SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2021] SC GLW 62

A1290/18

JUDGMENT OF SHERIFF S REID

in the cause

DANIEL BOYLE

Pursuer

against

GREATER GLASGOW AND CLYDE HEALTH BOARD

Defender

Pursuer: Ms D. Forbes, Advocate; Alan Meechan Solicitors, Blackburn
Defender: Ms J. Cartwright, Advocate; NHS Central Legal Office, Edinburgh

Glasgow, 4 June 2021

The sheriff, having resumed consideration of the cause, MAKES the following findings-in-fact:

(1) In June 2009, the pursuer, who was then suffering from the effects of a mental disorder, namely, paranoid schizophrenia and dissocial personality disorder, was found to be unfit to stand trial in criminal proceedings against him in Glasgow Sheriff Court.

(2) Following an examination of facts in the criminal proceedings, the pursuer was made subject to a compulsion order and a restriction order (hereinafter referred to cumulatively as "the CORO"), in terms of sections 57(2)(a) & (b) of the Criminal Procedure (Scotland) Act 1995.

(3) From 2009 until 18 July 2014, the pursuer was detained at the State Hospital, Carstairs; thereafter, from 18 July 2014 until 6 December 2017, he was detained at

Rowanbank Clinic, Stobhill; and thereafter, from 6 December 2017 to date, he has been detained at Leverndale Hospital, Glasgow, all by virtue of the CORO.

(4) The State Hospital, Carstairs is a psychiatric hospital designated as a high secure unit ("HSU"), it is operated by a special health board known as The State Hospitals for Scotland, and forms part of the National Health Service ("NHS").

(5) Rowanbank Clinic is a psychiatric hospital designated as a medium secure unit ("MSU"), and Leverndale Hospital, Glasgow, is a psychiatric hospital designated as a low secure unit ("LSU"), both of which are located in Glasgow, operated by a health board called Greater Glasgow & Clyde Health Board ("the defender"), and form part of the NHS.

(6) Woodland View is a psychiatric hospital designated as a LSU, it is located in Irvine in Ayrshire, it is operated by a health board called NHS Ayrshire & Arran, and it forms part of the NHS;

(7) Surehaven Glasgow is an independent psychiatric hospital designated as a LSU, it is located in Glasgow, it is privately owned and operated, and does not form part of the NHS.

(8) During the period of the pursuer's detention in Rowanbank Clinic (from 18 July 2014 until 6 December 2017), the pursuer's responsible medical officer ("RMO") was Dr Brian Gillatt.

(9) Overall, during his period of detention within Rowanbank Clinic, the pursuer made good progress in the treatment of his mental disorder; with the result that, in June 2016, with the agreement of his RMO, the pursuer was referred to Dr Craig Morrow, consultant forensic psychiatrist at Leverndale Hospital, for assessment as to his suitability for transfer to the LSU at Leverndale Hospital.

(10) On or about 27 July 2016, pending the outcome of Dr Morrow's formal assessment of the pursuer's suitability for transfer to the LSU at Leverndale Hospital, the pursuer's name

was placed by the defender on a waiting list for a bed within Leverndale Hospital; that waiting list was maintained by the defender's staff within a department known as the Directorate of Forensic Mental Health and Learning Disabilities; and the defender's staff within that department were responsible for monitoring, identifying and notifying *inter alia* managers of the defender's psychiatric hospitals, and RMOs such as Dr Gillatt, of the availability of suitable accommodation within and outwith the defender's territorial area for patients such as the pursuer.

(11) As at 27 July 2016, according to the waiting list maintained by the defender's staff, thirteen patients were identified as waiting for a bed to become available within Leverndale Hospital, with the pursuer being last on the list.

(12) In or around August 2016, the pursuer applied to the Mental Health Tribunal for Scotland ("the Tribunal") for an order under section 268 of the Mental Health (Care and Treatment) Scotland) Act 2003 ("the 2003 Act") *inter alia* that he was then detained in conditions of excessive security.

(13) On 8 September 2016, following his assessment by Dr Morrow, the pursuer was accepted by Dr Morrow as suitable for transfer from Rowanbank Clinic to Leverndale Hospital, on which date the pursuer was likewise deemed by his RMO to be suitable for transfer to the low secure conditions at Leverndale Hospital.

(14) On 24 November 2016, the Tribunal issued an order ("the First Order") declaring that the pursuer was detained in conditions of excessive security and directing the defender to perform its statutory duties under section 268 of the 2003 Act within three months of the date of the First Order.

(15) As at 24 November 2016, twelve patients were named on the defender's waiting list, all of whom were seeking transfer to the first available bed within the LSU at Leverndale Hospital, with the pursuer featuring as ninth on that list.

(16) By 24 February 2017, upon expiry of the three month time limit specified in the First Order, the defender had not identified a hospital (i) which the defender and the Scottish Ministers agreed was a hospital in which the pursuer could be detained in conditions that would not involve the pursuer being subject to a level of security that was excessive in the pursuer's case, and (ii) in which accommodation was available for the pursuer; nor had the defender given notice of the name of such a hospital to the managers of Rowanbank Clinic, being the hospital in which the pursuer was then detained; nor had the pursuer been transferred to any such hospital.

(17) Specifically, by 24 February 2017, no bed was yet available for the pursuer within the LSU at Leverndale Hospital.

(18) On 24 February 2017, Dr Fiona Cooper, a Higher Trainee in Forensic Psychiatry, to whom Dr Gillatt had delegated certain of his duties as RMO to the pursuer, discussed with the pursuer the possibility of the pursuer being transferred to the LSU at Woodland View, Irvine.

(19) In the course of this conversation with Dr Cooper, the pursuer clearly and firmly communicated to Dr Cooper that he did not want to be transferred to Woodland View.

(20) On 28 February 2017, the defender's staff within the Directorate of Forensic Mental Health and Learning Disabilities decided that, due to the lack of projected bed availability at Leverndale Hospital, the pursuer should be referred to Woodland View for assessment as to his suitability for transfer there; such a referral is known as an "out of area" referral; funding

to pay for the "out of area" referral was approved by the defender; and the pursuer's RMO was instructed to make that referral.

(21) On 3 March 2017, in compliance with the defender's instruction, Dr Fiona Cooper, as Dr Gillatt's delegate, duly referred the pursuer to Dr Dawn Carson, a consultant forensic psychiatrist at Woodland View for assessment as to the pursuer's suitability for transfer there.

(22) Item 6/1 of process is a true copy of the letter of referral dated 3 March 2017 sent by Dr Fiona Cooper to Dr Dawn Carson.

(23) On 16 March 2017, at a further hearing, the Tribunal issued an ("the Second Order") declaring that the pursuer continued to be detained in conditions of excessive security and directing the defender to perform its statutory duties under section 269 of the 2003 Act within a period of three months of the date of the Second Order, that is, by 16 June 2017.

(24) Item 5/1 of process is a true copy of the decision of the Tribunal dated 16 March 2017.

(25) On 20 March 2017, Dr Dawn Carson visited Rowanbank Clinic to meet with the pursuer for the purpose of assessing his suitability for transfer to Woodland View.

(26) Prior to his meeting with Dr Carson, the pursuer had clearly and firmly communicated to nursing staff at Rowanbank Clinic that he did not wish to be transferred Woodland View.

(27) At their meeting on 20 March 2017, Dr Carson having explained to the pursuer the purpose of her visit, the pursuer clearly and firmly communicated to Dr Carson that he did not wish to be transferred to Woodland View because he and his family considered that it was too far away for family visits to take place; he declined to be assessed for such a transfer; he explained to Dr Carson that he would prefer to wait for a bed to become available at Leverndale Hospital which he and his family considered to be more convenient

for visits; he explained to Dr Carson that he knew that this decision by him would mean that he may remain detained within the LSU at Rowanbank Clinic for a longer period but considered that the delay would be worth it eventually; he acknowledged that his refusal to consider a transfer to Woodland View may impact upon his rehabilitation and recovery, and ultimately may delay his discharge into the community, but the pursuer was insistent that he was willing to accept this risk; and he adhered to his decision notwithstanding Dr Carson's offer to explore options to support family visits to the pursuer if he was transferred to Woodland View.

(28) The pursuer's decision to refuse the opportunity of a transfer to Woodland View was not an impulsive stance on the part of the pursuer, nor was it influenced by any form of mental illness impacting upon his judgment, but was instead a firmly-held view, expressed by him over a considerable period of time, and supported by his family.

(29) On 20 March 2017, Dr Carson advised the pursuer and medical staff within Rowanbank Clinic that she remained prepared to complete an assessment of the pursuer with a view to having him transferred to Woodland View should he change his mind; and she repeated her willingness to do so in a letter dated 12 June 2017 to Dr Gillatt, a true copy of which forms item 6/3 of process.

(30) On 21 March 2017, Dr Dawn Carson sent an email to Dr Gillatt at Rowanbank Clinic explaining the outcome of her meeting with the pursuer.

(31) As at March 2017, Woodland View was a new low security psychiatric hospital which had only just opened in January 2017; it was then only partially occupied; Dr Carson and her employer, NHS Ayrshire and Arran, being the health board that operated Woodland View, were then in the process of actively recruiting patients (including "out of

area" patients, notably from the defender's territorial area) to fill the vacant accommodation that was then available there.

(32) But for the pursuer's refusal to countenance a transfer to Woodland View, the pursuer would have been assessed by Dr Carson as suitable for transfer there; accommodation there would have been identified as available for the pursuer; the defender would have agreed with the Scottish Ministers and the managers of Woodland View that Woodland View was identified as a hospital in which the pursuer could be detained in conditions that would not involve him being subject to a level of security that was excessive in the pursuer's case, and in which accommodation was available for the pursuer; the defender would have notified the managers of Rowanbank Clinic that Woodland View, Irvine had been so identified; and all of the foregoing would have occurred prior to 16 June 2017 (that is, prior to expiry of the deadline in the Second Order).

(33) *Separatim* but for the pursuer's refusal to countenance a transfer to Woodland View, Irvine, the pursuer would have been transferred to Woodland View, Irvine prior to 16 June 2017 (that is, prior to expiry of the deadline in the Second Order).

(34) In the event that the pursuer had been transferred to Woodland View, Irvine prior to 16 June 2017, he could subsequently have been transferred to Leverndale Hospital, if a bed had subsequently become available for him there, with minimal impact upon his rehabilitation or recovery plan.

(35) On 30 March 2017, in a discussion between the pursuer and his RMO, Dr Gillatt explained to the pursuer that a transfer to the LSU at Woodland View, Irvine was "likely to be the only option in the foreseeable future" given the continuing non-availability of a bed in at Leverndale, but the pursuer remained unwilling to consider a transfer to Woodland View.

(36) On multiple occasions thereafter, the pursuer advised his RMO (Dr Gillatt) and medical and nursing staff at Rowanbank Clinic of his firm view that he did not wish to be transferred out of the Glasgow area and, specifically, that he did not wish to be transferred to Woodland View.

(37) On 7 April 2017, in the course of a discussion with Dr Cooper, the pursuer advised Dr Cooper that he would be willing to consider a transfer to the privately-run LSU at Surehaven Glasgow in Drumchapel.

(38) On 10 April 2017, in a further discussion with Dr Cooper, the pursuer remained adamant that he did not wish to transfer to Woodland View.

(39) On 3 May 2017, the pursuer was advised by medical staff of the possibility of a bed becoming available in the privately-run LSU at Surehaven Glasgow, Drumchapel; with the pursuer's consent, a referral was sent by the medical staff of Rowanbank Clinic to Surehaven Glasgow requesting that the pursuer be assessed for suitability for a transfer there; on 31 May 2017, the assessment was duly carried out; on 8 June 2017, a letter from Surehaven Glasgow, confirming the pursuer's suitability and acceptance for transfer there, was received by Rowanbank Clinic; and on 9 June 2017, the defender confirmed to the managers of Surehaven Glasgow that the defender would fund the cost of the pursuer's placement within Surehaven Glasgow.

(40) In the event, no accommodation was ever identified as available for the pursuer within Surehaven Glasgow.

(41) On 12 September 2017, the defender's staff within the Directorate of Forensic Mental Health and Learning Disabilities discovered that the transfer of the pursuer to Surehaven Glasgow could not proceed in any event due to a history of antagonism between the pursuer's brother and another patient then residing there.

(42) Meantime, on 7 June 2017, the pursuer was assaulted within Rowanbank Clinic by another patient; the pursuer was punched on the back of his head; no injury was sustained by him.

(43) By 16 June 2017, upon expiry of the three month time limit specified in the Second Order, the defender had not identified a hospital (i) which the defender and the Scottish Ministers agreed was a hospital in which the pursuer could be detained in conditions that would not involve the pursuer being subject to a level of security that was excessive in the pursuer's case, and (ii) in which accommodation was available for the pursuer; nor had the defender given notice of the name of such a hospital to the managers of Rowanbank Clinic.

(44) On 11 July 2017, the pursuer updated the statutory advance statement within his medical records, by stating: "If I do require to be treated in hospital I would prefer to be in Leverndale Hospital as this is the best location for my family."

(45) Throughout August 2017, medical and nursing staff within Rowanbank Clinic communicated with Surehaven Glasgow seeking clarification as to whether a bed was available for pursuer there, but all to no avail.

(46) By 1 September 2017, with no bed having yet become available for the pursuer within Surehaven Glasgow, the pursuer's RMO, Dr Gillatt, decided to take preparatory steps (including seeking Scottish Ministerial permission for pre-transfer visits by the pursuer to Leverndale) to facilitate a subsequent transfer of the pursuer to Leverndale Hospital, in advance of accommodation for the pursuer becoming available there in due course.

(47) On 11 October 2017, the Scottish Ministers agreed in principle to the pursuer's transfer to Leverndale Hospital, once a bed became available there.

(48) On 6 December 2017, accommodation having finally become available for the pursuer in Leverndale Hospital, with the agreement of the Scottish Ministers and the

managers of Leverndale Hospital, the pursuer was transferred there from Rowanbank Clinic.

(49) Throughout the period from 27 July 2016 to 6 December 2017, the pursuer's name remained on the defender's waiting list for transfer to a LSU; throughout that period, the pursuer's potential transfer continued to be discussed at weekly bed management meetings of the defender's staff within the Directorate of Forensic Mental Health and Learning Disabilities; and throughout that period the defender's staff continued to monitor and seek to identify available accommodation for the pursuer in psychiatric hospitals of suitable security conditions.

(50) In general, a detained patient such as the pursuer would expect to remain within a LSU for approximately two years following which, absent any clinical deterioration in the patient's mental condition, the patient would generally expect to become eligible for transfer from the LSU to a community forensic accommodation, but it is nevertheless reasonably common for a patient to remain detained within a LSU for a period in excess of two years.

(51) Community forensic accommodation for detained patients such as the pursuer is managed by third parties (notably, local authorities and private sector providers) and its availability is extremely limited and unpredictable.

(52) In March 2020, by reason of the global Covid-19 pandemic, all transfers of patients from LSUs to community forensic accommodation were suspended;

MAKES the following findings-in-fact and in-law:

(1) As at 16 June 2017, upon expiry of the three month time limit specified in the Second Order, the defender was in breach of its statutory duties under sections 269(4) & (6) of the 2003 Act in respect that, by that date, the defender had failed to identify a hospital (i) which

the defender and the Scottish Ministers agreed was a hospital in which the pursuer could be detained in conditions that would not involve the pursuer being subject to a level of security that was excessive in the pursuer's case, and (ii) in which accommodation was available for the pursuer; and, further, in respect that, by that date, the defender had failed to give notice to the managers of Rowanbank Clinic, being the hospital in which the pursuer was then detained, of the name of such a hospital.

(2) Between 16 June 2017 and 6 December 2017, the defender remained in breach of its statutory duties under sections 269(4) & (6) of the 2003 Act;

(3) The pursuer has not suffered any loss, injury or damage as a result of the defender's breach of its statutory duties under sections 269(4) & (6) of the 2003 Act;

(4) Specifically, the loss, injury and damage claimed by the pursuer was caused, not by the pursuer's said breach of its statutory duties, but by the pursuer's own conduct in persistently refusing to countenance or accede to a transfer to the LSU at Woodland View, Irvine throughout the period from 24 February 2017 to 6 December 2017;

MAKES the following findings-in-law:

(1) The pursuer not having suffered loss, injury or damage as a result of the breach of statutory duty of the defender, the defender should be assoilzied;

(2) In any event, the sum sued for not being a reasonable estimate of the loss, injury or damage suffered by the pursuer as a result of any breach of statutory duty by the defender, decree therefor should not be granted as craved;

THEREFORE, Repels the pursuer's pleas-in-law numbers 1 and 2; Sustains the defender's pleas-in-law numbers 2, 3, 4, 5 & 6; and ACCORDINGLY, Grants decree of absolvitor in

favour of the defender, whereby Assoilzies the defender from the craves of the writ; meantime, Reserves the issue of expenses *sine die*, to be determined at a hearing to be hereafter assigned.

SHERIFF

NOTE:

Summary

[1] In 2009, Mr Boyle was found to be unfit to stand trial in criminal proceedings against him. He was then suffering from the effects of a mental disorder, namely paranoid schizophrenia and dissocial personality disorder. He was made subject to a compulsion order ("CO") and a restriction order ("RO") and has been detained in various secure hospital facilities ever since.

[2] This action concerns the circumstances in which he came to be transferred from Rowanbank Clinic (a medium secure unit or "MSU") to Leverndale Hospital (a low secure unit or "LSU") in December 2017.

[3] Mr Boyle complains that the defender, as the relevant health board, delayed in transferring him from the MSU to the LSU.

[4] His complaint is not simply that he was held in conditions of excessive security for about six months longer than he should have been, but that his rehabilitation, treatment and eventual discharge from hospital have thereby been interrupted and delayed. Significantly, he claims that his ultimate discharge from hospital (into community forensic accommodation) was thwarted, because, following the onset of the global Covid-19 pandemic and resulting suspension of transfers from secure hospitals, he became trapped in

LSU accommodation when, but for the delay, he would otherwise have long since left that secure hospital environment.

[5] The unusual feature of the action is that Mr Boyle seeks the remedy of damages. The sole ground of action is the defender's alleged breach of statutory duty under section 269 of the Mental Health (Care and Treatment) (Scotland) Act 2003. As far as I am aware, this is the first such action of its kind under this legislative provision.

[6] The critical background is that, in November 2016, the Mental Health Tribunal for Scotland ("the Tribunal") issued an Order under section 268 of the 2003 Act ("the First Order") declaring that the pursuer was then detained in conditions of excessive security and directing the health board to identify a suitable hospital for the pursuer's detention within three months. The defender failed to comply with the First Order.

[7] In March 2017, a second hearing was convened before the Tribunal. It then issued an Order in terms of section 269 of the 2003 Act ("the Second Order") declaring that the pursuer continued to be detained in conditions of excessive security and directing the defender to identify a more suitable hospital for his detention within a period of three months of the date of that Second Order (that is, by 16 June 2017). It is said that the defender likewise failed to comply with the Second Order until 6 December 2017, when the pursuer was belatedly transferred to Leverndale Hospital.

[8] In summary, I have concluded that, between 16 June 2017 and 6 December 2017, the defender was indeed in breach of its statutory duties under section 269(4) & (6) of the 2003 Act.

[9] However, I have also concluded that the defender's breach did not cause the pursuer to suffer any of the loss, injury or damage complained of. Instead, the sole cause of the

pursuer's alleged loss was his own persistent refusal to countenance or accede to a transfer to a low secure unit at Woodland View, Irvine.

[10] Lastly, I have offered some brief observations on the approach to the issue of quantification in a case of this nature, notwithstanding the pursuer's failure to prove the necessary causal link between the defender's breach of statutory duty and the loss, injury and damage allegedly suffered by him.

The statutory framework

[11] The pursuer's claim proceeded to proof only upon an alleged breach of the defender's statutory duties under section 269 of the 2003 Act. So far as material, the relevant statutory framework is as follows:

> "268(2) On the application of [the patient], the Tribunal may, if satisfied that the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient, make an order—
>
> (a) declaring that the patient is being detained in conditions of excessive security; and
> (b) specifying a period, not exceeding three months and beginning with the making of the order, during which the duties under subsections (3) to (5) below shall be performed.
>
> (3) Where the Tribunal makes an order under subsection (2) above in respect of a relevant patient, the relevant Health Board shall identify a hospital—
>
> (a) which is not a state hospital;
> (b) which the Board and the Scottish Ministers, and its managers if they are not the Board, agree is a hospital in which the patient could be detained in conditions that would not involve the patient being subject to a level of security that is excessive in the patient's case; and
> (c) in which accommodation is available for the patient…
>
> (5) Where the Tribunal makes an order under subsection (2) above in respect of a patient, the relevant Health Board shall, as soon as practicable after identifying a hospital under subsection (3), give notice of the name of

the hospital so identified to the managers of the hospital in which the patient is detained…..

269 (1) This section applies where—

(a) an order is made under section 268(2) of this Act in respect of a patient; and
(b) the order is not recalled under section 271 of this Act…

(2) If the relevant Health Board fails, during the period specified in the order, to give notice to the Tribunal that the patient has been transferred to another hospital, there shall be a hearing before the Tribunal.

(3) Where such a hearing is held, the Tribunal may, if satisfied that the test specified in regulations made under section 271A(2) of this Act is met in relation to the patient, make an order—

(a) declaring that the patient is being detained in conditions of excessive security; and
(b) specifying—

(i) a period of 28 days; or
(ii) such longer period not exceeding three months as the Tribunal thinks fit, beginning with the day on which the order is made during which the duties under subsections (4) to (6) below shall be performed.

(4) Where the Tribunal makes an order under subsection (3) above in respect of a relevant patient, the relevant Health Board shall identify a hospital—

(a) which is not a state hospital;
(b) which the Board and the Scottish Ministers, and its managers if they are not the Board, agree is a hospital in which the patient could be detained in conditions that would not involve the patient being subject to a level of security that is excessive in the patient's case; and
(c) in which accommodation is available for the patient….

(6) Where the Tribunal makes an order under subsection (3) above in respect of a patient, the relevant Health Board shall, as soon as practicable after identifying a hospital under subsection (4)…above, give notice of the name of the hospital so identified to the managers of the hospital in which the patient is detained….

272 (1) The duties imposed by virtue of—

(a) an order under section 264(2) of this Act, or

> (c) an order under section 268(2) of this Act,
>
> shall not be enforceable by proceedings for specific performance of a statutory duty under section 45(b) of the Court of Session Act 1988.
>
> (2) Without prejudice to the rights of any other person, the duties imposed by virtue of—
>
> (a) an order under section 265(3) of this Act, or
> (c) an order under section 269(3) of this Act,
>
> shall be enforceable by proceedings by the [Mental Welfare Commission for Scotland] for specific performance of a statutory duty under section 45(b) of that Act of 1988."

Section 271A(2) states, so far as material, that Regulations specifying the test that must be met (under sections 268 and 269):

> "… must include as a requirement for the test to be met in relation to a patient that the Tribunal be satisfied that detention of the patient in the hospital in which the patient is being detained involves the patient being subject to a level of security that is excessive in the patient's case."

The "test" referred to in sections 268, 269 & 271 of the 2003 Act is set out in the Mental Health (Detention in Conditions of Excessive Security) (Scotland) Regulations 2015 (SSI 2015/364) ("the 2015 Regulations"). Regulation 5 of the 2015 Regulations states:

> "The test for the purposes of sections 268(2), 269(3) and 271(2)(a) of the 2003 Act is met in relation to a patient if detention of the patient in the hospital in which the patient is being detained involves the patient being subject to a level of security that is excessive in the patient's case."

The original grounds of action

[12] At this juncture, in order properly to understand the pursuer's claim (as it proceeded to proof), it may be helpful to pause and consider the claim in its original form. As originally averred, the pursuer's claim was based upon two discrete grounds: first, an alleged violation of the pursuer's Convention Right under Article 5(1)(e) of the European

Convention on Human Rights ("ECHR"); and second, an alleged breach by the defender of its statutory duties under *each* of sections 268 and 269 of the 2003 Act.

[13] At debate, the defender challenged the relevancy of these grounds. I issued a written judgment on 7 November 2019 ([2019] 11 WLUK 126; 2020 GWD 1-5) in which I concluded that the pursuer's first ground of action (the alleged violation of Article 5, ECHR) was irrelevant, and excluded the related averments from probation. That was because Article 5(1)(e), ECHR is concerned with the lawfulness of a person's detention, not with the conditions of, or treatment within, such detention. In substance, the pursuer's complaint in the present case relates to the conditions of his detention, not to the lawfulness of that detention. Therefore, Article 5, ECHR was not engaged at all on the pursuer's averments. In my view, this conclusion was inescapable having regard to the judgment of the European Court of Human Rights in *Ashingdane* v *United Kingdom* (1985) 7 EHRR 528, as applied by the House of Lords in *R (on the application of Munjaz)* v *Mersey Care NHS Trust* [2006] 2 AC 148, and as followed by Lord Turnbull in *S* v *Scottish Ministers* 2015 SLT 362. I declined to follow obiter dicta of Lord Stewart in *Sherrit* v *NHS Greater Glasgow and Clyde Health Board* [2011] SLT 480, which suggested a possible "more nuanced reading" of Article 5(4), ECHR.

[14] The second ground of action (the alleged breach of statutory duty), insofar as it was founded upon the defender's failure to comply with the Tribunal's First Order (under section 268(2) of the 2003 Act), was also irrelevant and fell to be excluded from probation. That was because, on a proper interpretation of the 2003 Act, a failure to comply with the Tribunal's First Order was not intended to be enforceable by civil proceedings at all, Parliament having prescribed a specific remedy for such non-compliance, namely a statutory right of review under section 269(2) of the 2003 Act (*Cutler* v *Wandsworth Stadium Ltd* [1949] AC 398; *Morrison Sports Ltd* v *Scottish Power plc* 2011 SC 1; *Campbell* v *Peter*

Gordon Joiners Ltd 2017 SC 13). However, in contrast, the second ground of action (the alleged breach of statutory duty), insofar as it was founded upon the defender's failure to comply with the Tribunal's Second Order (made under section 269(3) of the 2003 Act), was relevant and suitable for enquiry at proof. That was because, in my judgment, on a proper interpretation of the 2003 Act as amended, a failure to comply with the Second Order of the Tribunal was intended to be enforceable by civil proceedings (including by means of an action of damages) at the instance of a person such as Mr Boyle, who fell within that limited and very specific class of person (namely "trapped" patients) for whom the statutory framework had been devised.

[15] So it was in this truncated form – namely, as a claim of damages for breach of statutory duty under sections 269(4) & (6) of the 2003 Act, in allegedly failing to comply with the Tribunal's Second Order made under section 269(3) – that the pursuer's claim proceeded to proof.

The rationale and history of the legislation

[16] It would be useful to continue on this diversion a little further with an explanation of the rationale behind the statutory appeal provisions under the 2003 Act, of which section 269 forms part.

[17] The 2003 Act had sought to address the mischief of mentally disordered offenders who found themselves "trapped" in conditions of excessive security within the State Hospital at Carstairs and certain other secure institutions.

[18] To that end, the legislation conferred upon detainees certain rights of appeal to and review by the Tribunal concerning their conditions of detention; and, in turn, the Tribunal

was empowered to make certain Orders if satisfied that the affected patient was indeed being held in conditions of excessive security.

[19] An initial problem emerged. It transpired that the statutory rights of appeal and review were rendered worthless because, for over a decade, the Scottish Ministers failed to introduce regulations to define the class of detainee by whom the rights were exercisable and the hospitals to which they applied. The detail of this particular executive omission is recounted more fully by Lord Reed in *RM* v *Scottish Ministers* 2013 SC 139. It continued to play itself out before Lord Turnbull in *S* v *Scottish Ministers* 2015 SLT 362. Thankfully, that omission has now been resolved, but the question remained: how did Parliament intend that these statutory rights of appeal should be enforced?

[20] In *G* v *The Mental Health Tribunal for Scotland* 2014 SC 84, Lord Reed discussed the rationale behind the enactment of sections 264 to 273 of the 2003 Act. He explained (at paragraphs [3] to [11]) that the preceding legislation, consolidated within the Mental Health (Scotland) Act 1984, had become increasingly out of step with current thinking about the treatment of mental disorders, the rights of patients, and the relationship between patients and the wider community. The Scottish Executive appointed a committee under the chairmanship of Bruce Millan, the former Secretary of State for Scotland, to review the 1984 Act. The committee produced a Report in 2001 entitled "New Directions: Report on the Review of the Mental Health (Scotland) Act 1984".

[21] A particular problem identified by the committee was the mischief of "entrapped patients". These were patients who no longer required the level of special security afforded by the State Hospital but for whom appropriate local services with lower levels of security were not available (Millan Committee Report, Chapter 27). The evidence heard by the committee was to the effect that there was little incentive for local health boards and trusts

to arrange such lower level secure psychiatric services; the local public was unlikely to welcome such services (indeed, quite the reverse); and funding arrangements created no incentive to develop them. The State Hospital Board strongly advocated that an explicit statutory duty be placed on health boards to commission local services to address the need for a range of medium and low security services for mentally disordered offenders.

[22] The Millan Committee expressed "considerable sympathy" with the position explained by the State Hospital Board on this issue but decided, instead, to propose "another means of addressing" the problem, which was said to be more directed at the rights of individual patients. This alternative mechanism involved the creation of a "continuing right to appeal against the level of security to which [the patients] are subjected" (Millan Committee Report, paragraph 83). The committee acknowledged that to detain a patient unnecessarily in conditions of high security was inconsistent with respect for the patient's rights. Further, the proposed development of medium secure units was thought to make it more likely that such an appeal right would be "practicable" (Millan Committee Report, paragraph 84).

[23] The committee went on to discuss how such a right of appeal might be made effective. In order to provide care at a lower level of security, arrangements would have to be made by the relevant health board. But such arrangements could involve practical difficulties which might be beyond the health board's control. If the necessary arrangements were not put in place, it would be undesirable that a patient who was still assessed as requiring some degree of secure care should simply be discharged. On the other hand, it was appreciated that the proposed right of appeal would be meaningless unless it led to an order which was "capable of being enforced" (*G, supra,* per Lord Reed at paragraph 8).

[24] Following consultation on this issue, the Millan Committee concluded that a "staged approach" was appropriate (*G, supra*, paragraph [9] per Lord Reed). The Millan Committee Report states (chapter 27, paragraph 89):

> "We therefore suggest that, should a patient successfully appeal to a Tribunal against the level of security, it should set a time within which the necessary provision should be arranged by the responsible health board. The time limit might be of the order of three months. Should arrangements not be made at the expiry of that period, representatives of the health board should be required to appear before the Tribunal to explain the position, and to confirm whether there is a prospect of a placement being found within a reasonable period. The Tribunal should be able to extend the time limit for a further period of no more than three months. If, at the end of that period, no provision has been made, the Tribunal could order that arrangements must be put in place to accommodate the patient within 14 days".

In brief terms, this translated to Recommendation 27.19 in the Millan Committee Report which states:

> "Patients should have a right of appeal to be transferred from the State Hospital, or a medium secure facility, to conditions of lower security".

[25] In a subsequent White Paper entitled "Renewing Mental Health Law – Policy Statement", the Scottish Executive broadly accepted the Millan Committee's recommendations as the framework for a future Bill, although it rejected or modified some of the recommendations concerned with mentally disordered offenders. An Executive Bill was then laid before the Scottish Parliament but, as introduced, the Bill did not contain any provision reflecting the Millan Committee Recommendation 27.19 (concerning "entrapped patients"). It is not difficult to speculate as to the reason for the omission. At that time, there was only one specialist medium secure unit in Scotland, namely the Orchard Clinic in Edinburgh. The facilities to accommodate "trapped" patients elsewhere were simply not then available.

[26] Nevertheless, in response to "Parliamentary promptings" (*RM* v *Scottish Ministers, supra*, paragraph 38), the Bill was amended at Stage 3 to incorporate the provisions which now form sections 264 to 272 of the 2003 Act. The amended Bill was passed by the Scottish Parliament on 20 March 2003. It received the Royal Assent on 25 April 2003. However, in recognition of the practical difficulties facing health boards, the commencement provision in section 333(2) allowed the entry into force of sections 264 to 273 of the 2003 Act to be delayed until 1 May 2006 "so as to allow sufficient time for additional facilities for affected patents to be commissioned" (*G, supra*, at paragraph [11]).

[27] The appeal provisions within sections 264 to 272 of the 2003 Act were praised by Baroness Hale of Richmond as "progressive and far-sighted" in conception (*G, supra*, paragraph [71]).

[28] Unfortunately, as mentioned above, this innovative legislation then became mired in governmental inaction. It sat toothless and impotent on the statute book for over 10 years following enactment due the failure of the Scottish Executive to make the necessary regulations to bring Chapter 3 of Part 17 of the 2003 Act (which incorporated the appeal provisions) into effective operation by 1 May 2006.

[29] In November 2012, in *RM, supra*, the Supreme Court granted a declarator that the Scottish Ministers' failure to draft and lay the necessary regulations before the Scottish Parliament prior to 1 May 2006, and their continued failure to do so since that date, was unlawful. Somewhat remarkably, nearly three years later, in May 2015, the necessary regulations had still not come into force. In *S* v *Scottish Ministers* 2015 SLT 362, Lord Turnbull noted the Executive's concession that "the state of unlawfulness" identified by the Supreme Court in *RM, supra* had "not yet been cured". The necessary regulations had still not been issued to bring the appeal provisions into effective operation, though, in

fairness to the Executive, another Mental Health Bill and a set of draft regulations were, by that stage, progressing through Parliament. Accordingly, Lord Turnbull concluded that a further declarator of illegality would serve no useful purpose.

[30] Later that year, the Mental Health (Scotland) Act 2015 ("the 2015 Act") was enacted, the Mental Health (Detention in Conditions of Excessive Security) (Scotland) Regulations 2015 were issued ("the 2015 Regulations"), and the 2003 Act appeal provisions for "entrapped" patients, in an amended form, finally came into effective operation.

The structure of the statutory appeal procedure

[31] How does the statutory appeal procedure work? The mechanism is broadly similar for detainees in the State Hospital (2003 Act, sections 264 to 266) and for detainees in other hospitals (2003 Act, sections 268 to 269). I shall focus upon the latter category as the pursuer falls into that category.

[32] There are two stages to the procedure. The first stage is this. Under section 268 of the 2003 Act, on the application of (among others) the defined patient, the Tribunal may, if satisfied that the "test" set out in section 271A(2) is met, make an order (a) declaring that the patient is being detained in conditions of excessive security and (b) specifying a period, not exceeding three months beginning with the making of the order, during which certain specified "duties" are to be "performed". (I refer to this as "the First Order").

[33] The "test" to be met before the First Order (and, indeed, the Second Order) can be made is defined in Regulation 5 of the 2015 Regulations (issued under section 271A(2) of the 2003 Act). It is that the patient's detention involves the patient "being subject to a level of security that is excessive in the patient's case".

[34] Two "duties" are then triggered by virtue of the making of the First Order. The relevant health board must "*identify*" a hospital (which is not a State Hospital) which the health board and the Scottish Ministers agree is a hospital in which the patient could be detained in conditions that would not involve the patient being subject to a level of security that is excessive in the patient's case and in which accommodation is available for the patient (section 268(3)) (my emphasis). As soon as practicable after identifying such a hospital, the health board must "*give notice*" to "the managers of the hospital in which the patient is detained" of the name of the hospital so identified (section 268(5)) (my emphasis).

[35] Separately, although not explicitly stated, it seems to be implied that where the Tribunal makes a section 268(2) order, the health board must also notify the Tribunal when the patient has been transferred to the other hospital. That is because section 269(2) provides that if the health board fails, during the period specified in the order, to "*give notice* to the Tribunal" (again, my emphasis) that the patient has been transferred to the other hospital, the second stage is triggered.

[36] This raises an interesting subtlety as to the precise scope of the duties incumbent upon a health board when a Tribunal order of this nature is granted. Is the statutory duty merely to "identify" suitable accommodation or does it extend to actually effecting the "transfer" of the patient? I shall return to this conundrum later, which was a crucial disputed issue at proof. Meantime, it is sufficient to observe that if the health board fails to give notice to the Tribunal that the patient has been transferred, a second stage of the appeal procedure is triggered.

[37] The second stage is this. Under section 269(2), absent notification to the Tribunal that the patient has been transferred, a further hearing must be convened before the Tribunal. No application by the patient (or anyone else) is required: the Tribunal itself is obliged to

convene it. At this further hearing, in terms of section 269(3), the Tribunal may, if satisfied again that the test set out in section 271A(2) is met, make an order (a) again declaring that the patient is being detained in conditions of excessive security and (b) specifying either a period of 28 days or such longer period (not exceeding three months) as the Tribunal thinks fit during which the specified duties must be performed. I refer to this as "the Second Order".

[38] A key difference between the First Order and the Second Order relates to the period of time within which the duties must be complied with. A further key difference between the two Orders is that, in contra-distinction with the First Order, if the Second Order is not implemented, the Act now makes no provision for any further mandatory Tribunal hearing to be convened.

[39] When the 2003 Act was first enacted, there was a third stage. It appeared in section 270 of the 2003 Act. It provided that, if the Second Order was not complied with, then yet a further hearing required to be convened before the Tribunal. At that further hearing, the Tribunal was empowered to make a third order in terms identical to the First Order and Second Order, but with this key difference: the third order required to specify a period of 28 days (no more, no less) during which the foregoing duties required to be performed. However, section 270 of the 2003 Act was repealed by the 2015 Act with effect from 16 November 2015, so there is no longer a third stage or a third order.

[40] It will be observed, of course, that neither the First Order nor the Second Order results in the discharge or release of the patient from detention.

[41] What then is the consequence of a breach of a First Order or a Second Order? Put another way, what civil remedies, if any, were intended to be available to enforce the rights and duties arising from a First Order or Second Order of the Tribunal? I discussed this issue

in my judgment following the debate, but it merits repeating here to explain my conclusions following proof.

What remedies are available to enforce the Tribunal's First Order?

[42] In my judgment, Parliament prescribed a specific remedy for a health board's failure to implement a First Order (made under section 268(2)). That specific remedy is the review process prescribed by section 269 of the 2003 Act. That is the only remedy available for a health board's failure to comply with a First Order. No other civil remedy is available.

[43] To explain, on a proper analysis, section 269(2) is not, in nature, a right of "appeal" at all, in the conventional sense. An appeal is an elective process: it normally requires a decision and choice by the appellant to pursue it; and it is initiated and pursued by the appellant. Section 268(2) involves such a right of appeal. In contrast, section 269(2) requires no decision, choice, application or even participation by the patient; it does not involve the exercise of any right vested in the patient, rather it involves merely the discharge of an obligation incumbent upon the Tribunal itself (to convene a hearing); and it is a mandatory process, triggered automatically by a failure to notify the Tribunal that the patient has been transferred. Properly analysed, section 269(2) creates a compulsory review process, not a right of appeal. That review process is the specific, though perhaps unusual, remedy chosen by Parliament to compel performance of the First Order under section 268(2).

[44] I am fortified in that conclusion by the terms of section 272(1) of the 2003 Act. It is a critical provision. It deals specifically with the issue of civil proceedings to enforce the Tribunal's Orders. Section 272(1) expressly *excludes* enforcement of a First Order by means of proceedings for specific performance of a statutory duty under the Court of Session Act 1988, section 45(b). The express exclusion of that civil remedy is logical in circumstances

where a mandatory review process (under section 269(2)) has been created by Parliament, and has yet to run its course.

[45] It also follows that the remedy expressly prescribed by Parliament (namely, the triggering of the mandatory section 269 "review" process) must be the exclusive and only remedy available to enforce a First Order under section 268 because, if the position were otherwise, and if two or more civil remedies were to co-exist, conflicting decisions (of the Tribunal and a Court) might then be at risk of arising.

[46] In addition, in my judgment, the conclusion that the section 269 review process is the specific and only remedy intended by Parliament to compel enforcement of the duties arising by virtue of the First Order, is consistent with the recommendations of the Millan Committee from which the legislation emanated. The Millan Committee recommendation was for a "staged approach" (per Lord Reed, in *G, supra*) whereby, if the First Order was not implemented, representatives of the health board would be given the opportunity to explain the position (including to confirm whether there was a prospect of a placement being found within a reasonable period) (chapter 27, paragraph 89). The Millan Committee's "staged approach", and the enacted legislation, was indeed progressive but it was, nevertheless, a compromise. It represents a balancing of competing interests, that is, the rights of the individual patients to be released from conditions of excessive security, and the realpolitik that suitable alternative hospital accommodation may just not be available in that initial prescribed period (under section 268), through no fault of the health board. The compromise is achieved thus: (i) the health board is afforded an initial period under section 268(2) (not exceeding three months) to comply voluntarily with the duties under the First Order, free from the threat of civil proceedings for specific performance under section 45(b) of the 1988 Act if it fails to do so; (ii) if it fails to comply voluntarily with the

First Order, the defender knows that the prescribed remedy for its breach is the convening of a mandatory review under section 269(2), at which the health board will require to explain itself, and may face the issuing of a Second Order, with which Second Order it must comply voluntarily within just 28 days (or such longer period not exceeding three months as the Tribunal may decide); and (iii) if it fails to comply voluntarily with the Second Order within the further period defined by the Tribunal, the health board is then exposed to the full weight of civil proceedings against it, including summary petition proceedings at the instance of the Commission for specific performance under section 45(b) of the 1988 Act (section 272(2), 2003 Act). In other words, the statutory compromise was that health boards were to be afforded a period of grace, variable from case to case but not exceeding six months at best, in which to find suitable alternative hospital accommodation for the trapped patient; but, after that period of grace, the boards would face civil proceedings if they had failed to comply.

[47] This is not to be understood as meaning that Tribunal Orders cannot be made, or can simply be ignored, if no suitable alternative place is or is likely to become available. If that were the case, Parliament's intention in enacting these sections "could be frustrated by mere inertia on the part of health boards" and the terms of section 272(1) (preventing the immediate enforcement of the First Order by means of civil proceedings for specific performance) would be "supererogatory" (*G, supra,* per Lord Reed at paragraphs [41] and [42]). As Lady Hale stated in *G, supra* (at paragraph [72]):

> "It would obviously defeat the object of the legislation if the authorities were able simply to say that no bed was available in another, less secure, hospital. It must be the case, as Lord Reed observes (paragraph [38]) that this is irrelevant to the first stage: deciding whether (in the case of a State Hospital patient) he requires 'to be detained under conditions of special security that can be provided only in a State Hospital' (section 264(2)) or (in the case of a patient in another hospital) he is 'being subject to a level of security that is

> excessive' in his case (section 268(2)). It must also be the case, as Lord Reed says (paragraphs 41, 54), that having decided that question in favour of the patient, the expectation is that the Tribunal will make an order unless in the particular circumstances of the case there is some good reason not to do so".

So, it is implicit that a First Order and Second Order can be made by the Tribunal, and the Second Order can be enforced by civil proceedings, at a time when no hospital bed has been identified in which the patient could be detained in appropriate conditions.

[48] However, the non-availability of accommodation in a hospital of a lower level of security is not entirely irrelevant. In the context of the parallel provisions under sections 263 & 264 of the 2003 Act (concerning transfers from a high secure unit to a MSU) the Supreme Court in *G, supra,* explicitly acknowledged that such a circumstance may, in certain situations, be relevant to the decision of the Tribunal to make an Order at all, or to a subsequent application to "recall" such a Tribunal Order under section 267 of the 2003 Act. This may be the "good reason" referred to by Lady Hale. Lord Reed commented (at paragraph [43]):-

> "….[T]he unavailability of accommodation in medium secure hospitals where the patient could be detained in conditions appropriate to his particular needs, including appropriate facilities for treatment, may in some circumstances be relevant to the tribunal's performance of its duty to have regard to the importance of providing the maximum benefit to the patient, in accordance with section 1(3)(f)…. [or] to the tribunal's duty to have regard to the importance of the provision of appropriate services to the patient, in accordance with section 1(6)…. Furthermore, to make an order where the tribunal was satisfied that there was no conceivable possibility that the patient could be accommodated in a medium secure hospital in appropriate conditions within any realistic timescale, and where an application for recall could not therefore be refused, would be unreasonable…"

By analogy, the non-availability of alternative accommodation in a LSU may also in "particular circumstances" (per Lady Hale, *supra*, paragraph [72]) be relevant to the making

of Orders under sections 268 or 269 of the 2003 Act or to the recall of such Orders under section 271 thereof.

[49] But no such "particular circumstances" applied in the present case. Here, the Tribunal duly made the First Order and the Second Order; no one has suggested it was unreasonable to do so; and no attempt was ever made by the health board to exercise its right to seek a "recall" of any such order under section 271 of the 2003 Act by reason of the alleged non-availability of alternative accommodation or otherwise (though, interestingly, a fleeting mention of that possibility does appear in a communication from Dr Gillatt to Dr Carson dated 4 April 2017: item 6/2 of process).

What remedies are available to enforce the Tribunal's Second Order?

[50] In contrast with the First Order, performance of the Second Order is not enforced by any form of statutory "review" procedure akin to the review process in section 269. Instead, insofar as Parliament has prescribed any remedy to compel performance of the duties arising by virtue of the Second Order, it expressly enacted (by section 272(2)) that those duties shall be enforceable by proceedings at the instance of the Mental Welfare Commission for Scotland for specific implement under section 45(b) of the Court of Session Act 1988.

[51] However, the express grant of such a right to the Mental Welfare Commission was plainly not intended to exclude enforcement of the Second Order by other persons (or, I would suggest, by other remedies). That much is clear from the express reservation of "the rights of any other person" which prefaces section 272(2). On an ordinary construction, the express right conferred upon the Commission by section 272(2) is in addition and without prejudice to, not exclusive of, the rights of any other person to enforce the duties arising by

virtue of the Second Order. What might those rights be, and by whom might they be enforceable?

[52] Applying the principles discussed in *Morrison Sports Ltd* and *Campbell, supra*, the duties arising by virtue of the Second Order can be seen to be intended for the benefit and protection of a limited and very specific class of person, namely "trapped" patients such as the pursuer. Those duties are, on an ordinary interpretation of the language used, intended to be duties in the fullest legal sense. In contra-distinction with the treatment of the First Order, Parliament has not legislated to compel enforcement of those Second Order duties in any prescribed manner (specifically, by way of a review process) or otherwise in a manner habile to exclude a private law action. According to Lord Browne-Wilkinson's default rules in *X (Minors)* v *Bedfordshire County Council* [1995] 2 AC 633 where, as here, a statute provides no other remedy for its breach and the Parliamentary intention to protect a limited class is shown, this indicates that a private right of action is available, since otherwise there would be no method of securing the protection the statute was intended to confer. Paraphrasing Lord Simond's famous dicta in *Cutler, supra*, since a statutory duty is prescribed but no remedy by way of penalty or otherwise for its breach is imposed it can be assumed that a right of civil action accrues to a patient who is damaged by the breach "for, if it were not so, the statute would be but a pious aspiration".

[53] How might those duties under a Second Order be enforced? The fact that section 272(2) of the 2003 Act expressly sanctions the remedy of specific performance under section 45(b) of the 1988 Act (albeit at the instance of the Mental Welfare Commission) to enforce the duties imposed by the Second Order is significant. This remedy has been described as "peculiar and drastic" (*Carlton Hotel Co. Ltd* v *Lord Advocate* 1921 SC 237). It is summary in nature, because the facts ought to be capable of rapid determination, usually

without the need for proof; and it is a remedy that is available only where the duty to be performed is clear and the precise terms of the requisite order can readily be stated (*McKenzie* v *The Scottish Ministers* 2004 SLT 1236). By expressly sanctioning this "drastic" remedy as a legitimate method of enforcing the duties arising by virtue of the Second Order, Parliament has confirmed that those duties are indeed clear, that the judicial order to be granted can be stated with precision, and that the underlying facts ought to be capable of rapid determination. If the duties are apt for enforcement by the Commission by the summary remedy of specific performance, then, logically, they must also be equally apt for enforcement by specific performance at the instance of an affected patient, such as the pursuer, who after all belongs to that limited class for whose benefit and protection the duties were enacted.

[54] But the matter does not end there. The summary remedy of specific performance under the Court of Session Act 1988 "was not intended to be an exclusive remedy" (*McKenzie, supra*, paragraph [17] per Lord Carloway). Many statutory duties may be enforced by ordinary action by a variety of civil remedies at common law such as declarator, interdict, an order *ad factum praestandum* or, as here, by the remedy of damages. Parliament's express and unqualified reservation, in section 272(2) of the 2003 Act, of "the rights" (note the use of the plural) of any other person is consistent with the conclusion that all such common law remedies are capable of being pursued, as appropriate, by an affected patient, including the common law remedy of damages.

[55] In conclusion, in my judgment, upon a proper construction of the relevant legislative provisions, a breach by the defender of the statutory duties imposed by virtue of the First Order (under section 268(2) of the 2003 Act) does not confer a civil right of action upon an aggrieved patient, because statute prescribes the specific manner in which performance of

those duties is to be enforced namely, by means of a mandatory review hearing under section 269; whereas a breach by the defender of the statutory duties imposed by virtue of the Second Order (under section 269(3) of the 2003 Act) does give rise to such a civil right of action by an aggrieved patient, and that by the whole panoply of available and apt civil remedies, because no other means of enforcement of such duties is prescribed (or, equally importantly, excluded).

[56] For these reasons, I concluded after debate that the pursuer was entitled to proof of his remaining averments of alleged breach of statutory duty under section 269(3) of the 2003 Act and alleged entitlement to reparation.

Issues in dispute at proof

[57] At proof, the issues in dispute fell into the following three broad categories.

[58] The first key battle-ground was the definition of the precise scope of a health board's duty when faced with a Second Order under section 269(3). Is the health board obliged merely to "identify" a LSU which could be suitable for the patient, or does the board's duty extend to actually transferring the patient there? Linked to this, to what extent are the patient's expressed preferences or wishes relevant to the discharge of the health board's duty, whichever form it may take.

[59] Second, a significant factual issue in dispute was whether the pursuer had refused the opportunity to be transferred to a LSU (at Woodland View), pending the offer to him of his "preferred" LSU bed within the Glasgow area (either within Leverndale Hospital or in a private facility known as Surehaven Glasgow). Certain ancillary disputed factual issues were linked to this, such as the precise content of the communications between Mr Boyle

and medical staff regarding bed availability elsewhere. The outcome of this disputed factual issue is relevant to the question of causation.

[60] Third, the nature and quantification of the pursuer's loss, injury and damage, if any, were in dispute. In this respect, it must be conceded that the pursuer's averments (in article 5) anent loss, injury and damage remained somewhat general and inelegant following debate. One specific issue should be noted. According to the pursuer's ragged extant averments, the defender was said to have been in breach of its statutory duty from the date of the First Order (on 24 November 2016) to the date of the pursuer's eventual transfer to Leverndale Hospital (on 6 December 2017). Standing my conclusions at the debate, I sought to make it clear to parties that that averment, as it stood, could not be correct in law, because (i) the effect of the First Order was, in effect, to afford a period of grace to the defender in which it was to perform its duties thereunder; (ii) in any event, a breach of the duties under the First Order was not enforceable by civil action; (iii) the effect of the Second Order was likewise to extend a period of grace to the defender in which to perform its duties thereunder; and (iv) while an alleged breach of the defender's duties under the Second Order was enforceable by civil action, in law the defender could only be said to have fallen into alleged breach, at earliest, on 16 June 2017, being the date of expiry of that extended period of grace. Accordingly, for the purposes of the proof, the maximum period during which the defender could relevantly be said to have been in breach of its statutory duty arising by virtue of the Second Order was the period from 16 June 2017 to 6 December 2017. To be clear though, that did not mean that any loss was confined to that period; it merely meant that the period during which any breach could be said to have subsisted was confined to that period.

[61] Against that background, I turn to examine the evidence at proof.

The evidence

[62] This proof was heard at the height of the second national lockdown imposed in late December 2020 to contain the resurgent Covid-19 pandemic. Of consent, the proof was conducted remotely via WebEx, with all parties participating simultaneously, by electronic means, from various remote locations under the control of the court. To the credit of everyone involved, it proceeded remarkably smoothly.

[63] In advance of the proof, signed written statements of all witnesses had been exchanged and lodged, the contents of which were deemed by prior interlocutor to constitute the evidence-in-chief of the signatories thereto, subject to supplementary examination-in-chief, cross-examination and re-examination, and under reservation of all issues of competency, relevancy and admissibility.

[64] At proof, I then heard oral testimony via video-conference from the pursuer himself (from office accommodation kindly made available to him by staff at Leverndale Hospital) and from his expert witness, Dr Michael Isaac, a retired consultant psychiatrist based in London. For the defender I heard testimony in like manner from three witnesses: Dr Brian Gillatt and Dr Dawn Carson, both being consultant forensic psychiatrists, and Kevin Tolland, lead nurse at Rowanbank Clinic. A joint minute of admissions was also lodged.

[65] The witness testimony was punctuated by a persistent machine-gun volley of objections to specific questions and lines of examination. In all but a tiny handful of instances, the impugned evidence was allowed under reservation. In the event, only three particular objections from this near constant barrage were insisted upon at the stage of closing submissions; none of those surviving objections had any merit; and I have repelled them all. The evidence thereby allowed is of no particular significance to the outcome so I

shall not prolong this judgment by dwelling further on the objections or the reasons for repelling them. I summarise the witness testimony below.

Daniel Boyle

[66] Mr Boyle (47), a detainee within Leverndale Hospital, adopted the terms of his witness statement. It addressed his assessment of the effect upon his rehabilitation of the defender's six month delay in transferring him to Leverndale. He spoke to his recollection of events from around May 2016, when he was first identified as suitable for a transfer to a LSU. He spoke to a conversation in February 2017 with Dr Fiona Cooper (the delegate of Dr Brian Gillatt, the pursuer's RMO) regarding the prospect of a transfer to Woodland View. He opposed such a proposed transfer. He believed it would eliminate contact visits with his family who lived in Glasgow. He understood he was on a waiting list for a transfer to the LSU at Leverndale Hospital. He did not wish to transfer first to Woodland View, only to be transferred to Leverndale at a later date, as this would require him to undergo a further period of "testing out". In March 2017 he had a brief meeting with Dr Dawn Carson of Woodland View; he insisted that the meeting had lasted no more than two minutes; that he had told Dr Carson that he did not want to transfer to Woodland View as it was too far away for his family to visit him there; and that there was no further discussion beyond that.

[67] He broadly agreed with the timeline of events set out in Dr Gillatt's witness statement (item 6/4 of process). A transfer to Surehaven Glasgow emerged later as a possibility, which he supported. In the event it never materialised due, he believed, to Surehaven's concerns of antagonism between another patient there and a relative of the pursuer. By August/September 2017, the plan had changed again, and he was to be transferred to Leverndale, but delays occurred, and a bed did not become available for him

until 6 December 2017. He recollected that he had been assaulted in Rowanbank by another prisoner on 7 June 2017.

[68] He denied that he was ever told that a transfer to Woodland View was the only option or that it was likely to be the only option in the foreseeable future. That said, he acknowledged that it was his choice not to go to Woodland View He said he had been told that he was at the top of the waiting list for a bed in Leverndale and that it wouldn't be too long until a bed became available. He denied that Dr Carson had discussed with him the possibility of support for family visits to Irvine; he denied ever having been told by Dr Gillatt that a transfer to Woodland View was the "only way to progress" or that it was the only likely option in the foreseeable future.

[69] In re-examination the pursuer testified that it was a "possibility" that, if he had been told that a transfer to Woodland View was the only available option in the foreseeable future, he may have agreed for an assessment to be carried out for his suitability for transfer there. Thereafter, he testified that he "would have probably went" but, in the event, he was never offered a bed there.

Dr Michael Isaac

[70] Dr Isaac (62), a retired consultant psychiatrist, with formidable qualifications and expertise, spoke to his expert report dated 6 July 2020 (item 5/6 of process). He acknowledged that his primary experience was with the English mental health legislation and that he was not expert in the details of Scottish mental health legislation, though he understood the principles to be similar.

[71] He spoke in general terms to the differing regimes, conditions and privileges within the MSU and LSU environments. He opined that if the pursuer had been transferred to a

LSU by, say, 1 July 2017, he would have gone through an initial assessment sooner, and would have started to build up the necessary experience to qualify for escorted and unescorted leave off the secure grounds by, say, December 2017. In the event, because his transfer to the LSU was delayed, that process (of building up escorted leave privileges) was delayed by six months.

[72] He stated that the average length of stay of a LSU detainee was about 18 months to two years; it was said to be uncommon for a patient's period of LSU detention to be less than that; but it was "reasonably common" for it to be more. From Dr Isaac's review of the medical records, the pursuer appeared to be progressing well within Leverndale; he was clinically stable; there was nothing to suggest that his "step-down" to community forensic accommodation would have been de-railed. On that basis, Dr Isaac opined that it was "very simple arithmetic" that following the pursuer's transfer to the LSU in December 2017, he would normally have been expected to be suitable for transfer into community forensic accommodation by December 2019. Therefore, if the pursuer's transfer to Leverndale had not been delayed in June 2017 by six months, the pursuer would probably have transferred to community forensic accommodation six months earlier, that is by "approximately" August or September 2019. He acknowledged this estimation was "not an exact science" and would depend on a number of factors, some non-clinical, notably the availability of such community accommodation.

[73] In cross-examination, Dr Isaac acknowledged that he was not familiar with the specific terms of the section 269 of the 2003 Act, though he was broadly familiar with the nature of the duty, which he understood to be similar in England. He acknowledged that a detainee subject to a restriction order, such as the pursuer, would also require Scottish

Ministerial approval for any transfer, even indeed to transition from escorted to unescorted leave. This was a significant additional bureaucratic process. It could vary in length.

[74] Dr Isaac acknowledged that if the relevant statutory duty was merely for the health board to "identify" suitable accommodation (and not to effect a transfer) within a time-scale his report might be said to be predicated upon an erroneous hypothesis. Likewise, if a suitable bed had been available for a patient, but the patient, with capacity, had simply refused to transfer, any resulting delay would have been the "choice" of the patient. Dr Isaac confirmed that he knew nothing of the possibility of the pursuer transferring to Woodland View.

[75] Dr Isaac stated that it was easier bureaucratically to transfer a patient between two LSUs than to transfer from a MSU to LSU. In England, detainees transfer "all the time" between different LSUs. That said, community integration may be easier if the LSU is closer to the patient's family. He opined that it normally takes about three months in a LSU to transfer from escorted leave within the LSU grounds to escorted leave outwith the grounds; overnight leave does not occur until much later in the rehabilitation programme; but all of the foregoing may vary from one patient to another. Transfer from LSU to a community forensic accommodation required the cooperation of local authorities and other agencies; there can be limits on accommodation availability; other factors which may affect the timing of a transfer (such as a risk of antagonism or exploitation between patients); and Dr Isaac acknowledged that he was not qualified to speak to the availability of such community accommodation in the Glasgow area.

[76] In re-examination Dr Isaac acknowledged that, upon transfer to a LSU, there would be a period of "testing out", which meant simply a period of assessment to see how the patient would react to increasing levels of freedom and how he settled with the new medical

team in the LSU environment. The initial testing out period was generally limited to three months, graduating to unescorted leave some months thereafter, depending on each patient. The patient's experience in the first few months in a LSU tended to be "somewhat more confining" than the patient's experience in the latter stages of a MSU. Dr Isaac opined that if a patient made a side-ways transfer from one LSU to another, the detainee would require to undergo a "brief period of getting to know the medical staff" in the second LSU, but the patient would not require to repeat all of the stages of "testing out" in the new LSU setting. At worst, there would be an "abbreviated period" of fresh testing out.

Dr Brian Gillatt

[77] Dr Gillatt (45), a consultant forensic psychiatrist since 2006, was the pursuer's registered medical officer ("RMO") during his period of detention at Rowanbank Clinic. He spoke to and adopted his witness statement (item 6/4 of process). This was based on his review of the pursuer's medical records, which he believed gave a true account of the history of the pursuer's transfer from Rowanbank to Leverndale. He spoke to the history of efforts made to transfer the pursuer to Woodland View, then to Surehaven, then to Leverndale, and of Dr Gillatt's clear view that the pursuer would have been transferred to Woodland View no later than 16 June 2017 but for the pursuer's refusal to accede to such a transfer. Dr Gillatt testified that the medical staff were "clear" with the pursuer that a transfer to Woodland View was the only option as at March 2017. He spoke of his knowledge of the unpredictability of bed availability within MSUs and LSUs. He had no control over bed management or bed availability within any LSU, still less over any "out of area" placement referral.

[78] He spoke to his attendance at weekly referral meetings. He did not attend the separate bed management meetings chaired by Mr Tolland. Throughout 2017, the pursuer remained on the waiting list for an available bed within Leverndale but, as far as he was aware, no bed became available for the pursuer until December 2017. He acknowledged that it was usually only in the period of the Second Order that a decision would be taken by the defender to look for an "out of area" placement. It was possible for a patient to transfer between LSUs, but the defender's preference was for patients to be transferred to a LSU within the defender's own area in order to "link in" more effectively with local teams; any repetition of "testing out", if a patient transferred between different LSUs, would be a matter for the relevant LSU team.

[79] With reference to Dr Carson's witness statement (item 6/6 of process), Dr Gillatt opined that the true timescale for transfer of the pursuer to Woodland View, if he had been assessed as suitable, would have been shorter than Dr Carson's estimated timetable. He would have "driven" a faster timetable for obtaining ministerial approval for overnight visits and pre-transfer visits to the LSU, and the pursuer could have been transferred within the timescale of the Second Order. It was correct that the pursuer had indeed been assaulted at Rowanbank by a fellow detainee, but this had occurred on 7 June 2017. Dr Gillatt disputed that the pursuer was at a higher risk of being assaulted within Rowanbank Clinic than in a LSU. Dr Gillatt agreed that there was no obvious clinical reason to justify a delay in the pursuer's transfer to a LSU; if the pursuer had transferred to a LSU six months earlier, he would have been six months further ahead in his rehabilitation; but Dr Gillatt did not agree that it followed that, but for the delayed transfer to the LSU, the pursuer would, by December 2019, have been living in community forensic accommodation. Such an outcome

would depend upon many variables, including the individual circumstances of the patient and the availability of such accommodation, which was limited.

[80] In re-examination, Dr Gillatt confirmed that he would have been concerned if the pursuer, though clinically stable, had been forced against his will to transfer to Woodland View, as this may have resulted in a "failed transfer". Community forensic accommodation was a "very limited resource". In Dr Gillatt's experience, having worked in a LSU from 2008 to 2011, LSU patients could sometimes wait a year for accommodation to become available in the community; and Dr Gillatt's impression was that the situation had not improved since.

Dr Dawn Patricia Carson

[81] Dr Carson (48), a consultant forensic psychiatrist of 17 years standing, is employed by NHS Ayrshire & Arran. She has been based at Ayrshire Central Hospital, Irvine since 2017.

[82] She adopted her witness statement (item 6/6 of process). She met the pursuer only once, on 20 March 2017, to carry out an assessment of his suitability for transfer to Woodland View. It had then only recently opened in January 2017 as an eight bed facility. Several beds remained empty for "quite a few months". Her meeting with the pursuer had "stood out" and was "unusual" because the pursuer had made it so clear to her that he did not wish to transfer to Woodland View at all. He felt it was too far away for family visits. He politely but firmly dismissed all discussion about options to support such visits; he stated he would prefer to wait for a bed to become available in Leverndale; she had explored the reasons for the pursuer's stated position; she had explained to him the consequences of his decision, that it may delay his transfer to a LSU because Leverndale did not have an

available bed, and that his recovery pathway and eventual discharge may be delayed; he appeared to understand the consequences of his decision; he confirmed that he knew this would mean a delay in a transfer to a LSU ("he shrugged his shoulders and said 'So be it' or words to that effect"); and, according to information given to Dr Carson by nursing staff at Rowanbank Clinic, he had held this view for some time. Dr Carson explained that she would have been reluctant to over-rule his clearly expressed wishes because a transfer to a LSU is very much "recovery-focused" and a forced transition could cause distress and a deterioration in the patient's mental health. She was aware from the pursuer's notes that a previous transfer had fallen through due to the pursuer having a positive drug test. Dr Carson confirmed that she told the pursuer and the Rowanbank nursing staff that she remained willing to complete the pursuer's assessment of suitability for transfer to Woodland View, should he change his mind. She spoke to her contemporaneous correspondence with Rowanbank medical staff (items 6/1, 6/2 & 6/3 of process). She confirmed that the pursuer appeared suitable for transfer to Woodland View. She adhered to her opinion that, if he had allowed her to complete her assessment, the pursuer would have been assessed as suitable for transfer to Woodland View, that a bed would have been identified as available for him there, and that, but for his refusal to countenance the notion, he would have been transferred during July 2017, with a margin of variation three to four weeks either way.

[83] In cross-examination she was challenged to as the reliability of her recollection of the meeting, absent the availability of contemporaneous notes. She adhered to her testimony. She recalled that the pursuer was "very matter-of-fact". She confirmed that Woodland View had vacant beds at that time (two of which were specifically ear-marked for "sale" to out of area" placements); she and NHS Ayrshire & Arran were "very keen" to accept him; but that

in her opinion it did not seem right to over-rule his clearly stated wish to remain at Rowanbank until a placement became available at Leverndale. She denied that the meeting had lasted for only two minutes, but agreed that she did not carry out a full review or assessment of the pursuer's suitability for transfer, given his expressed opposition.

[84] She spoke to her estimated timeline (described as a "rough approximation") to transfer the pursuer to Woodland View, if he had consented. She acknowledged that there would be period of transition or testing-out, following the pursuer's transfer, to build up trust and a relationship with staff. She had no experience of patients transferring between LSUs, but acknowledged that may be possible.

Kevin Brian Tolland

[85] Kevin Tolland (48), a registered nurse, is employed by the defender as lead nurse at Rowanbank Clinic, Glasgow. He qualified in 1993.

[86] He spoke to his additional duties and experience as the "bed manager" within the defender's Directorate of Forensic Mental Health and Learning Disabilities. Adopting his witness statement (item 6/5 of process), he spoke to the timeline of bed management decisions regarding the pursuer from 8 June 2016 until the date of his eventual transfer to Leverndale on 6 December 2017. His statement was based upon his review of the contemporaneous minutes of the defender's referral meetings and the Directorate's separate bed management meetings chaired by him during that period. The two meetings (referral meetings and bed management meetings) were different in nature, as were the attendees. The pursuer was first identified by the Directorate as potentially suitable for transfer to a LSU on 8 June 2016; he was referred to a psychiatrist within Leverndale for assessment of his suitability; on 27 July 2016, he was duly assessed as suitable for transfer; and, on that date,

the pursuer's name was added to the defender's waiting list for an available bed within Leverndale Hospital. The pursuer's name remained on the waiting list throughout, and his case continued to be discussed at weekly bed management meetings thereafter. Mr Tolland described the mechanism for effecting transfers from MSUs to LSUs, and from LSUs into community accommodation, the latter being dependent upon resources made available by Glasgow City Council and private care providers, with the result that a "bottle neck" can arise causing delays in transfers. Even when a patient is referred for assessment for an "out of area" placement, the patient continues to feature on the Leverndale waiting list, and will be considered for transfer there once a bed becomes available. If a patient is transferred to an "out of area" bed, that patient will also remain on the waiting list for a bed within Leverndale Hospital, but their precedence on the list will then alter, with priority being given to a MSU patient awaiting a transfer to a LSU. He testified that it would be possible for an agreement to be reached for a patient who had been transferred to an "out of area" bed to retain his or her priority on the waiting list for Leverndale. This was said to be "not a common thing" but a "possible thing", though he had not had experience of it.

[87] In cross-examination, Mr Tolland stated that those patients who had the benefit of a Second Order were afforded greater priority than those who did not. By 24 November 2016, eight patients had priority before the pursuer for transfer to Leverndale. By March 2017, the pursuer was fourth on the defender's waiting list.

Closing submissions

[88] Extensive written submissions and supplementary written submissions were lodged for both parties, supplemented by brief oral submissions, for which I am grateful. For the sake of brevity, I shall not repeat the content here.

Assessment of the evidence

[89] I was impressed by the testimony of all of the defender's witnesses. It was careful, thoughtful and measured; it was broadly consistent; it was reliably informed by the witnesses' reviews of contemporaneous records (extracts of which were referred to in their written statements, where appropriate); and in certain respects it was also vouched by contemporaneous documentation lodged in process. For these reasons, I accepted the testimony of the defender's witnesses as both credible and reliable.

[90] The pursuer's expert witness, Dr Michael Isaac, was also a most impressive and thoroughly engaging witness. However, by his own concession, fairly made, he was unable to speak to key issues of a local (Scottish) nature, such as the usual timescales for LSU or community forensic accommodation to become available here. While I was content to accept some of Dr Isaac's general estimates of broad timescales within which a detained patient, such as the pursuer, might expect to migrate from LSU to community forensic accommodation, little significance came to be attached to that because, as Dr Isaac fairly acknowledged, this was "not an exact science" and would "depend on a number of factors", not all of which were explored exhaustively in his evidence. Further, Dr Isaac's opinion was predicated upon the assumption that the health board's statutory duty was to *transfer* the patient, not merely to *identify* and *notify* certain persons of available accommodation. It took no account of the possibility that the pursuer may have been the cause of his own continued detention in conditions of excessive security. He acknowledged that in preparing his report he had no knowledge of the possibility of LSU accommodation at Woodland View being made available to the pursuer, or of the pursuer's allegedly persistent refusal to countenance a transfer there. In cross-examination, he explicitly acknowledged that if an LSU bed had

indeed been available sooner, but the pursuer had decided not to go to it, then, since the pursuer "had capacity", that would have been "his choice". In the event, my adjudication on these separate issues of fact meant that the attractive but general theoretical analysis in Dr Isaac's report came to be diminished in practical relevance.

[91] Lastly, the pursuer himself struck me as a perfectly honest witness, doing his very best to give a truthful account of events. Indeed, he was entirely candid on the material issue of his dismissive attitude towards the proposed transfer to Woodland View. However, on other issues of fact, on which his recollection of events and discussions several years ago differed from the testimony of the defender's witnesses, I regarded his recollection as unreliable and preferred the account of the defender's witnesses, not only because of the accumulated weight and internal consistency of the body of evidence from the defender's impressive witnesses, but also because the testimony of the defender's witnesses bore to be informed and supported by their review of contemporaneous medical records and notes (extracts of which were referred to in the defender's witness statements) and, in certain respects, vouched by contemporaneous documentation separately lodged in process.

Discussion

What is the scope of the health board's duty under section 269?

[92] In order to determine whether the defender has breached any of its duties under section 269, it is necessary first to define the precise scope of those duties.

[93] There is perhaps an understandable assumption that the duty upon the health board is to *transfer* the patient within the Tribunal's defined timescales. While the physical transfer of the patient may be the normal and expected consequence of a health board performing its obligations under section 269, in my judgment the health board's duty under section 269 is

narrower in scope. On a proper interpretation of the legislation, the board's statutory duty under sections 268 & 269 is merely to *identify* available accommodation in a suitable hospital (or hospital unit) of a lesser level of security, and to *notify* the managers of the hospital in which the patient is detained of the name of that other hospital; the board's statutory duty under sections 268 & 269 does not extend to actually *transferring* the patient to that other hospital. Sections 268 & 269 are concerned primarily with the identification of an available physical resource. A failure to effect a transfer to that available resource, once a health board has performed its narrower duty to identify it (and give notification of it), might be the subject of separate judicial review proceedings at the instance of an aggrieved detainee, but the proceedings would not be founded upon a breach of the statutory duty under section 269, because that particular duty would already have been fulfilled. This conclusion follows naturally from the plain wording of the statute.

[94] Consider the nature of the First Order under section 268(2) of the 2003 Act. The order is two-pronged. The first part is a declaration of the existence of the offending state of affairs (namely, that the patient is being detained in conditions of excessive security). The second part is a specification of a time-scale within which two specified "duties" shall be "performed".

[95] But what are these two specified duties? They are very precisely defined as "the duties under subsections (3) to (5) below" (2003 Act, section 268(2)(b)). When one looks at subsections (3) to (5) of section 268 it is clear that the specified "duties" do not include a duty to transfer the patient. That could quite easily have been stated, if Parliament had so intended. Instead, the duties are much more narrowly and elaborately defined. The duties are to *identify* and to *notify*. There is no duty to *transfer*.

[96] The health board's first duty appears in section 268(3). (In Mr Boyle's case, it is section 268(3), not section 268(4), which applies, because Mr Boyle is a "relevant patient" by reason of the subsistence of the CORO.) Section 268(3) states that the health board must "identify" a hospital which is not a state hospital; which the relevant health board and the Scottish Ministers (and the managers of the identified hospital, if not managed by the health board) "agree" is a hospital in which the patient could be detained in conditions that would not involve the patient being subject to a level of security that is excessive in his case; and in which accommodation is available for the patient. So the first duty is to identify available accommodation in a suitable hospital; it is not to transfer the patient there.

[97] The health board's second duty appears in section 268(5). It states that, as soon as practicable after identifying available accommodation in such a hospital, the health board must "give notice" to the managers of the hospital (in which the patient is being detained) of the name of the hospital so identified. So the second duty is to notify specified persons of the identification of the location of that available accommodation; again, it is not to transfer the patient there.

[98] In the context of a First Order, the legislation does make one explicit reference to the transfer of the patient. It appears in section 269(2). It states that if the health board fails, during the period specified in the First Order, to "give notice" to the Tribunal that the patient has been transferred to the other hospital, then the second stage of the statutory appeal procedure is triggered. On a proper construction, this provision can be seen to be, again, no more than a notification provision. It does not, in its terms, impose a duty on the health board to transfer the patient; instead, it merely states that a particular consequence will follow if the health board fails to *notify* the Tribunal that the patient has been transferred within the time-scale specified in the First Order. The consequence is that a further hearing

shall be convened before the Tribunal, at which the Tribunal must decide whether or not to issue a Second Order. Section 269(2) does not create or impose a statutory duty at all; it merely defines a consequence if a certain state of affairs exists (i.e. if the Tribunal is not notified of a transfer having taken place).

[99] Now, consider the nature of the Second Order under section 269(2) of the 2003 Act. It follows the same structure and carefully elaborate wording. It is also two-pronged. Again, the first part is a declaration of the existence of the offending state of affairs (namely, that the patient is being detained in conditions of excessive security). The second part is a specification of a further time-scale within which, again, two specified "duties" must be "performed".

[100] Again, these two specified duties are very precisely defined as "the duties under subsections (4) to (6) below" (2003 Act, section 269(3)(b)). When one looks at subsections (4) to (6) of section 269, it is clear that the specified "duties" do not include a duty to transfer the patient. That could quite easily have been stated, if Parliament had so intended. Instead, the duties are much more narrowly and elaborately defined. Again, as with the First Order, the duties incumbent upon the health board are to identify and to notify. There is no duty to transfer.

[101] The first duty under the Second Order appears in section 269(4). (Mr Boyle is a "relevant patient" by virtue of the CORO, so section 269(4) applies, not section 269(5).) Section 269(4) states that the health board must "identify" a hospital which is not a state hospital; which the relevant health board and the Scottish Ministers (and the managers of the identified hospital, if not managed by the health board) "agree" is a hospital in which the patient could be detained in conditions that would not involve the patient being subject to a level of security that is excessive in his case; and in which accommodation is available

for the patient. Therefore, the first duty is to identify available accommodation in a suitable hospital; it is not to transfer the patient there.

[102] The health board's second duty under the Second Order appears in section 269(6). It states that, as soon as practicable after identifying available accommodation in such a hospital, the health board must "give notice" to the managers of the hospital (in which the patient is being detained) of the name of the hospital so identified. So the second duty is defined, very carefully, as a duty to notify specified persons (the managers of the hospital in which the patient is detained) of the name of the hospital in which the available accommodation has been identified; it is not defined in any wider terms, such as to transfer the patient to that other hospital.

[103] In the context of a Second Order, there is no provision equivalent to section 269(2). That is unsurprising because the purpose of the notification provision in section 269(2) is merely to trigger the second stage of the statutory appeal process. If the patient is not transferred following the making of a Second Order, there is no further mandatory hearing before the Tribunal. Instead, it is then up to the patient to decide whether any civil remedy may be available.

[104] Why does the legislation not include a duty to transfer the patient? In my judgment, the answer is because the specified statutory duties are concerned essentially with an administrative or managerial issue, namely resource availability. The purpose of the statutory duties is to compel a health board to make available a certain valuable physical resource as and when it may be required, namely a vacant bed in a hospital with suitable security conditions. However, the final decision to transfer a patient from one hospital to another may involve different and wider considerations, including (but not restricted to) issues of medical judgment, or the patient's expressed preference, or other circumstances

pertaining to the patient (but not associated with conditions of hospital security). For example, a patient's mental or physical condition, or his ongoing compliance with treatment, may deteriorate or fluctuate, making a transfer inappropriate on medical grounds; or a decision to transfer may be influenced by the discovery of information as to the nature of a patient's personal relationship with another detainee or detainees, perhaps giving rise to a risk of antagonism, disorder or exploitation; or, as we have in the present case, the patient may express a clear preference or wish that impacts adversely upon a decision to transfer. While the (administrative) act of identifying an available bed in a hospital of suitable lesser security conditions may often coincide and accord with the separate (wider) decision to sanction the transfer of the patient there, that will not always be so.

[105] The issue of the patient's expressed preference requires to be approached with particular care. In the first place, as Lady Hale observed in *G v The Mental Health Tribunal for Scotland* 2014 SC 84 (at paragraph 73);-

> "…the search for an appropriate bed need not be confined to Scotland. If there are appropriate facilities in England, Wales or Northern Ireland, then the patient can be transferred there."

Thus, for the purpose of discharging its (administrative) duties under sections 268 & 269 of the 2003 Act, a health board need only identify available accommodation in a hospital that "could" accommodate the patient in conditions of appropriate lesser security. The precise location of the hospital, provided it is in the United Kingdom, is a matter for the health board to determine. This is not about freedom of patient choice. It is about ensuring that a specific public resource (available accommodation in a hospital of suitable lesser security conditions) "could" be made available to a patient, if required. That limited resource can properly be identified anywhere in the United Kingdom.

[106] However, it is entirely conceivable that a patient may express a strong preference as to the location of the hospital to which he or she wishes to be transferred. A patient might insist on a transfer to a particular hospital somewhere in Scotland outwith the relevant health board's area, in order to be with some dear friend who is also detained there; or a patient may implacably oppose a transfer to a particular hospital within the health board's area due to some personal grudge or historic animosity with present staff or patients there; or the patient may insist on a transfer to a hospital in England to be closer to family there; or all number of other preferences or partialities may be voiced.

[107] In my judgment, none of these expressed "wishes" is relevant to the discharge of the health board's narrow statutory duties under sections 268 & 269 of the 2003 Act. That is because the focus of those statutory duties is upon the suitability of the *security conditions* in that other hospital and the *availability of a bed* there; the suitability to the patient of the *location* of the hospital is nothing to the point.

[108] I acknowledge, of course, that persons (including health boards) exercising functions under the 2003 Act must "have regard" to certain "matters" when discharging functions under the Act. One of those matters is the expressed views of the patient. However, those matters need only be taken into account "insofar as they are relevant to the function being discharged" (2003 Act, section 1(2)). This qualification is important. It is reiterated in section 1(3)(a), which explicitly defines the "wishes and feelings" of the patient that are to be taken into account as being those "which are relevant to the discharge of the function". In my judgment, the patient's personal preference as to the precise location of a hospital of lesser security in which he or she might like to be detained is neither here nor there, in the narrow context of a health board seeking to discharge its (administrative) statutory duty to

identify a resource availability, that is, a vacant bed in a hospital of suitable lesser security conditions.

[109] However, separately, when one comes to consider whether a patient should in fact be transferred to that available bed in that particular identified hospital, the patient's expressed "wishes and feelings" then become highly relevant. The patient may have expressed a firm preference not to transfer to that particular hospital, notwithstanding that its lesser security conditions are perfectly suitable for him or her and that a bed is available there. The patient's expressed wishes may be rational or ridiculous, reasonable or exaggerated, but either way they must be taken into account. They may not be determinative, the weight to be attached to them may vary, they may be over-ridden in appropriate circumstances, but the health board and the treating medical professionals must still have regard to them. Depending upon the particular circumstances of the case, it is conceivable that the health board, RMO and hospital managers might reasonably conclude, for example, that the forced transfer of the patient to the other hospital, against his or her express wishes, would be sufficiently detrimental to the patient's health or welfare (including progress in his or her rehabilitation) that it should not be actioned. Other considerations may support that decision, such as an informed assessment of the "range of options" available in the patient's case (per section 1(3)(e), 2003 Act), such the likelihood of an alternative bed becoming available elsewhere in a location that would meet with the patient's approval.

[110] In that scenario, the health board could still take the necessary steps to discharge its narrow statutory duties under sections 268 & 269 (to identify an available bed in another hospital of suitable lesser security conditions, and reach the necessary agreement with, and notify, the relevant interested parties), notwithstanding that a separate decision is then

taken, for other reasons, not to transfer the patient to that other identified hospital. In that way, the board's statutory duties to identify and to notify are performed; the discrete decision not to transfer the patient (or, indeed, to transfer him against his wishes) may the subject of separate judicial review proceedings involving scrutiny of different considerations.

[111] The circumstances of the present case might well have provided a neat illustration of just such a scenario. In the event though, for reasons explained below, that scenario did not quite materialise because the health board failed to take the necessary steps open to it to discharge its statutory duties under section 269.

Did the health board breach its statutory duties under section 269?

[112] Having clarified the precise scope of a health board's duties arising by virtue of a Second Order made under section 269, the next question is whether the defender discharged those duties in the present case. In my judgment, it failed to do so.

[113] In terms of the Second Order, the defender had until 16 June 2017 to perform its two duties thereunder. Those two duties were (i) to "identify" a hospital which is not a state hospital; which the defender and the Scottish Ministers (and the managers of the identified hospital, if not managed by the defender) "agree" is a hospital in which Mr Boyle could be detained in conditions that would not involve him being subject to a level of security that is excessive in his case; and in which accommodation is available for him; and (ii) as soon as practicable after identifying such a suitable hospital, to "give notice" to the managers of the hospital (in which Mr Boyle was being detained) of the name of the hospital so identified.

[114] In the event, while Dr Cooper did refer Mr Boyle to Woodland View (within the territorial area of NHS Ayrshire & Arran) for assessment of his suitability for transfer, and

while Dr Dawn Carson did attend at Rowanbank for that express purpose, the assessment was never completed. Accordingly, accommodation at Woodland View was never confirmed as being available for Mr Boyle and he was never accepted as suitable for transfer there. On the evidence, the most that could be said was that if the assessment had been completed, Mr Boyle would have been assessed as suitable for transfer to Woodland View; that accommodation would have been available for him; and that he would have been accepted as suitable for transfer there. In the event, none of this actually occurred.

[115] As a result, the defender never did "agree" with the managers of Woodland View that Mr Boyle could be detained there in suitable conditions of lesser security. Likewise, the defender never did "agree" with the Scottish Ministers (for their separate interest, standing Mr Boyle's status as a "relevant patient") that Mr Boyle could be detained at Woodland View in suitable conditions of lesser security. For those reasons, that element of the defender's duty under section 269(4)(b) of the 2003 Act was never fulfilled.

[116] In a similar vein, the referral never reached the stage of a bed being identified as available for Mr Boyle in Woodland View. For that reason, that discrete element of the defender's duty under section 269(4)(c) of the 2003 Act was also never fulfilled.

[117] Lastly, the defender never did "give notice" to the managers of Rowanbank Clinic (being the hospital in which Mr Boyle was then detained) of name of a hospital (i.e. Woodland View, Irvine) having been so identified, for the purposes of complying with the Second Order under section 269 of the 2003 Act. Accordingly, that discrete element of the defender's duty under section 269(4)(c) was also never fulfilled.

[118] Ironically, if Dr Carson had simply completed Mr Boyle's assessment, I am satisfied on the compelling evidence of Dr Carson and Dr Gillatt that the pursuer would have been assessed as suitable for transfer to Woodland View, Irvine; that a bed would have been

identified as available for him there; that he would have been accepted by the managers of Woodland View as suitable for transfer there; that the Scottish Minsters, for their discrete interest, would likewise have agreed; and that the defender would have notified the managers of Rowanbank Clinic (where Mr Boyle was being detained) that Woodland View had indeed been so identified for the purposes of section 269(4) of the 2003 Act, all prior to expiry of the prescribed deadline in the Second Order. In that event, the defender's statutory duties under the Second Order would have been discharged.

[119] But proof of the counter-factual, however likely, is not sufficient to discharge the statutory duties under the Second Order. On the evidence, as a matter of fact, the defender did not discharge its duties of identification and notification under sections 269(4) & (6).

[120] The error into which the defender has fallen is that it has conflated two discrete issues: (i) first, the taking of steps to discharge its (essentially administrative) duties under section 269 to identify available accommodation in another hospital of suitable lesser security conditions; and (ii) second, the taking of a separate decision as to whether or not to actually transfer the patient to that other hospital.

[121] The error has arisen because, when addressing the first issue, the defender has allowed itself to be diverted by an irrelevant consideration, namely, Mr Boyle's expressed preference as to the location of the hospital to which he wished to be transferred. By taking that irrelevant factor into account, the defender then failed to take the necessary steps that were open to it to discharge its duties under the Second Order. Specifically, it failed to procure that its referral of Mr Boyle to Dr Carson for assessment was completed; it thereby failed to identify available accommodation at Woodland View; it failed to "agree" as much with the Scottish Ministers and the managers of Woodland View, Irvine; and it failed to give notice to the managers of Rowanbank Clinic that Woodland View had been so identified. In

all likelihood, all of this could readily have been achieved prior to 16 June 2017. If those steps had been taken, the defender would have discharged its statutory duties, and could then have addressed its mind to the second issue (namely, whether, notwithstanding the identification of available accommodation in a hospital with suitable security, it was appropriate to take a decision to transfer Mr Boyle there against his wishes). In the context of that second issue, Mr Boyle's expressed preference would certainly have been a relevant consideration alongside others (including the "range of options" available in Mr Boyle's case, such as the likelihood of a bed becoming available in due course in his preferred location: section 1(3)(e), 2003 Act). In the context of that second issue, the decision not to transfer Mr Boyle against his express wishes is likely to have been entirely justifiable in the circumstances.

[122] The same analysis applies to the prospective transfer to Surehaven in Glasgow. On 3 May 2017, the pursuer was first advised of the possibility of a bed becoming available in the privately-run LSU at Surehaven, Drumchapel; with the consent of the pursuer, a referral was sent by the Rowanbank medical staff to Surehaven requesting that the pursuer be assessed for suitability for transfer to Surehaven; on 31 May 2017, the assessment was duly carried out and the pursuer was accepted for transfer to the LSU at Surehaven; and a formal letter, confirming the pursuer's acceptance for transfer, was received by Rowanbank from Surehaven on 8 June 2017. However, none of the foregoing is sufficient to discharge the defender's two duties under the Second Order.

[123] Firstly, according to the evidence, no bed was ever identified as available for Mr Boyle within Surehaven. The "acceptance" of his transfer there, however formal, could only ever have been an acceptance in principle. It was always subject to a bed becoming available, which never happened. Accordingly, section 269(4)(c) of the 2003 Act was never

satisfied. Secondly, there was no evidence of any agreement of the Scottish Ministers that Surehaven was a hospital in which Mr Boyle could be detained in security conditions suitable to his case. Accordingly, section 269(4)(b) of the 2003 Act was not satisfied. Thirdly, no "notice" was ever given by the defender to the managers of Rowanbank that Surehaven had been so identified, in compliance with the Second Order. Accordingly, section 269(6) of the 2003 Act was not satisfied.

[124] The same analysis can be applied to the original prospective transfer to Leverndale. While it is correct that a formal letter was received by Rowanbank Clinic as far back as 8 September 2016 accepting the pursuer as suitable for transfer to Leverndale, no accommodation was identified at that date as being available for Mr Boyle, or indeed for well over a year thereafter. Therefore, the requirement in section 269(4)(c) was not fulfilled as at 8 September 2016. Further the defender did not at that time "agree" with the Scottish Ministers that Leverndale was a hospital in which Mr Boyle could be detained in suitable security conditions, for the purposes of fulfilling the requirement in section 269(4)(b). According to the evidence, it was not until 11 October 2017 that any agreement "in principle" was first reached between the defender and the Scottish Ministers for the transfer of the pursuer to Leverndale. Even then, still no bed had been identified as being available for the pursuer. Only by 6 December 2017, when Mr Boyle was finally transferred, can it be reasonably be concluded (albeit by inference, absent any more specific evidence) that all of the statutory duties under the Second Order had by that date been performed, with accommodation within Leverndale plainly having been identified as available for the pursuer, agreement presumably having been reached with the Scottish Ministers as to the suitability of security conditions there for Mr Boyle, and due notice thereof having been given to the managers of Rowanbank Clinic.

[125] The upshot is that, as at 16 June 2017, the defender was indeed in breach of its statutory duties under section 269 of the 2003 Act. There is no evidence to support the conclusion that those duties were performed prior to 6 December 2017.

Causation

[126] When a breach of statutory duty is founded upon and established, it is still necessary for the pursuer to aver and to prove causation (*Bonnington Castings Ltd* v *Wardlaw* 1956 SC (HL) 26; *McWilliams* v *Sir William Arrol & Co. Ltd. and Anor* [1962] 1 W.L.R. 295).

[127] In my judgment, notwithstanding that between 16 June 2017 and 6 December 2017 the defender was in breach of its statutory duties under section 269(4) & (6) of the 2003 Act, it is incontrovertible that that breach did not cause the pursuer to suffer the loss complained of. Instead, the sole cause of the pursuer's alleged loss, injury and damage was the pursuer's own conduct in persistently refusing to countenance or accede to a transfer to the LSU at Woodland View, Irvine throughout the period from 24 February 2017 to 6 December 2017, most significantly at his meeting with Dr Dawn Carson on 20 March 2017.

[128] In leading questions in re-examination, the pursuer's counsel sought to soften the harsher edges of the pursuer's resolute refusal, by seeking to elicit evidence to the effect that Mr Boyle's communications may have been no more than an expressed preference,; that they may not have been final in nature; that they may have been misinformed by incomplete information as to the likely availability of a bed in a LSU in Glasgow. I reject those belated embellishments.

[129] On the evidence, I am satisfied that Mr Boyle had set his face firmly against a transfer to Woodland View. He was not prepared to countenance it. He had made his decision crystal-clear to everyone concerned, including Dr Carson (on her meeting with him for the

express purpose of carrying out the assessment) and the Rowanbank medical and nursing staff. He knew he was taking a chance by so doing, but he was fully aware of the risks, and was willing to take them. The evidence to this effect is overwhelming.

[130] It is vouched by the written decision of the Tribunal dated 16 March 2017 (item 5/1 of process), which records Mr Boyle's clearly expressed view that he wanted to be transferred to Leverndale and nowhere else. The Tribunal records the evidence heard from the pursuer as follows:

> "15. …. [Mr Boyle] indicated that, in his view, a transfer to Woodland View was not an option as it was too far and too expensive for his family to visit him. He would rather wait in Rowanbank and wait for a place to become available in Leverndale. His partner stayed in the Cardonald area and Leverndale was much more suitable.
>
> 16. ….. If no move was available he would like to proceed to unescorted leave from Rowanbank and for consideration to be given to an ultimate discharge from Rowanbank…."

It is vouched by the entries extracted from the contemporaneous Rowanbank clinical notes as spoken to by Dr Gillatt. It is vouched by the documentary evidence lodged in process by the defender, comprising the contemporaneous correspondence between Dr Carson and Dr Gillatt. It is vouched by the clear, specific and consistent testimony of Dr Gillatt and Dr Carson, supported by Mr Tolland's parallel account of the chronology of events derived from his separate review of contemporaneous records available to him. It is vouched by the parties' joint minute of admissions. Paragraph 13 of that joint minute states:

> "During a meeting with the RMO the pursuer stated that he did not want to be transferred to Woodland View…and that he wanted to remain in Rowanbank Clinic as it was more suitable for family visits."

It is vouched by Mr Boyle's own account under oath in these proceedings. In his oral testimony, he did not shy away from this particular issue. He was clear that he did not wish

to go to Irvine and had said as much to everyone who had an interest to know - to the medical and nursing staff at Rowanbank; to the Tribunal; and, most critically, to Dr Carson when she came to assess him for transfer. His recollection of his meeting with Dr Carson was vivid. By his own account, he had left her in no doubt that he was not prepared to countenance even the prospect of a transfer to Irvine. Mr Boyle was insistent that that critical meeting lasted for no more than a couple of minutes, because Mr Boyle had made his position absolutely clear to her from the outset: he was not going to transfer to the LSU in Irvine, and that was the end of the matter. There was, in his mind, nothing further to discuss. Counsel's ingenious attempts, notably in re-examination and submission, to soften the edges of that unyielding position were unconvincing.

[131] But for Mr Boyle's firm refusal, I am satisfied on the evidence that Mr Boyle would have been assessed by Dr Carson as suitable for transfer; that accommodation would have been identified as available for him there; that all the necessary notifications would have been effected; and, indeed, that Mr Boyle would in fact have been transferred, all by no later than 16 June 2016 (the date of expiry of the deadline in the Second Order). Woodland View was a new facility, only partially occupied; two places, both vacant, had been specifically ear-marked for "sale" to other health boards as "out of area" placements; only the defender had been approached to purchase those beds; and Dr Carson was confident in her testimony that Mr Boyle would otherwise have been suitable for transfer to Irvine.

[132] Though it would not have been strictly necessary for the purpose of discharging the defender's statutory duties, Dr Gillatt was also confident the pursuer's transfer could in fact have been effected by 16 June 2017. On this issue, Dr Gillatt struck me as an astute and determined individual, with the experience and know-how to ensure that the necessary procedures would indeed have been implemented within that timescale. In her oral

testimony, Dr Carson deferred to Dr Gillatt's assessment on that timing issue, and acknowledged the speed with which Rowanbank had, in the past, addressed such issues.

[133] Accordingly, in my judgment, the effective cause of the pursuer's continued detention in Rowanbank from 16 June 2017 to 6 December 2017, in conditions of excessive security, was his own voluntary decision – clear and unequivocal, persistent and unyielding – to reject the opportunity to transfer to the LSU at Woodland View.

Quantum

[134] Standing my conclusion on the issue of causation, I do not require to address the question of quantum. However, I am conscious that the scheme to allow excessive security appeals to the Tribunal only came into force in 2015 and there are no reported cases quantifying the damages payable for breach of a Second Order or indeed expressly contemplating damages as a remedy. Therefore, since we are charting new territory, it may be appropriate if I express just a few observations on the issue, for what little they may be worth.

[135] The first observation I would make is to emphasise that this claim is an action of damages for reparation for breach of a statutory duty. It does not involve the violation of any Convention Right. By way of guidance in seeking to quantify damages in this action, I was referred by counsel to only two cases: *Kolanis v United Kingdom* (2006) 42 E.H.R.R. 12 and *R (on the application of Sturnham) v Parole Board* [2013] 2 A.C. 254. Both involved alleged violations of Article 5(4) of the European Convention on Human Rights ("ECHR"), where the chance that had been lost by the breach was the chance to gain liberty from detention (albeit perhaps with conditions).

[136] There is a superficial attraction in seeking to drawing analogies with such cases, but in truth the exercise is doomed. No true comparison can be drawn between, on the one hand, an award of damages as "just satisfaction" for the violation of a Convention Right under the Human Rights Act 1998 and, on the other, an award of damages in a reparation action for breach of duty at common law or under statute. The vindication of Convention Rights is considered to be of paramount constitutional importance. The fundamental nature of those rights means that awards of damages, if made, are very different in nature from conventional common law awards of damages under the law of delict or tort. Indeed, it has been observed that the Human Rights Act 1998 "is not a tort statute" at all; its objects are "different and broader" (*R (on the application of Greenfield)* v *Secretary of State for the Home Department* [2005] 1 W.L.R. 673 per Lord Bingham of Cornhill). An award of "just satisfaction" damages under section 8 of the Human Rights Act 1998 has been said to be truly "a public law remedy of constitutional damages" (Clayton & Tomlinson, *The Law of Human Rights,* para. 21.15), and belongs properly "in the sphere of public rather than private law" (*HM Advocate* v *R* 2003 S.C. (P.C.) 21 per Lord Rodger). Such awards may reflect a sense of public outrage, or may seek to emphasise the importance of the constitutional right or the gravity of the breach, or may seek to deter further breaches (*Attorney General of Trinidad and Tobago* v *Ramanoop* [2006] 1 A.C. 328). These considerations (of vindication, deterrence and the like) are far removed from the simple, long-established compensatory principle that underpins an award of delictual damages at common law. In *R (on the application of Lumba)* v *Secretary of State for the Home Department* [2011] 2 W.L.R. 671 an attempt was made in the Supreme Court to import the vindicatory principles of such awards to common law damages for tort. In the leading judgment, Lord Dyson opined that the

implications of awarding vindicatory damages in such cases would be far reaching and tantamount to "letting… an unruly horse loose on our law".

[137] In conclusion, damages awards in cases involving violations of Convention Rights are so conceptually different from delictual damages claims that no guidance can properly be drawn from a comparison of the two.

[138] My second observation is that, on a proper analysis, it seems to me that a claim of this kind is really a claim of damages for loss of a chance. Provided the health board performs its statutory duty to identify (and to notify relevant persons) of available accommodation in a hospital of suitable lesser security conditions, the pursuer thereby attains the chance of being transferred there. In practice, one may quickly tend to follow the other, but that is not necessarily so, as the present case illustrates. The patient's statutory right is not actually to be transferred from one hospital to another; the patient's statutory right is merely to expect a resource to be identified (i.e. available accommodation in a hospital *anywhere* in the United Kingdom of suitable security conditions), so that he has the opportunity to access it when a separate decision, if appropriate to his particular circumstances, is taken to effect such a transfer, having regard to other, more extensive considerations. In the context of a lost chance claim, issues of causation and quantification must be carefully distinguished (*Allied Maples Group Ltd* v *Simmons & Simmons* [1995] 1 WLR 1602), particularly where the occurrence of the loss is dependent upon the hypothetical acts of both the claimant and independent third parties.

[139] In contrast with cases like *Kolanis* and *Sturnham, supra*, it is also worth noting that the chance that will have been lost by a breach of this statutory duty will not generally involve any sharp demarcation between detention and liberty. Instead, the chance lost by the alleged breach will generally be the chance merely to attain a less restrictive form of

detention. Quantification of the loss in such cases requires a comparison of the allegedly more restrictive "pre-transfer" security conditions actually endured by the pursuer at Rowanbank for the unwanted final six months of his detention there, with the allegedly more liberated "post-transfer" security conditions (and associated freedoms) that would have been endured by the pursuer at Leverndale in that period. Total liberation from detention is not the *de quo* of the statutory duty or correlative right.

[140] Turning to the evidence in the present case, my third observation is that I heard very little substantive evidence allowing me to make any such informed or reliable comparison of the pre-transfer and post-transfer security regimes and freedoms at Rowanbank and Leverndale respectively. As a result, I was unable to reach anything but the most general of conclusions as to the loss of amenities suffered by the pursuer during the six month delay. True, I have some testimony from the pursuer in his witness statement, but it does not advance matters greatly because it is high-level and general in nature, it lacks detail, and critically it focusses only on the pursuer's post-transfer regime of activities at Leverndale. The witness statement fails to compare that with the allegedly more restrictive pre-transfer regime endured in the latter stages of the pursuer's detention at Rowanbank. In paragraph 6 of his witness statement, the pursuer describes what I assume to be a more liberated experience enjoyed by him at Leverndale: he speaks of building up to "escorted" and "unescorted" time off the grounds at Leverndale (but how frequently, over what period, and what exactly is involved in this "time off the grounds"?); he speaks of attending group meetings "as required" (but what does that mean?); he speaks of now having "full days off the ward" for Restart Groups and family shopping days (but again how frequently, since when, and what exactly does that freedom entail?) and of having "as much time off the ward as is capable" (but what does that mean in practice?). I have no clear gauge as to the

substance or extent of these supposed new freedoms. More importantly though, I have no evidence as to how this post-transfer regime compares, in substance or extent, with the more restrictive pre-transfer regime that is said to have been endured by him at Rowanbank during his latter six months there. Only by having that comparison can I properly understand the nature of the "chance" that the pursuer has allegedly lost. That comparison is missing from the testimony.

[141] Interestingly, in a tranche of testimony from Dr Isaac (which I was content to accept), he explained that the level of freedom experienced by a patient, such as the pursuer, towards the latter end of his detention in a MSU is not significantly different from the freedom experienced at the early stages of detention in a LSU. If anything, the latter regime may be perceived by the patient as rather more restrictive because the patient loses some of the freedoms and privileges built up over time within the trusted and familiar environment of the MSU while he goes through a period of "testing out" (of between one month at a minimum to three months at most, according to Dr Isaac) within the new environment of the LSU. Accordingly, it seemed to me that the pre-transfer regime within the latter stages of the pursuer's detention at Rowanbank may not, in fact, have been significantly different from the post-transfer regime he would have experienced in his first three months or so at Leverndale. Quite how the post-transfer regime may have differed thereafter is not at all clear to me from the paucity of evidence available.

[142] In recognition perhaps of this inherent vagueness in defining what exactly had been lost by the pursuer by reason of the alleged "extra" six month period of detention in MSU, the pursuer sought to approach the issue of damages from the other end, by arguing that his eventual date of discharge from Leverndale into community forensic accommodation had been delayed by (at least) 6 months by reason of the defender's breach of statutory duty in

transferring him there in the first place. It was an attractive argument, plausibly presented by Dr Isaac. However, I concluded that the expert evidence on this particular issue was conflicting, general in nature, and, ultimately, inconclusive.

[143] Firstly, Dr Isaac conceded that the estimation of the length of a patient's detention in a LSU, and of his eventual transfer to community forensic accommodation, is "not an exact science", nor does it operate within tightly-defined timescales. It could not be stated with precision that Mr Boyle would have been transferred from a LSU to community forensic accommodation two years after his transfer from the MSU. Besides, in Mr Boyle's case, as a person subject to a CORO, the consent of the Scottish Ministers would also have been required to any transfer into the community. There was no evidence of the factors that the Ministers might consider relevant, or of their likely attitude, or of the usual time-scale for reaching such a decision. Critically, third party involvement is also required to allow any move from a LSU to a community placement. From all accounts, community forensic accommodation is in desperately short supply, with the result that it is not at all uncommon for there to be considerable delays in facilitating the transfer of patients from a LSU to community-based accommodation.

[144] Secondly, I simply did not have the quality of evidence available from a reliable source to allow me to gauge, with any confidence, the usual or likely timescales involved in effecting the transfer of a patient such as Mr Boyle from a LSU to community forensic accommodation. Dr Isaac fairly conceded in cross-examination that he could not speak to the usual time-scales for such accommodation becoming available in Glasgow. Dr Gillatt who, alone among the witnesses, did have some direct experience of the issue (albeit historic), spoke of being aware of 12 month delays before such transfers could be effected.

[145] In my judgment, there was no reliable evidential basis before me to make a finding-in-fact that the pursuer's ultimate release into the community had been delayed to any measurable extent by the six month delay in transferring the pursuer to a LSU at Leverndale. Too many variables were left unaddressed in the expert testimony. Among those fluctuating imponderables was the glaring uncertainty as to the provision by independent third parties of suitable community forensic accommodation (no reliable evidence to that effect having been led); there was uncertainty as to the attitude of the Scottish Ministers to the pursuer's return to the community (no evidence having been led of ministerial practice, policy or the likely approach in this case); and there was uncertainty as to the attitude and opinion of the patient's current RMO within, and of the managers of, the LSU at Leverndale responsible for the pursuer's care (none of whom were called to give evidence but who would, after all, have been in the best position to opine on the pursuer's actual progress within the LSU, of his current and anticipated eligibility or ineligibility for transfer from the LSU, of the usual timescales to effect such a transfer into community accommodation, and of the impact, if any, on Mr Boyle's treatment and rehabilitation of the six month delay in transferring him to Leverndale). For completeness, I also observe that, on the basis of Dr Gillatt's reliable chronology, I have found that the assault on the pursuer while he was at Rowanbank Clinic took place on 7 June 2017 (not in July 2017, as the pursuer avers on record). Therefore, it is irrelevant as a head of damage because it occurred prior to the date on which the defender first fell into breach of its statutory duties.

[146] In the foregoing circumstances, standing what appeared to me to be the deficient state of the evidence on the quantification of loss, I would have felt constrained to make no more than a nominal award of damages in favour of the pursuer in recognition of the

pursuer's lost opportunity to enjoy a generally less restrictive environment for a short period in the latter stages of his detention at Rowanbank.

Decision

[147] For the foregoing reasons, I have repelled the pursuer's pleas-in-law 1 & 2, sustained the defender's pleas-in-law 2, 3, 4, 5 & 6, and have granted decree of absolvitor in favour of the defender. The issue of expenses is reserved meantime.