SECOND DIVISION, INNER HOUSE, COURT OF SESSION

[2024] CSIH 21
XA39/2023

Lord Justice Clerk
Lord Malcolm
Lord Doherty

OPINION OF THE COURT

delivered by LORD DOHERTY

in the Appeal to the Court of Session under section 322(1)(g) of
the Mental Health (Care and Treatment) (Scotland) Act 2003

by

AB

Appellant

against

A decision of the Mental Health Tribunal for Scotland dated 19 July 2023 communicated to the appellant on 2 August 2023

Appellant: Springham KC, Black; Balfour and Manson LLP
Respondents: J McKinlay; Mental Health Tribunal for Scotland
Interested Parties: D Edwards; Scottish Government Legal Directorate

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30 July 2024

Introduction

[1] The appellant is aged 80. He is a patient in hospital where he receives compulsory medical treatment by reason of a Transfer for Treatment Direction ("TTD"). The respondent is the Mental Health Tribunal for Scotland. The interested parties are the Scottish Ministers.

[2] In 1988 the appellant was convicted of rape and murder. He was sentenced to life imprisonment with a punishment part of 14 years. In March 1992, because of a deterioration in his mental health, a transfer direction was made (in terms of section 71 of the Mental Health (Scotland) Act 1984) and he was transferred from prison to the State Hospital. The transfer direction was required because prisons do not have power to provide compulsory medical treatment to prisoners. Compulsory treatment (now under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003) for prisoners can only be provided in hospital. The appellant was returned to prison in December 1992, but his mental health again deteriorated. In December 1993 a further transfer direction was made and he was re-admitted to the State Hospital. He remained there until September 1998, at which time the Secretary of State for Scotland consented in terms of section 29(1) of the Mental Health (Scotland) Act 1984 to his transfer to a different hospital. In January 2001 the Scottish Ministers consented in terms of section 29(1) to his transfer to another medical facility; and in May 2009 they consented in terms of section 218(3) of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") to his transfer back to the previous hospital. In May 2021 the Scottish Ministers consented to his transfer to another hospital, and in June 2021 they consented to his transfer back to the previous hospital. He has been detained there compulsorily for treatment since that date by reason of the December 1993 transfer direction. In terms of article 29(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Transitional and Savings Provisions) Order 2005 (SSI 2005/452) that transfer direction falls to be treated as if it was a TTD made in terms of section 136 of the 2003 Act.

[3] Following a review in early 2023 pursuant to sections 206 to 208 of the 2003 Act, which review included the obtaining of a report from Dr Chris O'Shea, Consultant Forensic Psychiatrist, the appellant's responsible medical officer ("RMO"), Dr Shani Ross, Consultant

Rehabilitation Psychiatrist, submitted a report to the Scottish Ministers opining that the criteria for a TTD were no longer met and recommending its revocation. The Ministers, having obtained their own report from Dr Stuart Doig, Consultant Forensic Psychiatrist, disagreed with the RMO's opinion and recommendation. They considered that the criteria for a TTD continued to be met. They referred the case to the respondent (in terms of sections 210(3) and 213(2) of the 2003 Act). The appellant obtained a report from Dr Karen Bett, Consultant Psychiatrist, who opined that the criteria for a TTD continued to be met. Following a hearing the respondent determined that the criteria were not met. It directed the Ministers to revoke the TTD. The appellant appeals to this court against the respondent's decision.

The relevant legislation

[4] The 2003 Act provides:

> "**1 Principles for discharging certain functions**
>
> (1) Subsections (2) to (4) below apply whenever a person … is discharging a function by virtue of this Act in relation to a patient who has attained the age of 18 years.
>
> (2) In discharging the function the person shall … have regard to the matters mentioned in subsection (3) below in so far as they are relevant to the function being discharged.
>
> (3) The matters referred to in subsection (2) above are –
>
> (a) the present and past wishes and feelings of the patient which are relevant to the discharge of the function;
>
> (b) the views of –
>
> (i) the patient's named person;
>
> …
>
> which are relevant to the discharge of the function;
>
> …

(c) the importance of the patient participating as fully as possible in the discharge of the function;

…

(e) the range of options available in the patient's case;

(f) the importance of providing the maximum benefit to the patient;

(g) the need to ensure that, unless it can be shown that it is justified in the circumstances, the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation;

(h) the patient's abilities, background and characteristics...

(4) After having regard to –

(a) the matters mentioned in subsection (3) above;

…

(c) such other matters as are relevant in the circumstances,

the person shall discharge the function in the manner that appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances. …

136 Transfer of prisoners for treatment for mental disorder

(1) This section applies where a person (in this section referred to as the "prisoner") is serving a sentence of imprisonment.

(2) If the Scottish Ministers are satisfied, on the written reports of an approved medical practitioner and a medical practitioner as to the matters mentioned in subsection (3) below, they may, subject to subsection (5) below, make a direction (referred to in this Act as a "transfer for treatment direction") authorising the measures mentioned in subsection (6) below.

(3) The matters referred to in subsection (2) above are –

(a) that the conditions mentioned in subsection (4) below are met in respect of the prisoner;

(aa) that —

(i) a mental health officer has agreed to the making of the direction, or

(ii) it has been impracticable to obtain the agreement of a mental health officer;

(b) that the prisoner could be admitted to the hospital to be specified in the direction before the expiry of the period of 7 days beginning with the day on which the direction is made; and

(c) that the hospital to be so specified is suitable for the purpose of giving medical treatment to the prisoner.

(4) The conditions referred to in subsection (3)(a) above are –

(a) that the prisoner has a mental disorder;

(b) that medical treatment which would be likely to –

(i) prevent the mental disorder worsening; or
(ii) alleviate any of the symptoms, or effects, of the disorder,

is available for the prisoner;

(c) that if the prisoner were not provided with such medical treatment there would be a significant risk –

(i) to the health, safety or welfare of the prisoner; or
(ii) to the safety of any other person; and

(d) that the making of a transfer for treatment direction in respect of the prisoner is necessary.

206 Review of hospital direction and transfer for treatment direction

(1) This section applies where a patient is subject to –

…

(b) a transfer for treatment direction.

(2) The patient's responsible medical officer shall, during the period of 2 months ending with the relevant day, carry out a review in respect of the direction by complying with the requirements set out in subsection (3) below.

(3) Those requirements are –

(a) to –

(i) carry out a medical examination of the patient; or

(ii) make arrangements for an approved medical practitioner to carry out such a medical examination;

(b) to consider –

(i) whether the conditions mentioned in subsection (4) below continue to apply in respect of the patient;
(ii) whether, as a result of the patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment; and
(iii) whether it continues to be necessary for the patient to be subject to the direction; and

(c) to consult –

…

(i) the mental health officer; and
(ii) such other persons as the responsible medical officer considers appropriate.

(4) Those conditions are–

(a) that the patient has a mental disorder;

(b) that medical treatment which would be likely to–

(i) prevent the mental disorder worsening; or
(ii) alleviate any of the symptoms, or effects, of the disorder,

is available for the patient; and

(c) that if the patient were not provided with such medical treatment there would be a significant risk–

(i) to the health, safety or welfare of the patient; or
(ii) to the safety of any other person. …

215 Powers of Tribunal on reference under section 210(3), 211(2) or 213(2) or on application under section 214(2)

(1) This section applies where–

(a) a reference is made under section 210(3), 211(2) or 213(2) of this Act;
…

(4) If the Tribunal–

(a) is satisfied that the patient has a mental disorder; but

(b) is not satisfied–

(i) that, as a result of the patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment; and

(ii) either—

(A) that the conditions mentioned in paragraph (b) and (c) of section 206(4) of this Act continue to apply in respect of the patient; or

(B) that it continues to be necessary for the patient to be subject to the direction,

the Tribunal shall direct the Scottish Ministers to revoke the direction to which the patient is subject.

(5) The Scottish Ministers shall, if directed to do so by the Tribunal under subsection … (4) above, revoke the direction to which the patient is subject.

…

216 Effect of revocation of direction

(1) This section applies where, under section 210(2), 212(3) or (4) or 215(5) of this Act, the Scottish Ministers revoke –

(a) a hospital direction; or

(b) a transfer for treatment direction.

(2) Where the Scottish Ministers revoke a direction they shall direct that the patient be admitted to a prison, institution or other place in which the patient might have been detained had the patient not been detained in hospital by virtue of the direction.

(3) The direction shall cease to have effect on the patient's admission to the prison, institution or place to which the patient is admitted by virtue of the direction under subsection (2) above.

…

322 Appeal to Court of Session against certain decisions of the Tribunal

(1) This section applies to the following decisions of the Tribunal –

…

(g) a decision to make a direction under section 215(3) or (4) of this Act;
…

(2) A relevant party to proceedings before the Tribunal may appeal to the Court of Session against a decision to which this section applies.

(3) Subject to subsection (4) below, in this section "relevant party" means–

(a) the person to whom the decision relates;

…

324 Appeals: general provisions

(1) An appeal–
…

(b) to the Court of Session under section 322(2) of this Act, may be made only on one or more of the grounds mentioned in subsection (2) below.

(2) The grounds referred to in subsection (1) above are–

(a) that the Tribunal's decision was based on an error of law;

(b) that there has been a procedural impropriety in the conduct of any hearing by the Tribunal on the application;

(c) that the Tribunal has acted unreasonably in the exercise of its discretion;

(d) that the Tribunal's decision was not supported by the facts found to be established by the Tribunal.

(3) The Tribunal may be a party to an appeal under section … 322(2) …

…

(5) In allowing an appeal under section … 322(2) of this Act the court–

(a) shall set aside the decision of the Tribunal; and

(b) shall–

(i) if it considers that it can properly do so on the facts found to be established by the Tribunal, substitute its own decision; or
(ii) remit the case to the Tribunal for consideration anew.

(6) If the court remits a case under paragraph (b)(ii) of subsection (5) above, the court may–

(a) direct that the Tribunal be differently constituted from when it made the decision; and

(b) issue such other directions to the Tribunal about the consideration of the case as it considers appropriate. …"

The hearing before the Tribunal

[5] The Tribunal considered documentary and oral evidence. Oral evidence was given by the appellant; his named person; the RMO; the appellant's Mental Health Officer ("MHO"), Ms Sarah Olsen; Dr O'Shea; Dr Doig; Dr Bett; and a criminal justice social worker, Ms Laura Braham.

[6] It was common ground that the appellant had a mental disorder (section 215(4)(a)); that it was not necessary for the appellant to be detained in hospital in order to protect any other person from serious harm (section 215(4)(b)(i)); and that the conditions mentioned in paragraph (b) and (c) of section 206(4) continued to apply. The contentious issue was whether it continues to be necessary for the appellant to be subject to the TTD (section 206(3)(b)(iii)).

The documentary evidence

[7] In her report the RMO opined that the appellant did not meet the criteria for a TTD. She considered his bipolar affective disorder to be in remission. In her view the matters of continued concern were the appellant's physical and sexual aggression and violence, and these were related not to his bipolar disorder but to his underlying personality disorder which could be managed in a prison environment. She noted that when the appellant was in prison he was extremely difficult to manage, became extremely depressed and attempted suicide. She observed:

> "If he was not provided with medical treatment, it is a possibility that [he] would have a manic relapse of Bipolar Affective disorder and with that would be of significant risk to himself and others. There is no confirmed evidence of manic or psychotic symptoms in many years. It is unknown what effect reducing with a plan to stop his medication would have on his mental state with possibility varying from no change in his mental state, to worsened emotional instability to a hypomanic, manic, or depressive relapse."

She concluded that it was not necessary for the appellant to be subject to the TTD.

[8] In his report Dr O'Shea noted that there were differing opinions as to whether the appellant had displayed recent symptoms of mania, with his previous RMO being of the view that he had manic symptoms in 2021. The appellant has bipolar affective disorder and a mixed personality disorder. The mainstay of his medical treatment is antipsychotic and mood stabilising medication. Dr O'Shea opined that without his psychotropic medications it would be likely that the appellant's mental health would deteriorate leading to a worsening of his manic symptoms and placing himself or others at risk of increased harm. His violence and aggression and sexually inappropriate behaviours were not attributable to his bipolar disorder but were caused by his personality disorder. His personality disorder could be managed in the prison estate. Dr O'Shea opined that it was no longer necessary for him to be subject to his TTD. He acknowledged that there would be concerns about the appellant's mental health deteriorating were he to be returned to prison. His psychotropic medications within prison would need to be supervised.

[9] The report from the appellant's MHO indicated that she had "come to agree with" the opinions of the RMO and Dr O'Shea and that she too was satisfied that the TTD criteria are no longer met. She suggested that the appellant will likely find a transfer back to prison very difficult, but "if he continues to consent to taking his prescribed medication and engages with the mental health team whilst in prison then his mental state should remain stable".

[10] In his report Dr Doig highlighted that transition from in-patient psychiatric services back to prison is a vulnerable period in a patient's care pathway and is associated with an increased risk of relapse in mental illness and suicide. The risk of the appellant disengaging from treatment for his bipolar disorder was real and likely to happen quickly in prison. In his forties he had coped poorly in prison and there was nothing to suggest that he was now likely to adapt to it more successfully. The TTD remained necessary. Continued treatment in hospital would be more beneficial to him than the treatment which could be provided in prison.

[11] In her report Dr Bett opined that the TTD remained necessary because of the real risk that if returned to prison the appellant would not take the medication for his bipolar disorder with consequent deterioration in his mental health. She noted that the appellant's cognitive impairment had been diagnosed as being multifactorial and non-progressive, but she considered it more likely to be progressive and attributable to vascular dementia.

[12] A letter to the Ministers dated 12 June 2023 from the Scottish Prison Service's Head of Health expressed concerns that non-compliance by the appellant with his medications could lead to a significant deterioration in his health. In her view it would be detrimental to the appellant to return him to prison.

The oral evidence

[13] The only summary of the oral evidence is provided in the Tribunal's decision. The salient points were as follows.

[14] The RMO indicated that the appellant had capacity to decide whether or not to take his medication. There was a significant risk to his health, safety and welfare and the safety of other persons if he did not take it. Nevertheless, in her view medical treatment did not require to be provided in hospital. She was not aware of the section 1 principles in the 2003

Act. Recently the appellant had been moved to a 4-bedded unit for male patients. He had settled there. A recent assessment of his cognitive impairment had produced a higher score than previously.

[15] Dr O'Shea accepted that if the appellant did not comply with his medication in prison his mental health could deteriorate. Nevertheless, he considered that the TTD was no longer necessary. He could be provided with the necessary treatment in prison.

[16] In Dr Doig's view the TTD was necessary because a transition back to prison would likely result in the appellant's disengagement from treatment for his bipolar affective disorder, with an increased and immediate risk of relapse in mental illness and suicide.

[17] The MHO agreed with the RMO and Dr O'Shea that the TTD was no longer required.

[18] Dr Bett opined that the complexity of the appellant's medical health problems made her believe that he would not agree to continue to take his medications in prison. As a result of his institutionalisation and cognitive decline she could not see how he could be transferred and managed with dignity in prison.

[19] Ms Braham deponed that in general needs are not met within the prison service to the same extent as within the NHS.

[20] The appellant's evidence was that he did not want to go to prison. If he went back he would end up cutting his wrists. While he did not like his new unit as much as his previous one, he was able to have conversations with staff which he found helpful.

[21] The named person's evidence was that it would be very bad for the appellant to go back to prison. It would be terribly hard for him to reintegrate there.

The Tribunal's decision and reasons

[22] At paragraphs 20 and 21 of its decision the Tribunal opined:

> "20 … Medical treatment which would be likely to prevent his disorder worsening, or alleviate any of the symptoms, or effects, of this disorder is available for the patient. The patient is receiving antipsychotic and mood stabilising medication and has nursing staff boundary management. Without this treatment his mental health would deteriorate, and he would relapse. If the patient were not provided with this medical treatment there would be a significant risk to his health, safety or welfare and to the safety of others. However, we accept the views of the RMO, Dr O'Shea and the MHO that none of the required treatment needs to be provided in a hospital setting.
>
> 21 … Whilst there is a complex clinical picture (and the personality disorder requires to be considered under the 2003 Act), we accepted that the distilled down management of medication and boundary setting need not be provided in hospital. It could just as effectively be provided in a prison setting for this patient."

[23] At paragraph 22 the Tribunal indicated that where there were differences of opinion it attached more weight to the evidence of the RMO and Dr O'Shea than to that of Dr Doig and Dr Bett. The RMO had most experience of the appellant. Dr O'Shea had ongoing experience of dealing with prisoners at HMP Addiewell. Dr Bett's evidence was undermined by her belief that the appellant had vascular dementia. Dr Doig's view was based on the appellant's historical reaction to prison. His view that the section 1 principle of maximum benefit would not be met was because he believed the appellant would be segregated in prison. Since in the Tribunal's view he was effectively being segregated in his new unit, a move to prison would not infringe that principle.

The appeal

Submissions for the appellant

[24] The Tribunal erred in law in deciding that the TTD did not continue to be necessary. The TTD continued to be necessary if the appellant required to be detained in hospital and given treatment compulsorily in accordance with Part 16 of the 2003 Act (*AB* v *Mental Health*

Tribunal for Scotland 2012 GWD 1-9; *cf. Scottish Ministers* v *Mental Health Tribunal for Scotland (JK)* 2009 SC 398, Lord Wheatley at paragraphs [7] and [39]). The Tribunal failed to address the question whether compulsory treatment would be likely to be required because of failure of the appellant take his medication. It focused rather on whether it was possible for the relevant treatment and medication to be provided in prison, which was a different question. The transfer direction had been made because of a deterioration in the appellant's mental health following non-compliance with medication in prison. On the evidence before the Tribunal there were risks of bipolar disorder relapse and suicide if he was returned to prison. There was no care plan or other basis in the evidence setting out how the transition to prison and those risks could be managed. Individually and cumulatively the failures to address these matters made the Tribunal's decision unreasonable. Moreover, the Tribunal had failed to give appropriate consideration to the section 1 principles, and in particular the importance of providing the maximum benefit to the patient (section 1(3)(f)). This was a very unusual case. The appellant was elderly and vulnerable. He had become institutionalised in hospital. Revocation of the TTD would involve his immediate transfer to prison whether or not an appropriate care plan had been put in place, because when the Tribunal directed the Scottish Ministers to revoke the TTD (section 215(4)) they were obliged to do so immediately (section 215(5)). That outcome was not consistent with the Tribunal having given appropriate weight to the section 1(3)(f) principle. The tribunal had also erred in proceeding on the basis that the appellant was "effectively being segregated in his new unit" and that there was a need to keep him apart from other patients, and that "*As a result* (emphasis added) … a move to prison would not infringe" the section 1(3)(f) principle.

[25] The Tribunal's reasons for its decision were not adequate (*Wordie Property Co Ltd* v *Secretary of State for Scotland* 1984 SLT 345, Lord President Emslie at p 348; *Scottish Ministers* v

Mental Health Tribunal for Scotland 2010 SC 56, Lord Carloway at paragraph [39]). While the degree of particularity required depended upon the nature of the issues to be decided (*South Bucks District Council* v *Porter (No 2)* [2004] 1 WLR 1953, Lord Brown at paragraph 36), reasons must be intelligible and the reader must understand why the decision-maker decided as it did and what conclusions were reached on the principal issues (*JC* v *Gordonstoun Schools Ltd* 2016 SC 758, Lady Smith at paragraph [63]). Here the decision left the informed reader in real doubt whether the Tribunal had in fact considered whether compulsory treatment in hospital continued to be necessary, rather than whether it was possible for the relevant treatment and medication to be provided in prison; and if it did consider whether compulsory treatment was necessary, it left the reader in real doubt as to why it concluded it was not necessary. The Tribunal had not made findings in fact on material matters. It was not clear from the reasons that it had grappled with the evidence of the risks of non-compliance with medication, deterioration in mental health, and suicide. The reasons did not indicate that Dr O'Shea gave evidence explaining how these risks might be managed satisfactorily in prison. The Tribunal simply accepted his view that the TTD was no longer necessary because it would be possible to continue with anti-psychotic medication and boundary care in prison.

[26] A related point was that on the basis of the evidence which it narrated the Tribunal did not have a proper factual basis for finding that treatment for the appellant could just as effectively be provided in prison.

[27] The court should allow the appeal, set aside the decision of the Tribunal, and remit the case to the Tribunal for consideration anew with a direction that it should be differently constituted. Such a direction was appropriate because since the decision the patient's

circumstances had changed. He had a new RMO and he had now settled in his new unit. It was desirable that the matter should be considered afresh.

Submissions for the respondent

[28] The appeal should be refused. The respondent was a specialist tribunal. Its decision should be respected unless it was quite clear that it had misdirected itself in law (*AH (Sudan)* v *Home Secretary* [2008] 1 AC 678, Baroness Hale at paragraph 30; *Volpi* v *Volpi* [2022] 4 WLR 48, Lewison LJ at paragraph 2).

[29] On a fair reading of the decision the Tribunal had addressed itself to the question whether compulsory treatment in hospital continued to be necessary. It had been entitled to decide on the evidence that it was not necessary. It had not erred in law in doing so nor was its decision unreasonable. It had taken account of all material considerations including the section 1 principles.

[30] The Tribunal's reasons were adequate. The informed reader would not be in any doubt as to the reasons for the decision and the material considerations taken into account in reaching it. The Tribunal had preferred the evidence of Dr O'Shea and the RMO to the evidence of Dr Doig and Dr Bett and had adequately explained why it did so. There had been a proper factual basis for its decision.

Submissions for the Scottish Ministers

[31] While the Scottish Ministers position before the Tribunal had been that the TTD continued to be necessary, they adopted a neutral stance in the appeal. They accepted that the Tribunal had addressed the correct issues; that it had not reached a decision which was unreasonable or otherwise erred in law; that it had been entitled to accept the evidence that all the challenges of a return to prison could be addressed and that accordingly the TTD did not continue to be necessary.

[32] Counsel stressed that this was a highly unusual case, because the appellant was very elderly and he had been in hospital for very many years. This was the Ministers' (and the Tribunal's) first experience of a direction for revocation of a TTD being made in such circumstances.

[33] Counsel accepted that criticisms could be made of the way the Tribunal had set out its reasons. However, if read fairly they were adequate and intelligible.

[34] Counsel highlighted that the Tribunal's understanding that the appellant was in effect segregated in his new unit was incorrect. He had his own room, as did the three other patients there. The appellant could associate with the other patients if he wished to. He could go to communal areas in the unit. He enjoyed regular escorted leave outside the unit. Notwithstanding the Tribunal's misunderstanding of this matter, it remained reasonably clear that it had had appropriate regard to the section 1 principles.

[35] The TTD remained in place until the Ministers revoked it. It was wrong to suggest that the Ministers were obliged to revoke it immediately upon receipt of the Tribunal's direction. Section 215(5) required to be given a sensible construction which was consistent with the ECHR rights of patients and which took account of the fact that making appropriate arrangements for their transition to prison and treatment may well require multidisciplinary discussion and planning. The Ministers' duty was to act expeditiously in making such arrangements and to revoke the TTD when that had been done.

Decision and reasons

[36] While a number of grounds of appeal were advanced, there is a very considerable overlap between them. In our opinion the critical questions are whether it is clear from the Tribunal's reasons that it has addressed the correct issue (whether compulsory treatment in

hospital continued to be necessary) and whether it is clear from the reasons that it has adequately explained why it reached the conclusions which it did.

[37] We are mindful that the respondent is an expert tribunal and that we should be cautious about attributing error to it. However, even having given the Tribunal's reasons the benefit of that approach, we conclude that both of the critical questions ought to be answered in the negative.

[38] In our opinion the informed reader is left in real doubt whether the Tribunal in fact considered whether compulsory treatment in hospital continued to be necessary, rather than whether it was possible for the relevant treatment and medication to be made available to the appellant in prison. The focus of those parts of the evidence which the Tribunal narrates and of the reasons for the decision which it gives appears to us to have been on the latter, not on the former.

[39] Even if, contrary to our view, the decision may be read as involving consideration of whether compulsory treatment was necessary, in our judgement it leaves the informed reader in real doubt as to why the Tribunal concluded such treatment was not necessary.

[40] The Tribunal relied heavily upon Dr O'Shea's evidence, which it preferred to that of Dr Doig and Dr Bett. At paragraph 12 of the decision it refers to Dr O'Shea's view that it would be "possible" to continue the appellant's anti-psychotic care in prison, and notes that Dr O'Shea accepted that if the appellant did not comply with his medication there was "more of a possibility" that his mental health could deteriorate. It notes that, even taking that risk into account, Dr O'Shea maintained his opinion that the TTD was no longer necessary. At paragraph 22 it observed:

> "We preferred the considered approach of Dr O'Shea who was conscious of the challenges to be faced on a return to prison, but nonetheless was of the view that these challenges could be addressed with careful planning."

[41] What we do not find at paragraphs 12 or 22 or anywhere else in the decision is any real explanation of the reasons for Dr O'Shea's conclusion. There is nothing to suggest that he indicated how much of a risk he considered there was of the appellant not complying with medication; or that he provided any explanation of just how such a situation could be managed, were it to arise, without resort to compulsory treatment; or that he provided any elaboration of what measures would be involved in the "careful planning" which he envisaged.

[42] We intend no criticism of Dr O'Shea. We do not know whether he did in fact give evidence which dealt with some or all of these matters. It is possible that he may have. The problem is that the informed reader simply cannot tell from the Tribunal's decision whether or not the reasons for Dr O'Shea's conclusion were satisfactorily explained by him during his evidence, and, if so, what those reasons were. These are serious defects. The Tribunal would not have been entitled to accept Dr O'Shea's conclusion if it lacked a properly reasoned basis. As Lord Reed and Lord Hodge observed in *Kennedy* v *Cordia (Services) LLP* 2016 SC (UKSC) 59:

> "[48] An expert must explain the basis of his or her evidence when it is not personal observation or sensation; mere assertion or 'bare *ipse dixit*' carries little weight, as the Lord President (Cooper) famously stated in *Davie* v *Magistrates of Edinburgh* [1953 SC 34](p 40). If anything, the suggestion that an unsubstantiated *ipse dixit* carries little weight is understated; in our view such evidence is worthless. Wessels JA stated the matter well in the Supreme Court of South Africa (Appellate Division) in *Coopers (South Africa) (Pty) Ltd* v *Deutsche Gesellschaft für Schädlingsbekämpfung mbH* [1976 (3) SA 352](p 371):
>
> > '[A]n expert's opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.'

> As Lord Prosser pithily stated in *Dingley* v *Chief Constable, Strathclyde Police* [1998 SC 548](p 604): 'As with judicial or other opinions, what carries weight is the reasoning, not the conclusion.'"

[43] These problems with the reasons are sufficiently serious to satisfy us that the appeal should be allowed, the decision of the Tribunal set aside, and the case remitted to the Tribunal for consideration anew. Neither the respondent nor the Ministers demurred from the appellant's suggestion that if a remit is to be made the Tribunal should be differently constituted. Having considered the factors which counsel for the appellant referred to, we are persuaded that that is the preferable course. We add two further observations.

[44] The first concerns the submission for the appellant that the Ministers were obliged to revoke the TTD immediately upon receipt of the Tribunal's direction. We disagree. We concur with counsel for the Ministers that section 215(5) requires to be given a sensible construction which is consistent with the ECHR rights of patients (cf. *RC* v *HM Advocate* 2020 JC 60) and which takes account of the fact that making appropriate arrangements for their transition to prison and treatment may well require multidisciplinary discussion and planning. The Ministers' duty is to act expeditiously in making such arrangements and to revoke the TTD once that has been done.

[45] The second involves the Tribunal's approach to the section 1 principles. At paragraph 22 it referred to Dr Doig's evidence that the section 1 principle of maximum benefit to the patient would not be met with a transfer to prison because he would be segregated there. It continued:

> "The difficulty with this view is that, on our assessment of the evidence, the patient was effectively being segregated in his new unit. His behaviour resulted in the need to keep him apart from other patients and from certain female staff members … As a result, on our understanding of matters, a move to prison would not infringe this section 1 principle."

In fact, it is clear that the appellant is not segregated from other patients or from staff in his new unit. He is free to associate with the three other male patients there if he wishes too. He has contact with staff there. He enjoys regular escorted leave outside the unit. Although at the hearing of the appeal the parties were unable to fully describe to the court the accommodation in the unit, a description is provided in the Mental Welfare Commission for Scotland's report on a visit to it in 2022. The report notes that the unit has a multidisciplinary team consisting of nursing staff, psychiatrists and occupational therapy staff, and that at the time of reporting a psychologist was about to be appointed. There is art and music therapy. There are 4 patient bedrooms, which were described as spacious with en-suite shower rooms. Patients are able to personalise their bedrooms. There is an assisted bathroom for those preferring to use a bath. There are communal areas and staff rooms. The communal areas include a lounge/dining area, a sitting room and a courtyard space. In short, not only is the appellant is not segregated or isolated there, the facilities and conditions appear to be better than he would be likely to experience in prison. In those respects the facts differ from those to which the Tribunal had regard when it applied the section 1 principles.

Disposal

[46] We shall allow the appeal, set aside the decision of the Tribunal, and remit the case to the Tribunal for consideration anew with a direction that it should be differently constituted.