hospital team could not be challenged without an independent report.

Issues arising This case taken with the next case of *McGlynn v Mental Health Tribunal for Scotland* which will be dealt with later, make it clear that when an independent report is asked for an adjournment should be granted, the point being that without such a report it is difficult to cross-examine contrary expert evidence.

Although the Sheriff Principal makes the point there could be occasions where the actions of the patient might lead to the inability of the solicitor to represent their client

it must be said in the context of persons with a mental disorder that one would imagine such occasions would be relatively rare.

Although yet to be decided, there are some comments in Inner House cases which suggest that not adjourning may not be an error in law. In other words there is not automatic right to an adjournment. Certainly in other fields of administrative appeals, such as asylum and immigration, adjournments are not granted as of right. There are a range of interests to balance, including the need to avoid proceedings which are prolonged to the disadvantage of the patient. However as a matter of generality a refusal to adjourn a case to obtain an independent expert report, medical (or potentially non-medical if sufficiently relevant), will provide the basis for considering whether an appeal can be brought.

McGlynn v Mental Health Tribunal for Scotland [2007] MHLR 16; 2006 GWD 12-248

Judgment of Sheriff Principal E.F. Bowen Q.C., 2 March 2006

Facts The patient was the subject of a short-term detention certificate granted under Section 44 of the 2003 Act. Authority to detain was due to expire on 14 November 2005. An application was made for an order and detention for a further five day period was authorized under Section 68. An adjournment was sought on the basis of insufficient time on the part of the solicitor to consult the patient and also, if necessary, to instruct the independent report. The application was refused and the decision was appealed.

Held The appeal was allowed. The matter turned on Rule 8 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005 and in particular Rule 8(2). This makes it clear that before the expiry of the five day period referred to in Section 68(2)(a) the Tribunal shall hold the hearing to determine whether an interim CTO should be made. In this case it was clear the Tribunal had not considered the making of an interim CTO. As regards the motion to adjourn, and consistent with the approach taken in the earlier case of *Byrne*, the Tribunal had acted unreasonably.

Issues arising In this case the Sheriff Principal also confirmed the correct form of procedure by way of appeals is by way of summary application under the Sheriff Court (Scotland) Act 1907, Section 3 (p).

The case is worthy of comment because in this case the Sheriff Principal considered that it should only be in exceptional cases that the Tribunal should be party to proceedings notwithstanding the terms of Section 324 (3). In Scottish practice it is certainly odd for a Tribunal to defend its own decision. That is more common in English administrative law. There are exceptions. For example Scottish licensing boards routinely defend their own decisions. It is fair to say that the view of the Sheriff Principal has not been taken up by other Sheriff Principals or indeed the Court of Session.

COMPOSITION OF THE TRIBUNAL AND ROLE OF NAMED PERSON

JB v Mental Health Tribunal for Scotland

Judgment of Temporary Sheriff Principal C.N. Stoddart, 12 January 2012

Facts JB, the mother of a patient, CB, brought an appeal under Section 320(1) (u) of the 2003 Act. On 12 November 2011, CB was made the subject of a short-term detention certificate and on the same day his mother was granted the status of named person by default by virtue of Section 251(1) of the 2003 Act. However on 16 November 2011 the MHO for CB applied to the Tribunal under Section 255(6) of the 2003 Act for an order under Section 257 to declare that JB was no longer to be the named person, on the basis that it was inappropriate for her to continue as such. On 24 November 2011 the Tribunal pronounced the order sought in terms of Section 257. JB lodged a Note of Appeal against this decision,

Held Appeal allowed and decision remitted to a differently constituted Tribunal to reconsider.

A fundamental point of competency emerged during the submissions which had not been focused in the Grounds of Appeal. The point arose because the decision of the Tribunal was made by a single member, namely a Convener, rather than a tribunal composed of more than one member.

Under reference to The Mental Health Tribunal for Scotland (Practice and Procedure)(No.2) Rules 2005 (SSI 2005 No.519), it was argued that the decision under appeal was of such an interim or preliminary nature as could legitimately be made by a single member under Rule 43, it was conceded that since at the time the decision was made there were no other live proceedings pending before the Tribunal, it could not be said that the Tribunal decision to remove JB as the patient's named person was an interim or preliminary matter in the context of other proceeding, all as required by Rule 41.

On the alternative argument that an interpretation of the 2003 Act supported what had been done. It was submitted that it was for the President of the Tribunal to allocate its decision-making functions to tribunals either consisting of three members or not; and that in consequence the President could competently allocate the making of a particular decision to a tribunal consisting of a Convener alone. This was what had happened in the present case and it was rendered competent as a result of the wording of paragraph 7(1) of Schedule 2, where the position of the statutory body (the Tribunal) was contrasted with the body which carried out its function (a tribunal). The very language used suggested that a Tribunal might be validly constituted by one member.

The Sheriff Principal held that the Tribunal was not properly constituted when it took the decision under Section 257 of the 2003 Act. When the MHO applied for an order

to remove the appellant as the named person for the patient, the Tribunal was faced with an important substantive decision. That such a decision was in fact taken is clear from the decision document; it appears that the Convener (sitting alone) heard oral evidence from the Appellant and considered a range of written material before making a number of Findings-in-fact. Before making the order sought, she set out the evidence on which these Findings were made and recorded the full reasons for her decision.

The Sheriff Principal held that the decision affected the rights and duties of the Appellant herself, but it also affected the position of her son, the patient. A patient in his position will always have a named person, either by nomination or by default and indeed if the person does not have a named person then the Mental Health Officer must take steps to ensure that a named person is appointed: see Section 255 of the 2003 Act. The role of the named person is to represent the interests of a patient and to support and (if necessary) intervene in proceedings on his behalf. The named person acts independently of the patient and has defined rights set out in law. In particular, the named person has the right to raise proceedings in respect of the patient and is entitled to receive intimation of any proceedings raised by anyone else. The named person is therefore an important figure with an equally important substantive role.

In the context of the application before the Tribunal in the present case, what had to be decided was whether it was inappropriate for the named person to continue in that role. If the Tribunal was so satisfied, then that named person would have no further part to play. That is a significant step in the proceedings and in his view was one which could not be taken by a Tribunal consisting of a single member.

Whilst in deference to the submissions made for the Tribunal there were statutory provisions which were capable of allowing for some decisions which can be made by a single member, for example in an emergency situation, or where by virtue of the Rules an interim or preliminary decision requires to be made in the context of other proceedings, there was no emergency in the present case Separately even if there had been other proceedings extant at the time the decision in this case had been taken, it could not be said that the decision on the named person was of an "interim" or "preliminary" nature. It was a final determination of the relative statutory rights and duties.

Issues arising In this case quite apart from the basic and important point of legal competency the case is a useful commentary on the role of the named person and is a clear statement of the importance of this person in the process.

CONFLICT OF INTEREST

KM v Mental Health Tribunal for Scotland [2009] MHLR 384 2009 GWD 40-694

Judgment of Sheriff Principal Sir Stephen Young Bt Q.C., 21 August 2009

Facts This was a case about conflict of interest. Here an application for a CTO was made. Regulation 5 of the Mental Health (Conflict of Interest) (Scotland) (No.2) Regulations 2005 allows a medical examination to be carried out even although there is a conflict in relation to the medical examination. All the conditions in Regulation

5(1)(a) to (c) require to be met before there will be a permitted conflict of interest. The argument was that Regulation 5(1)(b) had not been met. This provides that "failure to carry out the medical examination will result in delay which would involve serious risk to the health, safety or welfare of the patient or to the safety of other persons". The Tribunal decided that this had been met and an order was made. The decision was appealed.

Held Appeal allowed. The Court held that there had been an error. It had considered what had been in the mind of the RMO at the relevant time rather than looking at matters objectively in determining whether as a matter of fact the carrying out the second medical examination would have resulted in a serious risk as required by Regulation 5(1)(b). The decision proceeded only on the basis that the RMO had thought about getting a second examination but they discounted taking this further because of delay. The Court pointed out that the Tribunal had to look at the circumstances at the time when thought was being given to carrying out the second examination and not at an earlier or later point in time.

There had to have been material to support the conclusion reached and in this case there were none before the Tribunal.

Issues arising This is a clear indication that the conflict of interest rules are to be applied strictly and that exceptions are only to be permitted insofar as they follow the statutory exception route.

It makes it clear that the Tribunal has to look at the circumstances of each case and the merits of each case and make clear findings of fact to support any decision reached-just as with any other material decision the Tribunal has to make.

In reaching a view on whether 5(1)(b) was met the Tribunal should have looked at what were the alternatives to carrying out the examination. In particular given any suggested alternative would there be any delay? If there was any delay what would the impact be on any statutory time limits and also on health, safety and welfare of the patient or the safety of other people and lastly why such an impact would have lead to a serious risk to the health, safety and welfare of the patient or the safety of others .

The Sheriff Principal was also critical of the way in which the hearing proceeded which he described as more of a "discussion" rather than something in keeping with a more formal hearing. In particular he considered that what had occurred had led to an element of confusion. What had occurred is probably what happens at many Tribunals where the Convener, RMO, solicitor for the patient and the MHO participated in matters generally and put forward matters which might be thought to be matters of evidence. Submissions were intermingled with that and there was a lack of clear questioning that one might expect at more formal tribunal proceedings.

I think most of us can relate to Tribunals which have gone that way for one reason or the other. Although nothing turned on that in this appeal is quite possible that a Court could be critical of proceedings conducted on this basis. As always there is a tension between informality and formality.

INQUISITORIAL ROLE OF MHTS

Laurie (Named Person for AL) v Mental Health Tribunal for Scotland 2007 GWD 32-555

Judgment of Sheriff Principal B.A. Kerr Q.C,. 30 August 2007

Facts The challenge here was to the decision of the Tribunal not to vary a hospital based CTO to a community based CTO. The named person brought the appeal.

The Tribunal had two options, either to discharge the patient to home, the option favoured by the named person along with the support of an independent psychiatrist or transfer to an alternative secure hospital environment. Both the RMO and the MHO wanted the latter. The argument was whether the Tribunal had acted unreasonably in the exercise of discretion in favour of that latter option.

Held The appeal was allowed. The Tribunal had failed to properly deal with one aspect of the evidence that required to be weighed in the overall balance.

The problem was that the position of the RMO was based on the position of another psychiatrist on the facilities available at the other hospital setting. Although – as is common – there was no positive challenge to the suitability of the alternative setting made at the Tribunal, the Sheriff Principal made the point that the hearing was not adversarial but had an inquisitorial aspect to it. In other words even in the absence of a challenge to the adequacy of an alternate facility, there was a duty on the Tribunal to explore whether the proposed facility was suitable. The Tribunal had to satisfy itself that where a range of options were put to it that the preference of any one option had to be based on adequate material.

In particular the Sheriff Principal felt that for matters to be adequately addressed it was necessary to secure the attendance of the other doctor who could give evidence about his report and be questioned about it. It was important that at least consideration be given to that procedural possibility even if it was not in fact done. What happened here was that his report was accepted without it being tested in any way. Although there was discretion on whether the other doctor should be called the Tribunal had to direct its mind to whether that discretion should be exercised.

The Court also made the point that the Tribunal appeared to have attached the same weight to this report as to other material which had been tested by questioning. That was a material error as well and that certainly fits in with the principles of the law of evidence whereby in general less weight should be attached to evidence that has not been subject to testing in Court than evidence which has been tested in this way.

Issues arising This is an important decision. It stresses the inquisitorial nature of the Tribunal and it is not enough for the Tribunal to approach matters on the basis of the arguments and submissions put by parties. This is driven by the need to ensure that

the outcome which is arrived at is in the best interests of the patient and there may be options or issues that are not adequately tested at the hearing which the Tribunal should take for itself. This is plainly difficult for the Tribunal as the Tribunal rightly expects parties who come to it to be fully prepared and to explore the issues thoroughly. However that does not absolve the Tribunal of the responsibility that the case makes clear exists.

Accordingly it is an arguable error of law or unreasonable exercise of discretion for a Tribunal to attach the same weight to the evidence of a witness who has not been subject to testing at the hearing as to the evidence of a witness who has. In that regard it should be recalled that in the cases where an independent psychiatric report is instructed it is often not the case that the psychiatrist speaks to that report. This case suggests that if the same weight is attached to such a report as to the evidence of say the RMO who gives evidence in person, which could open up a challenge.

As for the question of the consideration of the exercise of discretion, this could be taken further. Plainly if one accepts that the Tribunal has an inquisitorial function there is likely to be a range of areas where the Tribunal could be open to criticism for failing to exercise discretion or as this case makes clear, even applying its mind to the question of whether discretion should be exercised at all.

CURTAILMENT OF CROSS-EXAMINATION

B v Mental Health Tribunal for Scotland 2008 GWD 36-543

Judgment of Sheriff Principal Sir Stephen Young Bt Q.C., 23 October 2008

Facts This was a case where a CTO was made on an interim basis. At the hearing the convener intervened in the cross-examination of the RMO on the basis that there had been repetition. There was a second hearing with a different Tribunal and a full order was made. There was an appeal against the decision to make the order on the basis that the actions of the convener at the first Tribunal had been procedurally objectionable. There had been a denial to test the evidence. The argument was that the second decision was open to challenge as it was tainted by what had happened at the first hearing. There was also separate challenge on the basis that the decision of the second Tribunal had been based on findings made by the first Tribunal.

Held The Sheriff Principal made it clear there had been no procedural impropriety. The convener plainly had discretion to control cross-examination.

There was an argument that the patient's solicitor had wanted to cross-examine on the question of insight and this had been curtailed but the Sheriff Principal was not impressed by that. There was nothing to show that the solicitor had put to the convener a desire to cross-examine on that point. Had he done so and the convener had refused to allow it then that might be a basis for challenge. This shows that the need of fairness challenges have to be based on practical reality. There is no good in complaining that there has been an unfair hearing if the argument or evidence that one seeks to bring in was not one which was even canvassed at the hearing.

This is different of course from the question of whether there is a matter which the Tribunal in its inquisitorial capacity should take for itself. The challenge there would be on the basis of unreasonable exercise of discretion.

It is also plain that the second Tribunal had not taken the view that its decision was based on the first Tribunal. From the decision it made it clearly rested its decision on the view that was before it enough evidence to justify the order.

On a subsidiary point the Sheriff Principal also rejected the argument that because the RMO had not formally adopted a written report it formed no part of the evidence.

Issues arising The decision is not surprising. It is a norm of legal proceedings and one only has to look at any of the standard texts on the Scottish court practice to understand that a judge has power to curtail cross-examination on the grounds that it is repetitive or the form that it takes is objectionable e.g. if it amounts to harassment. The Tribunal plainly has to carry out its work under a real degree of pressure of time and time must be used effectively.

It is plainly the case that if a convener is going to take the step of curtailing cross-examination that has become repetitive to establish with the solicitor the scope of cross-examination or whether there are other matters that need to be clarified. If the solicitor does indicate there are other matters that need to be dealt with then these should be focused on. Provided they truly are distinct matters and not just a variation on a repetitive theme a refusal by a convener to allow cross-examination would amount to an error in law.

The case also makes the point that there is no need for a witness at the Tribunal to formally adopt the terms of any written material before the Tribunal. It has already been lodged and it can be seen to form part of the material in the case.

On a point of personal practice I will usually flag up at the Tribunal that the Tribunal has read the various reports and are aware of their contents.

FAIRNESS-EVIDENCE BY TELEPHONE

JG v Mental Health Tribunal for Scotland 2001 GWD 22-502

Judgment of Sheriff Principal C.A.L. Scott, 17 June 2011

Facts This case related to the practice of taking evidence over the telephone. This of course happens from time to time and can present particular difficulties. Here it was the RMO who gave evidence.

The Tribunal granted an application by the RMO to vary an order from a community based order to a hospital based one. The evidence of the RMO was taken by telephone call and it was argued by the patient that there had been unfairness.

In particular another person had been in the background when the RMO was giving evidence. Although the RMO had stated that he was on his own it was later accepted that he had in fact passed a note to a patient. The argument was that under the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005 Rule 66(1) provided that a hearing should take place in private and the argument was that there had been a breach of these rules. The Tribunal being aware of the breach should have acted on it and there was procedural impropriety.

On a more practical level the argument was that the quality of the telephone contact in terms of the line available had caused difficulties and there was a difficulty on part of the solicitor in properly examining the RMO. Finally it was argued that the Tribunal had failed to carry out a proper exercise in balancing the question of the breach of procedure and the unsatisfactory quality of the evidence in coming to the decision it did.

Held Appeal dismissed. The Sheriff Principal was clear that there had been no procedural impropriety. Evidence by telephone is specifically envisaged by Rule 52(2)(c) of the 2005 Rules.

There had been technical difficulties but these had been minimal and did not prejudice the conduct of the hearing. The transcript made it clear that both the Tribunal and the agent had been able to obtain evidence from the RMO. Even although the Tribunal had to some extent been critical and had some reservations about the RMO arising from his change of position on whether he was alone, there was nothing wrong in the Tribunal accepting other parts of his evidence. That was the correct approach.

Issues Arising Along the way Sheriff Principal Scott seemed to make the point that Rule 66 is not about attaching confidentiality in any strict or absolute sense to proceedings, rather it was more concerned with circumstances in which a public hearing should or should not take place. In that regard even if Rule 66 meant that only those participating in the hearing should know what was discussed, it could not be maintained that privacy had been breached here when there had been someone present independent of the case and disinterested in it for a brief period, namely the other patient.

He also made the helpful point that the Tribunal should regulate its own procedure albeit it should be alert to ensure that flexibility also delivers fairness and against that background taking telephone evidence should not, in principle, present any problems.

There are of course practical issues here as well. It is not uncommon for the RMO in giving evidence by telephone to be in a clinic or has further commitments and one sometimes gets the impression they are under some pressure of time. That may not be ideal for them or for the Tribunal.

In terms of assessment or credibility and reliability of a witness actually seeing them give evidence can be important as well and there may be circumstances in which a solicitor would wish to press for the RMO to attend the hearing in person where they consider that fairness means that hearing by telephone would not be sufficient. The Tribunal would have to determine such a matter on its merits and exercise discretion as appropriate.

FAILURE TO HOLD A HEARING

Smith v Mental Health Tribunal for Scotland 2006 SLT 347; [2007] MHLR 17; 2006 GWD 10-178

Judgment of Lady Smith

Facts Here the patient had been detained under a short-term detention certificate under section 44 of the Act for a period of 28 days. An application was brought by the MHO for a CTO. This was brought in time and it extended the certificate by five days to midnight on 14 February 2006 under Section 68 of the 2003 Act. Section 69 of the Act provides that where Section 68 applies the Tribunal shall before the five days expires decide whether an interim CTO should be made and if not, simply to determine the application. The Tribunal advised the MHO it was not possible to have a hearing within the five days and he sought judicial review. He was successful.

Held Lady Smith had no difficulty in holding that this was a clear breach of the statute. It was an unqualified obligation.

Issues arising This seems straight forward enough but perhaps the real message of the case is that judicial review can be a useful remedy for decisions of the Tribunal which are not subject to right of appeal.

It is probably the case that a number of procedural decisions made by the Tribunal are capable of being judicially reviewed in the absence of any right of appeal. The common law remedy of judicial review is available unless there is an alternative statutory remedy. If such a remedy exists, then subject to some exceptions, it must be used.

DEFECTIVE PAPERWORK

Beattie v Dunbar and Mental Health Tribunal for Scotland 2006 SCLR 777; [2007] MHLR 7; 2006 GWD 10-180

Judgment of Sheriff Principal B.A. Lockhart, 22 February 2006

Facts In this case an application for a CTO was made and it was submitted by the patient that the MHO should not have made the application to the Tribunal as the application was incompetent and the Tribunal had no jurisdiction to hear the application. The basis for the argument was that the two mental health reports which accompanied the application did not satisfy the requirements of Section 57 of the 2003 Act on the basis that one of the reports that (from a Dr O) did not state in terms that the medical practitioner was satisfied that the making of a CTO was necessary as required by Section 57(3)(e) as he had not shaded the relevant sphere in the form used

and secondly that the two medical reports did not specify the same measures which the medical practitioners thought were necessary.

Held Appeal dismissed. The totality of the report from Dr O made it clear that he was satisfied that the making of the CTO was necessary. The omission of the shading of the printed box did not matter.

Although the page on the report setting out the measures had been mislaid before the Tribunal, again it was clear from the report as a whole that hospital treatment was required because the patient was uncooperative.

In substance therefore the report complied with the provisions of Section 57(3) and (4) of the Act and there was a coincidence between the measures specified in that report and the other report specified in the mental health report.

Issues arising This case probably turns on the view that the forms used by doctors to complete mental health reports are not prescribed. What is important is the totality of the information in the report rather than the form which it takes.

The Sheriff Principal also made some comments that it would only be in very exceptional cases on a specific cause shown that an independent report obtained by a patient with a view to challenging the conclusions in the MHO's report should not be available to the Tribunal. His view was the interests of justice required that such a report should be available given that the Tribunal was concerned with what is in the best interests of the patient.

There are of course issues under Article 8 ECHR here and the position may not be as straight forward as the Sheriff Principal suggested. Such a report might well engage privacy issues and may be contrary to the interests of the patient as viewed by the patient.

It should also be recalled at paragraph 12(4) of Schedule 2 to the 2003 Act that it 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. Although one can understand what the Sheriff Principal was driving at it would seem that there is no power on the part of the Tribunal to compel production of a report.

M v Murray 2009 GWD 14 – 227

Judgment of Sheriff Principal B.A. Lockhart, 17 April 2009

Facts This was a case where following upon a short-term detention certificate an application for a CTO was made. The argument before the Tribunal was that the application should be dismissed because the report provided by the GP failed to comply with Sections 57 and 58 of the Act and the Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005. The Tribunal did not accept this and made an interim CTO.

Held The appeal was dismissed. It was necessary to look at the information before the Tribunal as a whole. The Tribunal made the decision based not just on what was in the application form and mental health reports but on all the evidence before it. The reports which accompanied the application did not require to be set out in any particularly precise way. It was sufficient that the material was enough to allow an MHO to consider that an application could support a CTO.

As with *Beattie v Dunbar* it would appear that only the most defective reports will lead to the conclusion that there is a problem with the application.

The Sheriff Principal also noted that a subsequent tribunal had made a further interim CTO albeit the case was subject to an appeal. He indicated that this was not good practice and the better course would have been to present a fresh application for a CTO.

LA v Mental Health Tribunal for Scotland 2001 GWD 26-594

Judgment of Sheriff Principal B.A. Lockhart, 20 July 2011

Facts In this case a patient applied to the Tribunal for the revocation of a short-term detention certificate.

In the usual way a Form DET 2 was used by the medical practitioner but at the hearing before the Tribunal it turned out that page 2 was missing. After an adjournment the RMO came back to say that she could not find it and was not sure if it had ever been completed. The solicitor challenged the validity of the certificate on the basis that without page 2 the certificate was not valid. Arguments were advanced that the certificate did not properly explain the reasons why the practitioners thought the conditions in Sections 44(4)(b) through to (e) were met. That was rejected and there was an appeal.

Held Appeal dismissed. The Sheriff Principal dismissed the appeal. The Tribunal had been entitled to hold that the practitioners complied with the provisions of Sections 44(4)(a) to (e) and 44(9) to the Act. The certificate had been valid. He made the point that the completion of the form or other MHTS document did not require to be approached as if it were a conveyancing deed. A broader approach was justified and the question was whether having had regard to all the material before it the provisions of the Act had been met with.

There had been a supplementary argument that the Tribunal had acted in a way that was procedurally improper because they had not adjourned to give consideration as to what had been said on a preliminary issue by the solicitor for the patient. In other words there was no need to simply hold an adjournment to deliberate on a preliminary submission.

The Sheriff Principal made the point that if the Tribunal was satisfied the point was without merit it could take that view. It again makes the point that the forms they used before the Tribunal are not statutory. What matters is substance, not form. What is said in any document requires to be taken into account and the issue is not whether particular boxes which have been no statutory basis have been completed.

IS A FAILURE TO FOLLOW PROCEDURE A FATAL FLAW?

Paterson v Kent 2007 SLT (Sh Ct) 8; [2007] MHLR 20; 2006 GWD 24-541

Judgment of Sheriff Principal RA Dunlop QC.

Facts Here the patient was detained on a short-term detention certificate. An application for a CTO was brought on time but again the Tribunal failed to comply with the time limit requiring him to hold a hearing within the five days of the extension of the short-term detention certificate as required by Section 69.

Notwithstanding this the Tribunal decided to grant the CTO. The argument for the patient was holding the hearing outside the time table of Section 69 vitiated the decision that was made as the Tribunal no longer had jurisdiction to determine the application.

Held Appeal dismissed. The Sheriff Principal held that in holding the hearing outside the statutory time table the decision of the Tribunal was not taken outside of its jurisdiction. That could not have been the intention of the Parliament in the absence of any clear indication that the consequences of failure to meet a statutory time limit led to nullity.

His approach turned to a great extent on the English criminal case in the House of Lords called *R v Soneji and another* [2005] 3 WLR 303, which is generally taken to be the key authority on the consequences of failing to comply with a statutory provision. The essential question is whether Parliament could fairly be intended to have in view total invalidity in the event of noncompliance.

The purpose of the Section 69 time limit is that if a hearing is not held within the five day period there will be a break in the detention of the patient. On the footing that such a detention is desirable because the patient requires to be in hospital it could not be said to be in the interests of the patient or indeed the public that the consequences of noncompliance with the time limit should be invalidity. Given that there is a statutory duty on the part of the MHO to make an application for the Tribunal this also emphasized the need to provide care and treatment to someone with a mental disorder.

Issues arising There was a separate challenge in relation to a decision from the patient to ask for an adjournment. The Tribunal had failed to adequately give reasons to address the merits of the motion for adjournment or whether the Tribunal itself should make an interim order. This is another example of the need for a reasoned explanation by the Tribunal on matters which were material in the case. Plainly an application for an adjournment could be of some materiality.

The case is also important because it is an illustration of the approach that should be taken more generally when one is dealing with a failure to comply with a statutory provision. It is important to realize though that *Soneji* is not authority for the view that all failures can be excused. Plainly each case will differ and much depends on the intention of Parliament and the interests of justice including prejudice to any parties.

JG v Mental Health Tribunal for Scotland 2010 GWD 40-817

Judgment of Sheriff Principal J.A. Taylor, 14 October 2010

Facts In this case the MHO gave notice to the patient of an intention to make a CTO application. This was even although she was only in possession of one mental health report and not the two the reports required to make such an application. The argument here was that the application was incompetent. The Tribunal rejected this and made a CTO.

Held Appeal refused. The Sheriff Principal held that any duty to give notice arose when the MHO came into possession for the first time of the two reports which met the requirements of Sections 53 to 58. There therefore had been a failure of the MHO to follow statutory procedure. Even so provisions on notification were not directory even although the word "shall" appeared. The deviation from the sequence in the statute was not substantial and broadly speaking notification had been achieved.

Even if this had not mandatory the patient had not suffered any prejudice. It had been plain that the MHO intended to make the application.

This is an early example of the Court applying the reasoning in a classic administrative law case of *London and Clydeside Estates v Aberdeen District Council* [1980] 1 WLR 182 and the English criminal case of *R v Sonej* [2005] WLR 303.

I think one can understand the approach taken here. Plainly underlying much of this is the view technical challenges are not in the best interests of the patient. Even so it should not be overlooked that in the *London and Clydeside Estates* case Lord Hailsham talked about there being a "spectrum of possibilities" (see page 189-90). It is not the case that every failure to follow statutory procedure should not have consequences. What matters is whether Parliament could have intended that the failure to follow procedure should be so severe that the proceedings come to a halt. One might also consider that if one has a case where there is a catalogue of failings which individually may not be significant, whether nevertheless and when taken as a whole, a fatal flaw arises.

N v Borland and Mental Health Tribunal for Scotland 2011 SLT (Sh Ct) 135; 2011 SCLR4 436; 2011 GWD 16-398

Judgment of Sheriff Principal B.A. Lockhart, 9 May 2011

Facts In this case the argument was whether a failure to comply with a statutory provision meant that a CTO application was invalid. There had been a failure to

lodge mental health reports before the expiry of the relevant 14 day period under reference to Section 57(7) of the Act.

In this case the Tribunal made the CTO. When the application was lodged with the Tribunal, in error the required two mental health reports did not accompany the application and were not in fact received until two days after the application had been made. Under Section 56(7) there is an obligation for an MHO to make an application before the expiry of 14 days beginning with the date of the mental health reports if they were the same date or where they were of different dates, the latest of the dates. Accordingly the 14 days started on the date of the joint examination for the two reports and expired on 10 March 2011 in this case. The argument was that as the application required to be accompanied by the reports and the reports were not received until the 14 day period had expired and so the application was invalid.

Held Appeal dismissed. The Sheriff Principal held the delay in lodging the reports did not mean the application was incompetent. There had been substantial compliance when the application, the report from the MHO and a care plan had been lodged. Only 15 hours had passed after the time limit had expired when there had been total compliance. There was no prejudice to the patient and the doctors were available to give evidence and be questioned and the patient could have led any evidence he wished.

Consistent with other decisions on this line it could not be said that Parliament would have intended that a failure to comply with Section 57(7) by a matter of hours could mean that the purpose of the legislation could be frustrated. All documentation and the findings and reasons of the Tribunal clearly made the point that the patient needed compulsory care. This was in the public interest and the appeal was refused.

EFFECT IN LAW OF PATIENT BEING ON LEAVE FOR MORE THAN 9 MONTHS WHEN ON CTO-DOES CTO LAPSE? EFFECT OF PATIENT ABSCONDING FOR MORE THAN THREE MONTHS, DOES CTO LAPSE?

DC, Petitioner [2011] CSOH 193

Judgment of Lord Stewart

Facts This Petition raises further challenging questions about the interpretation of the 2003 Act. As presented the issue in this case was whether when an RMO on 6th May 2009 purported to extend leave of absence beyond 9 months in a 12 month period did that mean that the underlying CTO lapsed? Did that entitle a patient who had been later recalled to hospital to seek damages?

In July 2009 a Tribunal had found that it had but in the Outer House of the Court of Session Lord Stewart was not satisfied that was so. However he did hold that there was an illegality here such that the petitioner might be entitled to damages.

Held The patient had been unlawfully detained. On the argument that the CTO had lapsed because of the grant of leave in excess of nine months he did not agree with

that line. Along the way he looked at *Paterson v Kent*; *JB* and *Soneji.* Dealing with this line and these cases he observed:-

"54. In saying this, I do not exclude the possibility that there are situations in which a rule, ruling or order otherwise valid can be invalidated or terminated by an ultra vires derogation, condition or qualification: but I am confident that this is not one of them. Counsel for the Third Respondents was correct to say that no party really supported the MHTS reasoning of 30 July 2009 leading to the conclusion that the CTO had lapsed. Counsel for the Petitioner presented his own, different case for the lapsing of the CTO."

In his view while detention and leave from detention may complement one another in the treatment plan, leave is not integral to detention in such a way that a flawed allowance of leave must, in the absence of clear direction in the statute, vitiate the CTO authorising detention. He was not persuaded that this was the intention of the legislature.

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

The common feature in all those cases was that the statutory time-scales were held to have been inserted for the purpose of securing a fair or efficient process. Trivial non-compliance was properly excused on the basis of lack of prejudice. The issue in this case was not about process but about substance. The legislature apparently accepted against the background of the Millan Report that over-long allowances of leave are potentially abusive and could occur for ulterior, resource-driven motives and risk prejudicing both patient interests and public safety. Clearly any time limits have to be, to an extent, arbitrary: but the legislature having made that judgement, the limits have to be complied with and enforced to the letter.

Ultimately on a straightforward reading of Section 127 is that the RMO simply has no power to grant a Suspension Certificate that results in a leave overshoot in the leave allowed. The words are "if the sum of [*past leave periods together with the period of leave proposed to be certified*] would exceed 9 months in the period of 12 months ending with the expiry of the period [*of leave proposed to be certified*] the responsible medical officer may not grant a certificate." The certificate therefore may not have been valid. It did not follow that this meant that the underlying CTO had also become invalid.

He had to deal with what "absconding" meant. He held that:-

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

That then took him to the nub of matters. Along the way he engaged in some very close analysis of the statutory provisions. However for him the key was Section 304(3).

He held that:-

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

Accordingly he held that there had been an unlawful detention because in terms of Section 304(3), the CTO had ceased to have effect because by the middle of August 2009 the patient had been an "absconder" for 3 months. The plain words of Section 304(3) meant that the CTO came to an end on that alternative footing. It followed that subsequent re-detention and purported decisions by the Tribunal in relation to a CTO which had in fact lapsed had been unlawful.

On the alternative argument advanced by the Respondents:-

" [78] I have to consider an alternative scenario, namely that the over-limit part of the Suspension Certificate is severable and that the Petitioner did not commence on unauthorised absence until the intra vires part had run its course. The first difficulty is that the Respondents, who contend for this scenario, are not in a position to tell me the date when intra vires absence became ultra vires, as it were. This could be fatal to their contention, above all in a context to which Article 5 ECHR applies: it would involve an assertion that the Petitioner was liable to be detained without specification of the date when he became liable.
[79] If the leave overshoot started after 16 June 2009, then the unauthorised absence might possibly have been interrupted by the re-detention on 16 September 2009. There would then not have been the continuous period of three months unauthorised absence in terms of section 304(3) before the Petitioner was again re-detained on 8

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

Issues arising Plainly this is an important case as along the way the Court does much to shed light on what being an absconder means (it discounted the need for intention given that one might be dealing with persons with serious mental health problems). It resolved the thorny question of "overshoot" grants of leave and it has made clear that the effect of being on unauthorised leave from a CTO for three months is that the CTO comes to an end.

One point the Court did not have to resolve is this. If a psychiatric patient detained under a hospital-based Compulsory Treatment Order [CTO] is given leave of absence during a number of discontinuous periods of, say, a few weeks at a time and days here and there, how do you calculate the cumulative period of "9 months in the period of 12 months" ending with the expiry of the latest leave period, which is the maximum total amount of leave allowable in terms of Section 127(2) of the Act?

His Lordship had this to say:-

"[2] The answer is that you cannot calculate it, or that you cannot calculate it with certainty, which may come to the same thing. At least none of the Counsel who appeared in this case could explain how to do it. This is because, I was told, the Interpretation Act, "calendar month" definition cannot apply in the context of section 127 (2); because the 2003 Act itself does not provide an alternative definition; and because, without other definition, "month" is a variable period, 28 days to 31 days in length, depending on the month in question, so that the cumulative period of "9 months" can mean 252 days or 279 days or anything in between.
[3] Consequential questions arise, the first of which is: does section 127(2) meet the standard of legal certainty for Convention Rights-compliance, particularly for compliance with Article 5 ECHR (right to liberty and security); and, if it does not meet the standard, what are the implications?"

However because as a matter of fact on any view the patient had been managed in such a way that he had exceeded the nine months in any event that did not arise as a practical question which needed to be resolved. It may need to be resolved in a future case and I would suggest that there may well be an issue of legal certainty here under reference to Article 5 ECHR. If there is a lack of clarity on what is meant by a month

in a context which relates to liberty where the issue of legal certainty is applied with particular rigour, there could well be an ECHR challenge.

In mental health matters there should be guarantees that are not inferior to those existing in criminal proceedings –see *De Wilde, Ooms and Versyp* v *Belgium (No 1)* (1979) 1 EHRR 373 at paragraphs 76, 79. A deprivation of liberty must be "in accordance with law". This means that it must meet both national law but also that the national law has the quality of certainty. The law must be sufficiently accessible, precise and foreseeable.

HUMAN RIGHTS

ARTICLE 5- CONDITIONS OF EXCESSIVE SECURITY, TRANSFER FROM ENGLAND AND CORRECT PROCEDURAL ROUTE FOR CHALLENGE

WS v Mental Health Tribunal for Scotland 2011 SC 43 2010 SLT 991 2010 GWD 29-607

Facts This was the decision of the Second Division of 20 August 2010. The patient was in a State Hospital and the Tribunal accepted under Section 264 of the 2003 Act that the patient was being detained in conditions of excessive security. He was then moved to a medium secure facility in Yorkshire. He was involved in a serious disturbance there and he was returned to the State Hospital under section 80 of the Mental Health Act 1983. He appealed the decision to return him there and relied on Section 220. An issue arose as to whether such an appeal was competent and the Tribunal refused to make an order under Section 220. In other words it did not hold the appeal to be incompetent. That in turn was appealed to the Court of Session. Before that Court it was argued that Section 220 should be read as being broad enough to provide a right of appeal to the Tribunal under Section 220 to ensure compliance with the ECHR.

Held Appeal dismissed. The Inner House had no difficulty in holding the appeal was simply flawed from the outset. A right of appeal only arose if a patient was transferred to the State Hospital under Section 218. That did not occur given the use of the powers under the 1983 Act. The Tribunal should not have made the decision it did simply to allow the patient to appeal to the Court of Session. It had no power for it so to act.

In relation to the ECHR Article 5 argument the court held that as the Convention argument had not been pressed in any real sense before the Tribunal it could not be taken on appeal to the Court of Session where appeals were limited to errors of law.

In any event the Court was not satisfied an ECHR argument arose as the patient still had remedies including judicial review of the decision of the Secretary of State for Justice. Also the patient could simply make an application under Section 264 that he was being detained under conditions of excessive security.

ARTICLE 6-LACK OF LEGAL AID FOR WORK BY CURATOR

Hughes (Curator ad litem to PH) v Mental Health Tribunal for Scotland [2007] MHLR 29

Sheriff Principal EF Bowen QC.

Facts Here an application for a CTO was made. A curator *ad litem* was appointed. Funding was available from SLAB for the curator to instruct a solicitor but he was not available to pay the curator for work carried out by him including such important matters as considering the papers, considering the views of the patient, instructing the solicitor and being present at any hearing.

At the hearing the solicitor made a submission that the patient could not have a fair hearing under Article 6 ECHR because of the absence of funding the curator was unable to carry out any work or be present at the hearing. The Tribunal rejected that submission and the solicitor withdrew from acting. The Tribunal proceeded and made a CTO. The curator appealed.

Held Appeal dismissed. In this case the Sheriff Principal held that there was no issue of inadequacy or legal representation. The curator having accepted the office should have proceeded with the duties of appointment. This included instructing legal representation and funding for that representation was available. The funding of matters for the curator was not a matter which the Tribunal required to consider.

Issues arising The first comment I would make is that in light of the subsequent decision of *Black (as curator litem of patient M) v The Mental Health Tribunal for Scotland and The Scottish Ministers* [2011] CSIH 83, it would not appear that a curator *ad litem* has any right of appeal to the Tribunal. If this matter had to be re-litigated it would have to be raised by way of judicial review.

There is one rider. Unfortunately the patient died before the judgment was issued and the Sheriff Principal made it clear that his views were therefore strictly speaking *obiter*.

It is of course the case that a new scheme was introduced by the Tribunal which now pays for the fees and expenses of the curator appointed by the Tribunal. The case nonetheless remains an interesting illustration of how ECHR Convention rights can be raised before the Tribunal but also of the need to focus on what the Convention right truly is. The Convention right *is the right to* ***legal*** *representation* and legal representation was available. At the same time it might be thought that in the circumstances of a patient with a mental disorder an issue might arise as to whether there was effective participation in the proceedings. The ECHR has emphasised consistently that the Convention rights must be practical and effective and not theoretical or illusory see for example *Artico v Italy* (1980) 3 EHRR 1.

ARTICLE 5-DOES A CURATOR HAVE A RIGHT OF APPEAL?

Black (as curator litem of patient M) v The Mental Health Tribunal for Scotland and The Scottish Ministers **[2011] CSIH 83**

Facts The case is of importance for a number of reasons and some time will be spent looking at it.

There M, an elderly woman suffering from senile dementia, was admitted to hospital as an emergency. A short-term detention certificate was granted by an approved medical practitioner under Section 44 of the 2003 Act, authorising the detention of the patient for a period of up to 28 days. A mental health officer applied to the Tribunal under Section 63 of the Act for a compulsory treatment order to be made in respect of the patient. The Tribunal appointed the appellant as curator *ad litem* to the patient, under rule 55 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Rules 2005, SSI 2005/519 on the basis that it was satisfied that the patient did not have the capacity to instruct a solicitor to represent her interests in the proceedings before it. The hearing of the application took place before the Tribunal.

The appellant was present, but the patient was not. Others present at the hearing included the patient's mental health officer, her responsible medical officer and her two daughters, D and E, who had been appointed as her joint welfare attorneys under Section 16 of the Adults with Incapacity (Scotland) Act 2000. D also attended as the patient's named person (by virtue of Section 251 of the 2003 Act), and in that capacity was represented by a solicitor. At the hearing, the appellant requested the Tribunal to adjourn its consideration of the application in order to obtain a medical report on the patient. The Tribunal refused to adjourn the hearing, and proceeded to make a compulsory treatment order. In the reasons which they gave for their decision, they explained that the medical evidence before them (which came from the responsible medical officer and from the patient's GP) was clear and unchallenged, and that there was no material advanced from which they could reasonably reach the conclusion that a further report was necessary.

The appellant tried to appeal to the Sheriff Principal against the order under Section 320 of the 2003 Act, on the ground that the Tribunal's refusal of an adjournment had been unreasonable and unfair. The decision of the Sheriff Principal was issued on 21 February 2011.

The Sheriff Principal noted that Section 320(5) lists the categories of person who are entitled to appeal, and that the curator *ad litem* of a patient is not included in that list. The appeal was therefore *prima facie* incompetent. Furthermore, the Sheriff Principal considered that the scope of the appellant's appointment as curator *ad litem* was restricted to representing the patient's interests in the proceedings before the Tribunal. Since those proceedings had come to an end when the Tribunal made the compulsory treatment order, it followed that the curator was *functus officio*: he had carried out the duty which he had been appointed to perform. The Sheriff Principal considered however that, since the Tribunal had authorised the patient's detention, it followed

that the patient was entitled under Article 5(4) "to take proceedings by which the lawfulness of [her] detention shall be decided speedily by a court". Section 320 made provision for such proceedings to be taken by the patient, but that was of little or no value if the patient lacked capacity and was unaware of the proceedings before the Tribunal. In those circumstances, the Sheriff Principal concluded that Section 320(5) might be incompatible with Article 5(4). Since he had no jurisdiction to make a declaration of incompatibility under Section 4 of the Human Rights Act 1998, and on the mistaken view that that provision is applicable to Acts of the Scottish Parliament (whereas such Acts are not "primary legislation" within the meaning of Section 4: see Section 21(1)), he remitted the appeal to the Inner House of the Court of Session under Section 320(4) of the 2003 Act.

Held There was no right of appeal in the name of the curator.

This is what the Inner House said. As the European Court of Human Rights held in *Winterwerp* v *The Netherlands* (1979) 2 EHRR 387, paragraph 39, Article 5 (1) requires three things: "*In the court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority - that is, a true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder."*

Given the inherent changeability of mental disorders, Article 5(4) requires not only an initial right of access to a court or tribunal to discover whether the criteria for detention have been met, but also "a review of lawfulness to be available at reasonable intervals" thereafter: see *Winterwerp*, paragraph 55. That review need not always be attended by the same guarantees as are required under Article 6, but: *"it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation...Mental illness may entail restricting or modifying the manner of the exercise of such a right, but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves*" (*Winterwerp*, para 60).

In the present case, the patient was initially detained by virtue of the short-term detention certificate granted by an approved medical practitioner under section 44 of the 2003 Act. That section reflects the requirements discussed in the *Winterwerp* judgment, since the certificate can only be granted by a medical practitioner with appropriate expertise (see Section 22 of the 2003 Act) who has examined the patient and who considers it likely that she has a mental disorder and that it is necessary to detain her in hospital (see Section 44 (1) and (3)).

An admission to hospital which complies with the procedural requirements of section 44, where the substantive grounds for admission do in fact exist, would appear therefore to comply fully with Article 5(1)(e).

In the present case, there is no dispute that the procedure prescribed by Section 44 was followed and that the substantive grounds for the granting of a short-term detention certificate did in fact exist.

The patient and the named person were thereafter entitled to apply to the Tribunal for the revocation of the certificate, under Section 50 of the 2003 Act. That section requires the Tribunal to revoke the certificate if not satisfied that the conditions laid down in section 44 continue to be met, or that it continues to be necessary for the patient's detention in hospital to be authorised by the certificate: Section 50(4). Before determining such an application; the Tribunal can appoint a curator *ad litem* to act on behalf of the person detained, and must afford specified persons, including the patient, the patient's named person, any guardian of the patient, any welfare attorney of the patient, and any curator *ad litem*, the opportunity to make representations and to lead or produce evidence: Sections 50(2) and (3).

This procedure is designed to secure the speedy release of a person who should not in fact have been detained in the first place or should not be detained any longer, as required by Article 5(4) of the Convention.

In that regard, it is important to understand that the Tribunal is a "court" within the meaning of that provision. As the Court observed in *Reid* v *United Kingdom* (2003) 37 EHRR 211 at paragraph 63: *"The 'court' referred to in this provision does not necessarily have to be a court of law of the classic kind integrated within the standard judicial machinery of the country. The term denotes bodies which exhibit not only common fundamental features, of which the most important is independence of the executive and the parties to the case...; but also the guarantees - 'appropriate to the kind of deprivation of liberty in question' - 'of [a] judicial procedure', the forms of which may vary but which must include the competence to 'decide' the lawfulness of the detention and to order release if the detention is not lawful."*

Following that approach, the equivalent English tribunal was treated in *Kolanis* v *United Kingdom* (2005) 42 EHRR 206 as a "court" within the meaning of Article 5(4).

In the present case, no application was made to the Tribunal under Section 50, and the patient continued to be detained under the short-term detention certificate until it expired. She was subsequently detained by virtue of the compulsory treatment order made by the Tribunal under Section 64 of the 2003 Act. That section again reflects the *Winterwerp* requirements, since the application for the order must be accompanied by two reports by medical practitioners stating *inter alia* that they are satisfied that the person has a medical disorder and that the making of a compulsory treatment order is necessary (Sections 57(4) and 63(3)); and the Tribunal can make the order only if satisfied *inter alia* that the patient has a mental disorder and that the making of the order is necessary (Section 64(5)). In addition, before determining the application, the Tribunal can appoint a curator *ad litem*, and is required to afford specified persons, including the patient, the patient's named person, any welfare attorney of the patient and any curator *ad litem*, the opportunity to make representations and to lead or produce evidence: Section 64(2) and (3).

Detention in accordance with the procedural requirements of Section 64, where the substantive grounds for making the order do in fact exist, would appear therefore to comply fully with Article 5(1)(e) of the Convention.

Furthermore, because a compulsory treatment order is made by a "court", within the meaning of Article 5(4), the judicial supervision of detention which is required by that provision is incorporated in the Tribunal's decision, as the European Court of Human Rights explained in *De Wilde, Ooms and Versyp* v *Belgium (No 1)* (1970) 1 EHRR 373, paragraph 76. There must in addition be provision for subsequent review of continued detention at reasonable intervals, as was explained in *Winterwerp* at paragraph 55.

The 2003 Act contains a number of provisions for such review, either automatically in the event of an extension of the order (e.g. under Section 101), or on the application of the patient or his named person (e.g. under Sections 99 and 102).

It followed from the foregoing that the Sheriff Principal was mistaken, in the present case, in considering that a right of appeal against the decision of the Tribunal was necessary in order for the lawfulness of the patient's detention to be decided by a court, as required by Article 5(4). The Tribunal is itself a "court", and the judicial supervision required by Article 5(4) was incorporated in its decision to make the compulsory treatment order. Article 5(4) does not require a right of appeal to another "court".

In providing a right to appeal against the Tribunal's decision, the 2003 Act requirements of the Convention. Nevertheless, where a right of appeal is provided, the Convention requires that the procedures on any appeal must in principle accord to the detainee the same safeguards as the procedures at first instance: see e.g. *Toth* v *Austria* (1991) 14 EHRR 551, paragraph 84.

That requirement is met in relation to the appeal procedures under the 2003 Act. In particular, so far as concerns the appointment of a curator *ad litem* to protect the interests of a patient who is not fully capable of acting for herself, both the Sheriff Principal and this court have the power to appoint a curator *ad litem* to the patient when necessary.

Against this background, the absence of any provisions in the 2003 Act enabling a curator *ad litem* who represented a patient before the Tribunal to appeal against the Tribunal's decision to make a compulsory treatment order does not in our view give rise to any incompatibility with the Convention.

The requirements of Articles 5(1)(e) and (4) are met by the procedure before the Tribunal itself. The Convention does not require a right of appeal against its decisions.

The concern of the Sheriff Principal is that a right of appeal, is of no practical benefit to a person who is unable to exercise it. This sort of problem is, however, inherent in mental illness, and its solution is not to be found within the Convention. As Baroness Hale of Richmond observed in *R (H)* v *Secretary of State for Health* [2006] 1 AC 441 at paragraph 23, in relation to the Mental Health Act 1983, the sort of concern

expressed by the Sheriff Principal leads to the conclusion, not that the legislation is incompatible with the Convention, but that every sensible effort should be made to enable patients to exercise their rights if there is reason to think that they would wish to do so. That objective is reflected in the 2003 Act.

Sections 250 and 251, in particular, provide for the appointment of a named person whose role, as explained in the Code of Practice issued under Section 274, is to protect the interests of the patient, and who has a right of appeal under Section 320 against the making of a compulsory treatment order. It is also relevant in this connection to note that the managers of the hospital where the patient is detained have a statutory duty, under Section 260, to take all reasonable steps to ensure that the patient understands the effect of the provisions under which she is detained, the rights of applying to the Tribunal which are available to her, and the availability of the independent advocacy services which must be provided under Section 259. Put shortly, the legislation seeks to ensure that patients' rights are practical and effective, notwithstanding the difficulties which may arise as a consequence of mental disorder.

The conclusion that a curator *ad litem* has no statutory right of appeal against a decision of the Tribunal does not entail that the curator is necessarily without any legal remedy if, for example, the Tribunal acts unfairly or wholly unreasonably. The Tribunal falls within the scope of the supervisory jurisdiction of this court. Although this court is likely to decline to exercise that jurisdiction in circumstances where a statutory right of appeal exists, it can be invoked, in appropriate circumstances, where there is no such right of appeal. In the present case, counsel for the Tribunal and counsel for the Scottish Ministers both accepted that it would in principle be open to the curator *ad litem* to bring a decision of the Tribunal under judicial review, on the basis that the curator would not be *functus officio* (since his application to the court would proceed on the basis that the proceedings before the Tribunal had not been validly completed), and he would have a sufficient interest in the matter complained of.

The Court also noted that the Mental Welfare Commission for Scotland has important supervisory functions under the 2003 Act, and that it would be open to a curator *ad litem* who had concerns about the operation of the Tribunal or the detention of a patient to draw those concerns to its attention.

L v State Hospital Board for Scotland 2011 SLT 233

Judgment of Lady Dorrian.

Facts L, a patient in the State Hospital subject to a compulsion and restriction orders brought a petition for judicial review of a decision of Board of the State Hospital. The Board decided that: (1) Visitors to the hospital would no longer be allowed to bring food parcels for patients; (2) Patients would no longer be allowed to order food from outside sources, although they would continue to be allowed to order one take away meal per month; and (3) That a fiscal pricing policy would be introduced into the hospital shop, designed to make purchases of low fat and low sugar foodstuffs and drinks a more financially attractive option than the full fat, high sugar versions. L sought to reduce the decision on two grounds –first that the respondents had failed to consult patients as they were required to do in terms of the Mental Health (Care and

Treatment) (Scotland) Act 2003 and second that the decision constituted a breach of the petitioner's rights under Article 8 ECHR. The case was decided by Lady Dorrian.

Held petition granted and decision reduced. (1) There had been inadequate consultation. The consultation did not enable patients to consider and to comment on all three options eventually put to the Board regarding visitors. As to purchasing, the option eventually selected by the Board, an outright ban, was not put before patients at all. (2) In *R (N) v Secretary of State for Health* [2009] HRLR 31 which related to a smoking ban in Rampton, it was agreed that the hospital was "home" for the purpose of Article 8.

As for Article 8 the Lady Dorrian agreed with the majority in *R(N)* that although Rampton was the appellant's home it was not and could not be treated as equivalent in all respects to a private home. It was clear that when making the observation that it would be deeply intrusive for the state to dictate what a person should eat and drink in the privacy of his own home, the Court in *R(N)* was contrasting this to the position within such an institution such as Rampton.

She also accepted the point made in that case that the degree to which a person may expect freedom to do as he pleases and engage in personal and private activity will vary according to the nature of the accommodation in which he lives. In particular this will be the case for those incarcerated in a prison or detained within the confines of the State Hospital.

However she had more difficulty with the view in *R(N)* that the restrictions imposed are "not simply because restrictions can be justified, but more fundamentally because of the nature of the institution in which he eats and drinks."

In the view of Lady Dorrian the limitations do arise from the nature of the place, but only because they are justified in terms of Article 8(2). The loss of control over those aspects of life which would otherwise be under a person's sole and direct control, the inability to pursue one's personal affairs or otherwise lead one's life exactly as one chooses, are all concomitants of the justifiable deprivation of liberty which follows on imprisonment or detention in the State Hospital. Restrictions which mean that main meals are in general restricted to those provided by the institution, that people cannot make their own food, or bring in alcohol, and are refused access to items one might find in a normal home are all justifiable as part of the ordinary, necessary and reasonable requirements of detention. Interference was thus not arbitrary but justified.

The approach of the majority in *R(N)* came close to saying that the rights of a prisoner or the inmate of a high security hospital are limited merely and automatically as a result of their confinement, whereas the position ought to be that the prisoners retain their rights under Article 8 , interference with which requires to be justified and also the ECHR cases show that the scope of Article 8 is extremely wide.

This case did not simply deal with a trivial aspect of everyday life. The freedom to receive food parcels from visitors and to make purchases from an external source are some of the few areas in which patients may exercise some sort of personal autonomy or choice. She reached the conclusion that a person's right to choose what they eat and drink is a matter in respect of which Article 8 is engaged. If that choice is interfered

with, it must be justified. In respect of a prisoner or a person confined in a secure hospital, interference to a certain extent can readily be justified. The general restrictions were justified.

The additional restrictions which the Board sought to impose had also to be justified. The Board did seek to do so on the basis of security or for any other general operational reason. The sole justification is that it is in the general interest of the health of the patients. It may be that the restrictions can be justified by reference to the risk to health of a substantial percentage of the hospital's population, given the assertion that those suffering from schizophrenia (80% of the hospital population) were at an increased risk of cardiovascular disease and obesity and double the normal risk of developing diabetes.

However, given the decision about the lack of consultation and the failure to take into account views of patients, and in the absence of reasons for selecting the most restrictive opinion in each case, it was not necessary to decide the point.

The Court did not accept the proposition that for the health reservation under Article 8 to arise the issue has to refer to public health in general. It was capable of applying where one has identified one particular section of the community which requires protection. The promotion of the heath of patients by reference to dietary needs, especially patients likely to be in the State Hospital for a long period, may be a sufficiently important objective to justify interference with Article 8 rights of patients.

The possibility of an increase in obesity/diabetes in the context of a prison population or that of a secure hospital gives rise to operational considerations for the institution as a whole and the responsibility of the Board for the care of those within the institution. These in turn are matters which bear on the effectiveness of the institution in meeting the ends it is created for.

Issues arising A very unusual case and an inventive use of Article 8. Although the views expressed by Lady Dorrian on Article 8 are strictly *obiter* as the case was not ultimately decided on Article 8 grounds, they are nevertheless important as a statement of the breadth of Article 8. She also makes it clear that the rather less searching approach for a justification for a restriction taken in *R(N)* should not be followed in Scotland.

It seems the following points about the scope of Article 8 can be made from the approach taken in this case.

First, the extent to which someone can live life in a way of their choosing must depend on the accommodation where that person lives. In a context of detention plainly there will be limitations. Such limitations must in turn be capable of being justified under Article 8(2). It is not the case that detention in a psychiatric hospital, including the State Hospital, means that the rights enjoyed under Article 8 are lost. They remain, but any limitation on any right has to be justified under Article 8(2).

PART 2-ENGLAND AND WALES

REASONING

RN v Curo Care (2011) UKUT 263 (AAC)

Facts and decision If the representative was right that the judge stated at the outset that the Tribunal would refuse to make a CTO recommendation, then reaching that firm conclusion (as opposed to an provisional opinion), and preventing the patient from arguing to the contrary, was a breach of natural justice and the ECHR right to a fair hearing under Article 6(1).

In any event, the lack of reasons for not making the requested recommendation amounted to an error of law.

There would be no point in setting aside the decision if a recommendation were impossible or not a realistic possibility, but this was not a case where a CTO would never become a realistic option in the foreseeable future: the Tribunal can make a CTO recommendation not only if it considers that the criteria are satisfied (here it did not) but also in order to trigger consideration of future steps that could be taken to move the patient towards eventual release. The decision was set aside and remitted to a differently-constituted panel.

This is what the Upper Tribunal said:-

"3. I will deal with the appeal first on the basis of Ms Drane's account of what happened at the hearing. On that basis, the tribunal failed to allow the patient to present the case he wished to present. Tribunals are entitled to preview the case before the hearing begins. That preview may lead the panel to come to provisional conclusions. That is proper and it is equally proper for them to tell the parties what they are. As Lightman J said for the Court of Appeal in Costello v Chief Constable of Derbyshire Constabulary [2001] 1 WLR 1437:

> *9. Mr Jarand, for the claimant, stated that at the commencement of the hearing before him, the judge said words to the effect that the Ford was obviously stolen, and he complained that the conduct of the judge in saying this precluded (at any rate the appearance of) a fair trial. But counsel adduced no evidence that the judge made this statement or that any complaint about it was made at the hearing, and the judge was not invited (as he should have been) prior to the hearing of this appeal to comment on this attribution to him. In these circumstances it is not open to the claimant to raise this matter on this appeal. But even if it was open to him and the judge indeed did make some such statement, it is to be borne in mind that, having preread the skeletons and papers, it was perfectly proper (if not inevitable) that the judge had formed a provisional view before coming into court and, if it was proper for him to have formed this view, it must equally have been proper for the judge to inform the*

> *parties of his view so long as he did not give the impression that he had a closed mind on this issue. For this disclosure enabled the parties to know the way he was currently thinking and accordingly where attention needed to be focused (most particularly by the claimant) at the trial to change his mind.*

4. What is not permissible is to reach firm conclusions and prevent the parties from arguing to the contrary. That is unwise, as Megarry J observed in John v Rees [1970] Ch 345 at 402:

> *As everybody who has anything to do with the law well knows, the path of the law is strewn with examples of open and shut cases which, somehow, were not; of unanswerable charges which, in the event, were completely answered; of inexplicable conduct which was fully explained; of fixed and unalterable determinations that, by discussion, suffered a change. Nor are those with any knowledge of human nature who pause to think for a moment likely to under-estimate the feelings of resentment of those who find that a decision against them has been made without their being afforded any opportunity to influence events.*

Not only is it unwise, it is a breach of natural justice and the Convention right to a fair hearing."

CM v Derbyshire Healthcare NHS Foundation Trust (2011) UKUT 129 (AAC)

Facts and decision Here the Tribunal's decision not to discharge was made in error of law, and was set aside, (a) because there was no real evidence to support its view that non-compliance with medication and the risk of consequent relapse in the near future would probably occur, (b) because it did not establish that in these circumstances it had complied with the 'least restriction principle', (c) because of the irrationality in paragraph 21 of its decision (in that as the risk was of what might eventually happen it was hard to see how the envisaged leave regime could test that risk), and (d) because continued detention for the purposes of avoiding a chaotic lifestyle or drug taking or the absence of drug counselling is not permitted by law on the facts of this case.

The judgment contains a discussion of the 'nature' and 'degree' tests.

Of particular interest are the following passages.

"Nature or Degree"

9. The words "nature" and "degree" in section 72(1)(b)(i) are to be read separately so that, for example, even if the degree of mental disorder does not make it appropriate for the patient to be liable to be detained for treatment, the nature of the disorder might make such detention appropriate (R v MHRT ex parte Smith [1998] EWHC 832 Admin).

10. The Code of Practice (2008) suggests (in paragraph 4.3):

"4.3 The criteria require consideration of both the nature and degree of a patient's mental disorder. Nature refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder. Degree refers to the current manifestations of the patient's disorder".

11. This does not quite reflect what I understand these ordinary words of the English language to mean but I accept this as the basis on which the parties, the expert witnesses and the First-tier Tribunal have dealt with the matter.

12. If the nature of a patient's illness is such that it will relapse in the absence of medication, then whether the nature is such as to make it appropriate for him to be liable to be detained in hospital for medical treatment depends on an assessment of the probability that he will relapse in the near future if he were free in the community and on whether the evidence is that without being detained in hospital he will not take the medication (Smirek v Williams (200) 1 MHLR 38 – CA; R v MHRT ex parte Moyle [2000] Lloyd's LR 143 – High Court).

24. In paragraph 21 of its decision the First-tier Tribunal stated:

"21. In the view of the Tribunal there is still useful and necessary and potentially beneficial work to be done with [the appellant] in hospital. Although he has completed substance misuse sessions and has made helpful contributions to group discussion, his insight into the risks associated with drug taking in the context of relapse prevention is still weak, He is still not committed to drug counselling in the community. And again, although he can organise his life in hospital and engage in activities, he is far from being able to accept responsibility for doing the same when he is on his own without the structure of the hospital to support him. Long term rehabilitation with graduated escorted and unescorted leaves into the community, where his ability to avoid risky behaviours can be monitored, has yet to be tested and [Dr E] said that a further period in hospital will be a real challenge to his commitment to show that he can provide a structure for himself".

26. I also observe that paragraph 21 of the First-tier Tribunal's decision is something of a non-sequitur. If the risk is of what might happen eventually, it is hard to see how this is tested by the periods of leave referred to in that paragraph. Also, that line of reasoning relates to the nature of the appellant's likely lifestyle on release, in particular drug taking and chaos, and not to the risk of non-compliance with medication and relapse in his mental state."

JLG v Managers of Llanarth Court (2011) UKUT 62 (AAC)

Facts and decision An appeal to the Upper Tribunal can only succeed if 'the making of the decision concerned involved the making of an error on a point of law'. The issue is whether the Tribunal did its job properly: whether (i) the tribunal asked itself the correct legal questions; (ii) it made findings of fact that were rationally based in the evidence; (iii) it answered the legal questions appropriately given its findings of fact; (iv) it gave the parties a fair hearing; and (v) it provided adequate reasons.

The UT is entitled to assume that the members of the Tribunal understand the basic legal concepts which they must apply, particularly with a specialist tribunal applying the same limited range of criteria repeatedly; the claimant's argument was essentially that the Tribunal failed to mention these matters, but there was nothing in the reasons to show that they did not understand them. The reasons, albeit discursively, had soundly and rationally addressed the statutory criteria."

DL v South London and Maudsley NHS Foundation Trust (2010) UKUT 455 (AAC)

Facts and decision The Tribunal failed to explain why it rejected medical and social reports which recommended absolute discharge. Their decision was set aside and the case remitted to the First-tier Tribunal for a rehearing.

LC v DHIH (2010) UKUT 319 (AAC)

Facts and decision The MHRT for Wales's decision not to discharge the patient, following a deferred conditional discharge, was inadequately reasoned because: (a) it took into account matters to which it had not referred in its original decision; (b) in relation to the newly-identified risk factors, either they must have been risk factors at the time of the original decision, or something unidentified must have happened to make them risk factors; (c) the tribunal could have deferred its decision for a report from the e proposed accommodation, given that all staff agreed with the transfer; (d) the transfer was recommended despite the above; (e) given the liability to recall inherent in a conditional discharge, no reason was given as to why it was necessary to retain the "support of the MHA for the time being" during the accommodation move.

The second decision had therefore to be set aside, so the original deferred conditional discharge decision remained effective, and the matter was referred to the First-tier Tribunal President for directions to arrange a further hearing.

RH v South London and Maudsley NHS Foundation Trust (2010) UKUT 32 (AAC)

Facts and decision Held that the Tribunal's reasons for refusing to grant the absolute discharge of a conditionally-discharged patient, against the unanimous evidence of the treating team and an independent psychiatrist, were adequate.

The Tribunal disagreed not with the witness's assessments but with their conclusions as to whether the restriction order should cease to have effect: that was the kind of judgment for which it is difficult to give reasons beyond those required to show that the tribunal has directed itself correctly as to the law and to show to what matters the tribunal has had regard.

The restrictions can continue in the absence of any mental disorder, and risk from possible future disorder is relevant, so the criteria here are very different from those for discharge of a CTO: in the latter a focus on the short-term position might be appropriate, whereas the Tribunal here had also to consider what might happen in the long term. Manslaughter can be punished by a life sentence with release being on life licence: this is a powerful indication that Parliament intended a long-term view of

risks to be taken; it is unsurprising that restrictions should in some cases remain in force for life.

The mere existence of current, or possible future, mental disorder is not enough to justify the continuation of a restriction order: regard must also be had to the seriousness of any risk of harm to others.

As under the new appeal system the First-tier Tribunal is not a party to proceedings, it is unsatisfactory for public authority respondents (the responsible authority and, in restricted cases, the Secretary of State) to make no submissions at all; submissions would assist even if drafted by non-legally-qualified caseworkers; for instance, the respondent might concede that the Tribunal erred in law but ask the Upper Tribunal to substitute its own decision rather than remit the case.

R (Manns) v London North and East MHRT (1999) EWHC 497 (Admin)

Facts and decision A Tribunal had been entitled to find that there was an enduring mental illness based on symptoms before transfer to hospital and that it was asymptomatic because of a response to medication; this entitled it to reject an opinion in favour of discharge which was based on the view that there was no enduring illness.

R (SSHD) v MHRT, re CH (2005) EWHC 746 (Admin)

Facts and decision There were no discernible reasons given for preferring patient's evidence to RMO's; material reason given in subsequent witness statement which had not originally been recorded.

GENERAL ERRORS OF SUBSTANTIVE LAW AND REASONABLENESS

MEANING AND LAWFULNESS OF "TREATMENT"

B v Croydon Health Authority (1995) Fam 133

Facts and decision In this case medical treatment for mental disorder under Section 63 of the Mental Health Act 1983 includes treatment of the symptoms of the disorder (as well as the disorder itself) and includes a range of acts ancillary to the core treatment and on the facts, nasogastric feeding was treatment ancillary to treatment for psychopathic disorder.

R (SC) v MHRT (2005) EWHC 17 (Admin)

Facts and decision In deciding not to discharge, Tribunal can consider disorders other than those from which the patient is classified as suffering.

ERROR OF LAW-BURDEN OF PROOF

R (DJ) v MHRT; R (AN) v MHRT (2005) EWHC 587 (Admin)

Facts and decision The correct standard of proof, where one applies, for the MHRT to apply is the civil standard.

R (AN) v MHRT (2005) EWCA Civ 1605

Facts and decision The MHRT should apply the standard of proof on the balance of probabilities to all the issues it has to determine.

"62. *Although there is a single civil standard of proof on the balance of probabilities, it is flexible in its application. In particular, the more serious the allegation or the more serious the consequences if the allegation is proved, the stronger must be the evidence before a court will find the allegation proved on the balance of probabilities. Thus the flexibility of the standard lies not in any adjustment to the degree of probability required for an allegation to be proved (such that a more serious allegation has to be proved to a higher degree of probability), but in the strength or quality of the evidence that will in practice be required for an allegation to be proved on the balance of probabilities.*

63. The flexibility that exists in the application of the standard is clear from In re H itself, where Lord Nicholls, whilst affirming the existence of a single civil standard, stressed that it had "a generous degree of flexibility" in respect of the seriousness of the allegation (page 586F – see also his reference, at page 587E, to "the in-built flexibility already mentioned").

This was consistent with the ECHR as:-

"78. In our judgment, the conclusion we have expressed above is in full conformity with the requirements of the ECHR.

79. In determining whether a detention on grounds of mental illness complies with article 5, the ECtHR has consistently applied the test laid down in Winterwerp v. Netherlands (1979) EHRR 387. For example, in HL v. United Kingdom (application no. 45508/99, judgment of 5 October 2004), the court stated at para 98:

> *"It is recalled that an individual cannot be deprived of his liberty on the basis of unsoundness of mind unless three minimum conditions are satisfied: he must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder (the Winterwerp judgment, at para 39 ...)."*

> *The court examined the material on which the applicant's detention had been based, and found that "the applicant has been reliably shown to have been suffering from a mental disorder of a kind or degree warranting compulsory confinement ..." (para 101).*

80. It seems to us that full effect is given to the Winterwerp test by the application of a standard of proof on the balance of probabilities and a recognition that cogent evidence will in practice be required to meet that standard. We note, too, that in Reid v. United Kingdom (2003) 37 EHRR 9, where the court repeated the Winterwerp test (see para 70 of the judgment), there was no suggestion that the standard of proof on the balance of probabilities was inappropriate or incompatible with the requirements of the ECHR, even though the court gave specific consideration to the two cases containing obiter dicta in support of that standard, namely Reid v. Secretary of State for Scotland and R (H) v. London North and East Region Mental Health Review Tribunal.

81. Mr Bowen has cited cases concerning the standard of proof required in other ECHR contexts. For example, in R (N) v. M [2003] 1 WLR 562 it was common ground, in the light of the decision of the ECtHR in Herczegfalvy v. Austria (1992) 15 EHHR 437, that the standard of proof for the purposes of determining whether medical treatment to which the patient does not consent is compatible with article 3 is that the medical necessity has been "convincingly shown": see the judgment of the Court of Appeal at para 17. At para 18 the court rejected a contention that the test was in effect the same as the criminal standard of proof, stating that no useful purpose is served by importing the language of the criminal law, that the phrase "convincingly shown" is easily understood and that the standard is a high one but it does not need elaboration or further explanation. In R (B) v. Dr SS [2005] EWHC 1936 (Admin), Charles J considered, but left open, the relationship between the "convincingly shown" standard adopted in R (N) v. (M) and the decision of the House of Lords in In re H as to the civil standard of proof in English law. He proceeded on the basis of the "convincingly shown" standard, treating it (as the parties had apparently agreed) as lying between the English civil standard and criminal standard.

82. Although the "convincingly shown" standard is arguably different from "reliably shown" and it is not necessary to decide whether that is so or not for the purposes of this appeal, it seems to us, as indicated above, that they are not likely to produce materially different results from each other or from the "clear and convincing evidence" test in Adddington v. Texas. Indeed, it seems to us to be desirable, so far as possible, for one single (though flexible) approach to be adopted for these different problems in the civil law.

83. However that may be, the language of "reliably shown" has been consistently applied under the ECHR for many years in the context of detention on grounds of mental health. It must be taken as the correct test, and the application of the standard of proof on the balance of probabilities in the way we have described is capable of meeting it."

Importantly the Court did recognise that there as a distinction between matters of fact and matters of evaluation and judgment.

It departed from the Court below and said:-

"103. We also think it likely that the tribunal's task will be made easier if, instead of dividing up the issues into matters that are susceptible to proof to a defined standard and those that are not, it approaches the entire range of issues by reference to the standard of proof on the balance of probabilities, whilst recognising that in practice the standard of proof will have a much more important part to play in the determination of disputed issues of fact than it will generally have in matters of judgment as to appropriateness and necessity.

104. For all those reasons, we respectfully differ from the conclusion reached by Munby J on this issue. We would hold that the tribunal should apply the standard of proof on the balance of probabilities to all the issues it has to determine. We would not, however, expect the difference between that approach and the approach favoured by Munby J to have much practical significance, given the limited role that the standard of proof will have in relation to matters of judgment and evaluation. Nor does the difference affect the outcome of the present appeal, since the tribunal appears to have applied the standard of proof on the balance of probabilities to all issues save the factual issues to which it applied a standard akin to the criminal standard."

In *R (H) v MHRT North and East London Region (2001) EWCA Civ 415* Section 73 MHA was held to be incompatible with Article 5 because burden of proof was placed on patient.

ERROR OF LAW-MEANING OF MENTAL DISORDER ; TEST OF NECESSITY; CONSIDERATION OF PROPORTIONALITY

DL-H v Devon Partnership NHS Trust (2010) UKUT 102 (AAC)

Facts and decision Here the Tribunal gave inadequate reasons for its decision not to discharge the patient; this decision was set aside and a re-hearing directed. Detention is authorised by reference to the twin requirements of treatment and protection, moderated by the word "necessary"; that demanding test provides ample protection without the need for any additional consideration of proportionality. There was also discussion of "appropriate treatment available" test in context of personality disorder and refusal of treatment. The following passages are of interest.

"The meaning of mental disorder

23. At one stage, I was troubled by the different approaches to classifying the patient's mental disorder that were present in the evidence. Sometimes ICD-10 was used, sometimes DSM-IV. They are broadly similar, but differ in their detail. To take one example, one of the criteria for antisocial personality disorder in DSM-IV is that the patient had a conduct disorder before the age of 15. ICD-10 does not list that as a criterion for dissocial personality disorder. Ms Butler-Cole satisfied me that the different criteria had not affected the classification of the patient's mental state on the

evidence in this case. I make the following comments for any value they may have in the future.

24. It is important to understand the purpose for which the criteria were devised. The specific criteria in ICD-10 are labelled as diagnostic criteria for research and the introduction to the published version of DSM-IV (4th edition) contains this warning:

> *'When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect."'*

That leaves open the question of how a patient's mental state is to be classified for the purposes of the Mental Health Act. The answer cannot depend on the manual that happens to be used. This is an issue that will have to be considered by the Upper Tribunal in an appropriate case. There must be an answer that provides protection for patients from vague or differing definitions while ensuring that those who present a danger are not left free to harm themselves or others for failing to meet over-prescriptive criteria."

"Proportionality

25. Mr Westgate argued that the First-tier Tribunal had to apply a test of proportionality to the patient's detention. He cited R (H) v London North and East Region Mental Health Review Tribunal [2002] QB 1. The Court of Appeal there gave a declaration that sections 72 and 73 of the Mental Health Act were incompatible with the Convention right in article 5(1)(e) of the European Convention on Human Rights. Section 72(1)(b) was amended accordingly. Mr Westgate relied on this passage:

> *'33. The circumstances of the present case, which are similar to those considered by Latham J in Ex parte Moyle [2000] Lloyd's Rep Med 143, are not uncommon. A patient is detained who is unquestionably suffering from schizophrenia. While in the controlled environment of the hospital he is taking medication, and as a result of the medication is in remission. So long as he continues to take the medication he will pose no danger to himself or to others. The nature of the illness is such, however, that if he ceases to take the medication he will relapse and pose a danger to himself or to others. The professionals may be uncertain whether, if he is discharged into the community, he will continue to take the medication. We do not believe that article 5 requires that the patient must always be discharged in such circumstances. The appropriate response should depend upon the result of weighing the interests of the patient against those of the public having regard to the particular facts.*

Continued detention can be justified if, but only if, it is a proportionate response having regard to the risks that would be involved in discharge.'

He also cited Witold Litwa v Poland (2001) 33 EHRR 53 at [78].

26. Building on those authorities, he argued that proportionality was not a question of fact and the judgment should be subjected to close scrutiny by a higher court (A v Secretary of State for the Home Department [2005] 2 AC 68 at [44]), giving appropriate respect to the view of the decision-maker (R (SB) v Governors of Denbigh High School [2007] 1 AC 100 at [30] and [68] and Belfast City Council v Miss Behavin' Ltd [2007] 1 WLR 1420 at [15], [31], [44]-[47] and [88]-[89]).

27. I am, of course, bound by all those decisions. However, they do not deal with the application of section 72 of the Mental Health Act. I do not consider that it is necessary either to introduce the concept of proportionality into the application of, or to extract it from the wording of, that section. Introducing it could divert attention from the wording of the legislation and bring with it connotations that are not appropriate in the mental health context. The tribunal must discharge the patient unless detention for treatment is necessary for the patient's health or safety or for the protection of others. The legislation authorises detention by reference to the twin requirements of treatment and protection, moderated by the word 'necessary'. That is a demanding test and provides ample protection for the patient without the need for any additional consideration of proportionality. I note that in R (CS) v Mental Health Review Tribunal [2004] EWHC 2958 (Admin), Pitchford J said at [52] that there was force in the argument that there was no additional requirement of proportionality."

The Upper Tribunal also set out a useful summary of the principles that might apply where issues of judgment are under appeal.

"28. Applying the normal principles that apply to appeals with respect to issues of judgment:

- *The First-tier Tribunal must explain why it exercised its judgment as it did. Its reasons must be adequate. They must explain at least what points the tribunal regarded as decisive (B v B (Residence Order: Reasons for Decision) [1997] 2 FLR 602 at 606). The more surprising the result, the more demanding the Upper Tribunal will be in assessing the reasons for adequacy (Jones v Governing Body of Burdett Coutts School [1999] ICR 38 at 47).*

- *There will only be an error of law in the First-tier Tribunal's exercise of judgment if the tribunal: (i) took the wrong approach in law; (ii) took account of an irrelevant factor; (iii) failed to take account of a relevant factor; or (iv) went wrong in what the courts have called the balancing exercise (G v G [1985] 1 WLR 647).*

- *In assessing the balancing exercise, the Upper Tribunal will treat the judgment with the respect appropriate to one made by a panel with combined expertise in the law, medicine and health or social care matters. The degree of respect will depend on the circumstances (Re Grayan Building Services Ltd [1995] Ch 241 at 254). In a mental health case, it must reflect the fact that the patient's liberty is at*

stake. Respect will only be appropriate in cases that are a 'close call' between the options available to the tribunal. That expression is deliberately vague; the issue does not allow of precise definition. This approach does not derive from a requirement for proportionality. It arises from the wording of the legislation when read in the context of basic principle and applied to the issue of continued detention.

- *If the Upper Tribunal re-makes the decision, it must exercise the judgment afresh, taking appropriate account of the way it was exercised by the First-tier Tribunal and of the expertise available to that tribunal (Evans v Bartlam [1937] AC 473 at 478), unless that exercise was defective in some way."*

PROCEDURAL ISSUES INCLUDING NATURAL JUSTICE

ADJOURNMENT

R v Nottingham MHRT, ex p Secretary of State for the Home Department (1988) MHLO 1

Facts and decision The Tribunal has no power to adjourn to give an opportunity for the patient's condition to improve or to see if an improvement already made is sustained.

BIAS AND NATURAL JUSTICE-PRECONCEIVED VIEWS

McGrady, Re Application for Judicial Review (2003) NIQB 15

Facts and decision The ability to disclose material to the representative on condition that it was not revealed to the patient was compatible with the Convention (obiter, since no decision had been taken on this yet).

The medical member's role is to form a provisional view on the patient's mental condition, rather than on the statutory criteria, and he discloses his conclusion during the hearing; if this approach is taken then there is no violation of Article 5(4), *DN v Switzerland* (2001) ECHR 235 distinguished.

R (RD) v MHRT (2007) EWHC 781 (Admin)

Facts and decision The communication by the medical member of a "very preliminary" view was lawful, even though it went to detainability and not merely to mental condition.

R (PD) v West Midlands and North West MHRT (2004) EWCA Civ 311

Facts and decision There was no appearance of bias when Tribunal medical member was employed by same Trust.

HUMAN RIGHTS

ARTICLE 5-NO POWER TO GRANT CONDITIONAL DISCHARGE IF IN SUBSTANCE THE DISCHARGE CONDITIONS WOULD BREACH ARTICLE 5

SSJ v RB (2011) EWCA Civ 1608

Facts and decision In this case the Court of Appeal held that the Mental Health Tribunal may not grant a conditional discharge in circumstances where the conditions would inevitably lead to an Article 5 deprivation of liberty.

This was a long running case in which an elderly man had been detained for any years in a secure psychiatric Hospital under a Mental Health Act section, with restrictions on his discharge. Initially, the First Tier Tribunal granted him a conditional discharge with considerable restrictions attached. That was then set-aside by the Regional Judge on the grounds that the decision was plainly wrong. The patient then sought judicial review of the Regional Judge's decision, which was granted by the Upper Tribunal (presided over by Lord Justice Carnwath, Senior President of Tribunals). Then, on the substantive appeal the Upper Tribunal rejected the Ministry of Justice's appeal. The Ministry of Justice then appealed to the Court of Appeal.

The Court of Appeal has decided that restricted patients could not lawfully be discharged from hospital under conditions that amount to deprivation of liberty. The previous decision of the Upper Tribunal had allowed such a move provided it was not to another hospital. The UT's position created a new and anomalous type of detention that could not have been envisaged by Parliament when it passed the Mental Health Act as it would provide less adequate safeguards for those so detained compared with other detained patients, which in turn would be discriminatory.

The judgment of Lady Justice Arden is illuminating as it considers the application of both Article 5 and Article 14 (prohibition on discrimination) to the Mental Health Act. The decision turned on whether the detention was "prescribed by law."

She had this to say:-

"***The "prescribed by law" issue under Article 8***

> *52. This is the most difficult issue. No person could fail to have sympathy with the decision of the Upper Tribunal in the circumstances of this case. The proposed conditional discharge would no doubt be more beneficial to RB than his continued detention in hospital. There is also the point made by Bean J in the IT case about this being a "curious area of human rights jurisprudence" (paragraph 32 above). The Secretary of State is in the unusual position of*

seeking to argue against a conditional discharge on the terms sought on the basis of human rights jurisprudence when (a) those terms would produce a more humane result and (b) RB is content with those terms.

53. *At the end of the day, however, I accept the submission of Mr Chamberlain that the original order made against RB authorised, and authorised only, detention in a hospital (see section 37 and section 41(3)(a) of the MHA, set out above). That conclusion seems to me to be the starting point. The consequence of that conclusion is that Mr Burrows is driven to rely for the authority to deprive RB of his liberty on the wording of section 73(2), which is wholly silent on that important point. The right to liberty of the person is a fundamental right. It has been so regarded since at least the time of the well-known provisions of clause 39 of Magna Carta, which in due course found its reflection in article 9 of the Universal Declaration of Human Rights and article 5 of the Convention. A person cannot have his right to liberty taken away unless that is the clear effect of a statute: see per Lord Hoffmann in R v Secretary of State for the Home Department, ex parte Simms [2000] 2 AC 115 at 131:*

    "Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual. In this way the courts of the United Kingdom, though acknowledging the sovereignty of Parliament, apply principles of constitutionality little different from those which exist in countries where the power of the legislature is expressly limited by a constitutional document."

54. *It is not enough that the patient is given a right to apply to the court (under section 73) if he does not know the legal basis on which he could lawfully be subjected to an order for conditional discharge to an institution other than a hospital on terms that he continued to be deprived of his liberty: see HL (paragraph 11 above). In this case, section 73(2) would not assist him because the only operative provision would be paragraph (b) of that subsection. The effect of this provision would be, for instance, that a patient who did not need to be detained in hospital for the purposes of any treatment, could be conditionally discharged on terms that involved a deprivation of liberty simply on the basis that the tribunal was not satisfied that it was not appropriate that he should not be liable to be recalled to hospital for further treatment. That provision simply does not address the reasons why in any particular case there is a need for him also to be deprived of his liberty.*

55. *The aim of the Strasbourg jurisprudence is, of course, to protect the individual against arbitrary action by the state. But that statement demonstrates important limitations on the jurisprudence. There is no Convention right to a particular type of treatment or care in detention. I would, therefore, dispute the conclusion of Bean J on that basis. If his comment (see paragraph 32 above) were carried to its logical conclusion, Strasbourg jurisprudence would*

require the UK to provide a particular form of care for a person in RB's decision. The thrust of that jurisprudence is, however, the provision of certain procedural guarantees as a bulwark against arbitrary detention by the State.

56. *As I have already pointed out, in fact the relevant jurisprudence of the Strasbourg court on this point is moulded by the doctrine of subsidiarity. It has been left to the UK Parliament to decide what is the right place for a person in the position of RB to be detained. That means that, if there is dissatisfaction with the statutory scheme, that is a matter to be taken up in Parliament unless RB can succeed under the next issue. Although a conclusion adverse to that of the Upper Tribunal is less liberal towards the individual, that result (again, unless RB succeeds under the next issue) is in law simply a function of human rights protection based on a international human rights instrument which adopts a principle of subsidiarity.*

57. *The points made by Mr Chamberlain underline this point because they show that Parliament could not have intended to create, as he puts it, a new species of detention that is potentially more detrimental to personal liberty than detention under the MHA. This is because the MHA does not specify the circumstances in which a tribunal can order a conditional discharge on terms that there is a deprivation of liberty. Moreover, section 73 appears, on its face, to be wide enough, on the Upper Tribunal's interpretation, to authorise detention for the purposes of containment rather than treatment, which is contrary to the policy of the MHA (see paragraph 24 above).”*

On the Article 14 point she made an important point about what constitutes “other status”.

62. *The justification issue*

63. *The rights of a restricted patient discharged conditionally to an institution other than a hospital on terms that he continues to be deprived of his liberty are inferior to those of a restricted patient who continues to be detained in a hospital, in particular with reference to the right to a review of his detention by the tribunal: see paragraph 27 above. In my judgment, there is no apparent reason for that disparity of rights and accordingly it weighs in the balance against the interpretation placed on section 73 by the Upper Tribunal.*

64. *I accept the submission of Mr Chamberlain that article 14, taken with article 5, is in point as regards this disparity. The words "other status" in article 14 (see paragraph 41 above) would cover a patient's status when detained in an institution which is not a hospital following their conditional discharge. In those circumstances, the Secretary of State would have had the burden of showing why, if he was wrong on the meaning of section 73, there are differences between the procedural rights given to the restricted patients detained in hospital and those detained in another institution to which they have been conditionally discharged. The onus is not on RB. Mr Burrows, however, submits that the two year period would be adequate for the latter group. That may or may not be so, but it does not really explain why they are*

not given the same privileges as the former group. Mr Chamberlain did not seek to support these differences.

65. *Accordingly I respectfully disagree with the statement in paragraph 53 of the judgment of the Upper Tribunal that there would be no breach of article 5 by reason of the order for conditional discharge which it made because the 1983 Act makes provision for the procedural safeguards guaranteed by article 5. The impact of article 14 has also to be considered.*

This case has wide implications not only for those detained subject to restriction orders but also those subject to guardianship since, on Arden, LJ's analysis, the absence of a clear intention for a section of the Mental Health Act to enable deprivation of liberty precludes such a power arising under the section.

FORCED TREATMENT

R (Brady) v Dr Collins (2000) EWHC 639 (Admin)

Facts and decision Here hunger strike was a manifestation or symptom of the patient's personality disorder, and the commencement of force-feeding was justified under Section 63 medical treatment for mental disorder; even if Section 63 did not apply, the patient lacked capacity and the doctors had acted in what they lawfully believed was his best interests.

The appropriate test when considering challenges to compulsory treatment under Section 63 was the "super-*Wednesbury*" test.

This was a case involving Ian Brady. The reference to "super-*Wednesbury* is no longer appropriate given the advent of the Human Rights Act 1998 on 2 October 2000. The Court would need to look at issues under Article 3 and Article 8 and possibly also Article 14. In relation to the latter the question can be formed thus? Should the Court take a different line when dealing with a mental patient with some capacity to make decisions about medical treatment as compared with a patient with a physical illness or disease who wishes to decline treatment? Can a difference in approach be supported under Article 14? This is what occurred in *R(PS) v Dr G* [2003] EWHC Admin 2335 which is considered next. The first issue is the Article 3 ECHR issue.

Article 3 of the Convention provides that:-

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment".

This prohibition is absolute and it is not limited by exceptions. There are two sub-issues raised by Article 3 which are relevant to this claim; the first is whether it is engaged and the second, if it is engaged, whether the proposed treatment can be justified on medical grounds.

In order to decide if Article 3 is engaged, it must be appreciated that:-

"Ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of the minimum is, in the nature of things relative; it depends on all the circumstances of the case, such as the nature and context of the treatment or punishment, the manner and method of its execution, its duration, its physical or mental effects and in some instances the sex, age and state of health of the victim" (T and V v. UK (1999) 7 BHRC 659) (with my emphasis added).

The Strasbourg Court explained the significance of Article 3 to the problem of imposing forced treatment on patients in psychiatric units when it stated, with my emphasis added, that:-

"The court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention is being complied with. While it is for the medical authorities to decide, on the basis of the recognisable rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Article 3, the requirements of which permit no derogation. The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a method which is a therapeutic necessity cannot be regarded as inhuman or degrading. The court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist" (Herczegfalvy v. Austria (1992) 50 EHRR 437, 484 at paragraph 82).

However as was noted in *PS*, although *Herzcegfalvy* determines how medical treatment can be justified, it is of little assistance as a precedent on whether Article 3 would be engaged in the present case for three reasons. First, *Herzcegfalvy* did not have capacity to consent, which was a fact to which the Strasbourg Court attached importance on the facts of that case; in contrast, PS does have capacity. Second, the treatment received by *Herzcegfalvy* was infinitely more intrusive and more invasive of the patient's autonomy than that which is proposed for the patient in *PS*-which was in the form of medication-as it entailed forcible feeding for a prolonged period under considerable restraint, resulting in the loss of his teeth and broken ribs, for example. Third, the degree of necessity for the treatment was absolutely apparent in *Herzcegfalvy*, since he was starving himself to death.

In clear view of Silber J. the case of *Herzcegfalvy* establishes that generally, "the established principles of medicine are in principle decisive; as a general rule, a measure which is a therapeutic necessity cannot be inhuman or degrading" (paragraph 82).

Other Article 3 cases are worth noting. In *Grare v. France* (1991) 15 EHRR CD 100, the Strasbourg Commission rejected as manifestly unfounded a complaint under Article 3 arising from a course of treatment which had distressing side effects for the applicant, who was a voluntary patient in a psychiatric hospital. The Commission's brief reasoning is that even if the treatment was capable of having distressing side effects, there was nothing to indicate that the treatment achieved the level of seriousness necessary to engage Article 3. If the treatment was an interference with his private life, it was then justified by the need to preserve public order and the

protection of the applicant's health. It is not clear whether the treatment in question was administered with, or without the consent of the patient, or by what means it was actually administered.

Subsequently, *Application No 1065/83 against Germany* at 7 EHRR 152 was a further Strasbourg Commission decision, which related to the forced feeding of a prisoner, who was on hunger strike. The violation of his autonomy was great and it occurred twice a day and seven times in all. Although that case involved a conflict between the prisoner's right to autonomy and his right to life, the Commission held that the case did not involve the appearance of a breach of Article 3 because inhuman treatment had to reach a certain stage of gravity, causing considerable mental or physical suffering. The Commission explained that for treatment to be degrading, the patient had to "undergo humiliation or debasement attaining a minimum level of severity". The Commission attached substantial importance to the fact that the treatment was in the prisoner's best interests and that it had been taken with a view to securing his survival.

Of importance in the assessment of a breach of Article 3 is *Keenan v United Kingdom* (2001) 30 EHRR 38, in which it was said that the assessment of the threshold for engaging Article 3 was relative as it depended on all the circumstances of the case which included the duration of the treatment, its physical or mental effects and in some cases, the age, health and sex of the victim.

The Court said that in considering whether treatment was degrading, it would have regard to whether the object of treatment was to humiliate or debase the person and whether the consequences would adversely affect him in a manner incompatible with Article 3 (paragraph 109). A further relevant factor would be whether the treatment evoked feelings of fear, anguish or inferiority, which were capable of humiliating or debasing the person and possibly breaking their physical or moral resistance or driving them to act against his will or conscience. The case established that the public authorities are under an obligation to protect the health of such persons.

In *N*, the Court of Appeal "did not find it necessary to hear argument on" whether Article 3 had been engaged [15]. At first instance in N, I had assumed as did the Court of Appeal subsequently that the proposed treatment reached the level of severity for Article 3 to be engaged. There was no finding in *Wilkinson* on whether Article 3 had been infringed.

In *PS* Silber J noted that the test to be applied before finding a breach of Article 3 is becoming stricter (paragraph 104), and significantly the Strasbourg Court has recently observed that:-

"Having regard to the fact that the Convention is a "living instrument which must be interpreted in the light of present day conditions", the Court considers that certain acts which were classified in the past as "inhuman and degrading treatment" as opposed to "torture" could be classified differently in future. It takes the view that the increasingly high standard being required in the area of the protection of human rights and fundamental liberties correspondingly and inevitably, requires greater firmness in assessing breaches of the fundamental values of democratic societies" (Selmouni v. France (2000) 29 EHRR 403 at paragraph 101).

The kinds of ill-treatment which fall within the scope of Article 3 have to be very serious as "the [Strasbourg] Court's case-law refers to "ill-treatment" that attains a minimum level of severity and involves actual bodily injury or *intense* physical or mental suffering", *Pretty v United Kingdom* (2002) 35 EHRR 1 at paragraph 52. The Strasbourg Court has stressed that "ill-treatment must attain a minimum level of severity before it will be considered to fall within the provision's code" and "the practice of the Convention requires compliance with standard of proof beyond reasonable doubt that ill-treatment of such severity occurred" (*Orhan v Turkey* App 25656/94 18 June 2002 paragraph 352).

Silber J summarised the law thus:-

"107. Thus, where medical treatment is administered on a patient against his or her will, Article 3 will only be contravened if:-

> *(i) the proposed treatment on the patient reaches the minimum level of severity of ill-treatment, taking into account all the circumstances, including the positive and adverse mental and physical consequences of the treatment, the nature and context of the treatment, the manner and method of its execution, its duration and if relevant, the sex, age and health of the patient ("the Minimum Level of Severity Sub-Issue") and*

108.

> *(ii) the medical or therapeutic necessity for the treatment has not been convincingly shown to exist ("the Convincing Medical or Therapeutic Evidence Sub-Issue").In determining if the claimant succeeds on his Article 3 claim, two separate sub-issues to be considered in turn and it is important to appreciate that the convincing medical or therapeutic evidence sub-issue only arises if there would otherwise be a breach of the Article 3 rights of PS because the minimum level of severity sub-issue has been reached. I should add that in case I am wrong and there is simply one issue to be considered, I will consider that issue after I have examined the two sub-issues to which I now turn.*
>
> *(i) The Minimum Level of Severity Sub-Issue*

109. Mr. Gledhill points out that there was no assessment of the effect on PS of anti-psychotic treatment administered to him during the trial period in 2002. He stresses that the medication is bound to have side effects and in any event, mere consideration of medication has the additional counter-productive effect of making PS anxious by the thought of medication, which is contrary to his beliefs."

On the facts of *PS* he had this to say:-

"110. It is, however, striking that although there was a trial period of using anti-psychotic medication as I have explained in paragraphs 55 and 58 above, it is not suggested the consequences of its use on that occasion to the claimant either individually or cumulatively reached the Article 3 threshold. Of course, unlike during

that trial period, PS does not now consent to its use and that is clearly a factor of considerable importance in showing that the Article 3 threshold has been reached.

111. So I must now consider the consequences of now giving Quetiapine to PS against his consent and his religious beliefs in order to see if they reach this minimum level of severity. Mr. Gledhill, who contends that they do, relies on the side-effects of Quetiapine and on the claimant's capacitated and reasoned refusal.

112. The main common side effects of Quetiapine are drowsiness and weight gain. The drowsiness is likely to be transient and to decrease with time; in any event, it is to a large extent dose-dependent. The weight gain from the dose of Quetiapine can be controlled by exercise, which is likely to be an effective remedy in the claimant's case because he is fit and health conscious. It is of considerable importance to remember that when he took Quetiapine, PS complained that he suffered from weight loss and loss of concentration.

113. Indeed, Quetiapine was chosen for him because of its limited side effects. If the treatment has to be administered to PS on a depot (injection) basis, it seems that this can cause more adverse side effects for the claimant; these effects would include sedation and neurological side effects which could be and would be counteracted by the anti-muscarinic medication authorised by Dr. W. It is appropriate at this point to consider the significance to this application of the fact that PS has capacity and still refuses to consent.

114. Mr. Gledhill contends that substantial importance must be attached to the fact that the administration of the proposed medication is contrary to PS's religious beliefs, second his other grounds for refusal and third, that it is common ground between the parties that PS has capacity; so it is said that he is different from an incapacitated patient as he is able to and does object to its administration. Thus, Mr. Gledhill submits that where a patient has capacity, the principle of personal autonomy becomes central to the law. He contends that cases such as Re W [2002] MHLR 411 make it plain that the law allows those with capacity to take treatment decisions which on any objective view are reasonable. As I have explained, the legislative provisions do make it clear that even if a patient, like PS, has capacity to object and he does object, then this objection can in appropriate circumstances be overridden whereas in this case, but not in W's case, the patient was held under the Act. (As I will explain in paragraphs 152 to 154 below, Re W relates to a factually different position from that which I am considering). There is no statutory provision nor any decided case which provides that capacitated refusal to consent overrides all other factors so that the treatment cannot under any circumstances proceed. The statutory regime shows clearly that this is not the case as I have explained in paragraphs 12 to 15 above.

115. Mr. Gledhill also seeks to obtain assistance from the approach of Simon Brown LJ in Wilkinson where he said that:-

> *"If in truth this claimant has the capacity to refuse consent to the treatment proposed here, it is difficult to suppose that he should nevertheless be forcibly subjected to it. True, Dr. Horne [the claimant's RMO] appears to regard it as his only hope of eventual return to the community. That said, however, its*

impact on the claimant's rights above all to autonomy and bodily inviolability is immense and its prospective benefits (not least given his extreme opposition) appear decidedly speculative" [30].

116. The learned Lord Justice was not saying there that a capacitated refusal "trumped" all other considerations but he was saying that it would be difficult on the facts of the Wilkinson case to authorise it. In other words, it was a case-sensitive comment and significantly, the case of the claimant is very different from Wilkinson in three important respects. First, the previous use of the medication to PS demonstrated the nature of the benefits to him of the proposed treatment. As I have explained in paragraph 55 above, there were substantial benefits to PS from the previous administration of Quetiapine between September and November 2002 and there is no reason to believe that those benefits would not reoccur if PS now takes the medication. In Wilkinson, the benefits were more speculative. Second, the risks of damage to the patient from the treatment were very substantially greater in Wilkinson's case than in PS's case. Simon Brown LJ explained that Wilkinson had previously had a heart attack and that he was suffering from angina and from a minor coronary disease with the result that there was a risk of a sudden death if the treatment in issue was administered, but fortunately that is not the position in PS's case. Indeed, PS did take the medication in 2002 and his complaints included shortness of breath and poor concentration. If these complaints were to recur if the medication is given, then the risks remain significantly much less serious from those found in Wilkinson. I have considered with care an extract from British National Formulary which was supplied to me by Mr. Gledhill and which sets out the side-effects that can be suffered by users of Quetiapine. In this case I have the additional benefit of knowing the effects of Quetiapine on PS when he used it last year and they are radically less than those that occurred in Wilkinson.

117. Third, Wilkinson had to be physically restrained on his bed. It was said by his RMO that Wilkinson's "rigid and fiercely antagonistic attitude in this matter is very unusual". By way of contrast, Dr. G said that if compulsory treatment is authorised, PS is likely to choose to take the medication orally and the side-effects of it are then likely to be less severe than if depot injection was used with the result that Article 3 is even less likely to be engaged. I accept this evidence, which seems sensible and credible in the light of his experience of PS and what happened when he was prescribed and took anti-psychotic medication in 2002.

118. In any event, there is authority that capacitated refusal does not preclude treating PS against his will because Hale LJ explained also in Wilkinson [80] that:-

> *"I do not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will. Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify. Whether the criteria for non-consensual treatment of the capacitated should be limited to treatment which is for their own safety (as opposed to their health) is a difficult and complex question. Mr. Bowen tried to persuade us that there was a developing consensus to that effect. There are indeed indications that the issue of capacity is assuming greater importance in the context of psychiatric treatment. But we*

have not yet reached the point where it is an accepted norm that detained patients who fulfil the In re MB [1997] 2 FLR 426 criteria for capacity can only be treated against their will for the protection of others or for their own safety".

119. I consider that very important factors in favour of Mr. Gledhill's case are the facts first that the claimant has capacity to consent to the treatment, second that he does not consent and third that the administration of the medication would be against his religious beliefs. Dr. W explained that there was a better than a 50/50 chance that without medication and the work that PS could do once that he had the necessary insight that he would relapse when he was next in the community. As I have explained, I found Dr. W to be an impressive witness whose evidence I found cogent on this point. Further, if PS were to relapse in the community, the consequences could well endanger his own life or that of others in the way that he did at the time of the 1995 offences.

120. I consider that even in the face of PS's capacitated opposition to it, the administration of anti-psychotic medication to PS would not reach the threshold of engaging Article 3 in the light of the possible benefits to him and the limited adverse consequences. If I had any doubt on this, I would have reached the same conclusion, in the light of the limited adverse consequences when PS took the medication in 2002. Indeed, adopting the language of the Strasbourg Court, the anticipated adverse consequences of administering the medication do not reach the "minimum level of severity" that "involves actual bodily injury or intense or physical or mental suffering" (see Pretty ibid and paragraph 103 above). Furthermore, the plan authorised by the SOAD is sufficiently flexible to respond to any adverse side-effects suffered by the claimant by changing the medication. In any event, as I have explained in paragraph 117, he is likely to consent if his present claim fails. Irrespective of that, the Article 3 claim fails but as I have heard argument on it, I will now briefly consider the second sub-issue."

On the Convincing Medical or Therapeutic Evidence Sub-Issue his conclusion was as follows:-

"121. At this stage I must assume, contrary to the conclusion that I have just expressed on the minimum level of severity sub-issue, that PS's Article 3 rights have been infringed. The Court of Appeal has recently explained that the approach to this sub-issue should be that:-

(a) "There is much to be said for the view that in these cases [in which the doctors seek to impose treatment which would contravene a patient's Article 3 rights], there is but one simple question: has the proposed treatment been convincingly shown to be medically necessary" (R (N) v. M [2003] 1 WLR 562 [19]) per Dyson LJ. Mr. Gledhill, who was also counsel for the patient on that appeal, points out that this comment was made without the benefit of argument and he contends that I should look separately at the individual questions that Dyson LJ mentioned and which I will now set out in sub-paragraph (b).

(b) The answer to the "simple question" specified in sub-paragraph (a) above, in Dyson LJ's words in R (N) v. M "will depend on a number of factors

including (a) how certain is it that the patient does suffer from a treatable mental disorder, (b) how serious a disorder it is, (c) how serious a risk is presented to others, (d) how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition, (e) how much alleviation is there likely to be, (f) how likely is it that the treatment will have adverse consequences to the patient and (g) how severe may they be?" (ibid).

(c) The proposed treatment must be in accordance with a responsible and competent body of relevant professional opinion (ibid [28] and see Re A (Male Sterilisation) 2000 1 FLR 549, 555).

(d) The mere fact that there is a responsible body of opinion against the proposed treatment is relevant to the question whether the treatment is in the patient's best interests or medically necessary, but it does not automatically mean that the treatment cannot be in the patient's best interests or not medically necessary (R (N) v. M (ibid [27] and [29]).

122. Relying on those principles, Mr. Gledhill submits that in the absence of any very strong contrary argument, the statutory provisions should be construed so that the court should not override the interests of those who have the capacity to refuse treatment and who do actually refuse, when as in PS's case there is no evidence of any danger posed by the claimant to himself, to other patients or to the public should he abscond. That, as Hale LJ explained in Wilkinson [24] in the passage that I quoted in paragraph 118 above, is not the correct criterion for deciding if the treatment in question should be permitted.

123. As I have explained in paragraph 116 above, in applying the test of the Court of Appeal whether in the form of the compartmentalised test advocated by Mr. Gledhill or of the "simple question" advocated by Dyson LJ, the fact that the claimant has capacity to consent to treatment but refuses to consent to it is a very important factor. There is, however, no basis whether derived from statute or from decided cases for concluding as Mr. Gledhill contends to be the case, that such objections of the claimant automatically and inevitably override all other issues except where the interests of other people would be affected if the medication was not administered. The views of the doctors on what constitutes the best interest of the patient is in itself also a very important consideration, which the court has to take into account. In any event, as I will explain, in this case even if Mr. Gledhill is correct and a compartmentalised approach should be adopted, the outcome will be the same as answering the "simple question" suggested by Dyson LJ. I must now consider the factors referred to by Dyson LJ and which I have set out in paragraph 121(b) above.

(a) How certain is it that the patient does suffer from a treatable mental disorder?

124. As I have explained, after considering the diagnosis issue I concluded that it is clear that the claimant is suffering from schizophrenia, which it is common ground is a treatable mental disorder.

(b) How serious a disorder is it?

(c) How serious a risk is presented to others?

125. The risk of PS causing injury to others is not very great as long as he remains in a safe and in a closely monitored environment of a medium secure unit, such as the one in which he is now living. I agree with Mr. Gledhill that it is also significant that the claimant's previous relapses have been remedied without medication. Nevertheless, as Dr. B correctly pointed out, if the claimant had a relapse in the community, the risk of injury might well be great but nobody can be sure about it. I found this evidence cogent and a factor of substantial significance as both in 1999 and 2002 there was uncertainty as to what PS had been doing or was intending to do and why during the periods before he returned to the hospital. There were and are, for example, serious and worrying doubts about his motives for going to the area in which he committed the 1995 offences in 1999 and a fear that he might have sought to contact the Pastor, even though previously he had received a caution from the police for stalking. Indeed, it was clearly a matter of great concern that PS returned to the area in which he committed the 1995 offences in 1999 in circumstances that were worrying in the light of the very serious 1995 offences that he had committed in that area. Miss. Laing points out correctly that even Dr. Hambidge accepted in cross-examination that if the claimant had not developed insight and had another schizophreniform episode and he was not detained early enough to start temporary medication, he might behave as he did on the earlier occasions when he had such episodes. Indeed, I would have reached that conclusion, in the light of the expert evidence to which I have referred in the absence of Dr. Hambidge's evidence. There was a great deal of compelling evidence which showed that the claimant presented a risk to others if he was under stress. On the basis of the evidence and of PS's previous behaviour, I conclude that Mr. Baker is correct when he submits as Miss. Laing does first that the claimant cannot function properly when he is under stress and second that he then behaves bizarrely and unpredictably, thereby making him a potentially dangerous individual to himself and to others, particularly to those known to him.

(d) How likely is it that if the patient does suffer from such a disorder the proposed treatment will alleviate the condition?

(e) How much alleviation is there likely to be?

126. It appears to be common ground that anti-psychotic medicine, such as Quetiapine, is appropriate treatment for schizophrenia. The thrust of the evidence from Dr. G, Dr. B and Dr. W was that there was a good prospect that such medication would achieve its objective of helping to prevent a relapse and to prevent a deterioration of the claimant's condition. I have no hesitation in accepting this evidence, which seems sensible and which is supported by the cogent evidence of how PS's behaviour and attitude improved when he used this medication in late 2002. Dr. G explained that when he took the medication, the claimant became more accessible and less focused in his religious beliefs. These changes would have enabled him to address his offending behaviour and to discuss it. Those were welcome improvements.

127. The expected benefits of the treatment are significant. Dr. G explained that one of the aims of treatment was to secure the claimant's discharge from hospital and that required the claimant's illness to be treated with the proposed medication. That reasoning is logical and sensible. I was very impressed with and accept the evidence of Dr. W, who was a careful and thoughtful witness and who considered that there was a good chance (expressed by him as being more than 50/50) that first, the proposed medication would achieve the purpose of suppressing PS's residual persecutory ideas and that second, it would satisfy the aim of helping the claimant to gain insight into his condition which was important because Dr. W thought that he lacked that insight at present.

128. Third, according to Dr. W, the proposed treatment would achieve the purpose that the treatment would act as a special protection against any possible future relapses on PS's part. I also accept the evidence of Dr. W that these purposes were and remain important because without medication and without the work that PS could do once he had the necessary insight, there was a better than a 50/50 chance that PS would relapse when he was next in the community. Dr. W also satisfied me that if there were any real doubts about the benefits of administering this anti-psychotic medication against PS's will, he would not have authorised it; I consider Dr. W's views on these matters to be justified and I accept them as sound and correct.

> *(f) How likely is it that the treatment will have adverse consequences to the patient and (g) how severe may they be?*

129. As I have already explained in paragraph 112 above, the most common adverse consequence that would be suffered by PS as a result of the proposed treatment would include drowsiness and weight loss, with additional risks of sedation and also neurological effects if the treatment is administered by injection. The drowsiness is transient and it will decrease in time, but it is also dose-dependent and it can be controlled if the medication has to be administered by injection. If the proposed medication was likely to have serious adverse effects, those could be removed as the plan authorised by the SOAD is sufficiently flexible to enable the treating team to respond to any untoward side effects by changing the medication by, for example, administering the prescribed anti-Parkinsonian medication. Significantly, as I have explained, the view of the treating team who know the claimant well is that if compulsory treatment is authorised, PS is likely to choose to take the medication orally. I agree with and accept that prediction; if it occurs, it means first that a breach of Article 3 becomes even more remote and second, that the potential side effects are likely to be less severe than if a depot injection had to be used. In reaching that conclusion, I have borne in mind that PS's lack of consent is an important factor, but it is not a decisive matter, particularly as PS lacks insight into his illness as a result of his illness.

130. I conclude that the proposed treatment will not have serious adverse consequences for PS. At the end of the day, I am also satisfied that in respect of each of the individual questions, the proposed treatment has been convincingly shown to be medically necessary. For the reasons that I have expressed, I would also reach the same conclusion by answering in the affirmative the simple question suggested by Dyson LJ in N namely "has the proposed treatment been

convincingly shown to be medically necessary?". Until now, I have been assuming that there are two sub-issues to be considered as set out in paragraph 107 above. In case I am wrong and there is merely one question, namely the claimant's Article 3 rights have been infringed, my answer would also be in the negative for the same reasons that I have expressed. Thus, I consider that the challenge based on Article 3 cannot succeed as it fails on both the minimum level of severity sub-issue and also on the convincing medical or therapeutic evidence sub-issue."

Article 8 of the Convention provides that:-

> *(1) Everyone has the respect for his private and family life, his home and correspondence.*
>
> *(2) There shall be no interference by a public authority with the exercise of this right except such that is in accordance with the law and is necessary in a democratic society in the interest of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

Individuals have the right not to be subjected to compulsory physical intervention and treatment and Article 8 is frequently engaged, where the minimum level of severity required in Article 3 cases has not been reached. Thus, a prima facie breach of Article 8 often occurs when treatment is given to a patient who does not consent even though he has capacity to do so.

Silber J had to reach a conclusion on Article 8 for that reason.

> *"... necessary in a democratic society for the protection of health"*

"133. The defendants contend that any breach of Article 8(1) is justifiable under Article 8(2) in this case because the proposed treatment was "in accordance with the law and is necessary in a democratic society ... for the protection of health". It is settled law that "necessary" in Article 8(2) is not synonymous with "indispensable" but the treatment would be justified "if the interference complained of [which in this case was the proposed treatment] corresponded to a pressing social need, whether it was proportionate to the legitimate aim pursued, whether the reasons given by the national authority to justify it are relevant and sufficient" (Sunday Times v. UK (1979) 2 EHRR 245 at 275 and at 277-278 respectively). This approach is logical because inherent in the interpretation of the Convention is its aim to strike a "fair balance between the demands of the general interest of the community and the requirements of the protection of the individual's fundamental rights" (see Sporrong and Lonnroth v. Sweden (1992) 5 EHRR 35 at 52). Any restriction on a guaranteed freedom, such as that set out in Article 8(1) of the Convention, must be proportionate to the legitimate aim pursued (Handyside v. United Kingdom (1976) 1 EHRR 737).

134. My starting point is that Parliament has set out the circumstances in which treatment can be imposed on a patient who does not consent and I have set out those

statutory provisions in paragraphs 12 to 15 above. I agree with Miss. Laing that the decision to administer the anti-psychotic medication has to be considered in the context that the medication is likely to lead to the claimant being rehabilitated rather than remaining subject to long-term incarceration, which would be the position if he does not obtain the medication. As I have explained in paragraph 128 above, I accept the evidence of Dr. W that the proposed treatment had a better than 50/50 chance of achieving three purposes; the first of which was principally to suppress his residual persecutory ideas, the second was to help PS to gain insight into his condition, into which Dr. W felt that at present he had no insight. The third purpose was as a specific protection against any future relapse. I also agree that without the medication, PS will continue to pose a danger to others if he is outside a hospital, especially he is in a stressful situation. Thus I conclude that the administration of the proposed medication "is necessary in a democratic society for the protection of health".

"... in accordance with the law ..."

135. In order to determine whether the proposed treatment satisfies the requirement of being "in accordance with the law", it is necessary to remember that "the best interests test" is the common law rule which shows the recognised criteria for establishing whether it is permissible to perform any proposed treatment is whether the proposed treatment is in the best interests of the patient.

136. This common law rule shows that the recognised criterion for establishing whether it is permissible to perform any proposed treatment on an incompetent adult is whether the proposed treatment is in the best interests of the patient. The idea or concept of medical necessity was established by the House of Lords in the case of In Re F (Mental Patient: Sterilisation) ([1990] 2 AC 1) especially by Lord Brandon at 55E and 56D, by Lord Goff at 78B and by Lord Bridge at 52C) as being a medical necessity which is the justification for treatment in a patient's best interests. Butler-Sloss P. has pointed out in NHS Trust A v. Mrs. M [2001] Lloyds Rep. Med 27, 35 that the "best interests" test at common law provides a more stringent safeguard than the Convention does.

137. In Re S (Adult Patient's Best Interests) [2000] 2 FLR 389 at 400, Butler-Sloss P explained, with my emphasis added, that:-

"I would suggest that the starting point of any medical decision would be the principles enunciated in the Bolam test and that a doctor ought not to make any decision about a patient that does not fall within the broad spectrum of the Bolam test. The duty to act in accordance with responsible and competent professional opinion may give the doctor more than one option since there may well be more than one acceptable medical opinion. When the doctor moves on to consider the best interests of the patient he/she has to choose the best option, often from a range of options. As [counsel for the Official Solicitor] has pointed out, the best interests test ought, logically, to give only one answer".

138. In essence, the President was stating that the courts have to approach the best interests test in two stages; they have first to see whether the proposed treatment was in accordance with "responsible and competent professional opinion" and, if so, then the court's second task is to choose the single best option. The President accepted that

her two-stage approach, with which Thorpe LJ agreed, was at variance with the comments of Lord Browne-Wilkinson in his speech in Airedale NHS Trust v Bland [1993] AC 789 at 884 (which were not agreed with or followed by other members of the Appellate Committee) which was that in accordance with Bolam, a number of different courses, rather than a single course, may be lawful in a particular situation.

139. Thorpe LJ in that case also explained the basis of the two-stage test and the width of the second stage, when he stated, with my emphasis added, that:-

"In deciding what is best for the disabled patient the judge must have regard to the patient's welfare as the paramount consideration. That embraces issues far wider than the medical. Indeed it would be undesirable and probably impossible to set bounds to what is relevant to a welfare determination. In my opinion, Bolam has no contribution to make to this second and determinative test of the judicial determination…. It is the judge's function to declare that treatment which is in the best interests of the patient and ..only one treatment can be best"

140. In that case, the President's approach similarly required that the court when dealing with the second stage should consider all relevant issues when she explained, with my emphasis added, that:-

"the principle of best interests as applied by the courts extends beyond the considerations set out in Bolam. The judicial decision will incorporate broader ethical, social, moral and welfare considerations"

141. The first stage of the President's test is satisfied in the present case because, as I have explained, the proposed treatment is in accordance with "responsible and competent professional opinion" as is shown by the views of Dr. B, Dr. G and Dr. W supported by Dr. Lowe and Dr. Myers, gave earlier SOAD certificates. In order to determine whether the best interests test has been satisfied in the sense of choosing the single best opinion, there are a number of sub-issues to be considered. In order to determine if the proposed treatment meets the best interests test. The first is whether the proposed treatment is likely to alleviate or prevent the deterioration of the claimant's condition. As I have just explained, Dr. W considered that this question can be answered in the affirmative for the reasons that I have explained in paragraph 128 above. I agree with that approach, which is supported by Dr. G and Dr. B. In any event, the improvements in PS noted after his trial of the medication in 2002 constituted an additional reason for reaching that conclusion.

142. The second sub-issue is whether there is a less invasive form of treatment that could be given to the claimant which would be likely to achieve the same beneficial results for him. Dr. Hambidge was suggesting that no treatment was necessary, but I am unable to agree with that opinion on the basis of my conclusions on the diagnosis issue. I was impressed by the evidence of Dr. W setting out the benefits of the proposed treatment. In any event, it is noteworthy that as I explained in paragraphs 53 and 54 above, Dr. Myers and Dr. Lowe both reached similar conclusions when acting as the SOADs earlier in 2002.

143. A third sub-issue to consider is whether it is necessary that the treatment should be given to PS with regard to (a) his resistance to treatment, (b) the degree to which

treatment is likely to alleviate or prevent deterioration of his condition, (c) the risk he presents to himself, (d) the risk he presents to others, (e) the consequences of the treatment not being given and (f) any possible adverse effects of the treatment.

144. As to (a), as I have explained, I agree with those who have previously treated PS that it is very likely that the claimant will agree to administration of the proposed medication other than on a depot basis. Turning to (b), as I have already stated, I consider that the treatment is likely to alleviate or prevent a deterioration for the reasons given by Dr. W and other doctors. The answer to (c) and (d) is in Dr. W's evidence, which also indicates the risks that he presents to himself or to others if he was not given treatment and he was outside his present environment when he suffered stress. Other doctors' support this evidence which is consistent with the claimant's behaviour at the time of his lapses in 1994, 1999 and 2002.

145. Turning to (e), the consequences of the treatment not being given is that the claimant is unlikely to be discharged unconditionally or to be able, if discharged, to cope in the community, especially if he suffers stress. As to sub-issue (f), as I have already explained I do not consider that any adverse effects of the medication would be very great, especially as no serious adverse effects of the treatment were apparent when the claimant took the medication at the end of 2002. Even taking into account the claimant's present hostility to the proposed treatment and his reasons for which are based on his religious views. I still do not consider that the adverse effect of taking into account this factor would be serious. Thus, I conclude that it is necessary that the claimant should have the proposed treatment as it will be in his best interest. That means that the proposed treatment thereby meets the requirement of being "in accordance with the law" but that leads to the further issue of whether it is a decision to require PS to have treatment is proportionate.

Proportionality

146. I have already explained that the adverse consequences to the claimant of taking the medication would be very limited while there were significant benefits. In those circumstances, I conclude that the administration of the proposed medication is not only "proportionate" but also, as I have explained, that it is also "necessary" for "the protection of health" of the claimant, as well as the safety and health of "others", especially when he is under stress. Thus, the Article 8 claim fails.

147. In any event, even if I was wrong on that approach, the SOAD and the RMO are entitled to an appropriate margin of discretion in making their decisions in relation to the administration of the proposed treatment. This provides an additional reason why I reject the contention that to administer the proposed medication to the claimant would infringe his Article 8 rights.

The Article 14 issue

148. Article 14 of the Convention deals with the prohibition of discrimination and it provides that:-

"The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any grounds such as sex, race, colour, language,

religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status".

149.In Wandsworth LBC v. Michalak [2003] 1 WLR 617, Brooke LJ considered that it would usually be convenient for a court when invited to consider an Article 14 issue to approach its task in a structured way by asking itself four questions and if the answer to any of those questions was in the negative, the claim was likely to fail with the consequence that it was unnecessary to proceed to consider the next questions. Those four questions are:-

"(i) Do the facts fall within the ambit or one or more of the substantive Convention provisions (for the relevant Convention rights see s1(1) of the 1998 Act)?

(ii) If so, was there different treatment as respects that right between the complainant on the one hand and the other persons put forward for comparison ("the chosen comparatives") on the other?

(iii) Were the chosen comparatives in an analogous situation to the complainant's situation?

(iv) If so, did the difference in treatment have an objective and reasonable justification: in other words, did it pursue a legitimate aim and did the differential treatment bear reasonable relationship proportionality to the aim sought to be achieved?" [19]

150. Brooke LJ, with whom the other members of the Court of Appeal agreed on this issue, pointed out that sometimes there may be a need for caution about treating these four questions as a series of separate hurdles that have to be surmounted in turn because there is a potential overlap between the considerations that are relevant when determining at any rate the last two and probably the last three questions [22].

151. In Wilkinson, Simon Brown LJ said he could not "see that Article 14 adds anything to the debate" [26]. Mr. Gledhill for the claimant, however, contends that on the facts of this case each of the questions referred to by Brooke LJ in the Wandsworth case must be answered in the affirmative and so a breach of Article 14 can be established.

152. In relation to the third and fourth questions, Mr. Gledhill points to the decision in Re W [2002] MHLR 411, which concerned a prisoner, who unquestionably suffered from a severe mental disorder but who significantly could not be detained under the Act because he did not meet the additional statutory criterion of treatability which applies in the case of psychopathic disorder but not in the case of mental illness. As W had a capacity, it was held that he could choose to refuse treatment for various self-inflicted wounds and instances of self-harm, even though those decisions of W were irrational or were manipulative in the sense that they were being used by him in a way that would force his transfer to a hospital.

153. Mr. Gledhill's submission is that mentally disordered individuals such as the claimant in Re W are entitled to refuse treatment to treat the consequences of this mental disorder because they are not held under the Act. The reasons for that is that

an additional criterion, namely the treatability of the underlying disorder is not satisfied in their case. He then contends that this raises the question why those who like PS suffer from a mental disorder, which allows their detention in hospital should be subject to an entirely different regime in relation to issues of consent. Mr. Gledhill submits that this also raises issues of proportionality. For those reasons, Mr. Gledhill submits that PS's Article 14 rights are infringed because Brooke LJ's questions can be answered in the affirmative.

154. In answer, it is said by the defendants that there are significant and relevant differences between PS and W because first PS, unlike W, is held under the Act and second, that PS meets the criterion of treatability. Indeed, the fact that PS can be treated for his condition while W cannot be treated justifies a totally different approach on the issue of administering treatment in PS's case from that adopted in W's case. I regard these points as valid and decisive in showing that the third and fourth questions in the Wandsworth case and set out in paragraph 149 above cannot be answered in the affirmative. In consequence, the Article 14 claim also fails."

There have been a series of cases in relation to forced treatment in England and Wales. To date there has only been one Scots case, decided in 2002. Human rights were argued in all of these cases.

In the *Wilkinson* case (*R(On the Application of Wilkinson) v Broadmoor Special Hospital Authority* [2001] EWCA Civ 1545) referred to in *R(PS) v Dr G* a patient challenged the use of force to take medication against his will. He alleged this breached Articles 2, 3 and 8 ECHR. He also alleged a breach of Article 6 if he was not permitted to cross-examine the doctors on why the treatment was needed.

The Court of Appeal decided that it was correct that doctors be required to attend court to justify such forced treatment. It also said that it had to be "convincingly shown" that treatment was medically necessary and in the best interests of the patient.

In *R(On the application of N) v Dr M and others* [2002] EWCA Civ 1789 the use of anti-psychotic drugs had been approved by the second opinion doctor. His independent psychiatrist did not give approval.

The claimant, N, applied for judicial review of the decisions taken by her Responsible Medical Officer and the Second Opinion Appointed Doctor (SOAD) to administer anti-psychotic drugs by injection, notwithstanding her refusal to consent to that treatment. Section of the Act provides for compulsory treatment of a patient where an SOAD has certified that the patient is incapable of understanding the nature, purpose and likely effects of that treatment, or the patient has not consented to it but the treatment should be given having regard to the likelihood of its alleviating or preventing a deterioration of his condition.

N disputed the diagnoses of the RMO and SOAD that she was suffering from a delusional disorder and a severe personality disorder. She obtained the opinion of an independent consultant psychiatrist who advised that N was unlikely to be suffering

from a psychotic illness and should therefore not be treated for such; and that N retained the capacity to make treatment decisions.

The judge at first instance, having cross-examined the relevant medical experts, concluded that N was suffering from a psychotic illness and that it was necessary that she should have the proposed treatment as being in her best interests. N had also argued that the forced treatment would amount to a breach of the Article 3 prohibition on inhuman and degrading treatment, but the judge found that the medical necessity for the proposed treatment had been convincingly shown and there was therefore no breach.

The question on appeal was whether the judge had been right to conclude that despite the fact that there was a reasonable body of opinion that the patient was not suffering from a treatable condition, it was nevertheless in N's best interests and "medically necessary" for the purposes of Article 3 that the proposed treatment should be administered.

The Court of Appeal began by asking what standard of proof would be required by Article 3 before a court could be properly satisfied that it was appropriate to give permission for treatment when faced with a patient's refusal to consent (in the absence of the patient's consent). Referring to the ECtHR case of *Herczegfalvy v Austria*, the Court confirmed that the judge had applied the right the test – ie the standard of proof required was that the court should be satisfied that medical necessity had been "convincingly shown". This was less than the criminal standard of proof, but clearly higher than a balance of probabilities test. In any event the phrase "convincingly shown" was easily understood and needed no elaboration or further explanation.

The judge had adopted the correct approach to the question of whether medical necessity for the proposed treatment had been convincingly shown. The answer would depend on a number of factors including:

· *how certain was it that the patient suffered from a treatable mental disorder;*

· *how serious the disorder was;*

· *how serious a risk was presented to others;*

· *how likely was it that, if the patient, did suffer form such a disorder, the condition would be alleviated by the proposed treatment;*

· *how much alleviation was there likely to be;*

· *how likely was it that the treatment would have adverse consequences for the patient; and*

· *how severe those consequences might be.*

In relation to the common law best interests test, the Court reiterated that it was necessary to ask whether the treatment satisfied the *Bolam* test ([1957] 2 All ER 118), i.e. that a doctor is not guilty of medical negligence if he has acted in accordance with a practice accepted as proper by a responsible body of persons who practice the same art. That was a necessary but not conclusive factor. The fact that there was a responsible body of opinion against the proposed treatment was relevant to whether it was in the patient's best interests or medically necessary, but no more than that. The court's task was to decide in light of ***all*** the evidence in the case whether the treatment should be permitted. The judge's conclusions were unassailable and, accordingly, the application was dismissed.

The Court of Appeal went on to clarify the circumstances in which the court should and could permit cross-examination in light of the *Wilkinson* case. Broadly speaking, cross-examination should only be ordered where this was *necessary* to enable the court to decide factual disputes for itself. It might be clear, even without oral evidence, that the case in favour of treatment had or had not been convincingly shown and cross-examination would not lead to a different conclusion. It should not often be necessary to adduce oral evidence and *Wilkinson* should not be seen as a charter for routine applications to the court for oral evidence in human rights cases generally

In another case a patient argued that they were entitled to a detailed statement of reasons as to why the second opinion doctor agreed to certify treatment against the will of the patient. The Court held that reasons should be given unless this was likely to cause serious harm to the health of the patient or any other person-see *R v Dr Graham Fegetter and the Mental Health Act Commission, ex p JW* [2002] EWCA Civ 554.

A Scottish challenge was taken based on *Wilkinson*. Treatment with anti-psychotic drugs was to be given against the will of the patient –see *M, Petitioner* 2003 SC 52 ; 2003 SLT 219; 2002 SCLR 1001. His argument was that an independent court was needed to meet Article 6 and that the treatment rules contained in the Mental Health (Scotland) Act 1984 were not needed in a democratic society.

The Outer House of the Court of Session did not find favour with this line. It held that a system which authorised compulsory treatment was a proportionate response to mental health needs. A person subject to the Act was not entitled to appeal decisions on treatment made under compulsory measures.

In that case M, who had been detained in a psychiatric hospital under the Mental Health (Scotland) Act 1984 Section 26 sought judicial review of a decision to administer anti psychotic medication to him despite his refusal to give his consent to such treatment. M contended that his detention and treatment were incompatible with the rights afforded to him by the Human Rights Act 1998 Sch.1 Part I, Articles 6 and 8 and 14.

The petitioner was admitted to a psychiatric hospital on a voluntary basis. He rejected efforts by the hospital staff to persuade him to resume taking a particular anti-psychotic medication. Four days later the petitioner sought to discharge himself, but was made the subject of an emergency admission under Sections 24 and 25 of the Act,

which empowered his detention for 72 hours. His responsible medical officer then presented a report to the manager of the hospital in terms of Section 26 of the Act, which led to the petitioner being detained for 28 days. That period was subsequently extended. Anti-psychotic medication was administered to the petitioner on four occasions when his status was that of a patient subject to short term detention in terms of Section 26 of the Act. The petitioner expressly declined to give his consent to the treatment, but accepted it without physical protest or resistance, having been advised that the responsible medical officer was legally empowered to administer the treatment to him without his consent.

The petitioner presented a petition seeking judicial review of various acts and failures to act regarding his detention under Section 26, and of the administration of medical treatment to him without his consent while detained under Section 26, on the grounds that his rights under Articles 6(1), 8 and 14 of the ECHR had been breached. The petitioner argued that by dispensing with the need for patient consent the Act deprived the petitioner of his common law right to refuse medical treatment, and it was accordingly a determination of his civil rights and obligations effected otherwise than by an independent and impartial tribunal (Article 6). He argued that the legislative provisions relating to administration of compulsory medical treatment without consent were broader than necessary in a democratic society and incorporated apparently arbitrary limits, and lacked appropriate procedural safeguards (Article 8) He argued that detained patients in mental hospitals were discriminated against (Article 14).

He maintained that as a medical officer was legally empowered to administer medication to a detained patient against his will, the act of detention deprived a patient of the common law right to refuse medical treatment and that such deprivation constituted a "determination" within the meaning of Article 6(1) but not a determination effected by an "independent and impartial tribunal".

M further contended that the interference with his rights was not, for the purposes of Article 8, "necessary in a free and democratic society".

Lord Eassie refused the petition on the basis that the reliance on Article 6(1) was erroneous as M's complaint related to the substantive content of the 1984 Act, namely the category of people defined by that Act to object to treatment by particular limits.

With regard to the Article 8 issue was whether or not the departure from the principle of autonomy was sufficiently proportional. In the instant case the action taken did not violate the rights guaranteed by the Human Rights Act. Lord Eassie said at paragraph [26] that:-

"26 I do not consider it necessary for me to set out in greater detail the recommendations of the Millan Committee since it is neither necessary, nor in any way appropriate, for me to express any view on those recommendations. All of its terms, the review of the literature, and the documents referred to by counsel for the petitioner, indicate that there is a current debate as to the definition of the areas in which involuntary treatment is appropriate. It may be that, as a result of that debate, the legislature may choose to alter the current provisions. But that does not mean that

the present provisions of the 1984 Act offend against the Convention. Given the understandable general recognition that in the treatment of psychiatric illness some degree of involuntary treatment may be appropriate, it appears to me that it has not been demonstrated that the provisions of part X of the 1984 Act, when properly viewed in the context of the Act, are so clearly out of line with the legislation in force in other states participatory in the Council of Europe that it can be affirmed that the provisions of the 1984 Act are 'not necessary in a free and democratic society'."

A separate line of argument that Article 8 was breached because of a lack of procedural safeguards was also rejected, mainly on the same footing that the authority to determine that compulsory medical treatment was needed flowed from the decision of the Sheriff under 1984 Act procedures that detention for medical treatment was necessary.

As for the Article 14 argument that too failed. Lord Eassie said:-

"36 The only comparator mentioned in the petition is 'a patient offered treatment for physical (rather than mental) disorder' [Record, p 25E – F]. The distinction between treatment for physical illness or injury and treatment for mental disorders is evident from, among others, the various papers and international documents to which I was referred. In the course of his submissions, junior counsel for the pursuer did not indeed seek to advance any argument that the petitioner was in an analogous situation to a patient offered treatment for physical injury. He set course on the rather different tack, not suggested in the pleadings, of referring to and adopting the submission respecting art 14 which had been advanced by counsel for the claimant in R (Wilkinson) v Broadmoor Special Hospital Authority , namely a comparison between voluntary patients in a mental hospital and detained patients in such a hospital, the submission being narrated or summarised by Simon Brown LJ at para [14] in these terms:

'Article 14 submits [counsel for the claimant], is also breached here because no sufficient reason exists for distinguishing between those capacitated patients who are detained and those who are not. Non-detained capacitated patients cannot, of course, be treated against their will. Even a detained prisoner, provided always he is of sound mind, can be allowed to starve himself to death: see Secretary of State for the Home Department v Robb [1995] Fam. 127 .'

That contention was not in the event one which the Court of Appeal in that case required to address but in my view it requires little imagination to see that those attending voluntarily for treatment of mental disorder are in a different position from those who, regrettably, are in a state requiring and resulting in their compulsory detention. It is also, in my view, not difficult, as respects a further comparison which counsel for the petitioner sought to introduce in argument, to see that there is a clear distinction between the position of a person convicted of a criminal offence and consequently detained in custody but yet of sound mind and a person who is detained

in a psychiatric establishment in order that he be treated for an illness which it is thought requires compulsory detention. All these comparators are plainly not in situations which may properly be described as analogous to that of the petitioner. In his submissions senior counsel for the petitioner sought to advance yet a further comparator, namely the distinction between a person detained under the 1984 Act during his first three months and detainees after that period. However, while it may well be that under that comparison one is talking in each instance of detained patients, the difference in treatment results from the need to draw a balance between the legitimate aim of treating mental illness and situations in which the patient may not have insight into the nature of his illness and the respect for the autonomy of decision which enters into the same equation under art 8 . In other words, the submission that there is a discrimination between the detained patient during his first three months following the initial administration of medication and subsequently is simply the presentation of the same argument as was advanced respecting arbitrariness under art8 . For the reasons already given I am unable to hold that the drawing of that line does not pursue a legitimate claim and is not disproportionate in a free and democratic society.

This case suggests that if there is no right of appeal then judicial review will remain the route of challenge. A human rights challenge could be brought. However as the careful analysis of Silber J suggests, such a challenge will be hard to win unless the facts are of the strongest kind and there is a decent contrary medical case to suggest the treatment is not necessary.

Wilkinson applied to the European Court of Human Rights. He did not succeed-see *Wilkinson v United Kingdom* [2006] ECHR 1171. His complaints did not get beyond the admissibility stage.

The applicant's complaints were all declared inadmissible. He had complained that: (1) medical treatment against his will was a breach of the negative obligations under Articles 3 and 8; (2) the authorities failed in their positive obligation under Articles 3 and 8 to provide suitable safeguards against the imposition of treatment that would violate his rights, in particular that the authorities should have sought approval from a court before imposing treatment and that he should have been able to bring a challenge against the treatment, before it took place, in a court which would have been able to provide a suitable level of review; (3) the inability to have a determination of his 'civil right' to autonomy in a court that would have provided a review on the merits was a violation of Article 6; (4) the lack of effective remedy was a breach of Article 13; (5) discrimination on the basis of his status as a detained patient was a breach of Article 14.

This is the approach the European Court took:-

> ***"B. Article 3 of the Convention***
>
> *The applicant invoked the said Article, which provides (in so far as relevant):*

"No one shall be subjected to ... inhuman or degrading treatment."

1. *Submissions of the parties*

(a) Negative obligation

The applicant submitted that the national authorities violated their negative obligation under Article 3 of the Convention by imposing medical treatment upon him against his will. He distinguished Herczegfalvy v. Austria (judgment of 24 September 1992, Series A no. 244, § 86) on the grounds that, in his case, there was compelling evidence that he had capacity to refuse treatment and/or that the treatment in question was not in his best interests. He urged the Court to conclude that the Government had failed to discharge its burden to prove the medical necessity of the treatment.

The Government argued that, at the time of the treatment in February and March 2000, there was a therapeutic need which had been convincingly demonstrated. They relied in particular on the witness statements of the RMO and the SOAD (see above).

The RMO had been responsible for the applicant's care since July 1999. He concluded that medication held out a real prospect of giving benefit to the applicant and offered the best prospect of his progressing. His view was that it would be unsafe to move the applicant to conditions of minimum security without a trial of such medication because the applicant had attempted to do dangerous things such as arson. He considered the applicant's heart and angina carefully. It was his view that the applicant did not have capacity to make the decision.

The SOAD interviewed the applicant, examined the clinical notes and discussed matters with a variety of those responsible for the applicant's treatment and care. He concluded that the RMO's treatment plan was reasonable and addressed an issue that was preventing the applicant's further rehabilitation. He concluded that it was "accepted practice to treat persons with paranoid ideation with antipsychotic medication" and that it would be "in the patient's best interests to do so". He concluded that the applicant "showed little understanding of the reasons or nature of the proposed trial of medication [and] was incapable of giving or withholding his consent to such treatment".

In response, the applicant disputed that a 'therapeutic need' for compulsory treatment had been 'convincingly demonstrated'. He contended that it was not enough to demonstrate the lawfulness of the treatment to show that two doctors, acting in accordance with a reasonable body of medical opinion, considered it to be appropriate.

(b) Positive obligation

The applicant also complained that the State was in breach of its positive obligation to provide sufficient safeguards against the imposition of compulsory treatment in circumstances where the applicant had, or might

have had, capacity to refuse treatment and did so refuse and/or where the treatment was not in his best interests. In particular, he alleged that the State had failed to provide a suitable mechanism for investigating whether the treatment would constitute a violation of Article 3 before it was imposed.

In response, the Government maintained that there was a raft of important safeguards against abuse which were more than adequate to meet Convention standards. First of all, the RMO is a doctor who acts in what he perceives to be the best interests of the patient. His professional judgment that the patient did not have capacity to make a decision and that treatment would be likely to be beneficial was the starting point. Secondly, Part IV of the 1983 Act provided for an independent second opinion to be reached in line with the judgment of the RMO before the treatment could be administered: the SOAD is appointed by the Mental Health Act Commission, an independent body and he forms his own professional judgment on the case. Thirdly, in order to form his professional opinion the SOAD is obliged to consult two persons professionally concerned with the patient's prior treatment. Fourthly, the SOAD is subject to a Code of Practice which sets out various procedural and substantive requirements that he must fulfil in forming his second opinion. Finally, in addition to the primary safeguards, there are remedies provided by the courts. If the doctors act negligently or in bad faith, they can be sued directly. In addition, the patient can bring judicial review proceedings which, in the light of the judgment of the Court of Appeal in this case, would be a full merits review, with cross-examination if necessary. Indeed, in controversial cases, the RMO or SOAD can obtain advance authorisation from the courts.

However, they submitted that prior involvement of the courts was not required by the Convention. They pointed to the fact that the White Paper did not require decisions as to involuntary treatment to be taken by a court but only by an 'independent authority', which could include an independent doctor (see § 4.2-4.3 cited above). Lastly, they pointed out that, in the above-cited Herczegfalvy case, the compulsory treatment had been administered without the prior authority of a court and this had not led to a finding of a violation of Article 3 or Article 8.

The applicant responded, disputing that judicial review proceedings would have provided a 'full merits review'. He pointed out that the scope of review in judicial review prior to 2 October 2000 (the coming into force of the 1998 Act) was governed by the Super-Wednesbury test which was not considered sufficient by the Court in Smith and Grady v. the United Kingdom (nos. 33985/96 and 33986/96, §§ 137-8, ECHR 1999 VI). Even after 2 October 2000, the courts did not go so far as to conduct a full merits review (see R (Daly) v Home Secretary [2001] 2 AC 532; R (N) v Dr M [2003] 1 WLR 562).

As to the 'mechanisms' which the State should have provided, he made the following points. In the first place, he should have been able to appeal against the proposed treatment to a court or court-like body before it was imposed (he relied on § 6.3-6.4 of the White Paper). Secondly, the safeguard provided by the SOAD was substantially weakened by the fact that he was only required to determine whether the proposed treatment was reasonable, not whether he

agreed with it. Thirdly, there was no reason why the principles in Glass v. the United Kingdom (no. 61827/00, ECHR 2004 ...) should not apply in the present case. Lastly, the argument that the treatment should be sanctioned in advance by a court was not run in the Herczegfalvy case.

2. The Court's Assessment

(a) Negative obligation

In the above-cited Herczegfalvy case, the Court said (at § 82):

> *"The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3, whose requirements permit of no derogation.*
>
> *The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist."*

The Court recalls that 'medical necessity', in this context, is not limited to life-saving treatment. It can also cover treatment, such as anti-psychotic medication, imposed as part of a therapeutic regime (see Buckley v. the United Kingdom (dec.), no. 28323/95). In addition, the decision as to what therapeutic methods are necessary is principally one for the national medical authorities: those authorities have a certain margin of appreciation in this respect since it is in the first place for them to evaluate the evidence in a particular case. The Court's task is to review under the Convention the decisions of those authorities (see H.L. v. the United Kingdom, no. 45508/99, § 98, ECHR 2004 ...).

The Court notes that, contrary to the position in the above-cited Herczegfalvy case, the central issue raised by the applicant in this context is solely the therapeutic necessity for the treatment, as opposed to the manner in which it was administered.

In this respect, it was the opinion of the RMO, the expert who had the closest contact with the applicant at the time, that the proposed treatment was in the applicant's best interests. In addition, the SOAD, an independent expert appointed by the Mental Health Act Commission examined the applicant, read the applicant's medical notes, consulted with the staff concerned and he too considered that the treatment was reasonable and, in particular, that the potential benefits of treatment outweighed the risks. The applicant alleged that the SOAD's examination lasted only five minutes. However, there was no evidence before the Court to support that assertion and the applicant himself made it clear that he did not allege that the SOAD had not taken reasonable care and indeed he conceded that he had no prospects of proving that the SOAD acted negligently. While the SOAD later withdrew his authorisation of

the treatment, this does not invalidate the SOAD's original opinion and, in any event, no evidence was presented, and the Court cannot speculate, as to his reasons for so withdrawing.

The applicant's contention was that, even if the treatment was not negligent, it was nonetheless incorrect. The Court considers that in many areas of medicine, not least psychiatry, decisions as to treatment are complex matters of judgment. Medical experts can legitimately disagree and such disagreement is not, in itself, demonstrative of an absence of medical necessity for the relevant treatment.

In the present case, the applicant has produced evidence from Dr G, a medical expert, who 'weighed up' the arguments for and against the treatment and came to a different conclusion to the RMO. It is true that some of Dr G's evidence may appear to have suggested that the RMO's treatment was unreasonable. However, the applicant made it clear that that suggestion was not part of his case to this Court and Dr G himself accepted that the RMO's assessment was based on a 'careful' review of the applicant's history and presentation and was reached 'in good faith and with concern for the applicant's welfare'. Dr G also acknowledged that there was at least some possibility of the applicant's benefiting from the treatment. Moreover, the Court notes that the RMO had significantly longer to assess the applicant than Dr G.

Furthermore, the RMO was not the first expert with care of the applicant to propose anti-psychotic treatment – Dr O, one of the applicant's previous RMOs, had also proposed it.

Finally, the RMO's decision to administer the anti-psychotic treatment was supported, not just by the independently appointed SOAD, but also by Dr S, who stated that he had experience of several patients, with previously undiagnosed mental illnesses, being so treated with successful results.

In conclusion, the evidence is not sufficient to show that the national authorities exceeded their margin of appreciation in diagnosing that there was a medical necessity for the treatment. As a result, this complaint must be dismissed as being manifestly ill-founded within the meaning of Article 35 § 3 of the Convention.

(b) Positive obligation

In Moldovan v. Romania (nos. 41138/98 and 64320/01, § 98, 12 July 2005) the Court said:

> *"The obligation of the High Contracting Parties under Article 1 of the Convention to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention, taken together with Article 3, requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to ill-treatment, including ill-treatment administered by private individuals (see M.C. v. Bulgaria, no. 39272/98, §§ 149-50, ECHR 2004-...; A. v. the United Kingdom, judgment of 23 September 1998, Reports 1998-VI, p. 2699, § 22; Z. and Others v. the United Kingdom*

[GC], no. 29392/95, §§ 73-75, ECHR 2001-V, and E. and Others v. the United Kingdom, no. 33218/96, 26 November 2002)."

The Court considers that there is a particular need for States to take such measures in the context of psychiatric hospitals, where patients are typically in a position of inferiority and helplessness (see the above-cited Herczegfalvy case).

In the present case, the Court notes the safeguards in place. The medical opinion of the patient's RMO was not sufficient to authorise the treatment: he also had to obtain a second opinion from an independently-appointed SOAD, who was obliged to consult two persons professionally concerned with the patient's prior treatment. This SOAD was then required to weigh the benefits of the treatment against the disadvantages before deciding whether the proposed treatment was reasonable in the light of the general consensus of appropriate treatment for such a condition.

The applicant argued that there ought to have been two further safeguards: the authorities should have, of their own accord, sought approval from a court before imposing treatment; or, in the alternative, he should have been able to challenge the treatment, before it took place, in a court which would have provided a suitable level of review.

As to the first of these arguments, the Court considers that given the role fulfilled by the SOAD and the facts of the present case, Article 3 did not require a prior application to a court. The above-described Recommendation does not require medical authorities to obtain such court authorisation: even in the case of particularly intrusive involuntary treatment, the authority required by the Recommendation is that of a 'competent body', defined to include persons distinct from the primary decision-maker and capable of making an independent decision. While the applicant relied heavily on the above-cited case of Glass, the first applicant in that case was not detained under the 1983 Act so that its safeguards did not therefore apply to him.

As to his second argument, the Court recalls that the applicant was given two injections. It accepts that he did not have the opportunity to challenge the first injection before it took place simply because he had no notice of it. Nonetheless the Court considers that, on the facts of this case, the lack of advance warning was compatible with the Convention since such a warning was likely, on the facts of the present case, to have caused serious harm to the physical or mental health of the patient and others. Indeed, the Court notes that the Recommendation does not require States to give advance warning to patients of proposed treatment in every case.

The applicant appeared to suggest that he did not have the opportunity to challenge the second injection prior to its administration before a court that could provide a suitable level of review. However, and even assuming that Article 3 would require such a review, the Court considers that this complaint is not borne out by the facts of this case. The applicant brought proceedings in early March 2000 after the second injection and prior to the incorporation of

the Convention into domestic law in October 2000. He was able to obtain an interim injunction preventing any further treatment pending the substantive hearing. That substantive hearing has not yet taken place (and neither has any further treatment) but, if it does, it would be decided on post-incorporation standards and the High Court would be required to examine whether the proposed treatment was medically necessary. There is no clear evidence that such a review would fail to measure up to the standards set by the Court in the Herczegfalvy case (see the Court of Appeal decision in this case and R (N) v M, cited above). There is equally nothing to suggest that, if the applicant had brought his challenge a week or two earlier, namely before the second injection, the situation would have been different: he would still have been able to obtain an interim injunction pending a substantive hearing; and the substantive hearing would still, in all probability, have been heard post-incorporation. Hence, on the particular facts of this case and assuming that Article 3 would require the availability of such a prior remedy, the applicant's complaint that he had no such prior review opportunity is unsubstantiated despite the fact that the impugned treatment was proposed prior to incorporation (a contrario, the above-cited H.L. case, § 140).

In conclusion, the Court considers that it has not been shown that the State failed to fulfil its positive obligations under Article 3 of the Convention. This complaint must therefore be dismissed as manifestly ill-founded within the meaning of Article 35 § 3 of the Convention.

C. Article 6 of the Convention

This Article provides (in so far as relevant):

> *"In the determination of his civil rights and obligations ... everyone is entitled to a fair and public hearing..."*

1. Submissions of the applicant

The applicant argued that the imposition of compulsory treatment constituted an interference with his 'civil rights' of self-determination or autonomy and to inviolability of the person. He submitted that he was entitled to a 'determination' of those rights by a Court on the merits, rather than by supervisory review. He relied, in particular, on the W. v. the United Kingdom judgment (of 8 July 1987, Series A no. 121, §§ 80-82, 87).

2. The Court's assessment

In so far as the applicant thereby complained that he did not have access, prior to treatment, to a court which could have provided a sufficient level of review, the Court has examined this complaint under Article 3 of the Convention above.

In so far as the applicant complained that he did not have access, after treatment, to a court that could have provided a sufficient level of review, it is recalled that the applicant did not allege that any action on the part of the

RMO or the SOAD was in bad faith or unreasonable so that section 139 of the 1983 Act effectively excluded any civil action.

The Court considers this complaint to be essentially the same as those made in Ashingdane v. the United Kingdom (judgment of 28 May 1985, Series A no. 93, §§ 55-60) and James v. United Kingdom (no. 20447/92, Commission decision of 5 May 1993) and that there is nothing in the facts of the present case which would distinguish it from those cases. For the detailed reasons set out in the Ashingdane judgment and James decision, respectively, the Court considers that this complaint of the applicant discloses no appearance of a violation of Article 6 § 1 of the Convention.

It follows that this part of the application must also be rejected as being manifestly ill-founded within the meaning of Article 35 § 3 of the Convention.

D. Article 8 of the Convention

The applicant further invoked this Article, which provides (in so far as relevant):

> *"1. Everyone has the right to respect for his private and family life...*
>
> *2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security ...for the protection of health ... or for the protection of the rights and freedoms of others."*

1. Submissions of the parties

The applicant raised the same complaints under Article 8 of the Convention as under Article 3 and the Government, in their observations, made the same arguments in response.

2. The Court's assessment

(a) Negative obligation

It is not disputed, and the Court finds, that the imposition of treatment on the applicant against his will on 17 February 2000 and 8 March 2000 gave rise to an interference with his right to respect for his private life, and in particular his right to physical integrity (on the latter point, see, mutatis mutandis, X. and Y. v. the Netherlands, judgment of 26 March 1985, Series A no. 91, § 22; Pretty v. the United Kingdom, no. 2346/02, §§ 61 and 63, ECHR 2002-III and Y.F. v. Turkey, no. 24209/94, 22 July 2003, § 33). The Court also finds that this interference, pursuant to section 58(3) of the 1983 Act, was lawful and pursued the legitimate aim of protecting the applicant's health. None of these points was disputed by the parties.

As to the necessity of the treatment, the Court refers, first of all, to its conclusions in that regard, set out above in the context of Article 3 of the Convention.

As to the capacity to consent, the Court notes that it was the opinion of the RMO that the applicant did not have such capacity. This conclusion was based on careful reasoning (see the RMO's witness statement cited above) and supported by the independently-appointed SOAD. As with the question of therapeutic necessity, the applicant did not argue that this decision was unreasonable but, rather, asserted that it was incorrect citing the "overall judgment" to the contrary of Dr G. The Court reiterates its reasoning above concerning the differing opinions (on therapeutic necessity) of the RMO/SOAD, on the one hand, and of Dr. G, on the other. It would add that Dr G accepted that one, if not two, of the applicant's reasons for refusing consent to treatment were based on paranoia.

In the circumstances, the Court considers that the applicant has not demonstrated that the hospital authorities were not entitled to regard him as lacking the capacity to consent to the treatment in question (see, mutatis mutandis, the above-cited Herczegfalvy judgment, at § 86). It concludes that the interference with his right to respect for his private life has not been shown to be disproportionate.

This complaint must also therefore be dismissed as manifestly ill-founded within the meaning of Article 35 § 3 of the Convention.

(b) Positive obligation

The Court has repeatedly held that, while the essential object of Article 8 is to protect the individual against arbitrary interference by the public authorities, it does not merely compel the State to abstain from such interference: in addition to this negative undertaking, there may be positive obligations inherent in effective respect for private or family life. These obligations may involve the adoption of measures designed to secure respect for private life (for example, Botta v. Italy, judgment of 24 February 1998, Reports 1998 I, § 33).

For the reasons set out above as regards the alleged breach of the positive obligations under Article 3, the Court considers that it cannot be said that there was a failure to provide sufficient safeguards to ensure respect for the applicant's private life.

Accordingly, this complaint must also be rejected as being manifestly ill-founded within the meaning of Article 35 § 3 of the Convention

D. Article 13 of the Convention

The applicant further complained under Article 13 that there was no effective remedy in respect of the alleged breaches of Articles 3, 6 and 8. Article 13 of the Convention provides as follows

> *"Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."*

The Court recalls that Article 13 requires a domestic remedy in relation to any "arguable claim" of a violation of another Convention right: for the reasons outlined above as regards Articles 3 and 8, the Court does not consider that this application discloses any arguable claim of a violation of Articles 3 or 8 of the Convention (Boyle and Rice v United Kingdom judgment of 27 April 1988, Series A no. 131, § 52). In addition, it is not necessary to rule on the complaint under Article 13 in conjunction with Article 6 since the latter constitutes the lex specialis as regards the complaint examined thereunder.

It follows that this part of the application must be rejected as manifestly ill-founded within the meaning of Article 35 § 3 of the Convention.

E. Article 14

The applicant invoked Article 14 which provides as follows:

> *"The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."*

The applicant complained that he was discriminated against on the grounds of his status as a patient in a psychiatric hospital. In particular, he submitted that there could be no justification for the fact that compulsory treatment was permitted in relation to capable individuals detained under the 1983 Act when it was not permitted in relation to other persons who were not so detained. Secondly, he submitted that he was provided with a lesser degree of legal safeguards against the imposition of unlawful treatment than the generality of patients.

The Court recalls, in the first place, that the decision of the RMO was taken on the basis of his conclusion (supported by the SOAD) that the applicant lacked capacity to consent. The Court has not accepted the applicant's suggestion under Article 8 that the RMO's finding was incorrect. Accordingly, there was no difference of treatment between capable individuals detained under the 1983 Act and other capable individuals, not so detained. The second complaint is undeveloped and unsubstantiated."

PART 3-EUROPE

DETENTION OF PERSONS OF UNSOUND MIND AND ARTICLE 5 ECHR

Article 5 provides:-

" *Right to liberty and security*

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

> *a. the lawful detention of a person after conviction by a competent court;*
> *b. the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;*
> *c. the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;*
> *d. the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;*
> *e. the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;*
> *f. the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition."*

GENERAL PRINCIPLES

Winterwerp v Netherlands (1979) 2 EHRR 387

Facts This is the classic case in the jurisprudence of the European Court of Human Rights on mental health detention. The patient had been detained on a compulsory basis under Dutch law. He made arguments under Articles 5 and 6.

He had been told of court orders which had been renewed from time to time but had not been given notice of proceedings in progress and had not been allowed to appear

or be represented. On other occasions requests for release were not given to the relevant court by the official in question who was entitled to take this action.

Because of his detention the patient lost his legal capacity to administer property. The European Court had to consider what unsound mind meant under Article 5(1)(e); whether the legislation was compatible with Article 5 and whether the automatic loss of capacity breached Article 6.

Held There had been violations of Articles 5(4) and 6. The Court had no difficulty in holding there had been breaches of both Articles 5(4) and Article 6.

In relation to the question of "unsound mind" the Court held that this did not mean a person could be detained simply because their behaviour or views differed from societal norms – whatever they might be! This is consistent with Section 328 of the 2003 Act and in particular Section 328(2) which puts limits on what can be considered a mental disorder so for example drug dependency or not acting as any no prudent person would act are not mental disorders. As for what was an "unsound mind" the Court said:-

"This term is not one that can be given a definitive interpretation: ... it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes ..."

It follows that in determining whether someone is of unsound mind there must be reliable evidence from an objective medical expert and a mental disorder must be of a kind warranting compulsory confinement and must persist during the period of detention (paragraph 39).

However since the medical profession are still developing a notion of what constitutes an unsound mind it should not be give too definitive an interpretation and relevant domestic law must be applied in line of current psychiatric knowledge (paragraphs 37 and 38).

An unsound mind does not include holding views or exhibiting behaviour that deviates from the prevailing norms of society (paragraph 37).

The Court held that there are three basic requirements for detention under Article 5(1)(e) – the mental disorder is established by objective medical evidence; the nature or degree of the disorder must be sufficiently extreme to justify detention and finally the detention should only last as long as the mental disorder at an appropriate level of severity persisted.

The procedure has to be one that is prescribed by law. "Prescribed by law" has a particular meaning in Convention jurisprudence. Law must be accessible, foreseeable and certain.

In relation to the question of review the Court heard there must be a review of periodic intervals which must be reasonable and the reviewing body must be "court-like" albeit it did not require to be a "classic court". It must be independent of the

Executive and parties and the procedure must be of judicial character. Broadly speaking this means the person affected should have access to such a body and the ability to be heard or represented.

Inevitably the European Court accepted that in dealing with a person with mental disorder there would require being certain flexibility in the exercise of procedure and the rights to be given to the patient but the core essence of the right should be maintained.

The Court also made the point that because of the particular circumstances prevailing in mental health cases there may in fact need to be special additional procedural safeguards.

An early application of these principles in a United Kingdom context arose in *Ashingdane v the United Kingdom* (1985) 7 EHRR 528 where the Court held there was no violation of Article 5(1) - even though the applicant, who was suffering from paranoid schizophrenia, had been exposed to the stricter regime of a new psychiatric institution, for nineteen months longer than his mental state required, the place and conditions of the applicant's detention did not cease to be those capable of accompanying "the lawful detention of a person of unsound mind".

Detention under Article 5(1)(e) is justified not only in the public interest but also on the interests of the individual themselves – G*uzzardi v Italy* (1983) EHRR 333 at paragraph 98.

MEANING OF DETENTION UNDER ARTICLE 5

Detention has the same meaning in mental health cases as it does with other types of Article 5 detention and so it covers both detention, special secure establishments and detention in non-secure hospitals – *Ashingdane v United Kingdom* at paras 42 and 47.

Substance not form is relevant to the determination of whether someone is detained. That came over very clearly in *HL v United Kingdom* (2005) 40 EHRR 32. This case is commonly known as "Bournewood".

HL, who suffered from severe autism and challenging behaviour, lacked capacity to decide where he wanted to live. After many years in a psychiatric hospital he lived with carers for three years. Then while at a day centre his behaviour deteriorated and he was informally admitted to hospital. He was denied contact with his carers for three months and the intention was to keep him in hospital. Because he was "compliant" it was asserted that he was not deprived of his liberty.

The European Court held that he had been deprived of his liberty. He had no recourse to the protections offered by the Mental Health Act 1983 (such as the ability to challenge detention and the restrictions on treatment). As a result of the lack of procedural regulation and limits, the hospital's health care professionals, most certainly in good faith, had assumed full control of the liberty and treatment of a vulnerable incapacitated individual. The absence of procedural safeguards and access to the court amounted to a breach of Article 5(1) and (4).

Note by way of contrast at the stage of the House of Lords, *R (L) v Bournewood Community and Mental Health NHS Trust* (1998) UKHL 24, the House of Lords had considered the issue of unlawful detention under English common law whereas the ECHR were concerned with deprivation of liberty under Article 5. That is an important distinction. The common law did not carry the procedural rights which exist under Article 5. That was the crucial distinction.

It was of course held in *Anderson v Scottish Ministers* [2003] 2 AC 602; 2002 SC (PC) 63 ; 2001 SLT 1331 that detention on the basis of treatability is not a sufficient basis for initial detention but that "serious harm test is". Nor was it contrary to the ECHR to change the criteria for admission or release because the notion of unsound mind and the requirements of the ECHR are not fixed. This is a clear application of *Winterwerp* on this issue.

Broadly speaking *Anderson* justifies retrospective legislation on mental health provisions. Moreover since psychiatric opinion is subject to change governments must be free to alter their laws and policies to reflect that change. Furthermore for detention in a hospital to be lawful (as an alternative to prison) for those with mental health problems, it is not dependent on there being an alleviation of the detainees mental health condition.

Nowicka v Poland [2003] MHLR 130 there was a violation of Article 5(1) on account of the applicant's detention for 83 days for psychiatric tests ordered during proceedings that concerned a dispute between neighbours.

In *M.R.L and M.-J.D. v France*, 19.05.2004, there was a violation of Article 5(1) (e) - maintaining the applicant on the premises of a psychiatric infirmary had no medical justification but was for purely administrative reasons (the applicant had been taken to hospital following a dispute between neighbours and had been presented to a psychiatrist who, not being able to diagnose his mental state precisely, decided to have him taken to the psychiatric infirmary of the police headquarters).

In *Enhorn v Sweden* [2005] 41 EHRR 30, there was a violation of Article 5(1) as other measures that would have been less severe than compulsory isolation to prevent the applicant from spreading HIV had not been envisaged; by extending over a period of almost seven years the order for the applicant's compulsory isolation, the authorities had not struck a fair balance between the need to ensure that the HIV virus did not spread and the applicant's right to liberty.

DETENTION NOT TO BE ARBITRARY

Under the Article there must be a relationship between the basis for detention and the place and conditions of detention. Arbitrariness also embraces the notion that the detention must be necessary or proportionate. There has to be a sufficient link between unsound mind and the need for detention for medical treatment.

It follows that for the detention to be lawful it will lawful if effected in a hospital, clinic or other appropriate institution designed to deal with mental illness– *Aerts v Belgium* (1998) 29 EHRR 50 at paragraph 46.

Accordingly temporary detention in a prison psychiatric wing pending placement in an appropriate hospital did not provide a proper therapeutic environment and was harmful to the individual's mental health and so Article 5 would be breached – *Aerts v Belgium* at paragraph 49 qualifying the earlier decision *Ashingdane v United Kingdom* (1985) 7 EHR 528 at paragraph 44.

Accordingly one issue relating to the lawfulness of detention under Article 5(1)(e) is the ability to test the appropriateness of the place or also of the conditions of detention –see *Aerts v Belgium* at paragraph 54. There the maintaining of the applicant in a psychiatric wing of an ordinary prison and not in a social protection centre designated by the competent Mental Health Board amounted to a violation of Article 5(1) - the psychiatric wing could not be regarded as an institution appropriate for the detention of persons of unsound mind.

In a child case, *Nielsen v Denmark* (1989) 11 EHRR 175, there was no violation of Article 5(1) where the hospitalisation in a Child Psychiatric Ward of the applicant, who was suffering from nervous disorders and whose custody was in dispute between his parents had been "a responsible exercise by his mother of her custodial rights in the interest of the child".

In contrast in *Varbanov v Bulgaria*, decided on 05.10.2000, the applicant was taken by force to a psychiatric hospital for tests on a public prosecutor's orders during court proceedings. There was a violation of Article 5(1) - the applicant's deprivation of liberty had been decided without any legal basis and domestic law did not afford the requisite protection against arbitrariness.

PRESCRIBED BY LAW

Further under Article 5(1)(e) the appropriate procedure laid down in domestic law must be strictly followed and the law itself must conform to the general requirements of the ECHR of what is "law". It must be accessible, clear and not arbitrary – *Winterwerp* paragraph 45. I do not think that this deviates from the line in domestic caselaw that not all failures of procedure are fatal. *Winterwerp* is concerned about material issues.

Where the procedural requirements of domestic law are not complied with, detention will be unlawful under Article 5(1)(e) – *Van Der Leer v Netherlands* (1990) 12 EHRR 567 at paragraph 22. There is a right to damages under Article 5(5).

In *Schneiter v Switzerland*, 31.03.2005 the application was inadmissible. The applicant's placement in solitary confinement had been "in accordance with a procedure prescribed by law"; the placement had not been arbitrary because the applicant, who had already been deprived of liberty in being admitted to a psychiatric hospital for various manic-delusional disorders and multiple drug addiction, probably

constituted a danger for himself and for others (he was in conflict with his father and had struck a nurse on the face).

EMERGENCY ADMISSIONS

Emergency cases can constitute an exception to the rule that individuals should not be detained until "reliably" shown to be of unsound mind – *Winterwerp* at para 39.

Where such an emergency confinement is authorized by domestic law there is no requirement as a matter of practicality that a thorough medical examination be carried out prior to detention. In these circumstances the interests of the community at large outweigh the rights of the individual and the normal guarantees implied by Article 5(1)(e) see *X v United Kingdom* (1981) 4 EHRR 188 at paragraphs 41 and 45. Accordingly it is sufficient for emergency admissions to consult experts and witnesses by telephone rather than hearing them in person – *Wassink v Netherlands* (1990) A/185-A at paragraphs 33-34.

In *Herz v Germany*, decided on 12.06.2003, there was no violation of Article 5(1) (e) where temporary confinement had the aim of establishing whether the applicant was suffering from a mental illness and had been ordered by the court based on a medical opinion. However there was a violation of Article 5(4) as the fact that a measure of temporary confinement had expired could not deprive the applicant of the right to challenge its lawfulness.

In the case of *C.B. v Romania*, decided on 20.04.2010, the Court found two violations of Article 5(1) (e) and 5(4), because the applicant's confinement in the context of proceedings brought against him by a policemen for bringing malicious accusations had been unlawful (confinement based on the investigators' doubts as to the applicant's mental health and on a medical certificate by a general practitioner who had never seen him; no alternative measure examined; use of force during arrest). There was a violation of Article 5(4) as the confinement measure had not been the subject of any review by the courts.

In the case of *Shtukaturov v Russia*, decided on 27.03.2008, the Court found a violation of Article 6(1), Article 8 and Article 5(1) and 4. The violation of Article 5(1) - the decision to hospitalise the applicant had been based purely on the applicant's legal status, as defined ten months earlier; the Court therefore considered that it had not been "reliably shown" that the applicant's mental condition had necessitated his confinement.

There was a violation of Article 5(4) - the applicant could not pursue any legal remedy to challenge his continued detention as he had been deprived of his legal capacity. A violation of Article 6 (1) as the proceedings to deprive the applicant of his legal capacity at his mother's request had been vitiated by procedural irregularities (in particular a ten-minute hearing).

VOLUNTARY ADMISSIONS

Article 5 does not stop voluntary admission and voluntary detention where someone seeks help. The fact that someone does so does not mean that the guarantees in Article 5 do not continue to apply. The right to liberty is too important for a person to lose the benefit of the protection of the convention for the single reason they give themselves up to detention – *De Wilde, Ooms* and *Versyp v Belgium* (1971) 1 EHRR 373 at paragraph 65. This is a reflection of the need to protect vulnerable persons. It is a good case to use to argue that someone is detained as a matter of fact even if not formally detained.

PERIODIC REVIEWS OF DETENTION

Article 5 (4) provides a review of any detention. For those detained on mental health grounds this must be a periodic review because detention is lawful only for as long as the condition persists and persists with sufficient intensity as was said in *Megyeri v Germany* (1992) 50 EHRR 584 at paragraph 22.

The reviewing body must be a court but this does not necessarily mean a court in the classic sense of the civil court. It is sufficient if the body is judicial in character. On the face of it the MHTS is such a body because it is independent of the parties and the executive and can provide procedural guarantees appropriate to the type of detention under review – see *De Wilde, Ooms and Versyp v Belgium* at paragraphs 76-77.

In the recent case of *Halilovic v Bosnia and Herzegovina* (2009) ECHR 1933 the appellant's detention for 4 years 5 months was pursuant to an administrative decision, as opposed to a decision of the competent civil court as required by the amended domestic legislation, and so breached Article 5(1); compensation of €22,500 was awarded. The Article 3 claim relating to conditions of detention failed.

Oversight by a specialized body like MHTS is sufficient provided it meets the criteria. It must be able to make legal binding decisions. It can.

An advisory opinion alone would not meet the criteria and see e.g. *Benjamin and Wilson v United Kingdom* [1998] EHRLR 226.

As was seen in the recent case of *Black (as curator litem of patient M) v The Mental Health Tribunal for Scotland and The Scottish Ministers* [2011] CSIH 83 this approach was confirmed by the Inner House.

NATURE OF PERIODIC REVIEW

Since continued detention under Article 5 remains lawful only for as long as the mental health condition persists and persists with efficient intensity the reviewing body (a) must have the power to investigate and determine the detainee's current mental state. Although in England and Wales at least habeas corpus proceedings may suffice in emergency cases, they are not exacting enough for general purposes, further review is required – *X v United Kingdom* (1981) 4 EHRR 188.

PROCEDURAL SAFEGUARDS AT REVIEW HEARINGS

What is required by way of procedural safeguards a periodic review will vary – *Wassink v Netherlands* at paragraph 30.

So for example in *Shulepova v Russia* (2008) ECHR 1666 there were violations of both Article 5(4) and Article 6.

Under Article 5(4) the applicant was not detained in accordance with a procedure prescribed by domestic law. There was also a violation of Article 6(1) as by appointing the hospital's employees as psychiatric experts, the domestic courts placed the applicant at a substantial disadvantage, in breach of the principle of equality of arms.

In *DN v Switzerland* (2001) ECHR 235 the psychiatrist who sat as judge rapporteur on the Administrative Appeals Commission had, before the hearing, concluded that the patient should not be released.

The European Court held that the patient had legitimate fears that the doctor had a preconceived opinion and was not acting impartially; this was reinforced because he was sole the psychiatric expert and the only person who had interviewed her. Article 5(4) having been breached, damages and costs were awarded. Of importance here is that the fears were objectively held. Essentially the appearance of matters would have led an independent observer to the conclusion that there was a reasonable appearance of bias.

Overall in terms of principle what is essential is that the person concerned should have proper access to a court and a proper opportunity to be heard either in person or through a representative. Further procedural safeguards may be required for those with mental health problems – see *Megyeri v Germany* at paragraph 22 and *Winterwerp v Netherlands* at paragraph 60.

The burden is on the authority detaining the person to justify the detention. Article 5(4) does not require detainees to prove grounds of unlawfulness nor in terms of procedure do they have to take the initiative themselves in obtaining legal advice and representation – *Winterwerp v Netherlands* paragraph 60. All of this imposes am inquisitorial burden on the reviewing body.

TIMING OF REVIEWS

The initial reviews should take place very speedily. So far example a six week delay would be unacceptable even as an emergency measure – *Winterwerp v Netherlands* at paragraph 66. Five months, four months, eight weeks or even 3 weeks have all been held to be too long and on the latter see *Wassink v Netherlands* paragraph 34.

The conduct of the patient can however be relevant so for example the following have been held to count against delay being relevant. So for example absconding *Keus v Netherlands* (1990) 13 EHRR 700 para 26, a need for additional reports *Boucheres v France* (1991) 69 DR 236 or the lodging of excessive proceedings as in *Luberti v Italy* (1984) 6 EHRR 440 paragraph 34 or the conduct of their legal representative

could be relevant in the term or whether a review has been conducted quickly enough. For conduct of a representative see *Boucheres v France.*

Subsequent reviews are not so strict. Even so there still needs to be expedition and short intervals are called for where conditional release has been ordered but then deferred- *Johnson v United Kingdom* (1997) 27 EHRR 296. There the applicant, who had been convicted of various offences, was placed in a high-security psychiatric institution on a judge's orders in 1984 and his release was ordered in 1989, his confinement no longer being justified. There was a violation of Article 5(1)(e) on account of the prolonging of the confinement after that date (lack of adequate safeguards, especially judicial supervision to ensure that the applicant's release was not excessively delayed).

Recently in *S v Estonia* (2011) ECHR 1511 the European Court looked again at delay. Under domestic law S a review hearing into her case should have been heard 'promptly' after the county court ruled on her compulsory admission to hospital, but was not heard for 15 days; no adequate justification was given; this was a considerable portion of the three-month admission period; the domestic supreme court noted the procedural violation but offered no redress: overall, there had been a breach of Article 5(1), in that she was not detained in accordance with a procedure prescribed by law. Compensation of €5000 was awarded.

RELEASE

In general terms the European Court has been cautious in relation to release. As was said in *Luberti v Italy* at paragraph 29:

"The termination of the confinement of an individual who has previously been found by a court to be of unsound mind and to present a danger to society is a matter of the concern, as well as that individual, the community in which he will live if released."

Where the release case concerns homicide the release assessment is particularly difficult – *Luberti* at paragraph 29; *Gordon v United Kingdom* (1986) 47 DR 36.

Even where an expert opinion is to the effect that a mental condition is no longer present this does not automatically justify release because the assessment of mental illness is not an exact science – *Johnson v United Kingdom* paragraph 61.

Conditional release include appropriate medication can be justified – *W v Sweden* (1988) 59 DR 158; *L v Sweden* (1988) 61 DR 62.

In the Scottish application of *Hutchinson Reid v the United Kingdom* (2003) 37 EHRR 9 there was no violation of Article 5(1) where the European Court in considering the risk that the applicant, who was confined to a psychiatric institution, might commit other offences, probably of a sexual nature, held that the decision not to release him, which had a legal basis in domestic law, had been justified.

CONDITIONS OF DETENTION

Under Article 5 detention must be lawful and in principle the detention of an individual is only lawful if effected in a hospital, clinic or other appropriate institution – *Aerts v Belgium* at paragraph 46. The reason why detention in a facility other than one of this is because the detention could be seen as arbitrary as not being for the purpose of treatment linked to mental health.

Recently in *Stanev v Bulgaria* (2012) ECHR 46 ; (2012) MHLO 1 the applicant's placement in a social care home for people with mental disorders and his inability to obtain permission to leave the home led to breaches of Article 5(1), (4) and (5). The living conditions in the home also led to breaches of Article 3, and of Article 13 in conjunction with Article 3. The lack of access to a court to seek release from partial guardianship breached Article 6(1). No separate issue arose under Article 8 so it was unnecessary to examine that complaint. Compensation of €15,000 was awarded.

Temporary placement in a prison psychiatric wing does not provide a proper therapeutic environment and can be harmful to health. If that is so then Article 5 will be breached – see *Aerts v Belgium* qualifying *Ashingdane v United Kingdom* paragraph 44.

More recently in *Hadzic and Suljic v Bosnia Herzegovina* (2011) ECHR 911 the applicants had been detained for several years in a prison 'Psychiatric Annex' which was an inappropriate institution for the detention of mental health patients, in breach of Article 5(1); the applicants were awarded compensation of €15,000 and €25,000 respectively.

TREATMENT AND ARTICLE 3

We have looked at issues on forced treatment under Scots and English law. It is worth stressing the Strasbourg principles. Article 3 provides:-

> *"* *Prohibition of Torture*
>
> *No one shall be subjected to torture or to inhuman or degrading treatment or punishment."*

The threshold of Article 3 is high. Where conditions of those detained under Article 5(1)(a) are so poor that they lead to a deterioration in mental health, Article 3 might be engaged, but not otherwise – *Aerts v Belgium* paragraph 66.

It is also difficult to show that treatment administered in itself is inhuman or degrading such as for example unpleasant side-effects caused by medication – *Garre v France* (1992) 15 EHRR CD 100.

Likewise the forceful administration of food and drugs to a patient on hunger strike together with the use of handcuffs fastened to a security bed provided that the measures conformed to "psychiatric principles generally accepted at the time" and could be justified on the grounds of medical necessity did not breach Article 3 – *Herczegfalvy v Austria* (1992) 15 HRR 437 at paragraph 83.

If the forceful administration of drugs is the only method for stabilising and ultimately improving the mental health of a patient then it can be justified even if carried out under constraint – *X v Germany* (1980) 20 DR 193; *Buckley v United Kingdom* (1997) 23 EHRR CD 129.

Bear in mind though according to paragraph 82 of *Herczegfalvy* because patients tend to be in a position of inferiority and lack power, extra vigilance is required in reviewing whether the ECHR is being complied with.

It should also be borne in mind that the ECHR is a living instrument to be interpreted according to contemporary standards and expectations. What was acceptable say in 1980 or 1990 may no longer be acceptable. One emerging issue is the question of whether in a situation where a patient retains some insight or limited capacity, whether forcible medical treatment can in fact be anti-therapeutic and therefore potentially in breach of Article 3.

Article 3 has been argued in the following cases. In *B. v Germany*, decided on 10.03.1988, there the applicant had complained about the conditions of his pre-trial detention, claiming that he had not been able to receive suitable medical treatment for his state of health, which had been weakened by the suffering he had endured in a concentration camp between 1940 and 1945. No violation of Article 3, the applicant having been treated for psychological problems in prison and the medical reports not being sufficiently conclusive to justify his allegations about incompatibility with detention.

Aerts v Belgium, maintaining of the applicant in a psychiatric wing of an ordinary prison and not in a social protection centre designated by the competent Mental Health Board. No violation of Article 3: the living conditions in the psychiatric wing did not seem to have had such serious effects on his mental health as would bring them within the scope of Article 3.

In *Peers v Greece* (2001) 33 EHRR 51, a prisoner detained in the prison's psychiatric hospital and then in solitary confinement. Violation of Article 3 on account of the detention conditions, which had diminished the applicant's human dignity and given rise in him to feelings of anguish and inferiority capable of humiliating and debasing him and possibly breaking his physical or moral resistance.

In *Romanov v Russia*, decided on 20.10.2005: detention of applicant in the psychiatric ward of the detention facility to undergo tests. Violation of Article 3: the applicant's conditions of detention, in particular the severe overcrowding and its detrimental effect on his well-being, combined with the length of the period during which the applicant was detained in such conditions, amounted to degrading treatment.

Article 3 has a procedural dimension as well as a substantive one. For example in *Filip v Romania*, decided on 14.12.2006, there was a violation of Article 3 because of the lack of a thorough and effective investigation into the applicant's allegation of ill-treatment in a psychiatric hospital.

In *Rupa v Romania*, decided on 16.12.2008, the applicant, who was suffering from psychological disorders and was registered by the public authorities as having a second-degree disability on that account, complained about inhuman and degrading physical conditions in police station cells. Violation of Article 3, especially on account of a lack of appropriate medical attention in view of the applicant's vulnerable psychological state (the authorities had been under an obligation to have him examined by a psychiatrist as soon as possible in order to determine whether his psychological condition was compatible with detention, and what therapeutic measures should be taken).

In the case of *Soering v the United Kingdom* (1989) 11 EHRR 439, the Court took the applicant's mental health into account (paragraph 109):-

"Although it is not for this Court to prejudge issues of criminal responsibility and appropriate sentence, the applicant's youth at the time of the offence and his then mental state, on the psychiatric evidence as it stands, are therefore to be taken into consideration as contributory factors tending, in his case, to bring the treatment on death row within the terms of Article 3".

Suicide or the risk of suicide can raise questions under Article 3 but also Article 2. In *Keenan v the United Kingdom* (2001) 33 EHRR 38, the applicant, who was suffering from paranoia, committed suicide in prison after being placed in the segregation unit as a punishment. There was no violation of Article 2 because no formal diagnosis of schizophrenia had been submitted to the Court and the authorities had made a reasonable response to his conduct, placing him in hospital care and under watch when he showed suicidal tendencies.

There was a violation of Article 3, on account of the lack of effective monitoring, the lack of informed psychiatric input into his assessment and significant defects in the medical care provided. Moreover, the imposition on him of a serious disciplinary punishment, which might well have threatened his physical and moral resistance, had not been compatible with the standard of treatment required in respect of a mentally-ill person.

In *Rivière v France*, decided on 11.07.2006, the applicant had been diagnosed with a psychiatric disorder involving suicidal tendencies and the experts were concerned by certain aspects of his behaviour, in particular a compulsion towards self-strangulation. He complained about his continued imprisonment in spite of his psychiatric problems which required treatment outside the prison. There was a violation of Article 3 as the applicant's continued detention without appropriate medical supervision had constituted inhuman and degrading treatment (prisoners with serious mental disorders and suicidal tendencies required special measures geared to their condition, regardless of the seriousness of the offence of which they had been convicted).

In *Renolde v France*, decided on 16.10.2008, there was a suicide in pre-trial detention of a man suffering from acute psychotic disorders in violation of Articles 2 and 3. The Court reiterated that the vulnerability of mentally ill people called for special protection and it was struck by the fact that, despite the applicant's first suicide attempt and the diagnosis of his mental condition, it did not appear that there had ever been any discussion of whether he should be admitted to a psychiatric institution. No

consideration seemed to have been given to his mental state – even though he had made incoherent statements during the inquiry into the incident and had been described as "very disturbed" – because three days after his suicide attempt he had been given the maximum penalty by the disciplinary board, namely 45 days' detention in a punishment cell.

In *De Donder and De Clippel v Belgium,* decided on 06.12.2011, there was a suicide in prison by a mentally disturbed young man placed in the ordinary section of the prison. There was a violation of Article 2 concerning the circumstances of the death of the young man in prison, but no violation of Article 2 concerning the effectiveness of the investigation. However reiterating its case-law to the effect that in principle, the "detention" of a person as a mental health patient was "lawful" for the purposes of Article 5 only if effected in a hospital, clinic or other appropriate institution, the Court held that there had been a

In *Wilkinson v United Kingdom* [2006] ECHR 1171, the applicant's complaints were all declared inadmissible. He had complained that: (1) medical treatment against his will was a breach of the negative obligations under Articles 3 and 8; (2) the authorities failed in their positive obligation under Articles 3 and 8 to provide suitable safeguards against the imposition of treatment that would violate his rights, in particular that the authorities should have sought approval from a court before imposing treatment and that he should have been able to bring a challenge against the treatment, before it took place, in a court which would have been able to provide a suitable level of review; (3) the inability to have a determination of his 'civil right' to autonomy in a court that would have provided a review on the merits was a violation of Article 6; (4) the lack of effective remedy was a breach of Article 13; (5) discrimination on the basis of his status as a detained patient was a breach of Article 14.

REMEDIES FOR CONDITIONS OF DETENTION

Compensation is available where conditions of detention fall below ECHR standards. Where conditions render otherwise lawful detention unlawful there is an enforceable right to damages under Article 5(5).

As a matter of procedure where an individual seeks an order that he or she is being transferred to an appropriate place as required by 5(1)(e) and seeks in addition compensation and default this is a determination of civil rights and obligations for the purposes of Article 6 – see *Aerts v Belgium*.

ALCOHOLICS

Article 5 can justify the detention of alcoholics and also vagrants.

Alcoholism and vagrancy are not uncommon factors in mental health cases although of course under the 2003 Act alcoholism or vagrancy are not in themselves a basis for detention. At most they might reflect an underlying mental disorder.

The purposes of Article 5(1)(e) includes the protection of the public and the protection of the individual himself or herself.

As a result alcoholics, under Article 5(1)(e), are not limited to clinical alcoholics and includes those temporarily under the influence of alcohol. Even so detention is only justified only where an individual poses a threat to others or a threat to himself – *Litwa v Poland* (2001) 33 EHRR 53 at paragraph 61.

Detention is not necessary unless authorities can show other measures short of detention were considered or rejected. It is not difficult to justify the intentions of someone under the influence of drink provided other measures have at least been considered – see paragraph 79.

"Vagrants" is not defined but the Convention did not disapprove a Belgian definition of vagrants as "persons with no fixed abode, no means of subsistence and no trade or profession"-see *De Wilde, Ooms* and *Versyp v Belgium* (1971) 1 EHRR 373.

MENTAL HEALTH AND ARTICLE 8

Article 8 may also be relevant. This Article provides:-

" Right to Respect for Private and Family Life

1 Everyone has the right to respect for his private and family life, his home and his correspondence.

2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

It protects privacy, moral and physical integrity. It can provide a basis for challenging conditions of detention and its threshold is not as high as Article 3. Article 8 is however qualified. Article 8 can be breached where the authority has enjoyed too much discretionary power in relation to interfering with correspondence, since this is often a detainee's only contact with the outside world – *Herczegfalvy* paragraph 91.

"The preservation of mental stability is an indispensable precondition to effective enjoyment of the right to respect for private life" -Bensaid v the United Kingdom (2001) 33 EHRR 10.

Any interference with private life must be in prescribed by law. It must be necessary (proportionate) in a democratic society so as to secure one or more of the aims in Article 8(2). The following cases show the possible reach of Article 8.

In *A.G. v Switzerland* although the application was held inadmissible (09.04.1997), the Court found that "the decision to place a person in guardianship constitute[d] an interference with private life that must be in accordance with the law and based on a legitimate aim".

In *Storck v Germany* , decided on 16.06.2005, the Court found a violation of Article 8 and Article 5(1) concerning the applicant's detention that had not been ordered by a court.

The above case also concerned forced medication. As regards this complaint, the Court found there had been no violation of Article 8 (it had not been proved that the applicant had not validly given her consent to the medical treatment). In the case of *Schneiter v Switzerland* (31.03.2005: application inadmissible), the Court found that the complaint under Article 8 was ill-founded because the forced medication had a legal basis and pursued a legitimate aim (protection of the rights and freedoms of others). The applicant, who was being treated in a psychiatric hospital for various manic-delusional disorders and multiple drug addition, had struck a nurse on the face.

However in *Shopov v Bulgaria* (02.09.2010, not final) the imposition of psychiatric treatment for over five years violated Article 8 as the continuing interference with the applicant's right to respect for private life had a legal basis, but the regular judicial supervision required by the relevant legislation had not been forthcoming.

Article 8 has been used in a number of non-detention contexts. So in *X. and Y. v the Netherlands* (1986) 8 EHRR 235 a 16-year-old girl, mentally handicapped, had been sexually abused by the son-in-law of the directress of the privately-run home for mentally handicapped children where she was living.

There was a violation of Article 8 as Dutch law did not allow for proceedings to be brought in the event of sexual violence against mentally handicapped minors of 16 or more.

In *Bensaid v the United Kingdom* (2001)33 EHRR 10, the applicant, who was treated for schizophrenia, complained that his proposed expulsion to Algeria would leave him without adequate medical treatment, threatening his physical and moral integrity. The Court held there was no violation of Article 8 – for the Court, the risk for the applicant's mental health was based on largely hypothetical factors and it had not been established that his moral integrity would be substantially affected by the situation.

In *K. and T. v Finland*, decided on 12.07.2001, the placement in care of the children of the first applicant, who had been hospitalised several times for schizophrenia amounted to a violation of Article 8 on account of the placement of one of the children, and no violation in respect of the other child, who had previously been placed in a home with the applicants' consent; his need for special care justified an emergency care order.

ARTICLE 8 AND LEGAL CAPACITY

Article 8 has been successfully invoked in contesting guardianship. Here are some examples.

Shtukaturov v Russia, decided on 27.03.2008, there the applicant was placed in guardianship at his mother's request. Violation of Article 8 - the court had based its decision on a medical report that had not analysed sufficiently the degree of the applicant's incapacity.

In *Berková v Slovakia*, decided on 24.03.2009, there the applicant, who had a mental disorder, was placed in guardianship. There was a violation of Article 8, because she had been prevented for too long from requesting the restoration of her legal capacity.

In *Salontaji-Drobnjak v Serbia*, decided on 13.10.2009, a placement in guardianship of the applicant, who had been diagnosed with litigious paranoia.

There was a violation of Article 8 on account of the serious limitation of the applicant's legal capacity (he was unable to independently take part in legal actions, file for a disability pension, or decide about his own medical treatment) and because the procedure which the domestic courts had applied when deciding on it had itself been flawed.

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