"A socially excluded group"[1]? – Hearing the voice of victims

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Introduction

There is a growing recognition that victims of crime have rights. The Government has declared itself determined to better meet the needs of victims of crime.[3] For this purpose the Domestic Violence, Crime and Victims (DVCV) Act 2004 was introduced, inter alia, to increase the protection, support and rights of victims and witnesses. The Act has introduced a number of measures, including the following:

- The appointment of an independent Commissioner for Victims and Witnesses.[5]
- A Code of Practice[6] has been published, which supersedes the Victims Charter and is binding on all criminal justice agencies. Its aim is to ensure that all victims receive the support, protection, information and advice they need.
- A Victims' Advisory Panel[7] has been established with the purpose of advising the Government on issues relating to victims and witnesses.

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1 *Joint Committee on the Draft Mental Health Bill. 23 March 2005. – Volume 1 Report. Paragraph 288. http://www.publications.parliament.uk/pa/jt200405/jtselect/jtment/79/7910.htm*

2 *Associate Solicitor at Bevan Brittan LLP; Member of the Victims Advisory Panel. The views expressed are those of the author in her personal capacity.*

3 *Rebuilding Lives – supporting victims of crime. Cm 6705 December 2005 p2*

4 *The DVCV Act 2004 came into force on 1 July 2005.*

5 *A Commissioner for Victims is provided for in s 48 Domestic Violence, Crime and Victims Act 2004. Unfortunately the appointment is yet to be made*

6 *The provision for a Victim's Code of Practice is set out in s 32 Domestic Violence Crime and Victims Act 2004. Following a consultation period , the Code of Practice for Victims of Crime was published on 18 October 2005, and took effect in April 2006.*

7 *The provision for a Victims' Advisory Panel is set out in s55 Domestic Violence Crime and Victims Act 2004 .*

The purpose of this article is to review how the needs of victims of mentally disordered offenders (MDOs) are being addressed by healthcare teams treating MDOs and by the Mental Health Review Tribunal (MHRT) in **providing victims**[8] **with information** and **giving victims a voice**[9]**.**

After the publication of the DVCV Act 2004 and following extensive discussions with the Home Office, the Lord Chancellor, the Department of Health (DH), and representatives of Victims' Organisations, the MHRT published a policy document setting out the rights of victims to access tribunal hearings.[10]

Subsequently in September 2005 the Mental Health Unit of the Home Office published guidance to clinicians[11] in relation to their duties to victims under the DVCV Act 2004. The DVCV Act 2004 and the MHRT guidance does not define a victim. However the Home Office guidance[12] states that:–

> *"The definition of "victim" is taken to include any person in relation to an offence who appears to the local probation board to be, or to act for the victim of the index offence. This includes a victim's family in a case where the offence has resulted in the victim's death or incapacity, and in other cases where the victim's age or personal circumstances makes it sensible to approach a family member in the first place."*

Information Sharing

There are two elements to information sharing: (1)The clinicians sharing information with the victim; and (2) the MHRT sharing information with the victim.

1. Clinicians sharing information with the victim.

The Home Office guidance states that the provisions of the DVCV Act 2004 do not place any statutory duty on clinicians to disclose information to victims and that the information whose disclosure is required under the DVCV Act relates to discharge and conditions of discharge.[13]

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8 *Victims want a criminal justice system where they are informed routinely about developments in their case, building on the introduction of Witness Care Units as a single point of contact for victims and prosecution witnesses. Victims should be told when charges are brought , dropped or changed, told about court dates and told when prisoners are being released. Rebuilding Lives – supporting victims of crime. Cm 6705 p6*

9 *The criminal justice system is founded on the principle that defendants are innocent until proven guilty. But that does not mean that it should focus only on them. Victims and their families must be able to express the effect of a crime on them. Victims voices should be heard in the CJS and in Government. Rebuilding Lives – supporting victims of crime. Cm 6705 p6*

10 *New procedures concerning the rights of access to MHRT Hearings of victims of certain criminal offences committed by patients. Professor Jeremy Cooper, Southern Regional Chairman, Jack Fargher, Head of MHRT Administration, HHJ Philip Sycamore, MHRT Liaison Judge, Mr John Wright, Northern Regional Chairman July 29th 2005.See Appendix A*

11 *Duties to Victims under the Domestic Violence, Crime and Victims Act 2004: Guidance for Clinicians. September 2005 Mental Health Unit Home Office. See Appendix B*

12 *ibid. Paragraph 6*

13 *ibid. Paragraph 8*

Pinfold reported that mental health professionals are uncertain about what information they may share, and that policy guidance is both inconsistent and scattered in a range of documentation.[14]There is a range of information that clinicians could potentially share with a victim, starting with when and to where a MDO is likely to be discharged, to details of treatment and previous history. A victim could reasonably argue that they are entitled to know when clinicians intend to recommend that a MDO is released; however it is quite another matter and would be in breach of the MDO's right to confidentiality to provide a victim with details of treatment and previous history. If however the risk assessment process identifies an individual at future risk from an MDO, then the right and the duty to disclose proportionately would arise.

One additional point for clinicians treating MDO's is that the Home Office guidance sets out some non-statutory good practice points.[15] In particular it is recommended that the Home Office will notify the Victim Liaison Officer (VLO)[16] where a patient is transferred to a different hospital and that the VLO will then make contact with the new Responsible Medical Officer (RMO). The guidance does not go on to say this, but a clinician who is not contacted within a reasonable period of a patient being transferred to his/her care could potentially seek to make inquiries as to the identity of the VLO for any victim.

2. The MHRT sharing information with the victim.

Prior to the DVCV Act 2004, victims of MDO's had very few rights to information. In 2002 the case of *T v Mental Health Review Tribunal (Defendant) & G (Interested Party)*[17] confirmed for the first time that victims have rights that can be enforced. In 1994 G was convicted of the manslaughter of his child. The MHRT refused T's application to be joined as a party to the proceedings.[18] Subsequently the MHRT ordered a conditional discharge. T, the mother of G's child, asked the MHRT to inform her of the current level of risk, conditions of treatment and any limitation on G's residence in a particular locality, conditions of treatment and date of release. The MHRT refused to provide her with this information. T argued that her rights under Article 2[19] and Article 8[20] of the European Convention on Human Rights (ECHR) were breached. The High

14 *Positive and inclusive? Effective ways for professionals to involve carers in information sharing. – Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D. Autumn 2004.p8*

15 *Duties to Victims under the Domestic Violence, Crime and Victims Act 2004: Guidance for Clinicians. September 2005 Mental Health Unit Home Office. See Appendix B paragraphs 13–17*

16 *The VLO is part of the National Probation Service Victim Contact Scheme and their role is essentially to provide certain information to the victim about the offender. See paragraph 7 of the Home Office guidance Appendix B attached. For further information see http://www.probation.homeoffice.gov.uk/files/pdf/Victim%20Contact%20Scheme%20Leaflet%20English.pdf*

17 *T v Mental Health Review Tribunal (Defendant) & G (Interested Party)[2002] EWHC Admin 247*

18 *As acknowledged further on in this article, T sought to challenge this decision in the High Court. She was unsuccessful.*

19 *Article 2 ECHR. (1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.(2) Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:(a) in defence of any person from unlawful violence;(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;(c) in action lawfully taken for the purpose of quelling a riot or insurrection.*

20 *Article 8 ECHR(1) Everyone has the right to respect for his private and family life, his home and his correspondence.(2) There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder of crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

Court stated that under rule 21[21] the MHRT had discretion upon disclosure, and that in the circumstances of this particular case there was no reason why T should not be told information about discharge, in particular, conditions as to restricting his area of residence and from contacting any particular person. Counsel for the MHRT[22] argued that it was not a function of a tribunal to take steps to promote the peace of mind or physical well-being of individual members of the public.[23] However Mr Justice Scott Baker decided that: "It seems to me necessary to ask what need the seeker…has for the information being sought",[24] and continued that it may be of benefit to the patient that a victim's concerns are allayed as far as possible.[25]

Subsequently the DVCV Act 2004 has given victims[26] of MDOs subject to restriction orders, limitation directions and restriction directions, the statutory right to make representations and to receive certain information from the MHRT. However the Act does not provide the same rights to information for victims of patients who are not in one of the above categories,[27] but who are nevertheless victims of a violent and sexual crime. One victim group argues that these rights to basic information should be extended to all victims of violent and sexual crime regardless of whether a restriction order has been applied.[28] The Act also does not apply to victims of incidents that occurred prior to 1 July 2005 as the legislation is not retrospective. However the guidance note from the MHRT makes it clear that if such victims give notice of their wish to be informed of any tribunal hearings they will have certain limited rights.[29] In particular paragraph 15 states "The victim shall have the right to a) apply to the tribunal in order to give evidence to the hearing, and b) to submit to the Tribunal any written evidence that he or she wishes the tribunal to consider."

In relation to sharing information, paragraph 12 of the MHRT guidance note states that the Tribunal Secretariat will inform the VLO[30] of the outcome of the hearing in writing within seven days. The guidance note from the Home Office[31] sums up the position when it states that the purpose of giving information to the victim is to reassure the victim and is not intended to lead to the disclosure of any information which is covered by patient confidentiality.

Giving victims a voice

There are two elements to giving victims a voice: (1) Giving the victim a voice with the healthcare team of the MDO prior to the MHRT; and (2) giving the victim a voice at the MHRT.

The voice of victims of MDOs has in the past rarely been heard either by healthcare teams treating

25 *Rule 21 Mental Health Review Tribunal Rules 1983.*

26 *Jenni Richards instructed by the Treasury Solicitor for the Defendant in the case of T v Mental Health Review Tribunal (Defendant) & G (Interested Party)[2002] EWHC Admin 247*

27 *T v Mental Health Review Tribunal (Defendant) & G (Interested Party)[2002] EWHC Admin 247 paragraph 22*

28 *ibid. paragraph 26*

29 *ibid. paragraph 35*

30 *Appendix A paragraph 2*

31 *These categories are victim(s) of an offender who receives a restricted hospital order or a hospital and limitation direction, or who is transferred to hospital from prison under a transfer and restriction direction.*

32 *Joint Committee on the draft Mental Health Bill Minutes of Evidence. Memorandum from the Zito Trust (DMH 174)*

33 *Appendix A Paragraphs 14–15.*

34 *The VLO is part of the National Probation Service Victim Contact Scheme and their role is essentially to provide certain information to the victim about the offender. See paragraph 7 of the Home Office guidance Appendix B attached. For further information see http://www.probation.homeoffice.gov.uk/files/pdf/Victim%20Contact%20Scheme%20Leaflet%20English.pdf*

35 *Appendix B paragraph 8*

MDOs or by MHRTs. There are no provisions in the Mental Health Act (MHA) 1983 to provide a structured system to engage victims proactively with a view to reducing risk. It remains to be seen whether the new, shorter, simpler Bill that the Government now proposes to use to make amendments to the MHA 1983 will deal with issues relating to victims.

1. Giving victims a voice with the healthcare team

It has been argued that if professionals working with MDOs actively sought to engage victims and hear their voice, the risk assessment undertaken by professionals might be enhanced.[32] Additionally if victims contributed in this way, the future care plan for the patient would be better informed and patients could also benefit from understanding the impact of their crime on the victim.

The arguments against engaging with victims tend to centre on issues of patient confidentiality, and the public interest criterion for breaching patient confidentiality is rarely applied.[33] Mental health professionals often think that they cannot or should not engage with people who report harassment or incidents involving MDOs. This view is ascribed to a belief …that "victims belong to the criminal justice system while patients belong to the health care system."[34]

However recent guidance from the Mental Health Unit of the Home Office[35] now makes it clear that: "It is for the clinical team and the VLO to decide the level of contact between them eg whether or not the VLO should attend any meetings with the team about the case. It may be helpful for the team to know the views of the victim of the offence."

In view of the Home Office guidance, clinicians who do not engage with a VLO in order to ascertain the views of a victim may need to subsequently justify this (to for example a future inquiry), and any decision in relation to this should be carefully documented in the patients' notes. Additionally, as argued above, it could be considered to be good practice for a RMO to seek out a VLO if the VLO does not identify and contact the treating team.

If victims are involved by the treating health care professionals in the risk assessments of MDOs then it is likely that any relevant information would be fed into the tribunal system by the Responsible Medical Officers (RMOs). This would make for a much more holistic approach to the care and treatment of the offender as the victim might have very relevant information to share with the treating team in relation to a particular offender.

2. Giving victims a voice at the MHRT

Rule 7(f)[36] allows the MHRT to give notice of the hearing to any person who in the opinion of the tribunal should have the opportunity of being heard. A patient might argue that notification to the victim was in breach of his entitlement to respect for his private and family life. Equally however the victim could argue that interference with Article 8(1) was fully justified under Article 8(2) because of the need to protect his or her own rights.

32 *Joint Committee on the Draft Mental Health Bill. 23 March 2005. – Volume 1 Report. Paragraph 290.*

33 *Joint Committee on the Draft Mental Health Bill Minutes of Evidence. Memorandum from the Zito Trust (DMH 174)*

34 *Joint Committee on the Draft Mental Health Bill. 23 March 2005. – Volume 1 Report. Paragraph 290.*

35 *Duties to Victims under the Domestic Violence, Crime and Victims Act 2004: Guidance for Clinicians. September 2005 Mental Health Unit Home Office paragraph 12*

36 *Rule 7(f) Mental Health Review Tribunal Rules 1983*

The case of *T v MHRT & G (Interested Party)*[37] was referred to earlier in this article. In February 2001, T had sought leave to seek judicial review of the tribunal's decision to refuse her application to be joined in the proceedings.[38] The Judge in that case concluded that the Regional Chairman had used his discretion reasonably. T could convey her views effectively by way of a written statement. In this case the judge said that there were "obvious difficulties" in having a victim participate in a tribunal hearing.

In considering whether a victim can participate in a MHRT, rule 22(4)[39] states that any party, and with the permission of the tribunal "any other person" may appear at the hearing and "take such part in the proceedings as the tribunal thinks proper". The MHRT guidance note[40] now confirms that there should be a rebuttable presumption in favour of granting the right to the victim to give evidence at the hearing in question,[41] and refers to Rule 5 in enabling the Regional Chairman to exercise this power on behalf of the tribunal at any time up to the hearing. The guidance note plainly now envisages that the victim should be able to give both written and oral evidence.

Allowing a victim to provide evidence at a MHRT raises a number of issues, as follows:–

1. Purpose of the victim's oral evidence;
2. Cross-examination;
3. Confidentiality;
4. Advocates;
5. Safety and Security;
6. Sensitivity to the needs of the victim;
7. Influence of victim's evidence.

* *Purpose of the Victim's oral evidence*

The role of the MHRT is primarily to consider whether the continuing compulsory detention of a patient is lawful, appropriate and necessary. In determining the involvement of victims and the evidence that they can provide, it is necessary to give careful consideration as to whether the purpose of allowing victims to make representations to the MHRT is to give victims some influence over detention itself, or over the conditions relating to any discharge, or simply to allow victims to become more involved and informed in the process.

A tribunal makes a discharge decision based on clear statutory criteria and a patient's representative might argue that a victim cannot assist the tribunal in this respect. Certainly the evidence of a victim is likely to have very little impact on the decision as to whether the Applicant suffers from a mental disorder. However it may be very useful when the Tribunal considers "protection of others."[42]

37 *T v Mental Health Review Tribunal (Defendant) & G (Interested Party)[2002] EWHC Admin 247*

38 *T v MHRT & G (Interested Party) [2001] EWHC Admin 602*

39 *Rule 22(4) Mental Health Review Tribunal Rules 1983*

40 *See Appendix A.*

41 *ibid. paragraph 16*

42 *A term which features within the statutory criteria to be considered by the Tribunal (ss72/73 Mental Health Act 1983)*

The Zito Trust argues that the MHRT has a duty to take evidence from identifiable and interested victims or potential victims when considering applications for discharge by MDOs.[43] Of course it may be that some victims are unable to contribute in an appropriate way but the tribunal must judge this on a case by case basis. Other victims may know the patient very well and may be able to make a very valuable contribution in helping the healthcare professionals and the MHRT to build up a complete picture of the patient.

** Cross-examination*

If a victim does give evidence in relation to discharge, this gives rise to the very difficult issue of whether the victim could be cross-examined on their evidence. A patient may argue that in accordance with Article 6,[44] he/she is entitled to cross-examine a victim on their evidence. The MHRT needs to ensure that the patient's right to a fair hearing is upheld. For cross examination to be effective, the patient would need to have prior notice of the victim's evidence, in the form of a written statement, which would need to be provided sufficiently far in advance for the patient (and indeed the detaining authority) to investigate the accuracy and relevance of any information contained within it.

Paragraph 18 of the MHRT guidance note states that according to Rule 14(2) "the Tribunal may receive in evidence any document or information, notwithstanding that such document or information would be inadmissible in a court of law." Whether or not a victim could be cross-examined by a patient is an issue best decided by the MHRT President on the basis of whether it is necessary in a particular case in order to ensure that an applicant's right to a fair hearing is not compromised.

** Confidentiality*

If the applicant submits any written evidence to the hearing, either in place of or in addition to attending the hearing, then Rule 1249 applies.[46] The guidance note confirms that victims need to be aware that no guarantees can be given that any representations they make will not be disclosed to the patient.[47]

In view of Article 5 ECHR and rule 12(2)[48] the MHRT needs to be able to demonstrate fully the justification for any non-disclosure. To date there have been no reported challenges in the courts of England and Wales in respect of the compatibility between rule 12(2) and the Convention.

However there has been a challenge in Northern Ireland, in which Kerr J[49] stated the following:–

> *"Where disclosure may cause harm to the applicant or the informant [of the information forming the basis of the non-disclosed report], the tribunal must balance the right of the applicant under Article 5(4) with the interests that may be adversely affected if the material is disclosed. In this*

43 *Joint Committee on the draft Mental Health Bill Minutes of Evidence. Memorandum from the Zito Trust (DMH 174)*

44 *Article 6 ECHR*

45 *Rule 12 Mental Health Review Tribunal Rules 1983.*

46 *Appendix A .paragraph 19*

47 *Appendix A Paragraph 8*

48 *Rule 12(2) Mental Health Review Tribunal Rules 1983. "As regards any documents which have been received by the tribunal but which have not been copied to the applicant or the patient, including documents withheld in accordance with Rule 6, the tribunal shall consider whether disclosure of such documents would adversely affect the health or welfare of the patient or others and , if satisfied that it would, shall record in writing its decision not to disclose such documents."*

49 *In the matter of an application by Laurence McGrady for judicial review [2003] NIQB 15*

context the tribunal will want to consider carefully whether the Convention rights of the informant would be infringed if the material that that person has provided in confidence is revealed to the applicant…A balance must be struck between, on the one hand, the requirement that an applicant applying for discharge should generally have the opportunity to see and comment on all material adverse to him and, on the other, that the safety of the informant should not be imperilled."[50]

In relation to the applicant's legal representatives the judge said that "while they may not disclose that material to the applicant, they may nevertheless take his instructions on the themes with which material is concerned." Therefore the patient could present material on matters raised even if he was unaware of the actual contents. The patient is not denied a fair hearing simply because material is withheld but unfairness would arise "if the tribunal failed to acknowledge that the applicant has not been able to see and answer specifically the details of the allegations made against him." He concluded that "provided they are conscious of this and cater for it in their approach to the assessment of the [non-disclosed report], the proceedings will not be unfair to the applicant."[51]

In response to this argument, a patient could argue that the outcome of the tribunal will be either that the patient is ready to be discharged, in which case the victim should be clear that there is no longer any threat to their well being and evidence need not be given confidentially, or alternatively the MHRT will consider that the patient is not ready to be discharged, in which case the victim's safety is maintained in any event. This somewhat simplified argument may provide little comfort to a victim who has already been attacked in some way by the patient, and who may have limited confidence in the protection afforded by the system. On occasions MHRTs will release patients who pose a limited risk to the public. For this reason, victims might argue that it is essential that tribunal panels have available to them all possible information from all relevant parties in making their decisions.

Ultimately the test will be whether disclosure would adversely affect the health or welfare of the patient or others.[52] The tribunal will need to consider whether the evidence will adversely impact on the mental state of the patient but the guidance note also clearly states that "others" could include the victim.[53] In practice each case will need to be decided on its merits before a tribunal (or Regional Chairman) as a pre-hearing matter. Sufficient time would need to be given so that the patient's representative could consider whether a challenge should be made. Clearly if such a decision were to be made it would need to be done when the patient is not present. There may also be occasions when the victim may not be present albeit that his/her statement is submitted in evidence. Additionally whether the statement should be admitted in any event is a question that will need to be decided by the MHRT particularly if the patient/patient's representative is not given the opportunity of cross-examining because of the victim's evidence.

* *Advocates/ representatives*

Advocates or representatives could provide essential guidance and psychological support to victims but they may also be able to resolve issues around the sharing of confidential information, such as where reports could be shared with representatives but not disclosed to the victim and the patient. Many victims want to explain the effect that the crime has had on their lives and want to feel that a court or tribunal has heard what they have to say. This basic psychological need has been

50 *ibid*

51 *ibid*

52 *Rule 12 Mental Health Review Tribunal Rules 1983.*

53 *Appendix A. Paragraph 19.*

recognised by the Government and as a result of the consultation entitled "Hearing the relatives of murder and manslaughter victims" the Government has been piloting victims' advocates in five Crown Court centres from April 2006.[54] In these pilot areas, courts will hear from an advocate speaking on behalf of a victim's family where a conviction for murder or manslaughter is secured. In relation to who will be represented, Lord Falconer has said "Where the deceased was killed by a member of his family, or there are multiple victims, it will be for the judge to decide who should be entitled to representation by an advocate and how."[55]

If the pilot is successful, it is conceivable that this service could be extended to MHRTs for the family of a victim of manslaughter. Rule 10(1)[56] allows for "any party" to be represented, but does not deal with funding. The DVCV Act 2004 does not consider the issue of public funding for legal representation of victims.[57] If victims are going to have a genuinely effective and supported voice at MHRTs they would need to have an advocate or representative who is properly funded by the state.[58] Additionally guidance would need to be given as to who specifically would be entitled to this funding. If victims were to be represented at tribunals this would require a large injection of additional resources by the Government. It would be important that any resources made available were additional in order that existing public funds were not diverted from the current representation of patients. There would undoubtedly be a vigorous debate as to whether state-funded representation would be an appropriate use of resources.

* *Safety and security.*

Issues concerning the safety and security of both patients and victims would need to be considered if a victim were allowed to attend the MHRT, and appear in effect as a hostile witness. Currently the majority of civil courts have a shortage of waiting rooms leaving many victims sitting in the same waiting area as their abuser.[59] Similarly many psychiatric hospitals may not have appropriate facilities, and these would need to be made available. If it is in the interests of justice that victims are heard at tribunals, security issues in themselves can not be a sufficient reason to preclude victims from attending. Many members of staff working in psychiatric hospitals have substantial experience of dealing with violent confrontations between individuals.

In criminal courts vulnerable victims are able to give evidence from a live TV link. If there was a very serious concern in an individual case regarding the safety and security of either party then consideration could be given to employing this method. In order to protect the safety and security of all parties, again additional resources will need to be made available in order that these issues are addressed.

* *Influence*

It is important that all parties are clear from the outset of the potential impact and influence that victims are going to be able to have in relation to the detention of a patient, in order that there is clarity about the role of different parties.

54 *Hearing the relatives of murder and manslaughter victims. Consultation. September 2005. CJS*

55 *The Victims Advocates Seminar 14 February 2006. Lord Falconer of Thoroton Q.C. (Lord Chancellor.) http://www.dca.gov.uk/speeches/2006/sp060214.htm*

56 *Rule 10(1) Mental Health Review Tribunal Rules 1983*

57 *Blackstone's guide to the DVCA Act 2004 : Oxford University Press: 2005 p98*

58 *In the aftermath The support needs of people bereaved by homicide : a research report. Victim support. February 2006. – This report notes that there is a complex range of advocacy and legal representation needs of victims in relation to MDOs, intra familial murders and other issues.*

59 *Blackstones'guide to the DVCV Act 2004: Oxford University Press: 2005 p98*

Some might argue that what happens to the patient in all respects should be determined entirely by the MHRT. One reason for this view is a belief that victims should have no influence whatsoever in relation to MDOs on the basis that involving victims in the process could result in inconsistencies in the treatment of patients, depending on the attitude of the victim to the MDO.

However, victims might argue that they should be enabled to voice their views in relation to the patient. It seems unlikely that many will simply want to emote in the tribunal on the basis that the process is cathartic for them.

Instead, some victims may feel that for their own personal safety (and possibly that of other family members) and peace of mind they should seek to influence any conditions attached to the conditional discharge of a patient. If so it would seem appropriate for those victims to give evidence once the issue of discharge had been decided.

Other victims might argue that they could fulfil a crucial role in assisting the Tribunal when it undertook its habitual risk assessment. In this case victims would need to give evidence before the question of discharge had been decided. If these victims are to feel empowered, valued and respected there is likely to be an expectation that their views should influence (but not be decisive on) whether and how the patient is discharged.

The tribunal has a public law duty to consider all relevant evidence and to make sure that the terms of the judgment enable the parties to analyse the reasoning.[60] If a victim does give evidence, the tribunal will therefore have to address the impact that the victim's evidence has had on its conclusions. In the event that the tribunal makes a decision with which a victim does not agree, the victim might have grounds to apply for a judicial review of the tribunal's decision, either for a failure to provide adequate reasons or for failing to take relevant evidence into account. The merit of any claim would depend upon the individual tribunal's decision.

Conclusion

Twenty years ago the UN Declaration on Basic Principles of Justice for Victims of Crime and the Abuse of Power asserted as a primary demand "victims should be treated with compassion and respect for their dignity." However historically the views of victims of MDOs have not been heard, and Mezey et al[61] found in 2002 "almost universal frustration" with the criminal justice system on the part of victims, and a strong sense that the offender was given more support and consideration than the victims bereaved families.

As attitudes towards victims change, a fair balance needs to be struck between the rights of the victim and the patient if the rights of both parties are to be developed and safeguarded. Victims should be enabled to be one part of the process in relation to MDOs. This more holistic approach would encompass a recognition that victims have a right to have their voice heard, and can make a valuable contribution in relation to assessing risk and also in relation to the care and treatment of MDOs, while at the same time recognising that MDOs have rights to dignity and privacy.

The Government has started to recognise the importance of victims and witnesses in achieving a

60 *Dyson LJ, in R (H) v Ashworth Hospital Authority [2003] 1 WLR 127, cited the judgment of Lord Phillips in a non-mental health case, English v Emery Reimbold & Strick Ltd (Practice Note) [2002] 1 WLR 2409*

61 *Mezey,G., Evans,C. and Hobdell,K. (2002) Families of homicide victims: psychiatric responses and help seeking. Psychology and psychotherapy : theory, research, 75(1), p65–75*

system that works efficiently and appropriately, and has demonstrated this in part through enacting the DVCV Act 2004. This legislation takes the rights of victims further than any other legislative measures to date. However, the provisions do not extend to all victims and crucially there is no statutory duty on healthcare professionals to include victims in their risk assessment or seek their views in relation to care plans when treating MDOs.

Currently the sharing of information across mental health services generally is poor.[62] The Home Office Guidance published in September 2005 encourages health care professionals to consider what level of contact there should be between the VLO and the treating team. The guidance reminds clinicians that it may be helpful for the team to know the views of the victim of the offence.[63] In the light of this guidance, clinicians who do not engage with a VLO in order to ascertain the views of a victim may need to subsequently justify this, and any decision in relation to this should be carefully documented in the patient's notes.

Additionally the MHRT guidance note[64] confirms that there should be a rebuttable presumption in favour of granting the right to a victim to give evidence at the hearing in question.[65]

If the Government intends to build on the work it has done to date there are two key issues that it must address as a matter of some urgency. Firstly it needs to consider how it is going to properly publicise and make MHRTs, victims and treating clinicians aware of the provisions of the DVCV Act 2004, the guidance from the MHRT[66] and the guidance for clinicians from the Home Office.[67]Secondly it is essential that sufficient additional resources are made available so that victims can be appropriately and effectively included in the care and treatment of MDOs.

62 *Positive and inclusive? Effective ways for professionals to involve carers in information sharing. – Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation R &D. Autumn 2004*

63 *See Appendix B paragraph 12*

64 *See Appendix A.*

65 *ibid. paragraph 16*

66 *See Appendix A*

67 *See Appendix B*

Appendix A

New Procedures Concerning the Rights of Access To MHRT Hearings of Victims of Certain Criminal Offences Committed by Patients

Part A: Tribunals Covered by the Domestic Violence, Crime and Victims Act 2004

Background

1. The *Domestic Violence, Crime and Victims (DVCV) Act 2004*, which received Royal Assent in November 2004, contains a number of measures to extend the Government's programme of improving services and support to victims of certain criminal offences (hereinafter described as 'victims'), from prison to hospital for psychiatric treatment, as well as offenders subject to hospital orders with restriction orders. This note provides information about the procedures for information-sharing, and forwarding victims' representations about discharge conditions.

2. The extended duty is **not** retrospective, and **applies only to victims where the Crown Court sentences the offender to one of the following disposals, if it occurred, on or after 1 July 2005 [See PART B below for the position regarding disposals prior to 1 July 2005]:**

- Those convicted of a sexual or violent offence, who are then made subject of a **hospital order with a restriction order**.
- Those found **unfit to plead and to have committed the act, and been charged**, or **not guilty by reason of insanity**, under the Criminal Procedure (Insanity) Act 1964 as amended by the DVCV Act 2004 in respect of a sexual or violent offence, and then made subject to a **hospital order with restrictions**.
- Those convicted of a sexual or violent offence, who are then made subject of a **hospital direction and limitation direction**.
- Those sentenced to 12 months imprisonment or more, for a sexual or violent offence, and transferred from prison to hospital, under a **transfer direction and restriction direction**.

3. The Home Office Mental Health Unit (MHU) carries out the Home Secretary's responsibilities under the Mental Health Act 1983, and related legislation. They direct the admission to hospital of patients transferred from prison, and consider recommendations from Responsible Medical Officers (RMOs) in hospitals for leave, transfer or discharge of restricted patients. MHU also prepare documentation for Mental Health Review Tribunals (MHRTs), and monitor patients who are conditionally discharged. Each restricted patient has a caseworker at MHU.

4. For each new case, including transferred prisoners, the Victim Liaison Officer (VLO) will contact the MHU caseworker. MHU will inform the VLO of the contact details for the care team or Responsible Medical Officer (RMO) in each case, where this is known.

Mental Health Review Tribunals

5. A detained restricted patient may apply to have his/her case heard by a MHRT once each year. If the patient does not apply, their case will be referred to a Tribunal by the Home Secretary every three years. In addition, after a conditionally discharged patient has been recalled, the Home Secretary must refer the case to a Tribunal within one month of recall. The Tribunal will consider whether the individual needs to be detained in hospital for the purposes of mental health treatment.

6. When the Home Secretary refers a patient to the Tribunal, MHU will forward the details of the relevant VLO to the **MHRT Office**. When an application is made to the Tribunal, the Tribunal office will obtain the details of the relevant VLO from MHU. In both circumstances, the MHRT Secretariat will then inform the VLO of the Tribunal date once it has been set, as well as the date the victim's representations must be received to be considered at the hearing.

7. VLOs should consult victims about their representations relating to discharge conditions and forward them to the Tribunal Office by the specified date.

Disclosure of Victim's Representations to the Offender

8. Victims should be made aware that no guarantees can be given that any representations they make will not be disclosed to the patient.

9. **The expectation is that all documents are disclosed to the patient** and the circumstances in which documents can be withheld are very limited. Rule 12 of the Mental Health Review Tribunal Rules 1983 allows for the Tribunal to withhold any document from the patient if they consider that disclosure would adversely affect the health or welfare of the patient or others. In such a case the Tribunal **must disclose the document to the patient's authorised representative (if the patient has one)**. This is done on the basis that the representative must not disclose the contents of the document to the patient, either directly or indirectly.

10. It is a decision for the Tribunal whether or not any document should be withheld under Rule 12. Where the victim wishes for this to be considered this should be clearly indicated on the victim's representations. The Tribunal will consider whether or not to disclose the document to the patient. This may be done at the hearing or by the Regional Chairman at a preliminary hearing, under Rule 5. A victim may request to attend in person to argue that a document be withheld, but whether or not this is allowed will be a matter for the discretion of the Tribunal.

11. Any application by a victim to attend the tribunal hearing and give oral evidence must be considered under the existing MHRT Rules **[see PART B, para. 16, below)**. The DVCV Act confers no new rights or obligations in respect of either attendance at MHRTs, or oral evidence heard by MHRTs.

Decision of the Tribunal

12. The Tribunal Secretariat will inform the VLO of the outcome of the hearing, in writing, within seven days. Where a Tribunal decides to direct the conditional discharge of a patient it may defer the discharge until it is satisfied that adequate arrangements have been made for the discharge to take place. It may impose any conditions on discharge for the protection of the public or the patient him/herself, such as residence at a stated address and supervision by a social worker (social supervisor) as well as cooperation with psychiatric treatment. Conditions relevant to victims would

relate to ‘no contact’ conditions or exclusion zones.

13. **Transferred prisoners** are eligible to be considered by a Tribunal, but they cannot be discharged in this way. However, the Tribunal may make recommendations on how they would have acted had the offender not been a transferred prisoner. Therefore, VLOs may forward the victim’s representations about conditions of discharge in these cases, as the Tribunal’s deliberations will be forwarded to the Parole Board where appropriate.

Part B: Cases Not Covered by the Domestic Violence, Crime and Victims Act 2004.

Background

14. As outlined at Part A above, *The Domestic Violence, Crime and Victims Act 2004 (‘DVCV 2004’)* came into force on 1 July 2005, **but it does not apply to victims of incidents that occurred prior to that date, as the Act is not retrospective**.

15. The MHRT has given careful consideration to the position of victims who have been subject to sexual or violent offences committed by persons who were subsequently detained under the provisions of the Mental Health Act 1983, where such assaults occurred prior to the introduction of the DVCV 2004. The MHRT has determined that where in such circumstances a victim wishes to have access to any future tribunal proceedings concerning that patient, they shall normally be permitted such access on the following terms:

- The victim must give notice to the MHRT of their wish to be informed of any future Tribunal hearing arising in connection with the named patient.
- Such notice must be in writing, and addressed to **Mr Jack Fargher, MHRT Head of Administration, 11 Belgrave Road, 5th Floor, London SW1V 1RS**. The MHRT will log and acknowledge in writing all such applications.
- The victim will subsequently be informed of the date, time and place fixed for any hearing concerning that patient in advance of the hearing.
- The victim shall have the right a) to apply to the tribunal to attend the hearing in order to give evidence to the hearing, and b) to submit to the Tribunal any written evidence that he or she wishes the Tribunal to consider.

Application to Attend the Hearing

16. Mental Health Reviews Tribunal Rules 1983, Rule 7 (f), allows the tribunal to give notice of the hearing to any person who in the opinion of the Tribunal, ‘should have an opportunity of being heard’. In the interests of equity, justice and a fair hearing and in line with the developing jurisprudence of Articles 6 and 8 of the European Convention of Human Rights, the Regional Chairmen of the MHRT have determined that there should be a presumption in favour of granting the right to the victim to give evidence at the hearing in question. This presumption could in limited circumstances still be rebutted, if evidence is provided by the patient, the Home Office or the responsible authority justifying such a rebuttal, and the Tribunal agrees.

17. Mental Health Reviews Tribunal Rules 1983, Rule 5, empowers the Regional Chairman to exercise the above power on behalf of the tribunal at any time up to the hearing.

18. The manner and format in which the applicant's oral evidence is presented to the Tribunal e.g. whether it is in the presence or absence of the other parties to the hearing, will be determined in each instance by the tribunal or the Regional Chairman, in advance of the hearing. In particular, it should be noted that Mental Health Reviews Tribunal Rules 1983, Rule 14 (2) states that 'the Tribunal may receive in evidence any document or information, notwithstanding that such document or information would be inadmissible in a court of law'.

19. If the applicant submits any written evidence to the hearing either in place of, or in addition to attending the hearing, Mental Health Reviews Tribunal Rules 1983, Rule 12, applies. This Rule requires the Tribunal to copy such written evidence to the patient, unless they are satisfied that its disclosure would 'adversely affect the health or welfare of the patient or others. The word 'others' can include the applicant. If the tribunal does decide not to disclose the written evidence to the patient it would still be forwarded to the patient's legal representative, but they would not be permitted to show the written evidence to the patient [see **PART A: paras. 8–10**).

Professor Jeremy Cooper, Southern Regional Chairman

Jack Fargher, Head MHRT Administration

HHJ Phillip Sycamore, MHRT Liaison Judge

Mr John Wright, Northern Regional Chairman.

July 29th 2005.

APPENDIX B

Duties to Victims Under the Domestic Violence, Crime and Victims Act 2004: Guidance for Clinicians

1. This note sets out guidance on new legal provisions which give the victims of mentally disordered offenders the right to certain information about discharge and conditions of discharge. The provisions are in the Domestic Violence, Crime and Victims Act 2004 ("the DVCV Act") and will come into force on 1 July 2005. They relate to the victim(s) of an offender who receives a restricted hospital order or a hospital and limitation direction, or who is transferred to hospital from prison under a transfer and restriction direction. The provisions do not place any statutory duty on clinicians to disclose information to victims, but this note gives guidance on relations with those authorities who are required to disclose information.

2. Details of the new provisions are set out at paragraphs 3 to 7 below; guidance for clinicians is set out at paragraphs 8 to 16 below.

Detail of new victim provisions

3. The new provisions:

- apply where a person is convicted of a sexual or violent offence (as defined in the DVCV Act – see paragraph 6 below) and receives a restricted hospital order (including an order made under criminal insanity legislation) or a hospital and limitation direction. They also apply following the transfer to hospital of a sentenced prisoner where a transfer and restriction direction are made;
- confer the same rights on victims of such offenders as are available to victims of crimes whose perpetrator receives a prison sentence.

4. The provisions are not retrospective; they apply only to cases where an order or direction is made on or after 1 July 2005.

5. Under the DVCV Act, local probation boards are required to identify whether a victim, or someone else acting for the victim, wishes to:

- make representations about whether a patient should be subject to any conditions if discharged from hospital, and if so, what conditions should be imposed;
- receive information about any conditions to which the patient is to be subject in the event of his discharge.

The probation board must then provide such information to the victim; in practice, this will be done through the Victim Liaison Officer (VLO).

6. The definition of "victim" is taken to include any person in relation to an offence who appears to the local probation board to be, or to act for, the victim of the index offence. This includes a victim's family in a case where the offence has resulted in the victim's death or incapacity, and in other cases where the victim's age or personal circumstances makes it sensible to approach a family member in the first place.

Statutory requirements

7. The Act places a duty on certain authorities to provide information as follows:

- **Probation board:** must inform the victim whether the patient is to be subject to any conditions if discharged; provide details of conditions relating to contact with the victim or his/her family; notify the victim of the date when a restriction order ceases to have effect; and provide such information to the victim as the board considers appropriate in all the circumstances of the case.
- **Home Secretary:** where discharge is considered by the Home Secretary, he must inform the probation board whether the patient is to be discharged; if so, whether it is a conditional or absolute discharge; and if a conditional discharge, what the conditions are. The Home Secretary must inform the probation board if he varies the discharge conditions or recalls the patient to hospital; and if he lifts the restriction order, the date of this.
- **Mental Health Review Tribunal (MHRT):** where an application is made to the MHRT by the patient or referred by the Home Secretary, the MHRT must inform the probation board whether the patient is to be discharged; if so, whether it is a conditional or absolute discharge; if a conditional discharge, what the conditions are; of any variation of conditions by the MHRT; and if the MHRT lifts the restriction order, the date of this.

Implications for clinicians

8. The DVCV Act does not place any statutory requirements on clinicians to disclose information. The information whose disclosure is required under the DVCV Act relates to discharge and conditions of discharge. Under the Act, the probation board may also provide "such other information to the victim as the board considers appropriate in all the circumstances of the case"; this is intended to allow the probation board the discretion to give information which will reassure victims. It is not intended to lead to the disclosure of any information which is covered by patient confidentiality.

MHRT applications

9. Clinicians are not required to notify the VLO when a patient applies or is referred to the MHRT; this will be done by the MHRT secretariat or the Home Office. Where transferred prisoners are remitted to prison, the Home Office will notify the VLO.

Contact with VLO

10. There should be liaison between care teams and the VLO in each case where a victim decides that they wish to make representations or receive information under the Act.

11. Where the court makes an order or direction, the VLO will check whether the victim wishes to make representations or receive information. Where they do, the VLO will make contact with the responsible medical officer (RMO) for the patient concerned. Where a prisoner is transferred to hospital with a restriction direction, the Home Office will notify the relevant offender manager; the VLO concerned will then contact the RMO.

12. It is for the clinical team and the VLO to decide the level of contact between them eg whether or not the VLO should attend any meetings with the team about the case. It may be helpful for the team to know the views of victim of the offence.

Non-statutory good practice

13. The requirements of the DVCV Act relate to discharge and conditions of discharge. The following guidance, on areas not covered by the DVCV Act, may be helpful regarding the disclosure of information to the VLO.

Transfer between hospitals

14. The Home Office will notify the VLO where a patient is transferred to a different hospital. The VLO will then make contact with the new RMO. VLOs may inform victims of the fact of transfer, on the understanding that they should not inform them of the name or location of the hospital.

Absconds

15. Where the Home Office is notified that a patient has absconded, the Home Office may notify the VLO, depending on whether there is any perceived risk to the victim.

Leave

16. The DVCV Act does not change existing Home Office practice with regard to considering leave requests. When considering an application for community leave, the Home Office always takes into account any victim considerations. The Home Office may seek information from the VLO when considering an application, but it is not anticipated that this will happen in all cases or that the Home Office will always notify the VLO where leave is granted (although the VLO may be aware of this through contact with the clinical team). If the VLO is notified that a patient has been granted leave, it will be on the understanding that details of the timing and purpose of the leave should not be disclosed to the victim.

Enquiries

17. Enquiries about this note should be addressed to:

Chris Kemp
Mental Health Unit
Home Office
2nd Floor, Fry Building
2 Marsham Street
London SW1P 4DF
Tel: 020 7035 1475
Mental Health Unit, Home Office

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