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Notes for contributors

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Foreword

The Foreword to the November 2005 issue of the JMHL voiced 'uncertainty' about the future of the *Draft Mental Health Bill 2004*[1] . A presumption was made that "the position will be clearer by the time of publication of the May 2006 issue". Well, the future of the 2004 Draft Bill has of course now been resolved - as all readers will know, it has followed the 2002 Draft Bill[2] into the shredder.

Instead the 1983 Act is to be amended, as recommended by (amongst others) David Brindle, public services editor of the Guardian, way back in March 2005[3] . So there is fresh 'uncertainty' to concern us - on this occasion, uncertainty about the detail of the proposed amendments. The debate over the direction of mental health law reform which was started with the appointment of the Expert Committee in October 1998[4] , and in which so many people and organisations have participated over the last eight years, is not yet concluded. The Department of Health have helpfully issued 'Briefing Sheets'[5] which give a flavour of the Government's intentions and hopes, but as relevant ministers and civil servants will know all too well, it will not be a smooth ride from briefing sheet to legislation. Following publication of the briefing sheets, we made attempts to commission a speedy response from various leading participants in the debate, but they were soon abandoned. All agreed that JMHL readers would prefer commentaries and reflections on the detail of the amendments rather than on what is presently in the public arena. On the presumption (yet another) that the proposed amendments will be published by the time the next issue is being prepared, we give an assurance that they will be considered then.

So far as this issue is concerned, we have decided to publish both articles which clearly sit within the term 'mental health law', and others which might be viewed as more on the fringes, but presumed to be on matters of interest to the majority, if not all, the JMHL readership.

We start off with two articles by Austen Garwood-Gowers, or, to be more honest, one article in two parts. Craftily (admittedly on our suggestion and with our encouragement) negotiating his way around our editorial policy of '5000 words maximum' per article, Dr. Garwood-Gowers in **'Vindicating the right to bodily security of the incapable in research (Parts I and 2)'** casts a knowledgeable, thoughtful, and critical eye over domestic and international provisions regulating research targeted at incapable persons. The trigger for this reflection is of course sections 30 – 34

1 *Cm 6305-1 (September 2004)*

2 *Cm 5538-1 (June 2002)*

3 *As noted in the Foreword to the November 2005 issue. See Society Guardian 30/3/05*

4 *The Report of the Expert Committee 'Review of the Mental Health Act 1983' was published by the Department of Health in November 1999.*

5 *Mental Health Bill Briefing Sheets A1 to A8 (April to June 2006) Gateway reference 6420; Bournewood Briefing Sheet (June 2006) Gateway reference 6794.*

Mental Capacity Act 2005, all bracketed within the statute under the heading 'Research'. Dr. Garwood-Gowers does not hesitate to make clear his overriding concerns, concluding his second article as follows:

> *"… it is important to note that research has long been a rich field for opportunists to pick on the vulnerable like vultures at a carcass. It is certainly no coincidence that most research abuses have been targeted against those typically less well equipped to resist them such as the incapable, poor and illiterate people (particularly in developing countries) and (above all) the animal kingdom."*

Claire Bentley, a solicitor, is a member of the Victims' Advisory Panel[6] . As such she is especially well-qualified to consider how the needs of victims of mentally disordered offenders are being addressed by healthcare teams treating such offenders, and by the Mental Health Review Tribunal (MHRT). In ' **"A socially excluded group"? – Hearing the voice of victims'**, Ms. Bentley, writing in her personal capacity, concentrates on two key objectives in providing more effective support and help for victims as set out in the Government publication, *'Rebuilding Lives – supporting victims of crime'*[7] , namely the provision of information to victims and the giving of a voice to victims. As Ms. Bentley makes abundantly clear, those professionals who work with offenders suffering from mental ill health, and MHRT panels when meeting with such patients, need ("as a matter of some urgency") to become aware of both legislative provisions and official guidance in respect of victims. To assist readers, we have attached to the article two appendices - MHRT guidance (July 2005) and Home Office guidance to clinicians (September 2005).

In **'Provocation: the fall (and rise) of objectivity'**, Kevin Kerrigan reviews "the recent turbulent history of the partial defence of provocation". As is clear from the article, in recent years the judiciary have not been speaking with one voice in conveying their views as to whether the "reasonable man referred to in the statute [*Homicide Act 1957*,(section 3)] should be an 'objective' reasonable man or whether he should have some of the 'subjective' characteristics of the accused". The answer to this question is clearly of the utmost importance for the defendant with mental health problems who seeks to rely on provocation as a defence to a charge of murder. As many readers will know, the Law Commission have entered the fray, and Mr. Kerrigan helpfully brings readers' attention to their two reports *'Report on Partial Defences to Murder'* (2004)[8] and *'A New Homicide Act for England and Wales?'* (2005)[9] . It seems improbable that academics amongst the readership will recognise either Mr. Kerrigan's 'Impatient professor' or, sadly, his 'Keen first year law student' – the article takes the form of an exchange between the two.

In our issue of December 2002, Edward Myers analysed the Court of Appeal decision in *Sutherland v Hatton*[10] in an article entitled *'Claiming Damages for Work Place Stress'*. In this issue, Kay Wheat re-visits the topical subject of **'Mental Health in the Workplace'**. In this, the first of two articles, Miss Wheat comprehensively considers ' **'Stress' claims and workplace standards and the European Framework Directive on Health and Safety at Work'.** Her second article, in the next issue, will consider the treatment of mental health of workers against the backdrop of the *Disability Discrimination Act 1995*.

6 *Established in accordance with section 55 Domestic Violence, Crime and Victims Act 2004.*

7 *Cm 6705 (December 2005)*

8 *Law Com. No 290 (2004) (Cm 6301)*

9 *Law Com Consultation Paper no 177 (2005)*

10 *[2002] WL 45314*

The Foreword to the November 2005 issue contained an expression of hope that this issue would contain detailed considerations of two highly significant judicial decisions pronounced by the House of Lords in the latter part of 2005. There simply was not time for the preparation of articles on these cases for that issue. The two cases were of course *R (on the application of MH) v Secretary of State for Health (and others)*[11] and *R v Ashworth Hospital Authority (now Mersey Care National Health Service Trust) ex parte Munjaz*[12] . We have duly made amends in this issue. In **'Executive Action and Convention Compliance? A Risk Unrecognised by the House'**, Kris Gledhill provides a critical analysis of the House of Lords decision in the former case, and (with one eye on Tolkien) in **'One Code to rule them all, one code to bind them: the seclusion of detained patients'** Simon Foster painstakingly conveys and comments on their Lordships' judgments in the latter. This issue contains a third case review. Paul Hope in **'Paternalism or Power? – Compulsory treatment under section 58 of the *Mental Health Act 1983*'** examines "the latest[13] in a series of challenges brought under the *Human Rights Act 1998* against compulsory treatment under Part IV of the *Mental Health Act 1983*", namely the Court of Appeal case, *R (on the application of B) v S and others*[14] .

We end with a couple of book reviews. Mat Kinton would appear to have read every page of the weighty tome which is **'Seminal issues in Mental Health Law'**[15] , "a collection of thirty-five essays, chapters and extracts on civil mental health law from various authors, drawn from a range of sources between 1973 and 2005", edited by Professor Jill Peay. David Hewitt provides a shorter and more light-hearted review of Kris Gledhill's **'Mental Health Tribunals – Essential Cases'**[16] , a seemingly invaluable loose-leaf resource for all those whose work or study requires a detailed knowledge of the MHRT. Both reviewers describe their respective books as "excellent".

Very regrettably, publication of this issue (as with the issue of November 2005) has been delayed. For this we sincerely apologise to the contributors, and of course to all subscribers. We give an assurance that plans are in hand to tackle the root causes. In the meantime we thank all those who have so generously contributed to this issue of the JMHL.

John Horne

Editor

11 *[2005] UKHL 60*

12 *[2005] UKHL58*

13 *Since acceptance of the review, there has been a further Court of Appeal decision in this area, R (on the application of JB) v Haddock and others [2006] EWCA Civ 961, to which Mr. Hope has helpfully made reference towards the end of his article.*

14 *[2006] EWCA Civ 28*

15 *Ashgate (2005)*

16 *Southside Legal Publishing Limited (2005)*

Vindicating the right to bodily security of the incapable in research – Part 1

Austen Garwood-Gowers[1]

Introduction

The concept of a right to bodily security centres partly on freedom from being forced to do things with one's body and freedom from intrusion on it. Restriction of this right can be consistent with respecting individuals but seemingly only where its exercise would clash with their own interests or the rights of others. In spite of this, restriction founded on meeting the mere needs of others has been a persistent feature of discourse, law and practice in a number of fields, not least research where it is often targeted at incapable persons.

Legal recognition of the right to bodily security vis-à-vis the needs of others

Civil law jurisdictions impose a legal duty to rescue in the common accident or emergency situation.[2] Such duties will certainly mandate (limited) bodily action but are unlikely to be strong enough to warrant actual bodily intrusion. The common law is opposed to both these forms of restriction of bodily security. The seminal case is *McFall v Shimp* No. 78-17711. 10 Pa D & C (3d) 90 (Pa 1978). Here the Allegheny county court was faced with an application from Robert McFall, an aplastic anaemia sufferer, to force his cousin, David Shimp, to continue testing to see if he was a bone marrow match and, if suitable, donate bone marrow. In rejecting the application his honour, Mr Justice Flaherty, observed that

> *"(t)he common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue."*[3]

1 *Senior Lecturer in Law, Nottingham Law School, Nottingham Trent University. Many thanks to Tom Lewis, also Senior Lecturer in Law at Nottingham Law School, for helpful discussion and thoughtful comments on the text.*

2 *Feldbrugge, 'Good and bad samaritans: A comparative survey of criminal law provisions concerning failure to rescue' (1966) 14 Am. J. Comp. L. 630, 655–6.*

3 *No. 78-17711 at 2.*

He went on to assert that:

> *"...For our law to compel the defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn...For a society, which respects the rights of* one *individual, to sink its teeth into the jugular vein or neck of one of its members and suck its sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence..."*[4]

Generally speaking, relevant international instruments concord with the common law position by emphasising the dignity, security and primacy of the individual. This is true, for example, of the *Universal Declaration of Human Rights* (1948), *European Convention on Human Rights* (1950), the World Medical Association's *Declaration of Geneva* (1948) *Physicians Oath* and its *International Code of Medical Ethics* (1949). The World Medical Association's *Declaration of Helsinki* (1964)[5] and the Council of Europe's *Convention on Human Rights and Biomedicine* (CHRB, 1997)[6] equally have this emphasis, but also contradictorily reflect the opposing ethos in their provisions concerning research on the incapable.

The *Declaration of Helsinki* and the CHRB.

The *Declaration of Helsinki* built on the principles for ethical conduct of medical experiments on humans that were laid down following the judgments at the Nuremburg Trials for Nazi war criminals, some of whom were doctors who had performed a range of horrific acts on humans in the name of medical experimentation.[7] Principles 24 and 26 of the Declaration are central to the standard of protection of the incapable in research. Principle 24 states that:

> *"For a research subject who is legally incompetent, physically or mentally incapable of giving consent or is a legally incompetent minor, the investigator must obtain informed consent from the legally authorized representative in accordance with applicable law. These groups should not be included in research unless the research is necessary to promote the health of the population represented and this research cannot instead be performed on legally competent persons."*

Principle 26 adds that:

> *"Research on individuals from whom it is not possible to obtain consent, including proxy or advance consent, should be done only if the physical/mental condition that prevents obtaining informed consent is a necessary characteristic of the research population. The specific reasons for involving research subjects with a condition that renders them unable to give informed consent should be stated in the experimental protocol for consideration and approval of the review committee. The protocol should state that consent to remain in the research should be obtained as soon as possible from the individual or a legally authorized surrogate."*

Whilst both principles are couched in restrictive terms, their effect is to allow some research that

4 *Ibid. See also Butler-Sloss LJ in St George's Healthcare NHS Trust v S [1999] Fam 26, 48.*

5 *Adopted by the 18th World Medical Association (WMA) General Assembly, Helsinki, Finland, June 1964, and amended most recently by 52nd WMA General Assembly, Edinburgh, Scotland, October 2000.*

6 *See further Zilgalvis, P, 'The European Convention on Human Rights and Biomedicine: Its Past, Present and Future' Chapter 3 in Garwood-Gowers, A, Lewis, T, Tingle, J (eds.), Healthcare Law: The Impact of the Human Rights Act 1998, Cavendish, 2001.*

7 *See Katz, J, Experimentation with Human Beings, 1972, Bognor Regis: Russell Sage Foundation, 305–6 particularly.*

is incompatible with the interests of the incapable person. Admittedly, principle 24 talks about the need for the research to be necessary to promote health but this is a reference to the health of the population. This means, for example, that research could be performed on an incapable sufferer of Alzheimer's disease where it was necessary to promote the health of Alzheimer's sufferers taken as a whole even if it did not benefit the individual sufferer, let alone have benefits that were sufficient to justify it as the optimal choice in terms of his or her interests.

The substantive requirement in the first sentence of Principle 26 may indirectly temper this problem but it does not solve it. However, there are at least two sound reasons why the deviation from best interests envisaged in these principles should not be given effect to. Firstly the Declaration specifically protects the primacy of the individual – Principle 5 stating that '(i)n medical research on human subjects, considerations related to the well-being of the human subject should take precedence over the interests of science and society'. Secondly, Principle 8 of the Declaration endorses an agenda of special, not lesser, treatment of vulnerable classes such as the incapable, stating that:

> *"Medical research is subject to ethical standards that promote respect for all human beings and protect their health and rights. Some research populations are vulnerable and need special protection. The particular needs of the economically and medically disadvantaged must be recognized. Special attention is also required for those who cannot give or refuse consent for themselves, for those who may be subject to giving consent under duress, for those who will not benefit personally from the research and for those for whom the research is combined with care."*

The *CHRB* falls into the same trap of having provisions concerning research on the incapable that deviate from full protection. Article 17 states that:

"1. Research on a person without the capacity to consent as stipulated in Article 5 may be undertaken only if all the following conditions are met:

   i. the conditions laid down in Article 16, sub-paragraphs i to iv, are fulfilled;[8]

   ii. the results of the research have the potential to produce real and direct benefit;

   iii. research of comparable effectiveness cannot be carried out on individuals capable of giving consent;

   iv. the necessary authorisation provided for under Article 6 has been given specifically and in writing; and

   v. the person concerned does not object.

2. Exceptionally and under protective conditions prescribed by law, where the research has not the potential to produce results of direct benefit to the health of the person concerned, such research may be authorised subject to the conditions laid down in paragraph 1, sub-paragraphs i, iii, iv and v above, and to the following additional conditions:

8 *These conditions relate to there being no alternative of comparable effectiveness to research on humans, the risks incurred by the subject not being disproportionate to the potential benefits of the research, prior approval by the competent body after independent examination of its scientific merit (including assessment of the importance of the aim of the research, and multidisciplinary review of its ethical acceptability) and the subjects being informed of their rights and the safeguards prescribed by law for their protection.*

i. the research has the aim of contributing, through significant improvement in the scientific understanding of the individual's condition, disease or disorder, to the ultimate attainment of results capable of conferring benefit to the person concerned or to other persons in the same age category or afflicted with the same disease or disorder or having the same condition;

ii. the research entails only minimal risk and minimal burden for the individual concerned."

Article 17(2)(i) is the key provision here because it makes it clear that the research does not have to be aimed at (or presumably have the prospect of resulting in) benefit to its subjects if it has a benefit to other persons in the same age category or afflicted with the same disease or disorder or having the same condition. In other words there are circumstances in which the incapable can be subject to research that is not in their interests, even some that will not convey any benefit on them whatsoever. This is hard to reconcile with Article 2 which states that in interventions on humans in the fields of medicine and biology,

> *"(t)he interests and welfare of the human being shall prevail over the sole interest of society or science."*

What is more, the fact that Article 17 targets the incapable for lesser treatments makes it hard to reconcile with Article 1 which requires signatories to,

> *"guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine."*

How should these internal inconsistencies be dealt with? Article 17, as a specific issue provision, could be read down in the light of Articles 1 and 2 which convey overarching norms. After all, as Zilgalvis notes, the aim of the Convention is 'to protect human rights and dignity and all its articles must be interpreted in this light.'[9] However, the presence of Article 26 complicates the issue. It stipulates that:

"1. No restrictions shall be placed on the exercise of the rights and protective provisions contained in this Convention other than such as are prescribed by law and are necessary in a democratic society in the interest of public safety, for the prevention of crime, for the protection of public health or for the protection of the rights and freedoms of others.

2. The restrictions contemplated in the preceding paragraph may not be placed on Articles 11, 13, 14, 16, 17, 19, 20 and 21."

Expressed in the permissive rather than the negative, it is evident that the purpose of this Article is to allow a measure of restriction of certain rights. The question that arises in the immediate context is whether that might include restricting the right to bodily security of the incapable simply to meet a need for research. Dr Elaine Gadd, former Chair of the Council of Europe Steering Committee on Bioethics (1999–2001), has stated Article 2 'means that wherever the interests of society and those of the individual conflict, the interests of the individual should in principle take precedence.'[10] Nonetheless, Article 2 does not appear in the Article 26(2) list and hence it must be read in the light of Article 26. Commenting on the relationship between the two, Dr Gadd has emphasised that,

9 *European Law and Biomedical Research in Biomedical Research, Council of Europe 2004, 168.*

10 *Gadd, E, 'General Provisions of the Convention,' (2001) 12(1) Journal International de Bioethique 21–49 at 26.*

> *"(i)t is important to distinguish the concept of society as a whole, and the fact that society is composed of individuals. Sometimes the interests of different individuals conflict and this conflict will need to be resolved."*[11]

It is implicit in any system recognising individual primacy that where the interests of individuals conflict, they will have to be weighed against one another and an appropriate resolution found in the light of this. Article 26 merely makes that process and the terms on which it is conducted more explicit and precise. However, in considering the scope of both Article 2 and 26 it is imperative to distinguish between rights and mere needs. Neither Article would preclude restricting protection of one person's right to bodily security where full protection of it conflicted with the rights of another person (consider, for example, a forced paternity test). However, there are a number of reasons why Article 26 should not be interpreted as allowing the right to bodily security to be diluted to protect the mere needs of others.

Firstly, such an interpretation would put Article 26 out of alignment with the very essence of the primacy principle protected in Article 2 and, where done selectively with a particular class, the equality principle protected in Article 1. Secondly, in doing so it would be contrary to the norm of pluralism that underpins democracy and thus unlikely to satisfy the Article 26 requirement of being 'necessary in a democratic society.' Thirdly, as will later be demonstrated, it would lead to the *CHRB* being incompatible with the European Convention on Human Rights.

Finally, it would put the CHRB out of kilter with the *Additional Protocol on Human Rights and Biomedicine, concerning Biomedical Research* (Strasbourg 25/1/05). Article 15 of the Additional Protocol, entitled 'Protection of persons not able to consent to research,' elaborates on Article 17 of the Convention and specifically Article 15(2)(i) mirrors the sentiments of Article 17(2)(i). However, this emphasis on allowing the primacy principle to be abandoned in research on persons not able to consent conflicts with the overall tenor of the Additional Protocol. More specifically, the preamble makes it evident that the reasons for agreeing the Additional Protocol included convictions 'that biomedical research that is contrary to human dignity and human rights should never be carried out,' that 'the paramount concern' is 'the protection of the human being participating in research' and 'that particular protection shall be given to human beings who may be vulnerable in the context of research.' Furthermore, Article 3 of the Additional Protocol specifically imports the sentiments of Article 2 of the Convention into the research context by stating that,

> *"(t)he interests and welfare of the human being participating in research shall prevail over the sole interest of society or science."*

In the light of these points, the only credible solution is to read down Article 17(2)(i) to the point of it protecting primacy with respect to research on the incapable.

The movement to reform English law

Domestic debate about when to allow intrusive research on the incapable adult has been biased by two common misconceptions: Firstly, that the CHRB and Declaration of Helsinki permit primacy violating research on the incapable adult (ultimately, as seen above, they should not be read as so doing); and secondly overly limited conceptions of what research interventions can be performed on such adults under the best interests standard.[12]

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11 *Ibid.*

12 *See further, Garwood-Gowers, A, 'The Proper Limits for Medical Intervention that Harms the Therapeutic Interests of Incompetents', chapter 10 in Garwood-Gowers, A, Wheat, K, Tingle, J, Contemporary Issues in Healthcare Law and Ethics, Reed Elsevier, 2005.*

Reform suggestions have particularly centred on the idea of using a "not against interests test" in relation to authorising non-therapeutic research on incapable adults[13] and, to a lesser extent, incapable people as a whole.[14] A variation on this theme is found in The Law Commission's Report *Mental Incapacity*[15] which concluded that research;

> *"which is unlikely to benefit a participant, or whose benefit is likely to be long delayed, should be lawful in relation to a person without capacity to consent if (1) the research is into an incapacitating condition with which the participant is or may be affected and (2) certain statutory procedures are complied with."*[16]

The procedures referred to include approval of the research by a Mental Incapacity Research Committee which, to paraphrase, must, amongst other things, satisfy itself that the research:

(a) is desirable in order to provide knowledge of the causes or treatment of, or of the care of persons affected by, mental disability;

(b) has an object which cannot be effectively achieved without the participation of persons who are or may be without capacity to consent; *and*

(c) will not expose such a person participating in the research to more than negligible risk and that what is done in relation to such a person for the purposes of the research will not be unduly invasive or restrictive and will not unduly interfere with his freedom of action or privacy.[17]

These recommendations were not adopted in the Draft Mental Incapacity Bill 2002.[18] However, the notion that reform in this area was completely dead and buried was dispelled by the House of Lords, House of Commons Joint Committee Report on the Draft Bill.[19] The Committee took the view that the law relating to research on the incompetent adult should be codified. It was 'concerned that if research were to take place in the absence of statute or any regulation the opportunity for abuse would be greater.'[20] This concern was deeply ironic given that its proposal for a statutory approach to research was centred on abandoning best interests protection of the incapable adult. That abandonment was something that the Committee, echoing the Law Commission, tried to justify in terms that related back to incapable adults as a class:

> *"We are reminded that if legal mechanisms prevented or deterred research with such people, then the development of treatments and the undertaking of treatment trials for disorders such as Alzheimer's disease would be very problematic. The range of medical research involving people with incapacity was considerable. Other examples include investigating why people with Down's*

13 *See, particularly, Medical Research Council, The Ethical Conduct of Research on the Mentally Incapacitated, Medical Research Council, 1991 and Gunn, M, et al., 'Medical Research and Incompetent Adults' (2000) Journal of Mental Health Law 60 at 66.*

14 *See, for example, Kennedy, I, Principles of Medical Law, 1998, Oxford, para's 1340–1345.*

15 *Law Commission, Mental Incapacity (Law Com No 231) (London: HMSO, 1995).*

16 *Ibid, para 6.31. The Commission also recommended procedural protections for the individual participant. – see para 6.36.*

17 *Law Com No 231, para 6.34. The Commission also envisaged the best interests test being abandoned in relation to other interventions that conveyed no direct benefit to the incapable adult but could be of significant benefit to others – see para 6.26.*

18 *Presented to Parliament in June 2002 by the Secretary of State for Constitutional Affairs. See clause 4 and clauses 26–29.*

19 *House of Lords, House of Commons Joint Committee on the Draft Mental Incapacity Bill, Session 2002–3 (Vol 1) HL Paper 189–1, HC 1083–1 (HMSO, 28 Nov 2003) para 275–288.*

20 *Ibid para 284.*

> *Syndrome are at such high risk of Alzheimer's disease, how best to treat the effects of acute brain injury, how to understand and manage problems such as self-injurious behaviour affecting people with autism…Research goes beyond the medical field and includes investigating factors influencing the quality of life of people with incapacitating disorders, or how they can be best helped to make decisions for themselves. In all these examples, some of the people will have the capacity to consent to research but others may not."*[21]

The Committee subjected its support for abandoning a best interests approach to a proviso of non-exploitation:

> *"When a person lacks the capacity to give consent, they should only be involved with medical research, if it is either in their best interests or if it is the only method of conducting research into their particular condition and everyone involved with the person is satisfied that this is a non-exploitative proposal which will not harm or distress the individual concerned."*[22]

This view fails to recognise that allowing the incapable to be utilised in interventions that are inconsistent with their interests necessarily constitutes treating them simply as a means to an end and, in this sense, must necessarily also be said to be exploitative and harmful. One could attempt to circumnavigate this problem by pointing out the benefits that might be gained for people who lack capacity as a whole if protection of them was diluted. However, this would be fatally flawed; either an intervention is in the best interests of an incapable individual, taking into account potential future benefit from advances that may be made in the field, or it is not, in which case it remains exploitative irrespective of these benefits.[23]

The report also seemed to uncritically adopt a very restrictive perception of the best interests test in the research context.[24] It particularly emphasised the opinion of the Royal College of Psychiatrists that the 'common law does not provide authority' for medical research on the incompetent 'as it cannot be argued that research is necessarily in that incapacitated person's best interests.'[25] As is evident from cases authorising living organ and tissue donation by incapable adults under a best interests test, including *Re Y (Mental Incapacity: Organ and Tissue Bone Marrow Transplant)* [1997] Fam 110, the best interests test does not in fact require an intervention to be necessarily in a person's best interests but simply that it is prospectively the best option for the incapable out of the choices available.

The Government responded by uncritically adopting the Committee's view, agreeing that the Bill 'should include provision for strictly controlled research to fill the gap that exists in the current law and the uncertainty and inequity this creates.'[26]

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21 *Ibid para 279.*

22 *Ibid para 283.*

23 *These issues are addressed in more detail under the convention rights section of Part 2 of this article.*

24 *House of Lords, House of Commons Joint Committee on the Draft Mental Incapacity Bill, Session 2002–3 (Vol 1) HL Paper 189–1, HC 1083–1 (HMSO, 28 Nov 2003), para 279.*

25 *See further Ev 104 MIB 824b para 3.2.*

26 *The Government Response to The Scrutiny Committee's Report on the draft Mental Incapacity Bill, Feb 2004. Available at http://www.dca.gov.uk/pubs/reports/mental-incapacity.htm*

The Mental Capacity Bill 2004

The Mental Capacity Bill, introduced in the House of Commons on 17 June 2004,[27] had four research clauses (30–33) which imposed three types of requirement on the researcher conducting intrusive[28] research with or in relation to the incompetent adult: Firstly to get the authorisation for the project from the "appropriate body" under Clause 31; secondly, to engage in such consultation of carers as required by Clause 32; and, thirdly, to satisfy certain additional safeguards. Clause 31, entitled 'Requirements for approval,' read as follows:

> "(1) The appropriate body may not approve a research project for the purposes of this Act unless it is satisfied that the following requirements will be met in relation to research carried out as part of the project on, or in relation to, a person who lacks capacity to consent to taking part in the project ("P").
>
> (2) The research must be connected with a condition which –
>
> (a) affects P, and
>
> (b) is attributable to the impairment of, or disturbance in the functioning of, the mind or brain.
>
> (3) There must be reasonable grounds for believing that the research would not be as effective if carried out only on, or only in relation to, persons who have capacity to consent to taking part in the project.
>
> (4) The research must –
>
> (a) have the potential to benefit P without imposing on P a burden that is disproportionate to the potential benefit to P, or
>
> (b) be intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or a similar condition.
>
> (5) If the research falls within paragraph (b) of subsection (4) but not within paragraph (a), there must be reasonable grounds for believing –
>
> (a) that the risk to P from taking part in the project is likely to be negligible, and
>
> (b) that anything done to, or in relation to, P will not –
>
> (i) interfere with P's freedom of action or privacy in a significant way, or
>
> (ii) be unduly invasive or restrictive.
>
> (6) There must be reasonable arrangements in place for ensuring that the requirements of sections 32 and 33 will be met."

Interestingly, Clause 31(4) was constructed so loosely as to allow, subject to certain conditions, the "appropriate body" to authorise projects merely when the burden to the incapable adult was not disproportionate to the benefit (Clause 31(4)(a)) and even when there was *no benefit* to them whatsoever (Clause 31(4)(b), subject to further provisos in Clause 31(5)). Whilst Clause 31(6)

27 *The change in emphasis from incapacity to capacity reflected a desire to stress the enabling ethos within the Bill's provisions.*

28 *Intrusive research under the Act means research that has sufficient implications for bodily security to mean that it would fall foul of relevant legal standards if performed on a competent person without consent – see further section 30(2).*

directed the appropriate body to make sure that appropriate arrangements were in place for meeting the requirements in Clause 32 or 33, neither of these clauses in this version of the Bill mandated a best interests approach to the authorising of research projects involving the incapable adult. The Joint Committee on Human Rights (JCHR) missed this key flaw.[29] This was probably because it used the research provisions of the CHRB as its main standards comparator.

Parliamentary Discussion

At the Bill's Third Reading in the Commons on 14 December 2004, Mr Kevin Barron, Labour MP for Rother Valley, tabled a new clause 3 which was designed to expand application of the philosophy of diluting protection of the incapable out from intrusive research to medical and surgical interventions more generally. It stated that:

> *"The Secretary of State may by order applying either generally or in cases of a specified description authorise the carrying out of any medical or surgical procedure in relation to a person without capacity to consent which, although not carried out for his benefit, will in the opinion of the Secretary of State not cause him significant harm and be of significant benefit to others."*

Sir John Butterfill, Conservative MP for Bournemouth West was one of several Parliamentarians to express concern about the breadth of this proposed reform. He recounted how his mother had been told at an NHS hospital that an operation could be performed on her for her benefit when in fact she was terminally ill with pancreatic cancer and the purpose of the operation was one of medical education.[30] Meanwhile, Mr Dominic Grieve, Conservative MP for Beaconsfield, attacked clauses 31(4) and 5:

> *"The fact that the research may be for the benefit of a wider section of society is arguably irrelevant. After all, if I am a person of full capacity and a doctor asks me whether I would be prepared to consent to tests, albeit not massively intrusive tests, which are not for my direct benefit but might benefit thousands of other people, as the law in this country currently stands – thank goodness – it is my right to say no. The idea that, if I were incapacitated, someone could make the decision for me is troubling."*[31]

With his Hon. Friend Mr Boswell, the Member for Daventry, Mr Grieve tabled an amendment adding a part (c) to Clause 31(4) requiring the research to be in the best interests of the incompetent person.[32] Not surprisingly, the Government, represented by Ms Rosie Winterton, the Minister of State for the Department of Health, sought to persuade both sides that the Bill did not need changing in either direction by stating that the proposed new clause 3 was:

> *"...unnecessary, because the Bill will allow for acts whose primary purpose is to benefit a third party, provided that those acts are in P's best interests. I reassure the House that the interpretation of best interests could be broader than P's medical best interests. I can confirm that the Bill will not prevent a genetic test for a familial cancer, for example, that might not be essential to P's medical care but would provide considerable benefit to some other family member."*[33]

However, she went on to fudge the issue of whether the research clauses as they stood were

29 *Joint Committee on Human Rights – Twenty-Third Report (Session 2003–4) paras 2.53–2.66.*

30 *14 Dec 2004 : Column 1594 available at http://www.publications.parliament.uk/pa/cm200405/cmhansrd/cm041214/debtext/41214-25.htm*

31 *Ibid column 1600.*

32 *See ibid.*

33 *Ibid column 1602.*

compatible with a best interests approach.[34] Attempting to pin her down, Mr Grieve proceeded to enquire whether the Government was 'comfortable' with a set of ethical values where 'research carried out on an individual that has no possible benefit to that individual' is 'justified on the ground that it is there for the wider public good.'[35] However, Ms Winterton rather evasively responded that she was;

> *"very comfortable that we are introducing a number of safeguards in the Bill. As the hon. Gentleman has said, research already can be carried out, but now safeguards will be introduced. I am confident that, as far as possible, medical ethics committees will ensure that research benefits individuals at the time. It may not always be possible for some research, particularly when it looks into causes, to be of direct benefit immediately, but it could well be in the future. It might also lead to alleviation of current symptoms."*[36]

Pursuing the matter further, Mr. Boswell noted that:

> *"Clause 1(5) makes a commitment that embraces the whole Bill; that acts done or decisions made should be in the best interests of the person involved. Is the Minister saying that that best-interests principle is suspended in the case of the research clauses? Yes or no?"*

Ms Winterton replied by saying that she was 'not saying that it is suspended' but that she thought that it would inevitably be:

> *"interpreted slightly differently in this part, for the simple reason that it is always extremely difficult to say that research is absolutely in someone's best interests. It is in the nature of research that it is almost impossible to prove that it would be of direct benefit."*[37]

The clause 31(4) issue was to crop up again at Day 3 of the Committee stage in the House of Lords with mixed views being expressed on it.[38] As a variation upon the introduction of a new part (c) to Clause 31(4), Lord Alton and Lady Masham proposed Amendment No 127 which stated that:

> *"The clinician and health-care workers responsible for the care of P shall remain responsible for protecting the life and health of P and shall, at all times, ensure that P's life and health are protected during the course of research.*
>
> *At all times, the life, health and well-being of P shall take precedence over the research being carried out on P and, in the event of any danger to P's life, health or well-being, P must be withdrawn from the project unless his life, health and well-being can be protected by the research being undertaken in a different manner."*[39]

The final version of the Bill, published on March 24 of 2005, may not have precisely adopted this amendment but it did incorporate its emphasis on primacy of the individual in research in a new clause 33(3) which stated that '(t)he interests of the person must be assumed to outweigh those of science and society.'

34 *Ibid column 1603.*

35 *Ibid column 1604.*

36 *Ibid column 1604–1605.*

37 *Ibid.*

38 *1 February 2005. Available at http://www.publications.parliament.uk/pa/ld199900/ldhansrd/pdvn/lds05/text/50201-17.htm*

39 *Ibid Column 162.*

Vindicating the right to bodily security of the incapable in research – Part 2

Austen Garwood-Gowers[1]

Introduction

The Mental Capacity Act 2005 (MCA) generally exhibits a stronger ethos of protecting the incapable in intrusive research than the last but one version of the Bill. However, sections 31(5) and 6 of the Act replicate clauses 31(4) and 31(5) of that version. As I noted in Part 1 of this article, these clauses are difficult to reconcile with the primary principle. Here I examine what effect, if any, they will have both on the process of authorising research projects involving intrusive research upon the incapable adult and on the ultimate use of the incapable adult in such research. This will involve analysis of the Act's provisions in the light of both ordinary rules of statutory interpretation and the interpretative obligation imposed by section 3 of the Human Rights Act 1998 (HRA).

A role for section 31(5) and section 31(6)?

Section 31 contains the conditions that an appropriate body must be satisfied are met if it is to approve a research project involving intrusion on an incapable adult.[2] Section 31(5) states that:

> "The research must–
>
> (a) have the potential to benefit P without imposing on P a burden that is disproportionate to the potential benefit to P, or
>
> (b) be intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or a similar condition."

1 *Senior Lecturer in Law, Nottingham Law School, Nottingham Trent University. I am very grateful to Tom Lewis, also Senior Lecturer in Law at Nottingham Law School, for his thoughtful comments and discussion on this article.*

2 *As Paragraph 10.13 of the Draft Code of Practice sent out for consultation on 9 March 2006 (and available at http://www/dca/gov.uk/consult/codepractise/draftcode0506.pdf) notes, 'The Secretary of State of Health (in respect of England) and the National Assembly for Wales (in respect of Wales) are required to set out in Regulation who is the "appropriate body" to give approval in relation to particular types of research project. It is currently envisaged that "the appropriate body" is likely to be an independent Research Ethics Committee.'*

Section 31(6) states that:

> "If the research falls within paragraph (b) of subsection (5) but not within paragraph (a), there must be reasonable grounds for believing–
>
> (a) that the risk to P from taking part in the project is likely to be negligible, and
>
> (b) that anything done to, or in relation to, P will not–
>
> (i) interfere with P's freedom of action or privacy in a significant way, or
>
> (ii) be unduly invasive or restrictive."

These provisions are couched in the kind of restrictive language that, to the unsuspecting or untrained eye, makes them appear to serve an important role in safeguarding the rights of the incapable adult. However, in fact, it is evident that if one takes these provisions in isolation they have the effect of diluting protection. It is only by treating them as superfluous in the light of other provisions that this effect is avoided. On a literal analysis they clearly are superfluous. Section 33(3) requires the interests of the potential subject of intrusive research to be treated as outweighing those of science and society, and by virtue of section 31(7), the appropriate body is required to have reasonable arrangements in place for ensuring that its requirements (along with those in the rest of sections 32 and 33) are met when the research authorisation process is taking place. To authorise a project involving primacy incompatible intrusion on an incapable adult may also amount to making a decision for the purposes of section 1(5), breaching its stipulation that acts and decisions made on behalf of incapable adults should be best interests compatible.

The other crucial point to make is that on a literal reading the MCA treats project authorisation and actual use of an incapable adult in intrusive research as two distinct legal phases. On such a reading, even if the Courts or an appropriate body were to interpret section 31(5) and 31(6) as allowing research projects involving best interests incompatible intrusion on the incapable adult to be authorised, such an intrusion could not be carried out because it would be inconsistent not only with section 1(5) but also section 30(1) in conjunction with section 33(3). Section 30(1) states that:

> "Intrusive research carried out on, or in relation to, a person who lacks capacity to consent to it is unlawful unless it is carried out–
>
> (a) as part of a research project which is for the time being approved by the appropriate body for the purposes of this Act in accordance with section 31, and
>
> (b) in accordance with sections 32 and 33."

Section 33(3) states that '(t)he interests of the person must be assumed to outweigh those of science and society.'

It is evident that, literally understood, sections 31(5) and 31(6) simply impose limited requirements on the appropriate body that are exceeded by other requirements. The question that remains is whether they can be given some effect on a purposive analysis? Some ministerial statements hint at the idea that the Act was intended to facilitate a trade off of the interests of the incapable adult against the need for research. However, the Minister declined a clear opportunity to exclude the use of the section 1(5) best interests principle in the research context when the Bill was at Third Reading in the Commons[3] What is more the late addition and ultimately enactment of a new

3 *14 Dec 2004.*

clause 33(3) requirement to protect the interest of the incapable adult subject over those of science in intrusive research, is very hard to square with an intent to give section 31(5) and 31(6) substantive effect. This is not to say that the legislation unequivocally supports a primacy approach, rather it is somewhat ambiguous.[4] However, under ordinary rules of statutory interpretation a purposive approach cannot be preferred over a literal one where Parliament's intent behind creating the provisions at issue is ambiguous.[5] What amibuity does facilitate is the application of various legislative presumptions. However, if anything, these further damage the arguments that sections 31(5) and 31(6) should be given substantive effect.

The presumption in favour of maintaining the common law position[6] will clearly favour a best interests approach. So too, it can be suggested, would the presumption in favour of protecting the rights of the citizen.[7] Lord Hoffman explained the scope and rationale of this presumption in *R v Secretary for State for the Home Department, Ex parte Simms* [2000] 2 AC 115, HL:

> *"Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual."*[8]

The right to bodily security is widely accepted to be a fundamental right which extends protection to both the capable and incapable. Its freedom from intrusion aspect is implicated in the protection of several other fundamental rights, including: The right to life; freedom from torture, inhuman and degrading treatment or punishment; freedom from slavery and servitude; the right to liberty and security of person; *and* the right to respect for private and family life. These rights are protected in Europe by, respectively, Articles 2–5 and 8 of the *ECHR*. This brings us to the question of whether the HRA section 3 obligation to interpret law compatibly with 'convention rights' so 'far as it is possible to do so' might be an alternate basis on which to argue that sections 31(5)-(6) of the MCA should be treated as superfluous. Section 3 of the HRA does not allow the Courts to go against the express or implied will of Parliament[9] but it does enable the Courts to reach outcomes compliant with convention rights to a greater extent than was previously possible.[10] In any event in a situation such as this where intention is ambiguous there is no barrier to its use. Thus the only question is whether convention rights compliance does preclude a role for section 31(5)-(6).

4 *The ambiguity is also present in the Act's Draft Code of Practice sent out for consultation.*

5 *See further, D. Greenberg, Craies on Legislation. London: Sweet and Maxwell, 8th edition, 2004, 561*

6 *See e.g. Francis and Francis (a firm) v Central Criminal Court [1988] 3 All ER 775.*

7 *This is done, for example, through the presumptions against taking property with compensation (Central Control Board (Liquor Traffic) v Cannon Brewery Co Ltd [1919] AC 742 HL, p752); retrospective effect of legislation (Waddington v Miah [1974] 1 WLR 683); denial of access to the Courts (Raymond v Honey [1983] 1 AC 1 HL); interference with the liberty of the subject (R v Hallstrom ex p W [1986] QB 1090) except in wartime (R v Halliday [1917] AC 260 HL); and non-compliance with international treaty obligations.*

8 *[2000] 2 AC 115, 131, HL*

9 *See, for example, R v Lambert [2002] 2 AC 545, HL.*

10 *See, for example, Brooke LJ in Goode v Martin [2002] 1 ALL ER 620, 629 CA.*

Convention Rights and Intrusive Research on the Incapable

In most cases authorisation of projects involving primacy incompatible intrusive research is not going to constitute a threat to the life of prospective participants, involve detaining them or rise to the threshold for being deemed slavery or servitude. However, it may generally violate Article 8 in its private life aspect and, at least in many cases, Article 3 in its inhuman and degrading treatment aspect. These rights could be used in isolation or in conjunction with Article 14 where the violation of primacy is class selective.

As far as Article 3 is concerned factors relevant to determining whether conduct reaches the minimum level of severity to be classed as inhuman and degrading for the purposes of Article 3 include: Its nature and context; the manner of its execution; its duration; its physical and mental effects, including any impact on health; and its object – for example, whether or not it is intended to humiliate or debase. A key case is *Herczegfalvy v Austria* (10533/83) (1993) 15 EHRR 432 where the European Court of Human Rights stated that as a general rule it would not be inhuman or degrading to subject incapable patients, if necessary by force, to 'a measure which is a therapeutic necessity.'[11] However, it did so with the proviso that, '(t)he Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.'[12] Whilst the Court would doubtless also allow this test to be waived in relation to an intrusion that was necessary to protect the rights of others, to allow it to be waived in order to better meet the mere needs of others would be to undermine its very basis. Thus the only difficulty in showing that Article 3 is violated by a best interests incompatible intrusion on the incapable in the research context, is in showing that the intrusion reaches the minimum severity threshold.

Questions of minimum threshold are not such a significant issue with Article 8. The private life aspect of Article 8 is engaged by compulsory urine testing according to the Court in *Peters v The Netherlands* (1994) 77A DR 75 and by even minor forms of compulsory medical intervention according to the Commission in *X v Austria* (1980) 18 D.R. 154 at 156. The real issue is whether the intrusion can be justified by Article 8(2). This states that:

> *"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 or crime, for the protection of health or morals or for the protection of the rights and freedoms of others."*

The purpose of the 'in accordance with the law' requirement is to provide the minimum degree of protection against arbitrariness required by the rule of law in a democratic society.[13] To this end measures must firstly have a basis in national law and secondly have the qualities of being accessible and foreseeable in terms of consequences for those affected and compatible with the rule of law.[14] Sections 31(5)-(6) will not change the fact that there is not a clear basis in domestic law on which to subject the incapable adult to best interests incompatible intrusions in the research context.

The 'necessary in a democratic society' requirement within Article 8(2) was interpreted by the

11 *(1993) 15 EHRR 432, para 82*

12 *Ibid.*

13 *Herczegfalvy v Austria (1993) 15 EHRR 432 para 91. See also McLeod v United Kingdom, Case 24755/94, Judgment 23 September 1998 and Hashman and Harrup v United Kingdom, Case 25594/94, Judgment 25 November 1999.*

14 *Ibid at para 88.*

Court in *Olsson v Sweden* (1988) A 130, para 67 as meaning that 'an interference corresponds to a pressing social need and, in particular, that it is proportionate to the legitimate aim pursued.' Restricting the right to bodily security to help meet the needs of others could be said to be connected to the health objective under Article 8(2). However, there are a number of reasons why at the proportionality stage, if not sooner, the Court is likely to find restriction on this basis to fall short of being necessary in a democratic society.

The first of these is that trading off bodily security to meet the perceived needs of others can be construed as counterproductive and intrinsically wrong in the manner described by Mr Justice Flaherty in *McFall*.[15] The second is that existing standards support the absolute position. Drawing on the experience of member states, the Court would find that some continental jurisdictions have a legal duty to rescue in the common accident, danger and emergency situation but that this is limited and is unlikely to justify anything of the order of trespass on the living person. Furthermore it would find the *Declaration of Helsinki* (1964) and, more especially, the *Convention on Human Rights and Biomedicine* (CHRB, 1997)[16] persuasive and, despite their research provisions relating to the incompetent, both of these may be deemed to support absolute protection.

Both of these reasons would bolster the Article 3 argument. Furthermore claims under both Article 3 and 8 might be bolstered by reference to Article 14. Article 14 states that:

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

It is breached where, without objective and reasonable justification persons in relevantly similar situations are treated differently or persons in relevantly dissimilar situations are treated in the same way. It is evident in this sense that Article 14 is concerned with the principle of equality. John Harris has argued in one article that moving away from best interests protection of the incapable adult is necessary to achieve equality.[17] However, having defined equality as the principle 'that each person is entitled to the same concern, *respect* and protection of society as is accorded to any other person in the community' (ital. added)'[18] he proceeds in a subsequent article to suggest that respect entails, 'not just respect for the choices of those competent to make them but also respect for the best interests or welfare of those who are not.'[19] To allow capable people to agree to some research that others may consider not to be in their interests whilst protecting the incapable from the same does not amount to discrimination. It simply affords the capable a choice that respect for their

15 *See reference to this case in the second paragraph of Part I of this Article. For further discussion of the arguments here see Garwood-Gowers, A, 'The Right to Bodily Security Vis-à-Vis the Needs of Others,' Ch 27 in Weisstub, D.N., Pintos, G.D. (eds.), Autonomy and Human Rights in Healthcare, 2006 (forthcoming) Kluwer Academic Publishing.*

16 *See, for example, Glass v UK [2004] 1 FLR 1019 where the Court used the professional standards Articles of the CHRB in order to help it reach the conclusion that a hospital's failure to involve the courts in a dispute about the care of a minor and to proceed with administering diamorphine with the consent of the child's legal representatives (the parents in this case) breached the child's Art 8 right to private life and could not be justified under Art 8(2) because it did not fulfil the necessity requirement. The CHRB is partly designed to elaborate the standards that should underpin assessment of ECHR rights in the context of biology and medicine. See Part I of this Article for further consideration of both the Declaration of Helsinki and the CHRB*

17 *Harris, J, 'The Ethics of Clinical Research with Cognitively Impaired Subjects' (1997) 5 Ital J Neurol Sci Suppl 9–13. See also Harris, J, 'Scientific Research as a Moral Duty' (2005) 31 JME 242-8*

18 *Ibid at 12.*

19 *Harris, J, 'Law and Regulation of Retained Organs: The Ethical Issues' (2002) 22(4) Legal Studies 527 at 529.*

autonomy warrants and denies the incapable that choice out of respect for the fact that, by definition, they lack the capacity to properly construe what is compatible with their interests in the given situation.

Given that selectively diluting protection of the incapable adult would be discriminatory, the remaining question from an Article 14 perspective is whether that discrimination can be objectively and reasonably justified. Much of Harris's attempt to justify diluting protection of the incapable adult is founded on the idea that all people have a moral obligation to participate in research:

> *"It is not plausible to believe that the costs of acting morally fall only on those competent to consent. So long as we ensure that such costs do not fall* more heavily *on those not competent to consent than on others I see no sound argument for exempting them from the demands of morality. They may not be* accountable *in law, if they do wrong, but there is no reason to ensure that they do wrong by exempting them from their moral obligations."*[20] (ital. added)

This idea is appealing to many but simplistic for at least two reasons. Firstly, it assumes that research is a beneficent activity when in fact whether or not it is depends on the context in which one is speaking. And part of the context in the West is the dominance of an atomovistic, mechanistic and deterministic approach to medicine that focuses on suppression of symptoms, surgery and other inherently limited tools. The medical establishment has typically supported and perpetuated this system in preference to one based on holistic prevention and cure partly out of a misguided allegiance to a Newtonian-Cartesian paradigm of hard science that is now a century outmoded in the light of new developments in the hard sciences, especially those in the field of quantam physics. What is more, vested commercial interests have underpinned the current approach not least in the research context where the focus is largely on the development of synthetic – and hence patentable – medicines. These problems link in with a second concern with Harris's approach which is that it fails to assess the merits of pluralism. Protecting individuality, particularly in relation to choices over the body, is important both as an end in its own right and as a function of maintaining a healthy society. What is more to suggest that it should be intruded upon for supposedly beneficent purposes is politically naïve in terms of the degree of reliance it places on the rational exercise of state authority. However, Harris, whilst admitting that it would be better if research could be pursued without the use of incapable adults, suggests that if the current position;

> *"jeopardises our capacity to pursue well founded research then perhaps we should remember that free-riding is not an attractive principle; nor is it a moral principle. We should not ... assume that those incompetent to consent would wish to be free-riders, nor that they be excluded from discharging an obligation of good citizenship which we all share."*[21]

Much the same point has been made by Gunn et al., in this Journal:

> *"If one wishes to gain the benefit of medical research, one has the obligation to offer oneself for participation. Otherwise, the person gaining the benefit of the research is a mere parasite on society, taking only the advantages and undertaking no risks."*[22]

Using terms like 'free-rider' and 'parasite' may serve the implicit purpose of both articles but is

20 *Ibid* 12.

21 *Ibid* 13.

22 *'Medical Research on Incompetent Adults' (2000) Journal of Mental Health Law, 60 at 63.*

pejorative and highly inappropriate even if one assumes that most of the modern research effort is beneficent. Some non-participants may be making good contributions to the world in other ways. What is more, though degrees of contribution may at times be considered a valid basis on which to change the way benefits are distributed it cannot be considered, at least where something as important as the right to bodily security is concerned, a valid basis on which to change the law relating to contribution, let alone to do so selectively with a particular class at the cost of the principle of equality of persons.

Gunn et al. put forward alternative arguments for moving the law away from a best nterests approach all of which are clustered around the idea that such change would be beneficial for incapable adults as a class. Firstly they argue that it would be,

> *"consistent with principles of normalisation and social inclusion. It challenges stereotypes that incompetent adults are a drain on society."*[23]

In response, it may be noted that participation *can* have these effects for incapable adults but will in fact be abnormalising where it is secured on a discriminatory basis. Gunn et al., also argue that not moving away from a best interests approach will limit the ability to generalize research outcomes to incapable adults[24] and thwart research which is more specifically for their benefit as a class.[25] Solbakk makes a similar point in relation to children.[26]

He suggests that by protecting the incapable from being involved in research of no real and direct benefit to them that is greater than minimally risky, the CHRB has encouraged a practice of selecting adults in non-therapeutic research instead of children as participants and of developing new standards for paediatric use on the basis of extrapolation of data from studies on adults. Solbakk notes how critics such as Brody[27] suggest that this leads to the paradoxical situation that children are often exposed to clinical decisions without appropriate guidance from research and that, consequently, diseased children are in danger of becoming therapeutic orphans.[28]

Solbakk uses this as a platform to argue that systematically protecting children from non-therapeutic research with a risk level that is greater than minimal could lead to an infringement of their right to equitable access to healthcare of appropriate quality, which he notes is explicitly protected by Article 3 of the *CHRB*.[29] However, this analysis would seem to be based on a myopic and ultimately biased reading of the CHRB. Article 3 only requires states, 'taking into account health needs and available resources', to take

> *"appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality."*

It would be extremely odd if it were deemed appropriate to provide for research needs in a manner that directly conflicts with Article 2 of the Convention and its sister provision, Article 3 of the Additional Protocol on Biomedical Research. What is more, as I have already argued in Part 1, it

23 *Ibid.*

24 *Ibid.*

25 *Ibid 61.*

26 *Solbakk, J.H., 'Uses and abuses of biomedical research,' p35–50 in Council of Europe Publishing (ed.), Biomedical Research, Council of Europe, October 2004.*

27 *Brody, B, The Ethics of Biomedical Research; An International Perspective, 1998, New York, Oxford University Press 177.*

28 *Ibid at 43.*

29 *Solbakk, J.H., 'Uses and abuses of biomedical research,' p35–50 at 43 in Council of Europe Publishing (ed.), Biomedical Research, October 2004, Council of Europe.*

is difficult to use the needs of a class of people to justify infringement of the rights of individuals who happen to be in that class. The Court of Appeal in Maryland was confronted with the issue in *Grimes and Higgins v Kennedy-Krieger Institute* 782 A2d 807 (2001). The key facts of this case were that a prestigious research institute, associated with John Hopkins University, had created a non-therapeutic research program involving certain classes of homes. Some homes, one with a child resident and others where families with young children were encouraged to reside by landlords complicit with researchers, were deliberately not provided with the full lead paint abatement modifications that had been provided to others. The majority concluded that:

> *"Whatever the interests of a parent, and whatever the interests of the general public in fostering research that might, according to a researcher's hypothesis, be for the good of all children, this Court's concern for the particular child and particular case, over-arches all other interests. It is, simply, and we hope, succinctly put, not in the best interest of any healthy child to be intentionally put in a non-therapeutic situation where his or her health may be impaired, in order to test methods that may ultimately benefit all children (para 221)."*

Of course it might in theory be possible to argue that if it is legitimate to trade off the right to bodily security vis-à-vis the needs of others in extreme circumstances then participation of incompetent adults in medical research is one such extreme circumstance. However, for common arguments to the effect that we need to dilute protection to make progress in relation to conditions like Alzheimer's disease, one could substitute the argument that we need to dilute protection of all classes of person to facilitate greater extraction of bodily material to help meet the need for transplantation and general biotechnological advancement. Or, more specifically, we could substitute the argument that we need to dilute protection of insensate dying persons to facilitate the need to prepare their body for use in transplantation, medical research or medical education after their death. Intrusive research on the incapable adult is not a special case at all but simply one example of modern medicine's massive reliance on the body to meet a plethora of medical needs.

Given the above arguments, one may sum up this section by saying that it is extremely likely that Article 8 and, at least in certain circumstances, Article 3 would be violated by treating the right to bodily security as relative vis-à-vis the needs of others. This extreme likelihood rises to the level of virtual certainty when one selects a particular class for such relative treatment.

Nonetheless, no amount of reassurance to the effect that the formal legal position is a primacy protective one can take away from the fact that the Government rather disingenuously sneaked sections 31(5)-(6) into the MCA when they serve no other function than to encourage researchers and the public at large to mistakenly view it as legitimate to deviate from a best interests approach. The Government is on the cusp of colluding with the abuse of incapable adults. Rather than wait for the Courts to pick up the pieces and lay out the *actual* (non) effect of sections 31(5)-(6), it should act to remove them before the Act comes into force.

Conclusion

In his dissenting judgment in *Olmstead v United States*, 277 U.S. 438, 479 (1928) Judge Brandies observed that:

> *"Experience should teach us to be most on guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding."*

The idea of attempting to do something useful for society or science is naturally appealing. However, such attempts are – like wooden horses – not always what they seem. Indeed, one may even conclude that to try and benefit society or science at the cost of the individual is fundamentally flawed from the outset. It is only when science and society are founded on respect that they are worthwhile. Founded on anything else they simply become a mechanism for abuse.

Much of the international community seems to have partially regressed from this realisation in the research context despite having committed itself formally to it in the wake of Nazi research atrocities. And whilst nothing post-World War II has matched the scale of Nazi experimental depravity, there have been serious atrocities. For example, some horrific radiation experiments were carried out on unknowing/uninformed servicemen and members of the public in the United States from the 1940s until the early 1970s[30] and in the UK the Ministry of Defence conducted experiments with chemical warfare agents on servicemen for decades at its Porton Down site, including experiments on at least 349 servicemen with potentially deadly doses of the nerve agent sarin.[31]

Some of these abuses have since been legally remedied,[32] but research continues to be an area ripe for abuses. Many regulators, medical establishments, researchers/research entities and even technically independent voices in the discourse are far too cosy with each other over an agenda which consists of uncritically lauding the benefits of research whilst simultaneously failing to fully respect the individual, even to the point of discrimination. Whilst some of that discrimination is undoubtedly unwitting, it is important to note that research has long been a rich field for opportunists to pick on the vulnerable like vultures at a carcass. It is certainly no coincidence that most research abuses have been targeted against those typically less well equipped to resist them such as the incapable, poor and illiterate people (particularly in developing countries[33]) and (above all) the animal kingdom.

30 *Makhijani, A and Kennedy, E, Human Radiation Experiments in the United States, Institute for Energy and Environmental Research, 1994 available at: http://www.ieer.org/sdafiles/vol_3/3-1/humanex.html*

31 *See further Plomer, A, The Law and Ethics of Medical Research, 2005, Cavendish Publishing, 45–46.*

32 *See, for example, In Re Cincinnati Radiation Litig 874 F Supp 796 (SD Ohio 1995), Re Maddison, Deceased [2002] EWHC 2567 Admin.*

33 *See further Macklin, R, Double Standards in Medical Research in Developing Countries, 2004, Cambridge University Press.*

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

Claire Bentley[2]

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.

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]

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

September 2005

Provocation: the fall (and rise) of objectivity

Kevin Kerrigan[1]

This article reviews the recent turbulent history of the partial defence of provocation. It assesses the current state of the law, the continuing dissatisfaction among the judiciary and academic commentators, and goes on to consider the current proposals for reform from the Law Commission. In an attempt to retain the reader's attention, it takes the form of a (wholly imagined) exchange between a professor and student. Any similarity to any living person is wholly co-incidental.....

Keen first year law student: Excuse me, can the Court of Appeal set aside a House of Lords decision as to the proper construction of a statute?

Impatient Professor: Of course not! The hallowed rules of precedent mean that the only court that can reverse a decision of the House is the House itself.[2] Why, their Lordships have only recently re-asserted this principle in emphatic terms.[3] Do keep up!

Student: So why didn't the Court of Appeal in *R v James; R v Karimi*[4] follow the House of Lords decision in *R v Morgan Smith?*[5]

Professor: Er...

Student: Perhaps it has something to do with the fact that the Privy Council in *Attorney General of Jersey v Holley*[6] overruled *Morgan Smith*.

Professor: Tch! Everyone knows that the Privy Council can't overrule a House of Lords decision.

1 *Principal Lecturer in Law, Northumbria University*

2 *See Practice Statement (Judicial Precedent) [1966] 1 WLR 1234*

3 *Leeds City Council v Price [2006] UKHL 10: "[The Practice Statement] was not intended to affect the use of precedent elsewhere than in the House, and the infrequency with which the House has exercised its freedom to depart from its own decisions testifies to the importance its attaches to the principle." Readers of this Journal will be familiar with the decision in IH (R (on the application of IH) v Secretary of State for the Home Department [2004] 2 A.C. 253) in which the House of Lords endorsed the Court of Appeal's decision to "set aside" an earlier decision of the House of Lords, R. v Oxford Regional Mental Health Tribunal Ex p. Secretary of State for the Home Department, [1988] A.C. 120. This was on the basis that the inability of a Mental Health Review Tribunal to review a decision to conditionally discharge a restricted patient gave rise to a breach of Article 5(4) of the European Convention on Human Rights. No discussion of the rules of precedent arose in the IH case and the constitutional basis for the Court of Appeal's decision is not entirely clear. The House of Lords in Price was very clear that certainty in the law "is best achieved by adhering, even in the Convention context, to our rules of precedent." Price did conceive of "very exceptional cases" where it may be appropriate for a lower court to set aside a House of Lords decision but the circumstances had to be "extreme" for this to be permissible and the normal approach would be to await determination of the matter by the House of Lords itself.*

4 *[2006] EWCA Crim 14.*

5 *[2001] 1 AC 146.*

6 *[2005] UKPC 23; [2005] 2 AC 580.*

Student: I think it may be due to the fact there were 9 law lords sitting in *Holley*, all accepting that they were ruling not only on the law of Jersey but also that of England and Wales. Apparently 6 of them decided that *Morgan Smith* wrongly interpreted the Homicide Act 1957 and preferred the interpretation of the earlier Privy Council decision in the Hong Kong case of *Luc Thiet Thuan v R*.[7]

Professor: You mean to say you have actually read these cases to which you refer?

Student: Of course – haven't you?

Professor: I, er, well... Hey this isn't about me. I think it might be time for a bit of Socratic dialogue. If you know so much about this, perhaps you could enlighten the rest of the class. For starters, what part of the Homicide Act was under consideration?

Student: Oh that is easy. It is section 3 which deals with provocation, the partial defence to murder:

> *"Where on a charge of murder there is evidence on which the jury can find that the person charged was provoked (whether by things done or by things said or by both together) to lose his self-control, the question whether the provocation was enough to make a reasonable man do as he did shall be left to be determined by the jury; and in determining that question the jury shall take into account everything both done and said according to the effect which in their opinion, it would have on a reasonable man."*

All the recent cases related to the so-called second limb of provocation. If the jury is satisfied that the accused may have been provoked to lose his/her self control (the first limb) they must go on in applying the second limb to assess whether the reasonable man would also lose his self control. It is the second limb that has caused all of the problems.

Professor: What was it about the second limb that was controversial?

Student: Well it is all to do with the old objective / subjective conundrum, isn't it?

Professor: Go on...

Student: You know; the question of whether the reasonable man referred to in the statute should be an "objective" reasonable man or whether he should have some of the "subjective" characteristics of the accused.

Professor: What difference would it make?

Student: Assuming that the jury thought the accused had actually been provoked to lose his self control when he killed the victim then, if the subjective approach won through, the jury would take into account the accused's own characteristics when deciding if a reasonable man would do the same. In other words in assessing the reasonable man's standard of self control he would have the characteristics of the accused.

So, for example, in *Luc Thiet Thian* the accused had brain damage; in *Morgan Smith*, he had severe depression; in *Holley* he was an alcoholic; in *James* the accused had an unspecified psychiatric condition that impaired his ability to control himself; in *Karimi*, he had post-traumatic stress disorder. If the subjective approach was applied, the jury would assess the standard of self control of the reasonable man with brain damage, with depression, with alcoholism etc.

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7 [1997] AC 131.

Professor: Is that really tenable? Some conditions are surely incompatible with the concept of reasonableness as commonly understood. How, for example, would the jury assess the reasonable response of an accused suffering from schizophrenia?[8]

Student: With great difficulty I guess! Indeed, advocates of the subjective approach have suggested that courts should not refer to the reasonable man at all. As Lord Hoffman stated in *Morgan Smith*:

> *"In my opinion, therefore, judges should not be required to describe the objective element in the provocation defence by reference to a reasonable man, with or without attribution of personal characteristics ... The jury must think that the circumstances were such as to make the loss of self-control sufficiently excusable to reduce the gravity of the offence from murder to manslaughter. ... In deciding what should count as a sufficient excuse they have to apply what they consider to be appropriate standards of behaviour."*[9]

Thus the jury would be assessing whether, in light of the accused's characteristics, including any mental disorder, the response to the provocation should properly be excused in part. As Lord Clyde put it, "whether the defendant exercised the degree of self-control to be expected of someone in his situation".[10] The advocates of this approach felt that it would not remove the objective nature of the test but it would accommodate the accused's individual characteristics:

> *"Society should require that he exercise a reasonable control over himself, but the limits within which control is reasonably to be demanded must take account of characteristics peculiar to him which reduce the extent to which he is capable of controlling himself."*[11]

Critics of the subjective approach point out that it enables the accused to be judged not by the uniform standard indicated by the statute but by his own standard. Lord Hobhouse in *Morgan Smith* was searing in his criticism of the subjective approach:

> *"... this approach requires the accused to be judged by his own reduced powers of self-control, eliminates the objective element altogether and removes the only standard external to the accused by which the jury may judge the sufficiency of the provocation relied on. By introducing a variable standard of self-control it subverts the moral basis of the defence, and is ultimately incompatible with a requirement that the accused must not only have lost his self-control but have been provoked to lose it; for if anything will do this requirement is illusory. It is also manifestly inconsistent with the terms of section 3. It makes it unnecessary for the jury to answer the question which section 3 requires to be left to them, viz, whether the provocation was enough to make a reasonable man do as the accused did. It becomes sufficient that it made the accused react as he did. It substitutes for the requirement that the jury shall take into account everything both done and said according to the effect which in their opinion it would have on a reasonable man a different requirement by reference to the effect which it actually had on the accused. These tests are in truth no tests at all."*[12]

Professor: Okay – what about the objective approach?

Student: If the objective approach prevailed, then the jury would assess the reasonableness of the accused's response to the provocation by reference to a reasonable man of ordinary fortitude. They

8 *For discussion of the conceptual difficulties inherent in the objective standard see Alan Norrie, "From Criminal Law to Legal Theory: the Mysterious Case of the Reasonable Glue-Sniffer" (2002) 65(4) M.L.R. 538.*

9 *Op. cit. at page 173*

10 *Ibid. at page 155*

11 *Ibid. per Lord Clyde at page 179*

12 *Ibid. at page 208.*

would not be told about the accused's peculiar characteristics insofar as they might affect his ability to control himself.

Professor: So on the objective approach, the accused's own characteristics are irrelevant?

Student: Hmm. Not entirely. Even on the objective approach the accused's characteristics are relevant to the *gravity* of the provocation. It is readily accepted that any particular idiosyncrasy of the accused should be taken into account insofar as it might have made the provocative conduct worse.[13] In part this is a consequence of the 1957 Act expanding the definition of what could amount to provocative conduct to include things said in addition to things done. If words could suffice, then it followed that verbal provocation directed at a particular characteristic of the accused should be taken into account by the jury in determining the reasonableness of the response. As Lord Diplock put it in *R v Camplin*,[14] the gravity of the provocation could depend on, "the particular characteristics or circumstances of the person to whom a taunt or insult is addressed."[15]

Professor: Let us be clear about this – on the objective approach if I have, say, epilepsy and someone taunts me about it to the point where I stab him to death, the jury can take account of my condition in deciding how reasonable it was for me to be provoked but not in deciding whether I exercised reasonable self restraint?

Student: Exactly – they would hear evidence of your epilepsy when deciding how aggrieved you would be by the taunts. This would clearly have some impact on the reasonableness of your response. However, they would have to put out of their mind any impact your epilepsy might have on your ability to control yourself. They should measure your response against their understanding of how the ordinary person who did not have epilepsy would react. Lord Devlin in *Camplin* suggested the following judicial direction:

> *"He should ... explain to them that the reasonable man referred to in the question is a person having the powers of self-control to be expected of an ordinary person of the sex and age of the accused, but in other respects sharing such of the accused's characteristics as they think would affect the gravity of the provocation to him."*[16]

Professor: Wait a moment, you said earlier it was a "reasonable man" but now it is a person of the age and sex of the accused. They are personal characteristics.

Student: Yes, I suppose they are. It could be argued that they are exceptions to the reasonableness, test but Lord Nicholls in *Holley* argued they were no such thing:

> *"The powers of self-control possessed by* ordinary *people vary according to their age and, more doubtfully, their sex. These features are to be contrasted with abnormalities, that is, features not found in a person having ordinary powers of self-control. The former are relevant when identifying and applying the objective standard of self-control, the latter are not."*[17]

Professor: Doesn't the objective approach mean that many people would be incapable of satisfying the standard expected precisely because they are not "normal"?

Student: Yes. Lord Nicholls acknowledged as much in *Holley*. He said that using the objective test, "...may mean the defendant is assessed against a standard of self-control he cannot attain ... Inherent

13 *R v Morhall [1996] AC 90.*

14 *[1978] AC 705.*

15 *Ibid. at page 717.*

16 *Ibid. at page 718.*

17 *Op. cit. at paragraph 13, emphasis in original.*

in the use of this prescribed standard as a uniform standard applicable to all defendants is the possibility that an individual defendant may be temperamentally unable to achieve this standard."[18]

Professor: Right, you have dawdled long enough. What did the cases decide then?

Student: In chronological order:

1997 – *Luc Thiet Thuan* – Privy Council – objective

2000 – *Morgan Smith* – House of Lords – subjective[19]

2005 – *Holley* – Privy Council – objective

2006 – *James; Karimi* – Court of Appeal – objective[20]

Professor: How did we get into this position in the first place? You said a moment ago that Camplin[21] established an objective test including a jury direction that referred to "ordinary" powers of self control. Did *Morgan Smith* overrule *Camplin*?

Student: No. Bizarrely, despite adopting diametrically opposing views, both the majority and minority in *Morgan Smith* claimed to be following the principles enunciated in *Camplin*. The majority took the view that Lord Diplock's speech in that case was not clearly indicative of a wholly objective approach. Lord Hoffman argued that the references to the sex and age of the accused were illustrative only and not intended to limit the relevant characteristics. Moreover, it was argued that Lord Diplock had made no clear distinction between characteristics affecting the gravity of the provocation and those affecting the accused's powers of self control. Essentially their Lordships in the majority employed a creative interpretation of the *Camplin* approach in order to fit with their view as to the principles underpinning the law and the needs of justice.

This was a judgement reaching to the fundamentals of criminal liability. The majority was concerned not just with practical difficulties with an objective test but with a perceived incoherence in the strict doctrine that sidelined the concept of capacity for self-control when considering provocation. Their Lordships were concerned that the law imposed a straightjacket which required a strict demarcation between the respective defences to murder which was not warranted by reality:

18 *Ibid. at paragraph 12. This has formed the basis of some of the criticism of the objective approach: "It is to be remembered that the House of Lords in R v G [2003] UKHL 50 recently expressed grave concern about the potential for injustice when objective standards are employed, and thus in that case a significant step away from the application of objective recklessness was taken. In this context, a return to objectivity, albeit in a different area of criminal law, seems incongruous." Neil Martin, "Continuing Problems with Provocation", N.L.J. 2005, 155 (7192), 1363.*

19 *There were a number of Court of Appeal decisions preceding Morgan Smith which rejected the approach of the Privy Council in Luc Thiet Thuan. These included R v Campbell [1997] 1 Cr App R 199 and R v Parker (unreported; 25 February 1997. Subsequently Morgan Smith was applied in a number of Court of Appeal decisions including: R. v Kimber (No.1), 2000 WL 1918494 R. v Lowe [2003] EWCA Crim 677; R. v Miah [2003] EWCA Crim 3713; R. v Rowland [2003] EWCA Crim 3636; R. v Smith 2000 WL 33122433; R. v Farnell [2005] EWCA Crim 1021; R. v McCandless [2001] N.I. 86.*

20 *Prior to the James/Karimi cases, a number of Court of Appeal cases had suggested that Holley would be followed in due course. In R v Van Dongen [2005] EWCA Crim 1728 the Court of Appeal said, "We assume, but do not decide, because it is not necessary to do so, that Holley, a decision of the Privy Council, would be taken as binding in England and Wales." In R v Faqir Mohammed [2005] EWCA Crim 1880 the Court of Appeal said, "Although Holley is a decision of the Privy Council and Morgan Smith a decision of the House of Lords, neither side has suggested that the law of England and Wales is other than as set out in the majority opinion set out in the majority opinion delivered by Lord Nicholls in Holley and we have no difficulty in proceeding on that basis."*

21 *Op. cit.*

> *"I think it is wrong to assume that there is a neat dichotomy between the 'ordinary person' contemplated by the law of provocation and the 'abnormal person' contemplated by the law of diminished responsibility..."*[22]

This ostensibly liberalising approach was heavily criticised outside the judicial arena as flawed in principle in that it conflated the idea of provocation as a partial *excuse* with the idea of diminished responsibility as a partial *denial of responsibility*:

> *"To offer an excuse ... is to attempt to provide a decent rational explanation for what one did. To deny responsibility, by contrast, is to assert that (because at the time one was not a sufficiently rational being) no rational explanation for what one did is called for. Defences in these two classes ... are not only different but incompatible. To make an excuse is not only not to deny one's responsibility; it is positively to assert one's responsibility. To deny one's responsibility is not only not to make an excuse; it is to undermine any excuse one might have made. That is because one cannot claim to live up to rationality's standards while also claiming that one should not be judged by rationality's standards."*[23]

In other words the two partial defences to murder *ought* to be conceptually and morally distinct but the subjective approach to provocation encouraged an unsustainable overlap between the defences. Nevertheless the idea of integrating the two defences has also had its proponents. For example, Mackay and Mitchell have argued strongly for the logic of the *Morgan Smith* decision to be recognised explicitly by the creation of a single defence which combined elements of provocation and diminished responsibility.[24]

Professor: But to come back to the current state of the law, you are saying that the majority view in *Morgan Smith* has *not* prevailed and that the objective approach is now the correct test in English law?

Student: Yes.

Professor: And you say this is the case despite the decision coming from the Privy Council, which is not even binding on English courts and despite the House of Lords decision being only 5 years old?

Student: Just so. Professor Andrew Ashworth acknowledged it was a novel approach to the development of the law but the reality was that *Holley* now represented the law:

> *"Is* Holley *binding on English courts? There may be a purist strain of argument to the effect that it is not, since it concerns another legal system (that of Jersey). However, the reality is that nine Lords of Appeal in Ordinary sat in this case, and that for practical purposes it was intended to be equivalent of a sitting of the House of Lords. It is likely that anyone attempting to argue that* Morgan Smith *is still good law in England and Wales would receive short shrift."*[25]

Professor: I don't see what is wrong with being a purist, but putting that on one side, why did the Privy Council think the House of Lords had misunderstood provocation?

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22 *Op. cit. note 5, above at page 168 per Lord Hoffman.*

23 *Gardner and Macklem, "No Provocation Without Responsibility: A Reply to Mackay and Mitchell", [2004] Crim. L. R. 212. See also Macklem and Gardner, "Compassion without respect? Nine fallacies in R. v. Smith" [2001] Crim L. R. 622*

24 *Mackay and Mitchell, "Provoking diminished responsibility: two pleas merging into one" [2003] Crim L. R. 745. See also Mackay and Mitchell, "Replacing Provocation: More on a Combined Plea" [2004] Crim. L. R. 218.*

25 *Commentary, [2005] Crim. L. R. 966 at page 971.*

Student: Well the interesting thing was that the majority in Holley did not actually say there was anything in principle wrong with the subjective approach in *Morgan Smith*. It was described as "one model which could be adopted in framing a law relating to provocation".[26] The entire thrust of the majority's attack on *Morgan Smith* was to do with the proper interpretation of the statute and the acceptable parameters of judicial interpretation. They believed the House of Lords had misconstrued section 3 of the Homicide Act 1957:

> *"However much the contrary is asserted, the majority view [in* Morgan Smith*] does represent a departure from the law as declared in section 3 of the Homicide Act 1957. It involves a significant relaxation of the uniform, objective standard adopted by Parliament. Under the statute the sufficiency of the provocation ("whether the provocation was enough to make a reasonable man do as [the defendant] did") is to be judged by one standard, not a standard which varies from defendant to defendant. Whether the provocative act or words and the defendant's response met the "ordinary person" standard prescribed by the statute is the question the jury must consider, not the altogether looser question of whether, having regard to all the circumstances, the jury consider the loss of self-control was sufficiently excusable."*[27]

This was based on the idea that the House of Lords in *R v Camplin*[28] had definitively addressed the implications of section 3 and had accurately identified an objective approach towards the standard of self control required as follows:

> *"It means an ordinary person of either sex, not exceptionally excitable or pugnacious, but possessed of such powers of self-control as everyone is entitled to expect that his fellow citizens will exercise in society as it is today."*[29]

This view was entrenched by reference to Lord Diplock's "model direction" in that case:

> *"He should ... explain to them that the reasonable man referred to in the question is a person having* the power of self-control to be expected of an ordinary person *of the sex and age of the accused, but* in other respects *sharing such of the accused's characteristics as they think would affect the gravity of the provocation to him; and that the question is not merely whether such a person would in like circumstances be provoked to lose his self-control but also whether he would react to the provocation as the accused did."*[30]

The law of homicide was said by the majority in the Privy Council to be a "highly sensitive and highly controversial area of the criminal law" and that Parliament had altered the common law by virtue of the Homicide Act. It was "not open to judges now to change ('develop') the common law and thereby depart from the law as declared by Parliament."[31]

The minority for its part emphasised the origins of the defence as a judicial response to the harshness of the law of murder:

> *"It was a humane concession to human infirmity and imperfection, acknowledgement 'that by reason of the frailty of our nature we cannot always stand upright'... And the rationale of the provocation defence is still the consideration of justice which gave rise to it, that the law should 'not require more from an imperfect creature than he can perform'."*[32]

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26 *Per Lord Nicholls at paragraph 22.*

27 *Ibid..*

28 *Op. cit.*

29 *Ibid. Per Lord Diplock at page 717.*

30 *Ibid. at page 718, cited by Lord Nicholls in Holley at paragraph 10; Lord Nicholls' emphasis.*

31 *Holley, op. cit. at paragraph 22.*

32 *Ibid. per the joint dissenting opinion of Lords Bingham and Hoffman at paragraphs 44–45.*

They agreed that the law relating to provocation required urgent review but so long as the defence was available it ought to be applied in line with the underlying rationale. The statute could and should be interpreted as requiring the jury to determine what matters to take into account in determining the reasonableness of the response and it was improper to undermine the jury's function by limiting the characteristics that could be considered. Lord Carswell agreed and added his concerns regarding the risk of confusing a jury:

> *"I hold the very clear view that the dichotomy between the gravity of the provocation and the level of self-control in reaction cannot readily be made comprehensible to a jury by the directions fashioned by a judge with the greatest care and clarity ... The formula is not only opaque ... but even if it can be comprehended by an intelligent jury, they are more than likely to ask themselves how they can sensibly decide whether an ordinary person would have reacted as the defendant did if he would not have found the acts or words provocative in the first place."*[33]

The minority view in *Holley* thus echoed the majority view in *Morgan Smith*. It reflected a determination to ensure the law of provocation did not demand a standard of control that was beyond the capacity of defendants to perform. Ultimately the majority thought that irrespective of the merits of the normative case for subjectivity, compliance with the statute required a return to objectivity.

Professor: So the subjective approach might be the right approach in principle but irrespective of this, the Privy Council thought the House of Lords' approach undermined the sovereignty of Parliament?

Student: Yes, that is a fair assessment. The matter has now been taken beyond argument by the Court of Appeal decision in *R v James; R v Karimi* which has endorsed the Privy Council decision as reflecting the law of England and Wales. I won't bother you with the constitutional acrobatics the Court had to perform in order to recognise the pre-eminence of the *Holley* precedent, but the Court did state:

> *"It seems to us that this can only mean that they [the minority judges in* Holley*] accepted that the decision of the majority clarified definitively the present state of English law. ... While we do not believe that it has any relevance to the resolution of these appeals, we should record that this court finds the reasoning of the majority in* Holley *to be convincing."*[34]

I ought to re-emphasise though that despite the majority of the Privy Council being neutral on the question of principle, numerous commentators have engaged in lengthy debate over the proper approach towards the question of the standard to be required in the defence of provocation.[35]

Professor: Nevertheless, the law is now settled. Thank you for an adequate, if somewhat over simplistic, assessment ...

Student: Er, sorry, that is not quite the end of the story. One thing that united all of their Lordships in *Holley* was the fact that the law was now in something of a mess:

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33 *Ibid. at paragraph 73. The majority thought these fears were "exaggerated" (paragraph 26).*

34 *Op. cit. note 4 above at paragraphs 25–26.*

35 *See for example Professor JC Smith, commentary at [2000] Crim. L. R. 1004; Macklem and Gardner, "Compassion without respect? Nine fallacies in R. v. Smith" [2001] Crim L. R. 622; Alan Norrie, "The structure of provocation" [2001] C. L. P. 307; Mackay and Mitchell, "Provoking diminished responsibility: two pleas merging into one" [2003] Crim L. R. 745; Gardner and Macklem, "No provocation without responsibility: A reply to Mackay and Mitchell" [2004] Crim. L. R. 212. Most, but not all of the comment is critical of the subjective approach.*

> *"In expressing their conclusion above, their Lordships are not to be taken as accepting that the present state of the law is satisfactory. It is not. The widely held view is that the law relating to provocation is flawed to an extent beyond reform by the courts ... Their Lordships share this view."*[36]

The Law Commission in its "Report on Partial Defences to Murder"[37] reviewed the rationale and operation of the provocation defence and made recommendations for reform. The proposal involved a new gender neutral partial defence for homicide committed in response to "gross provocation", fear of serious violence or a combination of both. The requirement for the accused to have lost his/her self control was removed, although it would not apply where the accused acted out of considered desire for revenge. In respect of the standard of self control, the Commission preferred the approach of the minority in *Morgan Smith* (now supported by the majority in *Holley*) which, it noted, also accorded broadly with the law in Australia, Canada and New Zealand.[38] Thus the new defence would only be available if "a person of the defendant's age and of ordinary temperament, i.e. ordinary tolerance and self-restraint, in the circumstances of the defendant might have reacted in the same or a similar way."[39]

In its consultation paper, "A New Homicide Act for England and Wales?"[40], the Law Commission provisionally proposed a new categorisation for murder whereby provocation would be a defence to first degree murder (where the accused intended to kill) and reduce this to second degree murder, not manslaughter. The principles would be the same as those outlined in the report on partial defences.[41] The Commission rejected the notion advocated by Mackay and Mitchell of combining the defences of provocation and diminished responsibility.[42]

The upshot is that we are likely in due course to see the fundamental review of the law of murder that has been widely called for. Whether this leads to a more coherent and workable defence of provocation remains to be seen.[43]

Professor: Right. Time for lunch. I think we might do this again next week. Can you please prepare something on reform of insanity?

Student: Er...

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36 *Per Lord Nicholls for the majority at paragraph 27. See also Lords Bingham and Hoffman at paragraph 44 and Lord Carswell at paragraph 77.*

37 *Report on Partial Defences to Murder (Law Com No 290) (2004) (Cm 6301).*

38 *Ibid. paragraph 3.110. See also paragraph 3.127: "The test under our proposal is not whether the defendant's conduct was reasonable, but whether it was conduct which a person of ordinary temperament might have been driven to commit (not a bigot or a person with an unusually short fuse). We believe that a jury would be able to grasp and apply this idea in a common-sense way. Because the test is not whether the defendant's conduct was reasonable, there is no illogicality in providing only a partial defence."*

39 *Ibid. at paragraph 3.168, Principle 1. In Principle 2 the Commission went on to explain the objective element: "In deciding whether a person of ordinary temperament in the circumstances of the defendant might have acted in the same or a similar way, the court should take into account the defendant's age and all the circumstances of the defendant other than matters whose only relevance to the defendant's conduct is that they bear simply on his or her general capacity for self-control."*

40 *Law Commission Consultation Paper no. 177, A New Homicide Act for England and Wales? (2005)*

41 *Ibid. paragraphs 10.7 and 10.23.*

42 *Report on Partial Defences to Murder, op. cit. paragraph 3.166.*

43 *See for example, the criticism of the Law Commission's proposals by Mackay and Mitchell, "But is this provocation? Some thoughts on the Law Commission's report on Partial Defences to Murder" [2005] Crim. L. R. 43.*

Mental Health in the Workplace (1) – 'Stress' Claims and Workplace Standards and the European Framework Directive on Health and Safety at Work

Kay Wheat[1]

This is first of two articles that will address mental health issues at work.[2] It is written in the context of the case[3] brought by the European Commission against the UK government alleging that the standard of care prescribed by the Health and Safety at Work Act 1974 falls below that required by the European Framework Directive on the introduction of measures to encourage improvements in the safety and health of workers at work.[4]

It will be argued that such alleged divergences between the UK and Europe are not clear cut, and, in the context of mental health, given the more nebulous nature of mental ill health and its causes, such divergences might be negligible.

I. THE STRUCTURE OF HEALTH AND SAFETY LAW IN THE WORKPLACE

1.1 Common law liability

At common law, injuries to mental health and physical health respectively, have been regarded differently.[5] Work place injury is compensatable (*inter alia*) under the law of employers' liability,

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2 *The second, and forthcoming, article will consider the treatment of mental health of workers and the Disability Discrimination Act 1995. Publication is planned for the next issue of the JMHL*

3 *Case C-127/05. The case is pending before the European Court of Justice. It is anticipated it will be heard this year.*

4 *Directive 89/391/EEC.*

5 *See Alcock v Chief Constable of South Yorkshire Police [1992] 1 AC 310.*

which is a species of negligence and constrained by the usual limiting factors.[6] The structure of the common law consists of an employer's 'personal' duty towards employers. This means that the employer cannot avoid responsibility by authorising another party to take on this duty; it is 'non-delegable'.[7] Generally the obligation is to provide competent fellow workers; a safe place of work in terms of both premises and equipment; and a safe system of work.[8] The standard of care is that of the reasonable employer,[9] although there is a form of strict liability in terms of vicarious liability which means that however careful the employer has been, it will be liable for the negligence of its employees.

1.2 The Health and Safety at Work Act 1974

There are UK statutes which overlay the common law position such as a number of 'independent' statutes[10] and the Health and Safety at Work Act 1974. The latter was introduced after the Robens Committee Report of 1972 which was the result of concern about the prevalence of industrial injuries and the need to rationalise the former piece-meal approach to health and safety legislation.[11] Sections 2 – 8 contain the duties of an employer. Section 2 covers the general duty to provide safe working conditions for employees, and the qualification that this is subject to what is 'reasonably practicable'. Section 2 also refers to the more specific areas where the duty arises: machinery; handling, storage and transport; information, instruction, training and supervision; and the place of work and the working environment (which is particularly applicable to mental injury in the form of so-called 'stress claims'). Section 2(2)(e) states that the employer must provide: "The provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work."

Section 3 imposes a duty in respect of non-employees, so that the obligation is to conduct the undertaking in such a way that non-employees are not exposed to risks to their health and safety. Section 7 imposes a duty on employees to look after their own health and safety. The duties do not depend upon actual harm, but upon the risk of harm.[12] Both physical and mental health are covered by the Act.[13] By virtue of section 15 of the Act, the Secretary of State is empowered to make regulations to deal with specific aspects of health and safety.[14] The Act imposes criminal liability only[15] but an action for damages will lie for breach of health and safety regulations made pursuant to section 15 unless the regulations exclude liability.[16]

6 *See White v Chief Constable of South Yorkshire Police [1999] 2 AC 455.*

7 *Wilsons & Clyde Coal v English [1938] AC 57.*

8 *Ibid.*

9 *Wilson v Tyneside Window Cleaning Co [1958] 2 QB 110.*

10 *For example, generally applicable statutes such as The Employers' Liability (Defective Equipment) Act 1969 (this provides for employers' liability in respect of defective equipment regardless of the employer's own reasonable care) and the Employers' Liability (Compulsory Insurance) Act 1969. There are also a number of specialist statutes such as the Mines and Quarries Act 1954.*

11 *The Committee on Safety and Health at Work 1970–72 (Cmnd 5034) (The Robens Committee).*

12 *R v Board of Trustees of the Science Museum [1993] 3 All ER 853.*

13 *Section 47(6).*

14 *e.g. The Control of Substances Hazardous to Health Regulations 1988 SI 1988/1657.*

15 *Section 47(1)(a) states there is no civil liability; Section 33 imposes criminal penalties*

16 *Section 47(2).*

1.3 The European Framework Directive

Article 137 (formerly Article 118) of the Treaty of Rome (as amended) states that the Community shall support the activities of Member States to protect workers' health and safety. Emanating from this is the general directive on health and safety known as the European Framework Directive.[17] In many ways the Directive reflects the employer's non-delegable common law personal obligation in as much as the employer cannot avoid the obligation by appointing external persons to carry out the obligation to 'ensure the safety and health of workers' (Article 5). The Directive applies to a wider category of 'workers' than those who satisfy the definition of 'employee' (Article 3). The main obligations are as follows:

> Article 6.....
>
> 1. Within the context of his responsibilities, the employer shall take the measures necessary for the safety and health protection of workers, including the prevention of occupational risks and provision of information and training, as well as provision of the necessary organization and means.....
>
> 2. The employer shall implement the measures..... on the basis of the following general principles of prevention:
>
> (a) avoiding risks;
>
> (b) evaluating the risks which cannot be avoided;
>
> (c) combating the risk at source;
>
> (d) adapting the work to the individual, especially as regards the design of work places, the choice of work equipment and the choice of working and work places, the choice of work equipment and the choice of working and production methods, with a view, in particular, to alleviating monotonous work and work at a predetermined work-rate and to reducing their effect on health;
>
> (e) adapting to technical progress;
>
> (f) replacing the dangerous by the non-dangerous or the less dangerous;
>
> (g) developing a coherent overall prevention policy which covers technology, organization of work, working conditions, social relationships and the influence of factors related to the working environment;
>
> (h) giving collective protective measures priority over individual protective measures;
>
> (i) giving appropriate instructions to workers;

.....

Article 7 states that the employer must provide protective and preventive services through the appointment of competent persons. If there are no competent persons within the organization, the employer must enlist competent external services or persons, and these persons must have the necessary capabilities and the necessary means to provide such services. Article 9 requires the employer to assess, respond to, and monitor the response to risks; including reporting of accidents. Workers must be provided with information about safety and health risks and the required

17 89/391/EEC.

protective and preventive measures (Article 10). The employer must provide for consultation with and participation by workers (Article 11) and provide adequate safety training to workers (Article 12). The Directive also imposes obligations on workers such as making proper use of equipment and protective clothing and informing employers of health and safety risks (Article 13). There are a number of more specific 'daughter' Directives[18] emanating from the Framework Directive which have been absorbed into UK law via regulations.

The European standard is therefore that of the competent person, unconstrained by consideration of cost, time or inconvenience.

1.4 Regulations

The Framework Directive was to be transposed into domestic law by 31 December 1992. Much of the content was already in force by virtue of the Health and Safety at Work Act 1974. However, the Management of Health and Safety at Work Regulations were issued in 1992 to deal with risk assessments. They were reissued in 1999, slightly revised, and with the addition of reference to the Directive's 'principles of prevention'.[19] These Regulations require employers to carry out risk assessments and effectively to carry out the obligations outlined above as stated in the Framework Directive.[20] Civil liability for breach of these regulations is specifically excluded.[21]

1.5 The link between UK statute and private law actions and the enforcement of the European Directive

It is trite law to say that not all statutory obligations give rise to private law actions. As we have seen, under section 47(1)(a) the Health and Safety at Work Act there can be no reliance on the Act in bringing a civil claim in respect of sections 2 – 8 of the Act. However, a civil claim can be brought in respect of failure to comply with regulations made under the Act.[22] In *Bailey v Command Security Services Ltd*[23] a failure to carry out a proper risk assessment in breach of the Management of Health and Safety at Work Regulations 1992 which do not give rise to civil liability, was, nevertheless, used to show that there had been common law negligence. In consequence even if there is no breach of statutory duty simply because the common law requirements have not been satisfied, civil liability can still arise through the imposition of the same standard of care as required by the relevant statutory provisions.

European Directives are instructions to member states to implement terms of the European Treaty, but the precise way in which states choose to implement a Directive is left to the state concerned.[24] An individual in a member state can rely directly on a Directive if it is sufficiently clear and unconditional.[25] This direct effect is 'vertical' only i.e. it can only be enforced against the state or

18 *Directives 89/654; Directive 89/655; Directive 89/656; Directive 90/269; Dirctive 90/270; Directive 90/394.*

19 *Management of Health and Safety at Work Regulations 1999, SI 1999/3242.*

20 *Regulations made under the daughter Directives are: the Workplace (Health, Safety and Welfare) Regulations 1992; the Provision and Use of Work Equipment Regulations 1992; the Personal protective Equipment at Work Regulations 1992; the Health and Safety (Display Screen Equipment) Regulations 1992; the Manual Handling Operations Regulations 1992 (these all make up what is often referred to as the 'six pack').*

21 *Management of Health and Safety at Work Regulations 1999, Reg 22(1).*

22 *Section 47(2).*

23 *[2001] WL 1535385.*

24 *Article 249 (3) EC.*

25 *Van Duyn v Home Office [1974] ECR 1337. In theory the member state should have transposed the Directive into national law so that reliance on the Directive itself should be unnecessary, but it might not have been transposed, or only partially or inadequately transposed.*

an emanation of the state that provides a public service.[26] However, Directives can also have indirect effect inasmuch as they can be used by national courts as an aid to interpretation of the relevant national law, and even legislation not specifically enacted to comply with European law.[27] Indirect effect means that cases would not be restricted to action against state enterprises.[28] This means that it would be possible for the UK health and safety regulatory framework to be interpreted in the light of the Framework Directive or for the Directive to be relied upon directly against a public service employer. It has been argued that some of the provisions of the Directive are sufficiently precise to be directly enforceable, such as a failure to take into consideration a worker's capabilities, to adapt work to an individual worker, or adequately to train a worker (Articles 6(2)(d), and Article12).[29]

There is a requirement under European law that there be an effective remedy for breach of European law.[30] The Health and Safety at Work Act and the 1999 Regulations do not admit of a civil remedy. Whilst many physical injuries are covered by the 'six pack' Regulations[31] which do give rise to a civil law right, the situation with regard to mental injuries, as we will see, is uncertain, and employees have to rely upon the common law, and in particular, on the principles in *Sutherland v Hatton*[32] (discussed below). There is no divergence from Europe here as long as one or more of three situations pertains (discussed below): the Framework Directive does not apply to mental injury; it applies in a different way so as not to demand the standard of the competent person; there is little difference between UK standards and the European standard.

It must be said, however, that if European law treats mental injuries in the same way as physical injuries, then the question arises as to whether there is an effective remedy when the 'reasonably practicable' test is applied. In *Cross v Highlands & Islands Enterprise* the Scottish Outer House held that the Framework Directive is concerned with general health and safety improvement and that there was no intention to confer an individual (private law) right of action in respect of any breaches.[33] We will re-visit this case later on in this article.

2. MENTAL HEALTH IN THE WORKPLACE

2.1 The common law – negligence liability

For the purposes of employment law, injuries to mental health can be divided into two categories: those induced by trauma and those induced by the wider working environment, but more

26 *Marshall v Southampton and South West Area Health Authority (No 1) [1986] ECR 723; Foster v British Gas plc and others [1990] ECR 1-3313; Doughty v Rolls Royce plc [1992] 1 CMLR 1045.*

27 *See Von Colson and Kamann v Land Nordrhien-Westfalen [1984] ECR 1337 and Marleasing SA v La Commercial Internacional de Alimentation [1990] ECR 1-4135. Note however, Hawkes v London Borough of Southwark (1998 20 February unreported) where, in the context of the Manual Handling Operations Regulations 1992, the Court of Appeal interpreted 'reasonably practicable' in accordance with pre-European Community law.*

28 *Webb v EMO Air Cargo (K) Ltd (No 2) [1995] 4 All ER 577.*

29 *J Hendy & M Ford Munkman on Employer's Liability 13th Edition (London, Butterworths, 2001) p 299.*

30 *Article 249 EC.*

31 *These are Regulations made under the daughter Directives are: the Workplace (Health, Safety and Welfare) Regulations 1992; the Provision and Use of Work Equipment Regulations 1992; the Personal protective Equipment at Work Regulations 1992; the Health and Safety (Display Screen Equipment) Regulations 1992; the Manual Handling Operations Regulations 1992 (these all make up what is often referred to as the 'six pack').*

32 *[2002] WL 45314.*

33 *[2001] SLT 1060 at 1088.*

commonly described as 'stress' claims. Trauma-induced injuries are less problematic at common law (but not necessarily fair or coherent) because of the limiting factors set down in non-employment tort law.[34] The key case in the employment context is *White v Chief Constable of South Yorkshire Police*.[35] For our purposes, the main element of the decision was whether mental injury caused by employers' liability can be treated differently from cases of ordinary negligence. The Court of Appeal[36] had held that the distinction between primary and secondary victims[37] did not apply when there is a pre-existing duty of care as in the case of the employer/employee relationship. The House of Lords disagreed; thus, if the employee is not a primary victim s/he must be a secondary victim and in consequence must have a close tie of love and affection with a primary victim, a condition that would not be satisfied simply by being work colleagues.

The 'stress' cases present a much more open-ended picture at common law. The first case was *Petch v Commissioner Customs & Excise*[38] and, although the claimant was unsuccessful, the general foreseeability test applied therein was applied in *Walker v Northumberland County Council*.[39] Mr Walker suffered a nervous breakdown following a significant increase in his workload about which he had complained. When he returned to work after taking a period of sick leave caused by the stress of his work, there had been no steps taken to alleviate his workload and he suffered a relapse and took ill-health retirement. The judge held that the first breakdown was unforeseeable for two reasons. First, the employing authority had no previous experience of workers becoming ill through overwork. Secondly, there was nothing in the personality of Mr Walker to alert them to the possibility of this happening to him. The second breakdown was, for fairly obvious reasons, held to be foreseeable and Mr Walker was successful.

Since *Walker*, stress cases have been examined by the higher courts. In *Sutherland v Hatton*[40] a set of general principles were set out by the Court of Appeal. The case concerned a number of conjoined appeals, and only one claimant succeeded. One of the unsuccessful claimants appealed to the House of Lords where his appeal was upheld (*Barber v Somerset County Council*[41]). However, the House of Lords endorsed the main principles set out by the Court of Appeal.[42] These can be summarised as follows:

1. For the purposes of employers' liability there is a difference between physical and mental injury, as risk of mental injury occurring depends upon differences in approaches to, and prioritising of, work (paras 5 and 23).

2. Foreseeability is the gateway to recovery as without this there is no breach of duty even if occupational stress has caused the mental injury (paras 23 and 24).

3. Facts relevant to foreseeability include the nature and extent of the work done by the employee

34 *Principally in the House of Lords decisions of Alcock v Chief Constable of South Yorkshire Police [1992] 1 AC 310 and Page v Smith [1995] 2 WLR 644.*

35 *[1999] 2 AC 455.*

36 *Frost v Chief Constable of South Yorkshire Police [1997] 1 All ER 540.*

37 *Primary victims are those who are either injured or foreseeably at risk of being injured or reasonably believe themselves to be (Page v Smith [1995] 2 WLR 644) and secondary victims are present at the traumatic event or its immediate aftermath and have a close tie of love and affection with one or more primary victims (Alcock v Chief Constable of South Yorkshire Police [1992] 1 AC 310).*

38 *[1993] ICR 789.*

39 *[1995] 1 All ER 737.*

40 *[2002] WL 45314. This case was considered in detail by Edward Myers in 'Claiming Damages for Work Place Stress' in JMHL December 2002, pp 283 - 292.*

41 *[2004] 1 WLR 1089.*

42 *The basis of the majority decision to uphold the appeal was that the Court of Appeal had insufficient reason to set aside the trial judge's findings.*

and overt signs from the employee or complaints or warnings from others. These indications must be plain to a reasonable employer (para 5).

4. There is no intrinsically stressful work, and employers are entitled to assume that the employee can withstand the normal pressures of the job, unless they know of some particular problem or vulnerability (para 29).

5. The employer can only take steps that are 'reasonable' (defined by the usual negligence standard of care considerations such as the magnitude of the risk of harm occurring, the gravity of the harm and the costs and practicability of preventing it). These steps will depend on the employer's undertaking, including its size, resources and demands that would be made on other employees (paras 32 and 33).

6. If the only reasonable step that can be taken is dismissal, the employer will not be in breach if he allows a willing employee to stay in the job (para 34).

7. An employer who offers a confidential advice service, with referral to counselling or treatment services, is unlikely to be found in breach of duty (paras 17 and 33).

A related and important question concerns how far an employee can consent to pressure at work. In *Smith v Baker*[43] the House of Lords rejected the argument that an employee could assume the risk of the employer's negligence. In other words, it is no defence if the risk should reasonably be guarded against. *Johnstone v Bloomsbury*[44] concerned the excessive hours worked by a junior doctor, which were covered by an express term in the contract. The employee's claim was based upon the implied contractual term that an employer will care for its employees' health and safety, and that this should override any conflicting express term. The case was only before the Court of Appeal on an interlocutory application and the issue was never fully litigated. By a majority, the court held that in principle it was possible to argue that an employee was not always bound by the express terms in his employment contract, but it turned on the judgment of Lord Browne-Wilkinson who made that finding on the basis of the particular wording of the contract, which gave a certain amount of discretion to the employer, and that discretion would have to be exercised reasonably in the light of the implied term. The implication is that if the term had not been open to use of discretion then the majority decision would have endorsed the primacy of the express term. This emphasises the unsatisfactory relationship between duties under contractual terms and tort as it is well established that the defence of *volenti non fit injuria*[45] – in other words, the plaintiff has voluntarily assumed the risk of injury, is rarely applicable in employers' liability cases of negligence[46] and is never available as a defence in actions for breach of statutory duty.[47] It is highly likely that the contractual approach conflicts with more stringent statutory standards, both UK and European, because they are about making workplaces safe and not about allowing workers to agree to work in unsafe conditions. Commendable as this may be, it is by no means clear what is meant by 'unsafe' in the context of mental health. Furthermore, European law itself provides for workers to consent to working conditions that might be less than optimal.[48]

43 *[1891] AC 325.*

44 *[1991] 2 All ER 293.*

45 *In other words, the defence that the plaintiff has voluntarily assumed the risk of injury.*

46 *Bowater v Rowley Regis Corporation [1944] KB 476.*

47 *Wheeler v New Merton Boardmills Ltd [1933] 2 KB 669.*

48 *Working Time Directive 2003/88/EC, in Article 17, permits certain derogations from e.g. Article 6 which sets a maximum working week of 48 hours.*

3. THE CHALLENGE FROM EUROPE

3.1 'Reasonably practicable'

The essence of the challenge from the European Commission is that section 2(1) of the 1974 Act which states that it is the duty of every employer to ensure the health, safety and welfare of all his employees at work so far as is 'reasonably practicable' is incompatible with the Directive. There is liability under the Directive for all aspects of health and safety and the only exception is under Article 5(4) which states: "This Directive shall not restrict the option of Member States to provide for the exclusion or the limitation of employers' responsibility where occurrences are due to unusual and unforeseeable circumstances beyond the employers' control, or to exceptional events, the consequences of which could not have been avoided despite the exercise of all due care". The Commission's view is that the 'reasonably practicable' qualification in UK legislation does not fit in to this exclusion.[49] No doubt its argument will be that it effectively permits an employer to escape responsibility if he can prove that the sacrifice involved in taking further measures, whether in money, time or trouble, is excessive in some way, and not just in the very exceptional situations envisaged by Article 5(4).

First, one needs to look at what 'reasonably practicable' means.[50] 'Practicable' means that the preventative measures must be possible in the light of current knowledge and invention.[51] It is a very stringent test, therefore, and means that the employer must take all available steps without regard to cost, time and inconvenience. It is the qualification made by the word 'reasonably' that potentially conflicts with the standard envisaged by the Directive. This implies that, although a measure might be possible, it is not reasonable to expect an employer to implement such a measure in terms of cost (either of materials or time or other forms of expense such as loss of production). The phrase 'reasonably practicable' was examined by the Court of Appeal in *Edwards v National Coal Board*[52] and it is clear that it does not mean the same as 'the employer took all reasonable care.'[53] In *Edwards* it was stated:

> *"Reasonably practicable" is a narrower term than "physically possible", and seems to me to imply that a computation must be made by the owner in which the quantum of risk is placed on one scale and the sacrifice involved in the measures necessary for averting the risk (whether in money, time or trouble) is placed in the other, and that, if it be shown that there is a gross disproportion between them – the risk being insignificant in relation to the sacrifice – the defendants discharge the onus on them.*[54]

There has been some doubt as to whether the *Edwards* gross disproportion test was endorsed by the House of Lords in *Marshall v Gotham Co Ltd*[55] but the leading authority on employers' liability cogently argues that it was so endorsed.[56] In *Taylor v City of Glasgow* it was said that the difference between reasonable practicability and the common law duty of care is that in the former case,

49 *Case C-127/05 (pleas in law and main arguments).*

50 *The qualification applies in other jurisdictions too, see for example Australia's Occupational Health and Safety and Welfare Regulations 1995.*

51 *Schwalb v Fass (H) & Son [1946] 175 LT 345.*

52 *[1949] 1 KB 704, CA.*

53 *However the standard may be the same when there is a risk of death or serious injury: Read v Lyons [1947] AC 156 at 173; Wright v Dunlop Rubber Co & ICI Ltd (1972) 13 KIR 255.*

54 *Op cit at 712.*

55 *[1954] AC 360*

56 *See J Hendy and M Ford Munkman on Employer's Liability 13th Edition (London Butterworths 2001) p 249.*

precautions must be taken to make a workplace safe as opposed to guard against reasonably foreseeable risks.[57]

The UK courts have taken a fairly broad brush approach to risk assessment in the case of physical injuries. In *Furness v Midland Bank plc*[58] the claimant appealed against the dismissal of her claim brought under the Workplace (Health, Safety and Welfare) Regulations[59] for damages for personal injuries arising from an accident at work in which she had slipped on water on an internal flight of stairs and fallen. The allegation was that the employer had shown no evidence of having a system for dealing with spillages and, as such, had failed in its statutory duty to take reasonable precautions to keep the stairs free from water. Her appeal was dismissed on the basis that, whilst it would have been reasonably practicable for the employer to have issued its employees with an instruction to watch out for water spillages, the infrequency of spillages and the fact that the premises were used by employees only, meant its failure to do so did not put it in breach of Reg. 12(3). This can be contrasted with *Ward v Tesco Stores*[60] where the risk of spillage was significant and obvious. Furthermore, UK cases have treated regulations made pursuant to the Directive such as the Manual Handling Operations Regulations[61] as imposing a general duty only. For example, in *Taylor v City of Glasgow* it was said: "[The Framework Directive] is not expressed with reference to an individual task. The obligation is one intended to be carried out in respect of the employer's undertaking generally and in advance of any particular operation."[62] In a very helpful review of the area[63] Hendy has concluded that the standard of the 'reasonably practicable' test is below that of the European Directive, but, given the gross disproportionality test set out in *Edwards* it is not a crude cost/benefit standard.[64]

However, if we are persuaded by the two statements in *Taylor v City of Glasgow* that first, there is an obligation under the reasonably practicable test to make the workplace 'safe', but secondly, under the European Directive, this relates to the generality of the employer's undertaking or parts of the undertaking rather than each individual task, then the standard can, arguably, be regarded as very similar. Further, it is arguable that the Directive itself envisages a more pragmatic approach as one of the principles of prevention, states that measures should be implemented to replace the dangerous by the non-dangerous or *the less dangerous* (Article 6(2)(f); emphasis added).

3.2 The Directive and mental health

In *Cross v Highlands and Islands Enterprise*[65] the judge concluded that the Directive was not intended to apply to mental health. In support of this, he referred to the European Commission's General Framework for Action in the Field of Safety, Hygiene and Health at Work[66] and its opening paragraph which stated that: "The objective of the Commission's policy in the field of safety and

57 *[2002] SC 364, at 378.*

58 *[2000] WL 1720378.*

59 *SI 1992/3004.*

60 *[1976] 1 WLR 810.*

61 *SI 1992/2793.*

62 *[2002] SC 363 at 374. See also Koonul v Thameslink Healthcare Services [2000] PIQR P123 where the generality of the risk assessment exercises was stressed, as opposed to looking at each and every task, and Postle v Norfolk and Norwich NHS Healthcare Trust [2000] 12 CL 283.*

63 *J Hendy, "Industrial Accident Claims: Reasonable Practicability" [2001] JPIL Issue 3, 209.*

64 *The cost/benefit test referred to is often described as the 'Learned Hand' test as set out by Hand J in the case of United States v Carroll Towing Co (1947) 159 F 2ds 169. It does not incorporate the concept of proportionality in terms of risk and preventative measures, nor the need for a balancing exercise between the size of the risk and the gravity of the likely damage.*

65 *[2001] SLT 1060.*

66 *1994–2000 (COM (93)560).*

health at work over the last thirty years has been to reduce to a minimum both work accidents and occupational diseases''.[67] The first reference to 'stress' was in a resolution of the European Parliament of 6 May 1994 which urged the Commission to investigate, as a priority, measures in the field of stress, both physical and mental. In *Cross*, the judge concluded that the reference to 'accidents' and 'diseases' could not include mental health problems, and that this was borne out by the resolution of the European Parliament which post-dated the Directive. However, the Object of the Directive states that ...''it contains general principles concerning the prevention of occupational risks....'' (Article 1) and this expression is repeated at various points throughout, so arguably the wording of the Directive itself is wide enough to cover mental health. In addition, Article 6(2)(g) refers to the development of an overall prevention policy which covers (*inter alia*) ''social relationships and the influence of factors related to the working environment'', which suggests that regard should be had to risks over and above those of a physical nature. A similar argument can be made in respect of Article 6(2)(d) which requires adaptation of work to the individual ''in particular, to alleviating monotonous work'' which suggests that there is more than the physical element of work under consideration. The fact that 'stress' can cause physical injury is another factor that supports the view that a demarcation between the two aspects of injury is not appropriate.[68] Furthermore, an argument can be made that, as the Directive was not intended to replace any domestic law if that law was more generous,[69] and as the Health and Safety at Work Act specifically applies to both physical and mental health, then this should be read in conjunction with the Directive so that mental health is within its ambit. Indeed, it is arguable that the Health and Safety Executive has implicitly endorsed this, for example by issuing an improvement notice against the West Dorset General Hospitals NHS Trust following stress-related claims by staff.[70]

At the time of both the Robens Report in 1972 and the European Directive in 1989 the risk to health in the workplace would have been considered primarily in terms of heavy industry and manufacturing. Since then, however, there have been significant changes. There has been a move away from manufacturing towards service industries and the huge increase in the use of computers.[71] There has also been a large increase in the number of small employers[72] and an increase in atypical work patterns such as homeworkers.[73] Privatisation has also affected the scale of undertakings. Thus the changes since 1990 make the large scale health and safety issues and solutions which informed this legislation increasingly inappropriate, whilst at the same time the new types of work arguably bring with them new forms of ill health.[74] The Commission Communication of 11 March 2002 highlights the need for legislation to adapt in a number of areas including the prevention of social and emotional problems (stress, harassment at work, depression, anxiety and addiction). It is clear that future European health and safety legislation will encompass

67 *[2001] SLT 1060 at 1087.*

68 *See the link between work related upper limb disorder and psychological factors, for example, S Tyrer, Editorial, Journal of Psychosomatic Research (1994) Vol 38 No 6, p 493.*

69 *Article 1(3), and see Stark v Post Office [2000] ICR 1013.*

70 *http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModelEmployer/OccupationalHealth/OccupationalHealthArticle/fs/en?CONTENT_ID=4063966&chk=ueKTN%2B*

71 *J McClean et al ''Till Death Do Us Part: Changing work relationships in the 1990s'' (1994) 1 Trends in Organizational Behaviour 111–136.*

72 *Health and Safety Executive Health and Safety in Small Firms (HMSO, London 1995).*

73 *S Fredman ''Labour Law in Flux: The Changing Composition of the Workforce'' [1997] Vol 26 337.*

74 *Apart from mental health risks there have been ergonomic changes such as the prolonged use of telephones and computer screens which can adversely affect physical health, see Alexander v Midland Bank (1999 27 July, unreported).*

mental health.[75] Future legislation will therefore explicitly refer to mental health and the same issues will arise with regard to the standard of care imposed.

4. MENTAL HEALTH UNDER A EUROPEAN REGIME – WHAT STANDARD OF CARE?

4.1 The reasonable employer under common law

The standard is that as outlined under the *Sutherland v Hatton* principles. Is it possible to argue that the differences between physical and mental health mean that, effectively statutory liability should not demand a higher standard than this? There are two potential key differences between physical and mental injury. First, the risk of mental injury depends upon the psychological differences between individual workers. Although there can be some deviation in terms of physical resilience,[76] generally speaking it is possible to point to fairly standard risks of someone being physically injured. It might be thought at first glance that cases such as *Paris v Stepney*[77] do not support this view; on the contrary, the physical disability was obvious to the employer. The other important plank of the reasonable employer test is that much of the onus falls on the *employee* to alert the employer to the risk to his or her mental health. Although the Court of Appeal regarded the nature and extent of the work done as relevant to the foreseeability of injury, the other key factor was that there should be clear indications of risk from the employee, and, further, it was stated that a reasonable employer is entitled to assume that the employee can withstand the normal pressures of the job *unless he knows of some particular problem or vulnerability*. This does not give the employer carte blanche to overload an employee with work; if this happens then the employee does not have to show any special vulnerability. However, if the workload is 'normal' then the onus falls on the employee to demonstrate this vulnerability. A 'normal' workload should be able to be established by fairly objective means, albeit that there would have to be job-specific (as opposed to employee-specific) criteria employed. It is instructive that of the four appeals heard by the Court of Appeal in *Sutherland v Hatton* the only one that succeeded was the case of an administrator who, it was shown, had been required to work grossly excessive hours over the 37 hours per week required by her contract of employment.[78] There are other objective markers that can be used to measure the risk of stress-related injury, such as evidence of workers not taking meal breaks, and explicit changes in job content, management structures and methods of working.[79]

However, we need to contemplate the possibility that, either we accommodate the argument that the Framework Directive applies to mental health, or a new European Directive is enacted in accordance with the Community strategy on health and safety at work.[80] In either case we have to ascertain whether European standards will be higher than those under UK law. If the UK loses the case currently brought by the Commission, the reasonable practicability test will be replaced by the

75 *Community strategy on health and safety at work (2002–2006) (COM(2002) 118).*

76 *The 'egg shell skull' is well-recognised, but there has to be foreseeability of some injury even if the extent of it is unforeseen (Bourhill v Young [1943] AC 92; Hewett v Alf Brown's Transport Ltd [1992] ICR 530).*

77 *[1951] AC 367: there was a duty to provide goggles to a one-eyed worker because of the gravity of a potential injury to his good eye.*

78 *[2002] WL 45314, para 61.*

79 *Under Cresswell v Inland Revenue [1984] 2 All ER 713 an employee is under a duty to adapt to new methods of working but adequate training must be given.*

80 *Community strategy on health and safety at work (2002–2006) (COM(2002) 118).*

competent person standard. If not, then it is probably safe to assume that the standard would not fall below reasonable practicability.

Although the common law standard implies risk assessment, it is in the statutory provisions that it becomes explicit and requires the workplace to be made safe. However, it is arguable that the less demanding common law standard is appropriate in the context of mental health, if only because it will be less clear as to *precisely* what the employer must do to prevent mental health problems developing as a result of the working environment i.e. because of the variability of employees' responses to stress. On this test the courts might well stress foreseeability of injury (even though we are not applying the negligence test). In any event, foreseeability has a particular pertinence to the reasonably practicable test.

4.2. Mental health and the 'reasonably practicable' test

As we have seen, this allows an employer to argue that preventative measures must not be grossly disproportionate to the risk of, and gravity of, the harm concerned. How much higher is this standard than that of the reasonable employer? The key word is 'grossly'. Preventative measures in mental health are more likely to be about job training, reporting opportunities (effectively incorporated into employment law by the statutory requirement to have a grievance procedure policy[81]) and, if there is some indication of a potential problem thereafter, appropriate monitoring. These are not likely to be onerous. Cases have succeeded under the 'reasonable employer' test on the basis that employees who have been off sick with stress-related illness did not have their situation effectively managed thereafter[82] or where some fairly simple instructions would have removed some key stressors from the employee.[83] It might be argued that the 'management' of such a case could be onerous if it required the employer to take on extra staff. This might be regarded as grossly disproportionate as long as the job the employee was doing did not impose excessive work demands.

Arguably employers should have nothing to fear from the imposition of higher standards because these standards do not require employers to continue to employ workers who are not sufficiently robust to carry out the essentials of the jobs concerned. Certainly the common law acknowledges this[84] as does the law of unfair dismissal.[85]

The approach of the UK courts to *generalised* risk assessment would not require risk assessment of individuals' approaches to their work to be part of any assessment.[86] The improvement notice issued to West Dorset General Hospitals NHS Trust by the Health and Safety Executive was because it did not have a work related stress policy or a risk assessment of work related stressors

81 *Section 1 Employment Rights Act 1996, Employment Act 2002 Schedule 2 and Goold (WA) (Pearmak) Ltd v McConnell [1995] IRLR 516, EAT.*

82 *See Unwin v West Sussex County Council [2001] WL 825227; Witham v Hastings & Rother NHS Trust [2001] WL 1346938; Young v The Post Office [2002] EWCA Civ 661.*

83 *Rowntree v Commissioner of Police of the Metropolis [2001] WL 1346941.*

84 *Sutherland v Hatton 2002] WL 45314, para 34.*

85 *Dismissal for lack of capability is a potentially fair dismissal under setion 98(2)(a) Employment Rights Act 1996.*

86 *See above, for example, the case of Taylor v City of Glasgow [2002] SC 364.*

and not because of individual cases.[87] Where gross disproportion might arise is in the provision of in-house counselling services,[88] particularly as such services are available externally and a small employer could use these if necessary.

4.3 Mental health and the 'competent person' test

As we have seen, the European 'competent person' is someone unconstrained by consideration of cost, time or inconvenience. If this is the relevant test then it might be useful to consider whether some of the provisions of the Framework Directive might have direct or indirect effect in a mental health context. Hendy and Ford have argued that Article 6(2)(d) of the Directive is sufficiently precise to be directly enforceable[89]. It is arguable however that this only applies to physical injury. Article 6(2)(d) states that one of the principles of prevention is for employers to adapt work to the individual. Not only is this not precise, but in the mental health context it could be said that it is *impracticable* to do this, not *reasonably impracticable*. The advantage of the above argument that practicability rather than reasonable practicability is key, is that the European standard of the competent person will be much easier to satisfy. If it is impracticable then it is not within the scope of the competent person's ability. Similarly Article 6(2)(g), which states that employers should develop a coherent overall prevention policy covering technology, organization of work, working conditions, social relationships and the influence of factors related to the working environment, is too vague to be enforceable, and gives rise to the same problems as Article (2)(d).

Unlike the case of physical health, therefore, preventative measures in the case of mental health, will usually be of a general nature only, such as risk assessments and the monitoring of those known to be at risk. A future European Directive on mental health in the workplace might be more precise and informative, although arguably the nature of mental health and workplace 'stress' might mean that, as at present, the imposition of 'higher standards' results in a situation where the employer who implements reasonably practicable measures, and the competent person, are the same characters in the context of mental injury because they are both constrained by individual psychologies and therefore by what is practicable.

87 *http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModelEmployer/OccupationalHealth/OccupationalHealthArticle/fs/en?CONTENT_ID=4063966&chk=ueKTN%2B*

88 *Sutherland v Hatton made it clear that, at common law, there was no obligation to provide such services, [2002] WL 45314, paras 17 and 33.*

89 *Op cit*

Casenotes

Executive Action and Convention Compliance? A Risk Unrecognised by the House

Kris Gledhill[1]

R (MH) v (1) Secretary of State for Health (2) Mental Health Review Tribunal
House of Lords, 20 October 2005
[2005] UKHL 60, [2005] Mental Health Law Reports 302

The House of Lords' interest in the impact of the Human Rights Act 1998 on mental health matters, evidenced by the number of cases it has heard[2], has continued with the case of *MH*. The two central issues arising were:

1. Whether automatic reviews of the lawfulness of detention by a court (in practice the Mental Health Review Tribunal) are required in relation to s2 detentions where the patient lacks capacity to apply for a Tribunal.

2. Whether a review is required pending the outcome of an application to displace a nearest relative (which extends the period of the s2 detention).

The House, in a judgment given by Baroness Hale, held that the statutory scheme was compatible with the requirements of the Convention, and in so doing overturned two declarations of incompatibility granted by the Court of Appeal, and restored the first instance decision of Silber J.

Facts

MH, an adult with severe learning disabilities, had lived with her mother, who, it was said, refused assistance from the authorities which might have been to MH's benefit. On 31 January 2003, following concerns about MH's behaviour, which was said to be escalating, and her mother's

1 *Barrister; p/t legal member of the Mental Health Review Tribunal; Editor of the Mental Health Law Reports.*

2 *R (B) v Ashworth Hospital Authority [2005] Mental Health Law Reports 47; R (IH) v Nottinghamshire Healthcare NHS Trust [2004] Mental Health Law Reports 51; R (Munjaz) v Mersey Care NHS Trust [2005] Mental Health Law Reports 276; R v (1) Tower Hamlets Health Care NHS Trust and (2) Snazell ex p Von Brandenburg [2004] Mental Health Law Reports 44; Ward v Commissioner of Police of the Metropolis and another [2005] Mental Health Law Reports 128; see also Anderson, Doherty and Reid v The Scottish Ministers and the Advocate-General for Scotland [2001] Mental Health Law Report 192 (Privy Council – considering the Mental Health (Public Safety and Appeals) (Scotland) Act 1999), and cases relating to criminal matters, R v Antoine [2000] Mental Health Law Reports 28, R v Drew [2003] Mental Health Law Reports 282, and R v H [2003] Mental Health Law Reports 209.*

ill-health and ability to cope, police and a social worker employed by Telford and Wrekin BC executed a warrant granted by the Magistrates Court under s135(1) *Mental Health Act 1983* after the mother refused to allow a mental health assessment to be carried out. MH was admitted to hospital for assessment under s2 of the 1983 Act, and a plan was formulated to place her under guardianship under s7 of the Act and admit her to a suitable residential setting. Guardianship can proceed only if the nearest relative does not object[3]: as MH's mother did object, an application was made to the County Court on 27 February 2003 pursuant to s29 of the Act for her displacement as nearest relative on the ground that her stance was unreasonable. The effect of the making of the application was that MH's detention under s2 was extended until the displacement proceedings, including any appeal, were completed[4].

A patient detained under s2 may apply to a Mental Health Review Tribunal[5], which may order release; however, the application has to be made within 14 days of the section being put in place[6]. Rule 3(1) of the Mental Health Review Tribunal Rules 1983 states that "An application shall be made to the tribunal in writing, signed by the applicant or any person authorised by him to do so on his behalf." MH made no application: it seems to have been felt that she did not have the capacity to make an application or to instruct solicitors. However, solicitors acting on her behalf subsequently did ask that the Secretary of State for Health use her powers under s67 of the 1983 Act to refer the case to the Tribunal, which was done. On 26 March 2003, a Tribunal upheld MH's detention. There had also been an attempt by MH's mother to use her powers of discharge under s23 of the Act, but this was barred by the Responsible Medical Officer under s25 of the Act, who certified that MH would be likely to act in a manner dangerous to herself or others if discharged, reflecting the statutory test which prevents a discharge by the nearest relative taking effect.

In the displacement proceedings, an interim displacement order was made on 1 August 2003, following which MH was admitted into guardianship; she had already been placed in accommodation on 21 July 2003, as a matter of leave under s17 of the Act. The final displacement order was made in July 2004, but an appeal from that was not completed until May 2005[7]: had no interim displacement been made, the s2 detention could have remained in place until that time.

The decision of Silber J – 22 January 2004, [2004] Mental Health Law Reports 155

The first instance decision was given whilst the displacement proceedings were still at a relatively early stage. The judge split the case into a number of distinct issues, each of which he answered against the arguments for MH.

Firstly, was s66(1) of the 1983 Act incompatible with Art 5(4) of the European Convention on Human Rights in relation to a s2 patient? This was a general challenge, which rested on the fact that the statutory right was limited, as it was a right given to the patient only (and so not exercisable by the nearest relative) and was limited to a right to make an application within 14 days. It was argued that this could not comply with Art 5(4), which gives a general right of application to a court. The solution for this defect, it was suggested, would be an automatic reference so that there would

3 *s11(4) of the 1983 Act.*

4 *s29(4).*

5 *s66(1).*

6 *s66(2).*

7 *see Lewis v Gibson [2005] Mental Health Law Reports 309.*

always be a review of the lawfulness of detention by a competent court. Silber J dismissed this argument, resting on the fact that the right in Art 5(4) is in terms a right to "take proceedings" to determine the lawfulness of detention, which does not encompass the need for an automatic review; this point was, he felt, fortified by the contrast with the language of Art 5(3), which requires that those arrested in criminal proceedings have a right to be "brought promptly before" a judicial official, which does not rest on an application being made. The judge also relied on the fact that the s2 detention was usually of relatively short duration.

The second argument for MH was specific to her status as a patient felt to be without capacity to instruct lawyers or take proceedings: it was that those without capacity must be provided with an automatic review. Reliance was placed on *Megyeri v Germany* (1992) 15 EHRR 584. In this case, a patient detained on grounds of mental disorder had not been represented by a lawyer in proceedings to review the lawfulness of his detention, in essence because he had not appointed one: the European Court of Human Rights found that there had been a breach of Art 5(4) because M had not been able to present his case, which had compromised the fairness of the proceedings, an essential component of judicial proceedings. The Court emphasised that special procedural safeguards may be called for to protect those not fully capable of acting for themselves on account of their mental disorder, and on the facts that meant that M should not have been required to take the initiative in obtaining legal representation. Applying that principle, the argument for MH was that the special procedural safeguard required was an automatic review.

Silber J did not accept this: his first reason was a repetition of the conclusion that Art 5(4) did not use the language of review, but provided a right to take proceedings; his second reason was that any need for special procedural safeguards had to depend on the context, which was a short period of detention and so not one requiring an automatic review.

The next argument for MH related to the fact that there had been an extension of the s2 detention by virtue of the application to displace the nearest relative: in such a case, there is no statutory provision allowing the patient to make an application to a Tribunal to consider whether detention remains justified. However, Silber J felt that the answer to this problem was that the County Court involved in the displacement proceedings was bound to exercise its role in accordance with Art 5 and so not allow any excessive delay. As such, there was no defect in the statutory scheme of the 1983 Act.

The fourth argument developed from the third by noting that the aim of the displacement proceedings on the facts was not to secure MH's further detention under s3 of the Act (detention for treatment) but to allow her to be transferred into guardianship: in this context, it was argued that the criteria for detention could not be made out and so any detention breached Art 5 of the Convention. Silber J rejected this argument on the basis that the criteria for detention were indeed made out (in light of the fact that a barring order had been issued to prevent MH's release) and the use of guardianship was akin to setting up a regime for release into the community which was permissible under Art 5 as long as it was not unreasonably delayed. The mechanism to ensure that there was no unreasonable delay was the duty of the County Court to act expeditiously, thereby ensuring either that the guardianship was put in place or the patient released.

All these arguments were revisited on appeal. There was one other challenge which was not pursued on appeal, which related to the Tribunal's refusal to consider the s25 dangerousness criteria on an application in relation to a s2 patient. Silber J held that an analysis of s72 of the Act,

which governs the powers of the Tribunal, indicated that it was not bound to consider those criteria in relation to a s2 patient, although it could do so in its discretion.

The decision of the Court of Appeal – 3 December 2004, [2004] Mental Health Law Reports 345

The Court of Appeal reached a radically different conclusion to Silber J in relation to the arguments as to compatibility, and granted two declarations of incompatibility under s4 of the Human Rights Act. By that time, the displacement order had been granted, although the appeal from that was pending.

Buxton LJ gave the first judgment. He dealt with two broad issues, which were the position of a patient without capacity detained under s2 and the position of a patient (whether with or without capacity) detained by virtue of the extension of a s2 order on account of the commencement of displacement proceedings. In relation to the first issue, he noted that the conclusion reached by Silber J resulted in an imbalance between those who were able to apply for a tribunal hearing and those who were not. He then posed the question whether it could have been the intention of those who framed the language of the Convention to produce this imbalance: this he answered by concluding that clearly it could not have been their intention. When this was analysed in terms of the language of the Convention, on which Silber J had relied, the reference in Art 5(4) to the right to "take proceedings" could not be construed as being intended to exclude from the protection of Art 5 a person who was unable to take proceedings because of their lack of capacity. This was so even though, as Silber J had noted, Art 5(3) used the language of being brought before a judge: Buxton LJ made the point that just because a criminal detainee must have their case considered by a judge, that does not mean that the state is not required to assist a detainee under other heads who was unable to assert the right to take proceedings. He made the point that the language of the Convention is not to be construed in an overly legalistic fashion: it is designed to set out guiding principles only, which then have to be applied to the facts of the particular case.

Two points made by way of preamble supported the conclusion that there were problems in the statutory scheme. The first was that the short period of detention under s2 – which Silber J felt justified the lack of a review for a patient without capacity – could not be relied on because it proved too much: if it was acceptable in such a case, it would also be acceptable for a patient with capacity; but in Convention terms, a period of 28 days without a review raised obvious concerns about compliance with Art 5(4). Secondly, Silber J's reliance on the County Court was also misplaced because it was not reviewing the lawfulness of detention (and so was not sitting as a court carrying out an Art 5 task) and the patient had no standing in the proceedings (but could only be a witness)[8].

As to the solution to the problem identified with the statutory scheme, Buxton LJ noted that the unjustified differential treatment of s2 patients without capacity meant that a mechanism was required whereby those cases could be referred to a Tribunal. Such a power was missing from the Mental Health Act 1983; although there are wide powers of interpretation provided by s3 of the

8 *This was because CCR Ord 49, r12(3)(b) at the time provided that anyone other than the patient could be made a party to proceedings. This was amended by the Civil Procedure (Amendment) Rules 2005 (SI 2005/352): see Lewis v Gibson [2005] Mental Health Law Reports 309, the appeal from the displacement proceedings in the MH case, for guidance on the procedural steps which should be taken to ensure that the patient is able to be made a party.*

1998 Act – which allow the courts to bend over backwards to secure a meaning compliant with the Convention – these cannot be used to read into the statute a provision which is simply not there. Accordingly, it was necessary to grant a declaration of incompatibility under s4 of the 1998 Act, namely that the 1983 Act required an amendment to make it compatible with the Convention. The other members of the Court of Appeal delivered concurring opinions.

Having dealt with the first issue, Buxton LJ turned to the second question raised, namely the continued detention of a patient under s2 by virtue of ongoing displacement proceedings. This was felt to be more straight-forward: as there was no judicial supervision of the lawfulness of detention during this period, there was a breach of Art 5(4). The proceedings in the County Court, on which Silber J had relied, were inadequate as displacement did not deal with the lawfulness of detention and the patient was not a party[9]. It was also held that the use of judicial review or habeas corpus would also be inadequate because they were not suited to consider the merits of the case for detention in the way that a Mental Health Review Tribunal could: review by the High Court of a decision to continue to detain a patient is not the same as the power of a specialist court to take a decision on the merits. As this also reflected a gap in the statutory regime, the remedy was a further declaration of incompatibility. The other members of the Court concurred with this.

The use of s67[10] of the 1983 Act

There was one matter on which Silber J and the Court of Appeal agreed, which was that the intervention by the Secretary of State to refer the case to a Tribunal was not a matter which could provide compliance with the Convention. This is because the principle enumerated in Convention case law, and adopted in jurisprudence under the Human Rights Act 1998, is that access to a judicial body which is controlled by the Executive is not adequate for the purposes of Art 5[11].

The decision of the House of Lords – 20 October 2005, [2005] Mental Health Law Reports 302

Baroness Hale (described by Buxton LJ in his judgment in the Court of Appeal as "a judge of unparalleled authority in the field of mental health law"[12]) disagreed with the Court of Appeal's construction of the statutory scheme. She gave the only speech, the rest of their Lordships agreeing with her.

Dealing first with the question of whether Art 5(4) required an automatic review, Baroness Hale adopted the reasoning of Silber J: "The short answer," she said at para 22, "is that Art 5(4) does not require that every case be considered by a court. It requires that the person detained should have the right to 'take proceedings'." She then supported this, as had done the judge, by contrasting this with the language of Art 5(3) and commenting that "The difference between a right to "take proceedings" and a right to "be brought promptly before a [court]" must be deliberate."

9 *At least not at that time: see preceding footnote.*

10 *'The Secretary of State may if he thinks fit, at any time refer to a Mental Health Review Tribunal the case of any patient who is liable to be detained or subject to guardianship (or to aftercare under supervision) under Part II of this Act.'*

11 *Addressed below.*

12 *At para 12; the context was Buxton LJ's reliance on comments from Hale LJ as she then was in the case of R (S) v City of Plymouth [2002] Mental Health Law Reports 118, [2002] 1 WLR 2582 [39] that "applications under s29 have to be dealt with quickly" to make the point that they had not been dealt with quickly on the facts of MH's case.*

Dealing with the obvious riposte that a right to "take proceedings" has to be practical and effective[13], Her Ladyship conceded that this was a "powerful argument" but felt that it lead to the conclusion not that a reference to a Tribunal was required but that "every sensible effort should be made to enable the patient to exercise that right if there is reason to think that she would wish to do so". And this is achieved by the statutory regime, since hospital managers are required to take such steps as are practicable to ensure the patient understands his or her right of access to a tribunal and how to apply, including giving advice on how to contact the Tribunal and solicitors[14], and the rules governing applications to tribunals are part of a user-friendly regime which allows an application to be made on behalf of the patient by anyone authorised to do so (relatives, social workers, nurses and advocates), subject only to the patient meeting the undemanding threshold of capacity to authorise that person to act. In addition, it was to be noted that although relatives (including the nearest relative) have no independent right of application to a tribunal, relatives and friends can ensure that the case is put before a judicial authority, including by stimulating a reference by the Secretary of State under s67 of the Act (as had happened on the facts). For these reasons, it was held that s2 of the Mental Health Act 1983 was not itself incompatible with Art 5(4) by not having an automatic review of those felt to be without capacity to apply.

The position of patients who continued to be detained as a result of the commencement of displacement proceedings was said to reveal a more unsatisfactory legal situation. This was because the commencement of displacement proceedings extends the s2 detention – which is meant to last for only 28 days at most before either lapsing or being replaced by a longer-term power of detention for which the admission criteria are more stringent and which brings fresh rights to apply to a tribunal (and referrals if no application is made). However, Baroness Hale held that it was not something which required a declaration of incompatibility because the regime can be operated compatibly with the Convention if the County Court makes a swift displacement order resulting in a s3 detention (or s7 guardianship), which gives a right to apply to a tribunal, or refuses to displace, thereby ending the detention; further, if the displacement proceedings drag on, Art 5(4) is not violated if the Secretary of State refers the case to a tribunal pursuant to her discretion, which must be exercised compatibly with the Convention and is subject to judicial review.

Effect of the Ruling and Need for Action by Others

In assessing which of the contrasting rulings is objectively better, it is worth noting, first, that Baroness Hale's final comment in relation to the s29(4) situation was that the while the section was not itself incompatible with Art 5(4) "the action or inaction of the authorities under it may be so"[15]. This comment is equally applicable to the case of the patient without capacity detained under s2: the section was held not incompatible because of the steps that could and should be taken, and so failures in this regard could breach the Convention.

13 *A long established principle of Convention jurisprudence – see as a good example Airey v Ireland (1979) 2 EHRR 305, in which it was determined that the right to a fair trial in civil proceedings might well require the provision of legal aid in order to be effective, even though the Convention makes express reference to legal aid only in the context of criminal proceedings.*

14 *Section 132 of the Act, which imposes a statutory duty to give advice, as supplemented by the Code of Practice issued under s118 of the Act, which includes guidance that hospitals should ensure that advice is given by people with appropriate training and that information provided includes material on how to apply to the Mental Health Review Tribunal, the availability of legal aid and information on solicitors.*

15 *Para 32.*

However, this final comment also demonstrates an obvious problem in the reasoning process Her Ladyship had adopted in reaching her conclusion. The starting point was, as it had been with Silber J, that the language of Art 5(4) involves a deliberate choice of a right to "take proceedings" and so automatic referrals could not be required: but the solution adopted in the s29 situation does not involve the patient taking proceedings whereby the lawfulness of their detention is tested. Rather, it involves the County Court being swift in determining whether to displace the nearest relative, or it involves the Secretary of State for Health making a reference under s67. Equally, in the case of s2 and the patient without capacity, Her Ladyship relies on the s67 power or on the power of others to sign an application form to a Tribunal on behalf of a patient who has not actually made an application to a Tribunal but may wish to do so. So these instances of why the statutory scheme is compatible with the Art 5(4) right to "take proceedings" all involve situations where the patient does not in fact commence proceedings but where a Tribunal is spurred into action by others to review detention or the County Court takes action in proceedings which the patient cannot commence.

The analysis of the problem in the Court of Appeal was more compelling, particularly in light of the established principle that there is no compliance with Art 5(4) if Executive action is required. This principle, as noted above, was accepted by both Silber J and the Court of Appeal, but it is not mentioned by the House of Lords. It is a principle which has been accepted by the domestic courts, and so it was behind a declaration of incompatibility that was not appealed by the government: in *R (D) v Home Secretary* [2003] Mental Health Law Reports 193, [2003] 1 WLR 1315, a declaration was granted that "the absence of any power in s74 of the Mental Health Act 1983 or any other provision enabling a "court", for the purposes of Art 5 of the Convention for the Protection of Human Rights and Fundamental Freedoms, to order the release of a prisoner: (a) who is sentenced to a discretionary life sentence; and (b) who is transferred to hospital under s47 of the 1983 Act and made subject to a restriction direction under s49 of the 1983 Act; and (c) who is subsequently the subject of a recommendation under s74(1)(b) of the 1983 Act; and (d) who is discharged from hospital but where the recommendation is accepted by the Secretary of State and he therefore remains in hospital, is incompatible with Art 5(4) of the Convention". The problem in this case was that the release of a life sentence prisoner from his or her sentence of imprisonment has to be a matter for a court (in practice the Parole Board[16]) to meet the requirements of Art.5(4). However a life sentence prisoner transferred to hospital, in relation to whom a Tribunal could only recommend release[17], had a statutory right to access the Parole Board only through a decision of the Home Secretary to allow such access. The Home Secretary had in fact announced in a Parliamentary answer[18] that such prisoners would be allowed access to the Parole Board via his power of referral just as if they had a right to apply under statute. But this declaration of policy, together with the availability of court action by way of judicial review, was held to be insufficient to comply with Art 5(4). Although permission to appeal was granted by the High Court, it appears that the result was accepted, and the law was then changed in the Criminal Justice Act 2003[19].

The principle in *D* that control by the Executive of access to a court breaches Art. 5(4) is a development of the principle that Executive action before release (ie after a court decision) is *not* sufficient for Art 5(4).

16 *Normally under s28 of the Crime (Sentences) Act 1997, though on the facts of the case, due to the date on which D had been sentenced, his access to the Parole Board was by virtue of s34 of the Criminal Justice Act 1991, even though it had been repealed.*

17 *Section 74 of the Mental Health Act 1983*

18 *Hansard HC Debates 20 June 1994, col 9*

19 *Section 295 added s74(5A) to the 1983 Act to provide that a transferred prisoner in hospital subject to a restriction direction could apply to the Parole Board and if the Board directed his release the restriction direction would cease to have effect on his release.*

An example of this from the European Court of Human Rights which also involved s74 of the 1983 Act is *Benjamin and Wilson v UK* [2003] Mental Health Law Reports 124, (2003) 36 EHRR 1. The Court found a breach of Art 5(4) in relation to transferred life-sentence prisoners who had been granted the status equivalent to those detained under a hospital order[20], since the consideration of their case by the Tribunal involved only the making of a recommendation for release under s74. It noted that the requirement of the Convention is that there be a court-like body which has the power to determine lawfulness of detention and order release[21].

Accordingly, intervention by authorities of the state is not sufficient for compliance with Art 5(4). This calls into question Baroness Hale's reliance on the availability of the s67 reference. In the s29(4) situation, the other matter on which she relied was the duty of the County Court to act speedily, but that does not deal with the point that the proceedings in the County Court do not answer the question of the lawfulness of detention. It may be that this is a matter which is answered implicitly (the more so now that the patient can be a party to the proceedings): but, again, there is authority from the European Court of Human Rights that what is required is a court which answers the question directly. To give a recent example to illustrate this point, in *Mathew v Netherlands* [2006] 1 Prison Law Reports ..., the issue was whether the conditions of detention in a prison in Aruba breached Art 3 of the Convention; the Dutch government pointed out that the criminal appeal court had taken account of the conditions of detention and had reduced the sentence accordingly, and so they argued that Mr Mathew was no longer a victim of a breach of the Convention, having had a remedy in the criminal proceedings. The Court held that Mr Mathew remained a victim, notwithstanding the action of the domestic court, because it had not been the function of that court to make findings as to whether there was a breach of Art 3. So by analogy, the County Court does not perform the function of the Mental Health Review Tribunal and so does not meet the requirements of Art 5(4).

In the case of the patient without capacity detained under s2, the principle that intervention by the Executive is not sufficient – which disallows reliance on s67 – must apply equally to the reliance placed by Baroness Hale on the duties of hospital managers to make sure that patients know of their rights of application. The managers, after all, have custody of the patient[22] and are clearly acting on behalf of the state in that regard. The whole point of the guarantees set out in the Convention, it must be remembered, is the view that the best way to ensure that fundamental liberty rights are protected is via the separation of powers doctrine. Pursuant to this, issues of liberty are for the courts and access to the courts must be direct. This is because of the risk that Executive action will be less than ideal because of problems ranging from politically-inspired deliberate policies to prevent people enjoying their fundamental rights through to lack of resources despite the best will, with problems of indifference somewhere in the middle.

This is why the analysis of Buxton LJ is better. His starting point is the obvious one that the Convention aims to set out guiding principles only: the expansive reading adopted by the European Court[23] makes this plain. That in turn means that not much can be read into the specific language "take proceedings": the question to be asked is what principle is guaranteed, to which the

20 *The now-abolished "technical lifer" status described in R (IR) v (1) Dr GJ Shetty (2) Home Secretary (No 2) [2004] Mental Health Law Reports 130*

21 *The Court cited long-established case law in relation to life sentence prisoners, Weeks v UK (1987) 10 EHRR 293 and Singh v UK (1996) 22 EHRR 1, and also DN v Switzerland [2001] Mental Health Law Reports 117,*

22 *Section 6 of the 1983 Act.*

23 *Including the need for steps to be taken to make rights practical and effective, referred to above.*

answer is access to a court to assess the lawfulness of detention. As did Buxton LJ, the rhetorical question to be posed is whether this guarantee should not apply in the case of someone who cannot actually "take proceedings", in part because their mental disorder (the very basis for their detention) means that they cannot actually do so.

It is true that Buxton LJ does not in terms deal with the difference in the language of Art 5(3) and Art 5(4), beyond saying that the fact that a criminal detainee must have their case considered by a judge does not mean that the state is not required to assist a detainee under other heads who was unable to assert the right to take proceedings. There are at least two further points which could have been made. First, there is the difference in context: the right to liberty combined with the presumption of innocence means that depriving someone of their liberty on the basis of arrest on suspicion of having committed an offence requires court intervention to assess the need for detention. This indeed is reflected in the language of Art 5(1)(c), which provides for arrest on reasonable suspicion "for the purpose of bringing him before the competent legal authority": there is no similar requirement in the other grounds of detention in Art 5(1), making plain that criminal arrest simply has a different context. It may also be that the question of bail is more susceptible of a summary determination, making it appropriate to have the language of s5(3).

Secondly, the existence of the Art 5(3) right in relation to a criminal arrestee does not exclude the Art 5(4) right of the same detainee, and so using the language of Art 5(3) in the Art 5(4) context amounts to using apples in a debate about the quality of oranges.

For these reasons, the Buxton position, as agreed to by the other members of the Court of Appeal, seems to have the benefit of principle. Baroness Hale's position, particularly in relation to patients without capacity, comes close to this in any event, since she allows applications to be made on behalf of the patient: this is not the patient taking proceedings, this is proceedings being taken on behalf of the patient. But since her argument rests on a view that it is the taking of proceedings by the patient which is the right guaranteed – even though the compatibility she sees in the existing scheme comes from proceedings not commenced by the patient – it would be far better to conclude that the Convention in fact requires that automatic references be provided, for reasons which reflect the principle underlying the Court of Appeal's position, namely that the important right guaranteed is a court decision, not access to a court to those who choose to participate in proceedings.

The Practical Application of the Ruling in Relation to Patients Without Capacity

It may be thought that the practical problem with the Court of Appeal's position, and the strength of the House of Lords' ruling, is that a declaration of incompatibility does not change the law, but rather amounts to a recognition of the unsatisfactory nature of the situation which is then left to political will to solve[24]. In other words, rather than wringing hands, Baroness Hale has set out a position which allows practical steps to be taken to ensure that there are Tribunal proceedings

24 *Just as, for example, the inability of patients to change their nearest relative has been recognised and accepted for several years (see FC v UK [1999] Mental Health Law Reports 174, 7 September 1999, in which the Court referred to correspondence from the government indicating that the matter would be resolved as part of a review of mental health legislation). See also JT v UK [2000] Mental Health Law Reports 254, 30 March 2000.*

which will examine the position of all patients caught in either of the two situations described.

It is true that the practical effect of the House of Lords' ruling is that there should be an increase in the number of cases put in front of Tribunals by s67 references and by applications made on behalf of patients: but there is nothing in the granting of a declaration of incompatibility which prevents those exercising public powers from doing what they can to ensure that Convention rights are met so far as possible pending a change in the legislation.

In relation to incapacitated s2 patients, s132 of the 1983 Act provides that hospital managers must ensure that patients know "what rights of applying to a Mental Health Review Tribunal are available to him": the same information must be provided to the nearest relative (except where the patient request otherwise) (s132(4)). Since Baroness Hale relied on the s67 power and the right of patients to authorise others to make applications for them, the information provided under s132 must presumably include these methods as well. Given that the use of formal powers over a patient is a good indication that the patient is not there voluntarily, could not this be taken as an indication that the patient authorises the making of an application to a Tribunal on their behalf, satisfying the low threshold of capacity to provide such authority, since it is an indication that the patient does not wish to be in hospital and would presumably want to question their detention by the available mechanism, namely the Tribunal? Further, since the s67 power is seen as a method of ensuring that there is compliance with Art 5(4), and the hospital managers have a power to alert the Secretary of State to the possible need to make a reference, and there is a general administrative law principle that those who have a power must consider whether to use it, it must fall to them to consider whether or not in every case of a patient under s2 who has not made or had made an application to the Tribunal, there should be a request to the Secretary of State to use the s67 power.

The net effect of this ought to be that every s2 patient should have their case placed before a Tribunal. As for the situation where a s2 detention is extended by s29 proceedings, either the s29 proceedings must be dealt with speedily or the Secretary of State must make a referral to the Tribunal, and a mechanism must be in place to allow s67 references to be made wherever displacement proceedings drag on for any reason.

Since the mechanisms identified by the House of Lords were ones within the requirements of Art 5(4), they would have applied in any event, given the duty of public bodies to act compatibly with the Convention, even if the ultimate conclusion was that a declaration of incompatibility was required because of the structural problem that reliance on Executive action is not sufficient to ensure that there is compliance with Art 5(4). But the fact is that practical problems exist: County Courts do not always deal with displacement proceedings speedily, and it is unlikely that the mechanisms identified by Baroness Hale are being used in all cases when they should be used. The likely corollary of the conclusion of the House of Lords is that further judicial review litigation will be needed to establish the natural consequences of their decision. This reinforces the practical need for an amendment of the legislation to ensure that there are automatic references, which is what the declarations of incompatibility should have accomplished (at least eventually). This in turn demonstrates that the Court of Appeal's approach was preferable: reliance on action by the Executive is not a safe way to ensure that Art 5(4) is met because of the practical problems which this may encounter. It is much better to have a legal requirement to make a reference than rely on hospital managers and the Secretary of State putting into place, as a matter of their discretion, mechanisms which cause references to be made.

One Code to rule them all, one code to bind them: the seclusion of detained patients.

Simon Foster[1]

R v Ashworth Hospital Authority (now Mersey Care NHS Trust) ex parte Munjaz [2005] UKHL 58 (On appeal from [2003] EWCA Civ 1036)

Introduction

The issue in this appeal was whether a hospital could lawfully implement a seclusion policy which departed from the framework in the Mental Health Act Code of Practice, 1999 revision ("the Code"). However, the significance of the case is much wider, going to the status of the Code as a whole.

The facts

Colonel Munjaz, a man in his late 50s, is a patient at Ashworth high security hospital. In 1999 Ashworth introduced a written policy governing the seclusion of patients detained there which diverged considerably from the framework in the Code, particularly with regard to the frequency of review. Mr Munjaz was subjected to seclusion on a number of occasions. He brought judicial review proceedings, challenging both the decisions to seclude him and the legality of Ashworth's policy as a whole. The court did not permit the claim in respect of Mr Munjaz's own seclusion to be pursued, but in 2000 Jackson J ruled that the provisions for review in Ashworth's policy were not ones which a reasonable authority could adopt: *R v Ashworth Special Hospital Trust ex parte Munjaz* [2000] MHLR 183.

Ashworth revised its seclusion policy. The new policy, which still diverged considerably from that in the Code, was put into effect in December 2002.

In July 2001 Mr Munjaz had brought fresh judicial review proceedings to challenge Ashworth's failure to amend its policy as required by the judge; the claim was amended to challenge Ashworth's new policy. Mr Munjaz also initially challenged the use of seclusion in his case but this aspect of his claim was not pursued.

The law

Section 118 of the Mental Health Act 1983 provides:

(1) The Secretary of State shall prepare, and from time to time revise, a code of practice–

(a) for the guidance of registered medical practitioners, managers and staff of hospitals, independent hospitals and care homes and approved social workers in relation to the admission of patients to hospitals and registered establishments under this Act and to guardianship and after-care under supervision under this Act; and

1 *Independent Legal Consultant; former head of Mind's Legal Unit*

(b) for the guidance of registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.

From the Introduction to the Mental Health Act 1983 Code of Practice (1999 edition), paragraph 1:

"... The Act does not impose a legal duty to comply with the Code but as it is a statutory document, failure to follow it could be referred to in evidence in legal proceedings."

Seclusion in the Code (extracts)

19.16 Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.

Seclusion should be used:

- as a last resort;
- for the shortest possible time.

Seclusion should not be used:

- as a punishment or threat;
- as part of a treatment programme;
- because of shortage of staff;
- where there is any risk of suicide or self-harm.

.....

Procedure for seclusion

19.18 The decision to use seclusion can be made in the first instance by a doctor or the nurse in charge. Where the decision is taken by someone other than a doctor, the rmo or duty doctor should be notified at once and should attend immediately unless the seclusion is only for a very brief period (no more than five minutes).

19.19 A nurse should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion, and present at all times with a patient who has been sedated.

19.20 The aim of observation is to monitor the condition and behaviour of the patient and to identify the time at which seclusion can be terminated. The level should be decided on an individual basis and the patient should be observed continuously. A documented report must be made at least every 15 minutes.

19.21 The need to continue seclusion should be reviewed:

- every 2 hours by 2 nurses (1 of whom was not involved in the decision to seclude), and
- every 4 hours by a doctor.

A multi-disciplinary review should be completed by a consultant or other senior doctor, nurses and other professionals, who were not involved in the incident which led to the seclusion if the seclusion continues for more than:

- 8 hours consecutively; or
- 12 hours intermittently over a period of 48 hours.

Ashworth's 2002 Seclusion Policy (extracts)

2. *Introduction*

2.4 ... The Code of Practice revised in March 1999 was written to encompass a wide range of mental health services and does not specifically consider the special situation of a high security hospital.

3.1 (Repeats almost verbatim para 19.17 of the Code.)

4.1 ff (Repeats para 19.16 of the Code with regard to the definition of seclusion and when seclusion should be used.)

...

9. *Review*

9.1 The RMO is responsible for the use of seclusion. Regular reviews must take place involving the RMO or deputy and Ward Manager or deputy. The details of these are given below.

9.2 If a doctor was not present at the time of seclusion, he must initiate a review on arrival within one hour and then at:

9.2.1 First day-medical review at 4, 8, 12 and 24 hours;

9.2.2 Day 2 to day 7 – twice per day;

9.2.3 Day 8 onwards:

[i] daily review by Ward Manager or Site Manager from different ward;

[ii] three medical reviews every 7 days (one being by the RMO);

[iii] weekly review by multi-disciplinary patient care team to include RMO;

[iv] review by Seclusion Monitoring Group as per paragraph 10 below

...

11 The use of seclusion for patients posing management problems

11.1 Any patient for whom the clinical team has to institute seclusion in excess of seven days, will be individually brought to the attention of the Medical Director or in their absence the Executive Nurse Director, by the chairperson of the patient's clinical team, with a resume of the reasons for the continuing use of seclusion, the care and treatment which the patient will be receiving and what is hoped will be achieved.

...

11.7 Each patient's case will be reviewed weekly by the clinical team and a written report sent monthly to the Seclusion Monitoring Group...

11.8 After six months, the Medical Director and Executive Nurse Director will participate in a clinical team review. The case will then be discussed at the Executive Team Meeting.

11.9 The Mental Health Act Commission will be informed if seclusion continues beyond 7 days and will receive progress reports on a regular basis.

The first instance hearing

The Secretary of State for Health submitted a statement to the effect that the Code was guidance only, and that he did not object to Ashworth introducing its own policy on seclusion. In the light of this, Sullivan J dismissed Mr Munjaz's claim: *R (Munjaz) v Ashworth Hospital Authority* [2002] EWHC (Admin) 1521. The judge declared that there was no issue estoppel in judicial review proceedings, so it was open to Ashworth to come to different conclusions from those reached by Jackson J in 2000.

In August 2002, in *S v Airedale NHS Trust* [2002] EWHC Admin 1980, Stanley Burton J dismissed another patient's challenge to seclusion outwith the framework of the Code, on similar grounds to Sullivan J.

Both patients appealed.

The Court of Appeal judgment

The appeals were heard together, with the Secretary of State, Mind and the Mental Health Act Commission (which submitted written evidence only) being joined as interveners. Both appeals were allowed: [2003] EWCA Civ 1036.

Hale LJ made the following findings, inter alia:

(i) The power to seclude a patient was implied from the power to detain, or possibly from common law necessity. This did not mean that all uses of seclusion were lawful.

(ii) Seclusion in the Code was within the scope of sections 118(1)(a) and 118(1)(b) of the 1983 Act.

(iii) Seclusion did not in itself constitute inhuman or degrading treatment, but there was always a risk that it could be in breach of Article 3 ECHR.[2]

(iv) Seclusion infringed article 8(1)[3] unless it could be justified under article 8(2)[4].

(v) Article 5[5] was not concerned with the conditions of detention: this was left to articles 3 and 8.

(vi) There was no statutory obligation for hospitals to follow the Code, but where there was a risk that agents of the state would treat their patients in a way which contravened their Convention rights, the state should take steps to prevent it. Thus the Code was not mere guidance, but should be observed by all hospitals unless they had a good reason for departing from it in relation to an individual patient.

Ashworth (but not Airedale Hospital) appealed to the House of Lords. The interveners and arguments were as at the Court of Appeal, except that Mr Munjaz adopted Mind's argument in respect of Article 8.

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

3 *"Everyone has the right to respect for his private and family life, his home and his correspondence"*

4 *"There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law as is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedom of others"*

5 *"Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases, and in accordance with a procedure prescribed by law: ... the lawful detention of persons... of unsound mind...."*

The House of Lords judgments

Their Lordships heard the case over three days and delivered their opinions on 13th October 2005. A majority of the House (3:2) allowed the appeal and dismissed Mr Munjaz's application.

Lord Bingham of Cornhill gave the leading judgment.

The first question for consideration was whether the Code (sic) fell within section 118(1) of the 1983 Act. His Lordship accepted the Court of Appeal's conclusion. "Admission" could not sensibly be read as referring only to the process of admission, to the exclusion of all that followed. Similarly, "medical treatment" as defined in section 145(1) of the 1983 Act was wide enough to cover the nursing and caring for a patient in seclusion, even though seclusion could not properly form part of a treatment programme.

The Code described itself as guidance. There was a categorical difference between guidance and instruction. In response Mr Munjaz laid emphasis on the consultation which preceded the drawing up of the Code, on the parliamentary sanction it received, on its issue by the Secretary of State and on the high importance of protecting detained mental patients, a vulnerable and defenceless sector of society, from any risk of abuse.

It was plain that the Code did not have the binding effect which a statutory provision or statutory instrument would have. But the matters relied on by Mr Munjaz showed that the guidance should be given great weight. It was guidance which any hospital should consider with great care, and from which it should depart only if it had cogent reasons for doing so.

The evidence adduced by the Trust made clear that the Code had been carefully considered. It was entitled to take account of three matters in particular. First, the Code was directed to the generality of hospitals and did not address the special problems of high security hospitals. Secondly, it did not recognise the special position of patients whom it was necessary to seclude for longer than a very few days. Thirdly, the statutory scheme deliberately left the final decision to those who bore the responsibility for detaining, treating, nursing and caring for the patients.

There were differences of practice, not all of them fully explained, between Ashworth, Broadmoor and Rampton[6]. It was not, however, for the courts to resolve debatable issues of professional practice but to rule on issues of law. If a practice was supported by cogent reasoned justification, the court was not entitled to condemn it as unlawful.

Ashworth's policy and the European Convention

Mr Munjaz did not contend that his own seclusion had been unlawful. Thus it was necessary to consider the compatibility with the Convention of the policy as a policy. For this purpose the Code was irrelevant: if the policy was incompatible, consistency with the Code would not save it; if it was compatible, it required no support from the Code.

It was to be assumed that the Ashworth policy was followed in the hospital. Seclusion was universally recognised to be an unwelcome necessity of last resort. It was justified only when necessary to protect others, and then for the shortest period necessary for that purpose. The potential injury which seclusion could cause to the psychological and physical well-being of a patient was universally recognised.

6 *The three High Security Hospitals*

The internal distribution of powers within member states was not regulated by the Convention. If Parliament chose to establish a framework of binding statutory provision, and to supplement those provisions by a Code which would guide but not bind local managers and healthcare professionals, there was nothing in the Convention which invalidated that decision.

Article 3

The Trust must not subject patients at Ashworth to treatment prohibited by article 3 or adopt a policy which exposed patients to a significant risk of such treatment. The policy, considered as a whole and properly operated, would be sufficient to prevent any possible breach of the article 3 rights of a patient secluded beyond 7 days, and there was no evidence that the frequency of medical reviews provided in the policy risked any breach of those rights.

Article 5

While Article 5 may avail a person detained in an institution of an inappropriate type it could not found a complaint directed to the category of institution within an appropriate system. The approach to residual liberty which appears to have prevailed in Canada (see *Miller v The Queen* (1985) 24 DLR 4th 9) did not reflect the jurisprudence of the European Court. Improper use of seclusion might found complaints under Article 3 or Article 8, and Article 5(4) provided that a successful challenge would result in an order that the detainee should be released, not that the conditions of his detention be varied.

Article 8

It was obvious that seclusion, improperly used, might violate a patient's Article 8 right in a serious and damaging way. This appeal, however, was directed to the compatibility of the Ashworth policy with the Convention. His Lordship had some difficulty in appreciating how seclusion could be said to show any lack of respect for a patient's private and family life, home or correspondence if it was used as the only means of protecting others from violence or intimidation and for the shortest period necessary. A detained patient, when in his right mind or during lucid intervals, would recognise that his best interests were served by his being prevented from acting in such a way.

If it was accepted that seclusion engaged article 8(1), it was necessary to consider justification under article 8(2). It was plainly necessary for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others. Properly used, seclusion would not be disproportionate because it would match the necessity giving rise to it.

Mind had submitted that the interference was not "in accordance with the law" because it was not prescribed by a binding general law. His Lordship could not accept this. The requirement was directed to substance not form. It was intended to ensure that any interference was not random and arbitrary but governed by clear pre-existing rules, and that the circumstances and procedures adopted were predictable and foreseeable by those to whom they were applied. Given the broad range of institutions in which patients may be treated for mental disorder, it was readily understandable why a single set of rules was thought to be undesirable and perhaps impracticable. The procedure adopted by the Trust did not permit arbitrary or random decision-making. The rules were accessible, foreseeable and predictable. It could not be said that they were not in accordance with or prescribed by law.

The Court of Appeal had given the Code a stronger effect than was permissible. Their conclusion gave the Code a weight which Parliament did not give it, which the Secretary of State did not support and which the Convention context did not require.

Lord Steyn, dissenting, said that the Mental Health Act 1983 was out of date. It was left to so-called soft law, in the form of a Code, to fill the gap.

The judgment of the Court of Appeal had demonstrated a thorough understanding of this sensitive and difficult branch of law. He agreed with the Court in respect of Articles 3 and 8 of the ECHR, the status of the Code, and the conclusion that hospitals might not depart from the Code as a matter of policy.

The only part of their judgment which his Lordship would not adopt was in respect of Article 5. Under English law a convicted prisoner retained all his civil rights which were not taken away expressly or by necessary implication. To that extent he had a residual liberty. The reasoning in *Miller v The Queen* (above) showed that where solitary confinement was unlawfully superimposed upon a prison sentence it could amount to a "prison within a prison". In *R v Deputy Governor of Parkhurst and others ex parte Hague* [1992] 1 AC 58 the House of Lords had ruled out this concept, but *Hague* predated the Human Rights Act 1998 and should no longer be treated as authoritative. A fortiori it should not be applied to mentally disordered patients who were not guilty of any legal or moral culpability.

It would also be wrong to assume that under the jurisprudence of the ECHR residual liberty was not protected. In *Bollan v United Kingdom*, App No 42117/98, 42117/98, the European Court of Human Rights had said:

> *"...The court does not exclude that measures adopted within a prison may disclose interferences with the right to liberty in exceptional circumstances."*

If substantial and unjust seclusion of a mentally disordered patient could not be protected effectively under Articles 3 and 8, it followed that a substantial period of unnecessary seclusion could amount to an unjustified deprivation of liberty.

It was wrong to focus exclusively or even primarily on the dictionary meaning of "guidance". The provision in section 118(2), and in the White Paper of 1981, for the Code to specify forms of treatment was inconsistent with a free-for-all in which hospitals were at liberty to depart from the Code as they considered right. Indeed, it seemed unlikely that Parliament would have authorised a regime in which hospitals could as a matter of policy depart from the Code.

The Court of Appeal had applied the dictum of Sedley J in *R v Islington BC ex parte Rixon* [1997] ELR 66, at 71, that local authorities might only depart from the Secretary of State's guidance for good reason. In the present case fundamental rights were at stake and even before the Human Rights Act 1998, an intense review on principles of proportionality was appropriate.

The Court of Appeal had stated: "Hence we conclude that the Code should be observed by all hospitals unless they have a good reason for departing from it in relation to an individual patient..." Given the manifest dangers inherent in seclusion, and the extreme vulnerability of the patients, this conclusion was sound.

The endorsement of the Code by the Secretary of State made his virtual disowning of the Code in these proceedings difficult to understand. The judgment of the majority of the House lowered

the protection offered by the law to mentally disordered patients.

Lord Hope of Craighead concurred with Lord Bingham. One of the virtues of the Code was that it was able to provide clear standards that were capable of being applied by all hospitals and all healthcare facilities.

In the introduction to its Seclusion Policy, it was noted that Ashworth Hospital admitted patients who were considered to present a grave and immediate risk to the public which could not be managed in conditions of lesser security. It was often the case that all other usual interventions such as psychological interventions and alterations in drug treatment had been tried.

Much of what was in the Policy complied with and elaborated upon the guidance which the Code offered. The departure from that guidance was explained by Ashworth's perception of what was needed for the management of the patients detained there whose behaviour fell outside the normal pattern of that exhibited by mental patients generally. There was a genuine and respectable difference of view among those who were responsible for the formulation of policy in this difficult and highly specialised field.

In a letter to Ashworth's solicitors, the Mental Health Act Commission had said that the Code had perhaps been written on the assumption that seclusion should not normally still be in place after three days, no matter how disturbed the patient might be at the time of seclusion; in that event other methods of management should be resorted to. This dispute was not something on which judges were competent to adjudicate.

Domestic law

With regard to section 118(1) of the 1983 Act, the words "the admission of patients to hospitals" could not be limited to the actual admission process. Seclusion was not part of the patient's treatment, but it fell well within the scope of the phrase "the medical treatment of patients suffering from mental disorder". The statutory basis for the guidance was to be found in section 118(1)(b) of the 1983 Act.

What did "guidance" mean in this context? There was no statutory obligation to comply with it. But it could not be divorced from its statutory background, from the process of consultation and from the Parliamentary procedure that had to be gone through. Statutory guidance of this kind was less than a direction, but more than something to which those to whom it was addressed must "have regard to". He would go further than the Court of Appeal. Those to whom the Code was addressed must give cogent reasons if in any respect they decided not to follow it. Those reasons must be spelt out clearly, logically and convincingly.

There were ample grounds for thinking that good reasons had been demonstrated at Ashworth. There was no doubt the situation there differed greatly from that in the generality of institutions in which mental patients might find themselves. The Code did not address this problem, nor was it designed to do so. Section 118(1) envisaged a single code of practice, not a series of codes designed for different types of hospital. A balance was struck in the Policy between the need for frequent medical reviews in the early stages and group monitoring in the longer term at less frequent intervals, bearing in mind that some patients at Ashworth were dangerous not just for short bursts but also for long periods, and the need to make the most efficient use of medical resources at the hospital.

The Convention rights

The proposition that it was the responsibility of the court to give the Code the weight and status that it needed to secure the patients' Convention rights was undoubtedly sound in principle. The reasons for any departure from the Code must be subjected to particularly intense and careful scrutiny.

No complaint was made about the way the Policy had been implemented at Ashworth, nor that it had been applied to the respondent in a way which had caused harm to him. There was no evidence that any other patient had suffered as a result of the way the Policy had been implemented.

Article 3

Inhuman or degrading treatment must attain a minimum level of severity. In *Osman v United Kingdom* (1998) 29 EHRR 245 the court had recognised that such obligations must be interpreted in a way which did not impose an impossible or disproportionate burden on the authorities. Regard must be had to the particular conditions, the stringency of the measure, its duration, the objective pursued and its effect on the person concerned.

The risk which must be considered was whether a patient might suffer ill-treatment of the required level of severity as a result of having been kept in seclusion under Ashworth's policy for longer than would have been the case under the Code. Dr Davidson's[7] report concluded that Ashworth's policy of fewer reviews after seven days increased the risk. But the evidence fell well short of demonstrating that the Policy gave rise to a serious risk of ill-treatment of the required level of severity. In view of the safeguards which it contained and the special circumstances that obtained in the hospital it would be disproportionate for Ashworth to be compelled to abandon it in favour of the Code.

Article 5

A person who was of unsound mind must be detained in a place which was appropriate for that purpose: *Aerts v Belgium* (1998) 29 EHRR 50. Beyond that, article 5(1)(e) was not concerned with the patient's treatment or the conditions of his detention. These matters must be dealt with under articles 3 and 8. In *Bollan v United Kingdom* (above) the court had said that disciplinary steps imposed on prisoners could not be considered a deprivation of liberty, but were modifications of the conditions of detention. The seclusion of a patient at Ashworth did not amount to a separate deprivation of liberty which engaged Article 5.

Article 8

Normal restrictions and limitations consequent upon prison life and discipline would not constitute in principle a violation of this Article. The Committee of Ministers had recognised that seclusion might be resorted to in appropriate circumstances.

Clearly there was a risk of a violation if this form of intervention was resorted to improperly or for longer periods than the person's mental condition justified. But there was no evidence that this was happening at Ashworth. The whole purpose of the Policy was to define the standards which must be followed and prevent abuse and arbitrariness. It was hard to see why, in these circumstances, the Policy should itself be thought to be incompatible with Article 8(1).

7 *Dr Davidson is a Consultant Forensic Psychiatrist, whose evidence had been adduced by Mr Munjaz in the Court of Appeal*

Assuming nevertheless that the Policy required to be justified under Article 8(2), his Lordship would conclude that it satisfied those tests. The aim was to prevent disorder or crime. Its purpose was to address the special considerations to be applied in a high security hospital, whose patients were considered to present a grave and immediate risk to the public and might do so also to other patients, staff and visitors. It also aimed to ensure that the procedure was resorted to in a way that was proportionate and that, even in long-term cases, it was brought to an end as early as possible.

The main thrust of Mind's argument was that an interference with Article 8(1) could not be justified unless it was "in accordance with the law". "Law" in this context was not limited to statutory enactment or to measures which had their base in a statute. It included the common law. But the measure must be formulated with sufficient precision and be sufficiently accessible to satisfy the criterion of foreseeability.

The Policy satisfied these requirements. Its procedures were spelled out with the same clarity and attention to detail as those in the Code. The Policy was published within the hospital so that it was available to all who needed to see them. The way this form of intervention was managed at Ashworth was entirely foreseeable.

Mind argued that the Code would not have the force of law if it was open to Ashworth to depart from it in formulating its own policy. The patient would not be able to foresee to a degree that was reasonable how this form of intervention might be exercised. His Lordship did not accept this. But the argument missed the point in any event, because the issue was not whether the Code was incompatible or at risk of being so, but was directed to the lawfulness of Ashworth's Policy.

There was no reason why Ashworth was not free to depart from the Code as a matter of policy, and not just in relation to individual patients or groups of patients. There was an obvious danger that, if the Code could be departed from in the case of individual patients or groups of patients, decisions to do this would be open to attack as being arbitrary. That was what Ashworth's Policy sought to avoid.

It was the quality of the law that mattered rather than the form it took. Its qualities were measured by its transparency, its accessibility, its predictability and its consistency. There was no doubt that the Code satisfied these tests, although there was no statutory obligation to comply with it. Ashworth's Policy did so too. It was true that Ashworth could alter its Policy, but every departure from the Code would have to be justified in the same way.

Concerns that a departure from the Code would lead to widespread variations in practice and undermine its status generally or that the House's judgment lowered the protection afforded by the law to mentally disordered patients were misplaced. Ashworth was the only place where a hospital had departed from what the Code said about seclusion in favour of its own policy.

Lord Scott of Foscote agreed with Lords Bingham and Hope. He also agreed with everything that Lord Brown had written, except in relation to article 8, where he concluded that the Ashworth policy did not have the necessary quality to render it compatible with the rule of law. This could not be right. "The law", for Article 8 purposes, did not consist only of statutes, directives, statutory codes etc. It must include, also, the variety of duties and rights arising out of the circumstances in which individuals and institutions found themselves that were imposed by the common law.

Ashworth owed a legal duty to the inmates of the hospital to take reasonable steps to protect him

or her from injury by other inmates. Ashworth could not choose its patients. It had to accept them, detain them and look after them. All of them suffered from some degree of mental disturbance – otherwise they would not be there. Some of them from time to time presented a danger to other inmates. Placing a patient in seclusion where the danger was sufficiently acute was a step that Ashworth's legal duty would require it to take. A dangerous patient's Article 8 rights could not justifiably be pitched at a level that required the hospital to leave other patients in unacceptable danger of harm. Once it was accepted that Ashworth had no statutory obligation to have a seclusion policy that conformed in every respect to the Code and that its policy was rational and reasonable in itself, there could be no room for any suggestion that its implementation for the safety of other inmates was otherwise than in accordance with the law.

Lord Brown, dissenting, said that the Court of Appeal had declared that, in relation to seclusion, the Code might only be departed from if there was good reason for the departure in the case of an individual or a group of individuals sharing the same characteristics. A majority of the House had concluded that the Code was guidance to be departed from only if the hospital had cogent reasons for doing so. The difference between these positions must be that, where the Code embodied one view and a hospital took another, the Court of Appeal would require the hospital to follow the Code but the majority of the House would not.

The case advanced by those who challenged Ashworth's Policy was, first, that the United Kingdom would be in breach of its obligations under the Convention if Ashworth were permitted to adopt a policy of its own; second, to ensure compatibility with Convention rights, section 118 must be construed to give greater weight to the Code; third, once the Code was given this additional weight, Ashworth became disentitled to adopt a different policy of its own.

The Court of Appeal had accepted the appellant's case with regard to articles 3 and 8 but not as to article 5. His Lordship agreed with regard to article 5. There was no evidence that the approach to seclusion up and down the country created so plain a risk of article 3 violations that the Secretary of State was bound to take corrective measures. There was further ground for rejecting the article 3 argument. The Secretary of State was obliged not to act incompatibly with a Convention right, but was not obliged to ensure that other public authorities acted compatibly.

On these issues his Lordship was in full agreement with the majority of the House. The issue revolving around article 8, however, he found altogether more difficult. The first question was whether seclusion engaged article 8 at all. There could surely be only one answer to that question. It was unthinkable that a mental patient could be subjected to seclusion without such interference being "in accordance with the law".

The case therefore turned on article 8(2), and above all on the requirement that any interference be effected "in accordance with the law". Nobody could dispute that seclusion as a practice was necessary. It could be justified under several of the grounds in article 8(2). But that was not a sufficient answer to the complaint of interference with article 8 rights. In *Malone v United Kingdom* (1984) 7 EHRR 14, nobody doubted the justification of phone-tapping but it was held not to have been in accordance with the law. In *Hewitt and Harman v United Kingdom* (1991) 14 EHRR 657, secret surveillance activities were based on a directive from the Home Secretary which did not have the force of law: the European Commission of Human Rights had concluded that the directive did not indicate with sufficient certainty the scope and manner of the authorities' exercise of discretion in carrying out their activities.

More was required by way of legal justification than that there existed a sufficient basis for the practice in domestic law. The phrase 'in accordance with the law' also related to the quality of the law, requiring it to be compatible with the rule of law. This encompassed notions of transparency, accessibility, predictability and consistency, to guard against the arbitrary use of power and to afford sufficient legal protection to those at risk of its abuse.

His Lordship had reluctantly concluded that the Code must be given something akin to the force of law with regard to seclusion. Without such a Code seclusion would not be regulated, save insofar as each hospital would be required to adopt, publish and practise a rational policy of its own. This, of course, was precisely what Ashworth had done. But by the same token, other hospitals might think it unnecessary to conduct reviews as frequently as in the Code. And there was nothing to stop Ashworth altering its policy whenever it thought it right to do so.

Although Ashworth ostensibly adopted the Code's definition of seclusion, at most times about 75% of the long-term secluded patients were being nursed in extended association. This different attitude resulted in widely differing approaches to the practice. One patient had been transferred from Ashworth to Rampton having been in seclusion for the best part of nine years. At Rampton his long-term seclusion had ceased, and although from time to time he had since been secluded, this had never been for as long as eight hours, or a total of twelve hours within any forty-eight hour period.

Under the ruling proposed by the majority of the House, patients and their carers must be reconciled to substantial departures from the Code by individual hospitals. Unless one looked to the Code for regulation carrying the force of law it was not to be found elsewhere. Hospital policies provided too insubstantial a foundation for a practice so potentially harmful and open to abuse as the seclusion of vulnerable patients.

The discordance of views in this case seemed both striking and unfortunate. The Joint Parliamentary Select Committee on Human Rights had recently expressed concerns about the low level of compliance with guidelines on seclusion. His Lordship hoped that it might prove possible to lay down a comprehensive and compulsory scheme for the regulation and review of seclusion which reflected not merely best practice generally but also such special problems as Ashworth experienced. Sooner or later, consensus must be reached upon the proper place of seclusion within mental hospitals. The issue had been a running sore for far too long.

Comment

So, in respect of seclusion at least, the Code of Practice no longer has the enhanced status given it by the Court of Appeal. The majority judgment may be welcomed by those advising Trusts but is likely to alarm patients' representatives, who have relied upon the Code as a basis for challenging practices they regard as oppressive. As Saimo Chahal points out in Legal Action [2006] April, pages 20–22, seclusion "raises significant issues of concern pointing to human rights violations". It is therefore important to look at the majority judgment in terms of both the legal arguments and also its practical implications.

There is a striking degree of unanimity between the Court of Appeal and their Lordships. Seclusion is justified in domestic law; the framework in the Code derives its authority from the 1983 Act, probably as 'treatment' under s.118(1)(b). However, it potentially violates Convention rights, so the court has an obligation to ensure that these are adequately protected. There is no

evidence that seclusion in Ashworth or anywhere else attains a level of severity such as to engage article 3. Article 5(1) is not engaged either (Lord Steyn dissenting), as it concerns the conditions of detention only. Thus the case turns on the application of Article 8.

It is hard to understand why Lords Bingham and Hope struggle to bring seclusion within Article 8(1). Both acknowledge its potential for harm; but Lord Bingham doubts whether Article 8(1) is engaged "if it is used as the only means of protecting others from violence or intimidation and for the shortest period necessary to that end" (para 32). Lord Hope states: "The whole purpose of the Policy ... is to define the standards which must be followed and prevent abuse and arbitrariness" (para 89). The logic is hard to follow. Surely what they say goes to justification under Article 8(2)? Or do they mean that they have such faith in the infallibility of the Ashworth regime that an article 8 violation could never arise? (The cases Lord Hope cites – *Raninen v Finland* (1997) 26 EHRR 563 and *Herczegfalvy v Austria* (1992) 15 EHRR 437 – are both concerned with mechanical restraint, a very different thing from extended seclusion.) Lord Brown is surely correct when he states (para 118): "... as a practice it will inevitably sometimes engage article 8: there are bound to be occasions when the patient's "personal autonomy" or "moral integrity" ... are undermined ..."

If article 8(1) is engaged, it must be correct that Ashworth's policy cannot be challenged on grounds of its legitimate aim; and it is not necessary to have as rosy a view of Ashworth as Lords Bingham and Hope to accept that the proportionality of the use of seclusion will inevitably be a matter for the clinical judgement of the staff concerned (i.e. *Bolam* strikes again).

"Accordance with the law" is another matter. Leaving aside Lord Scott, whose argument – 'Ashworth have a duty to protect other patients, so their policy must be lawful' – begs too many questions (what if Ashworth said they had no choice but to shackle patients to their beds?), the Lords split 2:2 on the issue. On the one hand, the policy derives its authority from the Code, is accessible and foreseeable; on the other, patients need the certainty of knowing that wherever they are held they are governed by a single document which has been the subject of extensive consultation and endorsed by the Secretary of State.

One's attitude to this probably depends on whether one accepts, with the majority of their Lordships, that Ashworth is a 'special case'. Lord Brown is the only one to question why the practice at Ashworth is out of step with Rampton and Broadmoor, which (it might be thought) have broadly similar populations. Lord Bingham says that "it is not for the courts to resolve debatable issues of professional practice..."

But this issue is surely at the heart of the appeal: what are Ashworth in fact doing when they seclude a patient for weeks, months or even years? It is plainly something different from what is envisaged in the Code, which is expressed in terms of hours. Their Lordships agree that seclusion is covered by the definition of 'treatment' in s.145 MHA, and yet seem to take at face value Ashworth's statement, following the Code, that they do not use seclusion as part of a patient's treatment.

Lord Bingham gives the game away in para 23: "It has been the experience of the Trust that the condition of those secluded for more than a week does not change rapidly and that it is in any event unsafe to rely on an apparent improvement without allowing enough time to pass to give grounds for confidence that the improvement will endure." In other words, patients are left in seclusion until they have learned to behave differently. Presumably the periods of extended association referred to by Lord Brown are to test whether they are ready to return to the ward. In

what way is this not 'behaviour modification', i.e. a form of treatment?

This is not to dispute that Ashworth has some very violent and aggressive patients, for whom the framework of seclusion in the Code may be inappropriate. Perhaps such patients indeed require a programme of individual behaviour modification, with its own procedure and review mechanisms. But it would be far more helpful if this could be acknowledged and a full debate held on an appropriate policy for all such patients, who are certainly not limited to Ashworth or even to the high security hospitals.

Lord Hope states (para 99) that the majority decision "should not be seen as an invitation to other hospitals ... to resort to their own policies ..." This seems optimistic. There is no obvious reason why other hospitals should not, if they wish, find 'cogent reasons' based on their unique circumstances to justify departing from the Code with regard to seclusion, or any other aspect of their care of detained patients which is not reinforced by statute. Whether readers think this matters will no doubt depend upon their professional standpoint.

Paternalism or Power? – Compulsory treatment under section 58 of the Mental Health Act 1983

Paul Hope[1]

R (on the application of B) v S and others
Court of Appeal; Lord Phillips CJ, Thorpe LJ and Rix LJ; 26 January 2006
[2006] EWCA Civ 28

Introduction

This case was the latest in a series of challenges brought under the *Human Rights Act 1998* against compulsory treatment under Part IV of the *Mental Health Act 1983*. The Court of Appeal again confirmed the statutory authority to impose treatment for mental disorder, even where the patient has capacity, although it has left a number of issues still unresolved.

The Facts

The patient, B, had been detained at Broadmoor Hospital under sections 37 and 41 of the *Mental Health Act 1983* (MHA) following his conviction for rape in 1995. He had been diagnosed by his Responsible Medical Officer (RMO), Dr SS, as suffering from bi-polar affective disorder and, from the time of his arrival at the hospital in April 1995, had been treated with anti-psychotic medication. Initially this was Depixol administered by depot injection, but from August 1997 this had been changed to Risperidone which B took orally and voluntarily. In May 1999 B began a medication-free trial period, although medication was resumed in February 2000 when his condition deteriorated.

In July 2003 a further medication-free period was begun but in July 2004, again following a perceived deterioration in B's condition, the RMO decided that medication should be resumed. B however, who was deemed to have the mental capacity to consent to or refuse treatment, now refused to undergo the proposed treatment. On 15th July 2004 the RMO sought a second opinion and obtained the required certificate to allow the imposition of treatment under s.58 MHA. On 19th July B obtained an interim injunction preventing treatment and initiated proceedings against the RMO and the Second Opinion Appointed Doctor (SOAD) for their decision to medicate him compulsorily, and against the Secretary of State, claiming that the imposition of treatment under s.58 MHA, in the face of his capacitated refusal, would infringe his rights under the *European Convention on Human Rights* (ECHR).

By the time of the hearing, the SOAD's certificate had almost expired, the RMO had anyway decided that he no longer wished to proceed with treatment and a further injunction had been granted. Despite this, B argued that his claim against the Secretary of State should be determined. In a judgment delivered in January 2005, Silber J refused B's application, holding that the claim was

1 *Saneline helpline volunteer; Sweet & Maxwell prize winner, LLM Mental Health Law Programme 2004–2006, Northumbria University*

academic, but nevertheless addressed all the substantive issues on the claim at some length and held that s.58 MHA was not incompatible with the ECHR.

Subsequently, in May 2005, the RMO decided that the circumstances had changed and that compulsory treatment was warranted. Having obtained the necessary second opinion certificate, he applied in June to the Administrative Court to discharge the injunction preventing treatment. In response, B commenced new judicial review proceedings to challenge the legality of treatment. The case was heard before Charles J who, in his lengthy judgment of September 2005, dismissed B's application, declaring that the proposed compulsory treatment would be lawful, and duly discharged the injunction.

The Court of Appeal was thus effectively required to deal with an appeal against the judgments of both Silber J and Charles J.

The Law

The *Mental Health Act 1959* had clearly prescribed the conditions under which patients could formally be detained for observation or treatment but, surprisingly, did not include specific provisions for compulsory treatment; this was regarded as implicit in the Act. Enactment of the MHA however, removed any uncertainties and, under Part IV (ss.56–64) brought the compulsory treatment of detained patients firmly within the statutory framework.

Section 63 MHA provides:

> *"The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within section 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer."*

The special safeguards of ss.57 and 58, which can be overridden when treatment is required urgently (s.62), apply to two categories of treatment: (a) the most serious treatments which require the patient's capacitated consent *and* a second opinion (s.57), and (b) other serious treatments which require the patient's capacitated consent *or* a second opinion (s.58). Where a second opinion is required, this is provided by an independent second opinion appointed doctor (SOAD) appointed for this purpose by the Mental Health Act Commission (MHAC). Treatments under s.58 include the administration of medication for mental disorder after three months from its first administration, as in B's case. Before issuing a certificate authorising treatment, the SOAD must, under s.58(3)(b), be satisfied that the treatment should be given to the patient 'having regard to the likelihood of its alleviating or preventing a deterioration of his condition'.

The provisions of s.58 might thus have seemed to provide unequivocal authority to treat even capacitated patients without their consent. The enactment of the *Human Rights Act 1998* (HRA) however, with its requirement (s.3(1)) that 'so far as it is possible to do so' statutory provisions be exercised in a manner compatible with rights under the ECHR, offered a route for challenge in the courts. A series of challenges to s.58 treatment, and therefore effectively to any compulsory treatment under Part IV, then resulted. The first of these was *R (Wilkinson) v RMO Broadmoor and MHAC SOAD*[2] in which the Court of Appeal held that where a decision to administer medical treatment to a patient without his consent under s.58(3)(b) was challenged by way of judicial review,

2 *R (on the application of Wilkinson) v Responsible Medical Officer Broadmoor Hospital, the Mental Health Act Commission Second Opinion Appointed Doctor and the Secretary of State for Health [2001] EWCA Civ 1545*

the court was entitled to reach its own view on the facts as to whether the treatment infringed the patient's rights, through oral evidence and cross-examination if necessary. The Court also held, obiter, that notwithstanding the statutory authority of Part IV MHA, when treatment was imposed without consent upon a protesting patient, with or without capacity, this would be a potential invasion of his Convention rights under Articles 3 or 8. Using the guidance of the European Court (ECtHR) in *Herczegfalvy v Austria*[3] though, a breach of these rights would be avoided if the 'therapeutic necessity' or 'medical necessity' for the treatment had been 'convincingly shown to exist'[4].

The compatibility of the treatment provisions of Part IV with Articles 3 or 8 was then examined more directly by the courts, firstly in *R (N) v Dr M*[5] and subsequently in *R (PS) v Dr G (RMO) and Dr W (SOAD)*[6 7].

In *PS*, Silber J[8] ruled that the forcible administration of medication was lawful under s.58 MHA, notwithstanding the patient's capacity and refusal to consent. He confirmed however, that administration of medication to a patient against his or her will would have the potential to contravene Articles 3 and 8, but only in the following defined circumstances.

Article 3 would be engaged if the proposed treatment reached the minimum level of severity *and* the medical necessity had not been convincingly shown to exist. Reaching the minimum level of severity would normally involve intense physical or mental suffering[9] and this would need to be proved 'beyond reasonable doubt'. To determine convincing medical necessity, the judge endorsed the checklist of factors to be considered which had been set out by the Court of Appeal in *N v Dr M* [para 19].

Compulsory treatment imposed on a non-consenting patient could often result in a prima facie breach of Article 8, but this could be justified under Article 8(2). Such justification would have to be based on the proposed treatment being 'necessary in a democratic society... for the protection of health' and 'in accordance with the law'. Silber J held that this latter phrase meant compliance with the common law test of best interests, in that the treatment must be in accordance with 'responsible and competent professional opinion' and that the best available option for treatment had been chosen[10]. This in turn meant that the proposed treatment was likely to alleviate or prevent deterioration in the patient's condition[11], that a less invasive treatment which would be likely to achieve the same beneficial result for the patient was not available, and that it was necessary for the treatment to be given to the patient with regard to (a) his resistance to treatment, (b) the degree to which treatment is likely to alleviate or prevent deterioration of his condition, (c)

3 *Herczegfalvy v Austria (A/242B) (1993) 15 EHRR 437 at 484–485*

4 *In Herczegfalvy the ECtHR appeared to use the terms 'medical necessity' and 'therapeutic necessity' interchangeably*

5 *R (on the application of N) v Dr M and others [2002] EWCA Civ 1789*

6 *R (on the application of PS) v Dr G (RMO) and Dr W (SOAD) [2003] EWHC 2335 (Admin)*

7 *For a comprehensive review and analysis of this judgment, see Bartlett, P. 'Capacity, Treatment and Human Rights', Journal of Mental Health Law, February 2004 pp 52–65*

8 *Silber J had given the first instance judgment in R (N) v Dr M and built on this in the PS case.*

9 *Pretty v United Kingdom (2002) 35 EHRR 1 at [52]*

10 *This two stage approach to the best interests test had been laid down by Butler-Sloss P in Re S (Adult Patient: Sterilisation) [2001] Fam 15 at 27–28*

11 *This element follows the wording of the statutory test under s.58(3)(b)*

the risk he presents to himself, (d) the risk he presents to others, (e) the consequences of the treatment not being given and (f) any possible adverse effects of the treatment[12].

This then was the clear legal framework regarding the imposition of treatment under Part IV MHA at the time B's first challenge came to the Administrative Court.

The Decisions

(a) Administrative Court (1)[13]

The first challenge brought by B, against the Secretary of State, was effectively a challenge to the judgment in *PS*, discussed above. His counsel, Paul Bowen[14], argued that medical necessity alone was insufficient justification for imposing treatment under s.58 on a competent patient who was refusing treatment. Instead he asserted that:

> (i) s.58(3)(b), when construed with the benefit of s.3 HRA, authorised compulsory treatment of a capacitated patient against his will only where it was convincingly shown that such treatment was both medically necessary ('the medical necessity requirement') and necessary to prevent serious harm either to the public or to the patient's health ('the threshold requirement'); or
>
> (ii) if s.58(3)(b) could not be construed in this way, a declaration of incompatibility under s.4 HRA should be considered.

Mr Bowen argued that his interpretation was supported by Articles 3, 8 and 14, and international consensus.

Although Silber J refused B's application, deeming it academic, he commented in some detail, albeit obiter, on all the substantive points in the claim, essentially by following and developing his own reasoning in *PS*.

On Article 3 he held that this would not automatically be breached *merely* because the patient had capacity to consent but did not do so; the 'minimum level of severity' would still need to be demonstrated on the facts. He also held that the ruling in *Herczegfalvy*, that treatment which has been convincingly shown to be medically necessary cannot infringe Article 3, applied equally to capacitated patients. His conclusions on Article 3 were reinforced by his assertion that the threshold of capacity for mental patients is not only low, but actually lower than for non-patients, thus increasing the case for overriding the refusal of treatment by detained patients assessed as having capacity. For this assertion he drew support from several sources, including the dicta of Hale LJ in *Wilkinson*[15], and the precise wording of s.58 MHA which suggested that the patient need only be '*capable* of understanding the nature, purpose and likely effects of the treatment', rather than *actually* understanding these things.

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12 *Silber J had developed this approach to the determination of the single best option for treatment in his first instance judgment in R (N) v Dr M and thus imported it directly into PS.*

13 *R (on the application of B) v Dr SS (1), Dr AC (2), Secretary of State for the Department of Health (3) [2005] EWHC 86 (Admin)*

14 *Mr Bowen had also represented the claimant in Wilkinson and appears to have refined and developed the arguments used there, particularly in relation to international consensus.*

15 *See Wilkinson, op.cit. at [80] per Hale LJ: "I do not take the view that detained patients who have the capacity to decide for themselves can never be treated against their will. Our threshold of capacity is rightly a low one. It is better to keep it that way and allow some non-consensual treatment of those who have capacity than to set such a high threshold for capacity that many would never qualify."*

On Article 8 he held, as in *PS*, that any breach of Article 8(1) could be justified under Article 8(2), but now made it clear that 'in accordance with the law' meant consideration of both the common law requirements of the 'best interests test', *and* the statutory requirements of s.58 MHA.

Having rejected the Article 14 challenges on the basis that the chosen comparators were not in an analogous situation to B, Silber J finally rejected Mr Bowen's extensive representations on the growing international consensus. Amongst other reasons, he held that none of the material was binding on English courts nor, since none of it had been incorporated into English law, did it allow a first instance judge to depart from established principles.

He concluded that in any event, the proposed imposition of treatment on B would not have infringed his Convention rights, irrespective of his capacity.

(b) Administrative Court (2)[16]

In the second hearing in the Administrative Court, following the RMO's decision that he now wished, with the support of the SOAD, to pursue treatment under s.58(3)(b), the challenge was made on different grounds; those issues which had been argued and had failed before Silber J were reserved for appeal.

Before Charles J it was contended by B's counsel, again Mr Bowen, that for the purposes of Articles 3 and/or 8, the required threshold of 'convincing medical necessity' for the proposed treatment had not been reached because (i) B had capacity to refuse treatment, and (ii) the evidence did not convincingly establish that he was suffering from bi-polar affective disorder that was relapsing.

The application was dismissed, with Charles J finding that the claimant lacked capacity and that the proposed treatment had been convincingly shown as a medical necessity. In setting out the legal framework for his decision, while substantially following the dicta of Silber J and earlier cases, Charles J added some additional, and in some cases contradictory, insights of his own.

In assessing B's capacity, he systematically applied the conventional three-stage test of *Re C*[17]. He found that B was able to comprehend and retain information concerning his proposed treatment. However, B's refusal to believe that he was or might be mentally ill meant that he could not effectively weigh in the balance the relevant information about the treatment in reaching a decision as to whether to accept or refuse it.

In respect of allegations of Article 3 breaches, the Court confirmed the authority of the *Herczegfalvy* approach, and also that the proposed treatment would not amount to a breach merely because a patient had capacity. Indeed B's refusal of treatment and the effects of its compulsion were regarded as more significant than the issue of whether he had capacity. Further it was confirmed that in judicial review of potential Article 3 breaches, the court must determine for itself whether medical necessity had been 'convincingly shown'. In attempting to clarify the meaning of this phrase, which had been recognised as a high standard of proof in *N v Dr M*[18] [18] but left undefined, Charles J reasoned that it must lie somewhere between the English criminal and

16 *R (on the application of B) v S and others [2005] EWHC 1936 (Admin)*

17 *Re C (Adult: Refusal of Medical Treatment) [1994] 1 All ER 819*

18 *See footnote 5 above*

civil standards. In B's case, the Court held it unlikely that the compulsory administration of anti-psychotic medication would result in a sufficient degree of severity to engage Article 3. In any event, there were sound and compelling reasons to believe that the proposed treatment would achieve many or all of its intended purposes, including alleviation of B's symptoms and the improvement of his chances of rehabilitation, and thus its therapeutic or medical necessity had been convincingly shown.

When considering justification for potential breaches of Article 8(1), the Court confirmed, as already decided in *PS*[19] and *B v Dr SS*[20], that the *Herczegfalvy* test was not appropriate. Rather the orthodox three-fold test under article 8(2) should be applied, namely: was the interference (i) 'in accordance with the law', (ii) for a legitimate aim, and (iii) 'necessary in a democratic society'. Charles J held that 'in accordance with the law' required a consideration only of the statutory provisions of Part IV MHA, and that Silber J had erred in holding that it also required an application of the common law test of best interests. He suggested though, that in many cases there would be no effective difference between an application of the statutory and the best interests tests. In B's case however, the parties had proceeded on the basis that if it had been convincingly shown that the proposed treatment was a therapeutic or medical necessity, then all of the elements of Article 8(2) would be satisfied and no alternative arguments would be advanced. Nevertheless for completeness, Charles J added that the proposed treatment of B was a therapeutic or medical necessity, that it satisfied the test in s.58 MHA, it was justified under Article 8(2) and it was in the best interests of B.

Having dismissed the claim for judicial review on all grounds, the Court discharged the injunction granted by Silber J preventing treatment, subject to a stay pending appeal.

(c) Court of Appeal[21]

Giving the reserved judgment of the Court, Lord Phillips CJ identified the five issues raised by the appeal:

i) Was the judge wrong to find that B lacked capacity? If not:

ii) Should the appeal be dismissed without consideration of the other issues, on the ground that these were academic? If not:

iii) Will compulsory treatment of a patient with capacity violate Articles 3, 8 and 14, or any of them, unless it satisfies the 'threshold requirement' (i.e. that the treatment was necessary either to prevent the patient causing harm to others or to protect the patient from serious harm)?

iv) Was the judge wrong to find that the proposed treatment constituted a medical or therapeutic necessity?

v) What is the nature of the procedure that the court should follow when judicial review is sought on Convention grounds of a decision to administer treatment under section 58?

On the first issue, the Court emphasised the importance which English law attached to the freedom of the individual to decide what should or should not be done by way of physical interference or invasion of the body. However the law also recognised exceptions to this principle, such as where

19 *See footnote 6 above*

20 *See footnote 13 above*

21 *R (on the application of B) v S and others [2006] EWCA Civ 28*

the patient lacked capacity to consent to such conduct. The particular position of mental patients was provided for in the MHA. In the section in question, s.58, the relevant test of capacity seemed to be laid down when it spoke of the patient being 'capable of understanding the nature, purpose and likely effects of' the treatment. The Court recognised that these words may not go far enough to define capacity and that in *Wilkinson* [66], it had been suggested that the *Re MB*[22] test of capacity used in relation to physical disorders was suitable for assessing capacity for the purposes of s.58(3)(b). Without appearing to apply this test rigorously, the Court held that:

> *"Whatever the precise test of the capacity to consent to treatment, we think that it is plain that a patient will lack that capacity if he is not able to appreciate the likely effects of having or not having the treatment."*

After anxious scrutiny of the evidence, Charles J had found that this was the position in B's case, and had therefore been correct to conclude that he lacked capacity.

On the second issue, the Court held that even though B had been found to lack capacity to consent to treatment, he may, with treatment, reach a state where his capacity was restored. The remaining issues, relating to the lawfulness of the compulsory treatment of a capacitated patient, should therefore be considered.

In addressing the third issue, the Court first made some general observations. The Court suggested that the submissions of B's counsel, Mr Bowen, had implicitly been based on two premises, both of which were unsound:

- *The 'threshold' requirement had to be demonstrated at the stage when it is proposed to administer treatment*. The Court pointed out that at this point the patient would have been detained and thus in a secure environment where his capacity for causing or experiencing harm was inherently reduced. Anyway, the Court would show that this premise was at odds with the scheme of the MHA
- *Autonomy, and thus capacity, was of critical importance in deciding whether a particular treatment could be imposed upon a detained patient*. The Court observed that with the fluctuating nature of B's illness this premise could lead to an absurd scenario in which B might regain capacity *only* with treatment, at which time he would be entitled to refuse treatment and consequently relapse and lose capacity once more. Charles J had therefore been correct to hold that capacity was not the critical factor in determining whether treatment could be given without consent, and that the fact of its compulsion was more significant.

The Court then explained that the MHA provided for an integral package of detention and treatment, and imposed restrictions to ensure that individual treatment was justified. If the detention of a patient for treatment pursuant to s.3 was justified on the ground that the treatment was necessary for the protection of others, it was not logical to consider treatment in isolation from the overall objective of the package, nor to apply a higher standard to justify the administration of treatment itself. The Court cited approvingly the dicta of Baroness Hale in

22 *Re MB (An Adult: Medical Treatment) [1997] 2 FCR 541*

R (B) v Ashworth Hospital Authority[23], a case dealing with the scope of treatment permitted under s.63 MHA:

> *"Once the state has taken away a person's liberty and detained him in a hospital with a view to medical treatment, the state should be able (some would say obliged) to provide him with the treatment which he needs."*

The Court also approved the observations of Silber J in *PS*,[24] that the compulsory treatment of a detained patient should be considered in the context of the likelihood that it would lead to the patient's rehabilitation and return to society. The objective of rehabilitation itself militated against any approach which ignored the overall object of the MHA package and imposed a separate 'threshold requirement' on treatment.

Following these general observations, the Court then considered the compatibility of the express provisions of the MHA with the ECHR. The leading authority was *Herczegfalvy*, in which the ECtHR had held that a measure which was a therapeutic necessity cannot be regarded as inhuman or degrading. The court nevertheless had to satisfy itself that the medical necessity had been convincingly shown. Though this case related to a patient who lacked capacity, in the more recent case of *Nevmerzhitsky v Ukraine*[25], the ECtHR had applied the same principles where the applicant was not mentally ill.

Moving to the fourth issue, the Court held that in the light of the findings of fact made by Charles J, he had been entitled to conclude that the proposed treatment of B was in his best interests and that it had been convincingly shown that it was a medical necessity. The Court did not feel it necessary to decide whether these tests were the same, nor whether Charles J had been right to hold that 'in accordance with the law' in Article 8(2) required consideration only of statutory provisions and not the best interests test. The Court observed though, that the best interests test should not be equated with that under s.58(3)(b) which was much narrower, but suggested that common law and medical ethics should ensure that SOADs would always apply it anyway before authorising treatment.

In addressing the final issue, the Court acknowledged the principle established in *Wilkinson* that in judicial review proceedings of human rights challenges to compulsory treatment under s.58, the claimant was entitled to require the attendance of medical witnesses to give evidence and be cross-examined. The Court noted though, that both in *Wilkinson* [62] and *N v Dr M* [36], there had been observations that cross-examination of medical witnesses should be ordered only *if necessary*. The Court reflected that it was undesirable that medical practitioners should have to attend court as witnesses rather than attend to their patients, and suggested that if s.58, which imposed clear preconditions for compulsory treatment, was properly complied with, then issues requiring cross-examination of medical witnesses should not often arise. This would require that the SOAD should give a truly independent assessment and not merely approval of the RMO's decision on the basis that it was not manifestly unsound.

Having thus dealt with all the issues raised, the Court duly dismissed the appeal.

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23 *R (on the application of B) v Ashworth Hospital Authority [2005] UKHL 20 at [31]. See Kris Gledhill's consideration of this case: 'The House of Lords and the Unimportance of Classification: A Retrograde Step'; JMHL November 2005, pp 174–185*

24 *See PS, op.cit. at [134]*

25 *Nevmerzhitsky v Ukraine; Application No. 54825/00*

Discussion

While the Court of Appeal may have determined the appeal, the judgment seemed to contain little new law. Somewhat disappointingly, it also failed to clarify or resolve a number of the undecided points or apparent contradictions in earlier judgments, particularly in the following areas.

(a) Capacity

The capacity of psychiatric patients remains problematic both in terms of its assessment and its significance.

The assertion of Silber J in the Administrative Court that the threshold of capacity for mental patients is not only low, but actually lower than for non-patients, surely cannot be correct. His use of the dicta of Hale LJ in *Wilkinson* [80] to support his assertion would seem to be a misrepresentation of her Ladyship's comments, since she did not appear to be talking specifically about mental patients, but more generally when she said: 'Our threshold of capacity is rightly a low one'. Indeed, even this is debatable for, as Bartlett[26] has observed, 'the threshold of capacity in England is not low at all...it is exceptionally high'. And Silber J's reference to the wording of s.58 to infer that the test of capacity of detained patients requires only *capability* to understand rather than *actual* understanding, seems at total variance with current practice. The MHAC has long held that SOADs should require both capacity and actual understanding of the treatment and its consequences – a view endorsed by Jones[27], who advises that the common law test of *Re MB* should be applied. The MHAC[28] has now specifically expressed concerns about Silber J's comments, and emphasised that different legal criteria should not be applied to the determination of capacity in detained patients and others. But in not addressing this element of Silber J's judgment, and also in itself not seeming inclined to apply the *Re MB* test rigorously, the Court of Appeal has allowed uncertainty about assessment of the capacity of psychiatric patients to continue.

On the significance of capacity though, the Court was crystal clear that it is not determinative of the authority to impose treatment under s.58, even where nobody is at risk from serious harm. Their reasoning merits closer scrutiny however. The Court aligned itself with the recent judgment in *R(B) v Ashworth Hospital Authority*[29] in believing that the MHA provided a package in which the authority for detention essentially provided the necessary authority for compulsory treatment – it was illogical to apply a higher standard to justify the administration of treatment itself. Yet deprivation of liberty is a quite different matter than violation of the person. As Gledhill[30] has commented, this type of reasoning comes close to implying that the loss of liberty due to mental disorder carries with it a consequent loss of any right of self-determination. Bartlett[31] has pointed out that there are jurisdictions where no patient with capacity, even a detained psychiatric patient, may be treated without his informed consent. In these jurisdictions, detained capacitated patients

26 *Bartlett, P. 'The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria', Medical Law Review 2003 11(3) pp 326–352 at p 335*

27 *Jones, R.M. 'Mental Health Act Manual', 9th Edition, London, Sweet & Maxwell, 2004 at paras 1-713 and 1-714*

28 *Mental Health Act Commission, 'Eleventh Biennial Report 2003–2005: "In Place of Fear?"', London, TSO, 2005 at paras 1.56–1.59*

29 *See footnote 23 above*

30 *Gledhill, K. 'The House of Lords and the Unimportance of Classification: A Retrograde Step', Journal of Mental Health Law, November 2005, pp 174–185 at p 184*

31 *See Bartlett (2003), op.cit. at pp 333–334*

apparently rarely refuse treatment, but rather tend to negotiate a mutually acceptable treatment solution with their psychiatrists. Despite the strenuous advocacy of lawyers like Mr Bowen however, the capacity of detained psychiatric patients has not reached this level of significance in the domestic jurisdiction. Nor is it likely to achieve any greater significance in future mental health legislation. For while the Richardson Committee[32], in developing proposals for reform of the MHA, had suggested that treatment be imposed on those with capacity only where this was necessary to prevent a substantial risk of serious harm to the patient or other persons[33], this recommendation was not incorporated in the White Paper[34] nor subsequent drafts of the now aborted Mental Health Bill[35] [36]. Nor does it appear to be included anywhere within the Government's subsequent proposals for amendments to the MHA.

(b) Best Interests and the Role of the SOAD

It is unfortunate that the Court of Appeal failed to clarify the status of the best interests test within Article 8(2) for, as Fennell[37] had much earlier pointed out, the legal test under s.58(3)(b) of likelihood that the treatment will alleviate or prevent deterioration, is very much looser than the best interests test. It had been further diluted by DHSS guidelines[38] so as to require SOADs effectively to apply only the *Bolam*[39] criteria of reasonableness rather than seek the best treatment option for the patient. That this had in fact been their approach, Fennell inferred, was evidenced by the consistently high level of agreement between RMOs and SOADs.

Since then, in *Wilkinson*[40], the judiciary have criticised the operation of the SOAD role as an effective safeguard for patients, regarding it as too much a review of the RMO's proposal and assessment of its reasonableness, albeit that this was in line with the then current MHAC guidelines[41]. Rather the SOAD was expected to exercise his own independent view of the desirability and propriety of treatment, and demonstrate a less deferential approach than appeared to be the norm. Despite this, the high level of agreement between RMOs and SOADs has continued to the present[42]. The MHAC has suggested, without evidence, that this attests to the success of the second opinion process and the care with which RMOs prepare their treatment plans.

Yet, in terms redolent of those used in *Wilkinson*, the Court of Appeal has again urged SOADs to conduct a truly independent assessment. On the other hand, it has also assumed that SOADs

32 *Department of Health, 'Review of the Mental Health Act 1983: Report of the Expert Committee', (The Richardson Report), London, DoH, November 1999 at paras 5.94–5.97*

33 *This, of course, had been precisely the basis of Mr Bowen's submissions in B v Dr SS*

34 *Reforming the Mental Health Act – Part 1: The new legal framework, Cm 5016-I, Department of Health, London, TSO, December 2000*

35 *Draft Mental Health Bill, Cm 5538-I Department of Health, London, TSO, June 2002*

36 *Draft Mental Health Bill, Cm 6305-I Department of Health, London, TSO, September 2004*

37 *Fennell, P. 'Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845', London, Routledge, 1996 at pp 204 and 208*

38 *Department of Health and Social Security, Dear Doctor Letter DDL 84(4), DHSS, 1984*

39 *Bolam v Friern Hospital Management Committee [1957] 2 All ER 118*

40 *See Wilkinson, op.cit. at [32]-[33] and [71]*

41 *Mental Health Act Commission, 'Advice to Second Opinion Appointed Doctors', Nottingham, MHAC, April 1999 at para 11*

42 *Mental Health Act Commission, 'Tenth Biennial Report 2001–2003: "Placed amongst strangers"', London, TSO, 2003 at para 10.37 and MHAC Eleventh Biennial Report, op.cit. at para 4.67. The number of second opinions where a significant change had been made to the RMO's treatment plan has in fact remained essentially static at about 2–3% of the total for over a decade.*

would anyway not be certifying treatment under s.58 unless satisfied that it was in the patient's best interests.

The judiciary really cannot have it both ways. If the SOAD's role as a safeguard for patients is operating effectively, such exhortations to independent judgment are unnecessary. If it is not, as the Court of Appeal inferred, and as the MHAC statistics might more probably suggest, then the Court has lost an opportunity to reinforce it by enshrining the best interest tests, with its associated requirement to seek the best possible treatment option, firmly within the meaning of 'in accordance with the law' in Article 8(2). While it is acknowledged that this test was developed within the common law principles of treatment of those without capacity, it is submitted that it should be equally applicable in the context of capacitated patients where their capacity is to be overridden and treatment decisions are to be made on their behalf, and imposed without their consent, under s.58(3)(b).

(c) Role of the Court

Wilkinson had established the principle that in judicial review proceedings of human rights challenges to compulsory treatment under s.58, the court must reach its own view on the facts. The observations of Hale LJ in that case, that cross-examination of medical witnesses should be ordered only if necessary, have since been cited and interpreted by the Court of Appeal in both *N v Dr M* [39] and the instant case [68] to suggest that the need for oral evidence and cross-examination in such cases would be exceptional. The lower courts have been somewhat more inclined to accept the benefits of such evidence. Silber J found it essential in *PS* [23], and Charles J[43] in his judgment in the Administrative Court specifically observed that, contrary to *N v Dr M*, cross-examination of medical witnesses would be helpful and informative in many cases. However, Collins J only reluctantly accepted the need to move beyond the court's normal review obligations in *R (B) v Haddock*[44], and in *R (Taylor) v Haydn-Smith*[45] he declined applications for oral evidence. (Both of these were s.58 challenges.)

As Bartlett[46] noted when commenting on the *PS* case though, even where the court has allowed oral evidence, there has been a tendency to deal with it in the manner of traditional judicial review, based more on assessment of witness credibility rather than the substantive engagement with the facts required by *Wilkinson*. And in respect of witness credibility, we should also note the inherent deference of the courts to the treating physicians. This has its origins in the dicta of Simon Brown LJ in *Wilkinson* [31]:

> *"Certainly, however, courts will not be astute to overrule a treatment plan decided upon by the RMO and certified by a SOAD following consultation with two other persons."*

This view was endorsed by the Court of Appeal in *N v Dr M*[47], and has since been echoed by Silber J in *PS* [82] and by Charles J in the Administrative Court in the instant case [68]–[70].

The Court of Appeal appeared to acknowledge the ambivalence of the judiciary concerning their

43 *See B v S (HC), op.cit. at [235]-[236]*

44 *R (on the application of B) v Haddock and others [2005] EWHC 921 (Admin) at [15]. As acknowledged later on in the text, this case has subsequently been considered by the Court of Appeal.*

45 *R (on the application of Taylor) v Haydn-Smith and another [2005] EWHC 1668 at [8]*

46 *See Bartlett (2004), op.cit. at pp 57–58*

47 *See N v Dr M, op.cit. at [38] per Dyson LJ: "Courts are likely to pay very particular regard to the views held by those specifically charged with the patient's care."*

approach to hearings of treatment challenges and admission of oral evidence, though unfortunately its own comments were not conclusive, and it specifically declined to comment on the observations of the first instance judges in the case. Nevertheless the inference of the Court's comments regarding both oral evidence and the status of the treating physicians, would clearly suggest that its position aligns with that of the appellate court in *Wilkinson and N v Dr M*. All this inevitably implies that in such judicial review proceedings, the odds will remain stacked against the claimant, since he can have little confidence that his own medical evidence will receive either adequate or impartial consideration.

More recently though, the judiciary were given a further opportunity to consider, inter alia, the nature and intensity of the review to be carried out by the court in such cases, when *B v Haddock*[48] was heard by the Court of Appeal. Their judgment has really done nothing to rebalance the odds, however. On the issue of oral evidence and cross-examination, the Court endorsed the view of the Court in the instant case in perceiving no inconsistency of approach between the decisions in *Wilkinson* and *N v Dr M*, and held that the Court in *Wilkinson* could never have intended or contemplated that every such case would require the hearing and testing of medical evidence [65]. And again the Court approvingly noted the dicta of earlier judgments regarding the particular deference to be shown by the courts to the views of treating physicians [14].

Conclusion

Contrary to what might have been anticipated, previous challenges under the HRA had afforded detained psychiatric patients no substantive rights in respect of their treatment – only some modest procedural protection. The judgment of the Court of Appeal in this case should therefore have come as no surprise. In its reasoning, it follows the earlier s.58 judgments. In its tone however, it aligns closely with the recent judgment of the House of Lords in *B v Ashworth*. In summary, the courts have now made it very clear that, provided due process is observed, the HRA will provide no impediment to the exercise of the wide-ranging powers of compulsory treatment under Part IV MHA, even where the patient has capacity and irrespective of whether refusal of treatment poses a risk of serious harm to the patient or others. The courts have shown little inclination to limit these powers and, though perhaps a topic for a different article, it might be argued that they have even sought to broaden them beyond the legislative intent. It would be of some comfort to think that the judiciary have been motivated by paternalism – true concern for the patients. It is hard to avoid the conclusion though, that it has become more an issue of power – and that it is much more convenient for everyone when the balance of power is left firmly in the grasp of the authorities.

48 *R (on the application of JB) v Haddock and others [2006] EWCA Civ 961*

Book reviews

Seminal Issues in Mental Health Law by Jill Peay

Published by Ashgate (2005), £135

This excellent resource is a collection of thirty-five essays, chapters and extracts on civil mental health law from various authors, drawn from a range of sources between 1973 and 2005 (with three-quarters of the selections dated after 1990). The texts, which are mainly academic journal articles, are reproduced with original typography, pagination and bibliographies which, whilst occasionally reduced to uncomfortably small font sizes, will be a help in research and referencing. It is indexed by name but not, unfortunately, by subject. The long introductory essay by the editor, Professor Jill Peay (London School of Economics), provides an interesting and useful commentary on the choices of material, highlights areas where the law has moved on from the positions discussed, and draws out a theme from the collection as a whole.

Whilst Peay suggests that this is a volume to be dipped into rather than read through, there is structure behind its arrangement, and I found it rewarding to read from cover to cover. The book is divided into three parts (titled respectively 'principles', 'process' and 'trends') and many essays provide a development, or a contrast, to preceding themes. In particular, the first half dozen selections in the 'principles' section, read in the order presented, serves as an excellent primer in the basic arguments at stake over the purposes of mental health law.

In her editorial introduction, Peay writes of her impression that mental health law has appeared to be in a state of flux throughout her working life. That working life spans the lifetime of England and Wales' *Mental Health Act 1983*: from doctoral research into Tribunal practice in the final years of the 1959 Act to participation in the expert committee originally charged by Government to consider how the 1983 Act might be subject to what was promised as "root and branch" reform. That promise has heightened the sense of shifting ground in mental health law over recent years, during which we have seen two massively detailed and universally derided draft Bills, as well as pre-legislative scrutiny procedures echoing former Royal Commissions in scale.

But this book appears as the reform process appears to have spectacularly collapsed, leaving a compromise remarkable even in comparison to the knockabout history of previous legislative change. There is to be no new Mental Health Act under this administration, but instead a slim amendment Bill to patch up those parts of the current law that are in conflict with human rights rulings, whilst also broadening the scope of professional discretion over the scope of its general powers. The cautious welcome given by mental health professional and patient groups to the dropping of the hugely unpopular draft Bill is tempered with anxiety that an amendment Bill could import some of its most worrisome aspects into current law.

In the past, Government's role in the development of mental health legislation has been characterised as one of arbitration between warring factions of professional interest, with lawyers arguing to curtail doctors' powers over their patients in the name of civil liberties, and doctors resisting such limitations in the name of clinical discretion. In contrast, our present age appears to present a veneer of agreement between these usually rancorous professional interests, in unified opposition to the plans of Government policy makers. Whether this is yet more evidence of shifting ground, or an ephemeral phenomenon of political alliances and *realpolitik*, it indicates to me that this is a good time to have a volume that seeks to set out, in Peay's words, "a clear perspective on our mutual history" and attempts ""to capture innovative critical moments in mental health law, put them into context with each other, make them readily accessible to readers and thereby, hopefully, avoid the wheel being rediscovered".

Whilst allowing that the extent of such a "race memory" of mental health law as her volume hopes to achieve is problematic amongst academics, Peay suggests that it is absent in Government policy-makers, as a result of the bureaucratic shuffling of civil-servants who may otherwise develop suitable expertise. As with all generalisations, this is unfair in some specific cases, and of course we should remember that decisions about policy are the responsibility of Ministers rather than officials. Nevertheless, looking on at a Government process that has so effectively alienated all of its "stakeholders" whilst building a theoretical system that proved impossible to resource, Peay's comment seems to me to chime with an analogy used by Aneurin Bevan, who wrote of leaders and thinkers losing touch with those who are grounded in reality by the nature of their work and becoming "adrift like passengers in an escaped balloon"[1]. The escaped balloon of the draft Mental Health Bill appears to have popped. Although it is perhaps far-fetched to suggest that it slipped its moorings for lack of a compendium of legal academia such as this (after all, academics and commentators on mental health law are quite capable of their own flights of fancy), the value of a resource such as this should now be self-evident.

In her introductory essay to this volume, Peay makes a number of well-judged observations about the instability of mental health law, including a proposition that there is probably no ideal system or approach that will transcend or dissolve the intrinsic tensions between civil rights ('autonomy-based principles') and civil society ('socially-based protective principles'). This is a refreshingly grounded acknowledgment, especially given that the editor of this book cannot claim to be non-partisan in current debates over the appropriate theoretical basis for psychiatric coercion: Peay concedes that her introduction, on its own terms and as a synoptic account of the essays that she has selected, "reads like an argument for capacity-based legislation".

Peay's theoretical even-handedness on the issue of the law's social function, which is echoed in a number of the essays in this volume, should, I think, be reflected upon by those who would criticise the present Government for trying to use mental health law for purposes of social control. Peter Bartlett's essay in this collection accuses such critics of sqeamishness, arguing (in echo of Bean and others in the volume) that social control is an inevitable and unavoidable component of mental health legislation. I think that I would rather take this view than try to divorce issues of social control from psychiatric practice, as the essayists with the most radical suggestions in this volume attempt. In a 1994 essay in the collection, Tom Campbell (incidentally the overall editor of the series in which this volume appears) proposed that if any form of preventive detention were

1 *Bevan, A. 1952 In Place of Fear, Chapter 2*

justifiable on grounds of risk to others, it should be justifiable in the case of *all* people, and not only those given some form of psychiatric diagnosis. Campbell accepts that his proposal might appear to be bizarre (and it is certainly counter-intuitive in terms of the general protection of civil liberties), but seems to suggest that this strangeness is merely an attribute of prejudice against the mentally disordered. I think that that he is mistaken in this, and gives insufficient weight to concerns that such rigorous ideological exclusion of 'social control' issues from the realms of medical law would be likely to criminalise and imprison vulnerable people who would otherwise be civil detainees in hospital. For some hard-headed types (one thinks of Thomas Szaz) this may be an acceptable consequence of the abolition of all traces of paternalism, but for many others there must be compromise to allow society to retain some protective function over the vulnerable. Indeed, although Campbell is surely right to want to remove discrimination on the basis of *diagnosis*, his proposal gives insufficient weight to the question of potentially justifiable discrimination on the basis of *prognosis*, which lies behind the treatability test operative for some conditions under the current law. I recall little discussion in this volume on the issue of 'treatability', and I wonder if this is a shortcoming, particularly given that the concept is under fire from the Government and is likely to be excised from the current criteria for compulsion under amending legislation. Whilst the practical effectiveness of the treatability criterion under the current law is often questioned, my own view is that it establishes an important and fundamental principle for compulsion that it may be dangerous to jettison.

However, concerns about social control are only part of the impetus behind the arguments for capacity-based legislation, and it is the role of a capacity-based threshold for intervention that is the volume's dominant theme. Some of the essays (e.g. Gordon on Canadian law in 1993; Richardson on English and Welsh law in 2002) set out a case for the abolition of mental health law per se in favour of a broad-ranging legislation dealing with the mentally incapable, although Richardson recognises that such a proposal has no chance of being accepted by the UK Government. Both writers, as with many supporters of a capacity-test in mental health law, justify their arguments on the discriminatory inconsistency between rules concerning the imposition of physical and mental health care. That there is such inconsistency is inarguable, but that is not the same thing as it being indefensible (there is a striking statement by Kathleen Jones in the first essay of the volume to the effect that the law tolerates ambiguity and paradox in its own workings, but is intolerant of such qualities when they are displayed by the mental health professions). In a pivotal essay in Peay's collection, taken from the pages of this journal in 2000[2] (but now regrettably divorced from a companion piece from Robert Robinson[3] putting an alternative view), Mike Gunn sets out a case for capacity-based legislation and, in a curious choice of phrase that attracts comment in Peay's editorial, accuses the Richardson Committee's proposals relating to capacity-based criteria as being "not pure" but "infected" with pragmatism. Peay counters that this overlooks the fact that the committee upon which she served had in fact put forward as alternatives a "consistent" capacity-based model and a "pragmatic" model, stating that the moral dilemmas in choosing between them were a matter for politicians. One might equally question the value of conceptual 'purity' in approaches to social policy. Such an answer to Gunn's reproach is given by one of the oldest essays in this collection: Treffert's article on the US from 1974 entitled "Dying with their rights on".

2 *'Reform of the Mental Health Act 1983: The Relevance of Capacity to make decisions'. Professor M. Gunn JMHL Feb 2000 pp39–43*

3 *'Capacity as the Gateway: an alternative view' Robert Robinson JMHL Feb 2000 pp 44–48*

If capacity is to take on a central role in future mental health law – and although the legislature for England and Wales may duck the issue this time, there is likely to be pressure on the domestic and Strasbourg judiciary to establish it on grounds on non-discrimination – it will be necessary to decide what it means to be capable of refusing treatment. Peay provides a useful run-through of approaches to defining capacity by Roth, Meisel and Lidz from 1997, and an older piece from Grisso and Appelbaum showing empirical studies based around the MacArthur Treatment Competence Study of the 1990s. The 1997 essay reaches the awkward conclusion that "the search for a single test of competency is a search for a Holy Grail"; the earlier essay used tests acknowledged to be too cumbersome for daily clinical use, but indicated that an assessment tool for clinical use was in development. The authors of this essay have indeed gone on to do much developmental work in conceptualising capacity-tests (although a reader of this volume will not be directed towards this, which is unfortunate). I believe that, even with the passing into law of the *Mental Capacity Act 2005*, there is still a need for a proper conceptual understanding of incapacity that could serve as a robust threshold for the imposition of psychiatric treatment in the face of refusal or resistance. Without such a definition, and confidence that it will be used in practice, I am unsure of its benefit in a mental health law context described by Peay as involving "questionable science, individual prejudice and overpowering beneficent intentions". The danger is of course that refusing consent to an intervention considered as necessary by your doctor is taken as a sign of incapacity. Anyone doubting the potential for fluidity in defining capacity should consider the remarkable fact that, in the last year, the Law Society and the Government informed a Parliamentary committee that any patient who required ECT would be unlikely to be in a position to capably refuse consent to it, when in practice over a third of statutory second opinion authorisations of ECT were to such patients[4]. Whatever else lies behind that fact, it seems likely that the notions of capacity involved are inconsistent. When Aneurin Bevan warned of the tendency for intellectual activity to drift he specifically pointed to the dangers of "symbol worship", where words persist whilst the reality that lies behind them shifts and changes, so that "ideas degenerate into a kind of folklore which we pass onto each other, thinking we are still talking the reality around us".[5]

This collection is nevertheless comprehensive enough to cater for most shades of enthusiast and doubter alike, and many essays are themselves examples of academic balance between competing claims (some authors whose general position one tends to perceive in caricature through an imagined familiarity with their arguments prove to be more nuanced in these pieces: for example the 'legalist' Larry Gostin wrote in 1983 on the importance of vigilance against attempts by the legal profession to erect a superstructure of technical procedures or cumbersome legal regulations, or to substitute the discretion of lawyers and courts for that of mental health professionals on matters of treatment). But between these covers, Marxist critique of the language of rights rubs against civil-libertarian demands of 'new legalist' perspectives, and Benthamite calls for codification of implicit powers sit alongside various sceptical examinations of the power of law itself. Unsworth's 1993 essay on Victorian law and lunacy is a stylish reminder of the value of the past in understanding the present, which has led me to search out his 1987 book *Mental Health Law and Politics* (his essay is also a good lead into the 'revisionist' historical approaches of writers such as Castel and Scull who otherwise fall outside of the scope of this volume). If mental health

4 *Mental Health Act Commission 2006, In Place of Fear? Eleventh Biennial Report 2003–05, para 4.71–3.*

5 *Bevan, A. supra*

services are undergoing 'reinstitutionalisation', as was claimed in the striking but controversial 2005 BMJ editorial by Priebe and Turner reprinted in this volume, those historians may yet be futurologists' best tools.

The medical sciences are represented with rather less range, being most visible in Peay's essentially polemical inclusion of a slice from Bentall's *Madness Explained* (2003) that argues a continuum between psychosis and normal mental functioning. Peay suggests that, by questioning the boundaries between madness and sanity, Bentall's arguments support the notion of legislation based upon decision-making capacity that is applicable to persons irrespective of diagnostic label. Perhaps so, but their inclusion in this volume also recalls the anti-psychiatry influences on the 'new legalism' that gave much impetus to current thinking on mental health law. This is not to say that Peay has constructed an anti-psychiatry subtext to her collection. I find Bentall's thesis (and in particular his use of a comparison between the boundaries of madness and the boundaries of hypertension) to be much more subtle than the anti-psychiatric canon to which it has a perhaps superficial resemblance (one that is noted by Bentall himself), and Peay's inclusion of a user perspective of mania from Kay Redfield Jamison is as effective a critique of Szaz or Laing as the 1978 essay included here by Antony Clare. But one professional standpoint – that of the "Neo-Kraepelinian" and traditional classificatory psychiatry challenged by Bentall's thesis – remains intriguingly alien to the concerns of this volume. It could be a mistake to read too much into this, as no doubt much written work in this field falls outside of the scope of this volume, although the products of this excluded approach – the diagnostic manuals DSM-IV and ICD-10 – are nonetheless themselves no small players in numerous criminal and civil courtroom dramas. Could it be that the relative consensus apparent in recent years between the medical and legal professions is more fragile than it appears?

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Mental Health Tribunals – Essential Cases[1] *by Kris Gledhill*

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You might say that opinions on the subject of the Mental Health Review Tribunal are mixed: some people loathe it while others merely dislike it. The same was said of the rule of Marshall Stalin. And yet the Government wants to give the MHRT more power.

At one time, way back when we were looking forward to a bright, shiny new Mental Health Act, it seemed the tribunal was to be placed at the very heart of the new system: it was to be capable of imposing compulsion on patients, and not merely discharging them, and was to have control over their treatment and also, in some cases, their leave or transfer and the selection of their nominated person. That, you might recall, was back in the days when England was considered a good bet for the World Cup.

How times have changed. And yet, even now, now that the draft MHB has gone the way of all flesh (and Sven-Goran Eriksson), it seems the tribunal is to retain its starring role.

When it announced that it was going to amend rather than replace the existing Mental Health Act, the Government said, gnomically, that it would be "taking order-making powers with regard to the Mental Health Review Tribunal." What did it mean? A subsequent briefing sheet said that hearings would be arranged more quickly and referrals made more frequent, but there remain concerns that eventually, we are going to be landed with one-person tribunals after all. And there's certainly going to be community compulsion, so that the reach of the MHRT will extend even further. There are some that will not be pleased to hear this.

Often, it seems that the MHRT is under attack from all sides: from patients and hospitals, the media, and the High Court; from its *clients*, as the DCA insists on calling them. (In *Kind Hearts and Coronets*, the 1949 film that starred the not-yet *Sir* Alec Guinness, one of the characters complains, "A difficult client can make things so distressing." He is a hangman.) The tribunal is too slow, we hear, or too reckless; it doesn't explain itself properly; it doesn't think about the victims.

Within the loose-leaf pages of Kris Gledhill's excellent new book can be found many reasons for the flak the MHRT receives.[2]

They're all here: the tribunal that discharged a patient because no one had thought to plan for his discharge; the tribunal whose medical member was employed by the detaining authority; and countless tribunals positively burning with frustration because they can't get doctors to do their bidding.

But it isn't Gledhill's purpose simply to state the case for the prosecution; this is not that sort of book.

1 *ISBN 0-9552071-0-X*

2 *Mr Gledhill is a barrister; a part-time legal member of Mental Health Review Tribunals; and the editor of the Mental Health Law Reports and the Prison Law Reports.*

Invariably, tribunals have reasons for acting as they do, and they are often logical, thought-through reasons. One of the merits of this book is that it gives a glimpse of those reasons and helps the reader to get a feel for the judicial process that produced them (anguished, conflicted and even tortured though that process might be).

The book is divided into twenty neat, logical chapters, each of which looks at a single aspect of Mental Health Review Tribunal work and considers how it has been addressed in the courts. So, for example, there is material on 'Adjournment', on 'Capacity – Patients without', and – of course – on the 'Medical member'. There are also four appendices, containing relevant extracts from the Act and the Rules, and from the ECHR and the HRA.

Each chapter has a brief introduction, and many are divided into sub-chapters addressing specific themes. So, for example, the chapter on 'Detention and discharge' deals with nine specific issues, including 'Admission criteria' and 'Nature or degree', but also 'Displacement action – tribunal during' and 'Barring order – tribunal following'.

In these chapters, Gledhill presents well over 100 cases, some whose acronymic titles are familiar – *IH*, for example, and *PD* and *CS* – and some that are less so. In almost every case, there is an introductory paragraph on 'Facts and outcome' and then extended passages from the judgment itself. In many cases, Gledhill adds useful cross-referencing and a brief, pithy commentary of his own.

There are challenging times ahead. The work of the MHRT is about to get more extensive, more complex, and we should make sure we understand it properly. We need to come to terms with the tribunal, to understand what it can – and cannot – be expected to do, and to appreciate the very real burdens under which it labours. This book has a very useful part to play in that process.

David Hewitt

Solicitor; partner in Hempsons

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