SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

IN THE ALL-SCOTLAND SHERIFF PERSONAL INJURY COURT

[2025] SC EDIN 11

PIC-PG109/22

JUDGMENT OF SHERIFF K J CAMPBELL KC

in the cause

DAVID DOWNIE (AP)

Pursuer

against

FIFE HEALTH BOARD

Defender

Pursuer: Allardyce, adv, Claire, adv; Livingston Brown, solicitors, Glasgow
Defender: McConnell KC; NHS Central Legal Office

EDINBURGH, 26 February 2025

Findings in fact

1. By at least 4 February 2004 the pursuer had been diagnosed with Bipolar Affective Disorder. He had undergone a period of compulsory in-patient treatment at Lister Hospital, Stevenage, between 4 July and 19 September 2002.

2. The pursuer was admitted to Stratheden Hospital, Cupar, between 7 May - 8 June 2004, following an episode of acute mental ill-health in Estonia.

3. Between around March and 27 July 2011 the pursuer underwent a period of inpatient treatment at Stratheden Hospital under the care of Dr Beveridge, consultant psychiatrist. A discharge summary described his diagnosis as "Bipolar affective disorder: Current episode – manic".

4. On 27 September 2011 Dr Beveridge described the pursuer as tending to be "impatient and demanding".

5. On 13 October 2011 Dr Beveridge described the pursuer as "being bullying and demanding". The pursuer was noted to be unhappy with the advice given and said that he did not wish to attend further.

6. The pursuer did not attend the defender's mental health services from 13 October 2011 until autumn 2015.

7. On 20 November 2015 the pursuer was admitted for a period of in-patient treatment to the Lomond Ward, Stratheden Hospital. Lomond Ward is a general adult psychiatric ward. The admitting doctor, Dr Andrew Smith, considered that the pursuer was experiencing a manic episode. On 24 November 2015 a CT1, Dr Pittock, reviewed him and concluded that he would be detainable if he tried to leave hospital.

8. On 30 November 2015 Dr Narayan reviewed the pursuer and made notes of his review.

9. On 3 December 2015 Dr Narayan reviewed the pursuer and made notes of his review. 1580 (manuscript).

10. On 7 December 2015 Dr Narayan and Charge Nurse Glen Lomax reviewed the pursuer and the former made notes of his review. The pursuer gave express permission for Dr Narayan to discuss his condition fully with Caroline Manson. During that review Dr Narayan spoke to Caroline Manson who expressed dissatisfaction at the prospect of the pursuer being discharged. She told Dr Narayan that if the pursuer was discharged she would bring him back the following day, and that Dr Narayan was wasting her time and the hospital's time. Following that review the pursuer was discharged. Dr Pittock prepared a discharge letter.

11. On 16 December 2015 the pursuer's GP, Dr Macdonald, wrote a manuscript letter which the pursuer gave to Dr Narayan when they met at a clinic that day. Following the clinic Dr Narayan emailed the pursuer's GP and wrote a post-clinic letter.

12. On 18 December 2015 Dr Narayan wrote to the pursuer identifying 6 January 2016 as a start date for a 2-week period of voluntary in-patient admission.

13. On 22 December 2015 the pursuer's GP emailed Dr Narayan. The GP informed Dr Narayan inter alia that the pursuer had left Ms Manson and that he was "behaving himself".

14. On 30 December 2015, the pursuer's GP, Dr Macdonald, contacted Dr Narayan expressing concerns about the pursuer's mental state. Dr Narayan arranged to see the pursuer on 31 December at 14.30 but the pursuer was unwilling to attend at that point in time. Dr Narayan wrote a letter for the attention of the doctor who would review the pursuer when he attended. Dr Narayan encouraged that doctor to detain the pursuer if necessary.

15. On 30 December 2015 the pursuer was involved in an altercation with his parents. He was arrested and released on bail, with a bail condition being that he "does not approach, contact, or communicate nor attempt to approach contact or communicate with Anita Downie and Kenneth Downie named in the charges in any way".

16. On 31 December 2015 the pursuer was reviewed by an SHO, Dr Jabbad. Dr Jabbad did not obtain a history from the pursuer, but instead took his history from Dr Narayan's manuscript letter. Dr Jabbad made notes of his review.

17. The pursuer was admitted on 31 December 2015 and remained an in-patient until 7 January 2015. Nursing notes relating to the pursuer were maintained for this period (JB2758-2776).

18. At 20.15 on 31 December 2015 Caroline Manson called Stratheden to ask about the pursuer. She was recorded as being his ex-girlfriend. He indicated that all he wanted her to be told was that he was fine.

19. On 7 January 2016 Dr Narayan reviewed the pursuer and made notes of that review. He noted that the pursuer had broken up with his partner. He assessed the pursuer, performed a mental state examination, and concluded that there was no reason to detain him. Neither Dr Pittock nor Charge Nurse Lomax disagreed.

20. At 23.30 that evening the pursuer was reviewed by a CT1, Dr Grove, at the request of nursing staff. Dr Grove assessed the pursuer and made notes of that assessment. At the conclusion of that assessment the pursuer was agreeable to remain an in-patient. At 23.50 the pursuer self-discharged.

21. Later on 8 January 2016, Dr Narayan made notes about the pursuer's presentation.

22. On 11 January 2016 the pursuer was brought to Stratheden and reviewed by Dr Pittock with Charge Nurse Lomax. She assessed him and made notes of her assessment. She concluded that there was no evidence that he was suffering from a major mental disorder. She discharged him, to be followed up in 2 weeks.

23. On or about 13 January 2016 the pursuer smoked cannabis.

24. On 13 January 2016 the pursuer was arrested and taken to Perth Police Station. On the morning of 14 January he was reviewed there by Dr Michelle McGlen, ST6 in Forensic Psychiatry. She assessed the pursuer, concluded that he required to be detained, and detained him on a Short Term Detention Certificate at 12.20pm. She planned for him to be taken to Stratheden. She wrote to Dr Narayan explaining the reasoning underlying her decision.

25. In anticipation of the pursuer's arrival at Stratheden, Dr Pittock discussed matters with Charge Nurse Glen Lomax. Following that discussion, at 14.50, Dr Pittock emailed several colleagues setting out some of the background to the pursuer's condition.

26. At 15.24 on 14 January 2016, Dr David Reid replied to Dr Pittock's email. Dr Reid was a consultant psychiatrist who was responsible for the IPCU. He stated in his email that he had discussed the pursuer's presentation with Dr Narayan and that it sounded more manic and that there might therefore be a treatable aspect.

27. Sometime before 16.00 on 14 January 2016 the pursuer arrived at Stratheden. He was assessed by Dr Pittock. She discussed a plan with Dr Narayan. The plan for the pursuer included his admission, the prescription of medication and review. She made notes of her assessment.

28. At 16.02 Dr Pittock emailed Dr Reid and others describing her assessment of the pursuer.

29. The pursuer underwent Illicit Substances testing following his admission to Stratheden on 14 January 2016. He tested positive for cannabinoids. The pursuer had been in police custody since his detention on 13 January 2016 until his admission to Stratheden. He did not have access to controlled drugs whilst in police custody.

30. On 15 January 2016 at 09.30 Dr Narayan forwarded Dr Pittock's email to a Dr Thomson, a clinical psychologist. At 09.40 a nurse made an entry in the medical records to the effect that the pursuer was "totally in control" of his actions.

31. Between 09.40 and 12.05 Dr Narayan reviewed the pursuer and made notes of his review. During that review the pursuer behaved in a threatening and abusive manner. That behaviour was reported to the police, and the pursuer was subsequently charged with and

pleaded guilty to a contravention of section 50A(1)(b) of the Criminal Law (Consolidation)(Scotland) Act 1995.

32. The pursuer remained an in-patient and subject to compulsory detention from 12.20 on 14 January 2016 until around 11.30 on 18 January 2016. During that period he received treatment from the defender's clinical staff. They made notes of their treatment of the pursuer.

33. At around 10.20 on 18 January 2016 Caroline Manson called Stratheden. Her call concerned, inter alia, her perception that there had been a lack of communication with her from the nursing staff and Dr Narayan. She expressed dissatisfaction with the pursuer's previous care, particularly his discharge.

34. At around 11.30 on 18 January Dr Narayan assessed the pursuer. Charge Nurse Lomax was present. Following his assessment Dr Narayan revoked the STDC. Dr Narayan made notes of his assessment of the pursuer.

35. Dr Narayan recorded on 18 January 2016 that he has asked the pursuer about contact with Caroline Manson. The pursuer expressly stated that he did not want Dr Narayan to talk to Caroline Manson, his parents, or anyone else about his medical condition or status.

36. Dr Narayan advised the pursuer to remain as an in-patient to receive treatment. The pursuer took his discharge against medical advice.

37. Dr Pittock wrote a discharge summary relating to the 14 to 18 January admission.

38. The pursuer went to Ms Manson's house after his discharge and remained there overnight.

39. At around 10.20 on 19 January 2016 Caroline Manson telephoned Stratheden and asked that a CPN be put in place immediately, and for details of a follow up plan for the

pursuer. The pursuer had explicitly expressed his wishes that no medical information was to be passed to her or his family. Dr Narayan recorded that fact in the notes.

40. On 19 January 2016, the pursuer smoked cannabis in the morning. Ms Manson called the police and reported that the pursuer had been abusive to her. At around 22.45, the police took the pursuer to the Emergency Department of Victoria Hospital, Kirkcaldy, where he was assessed by Dr Elizabeth Rose, CT1 in psychiatry. She performed and recorded a mental state examination of the pursuer. Following her assessment she discharged him back to the care of the police.

41. Dr Narayan wrote to the pursuer on 19 January 2016.

42. At 00.30 on 20 January 2016, Dr Rose sent an email to Dr Pittock. In that she stated that when examining the pursuer on 19 January 2016 she found him "rather pressured and grandiose but nil warranting admission". Dr Pittock replied at 08.34 stating that the pursuer was always grandiose and somewhat pressured.

43. In the period between 20 January and 6 February 2016 the pursuer took up residence with a patient under the treatment of Dr Alistair Morris, consultant psychiatrist. A community psychiatric nurse visited that patient and considered that it was clear that both the pursuer and the other patient had been using significant amounts of drugs and alcohol. The CPN looked for evidence of mental illness in the pursuer but was unable to find any.

44. On 21 January 2016, the pursuer was verbally abusive to Ms Manson and the police were called. They took him to Stratheden. At 11.30, he was assessed by Dr Christopher Olley, Speciality Doctor in Psychiatry. Charge Nurse Lomax was present at the assessment. Dr Olley and Charge Nurse Lomax did not consider that the pursuer met the criteria for detention and he decided to leave the ward. Dr Olley made notes of his assessment. After

having made those notes, he discussed the pursuer's presentation with Dr Narayan and wrote to the pursuer's GP.

45. On 22 January 2016, the pursuer appeared in court and pleaded guilty to certain charges. Sentencing was deferred.

46. On 6 February 2016, the pursuer was arrested and charged with driving with excess alcohol in his breath. He was held in custody at Perth Sheriff Court. The G4S custody officers at Perth Sheriff Court observed no abnormal behaviour by the pursuer, nor were they concerned that he was exhibiting symptoms of mental illness. The Procurator Fiscal Depute requested that he be psychiatrically assessed.

47. On 8 February 2016, the pursuer was assessed in the cells at Perth Sheriff Court by Dr Morris. The assessment lasted between 40 minutes and an hour. Dr Morris considered that the pursuer's:

> "difficulties are likely related to his maladaptive coping strategies in the context of personality disordered traits, primarily of an emotionally unstable and narcissistic type, psychosocial stress and substance misuse".

He found no clear evidence of mental disorder and advised that the pursuer could be processed down a criminal justice route in the usual fashion. Following his assessment Dr Morris wrote to the pursuer's GP setting out his assessment. He copied that letter to the pursuer's treating psychiatrist, Dr Howson, and to Lomond Ward at Stratheden.

48. On 9 February 2016, the pursuer attended an outpatient psychiatric clinic. He was assessed by Dr George Howson, consultant psychiatrist. Following the clinic Dr Howson wrote to the pursuer's GP.

49. On 11 February 2016, the pursuer spoke on the telephone to Dr Howson. Dr Howson made notes of the telephone conversation. He recorded that his impression was

the pursuer appeared quite in control of the conversation, and was aware of his court attendance due the next day.

50. On 19 February 2016 the pursuer was assessed by Dr Niyaz Ahammed, consultant forensic psychiatrist. Dr Ahammed recorded his assessment in a letter to the Prison Medical Officer at HMP Perth.

51. On around 22 February 2016, the court sought a report on the pursuer. Between 22 and 26 February 2016, Dr Morris telephoned HMP Perth and spoke to nursing staff at the prison about the pursuer. He also reviewed Dr Ahammed's letter following the 19 February assessment. Dr Morris emailed Dr Howson on 26 February 2016 about the pursuer.

52. On 4 and 10 March 2016, Dr Howson interviewed the pursuer at HMP Perth. On 15 March 2016 he wrote a psychiatric report on the pursuer.

53. On 22 March 2016, Ms Manson was strongly against the pursuer's continued detention, and felt instead that he could return home with suitable aftercare. That view was consistent with the view she expressed when she called Lomond Ward on 19 January 2016.

54. On 1 April 2016, Dr Jacqueline Drummond, consultant forensic psychiatrist, wrote a report on the pursuer. She concluded that he was having a manic relapse of bipolar affective disorder, and that while he presented with emotionally unstable and narcissistic personality traits, it was difficult to assess his personality while he was manic. Accordingly, she considered his primary diagnosis at that time to be bipolar affective disorder.

Findings in fact and law

1. The pursuer has not suffered, loss injury and damage as a result of the fault and negligence of the defender or its staff for whom the defender is in law responsible.

2. The defender is entitled to be assoilzied.

NOTE

Introductory

[1] This is an action of damages for what the pursuer contends was negligent management of his care by a clinician employed by the defender health board during an episode of mental ill-health in January 2016. All issues of liability, causation and damages are in dispute. I heard evidence in this case on 13-16 and 20-22 August 2024. The pursuer gave evidence, and led evidence from Dr Yaneen Qureshi, Peter Davies, Dr Alan Scott, Dr Jacqueline Drummond, and Dr Michelle McGlen. The defender led evidence from Dr Vinay Narayan (the clinician whose conduct was averred to have been negligent), Senior Charge Nurse Glen Lomax and Dr Nabila Muzaffar. Another witness for the defender, Dr Alistair Morris, gave evidence at a commission held on 31 July 2024, and a transcript of the commission is 31 of process, together with a report by the commissioner (32 of process). At the close of the evidence, I appointed parties to exchange and lodge written submissions, which are now in process, and I heard parties' oral submissions on 28 October 2024.

[2] The productions in this case are organised in a joint bundle of medical records (JB page number) and a core bundle of reports and other documents (CB page number). Parties also tendered a short joint minute (33 of process), agreeing that the medical records are what they bear to be (but without agreeing that they could be treated as evidence without being spoken to); and that the social work records (5/7) and police records (5/8) are to be treated as the evidence of the authors without being spoken to. Whilst that agreement was of some assistance, it would have been of greater help to the court to have agreement about what, if any, facts parties were agreeing from the social work records and police

records in particular, as the social work records were put to a number of witnesses who were not the authors and who had no prior personal knowledge of them.

Evidence for pursuer

David Downie

[3] The pursuer is 51. He performed well at High School, obtaining seven "O" Grades. He left midway through sixth year. The pursuer began playing golf whilst at school and after leaving school, attended Midland College, Texas on a golf scholarship for a period of 6 months. He returned home because he was homesick and also because his grandfather had died. The pursuer continued playing golf as an amateur to a high standard, and turned professional at the end of 1995. The pursuer played golf as a professional until 1999, participating in the PGA Master Card Tour and the Hippo Tour. The pursuer retained his tour card each year but in his own words, he was not setting the world on fire. After bringing his tournament career to an end, the pursuer secured employment with an investment marketing company, Vintage Hallmark, which he learned of through contacts in the golf world. The pursuer worked with Vintage Hallmark until 2002. The pursuer then set up his own golf management company, looking after four or five professional golfers. The pursuer carried on that business until 2005. In 2004, the pursuer established a separate business, an online platform to bring golfers together. The pursuer was involved in this business, Golfers Connect, between 2004-2011. The pursuer's income from these businesses were enough to support himself but were not as good as his income at Vintage Hallmark. The pursuer was also doing some coaching work with a number of golfers up to 2010. At the end of 2012, the pursuer undertook training with the Big Green Company in Macclesfield in the renewable energy sector. This involved the sale of solar panels. The

training lasted a week and the pursuer thereafter worked for the company for a week. He stopped working for the company because they did not pay fuel and expenses to travel to sales appointments and his first call had been a 220 mile trip. The pursuer thereafter established his own business, Drumoig Renewables Ltd. There were a number of other people known to him who became involved in the business at the start. The company was promoting an infrared heater to the general public initially, and thereafter to local authorities and housing associations. These included the Hebrides and Housing Partnership, Cairn Housing Association, Albyn Housing Association and Shetland Islands Council. The pursuer borrowed money to invest in the business totalling roughly £54,000; his partner Caroline also invested in the business. The pursuer resigned as a director of the company in November 2015, because the manufacturer whose products the company was marketing was placing the company under pressure to move more product and also wanted to have a direct relationship with the housing associations. The pursuer has been signed off work medically unfit since May 2016.

[4] Towards the end of June 2002 the pursuer stopped sleeping properly. He was under pressure because Vintage Hallmark was closed by its associated US Company and the pursuer had a mortgage with no income coming in. The pursuer went to Lister Hospital in Stevenage on 4 July 2002, for psychological evaluation. His then partner was at that time 6 months pregnant. The pursuer was diagnosed with bipolar disorder. The pursuer presented as very manic. He was loud, verbally aggressive, confused, scared and anxious. The pursuer went voluntarily to the Lister Hospital but he was unhappy with the accommodation and sought to leave. At that point he was detained. A one night stay became a 2½ month stay. With reference to his medical records, the pursuer accepted that he was using alcohol heavily in 2004, he began to self-medicate to manage his moods. If he

felt unwell he would drink more than he ordinarily would. In the past the pursuer had also used cannabis. He no longer does so. He does drink alcohol, but less so than previously. The pursuer considered that cannabis had no relationship with his health.

[5] In 2004, the pursuer was working in Estonia with a former colleague from Vintage Hallmark, setting up a call centre. The pursuer became very unwell and was taken to a hospital in Tallinn in Estonia where he remained for a fortnight. He was tied to a bed for 3 days during that period and was experiencing a manic episode. The pursuer's mother and a friend of hers came from Scotland to Estonia to bring the pursuer back to Fife. After a period at home of 2 weeks, the pursuer went voluntarily to Stratheden Hospital for assessment. At this point the pursuer was manic, his confidence was through the roof and he believed he could do anything. At the same time he could not hold a conversation coherently; he was asking and answering questions before the other person could speak. He had pressure of ideas about business plans and was concerned about world events. In 2002 and 2004/2005 it had taken the pursuer about 3 months to recover sufficiently to feel comfortable. In 2011, it had taken a lot longer, and in 2016 a lot longer still.

[6] In 2011, the pursuer had a new partner, who was expecting their child. The pursuer felt scared and anxious and became very manic. His sleep decreased and he had more energy and was troubled with interests of thoughts. Initially the pursuer thought he was elated because of the birth of his daughter, however that did not pass and he was admitted to Stratheden Hospital; where he remained for 6 months. Initially he was there voluntarily, and was then sectioned because he was not conforming to the medication regime. The pursuer was manic with pressurised speech, racing thoughts, he was very active and also really sleepy. Some of his behaviour was inappropriate, including verbal aggression, mainly directed towards the psychiatrists. The pursuer's condition settled, and the compulsory

treatment order was revoked in August 2011. He experienced low mood, which was always the same coming down from a manic episode. He attended the doctor in September and October 2011, and did not attend with mental health problems again until 2015.

[7] In November 2015, the pursuer was very upset and angry; he was becoming unwell through distress arising from the business. He was at that time living in the Hebrides because of the contracts which the business had and was managing his illness with alcohol because his mood was fluctuating. The pursuer was admitted to hospital on the 20 November 2015 following a referral by his GP (JB1564). The pursuer recalled some but not all of the incidents described in the clinical summary prepared by Dr Drummond on 21 March 2016 (JB1886-1894, at 1889). The pursuer did have a recollection of sleeping poorly and of having increased irritability; when he was unwell, the pursuer was unable to sit still. He did not accept he was short tempered other than on the golf course. He accepted that drinking too much was a concern when he was becoming unwell. He also became more hostile when he was unwell. The pursuer was discharged on 7 December 2015. The discharge summary records for the first time a diagnosis of mixed personality disorder. The pursuer thought that Dr Narayan had given a diagnosis of a borderline personality disorder. Prior to that, the pursuer had understood, since 2002, that he had bipolar disorder.

[8] The pursuer was given a variety of mental health medications during his admissions to hospital and continued to take them after the period of discharge because it was necessary to manage the experience of coming down from the manic episode. He had not taken drugs consistently between 2002-2004. He had taken them for some time after the episode in 2004, including depakot but not consistently. He did not take drugs at all between 2011-2015. The pursuer considers he has good knowledge of medications which he uses because he knows what does not work in his case. All mental health medications affect different people

differently. For example, lithium had worked very well for the pursuer but haloperidol had not. However managing the medication was difficult, for example, finding the level of lithium had been challenging to get the right amount when he was coming down from the manic episode to avoid getting depressed.

[9] The consultation with Dr Narayan on 16 December 2015 was the first occasion when the pursuer was told that he might have a personality disorder. He had never been told that he did not have a mental health disorder prior to that. The diagnosis is set out in the discharge summary dated 17 December 2015 (JB517-518).

> "It was considered by his Consultant, Dr Narayan, that Mr Downie did not display any evidence of Bipolar Affective Disorder but instead that many of his traits seem to be longstanding without much fluctuation. This was supported by his previous notes. It seemed perhaps more likely that Mr Downie suffered from a mixed personality disorder as he displayed more narcissistic and emotionally unstable personality traits. No clear improvement to mood was seen with Lithium but it was decided to continue it to review his mood in the long term."

The pursuer said his symptoms then were the same as in 2002. The pursuer's immediate reaction was to think "great. I don't have a mental disorder; I have something that can be fixed". In his view that was when the problems with his family had began. Matters became troublesome because everyone that the pursuer knew had said to him that he needed to be on medication to which he would reply "you're not a medical professional, I've been told not to take any medication", and that was on the basis that he had advised that he was not mentally unwell.

[10] On 30 December 2015, the pursuer had an argument with his father, which resulted in the pursuer being arrested and put on bail with conditions to stay away from his father's house. The pursuer was admitted to hospital on 31 December 2015 as an emergency admission. He was examined by Dr Jabbad (JB1587). The pursuer had no clear recollection if he was detained at that time because he felt he was in and out of hospital all the time at

that period, which was a very confusing time for him. However, Dr Narayan had arranged for an admission on 6 January 2016. The pursuer signed a document agreeing to conduct himself in a particular way in regards to treatment (JB1583) at the time of admission. This contained the treatment plan, involving the use of valproate (a mood stabiliser) trazodone (for sleep disturbance) and quetiaipine (an anti-psychotic). The pursuer agreed to comply with staff direction, particularly in relation to drug screening. The pursuer agreed to display appropriate behaviour to staff and fellow patients, the pursuer agreed that if he displayed aggression, or brought alcohol or drugs onto the ward he would be discharged. The pursuer recalled signing the document but not recall Dr Narayan being present, his recollection was it was Nurse Lomax. On 7 January 2016, the pursuer was reviewed as his behaviour was noted as being aggressive. The pursuer recalled being very angry possible because he had to be breathalysed even though he said he was not drinking. Later on 7 January, at 2350 hours the pursuer asked to leave the hospital late at night. On 11 January 2016, the pursuer was brought back to hospital as a place of safety admission and his presentation was recorded at JB1595-1596. On 14 January 2016, Dr McGlen examined the pursuer (JB567). The examination was carried out in police cells. Her conclusion was he was not fit for court appearance and that a short-term detention certificate be considered for possible IPCU admission. The behaviour recorded by Dr McGlen was not how the pursuer would normally behave. The pursuer did not recall a conversation with Dr McGlen about being admitted initially to Lomond ward and if that did not work out being transferred to the IPCU.

[11] In the nursing notes for 15 January 2016 it was noted that the pursuer had become increasingly argumentative during Dr Narayan's ward round at 12.05 (JB1784). He had made a verbal threat to Dr Narayan, and it was noted that if he continued causing issues on

the ward, the police were to be called. The pursuer had no recollection of this episode but would expect the police to be called based on what was written. At 23.00 the same day, the pursuer was noted to be behaving aggressively (JB1786), and the police were called (JB1787). At about 04.35 on 16 January, the police were called again, as the pursuer had been verbally aggressive and had called an ambulance from the ward. At 00.57 on 18 January 2026, nursing staff noted the pursuer was threatening ward staff with threats of personal violence to them and their families. At 06.00 that day he was seen to be asleep having been given intra-muscular haloperidol earlier. At JB1799 it was noted that his sodium valproate was to be increased and the short term detention certificate revoked. The pursuer was to be discharged because he wanted to drink alcohol when he is off the ward, which was not agreed by Dr Narayan. The pursuer was therefore discharged against medical advice.

[12] The short-term detention certificate was revoked and the pursuer left hospital. He was at that point homeless because he could not go back to his parents or his own home. He slept rough and also stayed for a period with a former patient from Stratheden who was a paranoid schizophrenic and whose flat was not a safe place. The pursuer felt that at the time he was discharged he was extremely unwell. On 5 February 2016, the pursuer was seen by social work for a criminal justice social work report. On 8 February, the pursuer had been detained by the police in connection with drink driving, he was seen by Dr Morris in the cells at Perth Sheriff Court. On 12 February 2016, the pursuer failed to attend for a hearing at Dundee Sheriff Court, because he went to Perth Sheriff Court instead and on 15 February he was remanded in custody and detained in Perth prison. He was there for 29 days before being transferred to Stratheden Hospital where he was a patient for 28 days followed by a further extension of 28 days. The pursuer was discharged from Stratheden on 10 May 2016.

[13] In cross-examination, the pursuer confirmed that he was psychiatrically well at present. He considers that he still has bipolar disorder and does not believe he has a personality disorder. His mood has been down but not clinically depressed since discharge from hospital in 2016. The pursuer is confident that if he had been treated correctly in November 2015 subsequent events would have been averted. The pursuer's recollection of events in December 2015 and January 2016 is very confused and although he has particular snapshots of events which he clearly recalls. A series of entries from the record were put to the pursuer who had no clear recollection of the events, in particular on 11 January 2016 (1595-1596), 13 January 2016 examination by Dr McGlen on 14 January, the nursing record for 18 January for 2016 (6/2, pages 2 and 3), 21 January 2016, examination of Dr Olley (page 1519), 9 February 2016, interview with Dr Howson, 19 February 2016 interview by Dr Ahmed and a nurse at Perth Prison, and review on 1 April 2016, (CB271),

[14] In relation to a Vintage Hallmark, the pursuer did not have an employment contract with the company, rather he put in a monthly commission sheet and would get paid his commission, less tax. Despite what was recorded, namely that he had been paid 10% of £3.4 million, in fact the pursuer received only 5% and rather less than that. The business came to an end when directors on associated American company ejected the directors of the UK company and closed the business down. The pursuer was aware that the directors subsequently went to prison because the company was a global fraud. In relation to Drummoig Renewables, the pursuer was well when he set up the business in 2013. The money in which he had invested, around £54,000, had been borrowed on credit cards, and the pursuer's partner Caroline had put in more of her own money. The company had a number of directors and consultants; there was an installer for the equipment, Gary Patterson was the consultant introducing business contacts. When the pursuer left the

business there were contracts in place. The pursuer had no idea why no documentation relating to the company was available to the court.

Dr Shehrzad Qureshi

[15] Dr Qureshi holds an undergraduate medical degrees from The University of London, a Masters degree in alcohol and drug addiction, and is a member of The Royal College of Psychiatrists. He has been on the Specialist Register of The General Medical Council since 2010. He is a clinician approved under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Dr Qureshi was a consultant psychiatrist in addiction psychiatry in NHS Lanarkshire from 2010-2022. He is a consultant psychiatrist at The Priory Hospital in Glasgow, and has held that post since 2019. Dr Qureshi prepares expert reports for The General Medical Council, the Nursing and Midwifery Council and legal firms. He has prepared approximately 150 reports per annum for the last 3 years. Dr Qureshi prepared two reports in connection with the present action, 5/4 and 5/5.

[16] At CB100, Dr Qureshi described bipolar affective disorder, which is a severe and enduring psychiatric illness. Manic episodes can begin abruptly, whereas depressive episodes can be more insidious. There is usually complete recovery between episodes. It is a relapsing and remitting condition for which there is effective treatment but no cure. It is an illness associated with considerable morbidity and mortality. Bipolar affective disorder is associated with comorbid conditions including substance misuse, depressive illness and anxiety disorders. The diagnosis of bipolar illness is reliant upon clinical assessment, based upon the finding criteria listed in the International Classification of Diseases Handbook (ICD10 at the time of the events). The condition is severe because the effects can be very damaging for the patient physically, in relation to the patient's mental health, and socially.

Manic episodes are characterised by recurrent episodes of elated mood and activity. Bipolar disorder usually first presents between the mid-teens and mid-twenties. The course of the illness is unpredictable, however 90% of sufferers experience a recurrence of symptoms after they have an initial manic episode. Manic illness is associated with gross impairment of insight. In this disinhibited state, there can be complete disregard for the consequences of sexual over-activity, reckless spending, dangerous driving and inappropriate business initiatives.

[17] Having regard to the clinical records, Dr Qureshi considered the pursuer experienced an episode lasting from November 2015-March/April 2016, comprising a single episode. There were points at which the pursuer appeared to have a normal presentation during that period, but people experiencing manic episodes are able to hold it together for periods of time, particularly in the early stages of an episode. Presentation can fluctuate and that is why a patient requires to be assessed over a satisfactory period of time; in Dr Qureshi's view, a few days is not a satisfactory period. Pressured or sped up speech is commonly found during manic episodes; that is because the patient's thought process is sped up and the thoughts jump about, so that the connection between thoughts and therefore speech can be lost. Agitation is commonly seen, as is difficulty sleeping. Treatment of the condition includes the prescription of mood stabilisers. These may take several weeks to work. The golden standard treatment is lithium, which takes several weeks to be effective because it works within a narrow concentration and accordingly requires regular blood tests to ensure the patient has the appropriate therapeutic concentration. Anti-psychotic medications are also used to treat delusions and hallucinations, and to help with anxiety. These can also help with improving the sleep pattern.

[18] At CB83 in Dr Qureshi's first report (1 August 2020), the interview with the pursuer is summarised. The pursuer reported that his sleep had become disrupted in the weeks culminating in his initial admission to Stratheden Hospital. The quantity of sleep he required became reduced and this was associated with abnormal elation of mood. This is a core symptom of bipolar disorder. The pursuer's recollection of some of his symptoms over the subsequent period was rather vague, which is not uncommon because manic illness can be associated with a loss of touch with reality as well as impairment of insight. Equally it was possible for the pursuer to have a very specific recollection of events, although these may also be tainted or coloured by the abnormal mood state, so that although they were very clear such recollections may not in fact be accurate. Dr Qureshi is familiar with legal requirements for a Short Term Detention Certificate ("STDC"). These include a requirement that the patient's decision making ability about treatment is significantly impaired. It was unlikely that a patient's decision making ability would change within a matter of days in the case of a manic illness. Dr Qureshi did not consider that the pursuer had a personality disorder because there would have been police involvement outwith periods of acute illness, and would likely have included police involvement. Personality disorder typically manifests in adolescence. Further, a borderline personality disorder is often characterised by repeated incidents of self-harm, and there was no record of that in the pursuer's case.

[19] When Dr Qureshi saw the pursuer in 2020 he was not acutely unwell but remained distressed. The pursuer described heightened anxiety, a loss of self-esteem and confidence. He expressed in particular a loss of faith that the right thing would be done by him if he were unwell in the future. He felt that he had not been treated properly and had suffered harm as a consequence both psychologically and socially. In preparing his report, Dr Qureshi had spoken to Caroline Manson, the pursuer's partner. The purpose of the

interview was to obtain independent evidence, there were periods when the pursuer's recollections were clouded by his illness. The pattern of behaviour which she reported, set out at CB85, was the same as the pursuer had described.

[20] Dr Qureshi explained that in psychiatry there are five diagnostic categories, which exist in a hierarchy as follows:

1. Organic conditions manifesting as mental health problems;
2. Psychotic conditions which manifest as acute or transient psychotic illnesses;
3. Mood disorders, including bipolar disorder and depression;
4. Anxiety disorders for example PTSD;
5. Personality disorders.

A practitioner would require to think through the hierarchy very carefully. Personality disorders can coexist with other conditions, but diagnostically the practitioner should start at the top and work downwards.

[21] Dr Qureshi considered the diagnosis of personality disorder made on 15 January 2016, was wrong. The symptoms recorded at the start of the admission and the response by the patient who appropriate treatment followed by bipolar disorder confirmed that. Having considered the previous medical history and in particular the 2002, 2004 and 2011 admissions made it even less likely that the diagnosis of personality disorder was correct. The pursuer's condition in 2015-2016 was as severe if not more so than the previous episodes leading to admission to hospital. Dr Qureshi had considered, in his report, CB105, whether the pursuer's presentation was primarily due to the use of illicit substances and/or alcohol. He was of the opinion that on the balance of probability that was not the case. That is because substance-induced psychoses are usually short lived and subside when the substance is discontinued. The history and course of the pursuer's illness was not

commensurate with a diagnosis of substance-induced psychosis. That was because he remained severely unwell, over an extended period of time, whilst detained in a hospital in the absence of substance use. Further, the pursuer's presentation included a reduction in sleep which is a key feature of bipolar disorder but does not feature in the presentation of personality disorder. Dr Qureshi considered that it was important to manage risk carefully during a manic episode because the patient's judgement can be grossly impaired. As a result they can pose very serious risk to themselves and others. Accordingly, it is important to manage such risks, namely risk to physical health to mental health and to social wellbeing. It would be very difficult if not impossible to manage a patient's medication if the patient had nowhere to stay in the event that detention was revoked.

[22] Dr Qureshi was not surprised that the pursuer felt harmed by his experience following discharge in January 2016. It appeared that there had been harm to his social wellbeing and his mental health. If he had received appropriate treatment at the time, it was more likely than not that the pursuer would have been in any better a position. The harm to his mental health, health and social wellbeing likely would not have happened. In relation to the obtaining of the views of his named person, Caroline Manson, while the pursuer had indicated he did not want medical information to be shared, in Dr Qureshi's view that was different from obtaining the views of the named person. The two were not necessarily inconsistent because a doctor could say that he could not discuss treatment but wanted the named person's views. In relation to the pursuer's management on a Short Term Detention Certificate ("STDC"), it is sometimes a difficult balance but having regard to the subsequent trajectory of the pursuer, it was likely that he would have required to have been on an STDC for 28 days. Retaining compulsory care for that period would have captured the symptoms more fully and allowed for treatment. In Dr Qureshi's view, in revoking the STDC,

Dr Narayan had not done what he would have expected the ordinarily competent consultant psychiatrist with ordinary care and skill to have done. At CB87, Dr Qureshi expressed the view that if the pursuer had been maintained on the STDC, this would have increased the likelihood he would have remained in hospital and thereby receive medical treatment. In making determinations relating to continued compulsory detention, Dr Qureshi accepted there is a clinical judgement involved. The process takes into consideration a range of factors such as the severity of the patient's symptoms, their level of insight, risk assessment and decision making capacity. Consultation with the named person could result in additional information being considered and thereby enhance the decision making process.

[23] In cross-examination, Dr Qureshi was familiar with the principle of the least restrictive treatment in the sense of the least restriction compatible with safe and effective treatment. There was a balance to strike and the STDC is a very important tool for that. Its purpose is to allow for assessment of the patient's condition and for provision of appropriate treatment, with safeguards for the patient built in. He agreed that a decision to detain or discharge involved the exercise of clinical judgement. A personality disorder and bipolar disorder can coexist. There is a very slight overlap in presentation as between the manic phase of bipolar disorder and borderline personality disorder in terms of impulsivity.

[24] Dr Qureshi accepted that the focus of the questions he had been asked to address in his two reports was to do with causation, however he had also answered questions about breach of duty because he considered what would ordinarily happen if the case were managed by a consultant psychiatrist acting with ordinary skill under the particular circumstances. He had not mentioned that in his report because he had been asked to address specific questions. The reference in his report (CB79) to the index incident referred

to the discharge of the relocation of the STDC on 18 January 2016. In his view the duration of the manic episode was from around November 2015 until about May 2016 after the pursuer was discharged. In his opinion the episode would have been shorter if the pursuer had received the appropriate treatment. If the patient had been reviewed by a psychiatrist 18 days prior to the index event that might be relevant depending on the grade of psychiatrist because the level of experience bears on the weight to be given to the clinician's view. A psychiatrist's view about whether the pursuer was detainable or not would be helpful. Dr Qureshi had been thinking about breach of duty from the outset from the perspective of what would normally happen, what should happen and what had happened. Dr Qureshi agreed that he had anticipated coming to court to give evidence about causation on the basis of his reports, rather than breach of duty. However, causation naturally flows from that. In relation to detention under an STDC, the purpose was to enable assessment and/or treatment when it was felt a patient was suffering from a mental disorder and had significantly impaired decision making and it was not possible to treat the patient voluntarily. In addition, there required to be a risk of significant harm to the health, safety and welfare of the patient or others so it was necessary to consider the risks of not continuing with STDC if one was in place. With bipolar disorder harm can accrue very significantly and very rapidly.

Peter Davies

[25] Peter Davies is an Employment Consultant and has given evidence many times. He produced two reports in connection with this action, 5/6 and 5/7, which he adopted in evidence. People who are disabled, particularly with mental health difficulties, are at a disadvantage in the labour market generally. The pursuer did not demonstrate consistency

in his employment history, he had not had a career but had moved from job to job. He is undoubtedly entrepreneurial and has worked most of the time. When he finds an opportunity he tends to throw himself into that wholeheartedly, perhaps at the risk of overworking and overstressing himself, or at least that appears to be a coincidence of timing. Mr Davies saw the pursuer in a video meeting in 2021 and in person in December 2023. In December 2023, the pursuer was trying to get back into working in golf and in particular golf coaching. While the pursuer has been involved in golf, it would be important for him not to do too much and for any business to be sustainable, it would be dependent on building a customer base. Another element which would require to be in place would be someone doing therapeutic to manage the volume of his work. Mr Davies was not surprised that the DWP consider the pursuer to be unfit and such work is the pursuer might be able to do more likely therapeutic value to be able to continue at a sustainable level.

[26] In cross-examination, Mr Davies indicated his conclusion was that had the pursuer had treatment, his behavioural issues might not have been in the public gaze, and he would have been in a better position to work as he had before. He explained the pursuer had described the problem with Drumoig as being his personal relationship with the manufacturer and that he hoped that by stepping back, the relationship could continue. Mr Davies agreed it would be helpful to have had sight of documents relating to the Drumoig business for example from HMRC and documentation of the contracts which the company were said to have established.

Dr Alan Scott

[27] Dr Alan Scott was formerly a consultant psychiatrist in Edinburgh from 1991-August 2012. Dr Scott produced three reports in connection with this case (5/1, 5/2 and 5/3 of process). The first report, dated 29 November 2018 (CB2-11) contains a summary of the medical records available from 2004 in the Record of Care. With reference to the record for 7 December 2015, recording there were "no symptoms of bipolar disorder", capacity and insight, and "no major mental illness", Dr Scott considered that was not consistent with the information in Dr Pittock's record for 23 November 2015. In particular, there was subjective elevated mood, pressure of speech and limited insight; that is not consistent with there being no major mental illness. Further, the pursuer's capacity was not assessed adequately. The pursuer's behaviour as documented on 3 January 2016 is not diagnostic of a manic episode but it is consistent with that in terms of an ICD10 criteria. The examination of 7 January 2016, was in Dr Scott's opinion, inadequately documented given the pursuer might be a person suffering a relapse of bipolar disorder. There is no focussed systematic mental state examination. There was inadequate recording of information about mood and associated symptoms. The information recorded is consistent with a relapse of bipolar disorder.

[28] Dr McGlen's examination on 14 January 2016, contains a record of mental state examination which is consistent with other symptoms suggesting a relapse of bipolar disorder though it was not possible to come to a diagnosis on that alone. It was not clear what the phrase "limited insight" meant in the context because it was not clear how it was assessed, but it clearly is the opinion of the doctor. The differential diagnosis of drug-induced illness was entirely reasonable, but the pursuer's previous admission indicated a similar pattern of relapse. The suggestion that admission to IPCU may be the

most appropriate outcome was notable and was what had been required in a previous relapse. Dr Scott could not say that admission to an open ward was not unreasonable, the pursuer would be a detained patient so that staff would have the authority to transfer him to the IPCU if required. In relation to the differences in the pursuer's presentation on admission compared with Dr McGlen's assessment, the fact that someone is suffering from a relapse of bipolar disorder does not mean that they do not have reactive emotions and might be relieved not to be in the police cells but in a therapeutic environment. That change in presentation did not rule out the possibility that the pursuer was experiencing a relapse of bipolar disorder.

[29] In relation to Dr Narayan's review on 15 January, the conclusion "there was no evidence of major mental illness" was not consistent with the information provided and did not take account of the temporary relief which might be experienced on entering a therapeutic environment. The pursuer required treatment. The pursuer had been admitted and was receiving treatment so that one might expect some improvement. It was also unclear why the pursuer should remain on powerful drug therapies if there was no evidence of major mental illness. No clear explanation was given for why the STDC was revoked on 18 January 2016. The pursuer's behaviour on the evening of the 15 January did not allow a diagnosis to be made on its own but was consistent with a diagnosis of a manic episode and the behaviours did require intervention and treatment. The behaviour noted at JB567/568 was an indication for consideration of transfer to the IPCU.

[30] In relation to the review by Dr Narayan on 18 January, it was stated that the pursuer demonstrated adequate insight and capacity, but there was no documentation about this. It was not clear if the pursuer had been asked for example if he believed he had a mental illness or what his condition was. There was no documentation of a systematic assessment

of his mental state. While it was possible that the grandiosity in the pursuer's presentation was attributable to borderline personality disorder, that was not consistent with the rest of the evidence which Dr Narayan and Dr McGlen had gathered. For example, the grandiose ideas noted in the police cell, labile mood and grandiose delusional statements about meeting the First Minister and having £42 million. It appeared that Dr McGlen considered that the pursuer's decision making ability was significantly impaired when she saw him on 14 January. His behaviour continued and there was no evidence for concluding that it was substantially changed by 18 January so that it was no longer impaired.

[31] Turning to the question of personality disorder, Dr Scott would be looking for records of behaviour in relation to arrest by police when he was in late teenage years/early twenties. The pursuer has no criminal convictions at that stage so a diagnosis appearing at the age of 42 is unusual. He considered that a diagnosis of personality disorder was unreasonable particularly given the knowledge of previous relapses of bipolar disorder resulting from those behaviours together with multiple informants reporting that his behaviour in 2015/16 was like previous relapses, for example the grandiose and religious delusions noted by Dr McGlen and relatives reporting that his behaviour was out of character.

[32] Dr Scott's second report of 26 August 2019 (CB12-65), sought to address harm suffered because of the discharge of the pursuer on 18 January 2016. Dr Scott's opinion is set out at paragraphs 24-27, and in short his conclusions were that the pursuer's health suffered because of the negligent discharge on 18 January 2016. The length of the relapse was probably longer and severity probably greater. If he had remained in hospital as a compulsory patient he would have received regular prescribed and "as required" medication. His safety had been put at risk because he had not been advised to stop driving,

irrespective of his discharge. His welfare had suffered. He was of no fixed abode and there was no clear plan for where he was to stay. On 19 January 2016, he was taken to A&E by police following an incident with his partner. On 21 January, he was taken by police to Stratheden as a place of safety after "erratic" behaviour. On 26 and 29 January he was arrested after altercations with his partner. On 6 February 2016 he was arrested on suspicion of drink-driving. Nothing which Dr Scott had seen or heard caused him to alter his opinion about that. Dr Scott's third report is dated 10 May 2021 (CB66-76), and addresses a number of specific questions proposed by counsel.

[33] In cross-examination, Dr Scott indicated that in preparing his reports, he relied on his clinical experience and knowledge. In this case, his reports were based on his review of the pursuer's records. Dr McGlen's letter following the 14 January 2016 episode indicated that she did not support a diagnosis of a drug-induced illness, and it was clear she did not know that the next day the pursuer would test positive for cannabis, which is something Dr Scott mentioned in his report. That was a sign of an active illicit drug use, which is clinically significant because people who take one drug may take another. The relevant question was the investigation of this over the passage of time. It was of interest that the clinical records contain no other reference to illicit drugs but did contain references to the times the pursuer left the ward to drink alcohol. It was a principle of the Mental Health (Care and Treatment) (Scotland) Act 2003 that the views of a patient's named person would be taken into account when carrying out functions under the Act. It was also true that the named person is not the only person whose views are taken into account. In particular, the views of the patient require to be considered. Dr Scott did not recall being told that the pursuer had at one point told medical staff that he had separated from Ms Manson. That would be important

information for the clinical team. It was possible that this would make it difficult for there to be continuing discussion between the clinical team and the pursuer's partner.

[34] In relation to the decision to revoke the short term detention certificate, Dr Scott considered this was negligent. There was no document to explain Dr Narayan's reasoning for his diagnosis. In Dr Scott's view the behaviour was so unreasonable given the evidence documented and to dismiss by bipolar disorder and to consider a diagnosis of personality disorder instead. In relation to Dr Narayan's note of 18 January 2016 (a transcript of which is 6/2) Dr Scott was critical of a number of aspects of the record. Going back to the build up to the event, there was no clear documentation about the family saying that the pursuer was unwell again. There was no recognition of symptoms documented by Dr McGlen. The phrase "demonstrates adequate insight" did not record what the pursuer was thinking about diagnosis and treatment. "Grandiosity" was a conclusion which Dr Narayan ascribed to personality however there was information about the pursuer's presentation from third parties. There was information to suggest he was not his usual self and was often unwell. The record fails to acknowledge that the pursuer had been documented as "less manic", which suggest there must have been manic symptoms. Dr Scott agreed that diagnostic uncertainty can occur, but if he were discussing a different diagnosis, he would be duty bound to explain why he was not taking account of the existing diagnosis in making his own diagnosis. Dr Narayan had not documented that. In relation to the entry that the pursuer "demonstrates insight" it was relevant that the pursuer was a detained patient. The clinician is meant to assess the patient's ability to consent to treatment. If detaining a patient Dr Scott would expect to be able to justify why the criteria were met or were no longer met, and to record that.

[35] In Dr Scott's second report (CB66-70), Dr Scott considered a number of particular points; in doing so he was responding to questions from counsel and the report sets out his answers. In Dr Scott's view Dr Narayan ought to have had regard to the matters set out in paragraphs (a) - (v). These were all relevant because the diagnosis and the conclusion of all of these things. In relation to Dr Morris's review on 8 February 2016 when the pursuer was in custody, Dr Scott's recollection was that Dr Morris had been influenced by information by the hospital and his contact with the hospital and had learned that the pursuer's progress was not necessarily typical bipolar disorder. Dr Howson's review (CB8) was the first occasion he had met the pursuer. It may be that he decided not to detain the pursuer because he considered he could continue with the assessment and others to provide information and support. It was not surprising that he had not detained the pursuer. The email from Dr Morris to Dr Howson (CB248) indicated he would have seen the developing diagnostic uncertainty. He examined the pursuer only once and Dr Scott could understand why he was not taking it particularly firm view about diagnosis. Dr Scott had seen Dr Muzaffar's report. They had differing views about the case. Dr Scott accepted there was a variation on the scale of reasonable professional opinion.

[36] In re-examination, Dr Scott would have expected Dr Narayan to know the pursuer's recent symptoms and the care received before carrying out his assessment. In relation to the history of cannabis use, while Dr Scott questioned the role this had played he could not say it had no significance.

Dr Jacqueline Drummond

[37] Dr Jacqueline Drummond is a consultant forensic psychiatrist, based at Stratheden Hospital. She has been a consultant since 2015. She reviewed the pursuer on 17 March 2016.

On 21 March 2016, she prepared a lengthy note of the pursuer's history and her findings on review (JB1886-1892), circulated to Dr Suresh Bheemaraddi. There is reference to diagnostic uncertainty in late 2015 in the email (JB1891), however, Dr Drummond had no doubt about diagnosis, and considered the symptoms to be those of bipolar disorder. The pursuer had an elevated mood. The uncertainty arose from review of the notes where a doctor diagnosed a personality disorder. Dr Narayan was involved and Dr Howson also. Dr Drummond was sure of her view following review of the notes and how the pursuer appeared at the time of review which was the more important factor. At JB1892, Dr Drummond discussed the possibility of managing the pursuer in the IPCU. The IPCU is a small and intensely-managed unit of eight beds where the staff-patient ratio is such as to allow management on that basis. At the time of her review, the pursuer was taking medication and did not require physical intervention, although he was verbally aggressive. Dr Drummond was not cross-examined.

Dr Michelle McGlen

[38] Dr Michelle McGlen is a consultant forensic psychiatrist with NHS Tayside and has been a consultant since early 2016. At the time when she saw the pursuer she was an ST6 grade, in the final 6 months of her training. She completed a short-term detention certificate in relation to the pursuer on 14 January 2016 (JB1841). That was her first involvement with the pursuer. At the time of her examination, the available information was very limited. She was aware of a previous diagnosis of bipolar disorder but also that there was some diagnostic uncertainty. The reasons stated in the STDC were:

> "[The pursuer] has a historical diagnosis of Bipolar Affective Disorder. He was arrested following a Breach of the Peace, and whilst in police custody has presented

> with acute behavioural disturbance… This presentation is consistent with either a relapse of his bipolar illness, or drug-induced psychosis.
>
> [The pursuer] is currently finding it difficult to retain and weigh up information about his health and treatment. He has demonstrated impaired decision making ability through his inconsistencies regarding hospital admission and is in my opinion given the above unable to make a consistent decision about his care and treatment at the present time.
>
> [The pursuer] requires further assessment in hospital to determine what treatment is appropriate. Given his current presentation, it would not be appropriate to do this in any other setting other (sic) than in hospital. He has not been able to give consistent consent to treatment in hospital on a voluntary basis and therefore detention is necessary.
>
> Due to [the pursuer's] current levels of disinhibition and chaotic presentation, he currently poses a risk to his own safety & welfare. He is also extremely irritable and has been verbally aggressive, indicating he may pose a risk to others of assault.
>
> [The certificate is necessary because] inconsistently giving consent for voluntary treatment. Due to current levels of disturbance he requires admission to hospital with no initial time out, therefore limiting his freedom and making voluntary treatment impossible."

Heather McIntosh, the mental health officer, accompanied Dr McGlen when she went to interview the pursuer. At the time the pursuer was showing an acute change in his presentation and that was consistent with him being mentally unwell. Dr McGlen had discussed the case with Dr Reid, who was the consultant psychiatrist responsible for the IPCU at Stratheden, because she felt that the pursuer might require to be transferred to the IPCU given the level of aggression at the time of arrest. The unit exists to provide management of more acutely unwell patients. She discussed the case with Dr Reid first, and she had subsequently been contacted by Dr Narayan to say that there had been further discussion with Dr Reid and it had been agreed it would be more appropriate to admit the pursuer to a general ward in the first instance. The reference in the transfer letter JB567 to the patient becoming unmanageable followed from the variety of presentations which might require increased levels of staffing and security found in the IPCU. Dr McGlen agreed that

entries in the nursing notes for 15 January 2016 were potentially the kind of behaviour which could be unmanageable on an open ward, however she was not able to say whether they would be manageable in the IPCU because that was a different service with which she was not associated.

[39] In cross-examination, Dr McGlen agreed that JB1519 is a manuscript letter written by her on 13 or 14 January 2016. It is substantially similar to the typed letter JB567/568 except for the final paragraph, which refers to a discussion with Dr J Drummond and Dr Reid. Dr J Drummond is Dr Jacqueline Drummond. It was difficult to say after 8 years which was accurate. Dr Drummond had oversight of the IPCU and may have redirected her to Dr Reid. She definitely spoken with Dr Narayan later. She did not think she had discussed the detail with Dr Drummond. The essence of the problem was getting a bed, she had been in a series of round robin phone calls which is why she had spoken to three people.

Defender's evidence

Dr Vinay Narayan

[40] Dr Narayan is the clinician whose conduct is impugned in this action. Somewhat unusually in a case of this kind, Dr Narayan's evidence was led as part of the defender's proof. Dr Narayan obtained his medical degree in 2001 in the Dominican Republic. He sat the UK professional equivalency exam in 2002, and has held a number of medical posts in the period since. He was a staff grade in Psychiatry at New Craigs from 2004-2014. He worked in care of the elderly in Glasgow in 2014, and was a locum consultant psychiatrist in Dundee later in 2014, and at Stratheden Hospital in 2015-16. He has been a locum consultant psychiatrist at the Carseview Centre in Dundee since 2017.

[41] Dr Narayan could not remember whether a ward round on 30 November 2015 was the first occasion when he saw the pursuer. The information available to him at that time for the ward round discussion was the nursing staff report from which he would ask questions formally to plan for the ward round. He would have had an opportunity to review the previous records and would have taken account of that. As at 30 November 2015, the pursuer was being given lithium and had a diagnosis of a manic episode in bipolar disorder. Dr Narayan agreed the pursuer was very likely to have been manic at that point.
Dr Narayan recalled speaking to the pursuer on a number of occasions about the use of substances; however, he was unable to recall specific dates or occasions when he had done so.

[42] In an email to the pursuer's GP on 17 December 2015 (JB1525), Dr Narayan's referred to "clear evidence of a mixed personality disorder including borderline and narcissistic personality." The pursuer presented with narcissistic traits of grandiosity, a sense that he was better than others, seeking admiration and not taking criticism well. The evidence for that was his emotional dysregulation, grandiosity, and ability to regulate his emotional state, escalating that at will. Reference to evidence of "splitting" refers to psychological technique found in personality disorder. A patient may say "you understand me" to one member of staff and go to another and say "you don't understand me" trying to split the staff approach to management of their care. "Black and white thinking" is about manipulating behaviour where patients present with clear distinctions in thinking and there is no room for compromise. In the statement there was "no major mental illness" in the context meant that the pursuer did not have active symptoms; he was not in a manic phase. At the time of the email 17 December 2015 and the GP reply of 22 December (JB1525) there was no sign of

manic behaviour by the pursuer. The pursuer told Dr Narayan that he had separated from his partner on multiple occasions and they got back together again.

[43] JB1585 records a review conducted by Dr Narayan on 7 January 2016, and written up by Dr Pittock. It refers to the pursuer having broken up with his partner and also to cannabis and excess alcohol consumption about which there were regular concerns.

A mental state examination is recorded and was performed by Dr Narayan. The plan was to manage the pursuer informally as there was "no reason for detention". Neither Dr Pittock nor Nurse Lomax disagreed with that approach. At 2330 hours on 7 January 2016, Dr Grove (a CT1) found the pursuer not to be detainable but at that point the pursuer was going to stay (JB1590). At 23.50 the pursuer discharged himself, and wanted to be reviewed later. He was breathalysed with negative result and walked out without his possessions (JB1589).

JB1592 is a record dated 8 January 2016, made by Dr Narayan. The pursuer's diagnosis had not been revoked. At JB1593, Dr Narayan noted the pursuer's "over-riding personality (BPD and narcissistic) prevents him from adhering to advice regarding medical treatment."

A result of the personality disorder was that the pursuer tends to clash with others and to present as challenging. He is likely to take out an opposite view from those giving advice.

On 11 January 2016 at 10.15, Dr Pittock made an entry when the pursuer was brought in as a place of safety (JB1595). Mental state examination was carried out. There was no evidence of major mental disorder, noted to be agreed with the charge nurse, who was Nurse Lomax, and the consultant. Dr Narayan could not remember whether he was the duty consultant at that time. Dr Narayan agreed that the description of the pursuer's presentation at Perth Police Station on 14 January 2016 was quite extreme. Dr Narayan could not recall discussing this with Dr McGlen at the time, but did not challenge what the letter said. Dr Narayan recalled the discussion described in the email timed 15.24 on 14 January 2016, but not the

precise timing. The proposed approach would be the least restrictive option because Lomond Ward was an open ward as against IPCU which is a closed ward. JB1599 was a record of Dr Pittock's examination of the pursuer at 1620 hours on 14 January 2016, and included a mental state examination. Dr Pittock had discussed the position with Dr Narayan. Dr Narayan could not recall the conversation but thought it was likely that it covered the matters recorded in Dr Pittock's record. JB1606 and 6/2 of process were an accurate record of Dr Narayan's assessment of the pursuer on 15 January 2016. Dr Narayan had not made a separate document recording a mental state examination in that note but would have assessed the pursuer's mental state at that time. The first four paragraphs in essence contained that assessment. Whenever one sees a patient one carries out a mental health state examination even although it is not always recorded separately in the records.

[44] Dr Narayan did not consider that he ever revoked the diagnosis of bipolar disorder. Dr Narayan had a vague mental image of himself and Nurse Lomax seeing the pursuer on the Monday 18 January 2016. Nursing staff would have advised about developments over the weekend. That information would have come via Nurse Lomax and Dr Narayan would probably also have read nursing notes. Dr Narayan had not observed pressure of thought or speech at the time. There was no disturbance in the train of thought; the pursuer was able to express himself. Dr Narayan had noted that the pursuer "demonstrates adequate insight" because he was able to recognise and appreciate what he was saying and able to have a discussion about his concerns since he was able to express himself without difficulty. The pursuer was given an explanation for his behaviour in the police cells in Perth which Dr Narayan had believed because of the manner in which it was given. The pursuer did not deny his behaviour, he was able to express why he had done it and described having "done it for the camera". Dr Narayan would likely have checked where the pursuer would have

used medication over the weekend but he could not say with certainty. At the time of examination there was no pressure of speech, no thought disorder. The pursuer was not suicidal, he was orientated and there was no sign of psychosis. Dr Narayan decided to revoke the short-term detention certificate because at review he was not satisfied that the pursuer had significantly impaired decision making. He felt the pursuer was aware of the situation and was making choices albeit poor choices. Accordingly, Dr Narayan did not believe the pursuer required to be detained for treatment. Dr Narayan had however advised the pursuer to stay voluntarily. At that time the pursuer was very explicit that he did not want clinical staff discussing his condition with Caroline Manson. The relationship was very difficult because it was off-on at the time. Dr Narayan felt the pursuer had capacity about this and would respect his wishes in relation to confidentiality.

[45] The pursuer's presentation recorded by Dr Rose on 21 January 2016 JB1506 did not describe anything substantially different from the pursuer's presentation at Stratheden on 18 January 2016. The emails of 20 January 2016 between Dr Rose and Dr Pittock (JB2526) did not contained anything different in presentation. Dr Olley's conclusion following review on the ward on 21 January 2016 was that the pursuer was not detainable (JB2532).

[46] In cross-examination, Dr Narayan confirmed that he is not on the GMC Specialist Register as a consultant psychiatrist, as opposed to a locum consultant psychiatrist. He explained that was because of his personal circumstances in relation to having a training visa and thereafter a work permit which was tied to a previous position which he held at New Craigs Hospital. He has been a British citizen since 2013 which allowed him to move and gain further experience. Dr Narayan explained he would have to put in a lot of further work to meet the criteria for the specialist register. He is happy in his current post and has therefore not made an application to be on a specialist register.

[47] While Dr Narayan accepted it was possible that the pursuer experienced a manic episode of bipolar disorder in November 2015, he saw signs of mixed personality disorder. The signs of an episode of bipolar disorder were evident initially but in his view, the presentation evolved towards personality disorder. It was evident throughout the admission that the pursuer was able to regulate himself. He was very disinhibited when in prison and in police cells during the dirty protest, but why would he take time to cover his genitals when doing so; someone who was so manic would not care to protect their dignity. The relapse of bipolar disorder was at least a couple of weeks' duration. Dr Narayan agreed that the past was a good indicator of likely future presentation, and while he had seen the pursuer's previous records he could not recall the timeframe of relapses during previous admissions. At JB1567 the pursuer was described as slightly better and not as manic as previously and Dr Narayan accepted that at that point, the pursuer had a manic presentation. Comparing recorded symptoms from the pursuer's admission in 2011, Dr Narayan considered that there were differences from the presentation in 2015/16. In particular the key component was that the pursuer was able to regulate himself when his demands were met.

[48] On 18 January 2016, Dr Narayan considered that the pursuer had signs of personality disorder, and further did not diagnose a relapse of bipolar disorder. That thereafter led him to revoke the short-term detention certificate. He did not accept that decision was wrong and stood by his decision at that time. When Dr Narayan left Stratheden, Dr Howson took over as the pursuer's RMO and thereafter his care was supervised by Dr Drummond. Her view as at April 2016, was that the pursuer was suffering from bipolar disorder (JB2386). Dr Drummond's view could be seen with the benefit of hindsight, however at the time Dr Narayan's perception was that the pursuer was experiencing symptoms of personality

disorder. Dr McGlen was not known to Dr Narayan. He did not accept that he would invariably defer to her as a forensic psychiatrist, it would depend on the circumstances. At JB568, Dr McGlen discussed the possibility of the pursuer being admitted to the IPCU, that admission decision was out of Dr Narayan's hands and he did not know who made the decision. He did not recall a conversation with Dr McGlen. JB1608 or 6/2 was a list made by Dr Narayan on 18 January 2016, describing the pursuer's presentation over the preceding weekend. The reference to the "events over the weekend" was likely based on reading notes or speaking to the nursing staff. Dr Narayan recalled the pursuer ripping up a document, he was not sure whether it was the short-term detention certificate. He could not remember whether the pursuer hit members of staff. He could not remember whether the pursuer threatened Staff Nurse Hutchison. Dr Narayan was asked why the pursuer was not sent to the IPCU and indicated that his thinking at the time was that the pursuer was displaying symptoms of personality disorder and that the pursuer's responses were behavioural. For example, he kept himself awake using coffee and splashing water on his face. Dr Narayan accepted that Dr McGlen's notes described the pursuer as very unwell. Dr Narayan accepted that he could have transferred the pursuer to the IPCU on 18 January 2016, thus ensuring that he did not have access to alcohol or illicit substances, and it might have been possible to make an assessment at that point.

[49] Dr Narayan was asked a number of questions about Dr Scott's report, which I heard under reservation. Dr Narayan agreed that Dr Scott was critical at section 6(b) that the records do not contain a document of assessment of the consideration of hypomania. At 6(c) there was criticism of records and in particular the absence of a record of the consideration of the drug regime. Dr Narayan accepted that in terms of the principles in the Mental Health (Care and Treatment) (Scotland) Act 2003 included having heard the views of the

patient's named person, who was Caroline Manson. He accepted that it would have been possible to take her views and tell her at the same time that he was unable to give details of the medical treatment. At the point where the short-term detention certificate was revoked, Dr Narayan felt that the pursuer was in a position to make his own decisions albeit he was making poor choices. He was offered ongoing admission and he made the choice to ignore it.

Glen Lomax

[50] Glen Lomax is a senior charge nurse and ward manager at Stratheden Hospital. He works in the secure unit there. Mr Lomax recalled the pursuer from the admission in 2016. He had a good relationship with the pursuer, the pursuer was very respectful but found it difficult being in hospital. He was brittle (in the sense of being edgy and on a fine line between being settled and unsettled on the ward) towards some staff. Mr Lomax was on duty on 14 January 2016. He did not remember the pursuer being brought to hospital; however the pursuer was on the ward when Mr Lomax arrived on duty. Mr Lomax was not clear which psychiatrist saw the pursuer immediately. He had a vague recollection of being present on 18 January when Dr Narayan assessed the pursuer and revoked the short-term detention certificate. Dr Narayan had asked Mr Lomax for his opinion about how the pursuer was doing. His recollection was the pursuer's presentation was appropriate; there was no grandiosity and he was talking appropriately. Mr Lomax was also aware there had been aggression towards nursing staff earlier. Mr Lomax did not remember very much of the meeting. In general, consultants and other doctors would want his input for assessment of more challenging patients because of his experience on the ward. If Mr Lomax had concerns about a psychiatrist's assessment, he would not say anything in front of a patient,

but would definitely raise concerns afterwards. He has a vague recollection of the short-term detention certificate relating to the pursuer being revoked, but not of the ins and outs of it. He was pretty sure that he had not disagreed with that decision at the time, and if he had disagreed he would have said so. Mr Lomax had some recollection of Dr Olley assessing the pursuer on 21 January 2016 but could not recall the detail of that. From the description at JB2532, Mr Lomax had no reason to consider the decision to detain the pursuer was incorrect at that time.

[51] In cross-examination, Mr Lomax confirmed he had seen between 20 and 30 patients with bipolar disorder, some of whom were in and out of hospital like a revolving door, not all were floridly elated. Patients can present with varying degrees of severity but in his experience, they tend to be either very elated or depressed for a longer period.

Dr Nabila Muzaffar

[52] At the outset of Dr Muzaffar's evidence, counsel for the pursuer indicated that he took an objection to the admissibility of the entirety of her evidence for reasons to be developed in submissions. He was content for her evidence to be heard under reservation, a course of which counsel for the defender agreed, and I was content to allow that to be done. I explain below at paragraphs 89-92 why I repelled that objection.

[53] Dr Muzaffar is a consultant psychiatrist with NHS Forth Valley. She has been a consultant there since 2003 and is in full-time practice in the NHS. In the course of her time as a consultant, she initially worked both with in-patients and out-patients. Thereafter, she worked in an in-patient team dealing with intensive home treatment for emergency assessments and treatment. From 2006-2019 she dealt with in-patient management followed by a period dealing with community cases and eating disorder patients. Since

February 2024, she has been the Associate Medical Director for Mental Health Services in Forth Valley Health Board. She has managed patients with bipolar affective disorder, which is a common presentation and has looked after such patients as in-patients, and at home in the community. Dr Muzaffar also has experience of managing patients with personality disorder, which in her experience has become a more common presentation. In that period there has been more recognition of personality disorder both as a standalone condition and comorbid with other mental health problems. In her experience, there is a higher number of patients presenting in periods of crisis, many with additional problems with substance abuse. Dr Muzaffar has experience of assessment and management of a wide range of psychiatric conditions. She has given evidence in court, including in the High Court. Dr Muzaffar has been carrying out medical - legal work since 2015, including clinical negligence cases and FAIs. All of her instructions in those cases have come from the NHS Central Legal Office; that has been by coincidence rather than by choice. Dr Muzaffar confirmed that she would take on a patient's medical-legal case if instructed, and did not consider herself to be "a hired gun" for a health board. She understood her role was to help the court and provide a balanced view. Her report was prepared for the court and she indicated that she has in the past provided reports which indicate that, in her view, there had been negligence in a particular case.

[54] Dr Muzaffar adopted her report of 31 January 2023 (6/1 of process) as evidence. She had listed the documents available to her (CB347). She had since seen two further reports from Dr Scott and two reports from Dr Qureshi. Dr Muzaffar had also seen medical records which are contained in the joint bundle. When considering the clinical records, Dr Muzaffar tried to capture the background and longitudinal picture of the patient's history. The pursuer had a number of admissions presenting as manic episodes of bipolar affective

disorder. There had been an admission under the care of Dr Beveridge from 3 May 2011. The pursuer had been described at various points on review as "bullying and intimidating" "impatient and demanding" (27 September 2011 JB1538) and (bullying and demanding) (13 October 2011 JB2568). Dr Narayan had taken this into account because past documentation informs the clinician's current view. Bullying, intimidatory and demanding behaviour were all potential signs of personality disorder suggesting impulsiveness and inability to control ones behaviour. These features were set out in ICD10 for both bipolar disorder and personality disorder. Dr Muzaffar was familiar with the symptomatology of both bipolar disorder and personality disorder.

[55] Personality disorder normally presents in early adulthood but not everyone with personality disorder presents to mental health services. A patient with a personality disorder may present at a time of crisis having previously been managing without help, or without experiencing a crisis affecting their coping mechanisms. Any stress affects the brain and may trigger mental health problems if a person is predisposed to them. Stress is certainly a triggering factor for personality disorder problems. At paragraph 56, Dr Muzaffar had noted the discharge letter did not disclose evidence of bipolar disorder; Dr Narayan had accepted that was not quite right. The record for 23 November 2015 (JB1565) was a clear entry of the diagnosis of a manic episode and in Dr Muzaffar's view there was not enough evidence in that document to support the diagnosis at that point. On 24 November 2015, the pursuer was reviewed by Dr Pittock (JB1566), who recorded that the pursuer "would be detainable if he tried to leave" and the pursuer therefore met all the criteria for detention except the necessity and in Dr Muzaffar's view the record should have fully stated that the pursuer should be assessed for detention should he seek to leave. The email timed at 16.30 on 17 December 2015 (JB1525) considered the possibility of diagnosis of

bipolar disorder but there was no evidence of such. The reference made by Dr Marks and Dr Pittock in November 2015 contained an impression that the pursuer was experiencing a manic episode and so it was against that background that Dr Narayan had agreed that it was not quite right to say that there was no evidence of such (ie mania). Dr Muzaffar agreed it would be more accurate to say that there was no evidence of mania at an early stage. Towards the end of the admission, on 7 December 2015, the presentation was not in keeping with mania. At around that time, the pursuer had been demanding medication which was more in the character of a personality disorder. In a manic episode a patient would be irritable respective of the trigger.

[56] It was a difficult assessment to make but if a patient was settled then irritable if denied medication that was more likely to indicate a personality disorder. The pursuer had some longstanding traits of personality disorder. It was also noted at that time that there was no clear improvement with lithium, and with bipolar disorder one would expect a much clearer response although not all patients with bipolar disorder do respond to lithium. The email reporting on the pursuer dated 22 December 2015 (JB2549) did not record any signs of manic behaviour. The GP appeared to consider there had been a relapse of bipolar disorder by 31 December 2015 and Dr Narayan wrote a letter following discussion with the GP and in contemplation with another colleague receiving that later in the day. In a letter dated 31 December 2015 (JB1522), Dr Narayan noted the pursuer's current diagnosis as:

> "1. Bipolar affective disorder (Axis I);
> 2. Query personality disorder (under investigation) Axis II;
> 3. Alcoholism."

The pursuer was thereafter seen by Dr Jabbad who recorded an impression of a manic episode, and also that there was no current reason to detain the pursuer. Dr Narayan recorded a telephone conversation on 8 January 2016 (JB1593), and his view that the

pursuer's behaviour was about control and that he retained capacity and was not then detainable. The diagnosis recorded at that point was:

> "1. Mixed personality disorder;
> 2. A history of bipolar affective disorder."

[57] Dr Muzaffar had no reason to criticise the characterisation as not detainable at that time. As at 11 January 2016, the pursuer did not come across as meeting the criteria for detention. On 14 January, there had been an enormous change and the decision to detain at that point was correct. Dr Muzaffar saw no reason to criticise the conclusions reached by Dr Olley to the time of the review discussed in paragraph 87 of her report nor in the review by Dr Howson. Dr Ahmmed had recorded that the pursuer "seemed in full control of what he wanted to disclose." Against that background, it was reasonable for there to be uncertainty about diagnosis at that point. Evidence from nursing staff was very relevant because they have much more contact with a patient and observe them throughout the day and at night, whereas the review by the psychiatrist was a snapshot and a patient could present differently in a meeting on the ward during the day.

[58] Under reference to paragraph 92(d) of her report (CB363-4), Dr Muzaffar explained her view that the decision to revoke the short-term detention certificate was appropriate and reasonable, as such decisions are challenging and the clinician has to make sure the criteria for detention are met. If another psychiatrist lays different weight on certain features, that was because in psychiatry there are no blood tests or scans, and diagnosis is based on the observations of staff, interview of the patient and information from others involved. Different psychiatrists could reach a different view. It is particularly difficult because of the overlap in symptoms between bipolar disorder and emotionally unstable personality disorder. There was a stark different between Dr Muzaffar''s view and Dr Scott's view.

However, their views were on a reasonable scale of professional opinion. She was at one end and Dr Scott was elsewhere on the reasonable scale of opinion. The 2003 Act required clinicians to have regard to the views of a range of people including named person and carer. The patient's views also require to be considered. The clinician is required to listen to a range of views but might not always require to tell the patient what those views were, because there may be circumstances where the patient had a very difficult or strained relationship, and that the patient may experience the psychiatrist talking to another person as a breach of trust. It would, for example, be relevant that if patient has told a clinician that they have broken up with the named person and a patient might say they did not want the doctor to speak at all to the named person. Different clinicians might take different views about that. Dr Narayan had acted reasonably in all the circumstances in not speaking to Ms Manson.

[59] In cross-examination, Dr Muzaffar confirmed that she was not indicating that the diagnosis in 2002, 2003/2004 and 2011 that the pursuer had bipolar disorder were wrong. Nor was she suggesting that the diagnosis should be personality disorder. Personality disorder had not been diagnosed earlier because the pursuer was managing his symptoms. Patients with personality disorder have ways of coping but a crisis situation or substance use tends to result in them presenting to psychiatric services. While ICD10 reports that personality disorder tends to appear in late childhood or adolescence, that is not to say that a patient will present to psychiatric services at that point. A longitudinal history is relevant; and in the case of the pursuer, showed that he appeared to be coping. Patients with a personality disorder may not come to the attention of psychiatric services. The pursuer demonstrated a personality disorder along with substance use and possibly bipolar disorder. Dr Muzaffar in her formulation said both were present. In her clinical experience,

patients sometimes present later with personality disorder where substance use is a contributory factor. In terms of the onset of personality disorder, emotional instability is likely to manifest in late adolescence and early adulthood. The pursuer has features of personality disorder. It would be speculating to say that those were present from an earlier age. It was true that the pursuer had presented to hospital in Stevenage with bipolar disorder in 2002 and appeared to get better with treatment. The relationship with personality disorder was at that time not explored and Dr Muzaffar did not accept that she had made no reference to the suggestion that on referral in 2015, the initial impression was a relapse of bipolar disorder; she had made a number of notes about his presentation. Dr Muzaffar was not aware that members of the pursuer's family told him he needed to get back on medication when he was discharged in December 2015, having been told there was no evidence of mental illness. Abstaining from substances at the time of the admission in 2015/16 was a contributory factor. While what has happened in the past is likely to be some indication of what will happen in the future, that does not always hold for psychiatric presentation, especially if substance use was involved. There was a period when the pursuer was drinking quite heavily, for example. Dr Muzaffar was referred to entries in the records for 20 November, 23 November, 26 November, 30 November 2015 (JB1564-1567) and a letter dated 31 December 2015. Dr Muzaffar did not refer to those and could only assume that the notes containing these were not available. Dr Muzaffar's report focussed on the admission during which the short-term detention certificate was revoked. She would have included earlier notes if she had had them. It would appear the psychiatric presentation had changed. The pursuer's presentation was challenging. In Dr Muzaffar's view a large component of the pursuer's behaviour had been influenced by substance use with alcohol and cannabis, and that had been the reason for contact with services and the deterioration in

his condition. Dr Muzaffar considered her conclusions were reasonably balanced and the report largely focussed on the revocation of the short-term detention certificate, and the pursuer's management at that time. A big part of her assessment was that the pursuer's behaviour was so different after the 14 January 2016.

[60] Dr Muzaffar agreed that there was no suggestion in the records of personality disorder until this was raised by Dr Narayan in December 2015. Once it had been raised it became difficult for other clinicians to ignore it since the additional diagnosis required management. Dr Muzaffar's focus was on the discharge from detention on the 18 January 2016. She did not consider the overall management of the pursuer's care to be the question for her report. Dr Muzaffar was not aware that Dr Narayan had changed his mind about diagnosis, she did not have any documentation to that effect. In relation to the admission in January 2016, if the pursuer had bipolar disorder, it might not have become manic; the crisis may have presented consistent with personality disorder or with substance use. If a patient has a diagnosis of bipolar disorder he or she would tend to be treated as if they had that. Trying to tease out these two diagnoses is very difficult in practice. The presentation in the cell on the 14 January 2016 was very bizarre and in keeping with an acute deterioration in mental disorder. However, when the pursuer came to the ward in the late afternoon that day, he was vastly different and threw doubt in Dr Muzaffar's mind. Manic illness was not presenting quite in that way but substance use was very much in her mind. Removing the patient from the stress of being in the police cell would not, in her clinical experience, necessarily immediately improve the condition of patient showing the degree of bizarre behaviour recorded. One would not expect then to see logical thought. Dr Muzaffar agreed with Dr McGlen's view about the short-term detention certificate being appropriate. It was good practice for her to have discussed matters with Dr Narayan. Dr McGlen's initial view

had been to transfer the pursuer to the IPCU. Following discussion it was agreed that he should go to Lomond Ward and be transferred to the IPCU if unmanageable; that was a reasonable approach because it was the least restrictive option. The pursuer was behaving pretty badly between 14-18 January 2016. That might be because of symptoms of bipolar disorder but equally because his demands were not being met and he had poor impulse control. These could be features of bipolar disorder but there was no thought disorder. His presentation in the cells was remarkably different to that on the ward.

[61] For the short-term detention certificate to remain in place, all the tests had to be met. Capacity does not depend on the presence of mental disorder; the pursuer could have hypomania but still have the ability to understand and engage with treatment. Dr Narayan should have recorded the complexity of the pursuer's presentation and circumstances. He had offered out-patient contact and the pursuer had previously been offered an in-patient stay but he had taken his own discharge. It was a duty of care to offer accommodation as the pursuer was likely to be homeless. There was an out-patient appointment in 2 weeks given the circumstances this could have been sooner. In Dr Muzaffar's view the diagnosis overlapped. To say that the only personality disorder was the diagnosis was not correct it should be an additional diagnosis not a replacement. The pursuer in her view has traits of narcissistic personality disorder. His presentation is also affected by substance abuse.

[62] In re-examination, Dr Muzaffar confirmed that the nurses in the Lomond Ward were not asking for the pursuer to be transferred to the IPCU. The nurses were not seeking a medical view. It was possible for a patient to have a bipolar disorder and a personality disorder. The past was an indication of future presentation but a presentation could evolve over time. Dr Muzaffar understood the focus of her report and evidence to be an admission under the short-term detention certificate in January 2016 and the decision to revoke that.

Dr Alistair Morris

[63] Dr Morris is a consultant forensic psychiatrist, based at the Orchard Clinic in Edinburgh. He obtained his medical degree from the University of Aberdeen in 2000. He also has also have a Masters degree in Psychiatry from the University of Aberdeen. Dr Morris completed both basic psychiatric training and higher specialist training in forensic psychiatry at the Royal Edinburgh Hospital. His name appears on the Specialist Register of the GMC. Dr Morris examined the pursuer in the cells at Perth Sheriff Court on 8 February 2016. His findings are set out in a clinical letter dated 8 February 2016 (JB1479). At that time one of his roles was as the consultant for the Forensic Community Mental Health Team, one of whose roles was to assess persons that were queried as having mental disorder in a custodial location. Dr Morris was asked to assess the pursuer following his arrest for an alleged drink driving offence, to further establish if there was evidence that he was mentally disordered or otherwise and whether he ought to be removed to hospital.

[64] Dr Morris had no clear recollection of reviewing the pursuer's medical records, but the information in pages 2 and 3 of the letter would have been obtained from the records. He might have asked his secretary to print copies of the most recent discharge letter, or he might have called one of the doctors or nurses involved in the most recent hospital admission. Following upon his examination of the pursuer, Dr Morris noted:

> "Objectively, it increasingly appeared as if his difficulties related to an abnormal personality structure, primarily of an emotionally unstable and narcissistic type that was decompensating in the face of a number of psychosocial stressors and substance misuse."

Dr Morris was picking up background information from the ward in relation to the pursuer's recent admission, which suggested that they did not think his presentation is due

to a severe treatable mental disorder such as bipolar affective disorder, but that instead they recognised that things were not normal, but that those behaviours were due to problems in the realm of his personality, particularly in the context of what they saw as an alternative explanation for his difficulties, which was emotionally unstable and narcissistic personality traits. Dr Morris understood that this was occurring due to the pursuer being under a lot of stress: there were relationship problems, and the pursuer was using a lot of substances. Following his examination, Dr Morris concluded the pursuer did not meet the criteria for detention under section 52D of the Criminal Procedure (Scotland) Act 1995

[65] In cross-examination, Dr Morris confirmed he was familiar with the ICD-10 criteria for diagnosing bipolar affective disorder, and personality disorders. Dr Morris accepted that an untreated an episode of mania could last 4 or 5 months. However, a patient experiencing mania of a degree that resulted in hospital admission would be treated whether they want to be treated or not, and usually they would respond to treatment with medication within a low number of weeks. Dr Morris's normal practice prior to an interview of the kind he had with the pursuer would be to ask his secretary to print off recent letters or any summaries that are immediately available on the electronic case-note system. He might consider calling a ward if it's someone who has been recently discharged to get additional information. He was unable to give a definitive position as to what was available prior to his assessment of the pursuer. The interview with the pursuer took 40 minutes to 1 hour. Dr Morris had no recollection of a conversation with Dr Narayan in February 2016, but accepted it was possible that he had had such a conversation.

[66] Dr Morris did not find evidence in the course of the assessment to contradict that which had been found during the pursuer's inpatient admission. There was the one odd statement that is consistent with a grandiose delusion, but there was an absence of other

clear symptoms of mental disorder. At JB 1479 Dr Morris wrote "I did not feel this was sufficient to indicate he was significantly mentally unwell". He had not ruled out the possibility that the pursuer was to some extent mentally unwell. However, psychiatry is not like a specialty like orthopedics where one could view an x-ray and say, "There's a broken bone." There were often shades of grey. Dr Morris did not diagnose the pursuer as having a personality disorder, certainly not as a definitive diagnosis. All he could say was that the man he saw at assessment was not presenting with the behavior noted by Dr McGlen, or Dr Howson, when Dr Morris saw him.

Submissions

[67] Parties lodged written submissions (numbers 34, 35 and 36 of process). It is not necessary for me to rehearse the written submissions at length; they are in process. I have taken full account of them. Rather, I cross-reference those submissions to the oral submissions of counsel, and deal with a number of other points arising in the discussion which follows.

Pursuer's submissions

[68] Mr Allardyce adopted the principal written submission for the pursuer. In relation to the defender's criticism of Dr Qureshi, counsel for the pursuer took full responsibility for the change in direction of the witness's evidence. Professor Rix was to have been the main witness for the pursuer but was not able to give evidence at the allocated diet. Dr Qureshi's evidence had accordingly been extended to address the issue of breach of duty. In relation to the timing of Dr Narayan's evidence within the sequence of witnesses, it had become apparent that the times when Dr Qureshi and Dr Scott would be available may be

problematic for overall scheduling; Dr Scott in particular had limited availability. It was thought better to take their evidence in sequence. In relation to the defender's submission about the reliability of the factual witnesses, counsel agreed that this was a case of some vintage. The court would require to consider with care the reliability of the witnesses, and the court should focus on the medical records, which counsel accepted were not drafted with the court in mind. Counsel accepted that the same strictures applied in relation to the pursuer's evidence, and the position was he had been suffering from a relapse of bipolar disorder at the time of the events he was describing in evidence, with consequent impact on his recollection.

[69] Counsel submitted that Dr Narayan had accepted he was wrong and so the only question was whether he was negligent. The pursuer's submission was that with so much evidence about negligence, the court might be able to determine the issue without expert evidence. Counsel indicated that the extensive extracts from the pursuer's agents' notes of evidence annexed to the written submission correlate to chapter 2 of the written submission. Counsel invited the court to review the agents' notes in order to follow the submission.

[70] Counsel submitted that Dr Muzaffar should not be treated as an independent witness because she was employed in the NHS in Scotland. I have dealt fully with both parties' submissions on this issue at paragraphs 89-92. If Dr Muzaffar's evidence was admissible, for broadly similar reasons, counsel invited the court to prefer the evidence of Dr Qureshi and Dr Scott. In any event, Dr Muzaffar said that she would have diagnosed bipolar disorder. Her report and evidence was of very limited value to the court because it was lacking information about the critical period. Dr Muzaffar was now the only clinician supporting the diagnosis of personality disorder by Dr Narayan, and he had changed his view. In relation to the argument about the range of a reasonable professional opinion,

counsel accepted there was a scale and submitted that the reasonable range was in the middle of that scale. On the assumption of a scale on 1-100, the reasonable range might be said to be between 40-60. Dr Muzaffar's position was, he submitted, logical. The diagnosis of personality disorder was wrong in hindsight. The pursuer was treated for bipolar disorder; the pursuer got better, which counsel submitted demonstrated that was the correct diagnosis.

[71] In relation to the chapter about the negligence of Dr Narayan, the pursuer's position was that in cross-examination, Dr Narayan had accepted three important points:

(1) That he was wrong not to diagnose the pursuer as suffering from a relapse of bipolar affective disorder on 18 January 2016;

(2) That he was wrong to diagnose the pursuer as suffering from a personality disorder; and,

(3) That on 14 January 2016, when the short-term detention certificate was granted, the pursuer was "seriously unwell" and that he would not have got better in the 4 days prior to 18 January, when the short-term detention certificate was revoked.

These were critical, and were the starting point for submissions developed in the written submission under the following headings:

- The decisions made by Dr Narayan about diagnosis were wrong.
- Dr Narayan changed his mind about how he viewed his diagnosis of the pursuer, over the course of events.
- No other doctor involved in the pursuer's care, who had not been influenced by Dr Narayan's diagnosis, made a diagnosis of personality disorder.
- The application of ICD-10.

- The STDC.
- The nature of signs, symptoms and behaviour shown on previous occasions and the same signs, symptoms and behaviour shown in the period November 2015 to January 2016.
- Ignoring what the pursuer's relatives were saying.
- What happened after the pursuer's discharge.

[72] Mr Clair then adopted the supplementary written submission for the pursuer anent scope of duty and quantum of damages. Counsel had nothing to add to the chapter on *quantum* of damages and tendered a copy of the passages from the Judicial College Guidelines referred to. In relation to scope of duty, counsel did not dispute the statement of the law (at paragraphs 88-92) in the defender's written submission; rather the question was its applicability. Reference was made to *SD* v *Grampian Health Board* [2024] CSIH 7. Counsel said this was a classic care and treatment case. Reference was made to paragraphs 80-81 of the court's judgment. The principle stated there was apt in a care and treatment case which differed from the situation in *Meadows*. Dr Narayan was not providing advice for a purpose. In *SD*, the court had declined to extend the principle relied on by the defender beyond advice cases. In consequence, the breaches of duty ought to result in damages being recoverable.

[73] In relation to the *ex turpi causa* point, the principle was that the court would exclude damages arising from relevant criminal convictions. However, some of the most compelling evidence was about the pursuer's time as a remand prisoner; thus it was submitted this did not flow from a relevant criminal conviction. Solatium is a broad concept, so that it would be open to award damages on the basis of any of the established breaches.

Defender's submissions

[74] Senior counsel adopted the written submission for the defender and indicated there were five overarching points:

(1) What actually happened between 13-18 January 2016;

(2) The cross-examination of Dr Narayan;

(3) That this case is not about diagnosis;

(4) The pursuer's expert evidence; and

(5) The weight of the evidence.

[75] Point 1 - Before 13 January 2016, the pursuer had a diagnosis of bipolar disorder, but also complicated personality traits (in the clinical sense). On 13 January 2016, the pursuer took cannabis (JB2814), and tested positive on 14 January (JB2814). All of the medical witnesses spoke to drug use as being a complicating factor in the pursuer's presentation. On 13 January 2016 that led to the pursuer being arrested, and on 14 January the pursuer presented in the way described by Dr McGlen in her review of the pursuer in the police cells in Perth. Senior counsel submitted she was right to detain the pursuer under the Mental Health Act, and at that point she could not have known about the drug use, but she was thinking about that as a possibility. The next day the evidence was clear because the pursuer had a positive drug test. The pursuer arrived at Stratheden in the late afternoon on 14 January 2016, by which time the drugs had mostly worn off and his presentation was perfectly normal, and Dr Pittock noted that. Senior counsel submitted that manic phases do not resolve in that way, and that was the evidence of all of the experts. The pursuer was detained; the pursuer was frustrated; on 18 January 2016 Dr Narayan revoked the short-term detention certificate, and the pursuer took his discharge against medical advice. The pursuer then consumed drugs and alcohol. That was the sequence of events. Senior

counsel did not dispute that thereafter, by April 2016, the pursuer was experiencing a manic episode.

[76] Point 2 - In relation to the cross-examination of Dr Narayan, as indicated in paragraph 12 of the written submission, the mode of cross-examination was entirely inappropriate. It was being suggested that he had done something illegal, which is a most serious allegation. Counsel for the pursuer had subsequently accepted that could not be stood up. It was important that witnesses are treated fairly and appropriately, and it was submitted that the unfairness was not remedied by the apology that was given because it was inappropriately qualified. The pursuer did mean the police would be called; that was clear from the wording of the question and the discussion afterwards. The pursuer thereafter seeks to rely on a concession from Dr Narayan. Counsel for the pursuer had said in the course of exchanges that Dr Narayan would agree that the earth was flat, indicating that the witness had inappropriately been browbeaten. Counsel knew that. The defender's position was that the concession should not be relied on. That was not to say however that the court should disregard the rest of his evidence. The important point was in relation to the non-relevance of Dr Narayan's evidence about his opinion, and in that connection reference was made to the decision of Lady Wise in *SD* at paragraphs 144 and 145, where the court discussed the notion of "putting the case" to a clinician whose conduct was impugned in an action of this kind, and whether that is useful.

[77] Point 3 - This case is not about diagnosis. The pursuer's submissions refer to "diagnosis" and "negligent diagnosis"; however, senior counsel submitted that ignored a number of important points. Firstly, there was no record for a case based on negligent diagnosis; second, there is no evidence about negligent diagnosis; and third, the court's ruling about these points during Dr Qureshi's evidence and in particular that this was not a

negligent diagnosis case. Accordingly, the court was invited to assess Dr Narayan's decision making against the background that the previous treatment was not challenged. Reference was made to *SD* v *Grampian Health Board*. That case concerned an allegation of negligence by a midwife which was rejected by the Lord Ordinary and was not the subject of the subsequent appeal. That became problematic in the challenge which was made to a later decision. Counsel submitted that the same issue arises here. The phrase "negligent diagnosis" appears regularly in the pursuer's submission and in the pursuer's draft findings in fact. Counsel submitted that was not open for discussion. This is not a negligent misdiagnosis case for the reasons already given and because the expert reports before the court did not address that. The report from Professor Rix is in the shadows and is irrelevant, since he had not been led to speak to it.

[78] Point 4 - The pursuer's expert evidence - Dr Scott accepted in evidence that he and Dr Muzaffar were on the scale of reasonable professional opinion, and Dr Qureshi said that too. Counsel submitted that in an action of this kind, a case on breach of duty could not succeed, because the pursuer's experts accepted that Dr Muzaffar's opinion was one which was reasonable, albeit one with which the disagreed.

[79] Point 5 - Weight of evidence. Counsel referred to paragraph 73 of the defender's submission which listed the clinicians who had formed a similar view about the pursuer's decision making ability. That was relevant because it bears on the decision to revoke the short-term detention certificate. Any conflict between the experts should be resolved in favour of Dr Muzaffar. The pursuer's experts had seen her report; it should have been obvious there were records they had not seen, for example Dr Rose's correspondence the day after and Dr Olley's review 2 days after. Both had agreed these were potentially

important matters. The pursuer's experts had not taken account of what other ordinarily competent doctors had done and thought.

[80] Dr Muzaffar's report - the pursuer criticised Dr Muzaffar for not setting out the issues; counsel submitted such criticism was not well founded At page 4 of the pursuer's written submission there were complaints about diagnosis; however, the case was not about diagnosis. At paragraph 92 of her report (CB364), Dr Muzaffar analyses the breaches of duty pled on record. Counsel submitted she had a solid idea of the issues in the case. The pursuer said she was seeking to divert attention - that was a serious criticism and lacked any coherent basis. Dr Muzaffar was cross-examined about underplaying reference to bipolar disorder, however it was clear that she accepted that the pursuer had a longstanding history of bipolar disorder, whatever other diagnosis might also be applicable.

[81] In relation to the pursuer's point that no other doctor had diagnosed personality disorder, the pursuer was in effect inviting the court to disregard the conclusions of Dr Rose, Dr Pittock, Dr Olley, Dr Morris and Dr Howson and parts of Dr Drummond's evidence. The court simply could not do that without more. Dr Morris had given evidence on commission and the pursuer had cross-examined Dr Morris about a "gold standard" review and he said the review had been a good gold standard review. There was no basis for saying the doctors were unduly influenced by Dr Narayan. Not least because the implication was that they did not do their job properly: there was no evidence of that.

[82] In relation to the pursuer's position about the short-term detention certificate, at page 20 of the pursuer's written submission about the pursuer's prescription medication being continued after discharge, and raising a question about why the short-term detention certificate would be revoked if the pursuer was still being treated. The answer to that was that the medications are mood stabilizers and are not only prescribed for bipolar disorder.

[83] A number of points arose from the pursuer's supplementary written submission. Firstly in relation to scope of duty, the defender's position in relation to the case of *Meadows* is the scope of duty discussion in that case is not confined to advice cases; see *Meadows* at paragraph 28. Counsel submitted that that had a comprehensive list of issues which were of general application and were not confined to advice cases. "Traditional" principles as discussed in *SD* do not indicate that the UK Supreme Court was departing from traditional principles albeit the position was articulated in seven points in the case of *Meadows*. All the statements in *SD* on this issue were, counsel submitted, obiter. *SD* did not amount to a narrower view, because the issue in that case was whether there had been obstetric negligence against the background of an earlier case formulated about midwife negligence and the midwifery case was not before the division. The pursuer appeared to be seeking to make the defender the insurer for all of the consequences but in fact the principles were much narrower.

[84] In relation to the *ex turpi causa* point, it was not correct to say this was applicable only to a post-conviction matter. That much was clear from the discussion in *Trayner's Latin Maxims*. The issue was also discussed in *Gray* v *Thames Trains* by the House of Lords.

[85] The pursuer's submission about solatium appeared to be premised on the defender causing bipolar disorder. However, on the evidence here, the course of the pursuer's illness was not altered. There was no suggestion that the illness was more severe than it would otherwise have been. In relation to the evidence of the pursuer being "ashamed" that was at the time but there is no evidence from the pursuer how his position was worse because of the alleged negligence in this case. The pursuer's points all arose from events pre-dating revocation of the short-term detention certificate. Further, some of the pursuer's submissions about loss of earnings/disadvantage on the labour market at paragraph 11 of

the supplementary note on *quantum* are not based on the evidence. In relation to the pursuer's claim for interest at 8% from 18 January 2016 on loss of employability that did not make sense (see paragraph 16 of the pursuer's supplementary note of argument). In relation to paragraph 17 of the pursuer's supplementary note, the court did not hear evidence from Ms Manson. Counsel renewed his motion for absolvitor.

Analysis and decision

Objections to evidence

[86] In the course of the proof, there were a number of substantial and substantive objections to lines of evidence, and in the case of one witness, to the entirety of the evidence. There are several issues where the point was of a general character, and for which it is convenient to set out my ruling and reasons at the outset.

Objection to case founded on misdiagnosis

[87] Firstly, during the evidence of Dr Qureshi, the defender objected to a line of questioning about the correctness or otherwise of the diagnosis of personality disorder. The defender's fundamental objections were to lack of record, and to the relevance of the line. It was submitted the elements of the case of fault set out in condescendence 10 all focussed on certain events in January 2016 and in particular to the discharge of the pursuer from compulsory care on 18 January 2016. Separately, the question about relevance was whether the evidence assisted the court, because the question which triggered the objection related to treatment in late 2015. The pursuer submitted the case was not only about the January 2016 admission and discharge, but also about negligent misdiagnosis under reference to

averments in condescendence 9(ii) "had the pursuer not been negligently discharged", and in condescendence 10 "in diagnosing et separatim before revoking the STDC…"

[88] I sustained the defender's objection. I was not satisfied that the record extends to a case founded on negligent misdiagnosis. I am not satisfied that the two averments referred to in the pursuer's submission do that, and there is no other averment which does so more specifically. It is clear that the averments enumerating specific duties in condescendence 10 focus on circumstances surrounding the decision to discharge the pursuer from the STDC on 18 January 2016. Submissions founded on the general principle of brevity of pleadings in chapter 36 actions are not a sufficient answer to the question of the extent of duty where the action is a case-managed clinical negligence claim proceeding under chapter 36A, as this action has been since it was remitted to this court on 29 November 2022. Further and in any event, that conclusion is fortified by the averment of *Hunter* v *Hanley* negligence later in condescendence 10: "the decision to revoke the STDC was one which no reasonably competent consultant psychiatrist would have taken if acting with ordinary care." In my view, that is the central issue in this action.

[89] While the ruling was made in the context of evidence of events in 2015, I clarified that the ruling applied to all efforts to introduce such evidence in relation to the admission in January 2016. Accordingly, the focus is on events between 14-18 January 2016, albeit earlier hospital admissions are part of the context.

Objection to evidence of Dr Muzaffar

[90] Secondly, prior to the evidence of Dr Muzaffar, counsel for the pursuer indicated an objection to the admissibility of her evidence in its entirety. However, he was content for her evidence to be heard under reservation, and I did that in order that the objection could

be dealt with fully following by her evidence. In short, the basis of the objection was that Dr Muzaffar was not an independent witness and did not meet the test in paragraph 51 of *Kennedy* v *Cordia* 2016 SC(UKSC) 59, at 73. The pursuer submitted that Dr Muzaffar could not be considered an independent witness as she is employed by the NHS in Scotland. It was submitted that an independent witness could be one from the private sector, or a recently retired practitioner, or one from outwith Scotland. Counsel did not accept that a clinician from a different Scottish health board from that employing the clinician under challenge would meet the test of independence, because all NHS staff in Scotland were ultimately paid from the same budget. The position was, he submitted, analogous to the practice of not leading evidence from a treating consultant in evidence about the measure of damages. Further, in this case, the pursuer submitted Dr Muzaffar had not produced a balanced and independent assessment. She had seen Dr Scott's report, and should therefore have known what the issues in this case are. She had not dealt directly with those issues.

[91] The defender submitted that there is no one body with the legal personality of "the NHS" in Scotland: there are separate health boards, which each have legal personality. It was not evident why a clinician employed by NHS Forth Valley would be partisan about events in Fife, a different health board area, where a clinician employed by an NHS trust in Newcastle would not. So far as concerned the critique of Dr Muzaffar's report, that shaded into the merits, but it was clear from paragraph 92 of her report (CB364ff), that Dr Muzaffar had considered the breaches of duty averred on record, and that she had a clear idea about the issues in the action.

[92] I have no hesitation rejecting the pursuer's objection to the admissibility of Dr Muzaffar's evidence. I was referred to *Kennedy* v *Cordia*, where the Supreme Court reaffirmed that the requirement of independence and impartiality of expert evidence is one

of admissibility rather than merely the weight of the evidence (L Hodge, paragraph 51). The argument that simply because she is employed by a health board in Scotland Dr Muzaffar lacks independence is misconceived. It was telling that on being pressed, counsel could point me to no decided case in which that proposition had been accepted. In the first place, senior counsel for the defender's submission about the legal structure of the NHS in Scotland is well-founded, see National Health Service (Scotland) Act 1978, section 2, where the delivery of health services via legally (and geographically) distinct health boards is provided. The fact that the budget for each board comes from money provided by Parliament takes the argument no further. Secondly, in order to raise a concern about independence for structural reasons, there would require to be evidence of a relationship of proximity such as to give concern to an informed bystander, such as an expert employed by the same board as the impugned clinician, or if he or she had worked as part of the same team as the impugned clinician at the time, or otherwise had some close professional connection. None of those features was present in this case.

[93] The pursuer's challenge to admissibility on the ground of impartiality also falls to be repelled. Dr Muzaffar has, thus far, only provided reports for defenders in civil claims; she was clear in her evidence that was happenstance. She has also provided reports in regulatory proceedings and FAIs, and Dr Muzaffar indicated that she had provided reports in which she was critical of clinicians. It is reasonable to suppose that some of those are likely to have resulted in cases being compromised before proof. Further, while Dr Muzaffar was firm in defending her opinion in evidence, I did not consider that she was dogmatic in her rejection of the conclusions of Dr Scott or Dr Qureshi. It appears that the focus of Dr Muzaffar's attention was on the period immediately around the revocation of the STDC on 18 January 2016. The pursuer submitted that she was thereby ignoring earlier

admissions and what the pursuer contends is their relevance. It may well be that the scope of her instructions (or her understanding of those instructions) was narrower than those of Dr Scott, but Dr Muzaffar was willing to engage with issues in the course of examination. Further as senior counsel pointed out in the course of discussion, section 92 of Dr Muzaffar's report engages directly with the duties averred in condescendence 10, so that she was plainly seised of the issues in dispute. Accordingly, I consider her evidence is admissible, and, having cleared that threshold, any weaknesses are rather questions of weight, to which I will come.

Objection to opinion evidence being sought from Dr Morris

[94] During the cross-examination of Dr Morris, objection was taken by counsel for the defender that the witness was being examined on matters of medical opinion, whereas the witness was led as a witness to fact, namely the circumstances of his examination of the purser on 8 February 2016. The evidence was allowed to be taken, under reservation of all questions of competency and relevancy. It was not clear how strongly the defender insisted in this objection at the close of proof. In my reading of the transcript of the commission, there was a good deal of questioning about diagnostic criteria, and what Dr Morris might have thought had he had certain materials or information which were not available to him. In examination of a witness, albeit one professionally qualified, led to speak to the facts of one specific interaction with the pursuer, that questioning was irrelevant.

Assessment of witnesses

[95] It was common ground that as the witnesses of fact were being asked about events at least 8 years prior to the proof, it was natural that recollections would have faded. Counsel

for the pursuer suggested the court should focus on the medical records. I consider that the records are certainly the starting place, though they do of course require to be interrogated and interpreted for the court by those who were there. I am satisfied that all of the witnesses were doing their best to assist the court. Some of the witnesses of fact had clearer recollection than others. The pursuer accepted quite candidly that he had relatively little recall of events from November 2015, to April/May 2016 due to the mental health difficulties he was then experiencing; details of some events were clearer than others.

[96] Doctors Drummond, McGlen and Morris and Charge Nurse Lomax gave evidence about relatively limited interactions with the pursuer. All were careful to distinguish what they could recall from memory and what they could not, sometimes prompted by reference to contemporaneous medical records. I accept their respective accounts of events in which they participated. Dr Morris gave evidence on commission on 31 July 2024. Dr Morris is a consultant forensic psychiatrist, and examined the pursuer in custody in Perth on 8 February 2016. In her supplementary report, 32 of process, the commissioner records:

> "I found Dr Morris to be a credible and reliable witness. He gave evidence in his capacity as an NHS doctor. He accepted that, due to the passage of time, his recollection of some matters was poor. He was forthcoming about gaps in his recollection and drew a distinction between matters which he struggled to recollect and those which he recollected more clearly. I formed the impression that Dr Morris was truthful and was doing his best to assist the court."

Position of Dr Narayan

[97] While Dr Narayan is of course the clinician whose conduct was averred to have been negligent in this action, and while he is a medical professional, he is a witness of fact in this case. The court's assessment of his evidence begins with that. As the defender's written submission points out, Dr Narayan is not an independent witness of fact. Nor, it can be added, is he called to give his professional opinion, though he was repeatedly challenged on

that. I respectfully agree with observations by Lady Wise in *SD* v *Grampian HB* [2022] CSOH 63, at paragraphs 144 and 145, that apparent concessions about breach of duty by clinical professionals are not to the point, and that the question of breach of duty is for the court alone.

[98] In the course of Dr Narayan's evidence, it was put to him in cross-examination that the designation "consultant" required the undertaking of specialist training and thus it was "illegal" to describe oneself was a consultant when one had not undertaken that training. Dr Narayan accepted that was correct. It was then put to him that it was illegal for him to call himself a consultant because he was not on the specialist register. At that point I asked to be addressed out with the presence of the witness about the source and implication of this line. Counsel for the pursuer was not immediately able to address me on the legal underpinning of the line because his notes on this point were not to hand, and I allowed the cross-examination to continue on a different point, with a clear indication that the topic would be revisited when I had been addressed on this matter. At the commencement of the following day's hearing counsel addressed me on this matter. Section 34D of the Medical Act 1983 makes provision about the specialist medical register and section 34D(10) makes a condition for registration on that register that a clinician has undergone specialist training. Dr Narayan had not undertaken specialist training. The National Health Service (Appointment of Consultants) (Scotland) Regulations 2009 [SSI 2009/166] require consultants to be on the specialist register - see regulation 3A. A locum appointment is not to exceed 12 months – regulation 4(1)(b). In short, the submission was that unless the consultant specifies himself as a locum consultant he is not entitled to call himself a consultant. Counsel for the defender submitted that the matter had been put to the witness in terms that he had done something illegal. That could not stand, and the question should be withdrawn

and the witness told accordingly. There was a broader question about the relevance of this line given that in terms of paragraph 1 of the joint minute, the medical records are agreed.

[99] In my view, the challenge to Dr Narayan in the form of an assertion that it would be *illegal* to call himself a consultant because he was not on the specialist medical register, would be extremely difficult to stand up as an offence. The witness undoubtedly is (and at the material time was) a locum consultant psychiatrist, and the correspondence so described him, and occasional lapses where he was simply described as a consultant, did not appear to leading to confusion because the correspondence in which it appeared was correspondence between clinicians. I considered that the line was without substance, and refused to allow it to be persisted with. Further, I considered that the witness was entitled to know that the line was not being pursued, since it was a direct challenge to his professional integrity. Accordingly, when Dr Narayan's evidence resumed immediately after I had dealt with this point, I required counsel for the pursuer to advise Dr Narayan accordingly.

[100] I consider that attack on the witness was misconceived as a matter of law, as well as being professionally discourteous in the context of this case. Whilst it is of course open to a party to challenge the professional qualifications of a witness tendered in evidence as a professionally qualified person, such challenge must have a proper foundation. That is most likely to be either on the basis that the person does not in fact hold the qualifications, or that there is some formal deficiency in the qualification. The former requires the challenging party to have evidence available to be tendered to the court, and usually put to the witness, in support of the challenge. The latter may be a question of evidence, or it may be a question of legal submission, or both. In this case, counsel for the pursuer was unable immediately to provide a legal basis for the challenge, and on the court returning to the point, it was evident that the challenge could not be made to stand. That ought to have been evident from the

outset. Forensically, the effect was to discomfit Dr Narayan such that some passages of his evidence thereafter were unreliable. That is not of assistance to the court. While there will be occasions when discomfiting a professional witness on an issue such as this will be appropriate, the foundation requires to be present, and the purpose ought to be more than mere personal affront.

[101] Dr Yaneen Qureshi, Peter Davies, Dr Alan Scott, and Dr Nabila Muzaffar were all led as skilled witnesses. I am satisfied they are all appropriately qualified as such. I discuss their evidence below.

Discussion - breach of duty – the law

[102] While the starting point for consideration of breach of duty remains *Hunter* v *Hanley* 1955 SC 200, the law is now more fully elaborated in Lord Hodge's opinion in *Honisz* v *Lothian Health Board* 2008 SC 235, to which I was referred by the defender. It is convenient to set out paragraphs 36-39:

> "[36] Counsel for the pursuer referred me to the following cases in relation to the test for negligence: *Hunter v Hanley*, *Maynard v West Midlands Regional Health Authority, Peach and anr v Chalmers, Gordon v Wilson* and *Bolitho v City and Hackney Health Authority*. Counsel for the defenders referred me also to *Whitehouse v Jordan* and *Sidaway v Board of Governors of the Bethlem Royal Hospital*. Parties agreed that the principal test to be applied was that laid down by Lord President Clyde in *Hunter v Hanley*, namely that the pursuer must prove that the doctor who is said to be negligent had been guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care. Further, it was not disputed that, as Lord President Clyde also said (p 206), to establish liability where he alleges deviation from normal medical practice the pursuer must prove (i) that there was a usual and normal practice, (ii) that the doctor had not adopted that practice and (iii) that the course which the doctor adopted was one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.
>
> [37] As in this case the pursuer alleges that the consultants responsible for his care were the negligent parties, the relevant standard of professional man is the standard of the consultant orthopaedic surgeon of ordinary skill. That this was inherent in the *Hunter v Hanley* test, and in England in the *Bolam* test, was confirmed by a trilogy of

cases in the House of Lords, namely *Whitehouse v Jordan* (Lord Fraser of Tullybelton, p 263), *Maynard v West Midlands Regional Health Authority* (Lord Scarman, p 638H) and *Sidaway v Board of Governors of the Bethlem Royal Hospital* (Lord Diplock, pp 892, 893, Lord Bridge, p 897C). This was not disputed.

[38] The main area of contention between parties as to the law was what was the proper approach for the court to take to the evidence of the consultant orthopaedic surgeons led by the defenders that they would have adopted the same practices as those which the consultants and senior registrars, against whom negligence is alleged, in fact adopted. Again, however, the matter is one decided by authority which may be summarised briefly in the following propositions.

[39] First, as a general rule, where there are two opposing schools of thought among the relevant group of responsible medical practitioners as to the appropriateness of a particular practice, it is not the function of the court to prefer one school over the other (*Maynard v West Midlands Regional Health Authority*, Lord Scarman, p 639F–G). Secondly, however, the court does not defer to the opinion of the relevant professionals to the extent that, if a defender led evidence that other responsible professionals among the relevant group of medical practitioners would have done what the impugned medical practitioner did, the judge must in all cases conclude that there has been no negligence. This is because, thirdly, in exceptional cases the court may conclude that a practice which responsible medical practitioners have perpetuated does not stand up to rational analysis (*Bolitho v City and Hackney Health Authority*, Lord Browne-Wilkinson, pp 241G–242F, 243A–E). Where the judge is satisfied that the body of professional opinion, on which a defender relies, is not reasonable or responsible he may find the medical practitioner guilty of negligence, despite that body of opinion sanctioning his conduct. This will rarely occur as the assessment and balancing of risks and benefits are matters of clinical judgment. Thus it will normally require compelling expert evidence to demonstrate that an opinion by another medical expert is one which that other expert could not have held if he had taken care to analyse the basis of the practice. Where experts have applied their minds to the comparative risks and benefits of a course of action and have reached a defensible conclusion, the court will have no basis for rejecting their view and concluding that the pursuer has proved negligence in terms of the *Hunter v Hanley* test (see para 36). As Lord Browne-Wilkinson said in *Bolitho* (p 243D–E), 'it is only where the judge can be satisfied that the body of expert opinion cannot logically be supported at all that such opinion will not provide the benchmark by which the defendant's conduct falls to be assessed.'"

I did not understand this statement of the law to be in dispute.

Breach of duty – the case on record

[103] It became apparent in the course of evidence that there was a dispute between parties about the scope of the breaches of duty on which the pursuer founds. I have already discussed the objection taken during the evidence of Dr Qureshi to a line about negligent mis-diagnosis. It is convenient to consider the evidence about each element of the pursuer's case of breach of duty on record. There are seven components to breach of duty averred in condescendence 10:

1. A duty to undertake and record a detailed mental state examination of the pursuer.
2. A duty to consider all relevant factors and information about the pursuer, including inter alia, the nature and duration of recent behaviour, his medication needs and whether the observations may have been modified by supervised medication.
3. A duty take account of the views of the named person, Caroline Manson.
4. A duty to apply recognised diagnostic criteria to the information.
5. A duty to consider whether the pursuer was likely, if the order were revoked, to be at risk of harm to himself or others.
6. Because Dr Narayan was the complainer in respect of an alleged criminal act committed against him by the pursuer, he had a duty to consult with an appropriate senior colleague, such as the clinical director in the general adult psychiatry service, to consider a change to the pursuer's psychiatrist.
7. A duty not to revoke the STDC.

1. A duty to undertake and record a detailed mental state examination of the pursuer.

[104] Dr Narayan's evidence was that when he reviewed the pursuer on 18 January 2016, he assessed the pursuer's mental state, but he had not created a separate document described in terms as a mental state examination. He said that in essence, the first part of the lengthy note in the medical records was his assessment at that time (JB1608-11, transcribed at 6/2).

[105] Dr Scott was critical of the record of Dr Narayan's examination of the pursuer on 18 January 2016, as he was of records of examinations on 7 and 15 January 2016. In his report of 29 November 2018, he offers the opinion that it was,

> "unreasonable that the medical records for the index admissions did not contain a documented explanation for the diagnosis of personality disorder. In my opinion, it was also unreasonable that the medical records for the index admissions did not contain a documented systemic mental state examination, with particular reference to the possibility of a relapse in his bipolar disorder." (CB9)

While Dr Scott goes on to address the revocation of the STDC in terms of clinical negligence (CB10A), it is noteworthy that in relation to recording mental state, the discussion is cast in terms of unreasonableness. That is of course not the test the court requires to apply in determining breach of duty in a case such as this. It is doubly unhelpful coming in the same paragraph as an entirely appropriate acceptance that at the time of the relevant events, there was uncertainty about the pursuer's diagnosis: a relapse of bipolar disorder, or traits of personality disorder coming to the fore. As Dr Scott records, and as the other expert witnesses observed in oral evidence, "diagnostic uncertainty itself can be reasonable in psychiatric practice where there are no diagnostic physical investigations such as a blood test or X-ray to establish a diagnosis."

[106] Dr Qureshi was not asked directly about the quality of the recorded mental state examination, nor does this feature in either of his reports (which were of course focussed on

causation points). Dr Qureshi agreed that his own record of the pursuer's mental state when he examined the pursuer is recorded in his report (CB86), and expressed the view that in-person examination was better than virtual/online, and that virtual was better than via telephone.

[107] Dr Muzaffar's view was that the record dated 18 January 2016 (JB1608-1611, transcript 6/2) did clearly document the pursuer's mental state at that time, although it was not headed with the description of mental state examination. The pursuer's appearance and behaviour were noted to be "reasonably calm, but easily agitated if not getting what he wants … at times quite charming". His pace of speech was noted in the following terms "no observation of pressure of thought or speech". His mood is noted as "irritable". It was noted that there was "no formal thought disorder". The pursuer's perceptions were noted: no psychosis was observed, he was orientated to time and place, and by implication, there were no perceptual abnormalities. In relation to insight, Dr Narayan had noted "demonstrates adequate insight"; the evidence of that would be someone acknowledging they have a condition and would accept treatment. The note did not record what the illness was; though drugs and alcohol had been discussed, and there was no dispute those were part of the pursuer's difficulties.

[108] While the record made by Dr Narayan on 18 January 2016 (6/2) is not described as a mental state examination, I accept Dr Muzaffar's evidence that in substance is what it is. That is what Dr Narayan considered he was recording, and he did so against the background of his prior reviews of the pursuer. To the extent that Dr Scott's evidence was that Dr Narayan had failed to undertake and record a mental state examination, I reject that evidence. It may not be the most optimally formatted record of such examination, but I am satisfied contains the central elements which the expert witnesses suggested were required.

There is a description of his behaviour and sleep state over the immediately preceding weekend, and a structured record of Dr Narayan's observations at review. Dr Scott and Dr Muzaffar were each able to analyse and comment on it, albeit offering different views, which also suggests that it was sufficient, if not the best example of its kind. In my view, the former rather than the latter is the standard. For these reasons, as well as the observations about Dr Scott's approach to this question, I prefer Dr Muzaffar's evidence on this issue. Accordingly I am satisfied there is no breach of this duty.

2. A duty to consider all relevant factors and information about the pursuer

[109] It is averred that those factors included inter alia, the nature and duration of the pursuer's recent behaviour, his medication needs and whether the observations may have been modified by supervised medication.

[110] Dr Narayan first encountered the pursuer as a patient during the admission in late November/early December 2015, in the course of a ward round on 30 November 2015. His evidence was that he would either have seen the pursuer's medical history before that ward round, or shortly thereafter. That would include the earlier hospital admissions, as well as assessments by other clinicians in the course of the current admission. He could not recall specifically whether he had seen Dr Marks's review from 23 November 2015 (JB1565) or Dr Pittock's review from 24 November (JB1566) prior to meeting the pursuer, but thought they would have been discussed on the ward round. By the time of the admission on 14 January 2016, Dr Narayan had seen the pursuer as a patient on a number of occasions over a period of weeks, and was aware of the views of other clinicians about the pursuer's illness.

[111] In relation to the admission on 14 January 2016, Dr McGlen's letter of 14 January 2016 following her assessment of the pursuer in the cells at Perth Police Station, was addressed to Dr Narayan, and he recalled seeing it. That letter summarises the pursuer's bizarre behaviour whilst in custody, and details Dr McGlen's assessment of the pursuer's mental state at that time. Dr Narayan thought he would have seen Dr Pittock's assessment on admission at 16.20 on 14 January 2016 (JB1599-1602), prior to his own review on 15 January, or at the very least to have spoken with her. Dr Pittock's note includes her assessment of the pursuer's mental state, and notes that she did indeed discuss the pursuer with Dr Narayan specifically in relation to the treatment plan (JB1602). That treatment plan includes prescription of sodium valproate (use to manage manic phase bipolar disorder), olanzapine (an anti-psychotic), and hydroxyzine ("for insomnia").

[112] Dr Pittock noted that on admission on 14 January 2016, the pursuer was:

> "very polite, courteous and entirely appropriate in behaviour. Speech normal in rate and volume; linear in form. Mood S [subjectively] okay; O [objectively] reactive and euthymic. Nil abnormal thought content. Cognition oriented to TPP and insight evident."

On 18 January 2016, Dr Narayan recorded information about the pursuer's behaviour noted by nursing staff over the weekend of 16-17 January 2016. He obtained that from the nursing records and/or from Charge Nurse Lomax.

[113] The pursuer's bizarre and delusional behaviour reported to Dr McGlen on 14 January 2016 appears consistent with a psychotic episode or a manic episode. However, that behaviour had changed markedly by the time Dr Pittock saw the pursuer in the late afternoon of 14 January and at the time of Dr Narayan's review on 15 January. It is relevant that on 13/14 January 2016, the pursuer had taken and had tested positive for cannabis. It was common ground amongst the expert witnesses that drug use was a relevant to the

pursuer's history, but somewhat surprisingly, they appeared reluctant to ascribe much significance to cannabis use in this episode. The evidence of all of the expert witnesses was that a manic episode would be unlikely to have settled in such a short space of time. That fact, and the evident change in behaviour was relevant to Dr Narayan's consideration of the pursuer's mental state, and the necessity for his continued detention. Dr Narayan said he would likely have checked if the pursuer had required medication over the weekend, but could not specifically recall; medication was relevant to overall assessment, depending on type and purpose.

[114] Dr Narayan had reviewed the pursuer several times since 30 November 2015. He said he would have reviewed the prior medical history in that period. In the immediate period of the admission of 14-18 January 2016, on his own evidence, Dr Narayan was aware of the assessment of the pursuer by other clinicians, and of the nursing records of the pursuer's presentation over the weekend of 16/17 January. He had himself seen the pursuer on 15 January and on 18 January 2016. As discussed above, the note made on 18 January 2016 records Dr Narayan's assessment of the pursuer's mental state; it also summarises his rationalisation of the revocation of the STDC. Of course the weight to be given to the various sources of information is a matter about which the experts disagree, but I consider that Dr Narayan took them into account.

3. A duty take account of the views of the named person, Caroline Manson.

[115] In his report of 29 November 2018, Dr Scott considered that it was unreasonable for Dr Narayan to have refused to meet or hear from Ms Manson on 18 January 2016. He was of the view that omission amounted to medical negligence because the normal practice was specified in law (CB10). In oral evidence, Dr Scott could not recall if he had been aware that

the pursuer had told medical staff that he and Ms Manson were separated at that time. Dr Scott accepted that the fact that the pursuer and his partner, and named person, were separated at the time of the admission in January 2016 was relevant information for the clinical team, and might make it difficult to have continuing discussion with her.

[116] Dr Qureshi noted (CB111) the pursuer had withdrawn his consent for medical information to be disclosed to Ms Manson. However, that was distinct from obtaining her views as named person. It would be possible for the doctor to indicate that he could not discuss ongoing treatment, but to seek the named person's views about revocation of the STDC.

[117] Dr Muzaffar noted (CB365) that the pursuer had withdrawn his consent for medical information to be disclosed to Ms Manson, and that as he had capacity to make that choice, Dr Narayan could not breach patient confidentiality. In her oral evidence, Dr Muzaffar indicated that if a clinician considered the criteria for continued detention on a STDC were not met, the doctor could not continue to detain the patient only based on the views of the named person.

[118] Dr Narayan was aware both from correspondence from the GP on 22 December 2015 (JB1525) and direct report from the pursuer on 7 January 2016 (JB1585) that the pursuer and Ms Manson were separated; indeed on the latter occasion, the pursuer said he was seeing someone else. It was evident that their relationship was at times highly charged. It is perhaps unsurprising that Dr Narayan was circumspect about contact with Ms Manson at this point in time. Dr Narayan also recorded on 18 January that he had asked the pursuer directly and "he expressly stated that he <u>did not</u> want me to talk to Caroline, Deborah or his parents or anyone regarding his medical condition/status." Which I take both to refer to discussion of his medical condition and his detention.

[119] In his note of 18 January 2016, Dr Narayan recorded that after reviewing the pursuer, and after taking the decision to revoke the STDC, he was informed that:

> "Caroline wanted to have a meeting with them but I explained to my secretary that [the pursuer] explicitly expressed that he did not want me to disclose any medical information about him."

In declining to have a meeting with Ms Manson, Dr Narayan may have considered that he was having regard to the wishes and feelings of his patient, the pursuer; and up to a point he was. However, Dr Narayan appears to have conflated the fact that the pursuer and Ms Manson were temporarily (as things turned out) separated and the limitations on the information he was thus able to convey, on the one hand, and the duty to take account of the views of the pursuer's named person, on the other. He may also have considered that in terms of section 1(9) of the 2003 Act, it was unreasonable or impractical to do so, and thus he was not, in the circumstances, required to do so. That point was not put to him in those terms. That said, there was no evidence that the views of Ms Manson, as they are recorded in the contemporaneous notes, would have led Dr Narayan to reach a different decision on revoking the STDC. Further, I consider that, as a matter of analysis of section 44 of the 2003 Act, Dr Muzaffar was correct in her view that if a clinician considered the criteria for continued detention on a STDC were not met, the doctor could not continue to detain the patient only based on the views of the named person. Accordingly whilst is correct to say that as a matter of fact, Dr Narayan did not seek the views of the pursuer's named person, there were reasons consistent with Dr Narayan's other obligations in terms of section 1 of the 2003 Act and common law (in relation to confidentiality) for so acting. I am not satisfied that any breach of duty amounts to professional negligence.

4. A duty to apply recognised diagnostic criteria to the information.

[120] Dr Narayan was cross-examined at length about diagnostic criteria listed in ICD-10 for both bipolar disorder and personality disorder. It was evident that he was familiar with ICD-10, and with its use as a tool to assist in diagnostic formulation. It was also evident that he was familiar with the key diagnostic indicators for bipolar disorder and for personality disorder. Dr Narayan also spoke about DSM-V in the formulation of the diagnostic indicators in the letter of 31 December 2015 (JB1521). There was no evidence that Dr Narayan had applied criteria originating other than in these recognised diagnostic classification systems.

[121] It was also apparent in the evidence of the expert witnesses that it is accepted there is room for diagnostic uncertainty in psychiatry to a greater extent than in other branches of medicine. It is convenient briefly to consider that evidence. Dr Scott agreed that diagnostic uncertainty can occur in psychiatry. If he was making a different diagnosis from another psychiatrist, he would explain why he was not taking account of the existing diagnosis. He considered Dr Narayan had not done that. Dr Scott had seen Dr Muzaffar's report. They plainly had differing views about the case. Dr Scott accepted there was a scale of reasonable professional opinion and that he and Dr Muzaffar were at different points on that scale. Dr Qureshi considered the diagnosis of personality disorder was not correct, but accepted that personality disorder and bipolar disorder can co-exist in a patient. Further, there is a slight overlap of the presentation of the manic phase of bipolar disorder, and borderline personality disorder in terms of impulsivity of behaviour. Dr Qureshi agreed there was a range within professional judgment might be exercised, but he considered that Dr Narayan's decision to revoke the STDC fell outwith that. He accepted that Dr Muzaffar reached a different view. Dr Muzaffar observed that unlike other branches of medicine, psychiatry

does not have blood tests or scans which assist with diagnosis. Diagnosis is formulated from interview with the patient, observation of the patient by doctor and staff, and information from others involved. Different psychiatrists might reach different views about diagnosis depending on the weight placed on particular elements of the history and information available. There would be a scale of reasonable professional opinion. There were overlapping symptoms in the presentation of bipolar disorder and emotionally unstable personality disorder.

[122] There was no evidence that Dr Narayan departed from accepted methodology, namely: interview of the patient, review of staff observations, collation of information from family and others. On the contrary, he plainly did those things. As I have noted above, he was aware of ICD10 diagnostic criteria and their use. Dr Narayan reached a different view about diagnosis from the experts, but acknowledged diagnostic uncertainty, as did at least some of the expert witnesses. Accordingly, I consider breach of this duty is not established.

5. A duty to consider whether the pursuer was likely, if the order were revoked, to be at risk of harm to himself or others.

[123] On 15 January 2016, Dr Narayan recorded (JB1602, transcript 6/2) that the pursuer presented as "very appropriate + stark contrast to yesterday", but was also "very irritable and loud". He noted that on a previous occasion there had been an incident when the pursuer had threatened the hospital shopkeeper, which would be managed by him not having time off the ward. By 18 January 2016, Dr Narayan recorded that on the weekend of 16/17 January, the pursuer had made numerous threats which had been logged and a threat to SN Hutchison, but "stating he was in control of his behaviour + despite making threats; would not hit anyone + staff should know this" (JB1608). Further, at the time of

Dr Narayan's review, there was no observation of pressure of thought or speech; there was no formal thought disorder; and the pursuer was not expressing suicidal ideas.

[124] Dr Scott placed weight on events shortly prior to the admission, particularly the call by the pursuer's sister on 3 January 2016, and the pursuer's mother on 7 January, the report of the pursuer walking miles in bare feet, his bizarre behaviour in the police cells on 14 January, and his tying a dressing gown cord around his neck on 17 January (CB73). Dr Qureshi's view was there was no evidence of suicidal thoughts during the admission 14-18 January 2016, a view with which Dr Muzaffar agreed.

[125] The context of the duty averred is a decision about whether to revoke an STDC. The conditions for the grant, and thus revocation, are contained in section 44(4) of the 2003 Act. There are five conditions. For present purposes, the relevant condition is contained in paragraph (d) in the following terms:

> "that if the patient were not detained in hospital there would be a significant risk –
> (i) to the health, safety or welfare of the patient; or
> (ii) the safety of any other person"

[126] I am not satisfied on the evidence that at the point of Dr Narayan's review on 18 January 2016, as a result of the pursuer's mental disorder, there was a significant risk to the health, safety or welfare of the pursuer, or to the safety of any other person. While presenting aggressively in the preceding days, it was recorded that the pursuer appeared to be more in control of his actions, and had expressly said that he would not follow through on threats. He had not in fact done so during the admission. Nor was there evidence of actual violence during the admission, or indeed during the admission in late 2015. Nor was the pursuer's behaviour by the time of the review on 18 January of the order of his behaviour in the police cells on 14 January. While there might well be risks, they were not

significant risks. Dr Narayan's conclusion about this condition was one supported by the balance of evidence available on 18 January 2016.

6. A duty to consult with a senior colleague in respect of an alleged criminal act committed against him by the pursuer

[127] Dr Narayan had no clear recollection of making a complaint to the police about the pursuer, nor of the police speaking to him, although as a matter of fact there were subsequent criminal proceedings against the pursuer. In any event, neither Dr Scott nor Dr Qureshi was asked about this point. It is the subject of comment in Dr Scott's third report (which comprises responses to a series of questions from counsel) at CB75. It is not mentioned in either of Dr Qureshi's reports, presumably because his initial instructions related to the topic of causation. Dr Muzaffar does address this in her report at 92C (CB365-366), but again she was not asked about this in chief or cross-examination.
I therefore proceed on the basis that this strand of the pursuer's case is no longer insisted in.

7. A duty not to revoke the STDC

[128] This is perhaps the culmination of the pursuer's case on breach of duty, since without revocation of the STDC, the pursuer would not have been in a position lawfully to leave hospital. It is germane to consider the structure of section 44 of the 2003 Act, which contains the authority for the making of STDCs, as well as the overarching provisions of section 1 of the Act. Insofar as relevant, section 44 provides:

> **"44 Short-term detention in hospital**
>
> (1) Where—
>
> (a) an approved medical practitioner carries out a medical examination of a patient;

…

(c) subsection (3) below applies,

the approved medical practitioner may, before the expiry of the period of 3 days beginning with the completion of the medical examination, grant a short-term detention certificate authorising, if the condition mentioned in subsection (6) below is satisfied, the measures mentioned in subsection (5) below.

…

(3) This subsection applies where—

(a). . . . . .

(b) the approved medical practitioner considers that it is likely that the conditions mentioned in subsection (4) below are met in respect of the patient;

(c) the approved medical practitioner consults a mental health officer; and

(d) the mental health officer consents to the grant of a short-term detention certificate.

(4) The conditions referred to subsection (3)(b) above are—

(a) that the patient has a mental disorder;

(b) that, because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired;

(c) that it is necessary to detain the patient in hospital for the purpose of—

(i) determining what medical treatment should be given to the patient; or

(ii) giving medical treatment to the patient;

(d) that if the patient were not detained in hospital there would be a significant risk—

(i) to the health, safety or welfare of the patient; or

(ii) to the safety of any other person; and

(e) that the granting of a short-term detention certificate is necessary.

(5) The measures referred to in subsection (1) above are—

(a) the removal, before the expiry of the period of 3 days beginning with the granting of the short-term detention certificate, of the patient to a hospital or to a different hospital;

(b) the detention of the patient in hospital for the period of 28 days beginning with—

(i) if, immediately before the certificate is granted, the patient is not in hospital, the beginning of the day on which admission under authority of the certificate of the patient to hospital first takes place;

(ii) if, immediately before the certificate is granted, the patient is in hospital, the beginning of the day on which the certificate is granted;

(c) the giving to the patient, in accordance with Part 16 of this Act, of medical treatment.

…"

[129] As will be evident, the section places the weight of the decision on the RMO's assessment by reference to the conditions in section 44(4), and it will be noted that the conditions in subsection (4) are cumulative.

[130] It is also relevant to note that in considering granting or revoking an STDC, a patient's responsible medical officer is required to have regard to the overarching principles contained in section 1 of the Mental Health (Care and Treatment)(Scotland) Act 2003. Insofar as material, section 1 provides:

> **"1 Principles for discharging certain functions**
>
> (1) Subsections (2) to (4) below apply whenever a person who does not fall within subsection (7) below is discharging a function by virtue of this Act in relation to a patient who has attained the age of 18 years.
> (2) In discharging the function the person shall, subject to subsection (9) below, have regard to the matters mentioned in subsection (3) below in so far as they are relevant to the function being discharged.
> (3) The matters referred to in subsection (2) above are—
> (a) the present and past wishes and feelings of the patient which are relevant to the discharge of the function;
> (b) the views of—
> (i) the patient's named person;
> (ii) any carer of the patient;
> (iii) any guardian of the patient; and
> (iv) any welfare attorney of the patient,
> which are relevant to the discharge of the function;
> (c) the importance of the patient participating as fully as possible in the discharge of the function;
> (d) the importance of providing such information and support to the patient as is necessary to enable the patient to participate in accordance with paragraph (c) above;
> (e) the range of options available in the patient's case;
> (f) the importance of providing the maximum benefit to the patient;
> (g) the need to ensure that, unless it can be shown that it is justified in the circumstances, the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation;
> (h) the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group.

(4) After having regard to—
(a) the matters mentioned in subsection (3) above;
(b) if subsections (5) and (6) below apply, the matters mentioned there; and
(c) such other matters as are relevant in the circumstances,
the person shall discharge the function in the manner that appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances.

…

(8) In subsection (3)(a) above, the reference to wishes and feelings of the patient is a reference to those wishes and feelings in so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise), appropriate to the patient.

(9) The person need not have regard to the views of a person mentioned in subsection (3)(b) above in so far as it is unreasonable or impracticable to do so.

(10) In subsection (3)(d) above, the reference to information is to information in the form that is mostly likely to be understood by the patient.

(11) In this section, a reference to 'discharging', in relation to a power, includes a reference to exercising the power by taking no action; and 'discharge' shall be construed accordingly."

[131] It will be noted that section 1 contains a number of matters to which a person discharging a function under the Act must have regard. Dr Narayan was undoubtedly discharging such a function. It will also be noted that the obligation is to do so "insofar as they are relevant to the function being discharged." (s1(2)).

[132] Dr Narayan noted on 18 January 2016 that the pursuer was not suicidal, he was orientated and there was no sign of psychosis. Dr Narayan decided to revoke the short-term detention certificate because at review he was not satisfied that the pursuer had significantly impaired decision making. He felt the pursuer was aware of the situation and was making choices albeit poor choices. Accordingly, Dr Narayan did not believe the pursuer required to be detained for treatment. Dr Narayan had however advised the pursuer to stay voluntarily.

[133] In his evidence, Dr Scott adopted the conclusion of his first report that it was unreasonable that Dr Narayan revoked the STDC on 18 January 2016 "because there had

been no evidence of bipolar disorder". He pointed to a number of elements of the pursuer's prior history:

- There was documented information consistent with the diagnosis of a manic relapse of his bipolar disorder.
- Dr Marks had diagnosed an episode of mania during November 2015.
- On admission on 31 December 2015, Dr Jabbad described pressured speech and elated mood, and his impression was of manic episode.
- The pursuer's mother reported the pursuer saying he was God on 7 January 2016.
- Dr McGlen's examined the pursuer on 14 January 2016 when the pursuer described grandiose delusions.
- The information listed was consistent with a diagnosis of relapse of bipolar illness, measured by criteria in ICD10.
- Dr Narayan did not make that diagnosis.

Therefore, in Dr Scott's opinion, he was negligent on the *Hunter* v *Hanley* standard (CB10A).

[134] Dr Qureshi's evidence about revocation of the STDC was more nuanced. He recognised that while management of a patient on a STDC is sometimes a difficult balance, his view, *with the benefit of hindsight*, was that the pursuer would likely have required to be on the STDC for 28 days (emphasis added). That would have allowed the pursuer's symptoms to be captured more fully, and for treatment to be administered. An STDC is an important tool for balancing the least restriction with safe and effective treatment, which is what Dr Qureshi understood by the least restrictive treatment principle in the Mental Health (Care and Treatment)(Scotland) Act 2003. The purpose of detention on STDC is to enable assessment and/or treatment when it was felt that a patient was suffering from a mental

disorder and had significantly impaired decision making ability, and it was not possible to treat the patient voluntarily. In addition, there required to be a significant risk of harm to the health safety or welfare of the patient or others, so it was necessary to consider the risks of not continuing with the STDC if one was in place. While the decision to detain or discharge a patient involves the exercise of clinical judgement, his view was that revoking the STDC on 18 January 2016 was *Hunter* v *Hanley* negligent.

[135] In her report, Dr Muzaffar considered that Dr Narayan's assessment was based on information from ward staff and meeting the pursuer jointly with Charge Nurse Lomax. Dr Narayan documented his assessment, which supports his clinical decision. Dr Narayan had diagnosed personality disorder in an outpatient setting, and had discussed it with the pursuer, who was accepting of the diagnosis at the time. It was also relevant that Dr Morris assessed the pursuer on 6 February 2016, and did not diagnose mania (CB366).

Dr Narayan's duty was to ensure the pursuer was treated in the least restrictive manner, in accordance with the 2003 Act. The role of the psychiatrist is to assess and manage mental illness, and if a patient is not considered to have a mental disorder affecting their capacity, then they have the choice to engage, or not, with the treatment without compulsory measures (CB367). The STDC having been revoked, the pursuer took his own discharge against medical advice. In oral evidence, Dr Muzaffar, was satisfied revocation was appropriate. The conditions in section 44 have to be met for an order to be made, and for it to remain in force. Such decisions are challenged, and clinicians have to be sure the criteria for continued detention are met. If another psychiatrist lays different weight on certain features, that was because in psychiatry there are no blood tests or scans, and diagnosis is based on the observations of staff, interview of the patient and information from others involved. Different psychiatrists could reasonably reach a different view. It is particularly

difficult in this case because of the overlap in symptoms between bipolar disorder and emotionally unstable personality disorder. There was a stark different between Dr Muzaffar's view and Dr Scott's view. However, their views were on the scale of reasonable professional opinion. She was at one end and Dr Scott was elsewhere on the scale of reasonable opinion. For the short-term detention certificate to remain in place, all the tests had to be met. Capacity does not depend on the presence of mental disorder; the pursuer could have hypomania but still have the ability to understand and engage with treatment. Dr Narayan should have recorded the complexity of the pursuer's presentation and circumstances. He had offered out-patient contact and the pursuer had previously been offered an in-patient stay but he had taken his own discharge.

[136] The STDC revocation was signed by Dr Narayan at 11.30 on 18 January 2016 (JB1850). It bears to record that Dr Narayan is no longer satisfied that the pursuer met the criteria for detention, and that he is no longer satisfied that it was necessary for the pursuer to be detained in hospital. The form contains the following note: "There is no major mental illness. Behaviour due to personality. Patient is responsible for his decisions." (JB1851). At the time the revocation was recorded, it was expressly noted that the pursuer had not been discharged from hospital (JB1851), reflecting Dr Narayan's advice to the pursuer to remain in hospital voluntarily.

[137] In my view, the pursuer's submissions about this issue were premised on the diagnosis of personality disorder being wrong and that the diagnosis ought to have been a relapse of bipolar disorder. I have already set out my reasons for sustaining the defender's objection to the case being one of mis-diagnosis. The experts were in any event agreed that there was diagnostic uncertainty in the pursuer's case at this time. More importantly, the focus on diagnosis in the pursuer's submissions downplays the fact that section 44 sets out a

number of conditions, all of which have to be met for an STDC to be made, and for it to continue in effect. I do not accept the submission in the pursuer's written submission that "it is clear that the factual basis for revoking the STDC was not made out." Whether the pursuer's diagnosis was bipolar disorder or personality disorder, the mental disorder condition would be met. It is therefore necessary to consider the other conditions. I have already dealt with the pursuer's separately averred duty to consider whether the pursuer would be a risk of harm to himself or others. As I noted above, the threshold in section 44(4) is actually more subtle, namely there must be a significant risk to the health, safety or welfare of the patient, or to the safety of any other person. Of the expert witnesses, Dr Qureshi was the most explicit about the importance of this condition. Both he and Dr Muzaffar agreed there was a scale of professional view about assessment of risk; and while neither accepted the conclusion of the other, each accepted they were on that range or scale. Further as Dr Qureshi acknowledged, he was looking at the matter with the benefit of hindsight, which Dr Narayan was not.

[138] Further, the evidence about the pursuer's decision making ability across January 2016, and particularly 14-18 January, indicates episodes of poor decision making on his part; but apart from Dr McGlen's examination in the cells at Perth on 14 January 2016, the evidence indicated no occasion in January when a clinician considered the pursuer's decision making capacity was so impaired that he required to be detained. In that connection, Dr Rose's view following examination at the request of police on 19 January 2016, the day following revocation of the STDC, was that the pursuer was "rather pressured and grandiose, but nil warranting admission" and discharged back to the police with advice about medication and avoidance of illicit substances (JB2526). I consider that a very significant finding, for itself and for its timing. I also accept Nurse Lomax's evidence that

had he disagreed with Dr Narayan about the pursuer's decision making capacity and risk, he would have said so, albeit not in front of the pursuer. Nurse Lomax is a very experienced mental health nurse, and I am satisfied that he would have had no difficulty in conveying that view to a consultant.

[139] Against that background, I am cannot conclude that no ordinarily competent locum consultant psychiatrist would have revoked the STDC on 18 January 2016. Accordingly, the pursuer's case on breach of duty fails.

Discussion - causation

[140] As I have found against the pursuer on the issue of breach of duty, the issue of causation does not strictly arise. For that reason, I prefer to reserve my opinion about how far the decision of the UK Supreme Court in *Meadows* v *Khan* [2022] AC 852, as considered by the Inner House in *SD* v *Grampian Health Board* [2024] CSIH 7, at paragraphs 80-81, may be applicable in the context of this case.

[141] However, lest I should be wrong about breach of duty I should set out my views on causation on the basis of a traditional "but for" analysis. The pursuer's averments about causation are, in summary, that, but for the averred breaches of duty as these appear in Cond 10:

1. The pursuer would have remained in hospital under supervision - he would have remained on STDC for the full 28 days, and that might have been renewed.
2. The pursuer would have been stabilised on medication and discharged without suffering "manic, psychotic illness"
3. He would not have driven a vehicle whilst suffering from acute illness.

4. He would not have been convicted of criminal offences.

5. He would not have committed embarrassing public acts and suffered the breakdown of personal relationships.

6. He would not have been remanded in custody.

7. He would not have suffered humiliation and irretrievable damage to his employability in news reporting of his behaviour.

[142] I found the pursuer's submissions in relation to causation diffuse. The main written submission is predominantly directed to breach of duty. However, in the chapter dealing with revocation of the STDC in particular, two matters bearing on causation are highlighted: the failure to take the views of the pursuer's named person, and secondly, an assertion of failure to take into account the provisions of section 1(6)(d) of the 2003 Act in relation to *"continuing care"*. I have already dealt with the pursuer's case about the named person, both as to breach of duty, and my view that it has no legally causal relationship with subsequent events.

[143] In relation to the rather larger point about continuing care, I consider that defender's submission well-founded that had the STDC not been revoked the pursuer would at most have remained a detained patient for the remaining 24 days of the certificate. I do not accept there was evidence to support a finding that there would necessarily have been a further period of detention. More importantly in relation to the question of causation, I consider that many, though not all, of the problems spoken to by the pursuer in relation to his work, his relationship with Ms Manson, his relationships with his family, his criminal behaviour and convictions, and finally his descriptions of embarrassment and humiliation, were either experienced prior to the revocation of the STDC, or inevitable as a consequence of events which had occurred prior to that point.

[144] Taking the evidence in relation to those broad headings in turn:

[145] Employment. The pursuer had resigned from Drumoig Renewables in autumn 2015, prior to the admission to Stratheden Hospital in November of that year. That plainly was not a consequence of events during the hospital admission in January 2016. The pursuer has been certified as unfit for work since 2016, and is in receipt of certain social security benefits. In both of his reports, Dr Qureshi speaks to the fact of the pursuer's work history, but it is noticeable that he neither states that the pursuer is permanently unfit for work, nor what his capacity might otherwise be (see CB89 and CB108).

[146] Relationship with Ms Manson. It was plain that the pursuer's relationship with Ms Manson was turbulent before and during the time of the admission in January 2016. On 16 December 2015, the pursuer described them as being at loggerheads, and on 7 January 2016, he told Dr Pittock that they had broken up (JB1585). By 11 January he had been spending at least part of his time with a former partner named Gill (JB1595) and by 13 January (the day of her telephone call to the police at 08.00) Ms Manson was aware that the pursuer had been sleeping with a former partner, and reported that to Dr McGlen (JB567). His behaviour had also been problematic enough that Ms Manson had called the police and he had been arrested. All of these events may well have had an effect on the pursuer's relationship with Ms Manson, but all pre-date revocation of the STDC. The pursuer and Ms Manson did resume their relationship some time after 18 January 2016, indeed he was in contact with her shortly after leaving hospital, though he did not resume living with her immediately. It is clear that Ms Manson was in contact with mental health and social work services in the immediate period after revocation of the STDC. To the extent that the pursuer's case is of a breakdown in his relationship with Ms Manson, that is not established on the evidence. To the extent that his case is that there were difficulties

after his discharge from hospital, there is some evidence which points to a direct causal association, for example about him sleeping in his car, and then living for a period with a former fellow patient.

[147] Relationship with pursuer's family. The pursuer's relationship with his family had deteriorated before the alleged breaches of duty. There were long-term underlying tensions: the pursuer described his parents as alcoholics, and that his mother and Ms Manson "hated each other". That was consistent with the records: the pursuer's mother reported to social workers that she felt that it was possible Ms Manson was emotionally and physically abusing the pursuer (CB270). The pursuer's relations with his parents deteriorated further on 31 December 2015, when an argument occurred which led to his sister calling the police and to his arrest. He subsequently received bail conditions not approach or contact them. These difficulties all pre-date the hospital admission on 14 January 2016, and revocation of the STDC on 18 January.

[148] Criminality. The pursuer's previous averments contending that his criminality was a consequence of his breaches of duty were excluded from probation after a diet of debate. Much of the criminal behaviour which remains on record took place prior to the alleged breaches of duty: the altercation with the pursuer's parents on 31 December 2015; the breach of the peace on 13 January 2016; and the racially aggravated harassment conviction arising out of his behaviour towards Dr Narayan on 15 January 2016. While he had not yet been convicted on 18 January 2016, his subsequent conviction was inevitable by that point. The pursuer's averment at page 10 of the record that "All such behaviour took place after Dr Narayan's negligent misdiagnosis" is thus inaccurate: much of it preceded the revocation of the STDC, though the convictions followed it. Nonetheless, an episode of criminal conduct did post-date the revocation; however that was the drink driving matter

which was, quite properly, excluded at debate. Finally on this point, I accept the defender's submission that the pursuer's averments at page 10 of the record that "He pled guilty to all allegations despite his innocence" is irrelevant and should not have formed part of his pleadings.

[149] Embarrassment and humiliation. The pursuer gave evidence about embarrassment in relation to his behaviour in the context of two specific points in time. The first was when looking at the record of Dr Pittock's review on 11 January 2016. The pursuer described reading that as making him feel "sick to my core". He repeated that phrase when describing how he felt when he read about the details of his review by Dr McGlen at Perth Police Station on 14 January 2016. The defender submits that was the only specific evidence before the court, and because of the point in time that it relates to, should not sound in damages. That is true so far as it goes; however, I consider that submission does not address the essence of the pursuer's claim under this heading. Of its nature, the pursuer's behaviour, whilst on remand for example, shouting and keeping other prisoners awake, or writing with faeces, is behaviour sufficiently detached from normal conduct, as to call attention to the pursuer in an embarrassing way. I consider that in principle, if such behaviour was causally connected to breach of duty, it might sound in damages. The defender's rather better point is the lack of focus in evidence about this.

[150] Remand in custody. The pursuer was remanded in custody on 15 February 2016 following a failure to appear on 12 February at a diet of deferred sentence on the charge of racially aggravated conduct. By that point, the pursuer had also been arrested and had appeared on the charge of drink driving. While I have no reason to doubt the pursuer's evidence that he found prison a terrifying place, I consider that it is not relevant to the issue of causation in light of the exclusion of his averments about his criminality. He was

remanded to custody in respect of charges which either pre-dated revocation of the STDC, or which are excluded from probation in the proof.

Discussion - damages

[151] Again, this aspect of the action is superseded by my decision on breach of duty, and I therefore set out my views briefly.

Solatium

[152] The pursuer was experiencing mental ill-health during the admission from 14 January 2016, and continued to do so following revocation, so this is not a case in which the pursuer can, or does, claim that his psychiatric disorder is a consequence of the breach of duty alleged. Were I to have been awarding damages, I consider that the correct approach to solatium in this case would be to compensate the pursuer for distress and discomfort for the period when he was not receiving consistent medical treatment which he might otherwise have received. The pursuer was remanded in custody on 15 February 2016 following his failure to appear at court on 12 February. He was transferred to Stratheden on 16 March 2016 on an assessment order. It follows that the period when the pursuer was not receiving consistent treatment was 2 months.

[153] In the pursuer's supplementary written submission, something is made of the pursuer's evidence that he has lost faith in the therapeutic relationship, in the sense that he is very mistrustful of psychiatric services. Such mistrust may be comprehensible, but in my view, it does not fall within the scope of damages for solatium, which is of course directed to pain, suffering and, in appropriate cases, loss of amenity.

[154] Counsel for the pursuer referred to section 4(A)(b) of the Judicial College Guidelines: "moderately severe" psychiatric damage. That is, however, premised on psychiatric injury being caused to a claimant who was previously well. In truth, this case is better analysed as being closer to the class of case where a pre-existing physical injury or condition is exacerbated for a period of time. Viewed in that way, I consider that it falls in the lower half of the "moderate" bracket. I would have awarded £12,000, together with interest.

Loss of earnings

[155] At the time of his admission to hospital in November 2015, the pursuer had already left his business Drumoig Renewables, and the business foundered. The business had been in difficulties which the pursuer ascribed to pressures from the main supplier of the products the company was marketing. None of that can be ascribed to events during the pursuer's admission to hospital in January 2016 and revocation of the STDC on 18 January. Also of significance from the point of view of assessing the pursuer's earning capacity, there was no documentary material about this business, nor the pursuer's earnings from it. Accordingly, it is not possible to form a view about his potential earnings if he were able to run an equivalent business.

[156] Somewhat surprisingly, apart from the pursuer himself, the only evidence about the pursuer's capacity for work came from Peter Davies. Mr Davies is a very experienced employment consultant, but so far as the court is informed, he has no medical qualifications. At any event, Mr Davies considered that the pursuer could undertake golf coaching but would need to take care to avoid overworking. I was at a disadvantage in not having a medical view about that nor about the important related question of the extent to which limitations on the pursuer's working capacity might be consequential on events in

January 2016. The pursuer is an entrepreneurial individual, who has tried his hand at a variety of occupations since his retirement from competitive sport. He has done so with varying degrees of success, including in the periods after episodes of mental ill-health. However, he has also experienced difficulties as a result of over-commitment to work in the past. Impressionistically, the pursuer's mental health may act as a limit on his capacity for work irrespective of events in January 2016, but I am unable to make a concrete finding to that effect. That is to some extent consistent with Dr Qureshi's reports, though as I have already observed he neither states that the pursuer is permanently unfit for work, nor what his capacity might otherwise be (see CB89 and CB108).

[157] I take as a starting point Mr Davies's projected earnings in golf coaching at the rates for 2015-16 (table 2 CB134), of £20,495 for 12 months, while there is force in the argument that the available evidence does not unequivocally support a period of disadvantage of 12 months, the pursuer, rightly, submits that awards of damages for loss of employability or disadvantage in the employment market are frequently impressionistic. That is especially so in the present case, given the nature of the pursuer's employment history, and the absence of documentary evidence. I would therefore have awarded £20,500 under the heading of loss of employability.

Services

[158] The pursuer seeks damages for services provided by his partner Ms Manson. I did not hear evidence from Ms Manson. It is averred that Ms Manson provided "care" and emotional support for the pursuer. That was the tenor of the pursuer's evidence, and he added that she helped him take his medication. I have already noted that the pursuer's relationship with Ms Manson was turbulent, and there was a period when they were

separated. Nonetheless, I accept that she has been a support to the pursuer. However, there is no evidence before me to indicate that she provided support as a direct result of the asserted breach of duty. She was providing support of the kind she had provided prior to the events with which the action is concerned. Accordingly, I would have found no loss made out under this head.

Conclusion

[159] For all of the foregoing reasons, I will grant decree of absolvitor to the defender. I will fix a hearing on expenses.