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Notes for contributors

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The Editor encourages the submission of articles, case reviews and comments on topics of interest in the area of Mental Health Law. When submitting manuscripts for publication, it would be helpful if authors could observe the following suggestions:

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Foreword

Only one issue of the JMHL was published in 2008. This is extremely regrettable because, since the launch of the Journal in February 1999, the aim has been to publish two issues per year. This is the second occasion over the ten years of the Journal's life on which we have failed in our objective. A letter of apology and explanation has been sent to our subscribers.

When I took on the editorship in September 2004, I determined to aim for publications every May and November. However, as regular readers will know, too often I have had to conclude Forewords with an apology for the lateness of the issue. To reflect the present reality of the fluidity of the publication dates, we have therefore decided to aim for *Spring* and *Autumn* issues each year. Every effort will be made to adhere to these seasons.

This *Spring 2009* issue leads off with the second part[1] of Anselm Eldergill's consideration of mental health law in the Republic of Ireland – '**The Best is the Enemy of the Good: the Mental Health Act 2001 (Part 2)**'. As I've stated on previous occasions, the JMHL's Editorial Board is very keen to publish articles about other jurisdictions, and these two contributions from Professor Eldergill (Visiting Professor to the Law School at Northumbria University) are very welcome.

The month of April sees the implementation of the much-anticipated Deprivation of Liberty safeguards[2], more than four years after the European Court of Human Rights ruled against the Government[3], and more than eleven years since the *Bournewood* litigation was first embarked upon[4]. As Best Interest Assessors and Mental Health Assessors get to grips with their new roles and responsibilities, no doubt one question dominates their training sessions – '**Restricting Movement or Depriving Liberty?**' Neil Allen (Barrister and Teaching Fellow at Manchester University) provides some timely assistance when he addresses this very question within his article.

Welcome amendments made by the *Mental Health Act 2007* to the *Mental Health Act 1983* have enabled the possibility of a lawful transfer of someone from one place of safety to another, following the application of powers contained within sections 135(1) and 136[5]. Clearly this will assist where an inappropriate place of safety has been chosen at the outset. The 'new' Code of Practice to the MHA 1983 makes clear what has been recognised for some time, namely that "a police station should be used as a place of safety only on an exceptional basis"[6]. But what is the reality? Maria Docking, Senior Research Officer for the Independent Police Complaints Commission, addresses this question in her summary of the recent IPCC research into '**The use of section 136 to detain people in police custody**'. The findings of the research give considerable cause for concern – hopefully local trusts and other NHS providers will recognise, as Ms. Docking urges, that they "should look at ways to address the situation as a matter of urgency".

As no doubt many readers of this Journal will be fully aware, the case of *Tarasoff v Regents of University of California* (1976)[7] has been at the forefront of the debate about medical confidentiality for many years.

1 *Part 1, 'The Best is the Enemy of the Good: The Mental Health Act 2001', can be found at pp 21–37 JMHL May 2008*

2 *Section 50 Mental Health Act 2007; Section 4A & Schedule A1 Mental Capacity Act 2005.*

3 *HL v UK, ECtHR, (4th October 2004) 40 E.H.R.R. 761*

4 *The 'first instance' decision was in the High Court by Owen J. on 9th October 1997.*

5 *See section 135 (3A) and section 136 (3)*

6 *Paragraph 10.21 Code of Practice (Mental Health Act 1983) (2008)*

7 *(1976) 551 P.2d 334*

Michael Thomas, a solicitor based in Auckland, New Zealand, courageously revisits the decision in '**Expanded Liability for Psychiatrists: *Tarasoff* Gone Crazy**'. His article aims to enlighten all of us (not only those psychiatrists for whom he states his paper is intended!) on developments of the *Tarasoff* doctrine both in the United Sates and the United Kingdom.

On previous occasions the JMHL has contained articles about Homicide Inquiries, both generally[8] and in relation to specific inquiries[9]. I am pleased that this issue contains another article on the subject. In '**Learning Lessons: Using Inquiries for Change**', Gillian Downham and Richard Lingham use their considerable experience as members of Inquiry Panels, to consider the controversial issue of the Panel's role (if any) post-publication of the Inquiry Report. They put forward a set of principles to be applied to the post-Inquiry stage "which may be applicable to other types of independent inquiry in the health and social care sector".

The final article is by Laura Davidson, Barrister. In '**Nearest Relative Consultation and the Avoidant Approved Mental Health Professional**', Dr. Davison considers three recent cases arising out of alleged failures to comply with various provisions relating to nearest relatives within the *Mental Health Act 1983*. These provisions will surely be the subject of more litigation in the years ahead, and so no doubt will be subjected to further scrutiny in the Casenotes section of future issues of the Journal.

On this occasion, the Casenotes section highlights three cases.

- Kris Gledhill (Senior Lecturer, University of Auckland Law School) has speedily and generously considered the first case of the Upper Tribunal's Administrative Appeals Chamber, *Dorset Healthcare NHS Foundation Trust v MH* (2009)[10], in '**The First Flight of the Fledgling: the Upper Tribunal's Substantive Debut**'.
- In '**Between a Rock and a Hard Place**', Paul McKeown (Solicitor/Tutor, Law School, Northumbria University) analyses the House of Lords decision in *Lewisham LBC v Malcolm* (2008)[11], a housing case which, given the issues which arose in the case, will be of considerable interest to readers of the Journal.
- Section 136 is considered once more in this issue. In **'"She took no reasoning": Enticing Someone into a Public Place**', David Hewitt (Visiting Fellow to the Law School at Northumbria University) looks at the criminal law case of *McMillan v Crown Prosecution Service* (2008)[12], and strongly suggests that it has implications for the use of section 136.

There are no book reviews in this issue – however we shall make amends in the *Autumn* issue, as there are a number of books published in recent months which deserve consideration.

As always, I am very grateful to each of the contributors to this issue of the JMHL.

John Horne

Editor

8 *See 'Reforming Inquiries following Homicides' by Anselm Eldergill, JMHL October 1999 @ pp 111 – 136, and 'Qualitative Analysis of Recommendations in 79 Inquiries after Homicide committed by Persons with Mental Illness' by Melissa McGrath and Professor Femi Oyebode , JMHL December 2002 @ pp 262–282*

9 *See 'The Michael Stone Inquiry – A Reflection' by Robert Francis QC, JMHL May 2007 @ pp 41–49*

10 *[2009] UKUT 4 (AAC)*

11 *[2008] UKHL 43*

12 *[2008] EWHC 1457 (Admin)*

The Best is the Enemy of the Good: The Mental Health Act 2001 (Part 2)

Anselm Eldergill[1]

§1 – INTRODUCTION

This is the second of two articles examining the *Mental Health Act 2001*, the main piece of mental health legislation in the Republic of Ireland. The first article, published in the previous edition of the journal, dealt with the new admission, detention, leave and transfer provisions[2]. This concluding article examines the new safeguards: the Mental Health Commission and the new tribunal and consent to treatment procedures.

Contents

§1 – CONSENT TO TREATMENT

As a general statement, the consent to treatment procedures in the 2001 Act offer weaker protection for patients than those in force in England and Wales *(Mental Health Act 1983)*, Scotland *(Mental Health (Care and Treatment) Scotland Act 2003)* and Northern Ireland *(Mental Health (Northern Ireland) Order 1986)*.

As with these other Acts, there are specific procedures concerning psychosurgery, ECT, medication, and 'other' treatments.

Definition of 'consent'

What constitutes 'consent' is defined in section 56. It 'means consent obtained freely without threats or inducements, where:

(a) the consultant psychiatrist responsible for … the patient is satisfied that [s/he] … is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

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1 *Solicitor; President of the Mental Health Lawyers Association; President of the Institute of Mental Health Act Practitioners. Visiting Professor, Law School, Northumbria University.*

2 *See Journal of Mental Health Law, May 2008, pp 21–37.*

(b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.'

Requirement (b) is not found in the 1983 Act and is a useful statutory protection.

Whether particular conduct constitutes a 'threat or inducement' may be difficult to determine. For example, what is the position where a consultant tells a patient who is unwilling to have ECT that the consultant is likely to be in a position to revoke the order following a course of ECT? Is this an inducement, part of the duty to give 'adequate information' about the likely effects of the treatment on the patient's mental state and symptoms, or both of these things? If the patient then consents, has that consent been obtained freely, which is arguably not quite the same thing as being given freely?

Psychosurgery

Section 58 provides that psychosurgery shall not be performed on a patient unless the patient consents in writing to the psychosurgery and it is authorised by a tribunal.

The tribunal must review any proposal for psychosurgery. Having done this, it must either (a) authorise the psychosurgery 'if it is satisfied that it is in the best interests of the health of the patient concerned',' or (b) if it is not so satisfied, refuse to authorise it.

Again, the drafting is rather loose. What is the position where a tribunal is satisfied that psychosurgery is in the best interests of the health of the patient but not that the patient has capacity to consent to the treatment? In other words, the tribunal is of the opinion that the patient is not capable of understanding the nature, purpose and likely effects of the proposed treatment. Although the tribunal believes that the patient's signed consent is legally worthless, as drafted this is not a matter for it. Likewise, what is the position where the tribunal believes that the patient's written consent was not obtained freely or that they were not given adequate information? Again, as drafted these are not matters which affect the tribunal's decision.

A second problem concerns the definition of 'a patient.' The psychosurgery safeguards, and Part 4 generally, only apply to 'patients'. According to the interpretation section, 'a person to whom an admission order relates is referred to in this Act as "a patient."'

It is strange that the definition of a patient does not also refer to people who are subject to renewal orders. Nevertheless, it is clear that the consent procedures apply equally to people whose admission orders have been renewed. No other interpretation is tenable given the renewable 3-month medication periods referred to in section 60.

What though of voluntary patients, some of whom may lack capacity to consent to having the treatment? Is the statutory intention that psychosurgery given to a voluntary patient does not need to be authorised by a tribunal because the recipient is not 'a patient' for the purposes of the 2001 Act? Given the drafting and the ambit of consent provisions in similar jurisdictions, it seems unlikely that 'voluntary patients' are 'patients' for the purposes of the ECT and medication safeguards in Part 4. Is the legal position the same therefore as concerns psychosurgery?

Electro-convulsive therapy

Section 59 provides that a programme of electro-convulsive therapy shall not be administered to a patient unless either s/he has consented in writing to its administration or (if unable or unwilling to consent) it

has been approved by the patient's consultant and 'authorised … by another consultant psychiatrist following referral of the matter to him or her' by the former.

The fact that the patient's consultant nominates the second-opinion doctor is an obvious weakness, and this part of the Part 4 scheme duplicates the scheme in Northern Ireland.

As with psychosurgery, one problem in practice may be too flexible an approach as to what constitutes consent. The key factual issue is usually not whether the person has signed a consent form but whether they had capacity to understand what they were signing, and capacity to understand the nature, purpose and likely effects of the treatment referred to in it. One must also then look at the adequacy of the information they were given.

The 2001 Act provides that a programme of ECT shall not be administered except in accordance with rules made by the Commission. These rules are the *Rules Governing the Use of Electro-Convulsive Therapy* (R-S59(2)/01/2006) (Mental Health Commission, Dublin, 1 November 2006).

There is also a code of practice on giving ECT to voluntary patients: Code of Practice *Governing the Use of Electro-Convulsive Therapy for Voluntary Patients* (COP-S33/02/2008) (Mental Health Commission, Dublin, January 2008).

Medication

Section 60 deals with giving medication for mental disorder. It is poorly drafted:

> 60.– Where medicine has been administered to a patient for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either–
>
> (a) the patient gives his or her consent in writing to the continued administration of that medicine, or
>
> (b) where the patient is unable or unwilling to give such consent–
>
> (i) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
>
> (ii) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,
>
> and the consent, or as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

The statutory scheme for medication is therefore essentially the same as for ECT: treatment requires the patient's consent or, if they are unable or unwilling to consent, the authorisation of a second consultant.

Several difficulties arise in addition to those already raised above about the quality of any consent apparently given in writing.

What is the position if a patient consents to further medication at the three-month point but then, a month later, seeks to withdraw the consent on experiencing unpleasant side-effects? As drafted, the scheme seems to allow the treatment to continue for a further two months before a second opinion is required.

Consider then the case of a patient who refuses further treatment with risperidone at the three-month point. The patient's consultant approves its continued administration and a second consultant authorises it. A month later the consultant changes the antipsychotic to olanzapine. Is a further second-opinion required at this stage? The wording of section 60 – 'the administration of that medicine shall not be continued …' suggests that a second-opinion in respect of olanzapine is only required three-months after 'that medication' is started.

Similarly, what if a patient detained on 1 January is prescribed antipsychotic X, this is changed to antipsychotic Y on 1 February, and then on 1 March antipsychotic Y is replaced by antipsychotic Z? Is it the case that she is now not entitled to a second opinion until she has been on antipsychotic Z for three months?

Other treatments

The general position is that treatments other than those specified above require the patient's consent. There is, however, a caveat in relation to incapacitated patients. A patient's consent is not required if s/he is incapable of consenting to the treatment by reason of their mental disorder and, in the opinion of their consultant psychiatrist, the treatment is necessary to safeguard their life; to restore their health; to alleviate their condition; or to relieve their suffering.

Seclusion and restraint

Section 69(1) provides that a person shall not place a 'patient' in seclusion or apply mechanical means of bodily restraint unless such seclusion or restraint is determined, in accordance with the rules made by the Commission, to be necessary for the purposes of treatment or to prevent the patient from injuring themselves or others and unless the seclusion or restraint complies with such rules. The term 'patient' here expressly includes a voluntary patient and a child in respect of whom an order under section 25 is in force.

The relevant rules are the *Rules Governing the use of Seclusion and Mechanical Means of Bodily Restraint* (R-S69 (2)/02/2006) (Mental Health Commission, Dublin, 1 November 2006). There is also a Code *of Practice on the Use of Physical Restraint in Approved Centres* (COP-S33(3)/02/2006) (Mental Health Commission, Dublin, 1 November 2006).

§2 – MENTAL HEALTH COMMISSION

The Mental Health Commission is the key body in terms of ensuring the proper operation of the Act, and safeguarding the rights of citizens under the statute.

Constitution

By section 35, the Commission consists of 13 members appointed by the Minister. Of the members, there must be one practising barrister or solicitor; three registered medical practitioners; two registered nurses; one social worker; one psychologist; one representative of the general public; three representatives of voluntary bodies; and one health board chief executive. There must be at least four female and four male members. Members of the Commission hold office for a period not exceeding five years.

Functions

The Commission's functions include appointing tribunals and tribunal members; establishing the tribunal panel of consultant psychiatrists; arranging a legal aid scheme for patients; preparing and reviewing a code

of practice; appointing the Inspector of Mental Health Services; maintaining a register of approved centres; prescribing statutory forms; prosecuting offences; and making rules concerning the use of seclusion and mechanical restraint.

Statistics

The Commission has published a number of very useful papers summarising the use made of the Act and the judgments of the High Court. These can be found on its website: www.mhcirl.ie.

There were 388 transitional patients detained under the *Mental Treatment Act, 1945* on the commencement date. In the 11 month period from 1 November 2006 to end September 2007 there were 1,894 admission orders and 1,101 renewal orders were made. There were 1,902 Mental Health Tribunal hearings during that period and 19 appeals to the Circuit Court against tribunal decisions, of which five reached the hearing stage.[3] It appears that none of these five appeals were successful.

§3 – MENTAL HEALTH TRIBUNALS

The Mental Health Commission must be sent a copy of any admission or renewal order within 24 hours. On receiving its copy, the Commission arranges for the patient's case to be reviewed by a Mental Health Tribunal.

The Commission assigns a legal representative and directs a member of the medical panel to examine the patient. The doctor appointed has 14 days within which to examine the patient, interview the consultant, inspect the patient's records and prepare a report for the tribunal.

The tribunal must conduct its review and make its decision within 21 days of the making of the order. It must affirm the order if it is satisfied that the patient is suffering from mental disorder and that any failure to comply with the statutory admission or renewal procedures has not caused injustice or affected the substance of the order.

Constitution and administration

The Act provides that the Commission shall from time to time appoint one or more tribunals, each of which shall be known as a Mental Health Tribunal, to determine such matters as may be referred to it by the Commission under section 17. Under the Act, the matters that may be referred to a tribunal are review proceedings following the making of an admission or renewal order; proposals to transfer a patient to the Central Mental Hospital; and proposals for psychosurgery.

Each tribunal consists of three members: a practising barrister or solicitor of 7 years standing, who acts as the chairperson; a consultant psychiatrist; and a lay member.

The Commission has devised *Procedural Guidance & Administrative Protocols* for tribunals.

The terms on which members are appointed

The terms of appointment may be problematic. Section 48 provides that a member of a tribunal shall hold office for such period not exceeding three years. Furthermore, a tribunal member 'may at any time be removed … by the Commission if, in the Commission's opinion, … his or her removal appears to the Commission to be necessary for the effective performance by the tribunal of its functions.'

3 *See Summary of Article 40.4 Judgments since Commencement of the Mental Health Act 2001, Mental Health Commission, Dublin (24 October 2007), p.1.*

A tribunal appointment is therefore a part-time appointment for three years made by a non-judicial body, which can remove the member at any time if it believes this is necessary for the effective performance of the tribunal's functions. Whether this appointment scheme complies with the minimum requirements of the European Convention on Human Rights must be doubtful. For example, in *Findlay v United Kingdom* (1997) 24 EHRR 221 at para. 73, the court stated that, 'In order to establish whether a tribunal can be considered as "independent", regard must be had inter alia to the manner of appointment of its members and their term of office, the existence of guarantees against outside pressures and the question whether the body presents an appearance of independence.'

The general principle is that a person exercising judicial functions should not be placed in a position where her or his freedom to discharge those functions without fear or favour, affection or ill-will, might be or appear to be jeopardised by his relationship with the executive. The fact that the Mental Health Tribunals are only quasi-judicial bodies was hinted at in *MR v Cathy Byrne & Others, Sligo Mental Health Services Respondent) and Mental Health Tribunal (Notice Party)* (2 March 2007),[4] where Mr Justice Neill said that, 'The principal reform is the establishment of the Mental Health Commission and Mental Health Tribunals, thus providing for a quasi-judicial intervention for the purposes of the independent review of detention of persons in approved centres alleged to be suffering from "mental disorders".'

Panel of psychiatrists

The Act requires the Commission to establish a panel of consultant psychiatrists to carry out independent medical examinations under section 17.

By section 17, when the Commission receives a copy of an admission or renewal order, it must direct a member of the panel to examine the patient, review their records and to interview the consultant psychiatrist, in order to determine in the interest of the patient whether the patient is suffering from a mental disorder.

Within 14 days, the panel member must provide the tribunal with a written report on the results of the examination, interview and review, and copy it to the patient's legal representative. The tribunal must have regard to this report before determining the review.

Mental Health Legal Aid Scheme

The Commission assigns a legal representative to represent the patient, from the Mental Health Legal Aid Scheme, unless the patient engages a solicitor themselves. According to the Commission, the purpose of assigning a legal representative is to enable the patient to present their case to the tribunal in person or through the legal representative, so that their views are articulated and any relevant material or submissions are placed before the tribunal. Where a patient is unable or unwilling to give instructions, the appropriate course for the legal representative will be to listen to the patient's views and to articulate them in the patient's best interest. A legal representative appearing before the tribunal in proceedings under this Act shall be entitled to the same privileges and immunities as a legal representative in a court.

The tribunal must arrange to give the patient or their legal representative a copy of any psychiatric report furnished to the tribunal under section 17, and also an indication in writing of the nature and source of any relevant information which has come to their notice in the course of the review.

4 *Unless a case referred to in this article has been given a formal citation, the case is unreported, in which case the date of the judgment is given; any quotations and observations are based on the transcript of the judgment. Many of the transcripts have been published on the Mental Health Commission's website (www.mhcirl.ie) and the website of the British and Irish Legal Information Institute (www.bailii.org).*

The Commission is developing quality assurance proposals for legal representatives of the kind developed by the Legal Services Commission in England and Wales. The initial position taken by the Law Society was not to accept them. There is no good evidence base in England and Wales that supports the view that these kinds of bureaucratic intervention by non-practitioners adds anything to the protection afforded to clients by professional training, a professional code and investigation by the professional body. There is much anecdotal evidence to suggest that such measures drive practitioners away from legal aid work. The key to any successful professional service is recruiting good calibre candidates, good training, continuing education, adequate funding and a strong professional body that is able to enforce standards of conduct.

Rules and procedure

There are no tribunal rules. Much is therefore left to a tribunal's discretion although section 49 makes some provision for giving directions and similar matters:

Directions concerning the attendance of the patient	A tribunal may, for the purposes of its functions, direct in writing the responsible consultant psychiatrist to arrange for the patient to attend before it. However, a patient shall not be required to attend if, in the opinion of the tribunal, such attendance might be prejudicial to his or her mental health, well-being or emotional condition.
Directions concerning the attendance of witnesses	A tribunal may, for the purposes of its functions, direct in writing any person whose evidence is required by the tribunal to attend before it. The reasonable expenses of witnesses directed to attend shall be paid by the Commission.
Directions concerning the production of documents	A tribunal may, for the purposes of its functions, direct any person attending before it to produce to the tribunal any document or thing in his or her possession or power specified in the direction. It may also direct in writing any person to send to it any document or thing in his or her possession.
General power to give directions	A tribunal may, for the purposes of its functions, give any other directions for the purpose of the proceedings concerned that appear to it to be reasonable and just.

The hearing

The Commission has set a standard that a minimum of three days notice of a hearing must be given to members and those required to attend.

Tribunal hearings are generally held at approved centres and the Commission appoints a Mental Health Tribunal Clerk to provide administrative assistance to the tribunal.

At a sitting of a tribunal, each member of the tribunal has a vote, and every question must be determined by a majority vote, including it seems points of law.

A tribunal must 'hold sittings' when undertaking a review. In other words, the statute precludes making a decision on the papers.

At sittings, the tribunal 'may receive submissions and such evidence as it thinks fit.' By section 49, the tribunal must, however, make provision for:

(a) notifying the consultant psychiatrist responsible … and the patient or his or her legal representative of the date, time and place of the relevant sitting of the tribunal,

(b) giving the patient … or his or her legal representative a copy of any report furnished to the tribunal under section 17 and an indication in writing of the nature and source of any information relating to the matter which has come to notice in the course of the review,

(c) subject to subsection (11), enabling the patient … and his or her legal representative to be present at the relevant sitting … and enabling the patient … to present his or her case … in person or through a legal representative,

(d) enabling written statements to be admissible as evidence … with the consent of the patient or … representative,

(e) the examination by or on behalf of the tribunal and the cross-examination by or on behalf of the patient … (on oath or otherwise as it may determine) of witnesses before the tribunal called by it,

(f) the examination by or on behalf of the patient … and the cross-examination by or on behalf of the tribunal … of witnesses before the tribunal called by the patient the subject of the review,

(g) the determination by the tribunal whether evidence at the tribunal should be given on oath,

(h) the administration by the tribunal of the oath to witnesses before the tribunal, and

(i) the making of a sufficient record of the proceedings of the tribunal.

According to the *Procedural Guidance & Administrative Protocols*, 'To put the patient at ease, it is recommended that where it is required that evidence be taken directly from the patient this be done as early in the hearing as is reasonably possible. Due consideration should be given by the mental health tribunal to each patient's mental health, well being or emotional condition when evidence is being heard.'

Whether proceedings are inquisitorial or adversarial

The *Procedural Guidance & Administrative Protocols* also state that 'the Mental Health Commission takes the view that under no circumstances should mental health tribunals be conducted in an adversarial manner. An inquisitorial approach which seeks to protect each patient's human rights and is governed by best interest principles, Section 4(1), is viewed by the Commission as the most effective manner in which to conduct a mental health tribunal.'

Although such a view has also sometimes been advanced by the senior courts in England and Wales, it is difficult to view such a statement as anything other than a fairly complete misunderstanding of the legal position. Mental Health Tribunal proceedings do, of course, have strong inquisitorial elements. For example, the tribunal members determine the procedure and call and question witnesses. However, equally obviously, there are strong adversarial elements, that are not part of a pure inquisitorial approach. Generally, there are parties, and those parties have rights. The patient has statutory rights to be present and to present their case; to call witnesses; and to cross-examine witnesses. Written statements are only admissible as evidence with the consent of the patient or their representative. The model is therefore a mixed inquisitorial-adversarial model, but hopefully not confrontational.

Right to a hearing in public

By section 49(9), 'sittings of a tribunal … shall be held in private.' Unlike in England and Wales, no provision at all is made for a public hearing at the request of the patient. In due course, the argument will

no doubt be made in some case that an absolute bar of this kind contravenes Article 6 of the European Convention on Human Rights. It is necessary to balance the patient's desire for a hearing in public against, having regard to matters such as their reasons for requesting a public hearing and the likely effects on their mental state, treatment and rehabilitation.

The tribunal's powers

The tribunal must conduct its review and make its decision within 21 days of the making of the order. It must affirm the order if it is satisfied that the patient is suffering from mental disorder and that any failure to comply with the statutory admission or renewal procedures has not caused injustice or affected the substance of the order.

The tribunal has a limited power to extend the usual 21-day duration of an admission order. Section 18(2) provides that the tribunal shall make its decision no later than 21 days after the making of the admission order (or the renewal order). However, by sub-section (4), this period may be extended by order of the tribunal for a further period of 14 days, either on its own motion or at the request of the patient. It may then be further extended by order of the tribunal for a second period of 14 days, but in this case only on the application of the patient, and only if the tribunal is satisfied that it is in the interests of the patient. Where an extension is given, the admission order (or renewal order) continues in force during the period of the extension.

In *T O'D v Central Mental Hospital, HSE (Respondent) and Mental Health Commission (Notice Party)* (25 April 2007), the Central Mental Hospital made a series of very basic errors in relation to the new detention provisions. On 6 December 2006, a renewal order was not made in time and the patient became a voluntary patient. He expressed an intention to leave and an admission order was made under section 24. For the second time, the hospital failed to renew an order in time, so the patient again became a voluntary patient. He again indicated a wish to leave, on 17 January 2007, and was detained. However, the admission order required by section 24 was not signed for a week, until 24 January. On review, the tribunal affirmed the admission order.

Mr Justice Charleton upheld the patient's detention, stating that a purposive approach to the legislation is required, that section 4 (best interests) infuses the entire legislation, and that the tribunal was entitled to take best interests into account. Indeed, had the tribunal not taken section 4 into account, that would have been grounds for judicial review:

> "26. … I have no doubt that in referring to these sections that concern the administration of involuntary detention, s.18(1) refers to the entirety of them and not simply to more minor matters as to typing, time or procedure. I would hold that the purpose of s.18(1) [tribunal's jurisdiction and powers] is to enable the Mental Health Tribunal to consider afresh the detention of mental patients and to determine, notwithstanding that there may have been defects as to their detention, whether the order of admission or renewal before them should now be affirmed. In doing so, the Mental Health Tribunal looks at the substance of the order. This, in my judgment, means that they are concerned with whether the order made is technically valid, in terms of the statutory scheme set up by the Act or, if it is not, whether the substance of the order is sufficiently well justified by the condition of the patient.
>
> In this regard, the Mental Health Tribunal was entitled to have regard to the fact that Mr O'D. was at all material times suffering from a serious psychiatric illness which required that he should be treated and which treatment was of assistance to him and to the community. In addition, they were

> obliged, in my judgment, to have regard to the fact that if the applicant had been discharged, which would have been the effect of their refusal to uphold the order, the applicant himself would have been at immediate risk from his paranoid delusional fantasies as would those with whom he might come into close contact. I would specifically hold that the purpose of s. 18(1) of the Act is to enable the Tribunal to affirm the lawfulness of a detention which has become flawed due to a failure to comply with relevant time limits."

A somewhat different approach was taken in *WQ v Mental Health Commission, Central Mental Hospital, Mental Health Tribunal (Respondents)* (15 May 2007), where Mr Justice O'Neill stated that section18(1) only excuses failures of a minor or insubstantial nature, which do not cause injustice. This approach is likely to be preferred to that of Mr Justice Charleston.

The tribunal's decision and reasons

The tribunal's decision must be recorded on a form prescribed by the Commission. Form 8 is used to record decisions to affirm or revoke an admission or renewal order. Form 9 is used to record decisions to extend the period of an admission or renewal order by up to 14 days. Adjournments are, of course, sometimes necessary.

The tribunal's decision and reasons must be given in writing to the Commission, the consultant psychiatrist responsible for the patient, the patient, their legal representative, and to any other person to whom, in the opinion of the tribunal, such notice should be given. The Commission guidelines state that decisions should wherever reasonably possible be given on the day of the hearing; and if not, as soon as possible thereafter and within the period specified in the Act.

Adequacy of reasons

According to Mr Justice Neill, in *MR v Cathy Byrne & Others, Sligo Mental Health Services Respondent) and Mental Health Tribunal (Notice Party)* (2 March 2007),

> "In approaching an assessment of the decision of the Tribunal as revealed by the record of it, both as to substance and form, in my view, it is not appropriate to subject the record to intensive dissection, analysis and construction, as would be the case when dealing with legally binding documents such as statutes, statutory instruments or contracts. The appropriate approach is to look at the record as a whole and take from it the sense and meaning that is revealed from the entirety of the record. This must be done also in the appropriate context; namely the record must be seen as the result of a hearing which has taken place immediately before the creation of the record, and it must be read in the context of the evidence both oral and written which has just been presented to the Tribunal. The record is not to be seen as, or treated as a discursive judgment, but simply as the record of a decision made contemporaneously, on specific evidence or material, within a specific statutory framework. i.e. the relevant sections of the Act of 2001 as set out above."

While that is generally correct, it would appear that a very low standard indeed was set in this case. The tribunal's reasons did not reveal any consideration at all of whether the applicant's condition would deteriorate, whether the absence of a renewal order would prevent the administration of appropriate treatment that could only be given by involuntary admission, or whether the patient's condition would benefit to a material extent by the making of the renewal order. In addition, the tribunal's finding, that "In the event of her being changed to a voluntary status compliance with medication and D.T. would not be guaranteed", applied an inappropriate test or standard.

The overriding test must surely always be whether the tribunal is providing both parties with the materials which will enable them to know that the tribunal has made no error of law in reaching its finding of fact.[5] The patient must know why the case advanced in detail on his behalf had not been accepted.[6] Proper, adequate and intelligible reasons should be given which grapple with the important issues raised and can reasonably be said to deal with the substantial points that have been raised.[7] However, the reasons for the decision cannot be read "in the air". Although the reasons may not be clear or immediately intelligible on their face, the decision is addressed to parties, who are an informed audience and so well aware of what issues were raised and the nuances raised by those issues.[8] Nor should the reasons be subjected to the analytical treatment more appropriate to the interpretation of a statute or a deed. The necessity for giving reasons is often underscored by the fact that it is often very important to know the reason why an application has been turned down.

Privilege

Tribunal documents, reports and statements are absolutely privileged.

Circuit Court appeals

Section 19 provides for an appeal to the Circuit Court against a decision of a tribunal. No appeal lies against an order of the Circuit Court other than an appeal on a point of law to the High Court.

If the tribunal affirms the order being reviewed, the patient has 14 days within which to appeal to the Circuit Court. The Circuit Court will revoke an order if it is shown to its satisfaction that the patient is not suffering from mental disorder at the time of the Circuit Court hearing. As drafted, the Circuit Court is not concerned with the second issue of failure to comply with the statutory procedures.

The procedure for Circuit Court appeals is set out in Order 47A of the *Circuit Court Rules 2001,* which was inserted by the *Circuit Court Rules (Mental Health) 2007*. It takes some three to four weeks to get a hearing in Dublin. In other areas, such as Galway, it seems that appeals have been given no priority and must take their place in the list.

The fact that the Circuit Court is not concerned with a tribunal's finding as to whether any failure to comply with the statutory admission or renewal procedures has caused injustice or affected the substance of the order may be unfortunate. It means that the way of appealing this part of the tribunal's finding is through habeas corpus or judicial review proceedings. Arguably, a single appeal procedure, encompassing both factual and legal findings, would be more efficient.

Habeas corpus and Article 40.4

Challenges to admission and renewal orders, and to tribunal decisions, may also be brought by way of habeas corpus proceedings under Article 40.4 of the Constitution of Ireland:

> 40.4. 1° No citizen shall be deprived of his personal liberty save in accordance with law.
>
> 2° Upon complaint being made by or on behalf of any person to the High Court or any judge

5 *Bone v. Mental Health Review Tribunal [1985] 3 All E.R. 330; Alexander Machinery (Dudley) Ltd. v. Crabtree [1974] I.C.R. 120 at 122.*

6 *R. v. Mental Health Review Tribunal, ex p. Clatworthy [1985] 3 All E.R. 699.*

7 *R. v. Mental Health Review Tribunal, ex p. Pickering [1986] 1 All E.R. 99; Bone v. Mental Health Review Tribunal [1985] 3 All E.R. 330; Seddon Properties Ltd. v. Secretary of State for the Environment (1978) 42 P. & C.R. 26; Re Poyser and Mills's Arbitration [1964] 2 Q.B. 467 at 478.*

8 *R. v. Mental Health Review Tribunal, ex p. Pickering [1986] 1 All E.R. 99.*

> thereof alleging that such person is being unlawfully detained, the High Court and any and every judge thereof to whom such complaint is made shall forthwith enquire into the said complaint and may order the person in whose custody such person is detained to produce the body of such person before the High Court on a named day and to certify in writing the grounds of his detention, and the High Court shall, upon the body of such person being produced before that Court and after giving the person in whose custody he is detained an opportunity of justifying the detention, order the release of such person from such detention unless satisfied that he is being detained in accordance with the law …

Where the High Court has ordered a patient's release, it has often directed delayed release in order to allow time for the patient to be detained under a valid admission order.

As previously noted, the court has taken a paternalistic approach to the legislation.

§4 – CONCLUDING REMARKS

There is much to commend. The strengths of the legislation include a relatively strong Mental Health Commission; supervision by tribunals of proposed transfers to the Central Mental Hospital; automatic tribunal referrals following admission and renewal; and the holding of tribunal hearings within 21 days.

On the debit side, the drafting is often weak. Apart from the ambiguities already referred to, there are no rectification provisions, which is an unfortunate error. No provision is made for transfers in and out of the jurisdiction, in particular with the United Kingdom.

There are also significant omissions compared with United Kingdom statutes. For example, the statute does not contain any community alternatives to detention, such as guardianship or supervision orders. There are no rehabilitation provisions of the kind found in Northern Irish legislation. The role of the applicant is limited to triggering a medical admissions process, rather than deciding whether an application is appropriate having regard to the medical recommendations. There is no duty to provide after-care to persons discharged from section. No provision is made for patients' correspondence or for making admission orders in criminal proceedings; and nor are there any pre-trial diversion powers. As in Northern Ireland, the legislation is very much based on a medical model: the psychiatric profession is dominant; the consent to treatment provisions are weak; the tribunal and legal representation and legal aid schemes are administered through a health service body; the next-of-kin or nearest relative has no power to discharge the patient or to block admission in cases where dangerousness is not an issue[9]; there are no independent managers of approved centres with discharge powers; and the Inspector of Mental Health Services must be a consultant psychiatrist. Furthermore, the tribunal's powers are relatively limited when reviewing an admission or renewal order. They may discharge or not discharge. There is no power to direct discharge on a future date, and no power to direct or recommend leave or transfer. Patients have no statutory right to obtain their own psychiatric report, and there is no after-care or social circumstances assessment to aid the tribunal. Overall, the scheme is good but not the best.

9 *This is perhaps slightly surprising given that Article 41 of the Constitution provides that, '1° The State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law. 2° The State, therefore, guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.'*

Restricting Movement or Depriving Liberty?

Neil Allen[1]

> *"It is of course helpful to know that the question is one of degree and the matters which should be taken into account in answering it. But one also needs to be told what the question is. What is the criterion for deciding whether someone has been deprived of liberty or not?"*[2]

This judicial appeal for clarity exposes a jurisprudential problem which threatens one of our most fundamental human values; the right to liberty. For no-one really knows what it means to be "deprived" of one's "liberty". The extremities are straightforward. Prisoners are deprived; picnickers are not. But liberty deprivations may "take numerous other forms [whose] variety is being increased by developments in legal standards and in attitudes".[3] Technology, too, has played its part in such developments by introducing novel ways of restricting movement beyond the paradigmatic lock and key. The more expansive those other forms, however, the greater the risk of legal uncertainty.

The challenge in this paper is one of interpretation. Article 5 of the European Convention on Human Rights 1950 protects the "liberty and security of person" which is said to have a "Council of Europe-wide meaning".[4] But how should this autonomous concept be transposed into English law? Adopting Berlin's classic dichotomy,[5] does liberty relate to the absence of external barriers or constraints, where we enjoy it to the extent that no-one is preventing us from doing whatever we might want to do (negative liberty)? Or does it concern the presence of internal factors, where we enjoy liberty to the extent that we are able to take control of our lives and self-determine in our own interests (positive liberty)?[6] These complex philosophical perspectives cannot be ignored and are, to varying degrees, protected by other Convention articles.[7] But article 5 is not concerned with such broad notions of liberty because it contemplates liberty in its *classic* sense. That is, the *physical* liberty of the person.[8]

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1 *Barrister, Young Street Chambers and the University of Manchester. The author would like to thank my his colleagues at the Institute of Science, Ethics and Innovation for their comments.*

2 *Secretary of State for the Home Department v JJ [2008] 1 AC 385 at para 39 per Lord Hoffmann.*

3 *Guzzardi v Italy (1980) 3 EHRR 333 at para 95.*

4 *Ibid n.2 at para 13 per Lord Bingham.*

5 *I. Berlin, 'Two Concepts of Liberty' in Four Essays on Liberty (Oxford: OUP, 1969).*

6 *The notion of autonomy can be derived from this concept of positive liberty; see I. Kant, Fundamental Principles (1785); G. Dworkin, A Theory and Practice of Autonomy (Cambridge: CUP, 1999); J. Raz, The Morality of Freedom (Oxford: Clarendon Press, 1986); J. Rawls, A Theory of Justice (Oxford: OUP, 1971).*

7 *For example, see N. Allen, 'A human right to smoke?' (2008) 158 New Law Journal 886 for a discussion of the extent to which the Health Act 2006 interferes with our liberty to smoke in the context of article 8 of the Convention.*

8 *Ibid n.3 at para 92; see also Engel v The Netherlands (No 1) (1976) 1 EHRR 647 at para 58. The reference to "security of person" in article 5 does not provide any separate interpretation from the right to liberty; see Altun v Turkey (Application no. 24561/94, 1 June 2004) at para 57. Contrast this with the interpretation afforded to analogous provisions in the Universal Declaration of Human Rights (article 3), the International Covenant on Civil and Political Rights (article 9), and the American Declaration on the Rights and Duties of Man (article 1).*

The circumstances in which this particular type of liberty might be deprived go to the heart of this paper. Although the issue will be considered principally in the context of the forthcoming statutory safeguards for the detention of hospital and care home residents,[9] what follows may be equally applicable to other forms of confinement. After outlining the distinction between simple and arbitrary detention, I shall critically evaluate the jurisprudence to identify potential cracks which threaten its future development. Finally, a fresh approach will be suggested which focuses upon the core elements of confinement and coercion in distinguishing restricted movement from deprived liberty.

Detention and Arbitrariness

The perceived dangers associated with psychiatric illness have long justified a person's detention, whether under the prerogative powers,[10] at common law,[11] or statute.[12] It is not uncommon for these individuals to be subjected to physical, mechanical or chemical restraints, and varying degrees of social isolation, be it from family or fellow patients. But the very nature of detention is transforming as science and technology develop innovative ways of restricting our freedoms. Sensors, pressure pads, and controlled locks enable others to remotely monitor our movements at home and to control our ability to venture outside. They are seen by many as a less restrictive alternative to hospital or care home detention which promote independent, supported living. To others, such measures simply substitute one form of detention for another.

Unsurprisingly, article 5 of the European Convention does not protect us from detention itself. Quite the contrary. For it expressly permits the lawful confinement of suspected and convicted criminals, illegal immigrants, truant children, alcoholics, drug addicts, vagrants, spreaders of infectious diseases and those of unsound mind. But article 5 may be violated even when the authorities have lawful grounds for detention. For the essence of the right to liberty is to safeguard individuals from *arbitrar*y detention by requiring liberty deprivations to be made in accordance with a procedure prescribed by law.[13]

The distinction can clearly be seen in the *Bournewood* case.[14] A compliant incapacitated man with autism was informally admitted to the intensive behavioural unit of Bournewood Hospital; a place from which he would have been prevented from leaving had he tried to do so. For the majority of the House of Lords, Mr L was not detained for the purposes of the tort of false imprisonment. Lord Goff drew a distinction between the actual restraint of a patient and restraint which was conditional upon them seeking to leave. Placed on an unlocked ward, the patient was free to leave and was not restrained by any physical barriers from choosing to do so. In those circumstances, he was not imprisoned unless he attempted to leave.

9 *Pursuant to Schedules A1 and 1A of the Mental Capacity Act 2005 as inserted by the Mental Health Act 2007.*

10 *The duty of the monarch as parent of the people, or parens patriae, to protect persons unable to care for themselves or their property dates back to the De Prerogativa Regis of 1324. See Eyre v Countess of Shaftesbury (1725) Gilb Ch 172; Smith v Smith (1745) 3 Atk. 204; Wellesley v Beaufort (1829) 2 Russ 1.*

11 *See Brookshaw v Hopkins (1772) Lofft 240 at 243; R v Coate and others (1772) Lofft 73 at 75; Anderdon v Burrows (1830) 4 C & P 210 at 213; Re Shuttleworth (1846) 9 QB 651; Nottidge v Ripley (1850) 14 LTOS 445; R v Pinder, Re Greenwood (1855) 24 LJQB 148; Fletcher v Fletcher (1859) 1 El & El 420 at 423–4; Scott v Wakem (1862) 3 F and F 328 at 333; Symm v Fraser (1863) 3 F and F 859 at 883; and R v Whitfield, ex parte Hillman (1885) 15 QBD 122 at 132.*

12 *See, for example, the Vagrancy Acts of 1714 and 1744; Madhouses Act 1774; Criminal Lunatics Act 1800; County Asylums Acts of 1808, 1811, 1815, 1828, 1845, and 1846; Care and Treatment of Lunatics Acts of 1828, 1842, and 1845; Lunatic Asylums Inspection Act 1842; Lunatic Asylums Acts of 1853 and 1863; Lunacy Acts Amendment Acts of 1862, 1885 and 1889; Lunacy Act 1890; Medical Treatment Act 1930; Mental Health Acts of 1959, 1983 and 2007.*

13 *Kurt v Turkey (1998) 27 EHRR 373 at para 122.*

14 *R v Bournewood Community and Mental Health NHS Trust, ex p L [1999] 1 AC 458.*

The approach of the European Court of Human Rights (ECtHR) was quite different.[15] Article 5 was considered engaged mainly because the clinicians exercised complete and effective control over his care and movements and he was not free to leave. The common law doctrine of necessity could justify such detention. But the key, quite distinct, issue was whether that detention was *arbitrary*. It was unclear who could propose his informal admission and for what reasons. There was no procedure requiring medical or other assessments to justify the admission or detention thereafter. No one knew its exact purpose or for how long it could last. No one had to be nominated who might object or make applications on Mr L's behalf. Furthermore, and because he lacked capacity, any treatment could be given in his best interests which, in 1997, was still being inappropriately determined according to the *Bolam* test for negligence.[16] Cumulatively, this total lack of procedural safeguards amounted to arbitrary detention.[17]

The process of informal hospital admission was never originally intended to enable a deprivation of liberty to take place.[18] Indeed, its common law basis was previously recognised[19] as being unsystematic, full of glaring gaps and not resting upon clear or modern foundations of principle. In order to conform with its international obligations, the government now had to plug this legal hiatus left in the wake of the ECtHR's ruling. Using the Mental Health Act 2007, a complex set of deprivation of liberty safeguards (DoLS) have been added to the Mental Capacity Act 2005 so as to avoid such arbitrariness. They require managers of publicly and privately funded[20] hospitals and care homes to identify incapacitated and mentally disordered adults who are at risk of having their liberty deprived. A detailed assessment process is then undertaken by the respective primary care trust or local authority to determine whether the person's best interests warrant their deprivation of liberty for up to twelve months.[21]

At the heart of these safeguards is the deprivation of liberty concept.[22] The Joint Committee on Human Rights proposed a statutory definition, whereby "if it is known that a person will be taken from their home to a place where they will be prevented from leaving, and complete and effective control will be exercised over their movements, that person is deprived of their liberty from the point of removal from their home."[23] However, this was rejected by the government which preferred to rely upon the jurisprudence of article 5 to determine the issue. Regrettably perhaps, the DoLS thus provide a complex answer to what remains a largely hitherto unknown question.

15 *HL v United Kingdom (2004) 40 EHRR 761 at para 91. For an excellent summary of the proceedings, see K. Keywood, 'Detaining mentally disordered patients lacking capacity: The arbitrariness of informal detention and the common law doctrine of necessity' (2005) 13 Medical Law Review 108.*

16 *See Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, 587.*

17 *Ibid n.15 at para 120. Article 5(4) was also violated because neither habeas corpus nor judicial review proceedings prior to the Human Rights Act 1998 were sufficient to adequately examine the Winterwerp criteria for detention (see Winterwerp v Netherlands (1979–1980) 2 EHRR 387 at para 39).*

18 *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954–1957 (Report Cmnd 169, HMSO, 1957) at paras 290–291. See N. Morris, (1958) 21(1) Modern Law Review 63.*

19 *Law Commission, Mental Incapacity (Law Com. No. 231, London, HMSO, 1995) at para 1.1. See also the judicial observations in Re F (Mental Patient: Sterilisation) [1990] 2 AC 1 at 51 and 71.*

20 *Mental Capacity Act 2005 s.64(6) as inserted by the Mental Health Act 2007 Schedule 9, para 10(4).*

21 *Mental Capacity Act 2005 Schedules A1 and 1A.*

22 *Ibid Schedule A1 para 1(1) refers to being "detained … in circumstances which amount to deprivation of the person's liberty" which has "the same meaning as in Article 5(1)" according to s.64(5).*

23 *Legislative Scrutiny: Mental Health Bill (HL 40/HC 288), 4th February 2007 at para 89.*

Guiding Principles from Strasbourg to London

Although it is "perilous to transpose the outcome of one case to another where the facts are different",[24] the domestic courts must "take into account" the jurisprudence of the Strasbourg court.[25] In particular, the principles laid down in *Guzzardi*[26] and *Engel*.[27] The government is yet to ratify article 2 of protocol 4 which provides a right to liberty of movement and the freedom to choose one's residence.[28] Yet its very existence assists in our interpretation of article 5. The distinction between them is said to be merely one of degree or intensity, not nature or substance. However, determining whether there has been a liberty deprivation "sometimes proves to be no easy task in that some borderline cases are a matter of pure opinion".[29]

It is significant to note that the ECtHR has so far applied these principles consistently to each of the six detention grounds listed in article 5(1). In *Guzzardi,* for example, a residence order confined a mafia member to a makeshift camp on a small part of the Asinara island, off the Sardinian coast. He lived with his family but was subject to a 9 hour curfew. He was able to move about the 2½ squared kilometre settlement during the rest of the day, could get permission to journey beyond its boundaries from time to time – although only under strict police supervision – and he had to report to the police station twice a day. Moreover, he was not free to make social contact with the outside world. In deciding that these measures constituted a deprivation of liberty, the majority of the Court adopted the same approach in their consideration of grounds (a), (b), (c) and (e).

Transferring a person under house arrest (article 5(1)(c)) to a psychiatric clinic for assessment (article 5(1)(e)) requires separate consideration to be given to the separate grounds for detention that have been relied upon.[30] Whether that person is deprived of liberty in the first place, however, is resolved using the same guiding principles.[31] Those of unsound mind may thus be deprived of liberty in a hospital.[32] Or in a Polish sobering-up centre if alcoholic.[33] Or within a French airport transit zone so as to prevent an unauthorised immigration entry.[34] The *Guzzardi/Engel* guidelines are equally applicable in cases where none of the exhaustive list of grounds is applicable. A ten day period of confinement in a Spanish hotel for "deprogramming" members of a sect is but one example.[35] Imposing non-derogatory control orders upon suspected terrorists would be another.[36]

A useful summary of these guiding principles was given in *JE v DE and Surrey County Council.*[37] An elderly blind man with dementia and impaired memory was confined to a residential care home. He had a

24 *R (Gillan) v Commissioner of Police of the Metropolis [2006] 2 AC 307 at para 23 per Lord Bingham.*

25 *Human Rights Act 1998 s.2.*

26 *Ibid n.3.*

27 *Ibid n.8.*

28 *Being a qualified right, it can be lawfully restricted, provided the state's interference is in accordance with the law, pursues a legitimate aim, and is necessary in a democratic society; see Raimondo v Italy (1994) 18 EHRR 237 at para 39 and Hajibeyli v Azerbaijan (Application no. 16528/05, 10 July 2008) at para 58.*

29 *Ibid n.3 at para 93.*

30 *See Atanasov v Bulgaria (Application no. 73281/01, 6 November 2008) at paras 71–72.*

31 *For example, see Mancini v Italy (Application no. 44955/98, 12 December 2001) where the Guzzardi principles were applied to article 5(1)(c).*

32 *HL v United Kingdom ibid n.15 (lockable ward); see also Storck v Germany (2005) 43 EHRR 96 (clinic); Ashingdane v United Kingdom (1985) 7 EHRR 528 (open ward); Shtukaturov v Russia (Application no. 44009/05, 27 March 2008) (locked ward).*

33 *Litwa v Poland (2001) 33 EHRR 53.*

34 *Amuur v France (1996) 22 EHRR 533.*

35 *Blume and others v Spain (2000) 30 EHRR 632.*

36 *Ibid n.2.*

37 *[2006] EWHC 3459 at para 77. See also LLBC v TG and others [2007] EWHC 2640 (Fam); A Primary Care Trust and P v AH and a Local Authority [2008] EWHC 1403 (Fam); and Salford City Council v GJ and others [2008] EWHC 1097 (Fam).*

significant degree of freedom within it, was also taken out for walks, and had regular telephone contact with his family and visits. However, staff would not accede to his repeated requests to return home and his wife was told that the police would be called if she attempted to remove him. Determining that his liberty was deprived, Munby J. outlined the following expansive approach taken by the ECtHR:

1) There are three elements relevant to the question of whether in the case of an adult there has been a 'deprivation' of liberty engaging the state's obligation under Article 5(1) (different considerations may apply in the case of a child where a parent or other person with parental authority has, in the proper exercise of that authority, authorised the child's placement and thereby given a substituted consent):
    (a) An objective element of a person's confinement in a particular restricted space for a not negligible length of time;
    (b) Subjective element, namely that the person has not validly consented to the confinement in question;
    (c) The deprivation of liberty must be imputable to the state.
2) As regards the objective element:
    (a) The starting point must be the concrete situation of the individual concerned and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of and a restriction upon liberty is merely one of degree or intensity and not one of nature or substance.
    (b) In [this] type of case, the key factor is whether the person is, or is not, free to leave. This may be tested by determining whether those treating and managing the person exercise complete and effective control over the person's care and movements.
    (c) Whether the person is in a ward which is 'locked' or 'lockable' is relevant but not determinative.
3) As regards the subjective element:
    (a) A person may give a valid consent to their confinement only if they have capacity to do so.
    (b) Where a person has capacity, consent to their confinement may be inferred from the fact that the person does not object.
    (c) No such conclusion may be drawn in the case of a patient lacking capacity to consent.
    (d) Express refusal of consent by a person who has capacity will be determinative of this aspect of 'deprivation of liberty'.
    (e) The fact that the person may have given himself up to be taken into detention does not mean that he has consented to his detention, whether he has capacity or not. The right to liberty is too important in a democratic society for a person to lose the benefit of the Convention protection for the single reason that he may have given himself up to be taken into detention.

This summary was not cited to the House of Lords when it was considering a number of related cases.[38] Control orders were imposed on those for whom there were reasonable grounds to suspect involvement in terrorism-related activity.[39] Individuals were electronically tagged and required to remain at home for 18 hours a day. The remaining 6 hours could be spent outside, but only within a designated urban area. Visitors were not generally allowed and unauthorised people could not be met outside. The police could conduct random searches and remove any items they wished. Their use of communications equipment was also restricted. The majority of the House of Lords adopted an expansive approach which foresaw numerous forms of liberty deprivation other than classic detention in prison. Deciding that these measures constituted a deprivation of liberty, their Lordships transposed the following principles into domestic law:[40]

1) There is no "bright line" separating deprivation of liberty from restriction on liberty with borderline cases falling within an area of "pure opinion".
2) The test is objective: the task of the Court is to assess the impact of the measures "on a person in the situation of the person subject to them".
3) Many relevant factors must be taken into account (e.g. the type, duration, effects and manner of implementation of the measures), but the starting point or "core element" is the length of the curfew.
4) Social isolation is a significant factor, especially if it approaches solitary confinement during curfew periods.

Those dissenting guarded against an over-expansive interpretation of the deprivation of liberty concept so as to maintain the necessary distinction between article 5 and article 2 of protocol 4. Preferring a narrower construction, which departs from the Strasbourg jurisprudence, Lord Hoffmann noted how imprisonment was the paradigm case for article 5 engagement, although "one may have some degree of deviation … without it ceasing to be … a deprivation".[41] The essential question was "whether his situation approximates sufficiently closely to being in prison".[42] Similarly, for Lord Carswell the criterion for a liberty deprivation was "illegitimate imprisonment, or confinement so close as to amount to the same thing".[43] Such divergence of judicial opinion does not bode well for the implementation of DoLS. Indeed, the following are amongst a number of issues which are likely to be exposed in forthcoming litigation.

38 *Ibid n.2; see also Secretary of State for the Home Department v GG [2009] EWHC 142 (Admin); Secretary of State for the Home Department v AU [2009] EWHC 49 (Admin); AH v Secretary of State for the Home Department [2008] EWHC 1018 (Admin); Secretary of State for the Home Department v AP [2008] EWHC 2001 (Admin); Secretary of State for the Home Department v E [2008] EWHC 585 (Admin); Secretary of State for the Home Department v MB [2008] 1 AC 440. For a useful commentary, see D. Feldman, 'Deprivation of liberty in anti-terrorism law' (2008) 67(1) Cambridge Law Journal 4.*

39 *The Prevention of Terrorism Act 2005 has replaced the Anti-terrorism, Crime and Security Act 2001 whose provisions enabling the detention of foreign nationals without trial was held to be unlawful in A v Secretary of State for the Home Department [2005] AC 68.*

40 *As summarised in Secretary of State for the Home Department v AH [2008] EWHC 1018 (Admin) at para 21.*

41 *Ibid n.2 at para 38.*

42 *Ibid at para 43 relying on the dissenting judgments in Guzzardi as adopted by the Court of Appeal in R (Gillan) v Commissioner of Police of the Metropolis [2005] QB 388, 406 and approved by the House of Lords [2006] 2 AC 307, 343.*

43 *Ibid at para 79.*

Jurisprudential Cracks

(a) A question of degree, not substance?

The ECtHR has never explained or justified why the difference between restricted movement and deprived liberty should be one of intensity or degree, rather than nature or substance, or indeed a combination of the two. Neither has this approach been doubted in English law. But the dichotomy is not easily drawn. A disciplinary measure for example, which would usually deprive a civilian of their liberty, may not necessarily deprive a serviceman if it does not sufficiently deviate from the 'normal conditions' of military life.[44] Is this because the measure is more *intense* for the civilian? Or is it because of the *nature* of military life? Or both?

Such dichotomous ambivalence can clearly be seen in *Ashingdane v United Kingdom.*[45] A patient subject to an indefinite restricted hospital order was transferred from Broadmoor to Oakwood hospital. The intensity of the security regimes differed dramatically. The former had barred windows, a high perimeter wall, and locked hospital blocks and outer gates. With such conditions of high security, Mr Ashingdane was permitted only two escorted periods of leave during his nine year stay. Oakwood hospital had no surrounding wall. Neither its main entrance nor reception area was locked and he was given unescorted leave to go home every weekend from Thursday till Sunday. Moreover, he could come and go as he pleased from Monday to Wednesday, provided only that he returned to the ward at night. And yet, according to the ECtHR, the differences between these regimes "were not such as to change the character of his deprivation of liberty as a mental patient".[46] Such a conclusion is difficult to draw if we focus solely upon the intensity of the measures without considering their nature.

The European jurisprudence considers both the nature of the detention and the degree of the liberty restrictions in other article 5 contexts. Where an individual is transferred from lawful house arrest into hospital detention, for example, nature and degree is relevant in determining whether separate justification under article 5(1)(e) is required for the latter.[47] Why, then, should the test for determining whether liberty is deprived be any different?

(b) Motives behind the measures

Our physical liberty may be restricted for a variety of reasons. The confinement could be therapeutic, preventative, rehabilitative, or punitive in nature, or a combination thereof. Should the confiner's motives be relevant? Might therapeutic detention be less likely to deprive liberty than its retributive equivalent? In *HM v Switzerland,*[48] an 84 year-old widow with a disputed diagnosis of senile dementia was placed in a foster home on account of serious neglect at home. Reference was made to the fact that this was in her own interests so that she would be provided with the necessary medical care and satisfactory living and hygiene conditions.

In *JJ,* there was judicial disagreement over this issue, even amongst the majority. According to Lord Brown, "[t]he borderline between deprivation of liberty and restriction of liberty of movement cannot vary according to the particular interests sought to be served by the restraints imposed."[49] Such a stance resonates with Berlin's concept of negative liberty by taking an *objective* look at the measures and their

44 *Engel n.8. Deviation from the norm explained why the 'strict arrest' of soldiers in locked cells engaged article 5 but their 'aggravated arrest' in unlocked designated places did not, despite not being free to leave.*

45 *(1985) 7 EHRR 528.*

46 *Ibid at para 47.*

47 *See Atanasov v Bulgaria ibid n.30 at para 71–2.*

48 *(2004) 38 EHRR 17 at para 48.*

49 *Ibid n.2 at para 107.*

impact upon *a* person who finds themselves in the situation of the person subject to them. Whereas for Baroness Hale, "restrictions designed, at least in part, for the benefit of the person concerned are less likely to be considered a deprivation of liberty than are restrictions designed for the protection of society".[50] This perspective conforms more to the philosophy of positive liberty with its more paternalistic undertones towards those lacking capacity. It takes account of the *subjective* characteristics of *the* person and the motives behind the measures, coupled with their effects upon that individual.

This jurisprudential crack has been fully exposed in *Austin v Commissioner of Police of the Metropolis*.[51] The House of Lords cautiously held that measures of crowd control taken in the interests of public safety would not infringe article 5 rights, provided they were proportionate, taken in good faith and enforced for no longer than was reasonably necessary. The purpose behind the restrictions was an additional factor to take into account, at least where article 5(1) did not permit the deprivation of liberty to be justified.

(c) Freedom to leave

Whether Mr L and Mr DE were free to leave their respective hospital and care home was considered to be the "key factor". But it has not featured elsewhere. Asylum seekers kept in an airport transit zone, for example, were held to be deprived of their liberty despite being (at least theoretically) free to leave the country at any time.[52] Moreover, in *JJ* the suspected terrorists were free to leave their homes daily between 10am and 4pm, provided they remained within a designated area. Similarly, in *Ashingdane* the patient was free to leave the unsecured hospital for most of the week and yet remained deprived of his liberty.

Whilst one's freedom to leave a particular location is a useful indicator of the restrictive regime's intensity, it may suffer from definitional problems. For example, if care home staff position an otherwise wandering resident in a deep bean bag, is he "free to leave" through the open door before him if he cannot get up? Munby J. defined being free to leave "in the sense of removing [oneself] permanently in order to live where and with whom [one] chooses."[53] Can a resident ever be free to permanently leave their accommodation when they lack the capacity to make that decision? Applying such reasoning to *JJ*, it would follow that anyone subject to a control order, *regardless of the length of curfew*, would not be "free to leave".

One's freedom to leave "*may* be tested by determining whether those treating and managing the person exercise complete and effective control over [their] care and movements".[54] Is this the *only* way? Might the individual's disabling condition, for example, satisfy this "key factor"? In relation to the right to life as protected by article 2 of the Convention, Baroness Hale recently commented, *obiter*, that whilst some patients are deprived of their liberty by the law, others like Mr L "are deprived of their liberty by their own condition."[55] If the physical liberty of a person can be deprived by their own immobility, this would radically broaden the scope of article 5. Not only would the law take account of the *external* restrictions being implemented by the managing authority. Consideration would also be given to otherwise liberating measures that the authority failed to implement to help the person overcome their *internal* restrictions.

50 *Ibid at para 58. See also R (Secretary of State for the Home Department) v Mental Health Review Tribunal (PH) [2003] MHLR 202.*

51 *[2009] 2 WLR 372. For commentary see D. Hewitt, 'Whose Liberty?' (2009) 153(6) Solicitors Journal 17. The Appellate Committee followed Lord Hoffmann's dissenting judgment in JJ. Much reliance was also placed on Saadi v United Kingdom (Application No 13229/03, 29 January 2008) at paras 68 and 74 which concerned arbitrariness rather than deprivation of liberty.*

52 *Amuur v France ibid n.34.*

53 *Ibid n.37 at para 115.*

54 *HL v United Kingdom ibid n.15 at para 91 (emphasis added).*

55 *Savage v South Essex Partnership NHS Foundation Trust [2009] 2 WLR 115 at para 101.*

(d) Consensual confinement

We consent to restrictions on our liberty on a daily basis. Airplane passengers, for example, cannot insist on being allowed to get off in mid-flight. Football crowds are often contained for periods before being permitted to leave the ground. Members of religious orders choose to live eremitic lives. The extent to which consent should influence the engagement of article 5 has witnessed a somewhat seismic jurisprudential shift. The ECtHR's former view was that "[d]etention might violate Article 5 even although [*sic*] the person concerned might have agreed to it".[56] In *HL v United Kingdom*[57] it recalled that "the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention". It was held in *Storck v Germany,* however, that "[i]ndividuals can only be considered as being deprived of their liberty if, as an additional subjective element, they have not validly consented to the confinement in question".[58] Furthermore, where a person is legally capable of expressing an opinion, their consent can be inferred if they are undecided as to whether or not they wish to stay.[59]

In relation to hospital and care home detention, if an otherwise detained person's capacitous consent is to preclude the engagement of article 5, no authorisation would have to be sought from the supervisory body. As a result, a substantial number would not be safeguarded against arbitrary detention. Indeed, the underlying aims of the Mental Capacity Act 2005, to promote autonomy and empower individuals, make this more likely, for every patient and resident must be assumed to have capacity according to the statutory principles. Moreover, the capacity assessment under DoLS need not be performed by a doctor or approved mental health professional.[60] In those circumstances, should the presence or absence of consent play such a decisive role in determining their right to liberty?

(e) Assessing capacity

The matter is compounded by uncertainty surrounding the issue of capacity. If the absence of consent is to be a necessary additional element to a liberty deprivation, the individual must have capacity to give that consent. According to the Act,[61] they must lack capacity "in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment". However, making that assessment may be far from straightforward.[62] The DoLS Code of Practice is silent on this issue. For no guidance is given as to what relevant information a resident must be able to understand, retain and use when deciding whether to consent to going into such accommodation.

Across the Atlantic, in response to the US Supreme Court's decision in *Zinermon v Burch,*[63] which touched upon issues similar to those in *Bournewood*, the American Psychiatric Association favoured what they considered to be a lenient but meaningful test.[64] This would require a person to understand that (a)

56 *De Wilde, Ooms and Versyp v Belgium (No. 1) (1971) 1 EHRR 373 at para 65.*

57 *Ibid n.15 at para 90.*

58 *Ibid n.32 at para 74.*

59 *Ibid at para 77.*

60 *It can be undertaken by a best interests assessor; see Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations (SI 2008/1858) regulation 6.*

61 *Mental Capacity Act 2005 Schedule A1 para 15.*

62 *For an interesting discussion of the legal issues, see P. Bartlett, 'The test of compulsion in mental health law: Capacity, therapeutic benefit and dangerousness as possible criteria' (2003) 11 Medical Law Review 326 at 336–344. See also Owen et al, 'Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study' (2008) British Medical Journal 337.*

63 *(1990) 494 US 113.*

64 *'Consent to Voluntary Hospitalisation', Task Force Report 34 (APA, 1992).*

they were being admitted to a psychiatric hospital for treatment; (b) their release may not be automatic; and (c) they could get help from staff to initiate procedures for release. However, such a low capacity threshold, reinforced by the statutory presumption of capacity in the 2005 Act, would result in more compliant patients being *de facto* detained without the protection of article 5.

(f) The inherent jurisdiction

Since Mr L's proceedings concluded in Strasbourg, the domestic legal landscape has changed dramatically in the sphere of substitute decision-making as the courts have striven to plug the Bournewood gap.[65] The High Court is transforming its inherent jurisdiction by developing a "protective jurisdiction" over both mentally incapacitated and "vulnerable"[66] adults that enables the regulation of "everything that conduces to [their] welfare and happiness".[67] This includes the power to authorise both their detention and the use of reasonable force should they attempt to leave.[68]

At this early stage it is unclear how the inherent and statutory jurisdictions will interface. Could the former be invoked to detain those who do not qualify for the latter? Or would this undermine Parliament's intentions? Early judicial signs indicate that the Mental Capacity Act 2005 exists alongside, and has not impliedly negated, the common law.[69] It therefore appears likely that the statutory authority to deprive liberty will operate in tandem with the common law power to detain which may not develop into the most harmonious of relationships.

A Fresh Approach? The Theory of Coerced Confinement

We know that article 5 is concerned with a particular type of liberty; the physical liberty of a person to move from one place to another. Opinions may differ as to whether a given set of measures are sufficient to cross the line that distinguishes restricted movement from a deprivation of liberty. On two points, however, a degree of consensus may exist. The reported judgments reveal two common themes, or core elements, when article 5 has been engaged. Firstly, the individual is always confined in a particular place, where they do not choose to be, for more than a negligible period of time. And, secondly, there is something extra, some additional factor present, which distinguishes simple detention from a liberty deprivation.

(a) A requirement for confinement

The diverse range of circumstances in which article 5 might be triggered does not lend itself to legal certainty. What does seem certain is that judicial references to the "concrete situation", "objective element" or "starting point" are indicative of a requirement for some form of confinement. Applying the *Guzzardi* criteria, different types of measures may restrict liberty, whose duration may vary as much as the

65 *As Sedley LJ noted in Re F (Adult: Court's Jurisdiction) [2000] 2 FLR 512 at 532, "the court itself can do much to close the so-called Bournewood gap in the protection of those without capacity."*

66 *The latter group extends beyond the remit of the Mental Capacity Act 2005 to include those who are incapacitated 'by reason of such things as constraint, coercion, undue influence or other vitiating factors' (Re SA (vulnerable adult with capacity: marriage) [2006] 1 FLR 867 at para 79 per Munby J). See M. C. Dunn et al, 'To empower or to protect? Constructing the 'vulnerable adult' in English law and public policy' (2008) 28(2) Legal Studies 234.*

67 *Re SA ibid at para 45. See also Ealing LBC v KS [2008] EWHC 636 (Fam); Westminster City Council v C [2008] EWCA Civ 198; X City Council v MB, NB and MAB [2006] EWHC 168 (Fam); Local Authority X v MM (By the Official Solicitor) and KM [2007] EWHC 2003 (Fam).*

68 *City of Sunderland v PS [2007] EWHC 623 (Fam) at para 16.*

69 *KC, NNC v City of Westminster Social & Community Services Department, IC (a protected party, by his litigation friend the Official Solicitor) [2008] EWCA Civ 198 para 54.*

manner in which they are implemented. But cumulatively they must amount to confinement. Being surrounded by four walls is certainly not a prerequisite; after all, the suspected mafiosa was bounded on one side by the sea.

In relation to hospital and care home detention, possible indicators of a liberty deprivation include the use of physical and chemical restraint, staff control over assessments, treatments, social contacts and residence and the loss of autonomy resulting from continuous supervision.[70] Other relevant factors may include a high staff to resident ratio, locked or lockable doors, a remote geographical location, and the use of subterfuge and electronic surveillance.

There are a number of ways in which the relativist requirement for confinement might be more clearly defined. Firstly, a better approach may be to consider it as a question of *both* intensity or degree *and* nature or substance. Solitary confinement, for example, is by its very nature a particularly intensive measure, even for short periods of time. Whereas being kept in hospital is less so, even for long periods. But the necessary degree of intensity may derive from the accumulation of other, more restrictive, measures such as being prevented from having contact with one's carers. Similarly, having to remain in a hotel for ten days with one's family is perhaps less intensive than a locked hospital ward; but being subjected to a psychological process of "deprogramming" changes the nature of that confinement.[71]

Secondly, it may be helpful to consider the circumstances enjoyed by the individual *prior to* the restrictions being implemented. It could be argued, for example, that the more familiar the nature of the surroundings, the more intensive must be the other measures before the circumstances can amount to confinement. This might go some way towards explaining why a 24 hour house arrest would engage article 5,[72] whereas a 12 hour home curfew each weekday and throughout the weekend would not;[73] nor a 10 hour curfew with a requirement not to leave home without informing the police.[74]

Thirdly, the person's freedom to leave should be but one factor in what is a complex equation. In general, the freer they are to leave, the less likely they can be said to be confined. But not being free to leave does not necessarily equate to a deprivation of liberty; for a person may not be free whilst their movement is being merely restricted. Thus, to overly rely upon this factor could potentially threaten the basic distinction between restricted movement and depriving liberty. Moreover, their ability to leave must be more than a theoretical possibility. A care home resident may face an open door through which he is free to walk. But he is not free to leave if staff are ready to bring him back in. Similarly, an asylum seeker's ability to leave a country "becomes theoretical if no other country offering protection comparable to the protection they expect to find in the country where they are seeking asylum is inclined or prepared to take them in."[75] This may explain why, according to the DoLS Code of Practice, to prevent a person from leaving, so as to guard against immediate harm, is unlikely without more to amount to a deprivation.[76]

70 *See Deprivation of liberty safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 (2008) at para 2.5.*

71 *Blume and others v Spain ibid n.35.*

72 *NC v Italy (Application no. 24952/94, 11 January 2001), para 33; Mancini v Italy (Application no. 44955/98, 12 December 2001), para 17; Vacher v Bulgaria (Application no. 42987/98, 8 October 2004), para 64; Nikolova v Bulgaria (No 2) (Application no. 40896/98, 30 December 2004), para 60; Trijonis v Lithuania (Application no. 2333/02, 17 March 2005); Pekov v Bulgaria (Application no. 50358/99, 30 June 2006), para 73.*

73 *Trijonis v Lithuania (Application no. 2333/02, 17 March 2005).*

74 *Raimondo v Italy (1994) 18 EHRR 237.*

75 *Amuur v France ibid n.34 at para 48. Syria was not a signatory to the 1951 Refugee Convention.*

76 *Ibid n.70 at para 2.10.*

As for the role of consent, fourthly, imagine an altruistic man with tuberculosis who consents to his therapeutic detention in order to protect the public.[77] Can he be said to be "deprived" of something which he is happy to give away? Presumably not. But what is the position if those responsible for his detention go beyond the restrictive measures to which he has agreed? Would his consent still mean that he was not then deprived? Or is this subjective element dependent upon the terms to which he initially consented? Rather than imposing an absolute embargo upon there being a deprivation of liberty, perhaps consent should be relevant to the intensity and nature of the objective element. It would also be relevant to the second feature of a deprivation.

(b) The missing ingredient

Confinement alone will not trigger the procedural due process required by article 5.[78] Something more is required. If the concrete situation is merely the "starting point", what considerations should follow? Baroness Hale captured the dilemma:

> *"My Lords, what does it mean to be deprived of one's liberty? Not, we are all agreed, to be deprived of the freedom to live one's life as one pleases. It means to be deprived of one's physical liberty … And what does this mean? It must mean being forced or obliged to be at a particular place where one does not choose to be … But even that is not always enough, because merely being required to live at a particular address or to keep within a particular geographical area does not, without more, amount to a deprivation of liberty. There must be a greater degree of control over one's physical liberty than that. But how much?"*[79]

In *HL v United Kingdom*, it was the clinicians' "complete and effective control" over Mr L's care and movements which ultimately tipped the balance. Would this threshold satisfy the horns of the dilemma? It would appear to sit uncomfortably with the *Ashingdane* decision. There, the detaining authorities certainly exercised *a* degree of control in permitting weekend leave and in requiring him to return to the ward during the remainder of the week. But would it not stretch ordinary language to describe that as "complete and effective" control? Moreover, what do the terms mean and how do they differ? In what circumstances might complete control be ineffective and effective control incomplete? There is also uncertainty regarding the proper approach to be taken. Is it a single or dualist approach? That is to say, should the presence and degree of control be part and parcel of the confinement issue; or should it be tackled after the concrete situation has already been established?

Confinement distinguishes restricted movement from detention. Perhaps a concept of coercion might be used to distinguish detention from a deprivation of liberty. After all, "[i]n many respects human rights law is all about the protection of the individual from undue coercion."[80] It could be argued that neither confinement without coercion, nor coercion without confinement, can deprive liberty. The former may justify an action for habeas corpus and false imprisonment; the latter may interfere with other articles of the European Convention. But both features could be required to be contemporaneously present in order to engage article 5.

77 *See ss.37–38 of the Public Health (Control of Disease) Act 1984 and the Public Health (Infectious Disease) Regulations 1988.*

78 *Austin v Commissioner of Police of the Metropolis [2008] QB 660 at paras 12 and 105. This was not doubted on appeal [2009] 2 WLR 372. For a discussion of the difference between being 'detained' and 'deprived of liberty', see D. Hewitt, 'Bournewouldn't' (2007) 157 New Law Journal 1600.*

79 *Ibid n.2 at para 57.*

80 *G. Richardson, 'Coercion and human rights: A European perspective' (2008) 17(3) Journal of Mental Health 245 at 246. See also BJ Winick, 'A therapeutic jurisprudence approach to dealing with coercion in the mental health system' (2008) 15 Psychiatry, Psychology and Law 25.*

Such an approach may explain the decision in *HM v Switzerland* where there was coercion without confinement, followed by confinement without coercion. A court order, implemented by the police, was used to convey the elderly widow to the nursing home. Although the ward was open, she was not free to leave and was arguably held in confinement.[81] But there was little in the way of coercion on the part of the detaining authorities *after* her admission. She had freedom of movement, was encouraged to have contact with the outside word and hardly felt the effects of her stay. Furthermore, she was undecided as to whether or not she wanted to stay but, within weeks of being there, agreed to stay.

A lack of coercion may also explain why, in *Nielsen v Denmark*,[82] the locked confinement of a 12 year-old boy in a psychiatric hospital for five and a half months was held not to amount to a deprivation of liberty. The ward was "as similar as possible to a real home"; he was permitted to attend libraries, playgrounds, museums, was able to visit his family regularly; and, towards the end of his stay, went back to school. Similarly in *Storck v Germany*[83] in relation to the patient's *second* stay on the locked ward of the psychiatric clinic. She presented of her own motion, remained there for four months and did not attempt to flee. Thus, although there was confinement, there was little evidence of coercion. She was assumed to be capable of validly consenting and accepted that she had "to a certain extent voluntarily" consented to her stay due to her need for treatment. After all, coercion can hardly be said to exist if the person capacitously consents to all of the terms of their confinement.

If coercion were to feature as one of the two core components of a liberty deprivation, further consideration would have to be given to its meaning. Prior to the 1970s, mainstream philosophical thought suggested that A coerced B when he used, or threatened to use, force or violence. Coercion thereby resembled A's ability to implement and enforce decisions over B's activities.[84] Although there remains no single definition, recent attempts have been made to particularise the concept.[85] Szmukler and Appelbaum helpfully describe a "spectrum of pressures" in the context of treatment which could be applied to confinement.[86] It ranges from persuasion, interpersonal leverage, and inducements or offers, through to threats and the use of compulsion. At some point along that continuum, coercion will be exercised either on the will or body of the coercee.

Conclusions

Interpreting the scope of article 5 demonstrates that, even in an area of such supreme importance as personal liberty, the law is not an exact science. Transposing the European concept into English law has proved troublesome, even before DoLS have come into force. The expansive approach, embraced by Munby J. in *JE* and by the majority in *JJ*, certainly provides significant judicial elbow-room to flexibly protect the right to liberty. But this is at the cost of legal certainty, with borderline cases becoming a matter of pure opinion. The literal approach, preferred by Lords Hoffmann and Carswell, promotes legal certainty but narrows the scope of article 5 protection and contradicts European jurisprudence.

81 *See para O-I6.*

82 *(1988) 11 EHRR 175.*

83 *Ibid n.32.*

84 *J. R. Lucas, The Principles of Politics (1966) (Oxford: Clarendon Press) at p57. Coercion has more recently been defined as when "one person intentionally uses a credible and severe threat of harm or force to control another" in T. Beauchamp and J. Childress, Principles of Biomedical Ethics (2001) 5th ed. (Oxford University Press, New York).*

85 *See S. Anderson, Coercion (2006) in Stanford encyclopedia of philosophy. Available at http://plato.stanford.edu/entries/coercion.*

86 *G. Szmukler and P.S. Appelbaum, 'Treatment pressures, leverage, coercion, and compulsion in mental health care' (2008) 17(3) Journal of Mental Health 233. See also R. Wynn, 'Coercion in psychiatric care: clinical, legal, and ethical controversies' (2006) 10(4) International Journal of Psychiatry in Clinical Practice 247.*

The unenviable task of resolving these issues may madden those seeking some legal litmus test to distinguish the "deprived" from the "restricted". However, given the diverse range of circumstances to which article 5 might apply, it is not surprising that the ECtHR has opted for a relativist approach. Detention, in conventional terms, is transforming as technology develops. Liberty deprivations may become more commonplace, particularly if an individual's condition is included in the complex equation. Given the jurisprudential cracks that arise from applying the same guiding principles to the six detention grounds, perhaps a fresh approach is required to tackle developments in legal standards and in attitudes. One option might be to equate the deprivation of liberty concept with a theory of coerced confinement. Whilst it may not provide all the answers, it certainly helps to clarify the issues but requires further deliberation. Perhaps, in the end, the answer lies in our philosophical stance on liberty. After all, the truth is that "out of the crooked timber of humanity no straight thing was ever made."[87]

87 *I. Berlin, The Crooked Timber of Humanity: Chapters in the History of Ideas (London: John Murray, 1990), p19 quoting I. Kant.*

The use of section 136 to detain people in police custody

Maria Docking[1]

Introduction[2]

Under section 136(1) of the *Mental Health Act 1983* ('the Act') if a police officer encounters an individual in a public place "*who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety…*". A place of safety is defined under section 135(6) of the Act as being "*residential accommodation provided by a local social services authority…a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons, or any other suitable place the occupier of which is willing temporarily to receive the patient*".

Once taken to a place of safety the individual "*may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care*" (s.136(2)). Section 44 of the *Mental Health Act 2007* has amended the section to allow transfer between places of safety where appropriate[3].

Following the mental health assessment, it may be decided that the person has no mental disorder and can be released; that the person needs further treatment but that this can be provided in the community, or they may need to be detained in a hospital for further treatment either on a voluntary or compulsory basis.

As early as 1990, official guidance has been that "*wherever possible, the place of safety in which the person might be detained should be a hospital and not a police station*"[4]. The Code of Practice to accompany the Act published in 1999 stated that "*it is preferable for a person…to be detained in a hospital rather than a police*

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2 *The research study which is the subject of this article was conducted by the author and research colleagues Kerry Grace and Tom Bucke for the Independent Police Complaints Commission (IPCC) and has been published as an IPCC research report: Docking, M., Grace, K. and Bucke. T. (2008) Police Custody as a "Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983*

3 *Home Office (2008) The Use of Police Stations as Places of Safety Under Section 136 of the Mental Health Act 1983. Circular 07/2008. Home Office: London.*

4 *Home Office (1990) Provision for Mentally Disordered Offenders. Circular 66/90. Home Office: London, page 2.*

station[5]". This has been strengthened in the recently revised Code of Practice, which states that "*a police station should be used as a place of safety only on an exceptional basis*".[6]

It is therefore widely accepted that police cells are not a suitable place to hold people who are mentally disordered; it can exacerbate their symptoms by heightening their levels of stress and anxiety. The most tragic outcome can be a death in police custody, with around 50% of deaths in police custody involving someone with mental health needs[7]. Taking someone with mental health needs into custody also has the effect of criminalising and stigmatising their behaviour.

Despite the consensus of opinion against using police custody as a place of safety, unless there are exceptional circumstances, there are no routinely collected data on the use of section 136 in police cells. The Department of Health publish annual figures on section 136 detentions involving an assessment in hospital[8], but the Mental Health Act Commission have noted that this "*is of questionable value because of its incompleteness, and because of marked regional variations in practice which make generalisation difficult*"[9]. In a recent report the Royal College of Psychiatrists noted that section 136 is the only civil detention under the Act which does not require a statutory form[10] and recommended that one be adopted for section 136 detentions in hospital and in police custody so that the total number of detentions can be accurately monitored.

There has been some research into the police use of section 136, the profile of those detained, and the outcome of the assessment across different types of places of safety, but these studies have tended to focus on London[11]. The aim of the study, which is the subject of this article, was to therefore provide a picture of section 136 usage across England and Wales to detain people in police custody. It sought to identify the demographics of those detained, the length and outcome of the detention and the reasons for variation in the use of police custody across different police force areas.

Methodology

The study collected data from all 43 police forces in England and Wales by sending a standard Excel spreadsheet designed for this purpose to force analysts to complete. The data they provided was obtained from police force custody IT systems and as such are reliant on the quality of the data entered onto the systems and the functionality of the search mechanisms. However, as there is currently no standardised

5 *Department of Health (1999) Code of Practice Mental Health Act 1983, Department of Health: London, Para. 10.5*

6 *Department of Health (2008) Code of Practice Mental Health Act 1983. Department of Health: London, Para. 10.21*

7 *Police Complaints Authority (2003) Memorandum of Police Complaints Authority's Evidence to Joint Committee on Human Rights into Human Rights and Deaths in Custody. Police Complaints Authority: London*

8 *Department of Health (2007) In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, NHS Trusts, Care Trusts, Primary Care Trusts and Independent Hospitals, England; 1995–96 to 2005–06. Office for National Statistics: London*

9 *Mental Health Act Commission (2006) The Mental Health Act Commission In Place of Fear? Eleventh Biennial Report. Mental Health Act Commission: London, page 281.*

10 *Royal College of Psychiatrists (2008) Standards on the Use of Section 136 of the Mental Health Act 1983 (2007). CR149. Royal College of Psychiatrists: London, page 5.*

11 *See for example: Rogers, A. and Faulkner, A. (1987) A Place of Safety. MIND's research into police referrals to the psychiatric services. MIND: London. Weller, M.P.I (1988) "The Local Use of Section 136". Bulletin of the Royal College of Psychiatrists, Vol. 12, June 1988, pages 235–236. Dunn, J. and Fahy A. (1990) "Police Admissions to a psychiatric hospital. Demographics and Clinical Differences between Ethnic Groups". British Journal of Psychiatry 154, pages 373 – 378. Simmons, P. and Hoar, A. (2001) "Section 136 use in the London Borough of Haringey". Medicine, Science and the Law, 41, pages 342–348*

way of recording and collating the data nationally it was felt that this would be the most appropriate way to gather the data. Forces were asked to provide the total number of section 136 detentions for 2005/06, the demographics of those detained, the length of detention, the outcome of the detention, and some forces were able to provide additional reasons for arrest. They were also asked to provide the figure for their total custody population for 2005/06 to enable a rate of section 136 detainees per 10,000 people in custody to be calculated.

A pilot exercise was completed with seven police forces to collect data for 2004/05 to assess the standard of the data and any potential problems in cleaning, formatting and analysing the data, prior to data being collected from all police forces for 2005/06. Despite the use of one standard spreadsheet to collect the data, inevitably the data was received in a variety of formats and different acronyms and police force codes were used. There was therefore a substantial period of clarification and cleaning of the data before the data was placed into SPSS and any analysis could begin.

The rate of section 136 detainees was used to group police forces into high, medium and low rate forces. These rates were then used to select a smaller number of police forces to participate in the second phase of the research. In addition, to ensure that a spread of police forces with different types of populations and policing environments, Her Majesty's Inspectorate of Constabulary force family data[12] was used to help identify forces. Six case study forces were chosen to give two low rate, two medium rate and two high rate police forces. Then a further 12 police forces were identified by choosing two 'most similar forces' for each of the six case study sites. This gave a total of 18 police forces (including the six case study sites) for initial telephone interviews – six forces with low rates of section 136 detentions; six forces with high rates; and six forces with medium rates.

Telephone interviews were conducted with the force custody lead or the force mental health liaison officer in these 18 police forces. The interviewees were asked a range of questions about possible explanations for different rates of section 136 detentions, training for front line officers and custody staff, multi-agency working and funding. The interviews were recorded and notes were made. The recording and the notes were then typed onto a simple proforma for each interview, which was then coded and added to a larger thematic matrix and analysed.

Face-to-face interviews were conducted at six police forces chosen to be case study sites. The relevant custody leads in the six police forces were asked to assist in the identification both of individuals in their forces and health and social care representatives for interview. Two custody sergeants and two health and social care representatives in each force were asked to participate in the interviews. In each area one health and social care representative was operationally focused and the other had a more strategic role. Where available, the mental health liaison officer in each force was also interviewed. Some force contacts arranged additional interviews with police and health and social care contacts that they felt would be useful to the study. A total of 33 interviews across the six sites were therefore conducted.

The case study interviews built on the themes of the telephone interviews, but sought to gain more in-depth knowledge and examine practice on the ground and relationships between practitioners. The interviews were recorded and sent for professional transcription and were then analysed using a coding framework and a thematic matrix.

12 *Her Majesty's Inspectorate of Constabulary produces data on 'force families' and 'most similar forces' as a means of grouping and comparing police forces. The data they use take into account factors such as population size and demographics, deprivation and unemployment levels, the type of environment etc. this data is unpublished.*

Research findings – nature and extent of section 136 detentions

Prevalence of section 136 detentions in police custody

The data received from forces showed that 11,517 were detained under section 136 and held in police custody as a place of safety between 1 April 2005 and 31 March 2006. Department of Health data for the same period show that there were 5,900 people detained in hospital who required an assessment under section 136[13]. This therefore means that approximately two-thirds of the 17,417 people detained under section 136 in 2005/06 were held in police custody rather than in hospital. The number of people held in police custody may be an underestimate, as some forces stated that if an individual had committed a minor offence this may be put as the primary reason for arrest on the custody system rather than the section 136 detention. As stated above, the Mental Health Act Commission has also cast some aspersions over the reliability of the Department of Health data[14]. Whilst acknowledging these potential problems with the data it is probably safe to conclude that despite the consensus against detaining people in police cells under this power, it remains the primary place of safety across England and Wales.

When comparing levels of detention across different police forces there were wide variations in the extent to which section 136 was used. The rates ranged from one section 136 detainee to 277 per 10,000 people held in police custody. The rate for all 43 forces was 55 section 136 detainees per 10,000 people held in police custody.

Demographics of those detained

Forty-one of the 43 forces were able to provide data on the demographics of those detained (10,736 detainees). Of these detainees, 34% were female, 61% were male, and the gender of 6% was unknown. The average age of the detainees was 36 years old, and the ages ranged from 12 to 89 years old. Figure 1 shows that 30% percent of the people were aged between 35 to 44 years, 26% were 25 to 34 years old and 17% were aged between 18 to 24 years old. Four per cent (420 people) of detainees were aged 17 years and under.

Forces were asked to provide data on whether the detainee had a fixed abode as this is an important factor in highlighting the potential vulnerability of detainees. However this data was missing in 43% of cases, thus limiting analysis. In terms of ethnicity, 78% were White, 4% were Black, 3% Asian, 1% Chinese/Other and 1% of Mixed ethnicity. Data on ethnicity was unknown/not stated in 14% of cases.

Previous research has shown disproportionality in the ethnicity of those admitted and detained under the Act[15]. This is particularly the case with Black people who were six times more likely to be detained than White people under Part II of the Act[16] and three times more likely than White people to be an inpatient in any mental health service in England and Wales[17]. Using data on the estimated population of England

13 *Department of Health (2007) op. cit*

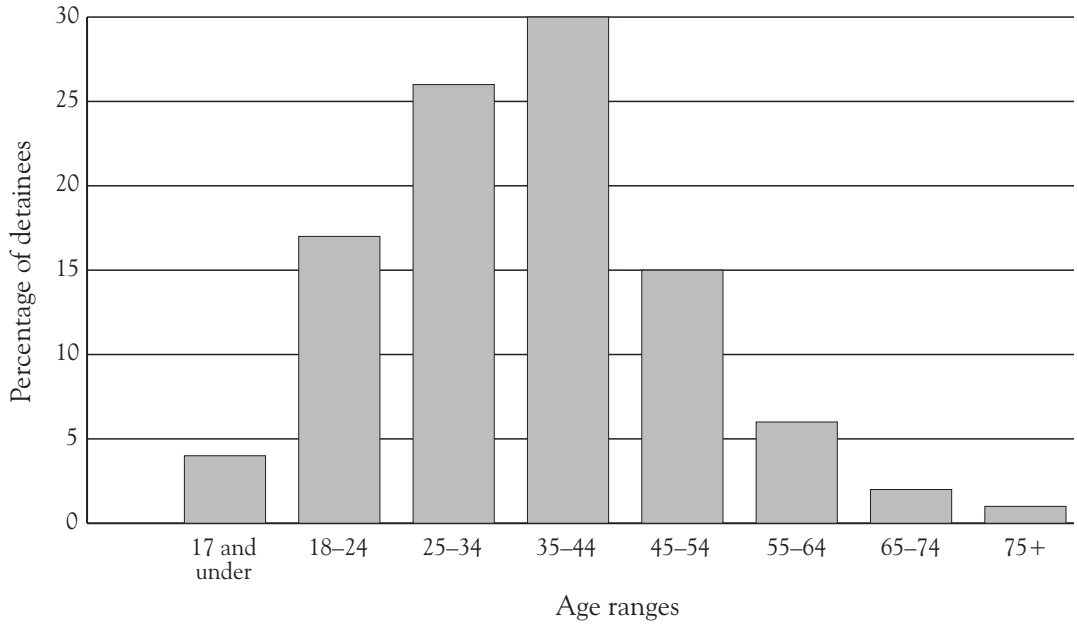
14 *Mental Health Act Commission (2006) op. cit.*

15 *See: Churchill, R., Wall, S., Hotopf, M., Wessely, S. and Buchanan, A. (1999) A Systematic Review of Research relating to the Mental Health Act (1983). Department of Health: London. Audini, B. and Lelliott, P. (2002) 'Age, gender and ethnicity of those detained under Part II of the Mental Health Act 1983'. British Journal of Psychiatry, 180: 222–26. Sashidharab, S. P. (2003) Inside Out: Improving mental Health Services for Black and Minority Ethnic Communities in England. Department of Health, London. Healthcare Commission (2007): Count me in 2007. Results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales. Commission for Healthcare Audit and Inspection: London*

16 *Audini, B. and Lelliott, P. (2002) op.cit.*

17 *Healthcare Commission (2007): op.cit.*

Figure 1: Percentage of section 136 detainees' age ranges



NB: The age of 758 detainees was unknown (7% of total sample) these have been removed from this sample so the percentages are based on those for whom age was known.

and Wales over ten years old by ethnic group and police force area[18] it was possible to calculate a rate of section 136 detentions per 10,000 people in the population by ethnic group and police force. Table 1 shows that across England and Wales, Black people were almost twice as likely as White people (1.7 times) to be detained and held in police custody under section 136 of the Act. People listed as being from 'Other' ethnic groups were 1.5 times more likely to be detained than White people. In comparison, there was little difference in the rates of detention for White and Asian people.

Police forces in more rural locations tended to have the largest potential disproportionate rates, particularly for *Black* detainees (not of all detainees), such as Avon and Somerset, Cambridgeshire, Cleveland and Warwickshire. This may be linked to these forces having generally high rates of section 136 detentions in police custody. Data on section 136 detentions in hospitals is only available at a national level and does not provide the ethnicity of those detained. It is therefore not possible to compare rates of detentions by ethnic group in hospitals across the areas to asses whether this disproportionality is replicated and follows the same pattern across the various police force areas.

18 *Ministry of Justice (2007) Statistics on Race and the Criminal Justice System – 2006. A Ministry of Justice Publication under Section 95 of the Criminal Justice Act 1991. October 2007. Ministry of Justice: London, page 118*

Table 1: Section 136 detainees rate per 10,000 people in population by ethnic group[19]

Police force	White	Black	Asian	Other	Total rate
Avon and Somerset	5.0	21.2	7.3	5.7	**5.4**
Bedfordshire	0.6	1.5	0.0	0.0	**0.6**
Cambridgeshire	4.4	21.0	6.3	11.5	**4.9**
Cheshire	0.0	0.0	0.0	0.0	**0.0**
Cleveland	5.2	22.2	10.4	15.1	**5.5**
Cumbria	1.5	0.0	0.0	0.0	**1.5**
Derbyshire	N/A	N/A	N/A	N/A	**2.1**
Devon and Cornwall	6.0	16.7	8.5	4.7	**6.1**
Dorset	1.2	0.0	2.4	4.3	**1.3**
Durham	2.6	0.0	0.0	9.6	**2.6**
Dyfed-Powys	3.8	0.0	0.0	0.0	**3.7**
Essex	N/A	N/A	N/A	N/A	**0.4**
Gloucestershire	3.8	7.6	4.9	16.4	**4.0**
Greater Manchester	0.6	1.9	0.5	0.0	**0.6**
Gwent	N/A	N/A	N/A	N/A	**7.8**
Hertfordshire	0.1	0	0	0	**0.1**
Humberside	0.5	0.0	2.7	5.6	**0.5**
Kent	0.3	1.0	0.0	0.0	**0.3**
Lancashire	0.7	1.6	0.4	0.0	**0.7**
Leicestershire	1.4	6.2	1.2	1.4	**1.5**
Lincolnshire	2.5	8.4	0.0	7.9	**2.6**
Merseyside	0.1	0.8	1.0	0.0	**0.1**
Metropolitan	0.1	0.2	0.1	0.2	**0.1**
Norfolk	0.4	0.0	0.0	0.0	**0.4**
North Wales	1.1	7.2	4.0	0.0	**1.1**
North Yorkshire	3.9	9.6	14.9	6.0	**4.0**

19 *When calculating rates for each force and across England and Wales, detainees with 'Unknown/not stated' ethnicity were included. Forces with N/A were unable to provide the ethnicity of their detainees.*
Forces with zero rates had few, if any detainees, within the ethnic group. City of London and Hampshire Police are not included in this table as they were unable to provide any demographic info on their detainees.

Northamptonshire	1.4	2.9	3.9	0.0	**1.7**
Northumbria	0.7	2.2	1.0	0.0	**0.7**
Nottinghamshire	3.0	14.0	8.7	3.9	**3.4**
South Wales	1.6	5.5	0.0	1.2	**1.6**
South Yorkshire	0.5	2.0	0.3	1.3	**0.5**
Staffordshire	2.5	4.5	0.0	0.0	**2.7**
Suffolk	0.8	2.8	0.0	0.0	**1.2**
Surrey	0.7	1.2	0.8	0.7	**0.7**
Sussex	6.9	16.1	3.5	45.4	**10.3**
Thames Valley	2.2	5.2	1.5	3.6	**2.3**
Warwickshire	2.6	21.9	1.4	7.5	**2.8**
West Mercia	4.5	14.6	4.8	0.0	**4.6**
West Midlands	3.8	14.1	3.8	7.9	**4.4**
West Yorkshire	7.0	18.9	4.8	10.2	**8.1**
Wiltshire	0.9	2.4	1.6	0.0	**2.9**
Total for England and Wales	**1.9**	**3.3**	**1.6**	**2.8**	**2.3**

Research findings – exploring different rates of detention

Identifying mental disorder

Previous research evidence has shown that the police tend to be quite accurate in indentifying individuals with more serious mental disorders which require hospital admission[20]. However, there are likely to be other individuals who are more difficult for the police to identify, such as those who require dual diagnosis for drug and/or alcohol use as well as their mental disorder. This will mean that some people are not detained under section 136 when they should be, and individuals who are not mentally disordered may be detained under section 136 when not necessary. It is important that officers are adequately trained in mental health awareness so that they feel able to recognise mental health needs and learning disabilities[21]. Initiatives in some low rate forces had also tried to address this problem by providing officers on the street with access to more information or resources. Examples included officers being able to (a) call named contacts at a local hospital for advice, (b) call an approved social worker to ask about particularly difficult individuals, or (c) having an aide memoire with key questions to ask the individual and information on local places of safety.

20 *Dunn, J. and Fahy A. (1990) op. cit.*

21 *NACRO (2007) Effective Mental Healthcare for Offenders: the Need for a Fresh Approach. NACRO: London, page 8.*

Detaining in a 'public place'

Evidence from interviewees touched on the issue raised in the case of *Seal v Chief Constable South Wales Police*[22] about what constitutes a 'public place', and where it is lawful for the police to detain people. The Mental Health Act Commission has also highlighted their concerns about people being detained under section 136 who have been asked, or obliged to, step outside their home[23]. Respondents, particularly, in high and medium rate forces, mentioned examples of individuals being detained in their homes or 'enticed' outside to be detained. Respondents suggested that this was done out of concern for the welfare of the individual; however it still remains unlawful. The Mental Health Act Commission has suggested that a possible solution could be for officers to have a dedicated telephone number to contact approved social workers (now, Approved Mental Health Professionals) to trigger an assessment[24].

Table 2: Length of time detained in custody[25]

	N	Percentage
Up to 6 hours	3,601	39
6:01 – 12:00	2,876	31
12:01 – 18:00	1,700	18
18:01 – 24:00	686	7
24:01 – 30:00	158	2
30:01 – 36:00	75	1
36:01 – 42:00	47	1
42:01 – 48:00	20	0
48:01 – 54:00	13	0
54:01 – 60:00	8	0
60:01 – 66:00	4	0
66:01 – 72:00	4	0
72:01 – 78:00	2	0
78:01 – 84:00	3	0
84:01 – 90:00	3	0
90:01 – 99:00	2	0
Total	**9,202**	**100**

NB: the length of time spent in custody was not known for 1,534 cases. These have been removed from the sample.

22 *[2007] UKHL31*

23 *Mental Health Act Commission (2008) Risks, Rights, Recovery. Twelfth Biennial Report 2005–2007. The Stationary Office: London, page 167.*

24 *Ibid.*

25 *There were 46 cases where the individual was detained for longer than 99 hours. However, it was confirmed with the relevant police forces that this is due to they way in which the release time is recoded on their system and does not reflect the length of time in custody. These cases were therefore excluded from the analysis.*

Time detained and length of detention

Sixty-five per cent of the detainees arrived at the police station between 6pm and 9am. This may be because there are a lack of alternatives or a lack of suitably qualified health and social care staff on duty, outside of regular office hours. It was possible to calculate the length of time spent in custody by section 136 detainees for 34 of the 43 police forces. Table 2 below shows that the majority of detainees are dealt within 72 hours. Seventy per cent spent 12 hours or less in police custody, with just over half of these people being detained for six hours or less.

The average length of time spent in custody for section 136 detainees was nine hours and 36 minutes. This is a relatively long period of time for someone who is likely to be distressed and anxious to spend in a police cell. Delays in the assessment process were associated with (a) a shortage of doctors approved under section 12 of the Act, (b) the availability of force forensic medical examiners and approved social workers, particularly outside regular office hours when fewer staff were available, and (c) the need for intoxicated detainees to become sober before they could be assessed. There were also delays in finding an available bed for individuals who needed further detention in a psychiatric unit.

These issues appeared to be less problematic in low rate forces as they had changed their protocols and agreements to improve working practices. They had set target times (the shortest of any of the forces) for attendance at the place of safety[26]; approved social workers (rather than custody officers) arranged for the section 12 doctor to attend which improved the response; and it may be that greater numbers of their force forensic medical examiners were section 12 approved. Two forces had access to psychiatric nurses either based in custody or providing outreach to custody which improved the timeliness of the assessment. Where emergency departments were used as places of safety, long delays were sometimes reported in waiting for an assessment due to other pressures on the staff.

Outcome of detentions

Forces were asked to provide data on the outcome of the detentions; for example whether someone had been further detained in hospital or if they were released back into the community. However, it became apparent when analysing the data and querying some of the issues that arose with police forces that the data was unreliable. Many forces would list the outcome as 'no further action' if the detainee had not been charged with a criminal offence; regardless if they had gone onto receive treatment for their mental disorder. Some police forces also used an 'other' option to include all those people who were detained under the provisions of Part 2 of the Act but combined this with other options, which made it impossible to differentiate between the different outcomes. It was therefore not possible to present any data on the outcome of these detentions. This raises major issues as it is not clear what percentage of section 136 detainees are released into the community or taken to hospital. If this data was available it would provide an insight into how appropriately the power is used and how this varies by police force.

Geographical factors in higher rates of section 136 detentions

Forces with high rates had some specific geographical factors which could lead to higher numbers of people needing to be detained under section 136. This included having well known suicide spots by cliff tops; being at the end of a train line; having transient populations on holiday, which were linked to a high intake of alcohol and drugs; and having high levels of deprivation. Deprivation and alcohol and drug use

26 *While it was acknowledged that the targets were not always met, they seemed to have contributed to the timeliness of the relevant practitioners and were generally met during normal office hours.*

were also problems in low rate forces, but it was felt that health and social care organisations were more proactive and took preventative action to deal with some people facing problems before they needed to be detained under section 136 (for example, asking GPs to identify and refer people for treatment services at an earlier stage and fully utilising the local Crisis Resolution teams).

Availability of alternative places of safety

The availability of non-police custody places of safety is the strongest factor in the differing rates of section 136 detentions between police forces. This also varied the most between the different rate forces. Alternative places of safety to police custody were more readily available and more commonly used in the medium and low rate forces than in the high rate forces. Of the 18 forces who took part in telephone interviews[27]:

- All six low-rate forces stated that they use emergency departments and psychiatric units as places of safety unless the individual was violent. Two forces also had diversion schemes in their areas.
- Of the six medium-rate forces;
    - Two used hospitals unless the detainee was violent *or* drunk.
    - One stated that they used hospitals but that this could sometimes involve travelling long distances, so custody was also used.
    - Two stated that they used both hospital and custody depending on how busy they were and the resources it would involve.
    - One stated that at the time the data was collected they were using police custody but that they were now using a hospital emergency department as an interim measure while building a dedicated place of safety.
- Of the six high-rate forces, five stated that custody was the only place of safety available at the time of our data collection, but three were in the process of developing alternatives. One stated that they had some alternative places of safety, but only in some areas of the force.

This strong association between the rates of section 136 detentions in police custody and the availability of alternative places of safety appeared to be linked to having good multi-agency relationships and agreements.

Use of alternative places of safety

Where alternatives to police custody were available, there were still additional factors which influence where an individual is detained. Generally it was agreed that if an individual was violent or attempting to self-harm they would be taken to custody where they could be restrained and not pose a risk to other patients. Intoxication was more complicated, with some respondents suggesting that people who were intoxicated needed to be taken to custody where they could sober up before being assessed. Whereas others felt that it was a health matter and the detainees should be taken to hospital. Willingness to accept individuals into hospital in different states of intoxication varied across the areas. At the most extreme, respondents in one area stated that their local psychiatric units would 'breathalyse' a detainee before they were willing to take them.

27 *Some caution should be exercised in these findings as it was not always clear whether the places of safety were available in 2005/06 when the data was collected.*

Provision and funding of alternative places of safety

Emergency departments are not ideal places of safety due to their very busy nature and the possible delays associated with this, along with the rather basic facilities for section 136 detainees at some hospitals. However, most respondents still felt it was a better environment than police custody for section 136 detainees. Respondents generally felt that psychiatric units were the most appropriate place for section 136 detainees, although as with emergency departments some units lacked suitable facilities for the assessment. In 2006 the Department of Health allocated £130 million for improving inpatient facilities, including places of safety[28]. NHS Commissioners of services in England could bid for this money to build places of safety. However, the funding only applied to the capital costs and no further funding has been made available for staffing the facilities.

In one case study area the local trust had successfully bid for the funding, built the place of safety and managed to staff it from existing resources for a pilot period of nine months. However, at the end of the pilot the staffing was no longer available and the facility has remained unused. In two other areas which had received the funding and were in the process of developing the new places of safety, concerns were also raised about how staffing resources would be found. The Royal College of Psychiatrists has recently highlighted their concerns about the staffing of section 136 suites[29].

Multi-agency working

Since the Morgan Report[30], the central proposal of which was enacted by the *Crime and Disorder Act 1998*, there has been an emphasis on joint working between the police and local authorities (and other relevant agencies) to prevent crime and ensure community safety. Whilst the main focus of multi-agency working has been on crime prevention it has also been applied to other areas and is important in ensuring that the police and health and social care organisations work together so that section 136 detainees are assessed as quickly as possible and receive the care they need. As stated above, the availability of alternative places of safety outside of police custody appears to be inherently linked to strong multi-agency working.

Examples of multi-agency working at both strategic and operational levels were seen in the various case study sites. However, it was more embedded and seemed to work more effectively in force areas with lower rates of section 136 detentions. The support of senior personnel both within the police and health and social care organisations was fundamental to prioritising section 136 and improving operational practice, including identifying and creating alternative places of safety. Information sharing and communication between the various organisations was often felt to be problematic and if addressed could help to improve relationships on a more general level.

Conclusions

This research sought firstly to identify the extent to which police custody is used as a place of safety, secondly to identify the make-up of those detained, and thirdly to examine reasons for variations in use across different police force areas. Whilst acknowledging the limitations of the data from forces, it is the first time there has been a picture of section 136 detentions in custody across England and Wales. The

28 *Department of Health (2006) Capital allocation process: £130 million for adult mental health services. Retrieved 23rd March 2006: http://www.dh.gov.uk/assetRoot/04/13/10/58/04131058.pdf*

29 *Royal College of Psychiatrists (2008) op. cit.*

30 *Standing Conference on Crime Prevention (1991) Safer Communities: The Local Delivery of Crime Prevention through the Partnership Approach (Morgan Report). Home Office: London.*

data shows that despite the rhetoric of official guidance and policy, police cells remain the most widely used place of safety under section 136 of the Act.

The data raises questions about the ethnicity of those detained and the reasons for the potential disproportionality of Black people detained under section 136. There is some evidence to suggest that Black patients may be more likely to experience 'adverse pathways' into the criminal justice system and have higher rates of detention under other parts of the Act[31]. Further insight into the data would be gleaned if comparable ethnicity data was available for detentions in hospitals under section 136 at a local level.

The quality of the data also meant that it was not possible to determine what happened to the individuals detained under section 136 once they had been assessed under the Act. This is a substantial gap in the evidence around the appropriateness and effectiveness of section use. Given that the use of section 136 deprives individuals of liberty and, when held in police custody, effectively criminalises their behaviour, it is vital that this is subject to accurate recording to enable any inappropriate or unjustified detentions to be identified. It could also help focus resources on those geographical areas that need them to minimise the use of police custody as a place of safety. Having one national form for detentions in hospital and police custody, and ensuring the data is collected and analysed centrally by the Healthcare Commission, and its successor the Care Quality Commission, would create more robust data which could be accurately and regularly monitored[32].

The development of alternative places of safety outside of police custody is crucial to minimising the use of police cells. This requires the leadership and support of senior personnel across the agencies, as this is imperative to enact change. This multi-agency approach can also help to address problems with the timeliness of assessments and provide more effective operational working practices. Funding for the staffing of dedicated places of safety is problematic and should be carefully considered by trusts when developing new facilities.

There are also issues around training of frontline officers and custody officers and staff. It is vital that police officers and staff have the knowledge and skills they require to conduct their roles effectively and confidently. They can not be expected to have the same level of expertise as mental health professionals but they should have a good awareness of mental health, understand how their powers can be used and be able to identify mental disorder. Joint training between the police and health and social care organisations will help improve knowledge and understanding and build more positive relationships between the agencies. It should also assist in willingness to share information on patients when appropriate. The provisions of the *Mental Health Act 2007* which took effect in November 2008 mean that any training will be timely.

The new Code of Practice[33] encourages the development of joint policies and protocols as a way of improving the use of section 136 at a local level. This study has shown that a wide variety of practice exists with custody rarely being used as a place of safety in some police force areas and always being used in others. It is unacceptable that such inequality should exist and that in many areas people who have committed no crime can be held for a substantial period of time in an environment which exacerbates their mental condition whilst criminalising their behaviour. It is a situation which should not be allowed to continue, and local trusts and other NHS providers or services should look at ways to address the situation as a matter of urgency.

31 Sashidharan (2003) op. cit.; Audini, B. and Lelliott, P. (2002) op.cit. and Healthcare Commission (2007) op.cit.

32 The Royal College of Psychiatrists (2008) op. cit. page 9 also recommend this.

33 Department of Health (2008) op. cit. para 10.16

Expanded Liability for Psychiatrists: *Tarasoff* Gone Crazy?[1]

Michael Thomas[2]

INTRODUCTION

The *Tarasoff*[3] decision has been branded "one of the most significant developments in medico-legal jurisprudence of the past century".[4] For the first time, a court held that psychotherapists have a duty to protect third parties from patients who pose a serious danger of violence to others.[5] That ruling of the Supreme Court of California has generated a great deal of litigation and controversy. Decision-makers and commentators remain divided on the wisdom and proper application of *Tarasoff*.[6] The decision continues to be the subject of significant debate both within the United States and abroad.

This paper is intended to serve as an update for psychiatrists on notable developments of the *Tarasoff* doctrine in the United States and United Kingdom. Most clinicians will be familiar with the basic *Tarasoff* doctrine. However, the author suspects that many clinicians will be troubled to learn the extent to which *Tarasoff* liability has extended in some jurisdictions.

Accordingly, the first part of this paper addresses notable judicial treatment of *Tarasoff* in several state jurisdictions within the United States. The second part discusses the more conservative approach of the United Kingdom, which affords clinicians discretion to warn potential victims in certain circumstances. The United Kingdom has struggled with, and so far rejected, the imposition of a *Tarasoff*-duty. However, a recent decision of the European Court of Human Rights opens the door for something comparable to *Tarasoff* in the United Kingdom.[7] The final part offers a critique of the *Tarasoff* doctrine and suggests that other jurisdictions, including the United Kingdom, may be wise to avoid this problematic doctrine.

1 *The author acknowledges the support of the Canadian Institutes of Health Research, which has made research into the subject-matter of this article, possible.*

2 *Solicitor, Auckland, New Zealand.*

3 *Tarasoff v Regents of University of California (1976) 551 P.2d 334 [Tarasoff].*

4 *Thomas Gutheil, "Moral Justification for Tarasoff-Type Warnings and Breach of Confidentiality: A Clinician's Perspective" (2001) 19 Behav. Sci. Law 345 at 345.*

5 *Alan Stone, "The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society" (1976) 90 Harvard Law Review 358 at 358.*

6 *Ann Hubbard, "The Future of 'The Duty to Protect': Scientific and Legal Perspectives on Tarasoff's Thirtieth Anniversary" (2006) 75 U. Cin. L. Rev. 429 at 429.*

7 *Osman v UK [1999] 1 FLR193. See Colin Gavaghan, "A Tarasoff for Europe? A European Human Rights perspective on the duty to protect" (2007) 30 International Journal of Law & Psychiatry 255 at 256.*

PART ONE: THE UNITED STATES

Before considering the development of the *Tarasoff* doctrine, it is worth briefly revisiting some key aspects of the *Tarasoff* judgment.

A duty to protect

Mental health professionals worldwide will be familiar with the protective duty fashioned by Tobriner J in *Tarasoff*:

> *Once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.*[8]

Essentially, the *Tarasoff* Court weighed the public interest in confidentiality and effective treatment of mental illness against the public interest in safety from violent assault.[9] The majority concluded: "The public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins".[10] The majority's rationale for creating the protective duty was: "In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal".[11] Thus, the duty was created to protect third persons from serious harm caused by dangerous patients.[12]

The "special relationship"

It is noteworthy that the duty of care found to exist in *Tarasoff*, and which is central to the Court's conclusion, is exceptional to the common law. It is a general rule of the common law that one does not owe a duty to control the conduct of another, or to warn those endangered by such conduct.[13] At common law there is no general duty to prevent others from suffering foreseeable loss or damage caused by the deliberate wrongdoing of third parties.[14] For example, there is no legal obligation on a bystander to intervene to prevent a murder. The fundamental reason is that the common law is reluctant to impose liability for "pure omissions" to act.[15] Nonetheless, some exceptions have been carved out of the general rule.

In *Tarasoff*, the Supreme Court stated that an exception exists when a defendant therapist stands in a special relationship either with the wrongdoer, or the foreseeable victim.[16] The Court held that there is such a "special relationship" between a patient and therapist, sufficient to support the existence of a duty to protect foreseeable victims. The Court's construction of this duty is central to its conclusion of liability against the therapist.

In a critical passage of reasoning, the majority held that the doctor-patient relationship was a "special relationship" sufficient to support the existence of a duty to exercise reasonable care to protect others from dangers emanating from the patient's illness.[17] The Court stated that therapy alone is sufficiently

8 *Tarasoff, supra note 3 at 350.*

9 *Ibid. at 351.*

10 *Ibid. at 352.*

11 *Ibid. at 353.*

12 *Alan Felthous & Claudia Kachigan, "To Warn and to Control: Two Distinct Legal Obligations or Variations of a Single Duty to Protect?" (2001) 19 Behav. Sci. Law 355 at 355.*

13 *Tarasoff, supra note 3 at 342.*

14 *Smith v Littlewoods [1987] 1 All ER 710 at 729.*

15 *Ibid.*

16 *Tarasoff, supra note 3 at 342.*

17 *Ibid. at 348.*

controlling for a duty to exist when the patient's potential for violence to another is foreseeable.[18] The Court did not require either a verbal threat from the patient, or control through hospitalisation, for the duty to be triggered.[19]

"Reasonably necessary" steps

The Court stated that the protective duty may require a therapist to take various steps depending on the facts of the individual case: "Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances".[20]

The Court's ruling leaves open to interpretation what actions would discharge the duty to protect an intended victim.[21] Thus, even if a therapist unequivocally warns a third party of threats made by a patient, if harm ensues a court may still hold that a therapist has failed to take sufficient steps to protect the victim.

Chaimowitz states that while the purpose of informing or warning is to protect, in some situations a warning may be insufficient, or even increase the risk to the victim.[22] Similarly, Appelbaum states that warnings are of "dubious utility"[23] and notes that the *Tarasoff* doctrine grants considerable scope to clinicians in the selection of a course of action that would protect potential victims:

> Although the first *Tarasoff* decision in 1974 established a "duty to warn" likely victims, when the case was redecided in 1976, the obligation was broadened to a "duty to protect", an approach adopted by subsequent courts. This change means the responsibility to protect third parties is not limited to a warning; other steps may be required. Clearly, when unidentifiable victims are involved, other measures must be taken. Depending on the circumstances, one might chose to hospitalize the patient (voluntarily or involuntarily), to transfer an already hosptialized patient to a more secure ward, or to maintain the outpatient status but begin medication, intensive individual therapy, family therapy, or other systems-oriented therapy, which might even involve the potential victim. Many clinicians will choose one of these steps whenever possible in preference to breaching confidentiality by issuing a warning.[24]

McNiel notes that several interventions besides warnings have been widely recommended for managing the risk of violence in patients who make threats.[25] McNiel states that additional options include involuntary hospitalization, intensified outpatient treatment, psychotropic medication, removal of weapons and conjoint sessions which may involve the person who is the target of the threat.[26]

Givelber states that while there may be some situations in which warning the victim is the most reasonable response, many therapists have suggested, since even before the *Tarasoff* decision, that

18 *Felthous & Kachigian, supra note 12 at 358.*

19 *Ibid.*

20 *Tarasoff, supra note 3 at 340.*

21 *Michael Huber, et al., "A Survey of Police Officers' Experience with Tarasoff Warnings in Two States" (2000) 51 Psychiatr. Serv 807 at 807.*

22 *Gary Chaimowitz, Graham Glancy & Janice Blackburn, "The Duty to Warn and Protect – Impact on Practice" (2000) 45 CJP 899 at 900.*

23 *Paul Appelbaum, "Tarasoff and the Clinician: Problems in Fulfilling the Duty to Protect" (1985) 142:4 Am J Psychiatry 425 at 427.*

24 *Ibid. at 426.*

25 *Dale McNiel, Renee Binder & Forrest Fulton, "Management of Threats of Violence Under California's Duty-to-Protect Statute" (1998) 155:8 Am J Psychiatry 1097 at 1099.*

26 *Ibid.*

different measures will be appropriate in other situations.[27] Liability will be determined by what a "reasonable" therapist would have done in the circumstances.

The impact of *Tarasoff*

Tarasoff was initially greeted with prophecies of doom from many within the mental health professions. They predicted that *Tarasoff* would extinguish the trust and confidentiality essential to effective psychotherapy.[28] However, the duty to protect has not been applied uniformly across the United States.[29] The issue of whether or not such a duty exists is a state tort law issue, not a matter of federal law.[30] States have variously embraced, expanded, restricted or rejected *Tarasoff.*[31]

California extends *Tarasoff*...

California is one state that has expanded the duty to protect far beyond its original limits. As a direct response to the *Tarasoff* decision, the legislature of California limited the broad duty to protect that it introduced, by codifying a narrower "duty to warn". The duty to warn is triggered only when a patient communicates to a therapist a serious threat of physical violence against a readily identifiable victim.[32] However, the courts of California have once again expanded the liability of therapists.

... to emergency settings...

In *Jablonski*[33], the Ninth Circuit Court of Appeals extended the duty to an emergency setting.[34] In that case, Jablonski was brought to the emergency department of a hospital by his girlfriend after he threatened her mother with a knife and attempted to rape her.[35] Dr Kopiloff examined Jablonski and diagnosed him with an anti-social personality disorder that rendered him "potentially dangerous".[36] However, Dr Kopiloff concluded that there was no basis for involuntary hospitalisation.[37] No attempt was made to locate Jablonski's past medical records, which would have revealed a history of schizophrenia and violence.

Shortly after his release from hospital, Jablonski attacked and murdered his girlfriend.[38] Despite the absence of any specific threat directed towards an identifiable person, the Court held the hospital liable for its failure to obtain Jablonski's past medical records and adequately warn the victim. Thus, *Jablonski* expanded *Tarasoff* by holding that a history of violent behaviour can reveal a danger that will be sufficient to indicate the foreseeability of harm to a particular victim or class of victims.[39] Further, a protective duty may be imposed on a treating psychiatrist even in an emergency setting.

27 *Daniel Givelber, William Bowers & Carolyn Blitch, "Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action" (1984) Wisconsin Law Review 443 at 465.*

28 *Daniel Shuman & Myron Weiner, "The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege" (1982) 60 North Carolina Law Review 893 at 914.*

29 *Fillmore Buckner & Marvin Firestone, "Where the Public Peril Begins: 25 Years After Tarasoff" (2000) 21 The Journal of Legal Medicine 187 at 200.*

30 *United States v. Chase 340 F.3d 978 at 996.*

31 *Hubbard, supra note 6 at 429.*

32 *Cal. Civ. Code 43.92.*

33 *Jablonski v. United States 712 F.2d 391 (9th Cir. 1983) [Jablonski].*

34 *Buckner & Firestone, supra note 29 at 201.*

35 *Jablonski, supra note 33 at 393.*

36 *Ibid.*

37 *Ibid. at 394.*

38 *Ibid.*

39 *Damon Walcott, Pat Cerundolo & James Beck, "Current Analysis of the Tarasoff Duty: an Evolution towards the Limitation of the Duty to Protect" (2001) 19 Behav. Sci. Law 325 at 330.*

... to threats reported by family members

In *Ewing*[40], the California Court of Appeal for the Second District held that the communication of a threat by a close family member was equivalent to a threat communicated directly by a patient and triggered a duty to warn the potential victim.[41] In *Ewing*, the patient confided to his father that he was considering harming his ex-girlfriend's new partner. The father notified the patient's therapist, Dr Goldstein, who arranged for the patient's voluntary hospitalisation at a nearby medical centre by a staff psychiatrist. The following day, the staff psychiatrist discharged the patient because he was not suicidal, despite Dr Goldstein urging him to keep the patient hospitalised.

Dr Goldstein had no further contact with the patient.[42] At no stage did Dr Goldstein warn the victim who was the subject of the patient's threat. The day after he was discharged the patient shot his intended target and then committed suicide. Dr Goldstein was held liable in negligence for failing to warn the victim based on the credible threat disclosed by the father.[43]

Ewing has been criticised by some scholars for extending the duty to warn beyond the scope and intent of the Californian legislation.[44] The legislation specifically states that a duty arises only when a patient communicates a threat to a psychotherapist.[45] The author shares Edwards's concern that *Ewing* opens the door to the imposition of liability on clinicians based on third-party, hearsay communications.[46] Edwards states: "There is no way Dr Goldstein could have truly known the intent or seriousness of the threat without the threat being conveyed directly to Dr Goldstein".[47] Yet, one phone call was enough for the Court to impose a duty upon Dr Goldstein.[48]

In a similar vein, Smith has criticised *Ewing* because, in her view, therapists will have no way of confirming whether "the communication is accurate, is made by a family member, or whether the family member is acting maliciously or in the best interests of the patient".[49] In Smith's view, *Ewing* creates "amorphous liability standards" for therapists.[50]

Nebraska: extending *Tarasoff* to the protection of strangers

In *Lipari*[51], the Federal District Court recognised a duty on therapists that extends to protecting strangers. In that case, a patient was receiving psychiatric care from a Veterans Administration. The patient purchased a shotgun and used it in a random attack at a crowded nightclub, killing one person.[52] The Court held that a duty to protect would arise, even though no specific threats were made by the patient against any specific person. Thus, the Court dispensed with the need for an identifiable victim and required "only that the doctor reasonably foresee that the risk engendered by his patient's condition

40 *Ewing v. Goldstein 15 Cal Rptr. 3d 864 [Ewing].*

41 *Robert Weinstock, Gabor Vari, Gregory Long & Arturo Silva, "Back to the Past in California: A Temporary Retreat to a Tarasoff Duty to Warn" (2006) 34 (4) Journal of the American Academy of Psychiatry and the Law 523 at 526.*

42 *Ewing, supra note 40 at 867.*

43 *Weinstock, Vari, Long & Arturo Silva, supra note 39 at 526.*

44 *Gwynneth Smith, "Ewing v. Goldstein and the Therapist's Duty to Warn in California" (2006) 36 Golden Gate U. L. Rev. 293 at 296.*

45 *Edwards, Deborah, "Duty to Warn – Even if it may be Hearsay? The Implications of a Psychotherapists Duty to Warn a Third Person when Information is Obtained from Someone Other than his Patient" (2006) 3 Ind. Health L. Rev. 171 at 182.*

46 *Ibid.*

47 *Ibid. at 183.*

48 *Ibid.*

49 *Smith, supra note 44 at 299.*

50 *Ibid. at 297.*

51 *Lipari v. Sears, Roebuck & Co. 497 F.Supp. 185 (D. Neb. 1980) at 187 [Lipari].*

52 *Buckner & Firestone, supra note 29 at 200.*

would endanger other persons".[53] Following *Lipari,* Nebraskan therapists have a duty to protect anyone foreseeably endangered by a patient.[54]

PART TWO: THE UNITED KINGDOM

Current position

The United Kingdom Court of Appeal has confirmed that UK psychiatrists have discretion, but not a duty, to warn potential victims in certain circumstances. *Egdell*[55] and *Crozier*[56] confirm that a psychiatrist is permitted to depart from the duty of confidentiality to issue warnings about a patient who is believed to present a real and serious threat to third parties.[57] Less certain, however, is whether a psychiatrist could be duty-bound to give a warning or take other steps to protect third parties from foreseeably dangerous patients.[58]

Whilst the courts in *Egdell* and *Crozier* recognised discretion to depart from the duty of confidentiality, they were not asked to, and did not recognise, a duty upon psychiatrists to do so. To date no such duty has been acknowledged in a United Kingdom court.[59] However, the European Court of Human Rights' ruling in *Osman*[60] has opened the door to the introduction of a doctrine analogous to *Tarasoff* in the United Kingdom.[61] Notwithstanding *Osman*, doubt surrounds the question of whether such a duty would be recognised by domestic courts.[62]

Osman

The United Kingdom is a signatory to the European Convention on Human Rights ("ECHR").[63] Accordingly, the ECHR applies to all residents of the United Kingdom[64] and it is unlawful for a public authority to act contrary to an ECHR right.[65] The ECHR may well impose obligations on healthcare professionals, including psychiatrists employed by the National Health Service ("NHS").[66] In particular, obligations might flow from Article 2 of the ECHR which affirms the right to life.[67] In *Osman,* the European Court of Human Rights' (ECtHR) used Article 2 to introduce a positive obligation to protect third parties into United Kingdom law.[68]

In *Osman*, Mrs Osman sued local police for failing to protect her now deceased husband. Mr Osman was shot dead by a teacher, Paget-Lewis, who had formed an obsessive attachment with their son. Mrs Osman argued that the police had failed to act on warning signs that Paget-Lewis represented a serious threat to her family.[69] The evidence indicated that Paget-Lewis was jealous of her son's relationship with another student at school. Paget-Lewis had allegedly vandalised the Osmans' property, wrote slanderous graffiti on school premises and stole a shotgun that was used in the shooting of Mr Osman. The English Court of Appeal dismissed the claim on a public policy ground – that the police could not be negligent for failures relating to the investigation of crime.[70]

53 *Lipari, supra note 51 at 194.*
54 *Walcott, Cerundolo & Beck, supra note 39 at 330.*
55 *W v Egdell [1990] Ch 359 [Egdell].*
56 *R v Crozier [1991] Crim LR 138 [Crozier].*
57 *Gavaghan, supra note 7 at 255.*
58 *Ibid.*
59 *Ibid.*
60 *Osman v UK [1999] 1 FLR 193 [Osman].*
61 *Gavaghan, supra note 7 at 256.*
62 *Ibid.*
63 *Ibid. at 257.*
64 *Michael Perlin, "'You Got No Secrets to Conceal': Considering the Application of the Tarasoff Doctrine Abroad" (2006) 75 U. Cin. L. Rev. 611 at 618.*
65 *Section 6(1) Human Rights Act 1998 (qualified by section 6 (2)).*
66 *Gavaghan, supra note 7 at 257.*
67 *Perlin, supra note 64 at 619.*
68 *Gavaghan, supra note 7 at 258.*
69 *Osman, supra note 60 at 199.*
70 *Ibid. at 207.*

Mrs Osman then petitioned the ECtHR for a remedy. On the facts, the Court dismissed the claim under Article 2 because the criminal conduct of Paget-Lewis was not reasonably foreseeable by the police. The Court held that Mrs Osman had:

> [F]ailed to point to any decisive stage in the sequence of the events leading up to the tragic shooting when it could be said that the police knew or ought to have known that the lives of the Osman family were at real and immediate risk from Paget-Lewis. While the applicants have pointed to a series of missed opportunities which would have enabled the police to neutralise the threat posed by Paget-Lewis, for example by searching his home for evidence to link him with the graffiti incident or by having him detained under the Mental Health Act 1983 or by taking more active investigative steps following his disappearance, it cannot be said that these measures, judged reasonably, would in fact have produced that result or that a domestic court would have convicted him or ordered his detention in a psychiatric hospital on the basis of the evidence adduced before it.[71]

Despite the dismissal of Mrs Osman's claim on the facts, critically, the Court stated that Article 2 could give rise to "a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual".[72] As to the scope of this obligation, the Court stated:

> [B]earing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities…. In the opinion of the Court where there is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.[73]

It is worth noting that the above passage from *Osman,* bears a close resemblance to the reasoning of the Supreme Court of California in *Tarasoff. Osman* has since been interpreted by one scholar as imposing a duty to protect third parties upon state employees in the United Kingdom, including psychiatrists employed by the NHS.[74] The duty is derived from Article 2 of the ECHR, which protects the right to life. However, unless and until an expanded duty is recognised, any legal recourse against state employed psychiatrists for failure to protect third parties would lie against the United Kingdom government and not against a psychiatrist personally.[75]

Palmer

Osman was considered by the English Court of Appeal in *Palmer*.[76] That case concerned a former psychiatric patient who abducted, sexually assaulted and murdered a 4 year-old girl.[77] One year prior to the murder, the patient stated that he had sexual feelings towards children and that a child would be

71 *Ibid. at 220.*

72 *Ibid. at 218.*

73 *Ibid.*

74 *Gavaghan, supra note 7 at 267.*

75 *Ibid. at 266.*

76 *Palmer v Tees Health Authority [1999] Lloyd's Rep Med 351 [Palmer].*

77 *Ibid. at 351.*

murdered after he was discharged from hospital.[78] The victim's mother sued the hospital for failing to foresee the risk of the patient committing serious sexual offences against children.[79]

At first instance, the judge struck out the claim and this decision was subsequently upheld by the Court of Appeal. On the facts, the Court of Appeal distinguished *Osman* because in the present case there was no prior relationship between the patient and the victim.[80] The Court held that because there was no pre-existing connection between the patient and the specific victim, the requisite degree of proximity for negligence was absent.

Significantly, Stuart-Smith LJ expressed reservations about the propriety of the *Osman* decision in the English context: "I respectfully agree with Lord Browne-Wilkinson that it is not easy to understand the decision of the Strasbourg Court in the context of the English law of negligence".[81] Further, the Court proceeded to reject *Tarasoff* itself. Lord Stuart-Smith stated that the *Tarasoff* duty proceeded on "the premise that there is a special relationship between the defendant and either the third or the foreseeable victims. In English law it is plainly not sufficient that this relationship exists only between the defendant and third party".[82]

Discussion

In the author's view, *Palmer* is an early indication that domestic English courts will be reluctant to apply *Osman* reasoning to cement a tort law duty on psychiatrists to protect third parties. Gavaghan states that the notion of a positive duty to protect third parties under domestic British law is a "very radical one".[83] However, some scholars view *Osman* as the first step towards the recognition of a European *Tarasoff*. In Hubbard's view, the *Osman* decision is "an early sign of how the law on duties to third parties may develop" in the United Kingdom.[84] Similarly, Perlin argues that *Osman* represents a move towards the recognition of a duty to protect. Perlin states that: "Of course, *Osman* was not, strictly speaking, a '*Tarasoff* case'. But there is no question in my mind that it helped create a judicial environment that will be more sympathetic to such claims".[85] Time will tell whether Perlin's prediction proves accurate. However, the early judicial indication from *Palmer* is that domestic English courts will be slow to impose a *Tarasoff* duty in that jurisdiction.

PART THREE: A CRITIQUE OF *TARASOFF*

There are several reasons why United Kingdom decision makers should be sceptical about *Tarasoff's* "enlightened approach".

Lack of control over patients

In many cases, a psychiatrist will lack the necessary degree of control over a patient to justify the imposition of a duty. For instance, psychiatrists usually have little control over voluntary patients who do not satisfy the criteria for involuntary commitment. Similarly, psychiatrists will have little control over outpatients.[86] For example, *Tarasoff* itself concerned a voluntary outpatient who was not in treatment at the relevant time; whose potential victim was out of the country at the time of the threats; and who

78 *Ibid.*
79 *Ibid.*
80 *Perlin, supra note 64 at 623.*
81 *Palmer, supra note 76 at 354.*
82 *Ibid. at 359.*
83 *Gavaghan, supra note 7 at 267.*
84 *Hubbard, supra note 6 at 441.*
85 *Perlin, supra note 64 at 625.*
86 *Stone, supra note 5 at 366.*

committed the murder three months after revealing his feelings during therapy.[87]

Support for this view can be found in the judgment of the Florida Court of Appeals in *Boynton*.[88] The Florida Court of Appeals strongly rejected the *Tarasoff* approach:

> Although other jurisdictions have followed the lead of the California Supreme Court in the landmark decision of Tarasoff v Regents of Univ. of California, we reject that "enlightened" approach. Florida courts have long been loathe *[sic]* to impose liability based on a defendant's failure to control the conduct of a third party.[89]

The Court stated that the "special relationship" between a patient and therapist relied on in *Tarasoff* to create the protective duty, is implicitly premised on a psychiatrist's ability to control their patient.[90] Yet, the *Tarasoff* Court did not address the issue of control.[91] In *Tarasoff*, the Supreme Court of California simply stated that:

> [T]here now seems to be sufficient authority to support the conclusion that by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient.[92]

In stark contrast, the Florida Court of Appeals recognised that most therapeutic relationships will not contain any element of control.[93] The Court held that the relationship between a psychiatrist and a voluntary outpatient lacked the necessary element of control for the creation of a duty to protect other parties.[94] It is submitted that the Court's reasoning is persuasive. Moreover, there must be strength in Stone's analysis: "Once the suggestion of control is eliminated, there is nothing in the nature of the relationship between a psychiatrist and his patient to support an exception to the tort law presumption".[95] In the absence of control, the *Tarasoff* Court appeared to rely upon the responsibilities inherent in social living and human relations, and the spirit of the Good Samaritan. The *Boynton* Court declined to "fashion a rule of law from such social duties".[96]

Causation problems

The second reason why *Tarasoff* should be avoided relates to causation. It is submitted that there are glaring problems of causation with the *Tarasoff* doctrine. Put simply, it is not clear that the psychologist's failure to warn the victim in *Tarasoff* could be said to have caused the victim's death. Conspicuously, there is no causation analysis in the *Tarasoff* decision.

It will be recalled that in *Tarasoff,* Tobriner J stated that the protective duty may require a therapist to take various steps depending on the facts of the individual case, including warning the potential victim, notifying the police, or taking whatever other steps might be reasonably necessary to protect the potential victim.[97] Further, Tobriner J stated: "Some of the alternatives open to the therapist, such as warning the victim, will not result in the drastic consequences of depriving the patient of his liberty".[98] However, a

87 *Gutheil, supra note 4 at 346.*
88 *Boynton v. Burglass 590 So. 2d 446 [Boynton].*
89 *Ibid. at 448.*
90 *Ibid. at 448.*
91 *Ibid. at 449.*
92 *Tarasoff, supra note 3, at 349.*
93 *Boynton, supra note 88 at 449.*
94 *Ibid.*
95 *Stone, supra note 5, at 366.*
96 *Boynton, supra note 88 at 451.*
97 *Tarasoff, supra note 3 at 340.*
98 *Ibid. at 350.*

therapist who has failed to warn a victim should not be liable for a victim's injuries or death if their failure to warn was not a cause in fact of such injuries or death.

Settled principles of tort law require factual causation before liability will be imposed in negligence. The 'but for' test is used to ensure this minimum level of factual causation. To satisfy this test, the plaintiff would have to prove that had Ms Tarasoff been warned of Mr Poddar's threat, she would have avoided being killed by Mr Poddar. It is far from clear whether a warning would have averted the danger. It is entirely conceivable that Mr Poddar would have killed Ms Tarasoff, notwithstanding that she was aware of the very danger posed by Mr Poddar. The most that can be said is that, due to the psychologist's failure to warn her, Ms Tarasoff lost the opportunity to avoid being harmed by Mr Poddar. Based on traditional common law principles of causation, this would be insufficient to establish causation.

Of course, it was open to the *Tarasoff* Court to relax the ordinary rules of causation and apply a lower standard of causation in the particular circumstances of the case. However, the Court did not do so. Moreover, the Court failed to explain how causation was established on existing principles.

It is submitted that a *Tarasoff* duty can only ever make sense in terms of causation if one interprets it as requiring a therapist to commit for involuntary treatment a patient who poses a serious danger to others. 'But for' causation would be established because the victim would certainly have avoided the harm had the therapist properly committed the patient. However, the majority in *Tarasoff* was careful to avoid establishing a duty on therapists to civilly commit a patient. Therefore, in the author's view, *Tarasoff* liability sits uncomfortably with traditional common law principles of causation.

Uncertain standard of care

A third reason to avoid a *Tarasoff*-type duty relates to the uncertain standard of care that the decision purports to impose upon therapists. The standard of care required by *Tarasoff* is that of the reasonable therapist:

> [T]he therapist need only exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances. Within the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is insufficient to establish negligence.[99]

Mosk J stated that a psychiatrist's prediction of violence stands to be examined against "conformity to standards of the profession".[100] Yet, one must wonder what common standards the court is referring to, when no such standards exist within the profession itself. Of course, psychiatry has developed a range of risk assessment tools designed to predict dangerousness. However, it appears that there is little consensus within the profession as to what constitutes reasonable practice. In his dissenting judgment in *Tarasoff*, Clark J referred to evidence that suggested:

> [T]he chances of a second psychiatrist agreeing with the diagnosis of a first psychiatrist are barely better than 50-50; or stated differently, there is about as much chance that a different expert would come to some different conclusion as there is that the other would agree.[101]

Unlike a physician's diagnosis, which can be verified by x-ray or surgery for example, a psychiatrist cannot verify his diagnosis, treatment or predicted prognosis except by long-term follow-up and reporting.

99 *Ibid. at 349.*
100 *Ibid. at 361.*
101 *Ibid. at 371.*

The Court in *Boynton* described the problem in this way: "The outward manifestations of infectious diseases lend themselves to accurate and reliable diagnoses. However, the internal workings of the human mind remain largely mysterious".[102]

Although *Tarasoff* purports to impose a standard of reasonableness, the reality is that the decision imposes an uncertain, higher standard of care that is determined by the hindsight judgment of a court. Because the standard is without meaningful content within psychiatry, the reality is that psychiatrists are exposed to potential liability unless they do in fact accurately predict dangerousness.[103] The question of whether a psychiatrist actually did predict dangerousness becomes indistinguishable from whether they should have done so.[104] The question will be whether a reasonable psychiatrist would have made that prediction, albeit under the guise of ascertaining whether this psychiatrist actually did so.[105] Surely it is unfair to impose such an uncertain, retrospective duty on psychiatrists.

The problem of confining a duty to protect

It has been seen that some jurisdictions within the United States have expanded the protective duty to emergency settings, to threats notified by family members and even to unknown victims. The possibility that the adoption of a protective duty in the United Kingdom might lead to a similar expansion must be of some concern.

The United Kingdom would be wise to note that many courts in the United States have struggled to confine the *Tarasoff* doctrine. Attempts to place reasonable limits on the duty have been fraught with difficulty. For example, the specificity rule (which requires specific threats against specific victims before a duty to protect will be imposed on a therapist) was created to limit and clarify the circumstances that would trigger the duty. Prima facie, the rule appears to successfully limit the protective duty. Indeed, variations of the rule have since been adopted in a number of states. The specificity rule is not, however, without weakness.

Borum and Reddy argue that the specificity rule creates an arbitrary precondition to the existence of a duty because, "threats should not be regarded as a necessary or exclusive factor for precipitating an inquiry about clinical concern".[106] They state that as a clinical and ethical matter, there may be circumstances when a psychiatrist is legitimately concerned about potential violence in the absence of a direct threat made by the patient.[107] Further, they argue that it is crucial to distinguish between a patient who communicates a threat and a patient who poses a threat by engaging in behaviour that indicates planning and preparation for violence.[108] It is true that some patients who verbalise threats ultimately act on them, but many do not.[109] A patient may pose a threat even though they have not communicated a threat to anyone.[110] Borum and Reddy state that it is those who appear to pose a threat that provoke the greatest level of concern.[111]

By excluding those patients who pose, rather than verbalise threats, the specificity rule may conceal the very danger that the duty was designed to protect against. It is submitted that the construction of the specificity rule is indicative of a broader judicial struggle to confine the duty to protect within reasonable bounds.

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102 Boynton, supra note 88 at 452.

103 Stone, supra note 5 at 371.

104 Gavaghan, supra note 7 at 263.

105 Ibid.

106 Randy Borum & Marisa Reddy, "Assessing Violence Risk in Tarasoff Situations: A Fact-Based Model of Inquiry" (2001) 19 Behav. Sci. Law 375 at 380.

107 Ibid.

108 Ibid.

109 Ibid.

110 Ibid.

111 Ibid.

CONCLUSION

Courts in the United States and, to a lesser extent, the United Kingdom, have acknowledged that in certain circumstances the public interest in protecting psychiatrist-patient confidentiality must yield to the public interest in preventing innocent third parties from violence. Notwithstanding the striking similarity in reasoning between *Tarasoff* and the decision of the European Court in *Osman*, early case law from England favours the more conservative, discretionary model enunciated in *Egdell*. For the reasons discussed above, the United Kingdom would be wise to stop short of converting the discretion to breach confidentiality in the public interest, into a tort law duty to protect third party victims. The Supreme Court of Texas summarised the tension inherent in the protective duty in the following extract:

> If a common law duty to warn is imposed, mental health professionals face a Catch-22. They either disclose a confidential communication that later proves to be an idle threat and incur liability to the patient, or they fail to disclose a confidential communication that later proves to be a truthful threat and incur liability to the victim and the victim's family.[112]

Finally, it is important that we keep in mind that the public may be safeguarded in more traditional ways.[113] Prior to *Tarasoff*, hospitalisation was the primary means of protecting potential victims from a patient's violent acts in the United States.[114] The author tends to agree with Felthous and Kachigian that hospitalisation remains "the most prudent and preventative measure to handle a patient who is seriously mentally ill, and as a result is dangerous to others".[115] Likewise, he agrees with Stone that, "emergency civil commitment generally remains the safest and least destructive way to deal with a crisis of violence in a mentally ill person".[116]

112 Thapar v. Zezulka 994 S.W.2d 635 (Tex. 1999) at 639 [Thapar].

113 Stone, supra note 5 at 374.

114 Felthous & Kachigian, supra note 12 at 356.

115 Ibid. at 370.

116 Stone, supra note 5 at 374.

Learning Lessons: Using Inquiries for Change

***Gillian Downham*[1] *and Richard Lingham*[2]**

"How long does it usually take for an inquiry's recommendation to be implemented?"

This was the question asked by the son of the late Mrs H who had been killed under tragic circumstances by MN, a young man suffering, so it emerged, from paranoid schizophrenia.

Twenty-one months after publication of the Report of the Independent Inquiry into the Care and Treatment of MN[3], her family was waiting to hear whether the inquiry recommendations had been implemented and the lessons learnt. With the pain of bereavement still evident they asked quiet, astute, intelligent questions.

For example, is 75 per cent compliance with an audit standard after nearly two years satisfactory? How would we know whether mental health services were now considered safe? How would we know that our recommendations had been appropriately implemented and the lessons learnt?

We begin by explaining how this situation arose. For this article is not about the procedure of inquiry investigation, nor is it about the content of the inquiry report or recommendations. Our focus here is on the post-inquiry process – what happens after an inquiry's recommendations are made.

When the perpetrator of a homicide has a history of contact with psychiatric services, an independent investigation into their care and treatment is mandatory and must be commissioned by the Strategic Health Authority[4]. Most such investigations are considered completed once the independent report has been published.

Unusually, the MN Independent Inquiry stated in its terms of reference *'the Inquiry Panel will conduct a review of progress against an agreed action plan six months after publication of the report'*. Even more unusually, we carried out an evidence-based review, producing two Recommendation Review Progress Reports[5] over

1 *Barrister, London, Chair of the Regulation of Medicines Review Panel of the Medicines and Healthcare products Regulatory Agency, tribunal judge of the First-tier Tribunal (Health, Education and Social Care), chair of five independent mental health homicide inquiries, all of which have had a minimum of six months follow-up by the inquiry built into the terms of reference.*

2 *Former Chair of a Health Authority, former Director of Social Services and member of the First-tier Tribunal (Health, Education and Social Care), chair of six independent mental health homicide inquiries and member on the panel of a further five such inquiries or NHS investigations*

3 *Independent Inquiry into the Care and Treatment of MN commissioned by Avon, Gloucestershire and Wiltshire Strategic Health Authority (later part of NHS South West) published June 2006*

4 *Department of Health Circular HSG 94(27), as amended by Department of Health guidance issued in June 2005*

5 *Reports by the Independent Inquiry into the Care and Treatment of MN: Six Month Review of Progress in the Implementation of Recommendations presented to the NHS South West Board on 15 March 2007 and Progress Report on the Implementation of Recommendations presented to the NHS South West Board on 19 March 2008*

a period of 21 months and presenting them both in public sessions to the Strategic Health Authority Board. In the week prior to each public presentation, the families of the victim and perpetrator received an embargoed copy of the Review Reports and we met with each family in private. It was at the final meeting with the family of the victim that the above searching questions were asked.

So how did we reply? Whilst we had found there was some real progress on the recommendations, the result was not as clear-cut as we, the families, or indeed the commissioners and providers of services might have hoped. The degree of implementation of a recommendation was often expressed in terms of percentage adherence to an audit standard or against a key performance indicator. Such measures of compliance are less tangible and less satisfying than a 'yes' or 'no' implementation of a recommendation.

And yet for the public, the services must show that lessons really have been learnt. This is a legitimate expectation in terms of public accountability. So, how can inquiries constructively be used to bring about change or at least establish the progress being made?

Post-inquiry: the missing link

The conduct of investigations following serious mental health, child and domestic violence incidents has been the subject of extensive national guidance and research.

However, nowhere is there any focus on the process by which recommendations arising from such investigations should be followed through to implementation. This is the missing link in the chain which should exist between the incident, the investigation and the lessons learned.

It is widely assumed this does not need to be specifically addressed and it may be asserted that implementation is essentially a management responsibility for local services. But we argue that whether the post-inquiry stage is conducted by the independent inquiry or by local commissioners of services, this should be approached in an impartial, structured way. There should be an understanding of the way particular recommendations need to be approached in order to oversee their implementation. There should be guiding principles.

Principles of inquiry follow-up

In order to open debate in this important area we offer our observations on this post-Inquiry stage. These can be considered as a set of principles which may be applicable to other types of independent inquiry in the health and social care sector. They are:

1. **Evidence:** Whether or not recommendations have been implemented should be established by means of evidence-based review.
2. **Independence:** The extent of implementation should be determined by independent, objective scrutiny, ideally by the independent inquiry chair and panel. Commissioning bodies should not leave provider organisations to be final arbiters of their own progress with recommendations.
3. **Accountability:** Independent review reports should be written and report-back should be to the families concerned in private and to the commissioning body in public, notably for the latter to fulfil its duties of direct accountability and openness.
4. **Full implementation of recommendations:** It should be assumed that all recommendations are to be implemented, whether at an agency, local or national level. If it is decided that a recommendation will not or cannot be implemented, for example, because an organisational structure no longer exists

or funding for it is unavailable, the reason for that decision should be made clear. This is especially important where there are potentially controversial reasons for non-implementation.

5. **Planned review of implementation:** A structured plan for review of implementation of recommendations should be agreed between the independent reviewer, the commissioner and provider of services. This should be more than an action-plan. As a blueprint for change, it should try to be comprehensible to service users, carers, victims and other people with legitimate personal interests. It should be made public and it should be up-dated periodically, for example after six months or a year. The implementation plan may include the dates of meetings to discuss progress, prioritisation and re-evaluation of recommendations, decisions on the evidence required to decide upon implementation and what will constitute full or sufficient implementation. It should specify the realistic outcomes sought and who will be involved in the process of achieving them. Consideration should be given to inclusion of service user and carer groups' representatives, along with any local ethnic or other community representation if relevant to implementation of the recommendations.
6. **No blame:** The implementation plan should state that the review is a constructive phase, with a focus upon improvement and provision of safe services rather than upon failure or blame.
7. **Completion:** An independent inquiry should not be considered completed and its lessons learnt until its recommendations have either been fully implemented or reached a satisfactory stage of completion, as decided by commissioners and independent reviewer. The reasons for the decision should be made public. There should be an agreed cut-off point for the independent review process with planned handover of remaining recommendations to other local independent bodies for scrutiny.

Types of recommendation

From the MN Inquiry it was possible to discern distinct types of recommendation.

Identifying the type will help to ensure problems are anticipated, implementation managed effectively and expectations realistic. We suggest that the following may be equally applicable across different organisations with different types of inquiry, investigation and review. Starting with the simplest and quickest type of recommendation:

1. **Practical:** At the simplest level are recommendations which require straightforward practical implementation. These responses to a major incident may be very obvious and may sometimes have been dealt with well before any independent inquiry.
2. **Commitment:** Recommendations may be framed in terms of commitment to a specific service improvement. For example, a commitment to involve service users and carers. Such recommendations may seem easily satisfied by means of publicity or a new post. Unfortunately however, it cannot be assumed commitment will lead to an improvement of standards. For that to be achieved, a commitment recommendation might need to be re-framed as a policy or professional practice recommendation.
3. **Policy and procedural:** At a more complex level are those recommendations which require the drafting and adoption of a revised operational policy or procedure. At its simplest, a recommendation could be considered implemented once the policy is published. If that is the intention, it should be made clear. It is more likely that the intention of the recommendation, even

if not explicit, is that the policy will become operational. Otherwise, it will remain only a hope or expectation. There should be an early agreement on what will constitute implementation and how that will be determined. Audit is likely to provide the key evidence needed.

4. **Professional practice:** Sometimes the clear intention – implicit or explicit – of a recommendation is that standards of professional practice should be improved. It may be intended this will flow from a revised policy, for example on risk assessment, going beyond a simple change in procedure or protocol. Professional practice recommendations may require:

   - Examination of records in order to support claims that supervision and training are taking place
   - Audit and performance management using validated operational data over a period of years in order to capture evidence of professional standards and sustained improvement in good practice

   There are potential pitfalls to the use of audit. It may not be easy to find the standards and key performance indicators that will properly measure the improvements sought and then there is the question of their interpretation. It may be unrealistic to expect 100 per cent compliance with a service standard based upon professional judgement. But what degree of compliance is acceptable – 95 per cent, 75 per cent, 55 per cent or less? This will need to be determined.

   Since the ultimate goal is a high professional standard, internalised and fully embedded in practice, professional practice recommendations are the most difficult to implement and may take time to complete. The higher the standard set or more extensive the change required, the longer one might have to wait. Implementation may need to be seen as an incremental process.

5. **Major organisational change:** Recommendations may at times demand large-scale change, either within the organisation or in partnership with other organisations. There may be complex contractual arrangements, funding, legal and political issues. Protracted negotiations may be necessary. Slow progress with major organisational change recommendations is to be expected.

6. **Commissioning:** These are further removed from front line changes in service provision but may be fundamental to lasting implementation of recommendations. Failures of communication across organisational boundaries are frequently cited in inquiries. Implementation planning may need to involve several commissioning bodies.

7. **National:** It may become apparent during an independent inquiry that a finding has national implications. The recommendations can feed into existing consultative structures or national research on specific topics. Alternatively, an inquiry can take the initiative and hold a national seminar of experts. Publicity may already have produced national concerns. The implementation of such large-scale recommendations will commonly require tenacity, the involvement of a number of agencies and support of the commissioning body.

8. **Common theme:** These arise when it is clear from other inquiries that a shared problem is particularly intractable. Mental health Trusts and Strategic Health Authorities are increasingly gathering information from their local investigations for the purpose of identifying themes. Nationally, that is also the trend. Whilst this is constructive, it is important to ensure that individual local recommendations are not forgotten. The various approaches should not be mutually exclusive.

Implementing the recommendations

How might the above work in practice?

During the twenty-one months of the post-MN Inquiry phase, we met on seven occasions with an 'MN Steering Group' set up by the Strategic Health Authority with representation by the Trust at medical director and nursing director level, PCT, local authority and with local service user and carer groups. We met on one occasion with the agencies responsible for implementing the national recommendations. We also received a great deal of evidence including new policies, training material and the results of audit and performance management using key performance indicators.

Were the MN recommendations implemented?

One straightforward practical recommendation had been implemented before the report was published. There were two commitment recommendations and both were completed insofar as there was undoubted commitment. Five of the recommendations required a revised or new policy, with three of these audited and two completed. Only two out of eleven professional practice recommendations were completed, though eight had been subject to audit or performance management and in most cases implementation was described by the inquiry in terms such as '*on its way to completion*' or '*not completed but we are confident it is being pursued*'. Out of four organisational change recommendations, none were in place when the inquiry ceased to exist but one was expected to be implemented within six months and another within two years. Three commissioning recommendations were made and although none reached the stage of completion all were in progress. Following a national seminar of experts a number of national recommendations were made which were taken into account in new national guidance. MN had been the third local independent inquiry to identify insufficient support for carers and inadequate care planning, the identification of these themes lending weight to the implementation of the MN local and national recommendations.

The MN Inquiry exposed the process of implementation to public scrutiny in a rare way. Before it finally withdrew, plans were made for handover of each incomplete recommendation to local bodies for independent oversight. We satisfied ourselves there would continue to be report-back on progress to the Strategic Health Authority in public session and were reassured that the families would continue to have an opportunity to express their views.

Follow-up by independent inquiry, investigation or review team

There is a risk of institutionalising the follow-up process by incorporating it into an organisation's internal action-planning structure. In our experience, follow-up by an independent inquiry can have several unique advantages:

- **Public accountability:** When a duty to undertake an effective investigation arises under Article 2 of the European Convention of Human Rights, there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability[6]. Even when Article 2 is not engaged, it is reasonable to expect that weaknesses identified by an official investigation will be rectified. An independent inquiry can dispassionately represent and pursue the wider public and victim's interests in ensuring that recommendations are implemented. It can if necessary expose the workings of the organisations concerned to public scrutiny thus providing authoritative

6 *Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance, National Patient Safety Agency, February 2008 and Paul and Audrey Edwards v UK, Application No. 46477/99 14 March 2002, ECHR, Current Law May 2002,477*

credibility to the process of accountability. Pressure exerted by an inquiry, along with families of the victim and perpetrator of the homicide, can ensure that the Strategic Health Authority becomes more truly accountable for the learning of lessons.

- **Familiarity with the recommendations:** Having identified the failures and made the recommendations, an independent inquiry knows exactly why each recommendation is necessary and what changes are needed. It is therefore well-placed to decide when and if learning has taken place, whether satisfactory progress has been made towards that goal or more evidence is needed and can write a recommendation review report linked directly to their original inquiry report. There is the added advantage that if an inquiry team expects to carry out the follow-up, it is likely to write thoughtful, constructive recommendations based on ownership of them.
- **Objectivity and impartiality:** The public look to independent inquiries and place their trust in them. That same confidence is needed for the follow-up, with independent inquiries able to review progress objectively, based on evidence.
- **Continuity and momentum:** Staff and organisational change can hamper implementation of recommendations. But the independent inquiry can provide continuity, maintaining interest in the implementation process through meetings and review reports. Our feedback suggests this was a constructive experience for those participating in the MN Inquiry implementation phase, welcomed by commissioners, providers and the families of the victim and perpetrator.

Of course it might be the case that an inquiry team is not able or does not wish to carry on through to the follow-up stage. It may be that commissioners do not consider it appropriate. And it is not unusual to find there are several investigations under way in one Strategic Health Authority area, which might benefit from shared review of some recommendations. Where there is the problem of potential duplication or overkill or a very real need to consider budgetary restrictions, some of the advantages of independent inquiry follow-up could still be gained by inclusion of members of inquiry teams on more broadly-based commissioner-led implementation teams. Or arrangements could be made for one-off opinions from the inquiry team. In some cases one major follow-up from an investigation might be more effective than too many, taking over several recommendations from others.

However it is achieved, each inquiry should have an objective, evidence-based post-investigation phase which should always be considered part of the whole inquiry process, with the goal of learning lessons from that inquiry.

The seven principles distilled from the MN Inquiry and described above should be applied even if the independent inquiry is not involved and follow-up is conducted entirely by local commissioners, whether that is a Strategic Health Authority, Primary Care Trust, Local Safeguarding Children's Board or new local domestic homicide review commissioning bodies (see below).

Lack of research and guidance on implementation of recommendations

There is a widespread view that lessons will naturally be learnt from a thorough investigation, review or inquiry in the health and social care services. Learning, it is assumed, will somehow occur, whether prompted by the shock of an incident, the investigation itself, publicity, dissemination of recommendations or by unseen provider services' responses.

Most guidance and research has therefore focussed on the process of investigation and formulation of an action plan – as if once the boat has been launched the voyage is completed. But what happens next?

Does this result in implementation of recommendations? No studies have successfully addressed the post-investigation stage and no guidance exists to help services with structured implementation of recommendations.

Below, we review approaches towards the learning of lessons as they have developed since 1994. In the context of one article we cannot cover this extremely interesting area in depth. It is unusual to cross boundaries and bring together investigation in the areas of mental health, children and domestic violence. In doing so, we have found it is striking that whatever the setting and however the investigation is carried out, there are broadly similar approaches – a point to which we return at the end of this section.

Early recognition of the value of inquiry follow-up

Over a decade ago, shortly after the Department of Health Circular on mental health homicide inquiries was produced in 1994, J Crichton and D Sheppard made the far-sighted proposal '*It should be part of any inquiry that the team is reassembled to comment upon the implementation of their recommendations locally*'.[7] Their remarks followed the refusal to adopt such a procedure for the inquiry *Big, Black and Dangerous: Report of the Committee of Inquiry into the Death of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients*[8]. Eleven years later in 2004, it was the absence of any formal procedure for follow-up of those recommendations or explanation for their non-implementation, that was remembered when the *Report of the Independent Inquiry into the Care and Treatment of David Bennett*[9] stated '*Many of the recommendations made in that report are disturbingly similar to recommendations that we include in this report but it is disturbing to find that little action has been taken upon them…..we express our grave concern at the apparent lack of reaction by anybody in authority to attempt to implement these and other recommendations made in that report*'.[10]

Adding her voice in 1996, Jill Peay, in *Inquiries after Homicide,* asked '*Do Inquiries have any legitimate continuing role where their recommendations are not implemented?*'[11] That question remained unanswered.

Learning lessons in the NHS

Across health services generally, the problem of learning lessons from untoward incidents was causing much scratching of heads. In 2000, *An Organisation with a Memory*[12] stated '*four National Confidential Inquiries operate in the NHS, but uptake of their recommendations is found to be insufficiently monitored, with the result that some measures are implemented while other recommendations appear in report after report*'. On inquiries and investigations it was said '*inquiry recommendations are not always sufficiently helpful or focussed; implementation and follow-up is patchy; and there is no systematic mechanism for disseminating learning from individual local investigations*'. Recommendations for improvement included '*introduce a single overall system for analysing and disseminating lessons from adverse events and near-misses*' and '*act to ensure that important lessons are implemented quickly and consistently*'.

7 *In Inquiries after Homicide, Jill Peay (ed), 1996, London, Duckworth, page 74*

8 *Pins H, Blacker-Holst T, Francis E, Keitch I (1993) Report of the Committee of Inquiry into the Death of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients. Big, Black and Dangerous. London, Special Hospitals Service Authority.*

9 *Blofeld, Sir J, Sallah D, Sashidharan S, Stone R, Struthers J (2003) Report of the Independent Inquiry into the Care and Treatment of David Bennett. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority*

10 *Supra page 63*

11 *Inquiries after Homicide, Jill Peay (ed), 1996, London, Duckworth, page 32*

12 *An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS, Chaired by the Chief Medical Officer, Department of Health, TSO, 2000*

Taking up the challenge, in 2002, *Building a Safer NHS for patients: Implementing an organisation with a memory*[13] set up the National Patient Safety Agency with the intention of establishing *'a system which ensures that lessons from adverse events in one locality are learnt across the NHS as a whole. The system will enable reporting from local to national level'.* This national tool does not deal with how to implement local recommendations arising from individual investigations, at the time they happen. That is a different task.

In their 2002 BMJ paper *The use and impact of inquiries in the NHS*[14] Keiran Walshe and Joan Higgins spoke for many commentators, writing *'Inquiries rely on their credibility and persuasive power to achieve change: they have no formal powers or authority…. The consistency with which inquiries highlight similar causes suggests that their recommendations are either misdirected or not properly implemented. Certainly there are few formal mechanisms for following up the findings and recommendations of inquiries'*[15].

Mental health investigations

In an effort to ensure that recommendations are formulated in a workable way, the National Patient Safety Agency published guidance in February 2008 entitled *Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance*[16]. This emphasises that recommendations should be 'implementable' and that victims, families and carers should receive a copy of the final report and action plan. It does not however say how recommendations should be implemented, neither does it suggest that there should be any independent process to review this, nor that victims, families and carers should be entitled to know whether the recommendations have been implemented.

The *National Confidential Inquiry into Suicide and Homicide*[17] obtains information on the kinds of recommendations made by inquiries and investigations, drawing together themes which have helpfully informed the Mental Health Act 2007 and its Code of Practice. However, this information-gathering has been concerned with the nature of recommendations, not the effectiveness of their implementation.

A Review of 26 mental health homicides in London committed between January 2002 and December 2006: a report for NHS London published in March 2008[18] has examined in detail several different formats for mental health investigations, some identifying themes, but none addressing the post-inquiry process of implementing recommendations.

Serious case reviews

Serious case reviews following child deaths or serious injuries have a very structured format contained in *Working Together to Safeguard Children*[19]. Each review is expected to result in action plans describing the change which should result, with findings and recommendations fed to Local Safeguarding Children Boards which *'should put in place a means of auditing action against recommendations and intended outcomes'.* Under the heading *'Learning lessons locally'* it is said *'Reviews are of little value unless lessons are learnt from them. At least as much effort should be spent on acting on recommendations as on conducting the review'.*

13 *Building a Safer NHS for patients: Implementing an organisation with a memory, Department of Health, 17 April 2002*

14 *Kieran Walshe and Joan Higgins The use and impact of inquiries in the NHS, BMJ 2002; 325; 895–900*

15 *Supra page 899*

16 *Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance, National Patient Safety Agency, February 2008*

17 *Avoidable Deaths: five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, The University of Manchester, December 2006*

18 *Published by Verita and Capsticks*

19 *Every Child Matters: Change for Children: Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote welfare of children, HM Government, TSO, 2006*

However, there is no structured post-review process to check on the implementation of recommendations.

The following three serious case review studies (i) reveal an absence of information on implementation of recommendations, (ii) show how difficult it is to obtain data on this subject, and (iii) indicate how few families are involved in reviews:

- In 2002 Ruth Sinclair and Roger Bullock, authors of *A Study of Serious Case Reviews and the Effects of the 1999 Guidance: A Research report*[20] said '*Without proven methods of achieving service change, the effects of revisions to guidance and investment in the post-qualifying training proposed so frequently by Serious Case Review panels will remain unknown*'.
- Wendy Rose and Julie Barnes in *Improving Safeguarding Practice: study of serious case reviews 2001–2003* [21] reveal that out of 40 case reports examined, only 8 included contributions from the family to the investigation, causing the authors to comment '*At the end of the reports read for this study, there was often an over-riding sense of frustration, of only knowing part of the story…There were few insights into the child or other family members' perspectives*' [22]. There was no suggestion of any accountability to the families for implementation of recommendations.

  In 30 out of 40 serious case review reports, recommendations were '*focussed and specific, and capable of being implemented*' and in 30 cases the accompanying action plan specified '*what action should be taken by whom, and by when*'. However in only 15 cases did reports state '*what outcomes these actions should bring about*' and in only 12 cases did they explain '*how the agencies will review whether the outcomes have been achieved*'.

  It was impossible to know whether outcomes had actually been achieved. Astonishingly, the author was not always named in the report. In addition, there had been a fundamental reorganisation of children's services and social care inspection services and it proved difficult to track down the authors who were named. Some reports were incomplete or missing action plans and the authors make it clear that the 40 reports obtained '*should not, therefore, be viewed as a representative sample*'.
- In a later study, *Analysing Child Deaths and Serious Injury through Abuse and Neglect: what can we learn?: a biennial analysis of serious case reviews 2003–2005*[23], a full sample of 161 reports were used with an intensive sample of 47 reports. Repeating previous findings, in only 9 out of the 47 cases were families involved in serious case reviews. This report, again, did not reflect upon the means by which recommendations could be implemented.

All in all, this reveals that once serious case reviews have been written it is difficult to establish what happens to the recommendations, let alone whether lessons have been learnt. With no independent oversight of implementation, lack of family involvement in most reviews and no suggestion of accountability to the families concerned (even though they may be potential victims of service failure)

20 *A study of serious case reviews and the effects of the 1999 Guidance; A Research Report, Ruth Sinclair and Roger Bullock, 2002, Department of Health, London, at page 52*

21 *Improving safeguarding practice: Study of serious case reviews 2001–2003, Wendy Rose and Julie Barnes, The Open University, Research Report DCSF-RR022, Department for Children, Schools and Families, published March 2008*

22 *No reason is given for non-involvement of families in serious case reviews. It stands in stark contrast to most mental health inquiries and in our opinion needs further investigation.*

23 *Analysing child deaths and serious injury through abuse and neglect: what can we learn?: A biennial analysis of serious case reviews 2003–2005, Marian Brandon, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth and Jane Black, Research Report DCSF-RR023, Department for Children, Schools and Families, published March 2008*

there is no external check on the outcomes[24]. Thus, each new serious case review will never know whether there has been implementation of any preceding review recommendations.

The need to learn lessons from earlier inquiries and the importance of independence and accountability of reviewing panels have again become salient in the recent case of Baby P. We argue that the adoption of the principles we have outlined above might help to prevent such a tragedy in the future.

Domestic homicide reviews

Serious case reviews may provide the model for a different form of deaths investigation. Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004 will, when implemented, place a statutory duty upon local bodies to establish a domestic homicide review when it appears that death of an individual over the age of 16 has resulted from violence, abuse or neglect by a person to whom the individual was related or in an intimate personal relationship or sharing the same household, '*with a view to identifying the lessons to be learnt from the death*[25]'.

Currently, police carry out their own investigations of such incidents by means of local Domestic Violence Murder Panels/Forums.

The position was set out in 2003 by the Metropolitan Police in *Findings from the Multi-agency Domestic Violence Murder Reviews in London*[26] which described the key aim of these 'murder reviews' as '*murder prevention. It is not about creating a blame culture, but rather about identifying how to improve inter-agency working and better safeguards for victims*'. The paper was based on 30 murders and 400 domestic violence cases. The authors refer to thirteen recommendations for health services coming out of one review alone, saying '*There needs to be some form of monitoring mechanism to ensure that this happens and the lessons do not get lost across different Health Trusts*'. They conclude '*Multi-agency Domestic Violence Murder Reviews should be put on a national footing*' with decisions made for taking forward recommendations at '*three levels: the agency, nationally and regarding legislation*' with a '*national warehouse/post-box*' *so that (reviews) are accessible to all*'.

In the same way that mental health homicide investigations and serious case reviews have been analysed to identify local or national themes (see above), the 2003 Metropolitan Police findings and a further 2004 Metropolitan Police analysis of 400 domestic violence cases (including 4 homicides) contained in '*Getting away with it*': *A Strategic Overview of Domestic Violence, Sexual Assault and 'Serious' Incident Analysis*[27] has identified themes, but, once again, these analyses have not concerned themselves with the means by which individual review recommendations should be implemented.

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24 *Evidence suggests this could also be the case internationally. Child Death and Significant case Reviews: International Approaches Nick Axford and Roger Bullock, Dartington Social Research Unit for Insight, Scottish Executive Education Department, June 2005 examined child deaths and significant case reviews in Australia, Belgium, Canada, England, Germany, Ireland, Israel, Jordan, New Zealand, Northern Ireland, Norway, Scotland, South Africa, Switzerland, US and Wales.*

25 *From Executive Summary of Consultation Paper: Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004, Home Office, June 2006*

26 *Findings from the Multi-agency Domestic Violence Murder Reviews in London; prepared for the ACPO Homicide Working Group, by Laura Richards, Consultant Behavioural Analyst, Metropolitan Police and Police Standards Unit and Commander Andre Baker, Head of Homicide Investigation, Metropolitan Police Service, Metropolitan Police, 9 October 2003*

27 *'Getting away with it': A Strategic Overview of Domestic Violence, Sexual Assault and 'Serious' Incident Analysis by Laura Richards, Consultant Behavioural Analyst, Metropolitan Police and Police Standards Unit and Commander Andre Baker, Head of Homicide Investigation, Metropolitan Police Service, Metropolitan Police, 16 March 2004*

Since 2006, planning has been underway for a national framework for domestic homicide reviews. Between June 2006 and September 2006, the Home Office consulted on its paper *Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004*[28] which states that '*The statutory purpose of a review is to learn lessons from the death*'. It is said that in practice this will include '*identifying how those lessons will be acted upon and what is expected to change as a result*'. A local review body is proposed, having a role similar to that of Local Safeguarding Children's Boards for serious case reviews. Guidance on the management and structure of domestic homicide reviews is awaited to coincide with implementation of Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004.

Domestic homicide reviews will occupy a middle ground, having features of child care serious case reviews and mental health homicide investigations. Where there is a history of mental illness, it is envisaged that the need for a domestic homicide review will usually be satisfied by a mental health homicide investigation.

Whatever the shape of the new domestic homicide review guidance, this is an opportunity to bear in mind the difficulties associated with serious case reviews and ensure independent review reports are produced with feedback to victims, families and the perpetrator. That process will be incomplete without a structured, independent post-review process, with appropriate accountability to families, to ensure outcomes can be tracked in order to establish whether or not lessons really have been learnt.

Inquiries, investigations and reviews

The reader might by now have wondered whether there is any difference between a review, an investigation and an inquiry. To the extent that each makes recommendations with a view to improving services, there is no difference between them.

The Inquiries Act 2005 is the framework for statutory inquiries and the explanatory notes to the Act state '*The aim of inquiries is to help restore public confidence in systems or services by investigating the facts and making recommendations to prevent recurrence, not to establish liability or to punish anyone.*'[29] No reference is made to any procedure for the implementation of recommendations.

Non-statutory independent mental health homicide inquiries may have features of statutory inquiries, but are now being renamed investigations, as illustrated by the recently published National Patient Safety Agency guidance, above. Procedure, in the form of taking evidence, is likely to be little changed, but there will be an additional emphasis upon examination of that evidence by means of root cause analysis. However, root cause analysis does not provide guidance as to the implementation of recommendations.

Child care serious case reviews and domestic homicide reviews are investigations by another name though they may not take oral evidence. They make findings and produce recommendations intended to improve practice, but do not review and publish reports on progress with implementation of recommendations.

Whatever their differences, inquiries, investigations and reviews establish by means of evidence what went wrong with services and make recommendations intended to improve those services. All frame their objectives in terms of learning lessons. This commonality of purpose suggests that a systemised approach to implementation of recommendations would be capable of broad application.

28 *Consultation Paper: Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004, Home Office, June 2006*

29 *Explanatory Notes to the Inquiries Act 2005 Chapter 12, TSO, 2005, paragraph 8*

Conclusions

There is a public interest in the learning of lessons from incidents of death or near-death where a duty of care may be owed by public services.

We do not address the many critics and criticism of inquiries here. It is true that hindsight bias can distort perception of risks resulting in recommendations which do not properly arise from the evidence. Some findings and recommendations have been repeated again and again, suggesting inquiries have proved unsuccessful in bringing about change. Cynics suggest it is the investigative process rather than the outcome which is important, satisfying a public need for explanation, apportionment of blame, sensemaking[30] and catharsis,[31] whilst others focus on the destructive potential of inquiries if they are badly managed[32]. As to the risk with which inquiries are concerned, serious violence cannot always be predicted[33], some commentators worry about over-predication of risk[34] and others reveal that risk is generally under-estimated[35]. Mental health homicide numbers seem to remain constant[36] leading to a popular view that inquiries are ineffective and pointless. But 14 per cent have been calculated as preventable[37], the National Confidential Inquiry into Suicide and Homicide saying *'It is time to change the widespread view that individual deaths are inevitable'*[38].

The plain fact is that independent inquiries, investigations and reviews still take place. Much is invested in them, financially, organisationally, and often emotionally. And they always produce recommendations, each crafted in the hope that they will be implemented and lessons learnt. We therefore make the straightforward assumption that the function of recommendations is to be implemented.

For the purpose of this article, we do not comment on the content of recommendations. Guidelines for improvement of inquiry, investigation and review procedure already focus on this. Nor do we question the desirability of gathering data from recommendations in order to identify local and national themes. Our concern is more immediate. It is to ensure the implementation of recommendations – the missing link in the chain between the incident, the investigation and the lessons learnt.

Currently, there are three problems.

- **Lack of basic data:** No-one knows how many recommendations made by countless independent inquiries, investigations and reviews have been implemented in health and social care in England.
- **Lack of standards:** There are no standards on implementation, no expectations and no body of data for the purpose of comparison. When the victim's family asked "How long does it usually take for an inquiry's recommendation to be implemented?" we could not provide an answer because there is none.

30 *Making Sense of Inquiry Sensemaking, Andrew D. Brown, Journal of Management Studies 37: 1 January 2000*

31 *Jill Peay, above, at page 29 and Louis Blom-Cooper at page 59*

32 *Review of Homicides by Patients with Severe Mental Illness, Tony Maden, Professor of Forensic Psychiatry, Imperial College, London, 15 March 2006, at page 66 states 'When reviewing Inquiry reports one is confronted by the unfairness of some comments made with the benefit of hindsight, and the consequent damage to morale in general, as well as to the staff directly involved'.*

33 *Supra page 66.*

34 *Sinclair and Bullock, above, at page 51 comment that the difficulty of predicting vulnerable children who are at risk of violent death or serious injury can result in 'false positive' cases, with provision of services to those who do not need them*

35 *The National Confidential Inquiry, above, states at page 5 'At final service contact, immediate risk was judged to be low or absent in 88% of cases'.*

36 *Supra at page 4 'Our data show no clear evidence for either a rise or a fall in the number of homicides by people with mental illness'.*

37 *Supra page 5. It further states that this 14 per cent 'are the cases most clearly related to service failure'.*

38 *Supra page 6.*

- **Lack of guidance:** There is no guidance on how the NHS, children's services or multi-agency domestic violence services will ensure recommendations are implemented. There is no model of good practice for this, nor have any factors been identified which might assist or impede progress.

We offer a starting point. Our suggested approach – based on principles and types of recommendation – is unique in that it is capable of application across child deaths, mental health homicides, domestic homicide reviews and where investigations following near-fatal injury and suicide raise public interest concerns.

Nearest Relative Consultation and the Avoidant Approved Mental Health Professional

Laura Davidson[1]

This article examines three recent cases involving *habeas corpus ad subjiciendum* applications arising out of alleged failures to comply with the provisions relating to nearest relatives within the Mental Health Act 1983 ('MHA'). One of these cases assists with the establishment of the identity of a nearest relative, and the two others consider the requirements of the consultation process to be carried out by an Approved Mental Health Professional ('AMHP') (formerly Approved Social Worker 'ASW'). The important implications of these decisions for patients, nearest relatives and hospitals are discussed in detail.

A patient's nearest relative (as defined under section 26 of the MHA) performs crucial functions which are intended to help safeguard a patient's rights. An AMHP has a duty to consult a person's nearest relative prior to recommending their detention for treatment under section 3 of the MHA (unless such consultation is not reasonably practicable or would involve unreasonable delay)[2]. If the nearest relative objects, the detention cannot take place unless the nearest relative is first displaced under the provisions of section 29 of the Act.

The first step, therefore, is the identification of the person's nearest relative prior to an application for admission under section 3. A list of various possible nearest relatives is to be found in section 26(1) of the MHA, with whole blood relatives and the elder or eldest of relatives of the same description being preferred (section 26(3)). To qualify as the nearest relative, the person must be over eighteen years of age (if not the patient's husband, wife, father or mother) (section 29(5)(b)) and if the patient is so resident, "ordinarily resident in the United Kingdom, the Channel Islands or the Isle of Man" (section 29(5)). Section 26(4) states that "where the patient ordinarily resides with or is cared for by one or more of his relatives", that relative (or the oldest carer relative) will be the person's nearest relative.[3] A husband or wife "permanently separated from the patient, either by agreement or under an order of a court", or who "has deserted or been deserted by the patient for a period which has not come to an end" will not qualify (section 26(5)(b)). For the purposes of this article, section 26(6) is of particular significance:

1 *Barrister, No 5 Chambers, London.*

2 *Section 11(4)(b) MHA (as amended).*

3 *Where the person is an in-patient in a hospital, this means the relative with whom he last resided or by whom he was cared for prior to his admission (s.29(4)).*

> *"…"husband", "wife" and "civil partner" include a person who is living with the patient as the patient's husband or wife or as if they were civil partners, as the case may be (or, if the patient is for the time being an in-patient in a hospital, was so living until the patient was admitted), and* ***has been or had been so living for a period of not less than six months****; but a person shall not be treated by virtue of this subsection as the nearest relative of a married patient or a patient in a civil partnership unless the husband or wife or civil partner of the patient is disregarded by virtue of paragraph (b) of subsection (5) above."*[4]

By way of section 11(4) of the MHA, a nearest relative may prevent a detention from taking place. There is no need for the objection to be reasonable, but it must be *conveyed* to an AMHP. A detention which proceeds despite a nearest relative's objection and without that nearest relative being first displaced under the provisions of section 29 of the MHA will be unlawful, and if brought, *habeas corpus* proceedings will succeed. This procedure has been incorporated into the Act for several reasons. The assumption within the relevant blocking provision is that a nearest relative is likely to know the patient well and to have an informed view as to whether or not their mental health has deteriorated sufficiently to warrant a hospital admission. For that reason, a nearest relative may object to such admission, even though experienced mental health professionals think otherwise. This power to say 'no' clearly is intended to reflect the importance of the right to liberty and the need for caution when subjecting someone to compulsory detention in order to avoid arbitrary denial of liberty.

R v The Hospital Managers of the Park Royal Hospital, ex parte Robinson, Queen's Bench Division (Administrative Court), 26th November 2007

There is no requirement for an AMHP to make enquiries as to the identity of a nearest relative, unless not to do so would have been unreasonable in the sense that no competent and careful social worker would have failed to have made them (see *Re D: Mental Patient (Habeas Corpus)* Lawtel 4/12/99, subsequently upheld in the Court of Appeal ((2000) 2 FLR 848)). In *Re D* (at 16) it was held that "the court cannot and should not inquire into the reasonableness of…[the ASW's] decision, only into the honesty of his assertion that it appeared that [the person consulted]…was the nearest relative". This was in part what the court was concerned with in *R v The Hospital Managers of the Park Royal Hospital, ex parte Robinson*, (26th November 2007). The facts of the case were complex, but the background was key to the court's final decision. The essence of the challenge was that the Claimant's nearest relative was his common law partner, rather than his aunt who had been his nearest relative by way of section 26(1)(g) prior to the couple's cohabitation of the requisite six month period. The case is important for a number of reasons, not least the comments of Bennett J (albeit strictly *obiter*) in relation to the calculation of the six month cohabitation period necessary for section 26(6) of the MHA to apply.

The Claimant R brought judicial review and *habeas corpus* proceedings in respect of his detention under section 3 of the MHA. He had a lengthy psychiatric inpatient history, both as a formal and an informal patient. In early January 2007 he rekindled a relationship with M, moving most of his belongings into her home in mid-January. R was then imprisoned for breach of a harassment order against his ex-wife in mid-February for a period of approximately two months. On his release from prison, he moved the last of his belongings into M's flat and the couple became engaged. In July 2007, R was detained in hospital under section during a brief period of relapse. Irrespective of these periods apart, the Claimant's case was that by mid-June, M had become his nearest relative under section 26(6) by way of six month cohabitation.

Unfortunately, R's relationship with M's family was stormy. On 22nd September 2007 R had an argument

4 *Emphasis added.*

with M's mother who was staying with the couple at the time, which resulted in the police being called. R agreed to move out temporarily, and he then spent six days sleeping either in his car or in friends' accommodation. On 28th September 2007, R presented himself to the Accident and Emergency department at his local hospital hoping to be admitted in order to obtain a roof over his head. He was found not to be exhibiting any symptoms of mental disorder and admission was refused. Later the same day however, the Defendant hospital admitted R under section 3 of the MHA, his aunt having been consulted as nearest relative, and having raised no objection to the admission.

Once admitted to hospital, R telephoned his partner, M, who immediately cut short a visit to the north of England in order to see him in hospital. During the course of the admission it was abundantly clear that the relationship was ongoing. On 2nd October 2007, M, considering herself to be R's nearest relative on the basis of cohabitation in excess of six months in accordance with section 26(6) of the MHA, made a written request for his discharge from hospital[5]. The discharge was not barred by R's Responsible Medical Officer ('RMO')[6]. R remained detained, however, and a letter to M informed her that she was not the nearest relative. The Defendant argued that M could not be his nearest relative for three reasons: firstly, he had been engaged to someone else the previous year; secondly, the Defendant's records indicated that his aunt was his nearest relative; and finally, when the ASW had assessed him, he had been of no fixed abode. The Claimant argued that the first two reasons had become irrelevant, and the latter was untrue, or alternatively, had been only a temporary state of affairs due to a short-lived argument.

On 12th November 2007, R made urgent judicial review and *habeas corpus* applications against the detaining authority. He also claimed damages, alleging that in refusing to release him, the hospital had violated his rights under Article 5(1) and Article 8 of the European Convention on Human Rights. He contended that as his nearest relative, M was entitled to order his discharge. It was submitted that since his RMO had not provided a barring report, his continued detention was unlawful.

The Defendant's case was that M was not R's nearest relative, either because the relationship had ended, or because various periods of enforced detention had interrupted the requisite six month period. On behalf of R it was submitted that in calculating that period it would be unfair, impractical, and contrary to Parliament's intention to take into account any periods of compulsory detention in prison or hospital; and further, that it would be unfeasible to expect an ASW or a hospital to have to make such calculations for every patient admitted under section.

Whilst it was the Claimant's view that the *habeas corpus* application could be decided on the papers, Mr. Justice Bennett agreed to the Defendant's application for an urgent *Wilkinson*-style[7] hearing with oral evidence taken three days later. At that substantive hearing, both R (on leave from hospital) and M gave evidence, in addition to the recommending ASW and R's social worker. R had made it clear to the ASW at the time of admission that due to the argument with his partner he was concerned that their relationship might be over. It was common ground, therefore, that the initial detention had not been unlawful since the ASW had been entitled to consult R's aunt as nearest relative; all that was required by section 11(3) was a reasonable belief on the part of the ASW that the appropriate person was being consulted. It was noteworthy, however, that even though their relationship was strained at the time, M said that if she had been consulted as nearest relative at the time of R's admission, she would have objected to it.

Mr. Justice Stanley Burnton, however, dismissed the Claimant's applications, finding that at the time of

5 *S.23(2)(a).*

6 *S.25(1). Since 3/11/08 the 'RMO' has been succeeded for most MHA purposes by the term 'Responsible Clinician' (s.34(1)).*

7 *R(on the application of Wilkinson) v Broadmoor Hospital [2001]EWCA Civ 1545.*

his admission to hospital on 28th September 2007, R had not considered his relationship with M to be ongoing. The fact that the relationship had in fact survived and was continuing was irrelevant. In the learned Judge's view, the relationship was not as settled and permanent as the statute envisaged. He found that M was not R's nearest relative, as the 'clock' measuring the requisite six month period under section 26(6) of the MHA had stopped when R was asked to leave the couple's flat in September 2007. Thus, at the time of his admission he was not living with M as if she was his wife.

The Judge also made comments which were strictly *obiter*, but which may have serious ramifications for the cohabitees of those with mental health difficulties in the future. He found that even if the relationship had not been interrupted in September 2007, R and M would not have cohabited for the requisite six month period. This was because in calculating that period for the purposes of section 26(6) of the MHA, a hospital should take into account periods apart, including, for example, any time spent abroad, and/or detention in hospital or prison (notwithstanding that such absences are under compulsion). The submissions made on behalf of the Claimant – that it would be impractical for a hospital to have to make such calculations, particularly in a situation where there was time pressure – were rejected by the court. The Judge found that such periods of detention would be recorded and easily ascertainable. Although the learned Judge acknowledged that it might be difficult to identify when a period of cohabitation began, a hospital was obliged to try, as it had a duty to investigate whether a six month cohabitation period had altered the identity of a patient's nearest relative.

According to Stanley Burnton J, whether or not a period apart would bring a cohabitation period to an end for the purposes of section 26(6) would depend on the nature and duration of the relationship when the interruption took place. Whilst not making a specific finding about when the cohabitation had begun, the Judge observed that R and M had been together for a relatively short period of time, and that R had kept some of his clothes at his previous accommodation until he left prison. The period of detention in prison would have interrupted the cohabitation. Whilst it could be argued that, but for the periods of compulsory detention, a couple would have continued to cohabit (and so to use enforced separation to reduce the requisite six month period would be unfair), the Judge found that to be a matter of speculation. Indeed, in this case the court found the cohabitation to have ceased in September 2007 due to an argument, and it was by no means certain that had R not been detained at various points during the year, the relationship would have been maintained.

In retrospect, it was clear that the cohabitation of R and M had not 'ceased' in September 2007, but rather a quarrel had caused a short-term separation. The temporary nature of that separation became abundantly clear only ten days after the couple's argument, when M returned immediately from her trip to the north of England to support her partner, and sought his discharge. However, it is quite right that an AMHP must judge the identity of the nearest relative according to the facts as they appear at the time, and it was open to the ASW in the case of R to conclude that his aunt was the appropriate consultee. The author submits that just as a husband and wife must be "*permanently* separated" for one to cease to be the other's nearest relative (section 26(5)(b)), any separation between a cohabiting couple must also be permanent for there to be a break in the chain of cohabitation. After all, the Judge set much store by the fact that Parliament must have intended a degree of permanency in a relationship to set the requisite period of cohabitation at six months, and yet he did not also consider that there must be a corresponding permanency of separation. The true position was ascertained shortly after admission; in fact the relationship had suffered no more than brief breakdown – a common feature of many relationships including marital ones. It was then that the detaining authority became aware of the identity of the correct nearest relative and, arguably, it should have acted on M's application for R's discharge.

It is clear from section 26(6) of the MHA that where cohabitation has not yet reached the six month stage prior to a hospital admission, the requisite period cannot be added to whilst the patient is in hospital: "or, if the patient is for the time being an in-patient in a hospital, *was so living* [as a spouse] *until the patient was admitted*, and has been or had been so living for a period of not less than six months..."[8] Presumably, however, where the cohabitation resumes on discharge, the six months period does not begin afresh.

In the event, R did not wish to appeal the decision, which is unfortunate because its consequences are potentially very serious for future patients. It is common for those afflicted with mental health problems to have a transient lifestyle, with difficulties in holding down permanent occupation, and often forensic histories. Those with mental health difficulties are more likely to develop friendships and relationships with other service-users, who may also have periodic admissions. Relapsing patients may well quarrel with those who come into contact with them. The 'revolving door' pattern of admission for those who suffer from mental disorder also means that any such six month period of cohabitation may be interrupted by further admissions. Yet, *ex parte Robinson* suggests that even short or informal admissions are to be taken into account. Whilst cohabitation is on the increase, relationships not cemented by marriage will provide less protection for such patients than their married counterparts. That said, now that the provisions for compulsory treatment orders are in force[9] the frequency of many patients' admissions to hospital is liable to reduce.

Furthermore, it is difficult to see how a busy AMHP is to calculate a period of cohabitation. The date upon which cohabitation begins may be uncertain, with information presumably coming from a patient. Again, information about periods of imprisonment or hospitalisation is likely to come primarily from a patient – the same patient who is considered to be sufficiently mentally disordered for admission. Contrary to the view of Stanley Burnton J, it is unlikely to be possible to make the appropriate enquiries of the prison service and/or hospitals within the necessary timeframe, particularly where there is thought to be a degree of urgency. In consequence, where cohabitation is less than for the period of a year or so, and an AMHP is aware that the patient being assessed has had other admissions to hospital (or prison) during the course of the same year, the consultation of a cohabitee is unlikely to occur; an AMHP will be liable to consult the person who would be the patient's nearest relative but for section 26(6). The temptation to ignore the cohabitee may be difficult to resist because an objection from them is, perhaps, more likely, given that they may feel more able to provide support to the person with whom they reside than another relative.

BB v Cygnet Health Care and London Borough of Lewisham [2008] EWHC 1259 (Admin)

In *BB v Cygnet Health Care and London Borough of Lewisham*, 4th March 2008, there was, in the end, no dispute about the identity of the correct nearest relative. Instead, the dispute centred upon whether there had been either an effective consultation of the nearest relative, or indeed any consultation at all. Although in the end the case turned upon the credibility of the witnesses, several findings may be of future application. The facts were these.

The Claimant BB had a diagnosis of paranoid schizophrenia and an extensive forensic history. He was detained in hospital between July and December 2007, but in receipt of extensive leave. Following discharge, he was detained again in hospital on 6th January 2008 and subsequently transferred to the

8 *Emphasis added.*

9 *Ss17A – G MHA*

private hospital run by the Defendant. Apparently due to the realisation that his detention up until then was unlawful, the Defendant hospital detained him under section 5(2) of the MHA (the doctor's holding power). An ASW employed by the local authority (the Interested Party) sought to assess the Claimant for admission under section 3. As required by section 11(4) of the MHA, the ASW contacted the Claimant's nearest relative, who at that time was his father. His nearest relative could neither speak nor understand English, and he mentioned a name which the ASW ascertained belonged to the Claimant's sister. Consequently the ASW contacted the sister (HB) by telephone. No attempt was made by the ASW himself to contact the Claimant's nearest relative again. The Claimant was subsequently detained under section 3 of the MHA. He applied to the court for a writ of *habeas corpus* on the basis that the requisite consultation of his nearest relative had not taken place and his detention at the hospital was consequently unlawful.

At an initial hearing on 11th February 2008 before Mr. Justice Forbes ([2008] EWHC 954 (Admin)), the Defendant hospital requested an adjournment in order (amongst other things) to obtain its telephone records because there was a dispute about the length of the telephone conversation between the ASW and HB. However, Forbes J. agreed to hear submissions on a preliminary issue, which (had he found for the Claimant) might have been the end of the matter. The Defendant's evidence on paper was that HB did not object to the admission either herself, or on behalf of her family or her father (the patient's nearest relative), despite the family being 'unhappy' about another admission. The ASW's evidence was that HB's only complaint had concerned the distance of the hospital in question from the family home. He claimed to have told her that she should inform her father as to what was proposed, and telephone him back if he objected. He also indicated that HB had told him to 'go ahead' with his assessment and use his professional judgement in respect of the admission (a suggestion strongly contested by HB). This was relevant not to whether the section 11 requirements had been fulfilled, but to the ASW's credibility. It was the Defendant's case that the ASW had then said that he would delay the assessment for 40 minutes to an hour to give HB the opportunity to consult her father and get back to him if need be. It was accepted that HB then telephoned her brother, and that the ASW visited him in hospital while that telephone call was taking place, but he had not asked to speak to HB.

It was submitted on behalf of the Claimant that it must have been obvious that HB and the rest of her family objected to an admission. The failure to use the word 'object' was irrelevant; this must flow from *Re GM (Patient: Consultation)* [2000] MHLR 41[10] (reaffirmed more recently in *R v East London NHS Foundation Trust and the London Borough of Hackney ex parte* M, QBD (Admin) 11th February 2009) which held that it was not necessary for an ASW to ask a nearest relative the specific question as to whether there was an objection to the application being made. As a nearest relative is likely to express an objection in layman's terms, it is difficult to see how unhappiness about the proposed course could be interpreted in any other way. This was accepted in *R v The Hospital Managers of the Edgware Community Hospital and Another, ex parte GD*, 27th June 2008 (a decision heard subsequently and discussed below), where it was acknowledged that "objection was something that might be gleaned from the totality of what was said, including the way in which it was said". Having been put on notice of an objection or a likely objection by the nearest relative, the ASW either avoided undertaking the consultation or made insufficient efforts to do so.[11]

10 *See para. 1–123, p.84 of Mental Health Act Manual by Richard Jones (Sweet and Maxwell, 11th ed.).*

11 *This was the situation in R v The Hospital Managers of the Edgware Community Hospital and Another, ex parte GD, 27th June 2008.*

Whilst the case law confirmed that consultation via a third party could be lawful (see *R v Managers of South Western Hospital, ex parte* M [1993] QB 683; [1994] 1 All ER 161), it was pointed out to the Judge that this was confined to circumstances where a *professional* was acting as the consulting person. It was further submitted that effective consultation – "the communication of a genuine invitation to give advice and a genuine consideration of that advice" (see *R v Secretary of State for Social Services, ex parte Association of Metropolitan Authorities* [1986] 1 All ER 164 at 167 (approved in *Re Briscoe* [1998] COD 402)) – could not take place via delegation to a third party if the ASW did not know whether that consultation had taken place or not, or indeed what the result of the consultation had been. Without telephoning HB back (or indeed on the facts asking BB if he could speak to her when she was on the telephone to him), the ASW did not know whether she had relayed the information to her father, or whether he objected to his son's admission. To fail to make these checks meant that effective consultation could not have taken place.

Furthermore, whilst it was the Claimant's case that HB did *not* tell the ASW that the decision as to the 'sectioning' of her brother should be left to the professionals, it was in any event irrelevant in relation to whether there had been a consultation with the Claimant's *nearest relative* (who was not at that time HB). It was the ASW's duty under section 11(4) to consult the nearest relative, and it was submitted that even had he asked HB to contact her father as alleged, this would not have sufficed. Even on the ASW's version of events, no attempt was made to contact HB a second time prior to sectioning the Claimant in order to ascertain whether or not her father had objected. The ASW knew not whether she had managed to contact her father or to reiterate their conversation. He knew not whether her father objected. Having failed to check the views of the nearest relative, they could not have been given "genuine consideration".

However, Mr. Justice Forbes held that the Defendant's evidence taken at its highest (*i.e.*, if true), *could* amount to the requisite consultation of the nearest relative under the Act. Consequently the matter was adjourned for a week for a full *Wilkinson*-style oral hearing, by which time the telephone evidence would be available. An order of disclosure with respect to HB's mobile telephone records was also made which showed that the relevant telephone call had lasted some forty minutes. At the reconvened hearing, the court heard oral evidence from HB, a nurse at the hospital and the ASW. As expected, HB's version of events was quite different from that of the ASW. She emphasised her dissatisfaction with the Slough Community Mental Health Team, in particular for failing to provide her brother with the aftercare to which he was entitled, and about which she had previously written several letters of complaint. Her evidence was that she had stated in no uncertain terms that it would be unacceptable to her family were the Claimant to be sectioned again. When the ASW had telephoned her she had protested at length, not only about the unit (which she felt was unsuitable), but also about the need for her brother to be sectioned.

Mr. Justice King allowed the Claimant's application and a writ of *habeas corpus* was granted, with his release ordered forthwith. The court found that whilst the law permitted the consultation of a nearest relative to take place through an intermediary (*R v Managers of South Western Hospital, ex parte* M [1993] QB 683 applied) and the consultation required by section 11(4) of the MHA could be satisfied by such means, the burden to show that proper consultation had taken place must fall upon the relevant ASW. On the evidence, the ASW had failed to discharge that burden. Whilst both witnesses had been wrong in their respective recollections as to the length of the telephone call, the Judge considered that the ASW's evidence as to the *content* of the telephone call was unreliable. Contrary to paragraph 11.13 of the Code of Practice to the MHA, the ASW had failed to complete an outline report at the hospital – something that gave the court little confidence about his overall ability properly to discharge his statutory

responsibilities. It was "highly unlikely" that HB had ever said she would rely upon his professional judgement as alleged, given the history of the case and HB's opinion about the past treatment of her brother by the mental health services. Further, the nurse gave evidence that following his telephone call to HB, the ASW had told her that he would try to make further contact with the nearest relative later. This was inconsistent with his evidence that the requisite contact had already been made, albeit through the intermediary of the Claimant's sister.

If what the ASW had said about relaying information to the nearest relative had been true, King J. considered that on discovering that HB was on the telephone to her brother when he visited BB to assess him, it would have been "incredible" not to have made an effort to talk to HB to ascertain whether she had spoken to her father and whether or not he objected. The ASW's reliability having been called into question, the Judge doubted that he had told HB to communicate the content of the conversation to her father, or indeed that he had requested that she call him back if the nearest relative objected to his son's detention.

By contrast, HB had sought legal advice and telephoned the ward to enquire whether or not her brother had been sectioned, and who had been noted as his nearest relative. She made it clear to the nurse on the telephone that neither she nor her father had consented to the detention. It was also significant that the letter before action in the matter was sent the very next day. Such behaviour was consistent with HB's insistence under cross-examination that she had repeatedly asserted to the ASW in no uncertain terms that her family did not wish the Claimant to be sectioned. Knowing that the Claimant had been in receipt of extensive section 17 leave since July 2007 and that a CPA meeting had already taken place, Mr. Justice King was satisfied that there were no public policy reasons to stay the writ (see *Re Briscoe* [1998] COD 402), which was granted. The Claimant was discharged from hospital with immediate effect.

Although *BB* was to a certain degree confined to its own facts, it is significant in the mental health law field for several reasons. Firstly, local authorities should be aware that if an AMHP either fails to complete the requisite paperwork or completes it inadequately, this might have an adverse impact upon his or her credibility where there is a dispute on the facts. Secondly, where an AMHP chooses to delegate to a third party the important task of consultation of the nearest relative, it must be borne in mind that the responsibility for consultation remains with him or her. The AMHP must ensure that the consultation did in fact occur, and that it was effective – and he or she must ascertain its result.

GD v The Managers of the Dennis Scott Unit at Edgware Community Hospital and The London Borough of Barnet, Queen's Bench Division (Administrative Court) 27th June 2008

A third case involving a nearest relative consultation recently before the courts was that of *GD v The Managers of the Dennis Scott Unit at Edgware Community Hospital and The London Borough of Barnet*, 27th June 2008. The Claimant GD suffered from schizophrenia. He was 29 years old and highly intelligent. He had been admitted to hospital frequently since the age of 15. In February 2008, GD began screaming at neighbours because he believed (wrongly) that they were making a noise. By way of section 26(1)(b), GD's father was his nearest relative. He strongly believed his son's illness should be treated with natural remedies. The Claimant's mother became concerned that her son's mental health was deteriorating. A team meeting was held on 12th June 2008, and his Community Psychiatric Nurse visited the house the next day, but GD would not let her in. A warrant under section 135 of the MHA was then obtained, although it was not executed by the police because, at his mother's behest, GD cooperated with the assessment at the family home. His admission to hospital resulted. Subsequently he challenged the

lawfulness of his detention in Edgware Community Hospital by way of *habeas corpus* proceedings on the basis that the ASW had failed to consult his nearest relative, who objected to his admission. The ASW's oral evidence was that no objection had been made at the time of the assessment by the nearest relative, and further, that any such objection (if made) was made too late.

At the time of the Claimant's assessment, his father and nearest relative was renovating a cottage in Wales. The ASW admitted that no attempt had been made to contact him prior to the assessment because he was concerned that should his father be alerted to the possible admission of his son to hospital, the Claimant might be removed from the home and taken elsewhere (as in the past).[12] Having obtained the nearest relative's telephone number from GD's mother on 14th June, the ASW left a message telling him that his son was being assessed under the MHA and that he would telephone again. He also telephoned a cottage nearby to ask the residents to try to contact the Claimant's father.

Despite poor reception at the remote location in Wales, GD's father picked up the ASW's message on his mobile telephone on 14th June 2008 and called the hospital only twenty minutes after it had been left. By that stage, the paperwork for the section 3 admission had already been completed. GD's father spoke to the ASW and strongly expressed his anger. His evidence was that he objected to his son's admission in no uncertain terms, calling the plan to admit his son to hospital "violent and evil and generally dreadful", although in oral evidence he was unable to recollect his precise words. The reception was poor, and the ASW was speaking from the kitchen in his family home which was noisy, but he acknowledged that the Claimant's father had been extremely negative about the plan to admit his son, that he had used the words, "how dare you?", and that it had been more of a monologue than a conversation. Although the ASW "accepted that the question of objection was something that might be gleaned from the totality of what was said, including the way in which it was said", he insisted that whilst the Claimant's father had been angry and upset, he had not heard an objection to the admission expressed. The Judge accepted the truthfulness of that assertion. However, somewhat contrary to the ASW's oral evidence, he had ticked a box on the statutory form 9 stating that it was not reasonably practicable to consult the Claimant's nearest relative or would involve unreasonable delay. In the ASW's written summary he completed a section entitled, "Consultation with Nearest Relative and Process for Finding Nearest Relative", where he recorded that an hour after their telephone call, the Claimant's father had telephoned again to object to the admission, but GD had already been admitted and his father was told of his right to discharge him.

The Defendant submitted that even if there had been an objection, it would have come too late as the requisite forms had already been completed. It had not been reasonably practicable to make contact with the Claimant's nearest relative until the morning of the assessment, and the consultation was not possible prior to the application being made. However, the Judge held (*obiter*) that the language of section 6 and the statutory forms made it plain that an application was not 'made' until handed in and Form 14 was signed. As Otton LJ held in *Re D (Mental Patient: Habeas Corpus)* [2000] 2 FLR 848 (at para.15), section 11 "has to be construed strictly. It involves the liberty or loss of liberty of a person".

The Defendant also submitted that where there is a subjective test (as in section 11(4) which requires consultation with whoever "*appears*" to the ASW to be the nearest relative), the court should not interfere absent dishonesty; *i.e.*, where the decision-maker was "plainly wrong" (*Re D: Mental Patient (Habeas Corpus)* Lawtel 4/12/99). The Judge accepted that "the court will inevitably be sensitive to the difficulties faced by those who have to make difficult decisions, sometimes in fast-moving and tense

12 *The Claimant's father sought his discharge under s.23 which was blocked by a barring report. At the time of writing, the local authority was taking steps to displace the Claimant's father as nearest relative under s.29 of the MHA.*

circumstances". However, he held that the Defendant's submission that the court should not interfere absent dishonesty was too narrow an approach, as a failure to comply with the statute was reviewable on normal public law grounds. A decision would be flawed not only where there was bad faith or dishonesty, but also if there had been a misuse of power or an application of the wrong legal test (*R v South London & Maudsley NHS Trust, ex parte WC* [2001] EWHC Admin 1025, [2001] 1 MHLR 187 applied).

The Claimant contended that there had been no proper attempt to engage in consultation at all, but rather an avoidance of it. The ASW had admitted that he had delayed attempts to contact GD's father, by which time he could have had no effective input. Further, there had been no reason for the assessment to take place immediately at the family home, given that the section 135 warrant obtained could have been executed and the Claimant removed to the hospital as a place of safety, providing ample time for consultation. Instead, the ASW and the professionals liaised with the Claimant's mother – no doubt because she supported the admission – apparently as a means of avoiding the requirements of the statute.

Whilst Mr. Justice Burnett found that those involved in GD's care were motivated only by GD's best interests, he found the Claimant to have been unlawfully detained. The Judge held,

> *"The duty to consult is one which exists to enable there to be a dialogue about the action proposed in respect of a mentally ill individual. The person consulted is entitled to have his views taken into account and, importantly, the consultation process should enable the nearest relative to object to the proposed course if he wishes. The consultation must be a real exercise and not a token one. If an objection is raised, it does not have to be a reasonable one. It does not have to be one which judged objectively is sensible."*

The Judge considered that the chances of involving GD's nearest relative in the process from the beginning had been intentionally limited because the professionals involved feared that the admission would be blocked. "[O]rdinarily there is no need to search uphill and down dale" for the nearest relative, but "in seeking to protect the best interests of GD they calculated that they should do no more than nod in the direction of consultation as contemplated by section 11(4). They set in motion a course of events which was designed to leave consultation with GD's father to the very last moment, and thus seriously inhibit the chances of his having any effective input into the process and the chances of his having an opportunity to make an objection."[13] Thus, what had occurred "could not properly be considered consultation at all". In essence, whilst not stated in terms, Mr. Justice Burnett found that any difficulties involved in contacting the nearest relative had been caused by the ASW himself because he had left the consultation to the eleventh hour, and so he could not hide behind the terms of section 11(4) by suggesting that consultation was "not reasonably practicable" or would have involved "unreasonable delay".

It is clear that the nearest relative's "significant role in the protection of the patient or otherwise acting in his or her interests" is "not lightly to be removed by invoking impracticability" (observations in *R v Bristol City Council, ex parte E* [2005] EWHC 74 (Admin) at para. 29, *per* Bennett J. (relying on *R v Secretary of State for Health, ex parte M* (2003) EWHC 1094)). It is worth commenting that in *BB v Cygnet Health Care and London Borough of Lewisham,* one possible defence might have been that it had not been reasonably practicable to consult BB's father about his son's admission, given that he did not speak English. On previous occasions a telephone translator had been arranged, which the court might have

13 *Arguably, the consultation that, on the written evidence, took place in BB v Cygnet Health Care and London Borough of Lewisham [2008] EWHC 1259 (Admin), 4th March 2008, was also merely a "nod in the direction of consultation", but Mr. Justice Forbes found it to be sufficient.*

accepted would have involved unreasonable delay[14] or would have been impractical at the time. Admittedly, when the ASW telephoned HB, his detention under section 5(2) still had 24 hours to run, which would have made such an argument more difficult.

Returning to *ex parte GD,* the deliberate failure to consult at a stage that would have permitted effective consultation had amounted to a misuse of power which "infected the application process from beginning to end". Accordingly, the application was allowed, and an order for the Claimant's immediate release was made by way of a writ of *habeas corpus*.

Conclusion

It is clear that the nearest relative continues to have a very important role, despite the somewhat arbitrary way in which a person may find themselves holding the position in law. It is likely that following the amendments made to section 29 MHA by the *Mental Health Act 2007*, which have (a) empowered the patient to seek displacement of the nearest relative[15] and (b) added the new ground of 'unsuitability'[16], some patients may acquire nearest relatives more in tune with their own thinking. Consequently AMHPs may find an increase in the raising of objections to detention under section 3. However, in view of *ex parte BB* and *ex parte GD,* AMHPs will have to make real attempts to consult such nearest relatives no matter how obstructive they may be considered. The author expects an increase in the number of applications to displace the nearest relative.

14 *However, see the observation of Richard Jones in his Mental Health Act Manual (11th ed.) on p.86 that "it is unlikely that this situation would often obtain".*

15 *s.29(2)(2a).*

16 *s.29(3)(e)*

Casenotes

The First Flight of the Fledgling: the Upper Tribunal's Substantive Debut

Kris Gledhill[1]

Dorset Healthcare NHS Foundation Trust v MH
[2009] UKUT 4 (AAC)

The Upper Tribunal's Administrative Appeals Chamber is the court from which most mental health law in England and Wales, and also the other parts of the UK, will come. Its first substantive decision on a mental health matter was handed down on 8 January 2009, and contains useful guidance on an important matter, namely the process for the disclosure of a patient's medical records when the detaining hospital does not wish to release the entirety of the records; and it also touches on various other aspects of the new appeal process and the procedural code applicable as from 3 November 2008. For these reasons, a comment on the decision is worthwhile, both to outline the new regime and because the decision involves several matters of interest[2].

The decision indicates that the parties were – no doubt understandably – unfamiliar with the new procedural regime for proceedings in front of the First-tier Tribunal's Health Education and Social Care Chamber, as contained in the *Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008*[3] ("TPR"). In addition to allowing the Upper Tribunal to offer important guidance, the decision hints at other interesting points that suggest that, despite the lengthy process by which the mental health legislation was amended and the new tribunal structure put in place, there will be significant litigation to bed down the new legal structure.

The new Tribunal Structures

MH, a patient detained under s3 of the *Mental Health Act 1983* ("MHA 1983") (detention for treatment), had applied to be released: the application will no doubt have been made to the Mental Health Review Tribunal under the provisions of the *Mental Health Tribunal Rules 1983*[4]. However, the hearing was due to occur on 12 November 2008, and so the process to be followed after 3 November 2008 fell under the jurisdiction of the new structure for Tribunals, including fresh appellate arrangements and the new procedural rules.

The MHA 1983 provided in s65 and Schedule 2 for Mental Health Review Tribunals for Wales and for

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2 *In due course, arrangements will no doubt be put in place for all Upper Tribunal decisions to be placed onto the Tribunal Service website in a manner that makes them easy to find; at the time of writing, the most easy to follow database is via the British and Irish Legal Information Institute, see www.bailii.org/uk/cases/UKUT/AAC/ where the case can be found by browsing to January 2009 (last accessed 27 January 2009).*

3 *SI 2008/2699*

4 *SI 1983/942, as amended on various occasions*

different regions in England: by the time the *Mental Health Act 2007* ("MHA 2007") was enacted, there were two regions in England, North and South. Section 38 of the MHA 2007 provided that there would be only one MHRT for England. The MHA 2007 was the end product of a lengthy process of reform of mental health law: there was an expert committee which reported in November 1999, a Green Paper in November 1999, a White Paper in December 2000, a Draft Bill in 2002 and a further Draft Bill of 2004, both of which proposed a replacement Mental Health Act, and finally a Bill introduced in 2006 to modify the 1983 Act but in a number of significant respects, which became the *Mental Health Act 2007*. The Draft Bill of 2002[5] proposed a new Tribunal structure: there was to be a Mental Health Tribunal (cl 3), the main function of which would be its responsibility for making orders for detention for treatment (cl 33ff) rather than reviewing administratively made orders, and also a Mental Health Appeal Tribunal (cl 4), to which there would be an appeal on any point of law arising from a determination by the Tribunal (cl 160ff). The Draft Bill of 2004[6] also proposed this new structure (cls 4 and 8), with similar powers (cls 38ff and cls 249ff). As noted above, the MHA 2007 made only a minor amendment, namely providing that there was only one Mental Health Review Tribunal in England rather than separate regional bodies.

However, also enacted in 2007 was the *Tribunals, Courts and Enforcement Act 2007* ("TCEA"), s3 of which provides for a First-tier Tribunal and an appellate Upper Tribunal; s7 of the Act allows for Chambers of the First-tier and Upper Tribunals. One of the Chambers of the First-tier Tribunal is the Health, Education and Social Care Chamber[7]: this has taken over the functions of the Mental Health Review Tribunal in England by way of the *Transfer of Tribunal Functions Order 2008*[8] as of 3 November 2008. In Wales, the Mental Health Review Tribunal for Wales continues to sit via s65 MHA 1983 and Schedule 2 to the Act[9]. Various parts of the 1983 Act has been amended by Art 9 of and Schedule 3 to the 2008 Order:

(i) references in the MHA 1983 to the Mental Health Review Tribunal have become references to the "tribunal" or the "appropriate tribunal";

(ii) the Order adds s66(4) MHA 1983, which provides that "(4) In this Act "the appropriate tribunal" means the First-tier Tribunal or the Mental Health Review Tribunal for Wales";

(iii) s77(3) and (4) are amended to indicate the tribunal to which the patient must apply (for those liable to be detained, this depends on the location of the hospital, for those on a community treatment order, it turns on the location of the responsible hospital, and for those subject to guardianship or for conditionally discharged patients it turns on where they reside.

Previously, the method of challenging a decision was judicial review to the High Court (or by special case stated under s78(8) MHA 1983 if that was a suitable approach[10]). Now, by reason of s9 TCEA 2007, applications can be made to review decisions of the First-tier Tribunal in England: this allows the Tribunal to correct accidental errors in the decision or the record of the decision, amend the decision, or set it aside and remake it or refer it to the Upper Tribunal[11]. In addition, it is possible to appeal to the Upper Tribunal: s11 TCEA 2007 provides that an appeal lies to the Upper Tribunal "on any point of law arising

5 *Cm 5538-1*

6 *Cm 6305-1*

7 *See the First-tier Tribunal and Upper Tribunal (Chambers) Order 2008, SI 2008/2684*

8 *SI 2008/2833*

9 *It has separate new rules, the MHRT for Wales Rules 2008 (SI 2008/2705), so the MHRT Rules 1983 have no further application.*

10 *See Bone v Mental Health Review Tribunal [1985] 3 All ER 330 and MP v Nottinghamshire Healthcare NHS Trust [2003] Mental Health Law Reports 39, the effect of which were that it would rarely be appropriate.*

11 *See TPR 44 for correcting mistakes, TPR 45 for setting aside a decision (which depends on a procedural irregularity and a finding that it is in the interests of justice to set aside a decision), and TPR 46–9 for the process of reviewing a decision (which turns on the Tribunal considering that there is an error of law).*

from a decision made by the First-tier Tribunal". There is also an appeal on a point of law to the Upper Tribunal from the MHRT for Wales, this arises from Art 6 of the *Transfer of Tribunal Functions Order 2008* and the consequential amendments made in Sched 3, para 60 of which adds s78A MHA 1983 to provide the statutory basis for the appeal[12]. A final change made in the 2008 Order is that the case stated appeal under s78(8) MHA 1983 is abolished by para 59(8) of Sched 3. An application has to be made for permission to appeal[13]. In England, the tribunal must consider whether to exercise its power to review the decision if satisfied that there was an error of law; if it decides not to review the decision or takes no action on a review, the tribunal then considers whether to grant permission to appeal. The Welsh tribunal merely considers whether to grant permission to appeal. If permission is refused, an application for permission may be made to the Upper Tribunal: this is governed by r21 *Upper Tribunal Rules 2008*[14].

The TCEA 2007 also provides that the Upper Tribunal has a judicial review function: ss15ff. It also adds sections to the relevant statutory provisions in England and Wales, Scotland and Northern Ireland to allow (and in most relevant situations to require[15]) the normal judicial review courts to transfer cases to the Upper Tribunal: ss19ff. The Lord Chief Justice has issued a Direction to transfer to the Upper Tribunal reviews of First-tier Tribunal decisions where there is no right of appeal[16]. However, the normal process of judicial review must be followed if the relief sought includes a declaration of incompatibility under the *Human Rights Act 1998.*

The Facts in the Case

MH sought disclosure of his medical records in the course of tribunal proceedings. The Trust agreed to the request, except for 10 sheets of the records: so, shortly after the new Tribunal provisions came into effect, on 5 November 2008, an application was made for a direction to compel disclosure. Deputy Regional Tribunal Judge Harbour considered the application and on 7 November 2008 made a direction under r5 TPR (case management powers), which includes a specific power in r5(3)(d) to "permit or require a party or another person to provide documents, information or submissions to the Tribunal or a party."

The direction was in two parts: first, that the patient's solicitor "be granted full and unfettered access to all her client's medical records, including any third-party material which is purported to fall within the meaning of s7(4) of the *Data Protection Act 1998*, and any material which is purported to fall within *Data Protection (Subject Access Modification) (Health) Order 2000*, SI 2000/413 (SAMO Health) or Reg 5(1) *Data Protection (Subject Access Modification) (Social Work) Order 2000*, SI 2000/415 (SAMO Social Work)." The second part of the direction allowed the hospital Trust to indicate whether any of that material ought not to be disclosed to MH by reason of the application of r14 TPR until a Tribunal had made an order on it. Rule 14 TPR[17] allows the Tribunal to make a direction prohibiting disclosure of a document "to a person" if it "would be likely to cause that person or some other person serious harm" and

12 *Sections 32ff TCEA 2007 provide powers to create rights of appeal to the Upper Tribunal from tribunals in Wales, Scotland and Northern Ireland.*

13 *See TPR 46 or r30 of the Welsh Rules: the latter refers to a "party" whereas the former refers to a "person" being able to make the application.*

14 *SI 2008/2698*

15 *The normal process of judicial review must be followed if the relief sought includes a declaration of incompatibility under the Human Rights Act 1998 or in certain other circumstances.*

16 *Available at www.tribunals.gov.uk/Tribunals/Rules/directions.htm (accessed 27 January 2008).*

17 *This is the replacement for the provisions of rr6 and 12 of the MHRT Rules 1983, which allowed non-disclosure on the basis of the adverse effect on the health or welfare of the patient or others.*

also that it is proportionate "having regard to the interests of justice."

The order was made on an ex parte basis, no doubt because of the close proximity of the Tribunal hearing. The Trust was served with the direction, and applied for a review of the decision under s9 TCEA 2007. The judgement records that the Trust did not make reference to the relevant provisions of the TPR (as outlined above, r49 TPR, which allows a review under r47 when an application is made for permission to appeal under r46). Any procedural irregularity is unlikely to be important on the facts: r7(2) TPR allows a Tribunal to waive failures to comply with procedural requirements if it is just to do so.

The Tribunal, which met on 12 November 2008, refused to review the decision of Judge Harbour but referred the question of disclosure to the Upper Tribunal: it stayed the underlying proceedings[18]. It purported to grant permission to appeal subsequently (of its own decision of 12 November, so it seems, though the Upper Tribunal records that it was considering both the decision of 7 November of Judge Harbour and the Tribunal decision of 12 November). The reasons given by the Tribunal for refusing to review the decision of Judge Harbour were that it was inappropriate for it to do so as "… the direction was made competently and by the Tribunal at a level of authority equivalent to (or greater than) that which we enjoy today…"[19].

By the time of the hearing in front of the Upper Tribunal[20], MH had been placed on a Community Treatment Order (under s17A of the *Mental Health Act 1983*): the parties agreed that the appeal had therefore lapsed (a conclusion with which the Upper Tribunal agreed), and so the Upper Tribunal made no order on the appeal[21]. However, it went on to give – albeit obiter[22] – guidance on various matters raised.

The Guidance Offered

(i) Jurisdiction

The first question raised was whether a case management decision could be appealed to the Upper Tribunal. Section 11(2) TCEA 2007 provides that "Any party to a case has a right of appeal": but this has to be read together with s11(1), which defines the right to appeal as "a right to appeal to the Upper Tribunal on any point of law arising from a decision made by the First-tier Tribunal other than an excluded decision". An "excluded decision" is defined in s11(5) and under s11(5)(d) this includes decisions taken under s9 TCEA to review or not to review an earlier decision.

However, the question was not whether the refusal on 12 November to review the decision of Judge Harbour was an excluded decision, but whether the case management process gave rise to a "decision" for the purposes of s11(1) TCEA. There is jurisprudence arising in the context of the Social Security Commissioners (whose work has also passed to the Upper Tribunal by reason of the *Transfer of Tribunal Functions Order 2008*) that not all determinations are "decisions". This has been approved recently at the level of the Court of Appeal, in *Secretary of State v Morina* [2007] 1 WLR 3033: in this case a determination of a legal member of a Social Security Appeal Tribunal (the equivalent of a first instance

18 *r5(3)(j) TPR.*

19 *Para 18 of the judgment.*

20 *The date of the hearing is not given on the transcript as released, which merely records the date of the judgment, 8 January 2009.*

21 *Para 9 of the judgment.*

22 *It was a decision of a three-judge panel of the Administrative Appeals Chamber, including the two Chamber Presidents, one of whom is the Deputy Senior President of Tribunals: so it has fairly good persuasive value even if it not technically binding.*

23 *s14(1) of the Social Security Act 1998*

tribunal) that an application for permission to appeal was out of time could not be appealed to a Social Security Commissioner, whose jurisdiction[23] was in the following terms: " … an appeal lies to a commissioner from any decision of an appeal tribunal … on the ground that the decision was erroneous in point of law." The Court of Appeal concluded that a refusal to extend time was not a "decision" and so the Commissioner – who had accepted jurisdiction but dismissed the claim on its merits – had erred in concluding that he had jurisdiction.

The parties in *MH* agreed the approach[24]: the jurisdictional provisions in s11 TCEA were express about what was excluded from the appeal process (ie excluded decisions) and so there was no need to adopt a limited definition of "decision". The Upper Tribunal, however, did not rule on this submission[25]: rather, it relied on an alternative but narrower ground that an interlocutory decision to order disclosure was not to be excluded from the definition of "decision"[26]. The Upper Tribunal then noted that, in any event, any conclusion that there was no right of appeal under s11 TCEA would merely have led to the Upper Tribunal exercising its alternative jurisdiction by way of judicial review[27].

The existence of the judicial review function may mean that it is moot as to whether the primary submission of the parties needs to be resolved, since the issue will proceed to the Upper Tribunal one way or another (assuming, of course, that procedural differences between the appeal and judicial review functions can be overcome). Of course, it is worth stating that it is highly unsatisfactory that the appellate process governing the detention of persons who are mentally disordered should be tied down by highly legalistic arguments of whether a decision is not in fact a decision when it comes to the appeal process. So if the point ever does have to be determined, it is to be hoped that the position adopted by both parties in *MH* will be accepted, with the result that any decision made by a First-tier Tribunal can be appealed unless it is an excluded decision (as set out in s11(5) TCEA). Any policy concerns supporting a limited definition of "decision" should not carry much weight: leave to appeal is required (so providing a filter mechanism), and leave will not be granted if either there is no merit in the appeal, or if it does not raise a point of law (as is required by s11(1) TCEA) or there is an alternative method of securing a reconsideration of the decision challenged (such as a review or, as should have happened on the facts, as discussed below, the reconsideration of the direction).

The technicality raised by the Upper Tribunal is not the only one that might arise in the context of the appeal provisions. Another obvious issue is what is meant by a "point of law" within s11 TCEA. Is it meant to cover just the substantive law relating to the powers under the MHA 1983? What of procedural points? More importantly, does it include what might be called a "public law" point of law (including the rationality of the decision), such as would have been raised in past judicial review proceedings? Is this something that falls within the separate judicial review function of the Upper Tribunal rather than its appeal function? There is the obvious difference that the First-tier Tribunal would be the named respondent in a judicial review and able to defend its decision: in an appeal, respondents are parties to the lower tribunal[28]. The *MH* decision indicates that procedural points of law are covered by the statutory reference to "point of law", but there was no judicial review type of challenge, and so the question of

24 *Para 6 of the judgment.*

25 *Para 8 of the judgment.*

26 *Paras 7 and 8 of the judgment; the submission was based on a comment of Sir Anthony Clarke MR in para 50 of Morina that "In some contexts the word "decision" might well include an interlocutory decision such as a refusal of an adjournment or an order to disclose documents. All depends upon the particular circumstances."*

27 *In Morina, the conclusion that the Commissioner had no power to hear the appeal meant that the challenge to it was by way of the remedy of judicial review to the High Court.*

28 *See r1(3) of the Upper Tribunal Rules.*

whether a public law challenge is within s11 TCEA will have to await another case. Having said that, it is worth noting that the Upper Tribunal's own guidance to potential appellants proceeds on the basis that a public law error of law is a ground of appeal: in its leaflet "Appealing to the Administrative Appeals Chamber of the Upper Tribunal from the First-tier Tribunal – Mental Health Decisions,"[29] examples given of being wrong in law include "The tribunal had no evidence, or not enough evidence, to support its decision" or "The tribunal did not give adequate reasons for its decision in the written statement of its reasons," both of which are obvious public law errors of law.

There is also a further procedural technicality that perhaps ought to have been addressed in *MH* but which was not, namely the ambit of the definition of an "excluded decision" within s11(5) TCEA (ie a non-appealable decision). This seems to have been an issue on the facts, because one of the decisions in front of the Upper Tribunal was the decision of the Tribunal on 12 November not to review Judge Harbour's direction. The important part of s11(5) is sub-para (d), which excludes from the appeal process a decision to review "or not to review" an earlier decision. In para 17 of the judgment, the Upper Tribunal notes that the response of the hospital to the disclosure order was to seek a review under s9 TCEA; and para 18 records that the Tribunal "considered reviewing the earlier decision; but decided that it should not do so". In other words, it was a decision made under s9 TCEA not to review an earlier decision, and so it seems that this was an excluded decision. If this analysis is right, it does not mean that the Upper Tribunal should not have proceeded to the merits of the case in front of it: it could have become a judicial review decision rather than an appeal in relation to the Tribunal decision of 12 November, and there was also the initial decision of Judge Harbour, though the judgment does not indicate that the correct procedural steps to have that matter in front of the Upper Tribunal – or the waiver of those procedural requirements – were taken.

(ii) Procedural Issues and the Overriding Obligation

Having decided that it had jurisdiction, the Upper Tribunal turned to the question of the impact of the addition to the procedural regime applicable to the First-tier Tribunal of the overriding objective "to deal with cases fairly and justly" (r2(1) TPR). The parties are required to "help the Tribunal to further the overriding objective" and also cooperate generally with the Tribunal (r2(4) TPR). This requires the parties "cooperate and liaise with each other concerning procedural matters, with a view to agreeing a procedural course promptly where they are able to do so, before making any application to the tribunal" because "dealing with cases fairly and justly … includes the avoidance of unnecessary applications and unnecessary delay"[30]. The Upper Tribunal noted that there may be instances where the parties could agree but would nevertheless require an order be made: for example, where a hospital might require a court order to overcome the requirements of confidentiality. In such a situation, the parties should identify directions they can agree and then put them before the Tribunal for its approval. Where there are genuine differences such that the Tribunal has to determine the appropriate way to proceed, the liaison between the parties should aim to agree what can be agreed and identify the issues on which the tribunal has to rule. The Upper Tribunal stressed also that the need to liaise has to be carried out so as not to produce unavoidable delay in an urgent situation.

The Upper Tribunal's reminder of the need of the parties to ensure that the overriding objective is secured

29 *Available at www.administrativeappeals.tribunals.gov.uk/FormsGuidance/howToAppeal.htm (accessed 27 Jnauary 2009; the document is labelled Version 1).*

30 *Para 13 of the judgment.*

is obviously appropriate: although new to the procedural rules relating to the First-tier Tribunal, it is a well-established part of both the *Civil Procedure Rules* and the *Criminal Procedure Rules* that govern other courts[31]. It is an essential part of the process of active case management: in an extreme situation, it might be enforced by way of the wasted costs regime in s29(4) TCEA 2007 and TPR 10(1). Nevertheless, as the Upper Tribunal noted, there may be occasions when a Tribunal order is required because the parties cannot deal with the matters by agreement, including when there are issues arising in relation to confidentiality or data protection; and that the right of the patient to a speedy review of his or her detention cannot take second place to the need to apply to the Tribunal only when cooperation does not work.

(iii) Tribunal Power to Reconsider Regional Judge Direction

As noted in the fact, the First-tier Tribunal had referred the matter to the Upper Tribunal after declining to review the decision of the Deputy Regional Judge. This was an error, or an overly timid approach[32]: the Upper Tribunal made plain that the Tribunal had the jurisdiction t reconsider the decision of the Deputy Regional Judge, there being no issue of seniority to inhibit it from such a step. This was particularly so as it could consider fuller submissions, namely those from the Trust that had not been in front of Deputy Regional Judge Harbour. The Upper Tribunal emphasised that the direction-making regime had significant flexibility and allowed account to be taken of fresh circumstances and arguments, to which it then moved.

However, before turning to that, it is worth trying to reconstruct the position of the First-tier Tribunal. Unfortunately, its reasoning process is covered only briefly, namely that it felt it was inappropriate to review a decision made competently by a Deputy Regional Judge. It is worth noting the review provisions set out in s9 TCEA 2007 and r49(1) TPR: it can only happen if there is an error of law in the initial decision. The First-tier Tribunal's view that the case management direction of Judge Harbour was made "competently" suggests that it felt that there was no error of law and so it had no power to review, which was the application in front of it; it then seems to have considered permission to appeal, which is consistent with the requirement in r50 TPR that an application for a review can be treated as an application to do other things, including seeking permission to appeal. The failure identified, which was the error made by the Trust and not corrected by the Tribunal, was not applying the case management regime with the correct level of flexibility.

(iv) "Appealing" Directions

The Upper Tribunal indicated that the Trust should not have sought a review of the direction made: rather, it should have asked the Tribunal to amend the direction. The flexibility in the regime allowing this to be done comes from two provisions: r5(2) TPR allows a direction "amending, suspending or setting aside an earlier direction" and the direction making procedure set out in r6 TPR states:

> "6(5) If a party, or any other person given notice of the direction under para (4), wishes to challenge a direction which the Tribunal has given, they may do so by applying for another direction which amends, suspends or sets aside the first direction."

This language does not suggest that r6(5) is the exclusive process. But the Upper Tribunal decision

31 *The Civil Procedure Rules can be found at www.justice.gov.uk/civil/procrules_fin/ and the Criminal Procedure Rules at www.justice.gov.uk/criminal/procrules_fin/.*

32 *Para 19 of the judgment.*

33 *Para 17 of the judgment.*

indicates that, on the facts, it was by far the best process. It stated[33] that "an application under those provisions was clearly the appropriate course". This would have allowed the First-tier Tribunal to consider representations that had not been before the Deputy Regional Judge and possibly have avoided the delay occasioned by the appellate process: and it would have resolved that the Trust was in fact willing to disclose the disputed pages to MH's solicitor, albeit on a slightly different basis than that contained in Judge Harbour's direction: but this alternative basis would have been acceptable to MH's solicitor.

Given the factual position in front of the Upper Tribunal, it is hardly surprising that it emphasised the value of r6(5) TPR. This is consistent with general civil litigation: an ex parte direction in legal proceedings will invariably have a provision in it granting the other parties liberty to apply to challenge the direction at an inter partes hearing, on the basis that an ex parte process does not allow all the relevant arguments to be considered; the reminder given by the Upper Tribunal[34] that any ex parte direction should include a specific reference to r6(5) TPR is in effect a reminder that "liberty to apply" should always be a standard direction.

What will be of interest as the case law develops is the extent to which a party who disagrees with a direction made after a contested process should make use of r6(5) TPR: if there are fresh arguments which can be advanced on a further consideration of the position, this may justify seeking a change in the direction. However, there will no doubt be circumstances in which there is nothing more that a party can say, leaving the alternative only of seeking to challenge the direction by way of review/appeal or judicial review (if there is no right of appeal). The discussion above of whether an "error of law" in the appeal provisions includes a public law error will also be relevant at this stage.

(v) Disclosure of Medical Records – The Substantive Position and the Correct Process

The main underlying issue was the extent to which medical records ought to be disclosed. The Upper Tribunal noted the general proposition of the full disclosure of all relevant materials[35], and then discussed the regime in r14(2)-(6) TPR to which reference was made in Judge Harbour's direction. However, it then noted that there is a more general regime to which reference should have been made, namely that material in the patient's records that is confidential from the perspective of a third-party may also be protected from disclosure. One example given was that of a potential carer for a patient having a medical condition relevant to their ability to care for the patient, which information had been passed on confidentially[36]. In such a case, the need for fair trial at the Tribunal (a right of the patient by reason of Art 6 European Convention on Human Rights) might conflict with the duty of confidence owed to the third-party (a right of the third-party by reason of Art 8).

The Upper Tribunal indicated that the language of r5(3) TPR gave the First-tier Tribunal adequate power to deal with these issues appropriately: this is the power to "(3) … (d) permit or require a party or another person to provide documents, information or submissions to the Tribunal or a party". The Upper Tribunal suggested the following points should govern the process (though it emphasised the importance of fitting the process to the individual case):

(i) the parties should always try to resolve things between themselves (para 24);

(ii) since full disclosure is the norm, the hospital (or other authority) raising questions of non-

34 Para 35 of the judgment

35 Citing at para 20 of the judgment the recent case of R (Roberts) v Home Secretary [2005] 2 AC 738, which arose in the context of hearings in front of the Parole Board.

36 Para 23 of the judgment

disclosure has the burden of demonstrating why there should be no disclosure (para 25);

(iii) if the responsible authority cannot obtain third-party consent to disclosure (or where it is impractical), the documents should usually (in fact, except in "quite exceptional circumstances") be disclosed to the patient's solicitor on the basis of an undertaking as to non-disclosure – which would be for the purpose of allowing the solicitor to decide whether to seek a direction for further disclosure (paras 26–8); the solicitor should then provide a skeleton argument as to why disclosure is necessary, to which the responsible authority should reply, and if the parties are not able to resolve the difference between them, an application should be made to the Tribunal (paras 29–30);

(iv) if exceptional circumstances arise in which a responsible authority cannot rely on an undertaking as to non-disclosure, it should set out the reasons and identify the relevant documents in a skeleton argument, to which the patient's solicitor will reply; if this does not allow the dispute to be resolved, the matter can go before the Tribunal (paras 29[37] and 30);

(v) although any dispute which requires a Tribunal decision will usually be capable of being determined on the day of the substantive hearing, a more complex situation might involve seeking a ruling in advance by a single judge, which in turn might require an oral hearing if it cannot be determined on the papers and might also involve inviting the third party to give views via the responsible authority (paras 31–2).

The last part of the guidance is worth noting in full. The judgment states at para 32:

> "32. We can also envisage circumstances in which the tribunal will need to obtain information as to the third-party's views on the issue of disclosure. Where this occurs, the tribunal should notify the responsible authority which should then obtain this information and submit it to the tribunal, thus avoiding where possible any direct involvement by the third-party in the tribunal's procedures."

The Upper Tribunal commented that a version of Deputy Regional Judge Harbour's order modified to refer to the process relating to confidential third party material would have been appropriate on the facts; and it added the suggestion referred to above that an ex parte direction should include a reference to the right to seek a modified direction under r6(5) TPR.

This part of the Upper Tribunal's guidance provides a useful reminder that the provisions relating to non-disclosure on the basis of causing serious harm (in r14 TPR) cannot be the exclusive regime, as issues of third-party confidentiality may arise. The *Human Rights Act 1998* is the obvious starting point for this. All public bodies, including courts, have to act in a manner consistent with the rights set out in the European Convention on Human Rights: s6(1) of the 1998 Act. This does not apply if a primary statute requires a breach of the Convention: s6(2). But nothing in the *Mental Health Act 1983* or any other statute requires a Tribunal to direct disclosure of confidential information irrespective of any Convention right involved, so the Convention must be followed when discretionary powers are being considered. Confidentiality invariably raises issues under Article 8 of the Convention, namely respect for private matters: the important point to remember is that Article 8 rights can be breached only if two elements are met. One element is substantive, namely that it is proportionate to breach the privacy rights involved. This proportionality can be met if disclosure is necessary to ensure a fair process at the Tribunal hearing for the patient. But there is an essential second element arising under Article 8: any breach of confidentiality must be "in accordance with the law". This requires a legal regime to determine the

37 *Note that the transcript as released has two paragraphs numbered 29: if this error is amended, the references to paragraph numbers after 29 in this article may become inaccurate by one.*

question of proportionality, which the process under r5(3)(d) TPR as supplemented by the guidance in this case provides.

Nevertheless, the process and substantive test for disclosure should perhaps be spelled out in the Tribunal Procedure Rules. The substantive test would no doubt be phrased along the lines of disclosure being ordered where it was reasonably required to ensure a fair hearing of the Tribunal. The process ought to include the involvement of any third party in the absence of good reasons. This is one aspect of the Upper Tribunal's decision that might require further consideration, given its view that the responsible authority should be the body that puts forward the views of the third-party.

The case of *R (TB) v Stafford Crown Court*[38], cited by the Upper Tribunal for the proposition that Arts 6 and 8 of the European Convention are involved, is important in relation to the process to be followed. TB was a prosecution witness in a criminal trial (she was the victim of an alleged assault). The defendant obtained an order for disclosure of her records (on the basis that they were relevant to her credibility); this was successfully challenged in judicial review proceedings on the basis that (i) the records were confidential, (ii) the confidentiality belonged to the patient, not the hospital, and (iii) the requirement in the *Criminal Procedure Rules* that cases be dealt with justly meant that the Crown Court had to give the witness notice of the application and allow her to make representations on the issue of disclosure, and it was not sufficient for the Trust to represent the patient as their interests might differ.

May LJ noted that the request for disclosure of TB's medical records meant that "22. … The court was being invited to trample on TB's rights of privacy and confidentiality". This meant that a procedure is required that is

> "23. … fair and affords due respect to the interests protected by Art 8. The process must be such as to secure that the views of those whose rights are in issue are made known and duly taken account of. What has to be determined is whether, having regard to the particular circumstances of the case and notably the serious nature of the decisions to be taken, the person whose rights are in issue has been involved in the decision making process, seen as a whole, to a degree sufficient to provide them with the requisite protection of their interests. …"

He went on to indicate in fairly strong terms the idea that TB's interests could be protected by the Trust:

> "27. I would firmly reject the suggestion that it would have been sufficient for the interest of TB to be represented only by the NHS Trust. The confidence is hers, not theirs. Their interests are different. They have a wider public interest in patient confidentiality generally and may have particular interests relating to her care which could conflict with hers. Mr Lock submits that the Trust should be able to advance these wider public interest submissions against disclosure without having the role cast on it of acting also as an advocate for the patient's confidentiality. I agree. I agree also that the Trust should not be saddled with the heavy burden of making enquiries of the patient, finding reasons why he or she might object and putting those reasons before the court. Further, there may be material in the notes which the Trust can legitimately withhold from the patient under s7 of the *Data Protection Act 1998* as modified by the *Data Protection (Subject Access Modifications) (Health) Order 2000.*
>
> 28. In my view, the burden of protecting TB's privacy should not be placed on the Trust. The burden resides with the court and she herself was entitled to notice and proper opportunity for representation."

It will be important for the Upper Tribunal to give reasons as to why this approach is not to be followed

38 *[2007] 1 WLR 1524, [2007] Mental Health Law Reports 115*

in relation to third-party confidentiality in the First-tier Tribunal setting. There are obviously some differences between an open court criminal trial and a private Tribunal hearing in which there is significant power to control publicity: the question will be whether these differences are such that the strength of May LJ's comments are diminished to such an extent that there is a presumption against direct involvement in the process by the third-party.

The reason why this process should be set out in the Rules is that it is sufficiently important that it should be available to all affected without the need for a search of case law; this is particularly so as not all patients are legally-represented, and the third party involved will invariably not be represented when the question of disclosure arises. In addition, the inclusion of the issue in the rules will allow consideration of the other issues that might arise, including its interaction with other provisions of the rules, which should not depend on a process as ad hoc as the development of case law. An obvious example of this is the medical examination of the patient under r34 TPR. In carrying this out, the medical member of the Tribunal is allowed to have access to the patient's records: in the course of this, the medical member may view material that is covered by third party confidentiality. What should happen if this material is so important to the formulation of his or her views on the case or the Tribunal's decision that it needs to be revealed to the parties so that they can deal with it, pursuant to the duty to act fairly. This was summed up by Stanley Burnton J in *R (Ashworth Hospital Authority) v MHRT; R (H) v Ashworth Hospital Authority* [2002] Mental Health Law Reports 13 at para 86:

> "86. … The parties should be given the opportunity to address and to comment on any significant findings of the medical member, both because fairness so requires and because they may have comments or evidence to put before the Tribunal that may lead it to depart from the provisional opinion formed by the medical member. …"[39]

This may obviously raise issues of third-party confidentiality if that is part of the material on which the medical member relies.

(vi) Status of Upper Tribunal Decisions

The final matter on which the Upper Tribunal gave guidance was the status of its decisions: this is fairly straight-forward and obviously sensible. In short the Administrative Appeals Chamber of the Upper Tribunal used the case to adopt the rules as to precedent which applied to Social Security Commissioners[40], namely that (1) the Judges of the Upper Tribunal speak with equal authority and their decisions on matters of legal principle should be followed; (ii) a decision of a Three-Judge Panel of the AAC is to be followed over a conflicting decision of a single Judge; and (iii) a single Judge should follow the decision of a Three-Judge Panel unless there are compelling reasons – such as a decision of a superior court affecting the legal principles involved; and a single Judge should follow another single Judge unless there is an error.

Additional Points of Commentary

There are two other points arising that merit comment, the first of which is the involvement of a "Deputy Regional Tribunal Judge": where does this title come from? As noted above, the TCEA 2007 establishes the First-tier Tribunal, and s4 of the Act provides for the appointment of judges of the Tribunal, which

39 *This was endorsed by the Court of Appeal, [2002] Mental Health Law Reports 314 at para 84.*

40 *See Case No R(I) 12/75, 12 August 1975, available at http://www.osscsc.gov.uk/aspx/view.aspx?id=599 (accessed 25 January 2009) – the Social Security Commissioners website, which will presumably transfer to the Tribunals website at some stage.*

explains the "Tribunal Judge" tag. The "Deputy Regional" part of the designation arises as follows. The Tribunal Chambers have a Chamber President (by reason of s7(2) and (3) TCEA 2007). The President of the Health, Education and Social Care Chamber, HHJ Sycamore, has delegated functions to the former Regional Chairs of the Mental Health Review Tribunal. They are now known as Regional Judges, and any deputies they appoint are Deputy Regional Tribunal Judges. (The titles may change during 2009, as Deputy Chamber Presidents are appointed and full-time salaried Tribunal Judges begin operation in relation to mental health work.)

The other point that is worth a comment is whether the parties' concession that the appeal had lapsed because MH had been placed on a Community Treatment Order ("CTO") was correct. There have been two relevant decisions to consider, one relating to what happens when a patient due for a Tribunal whilst detained on s2 MHA 1983 (detention for assessment) is placed on a s3 order, the other relating to a s3 patient placed on the now deleted after-care under supervision provisions of s25A[41]. The former situation arose in *R v South Thames Mental Health Review Tribunal ex p* M 3 September 1997, [1998] COD 38. M was detained under s2 MHA 1983 on 9 July 1997; on 10 July she applied for a Tribunal hearing, and the date was fixed for 18 July. On 15 July, she was placed under s3 MHA. The decision giving rise to the proceedings was that the Tribunal's view that it was the hearing to which she was entitled to apply having been placed under s3 MHA – in other words, that she had no further right to apply to a Tribunal[42]. Collins J determined that the Tribunal view was wrong: M had a right to apply to a Tribunal from the fact of admission under s2, had exercised that right, and had not lost it by the change of status from s2 to s3. So the Tribunal hearing did not extinguish the separate right arising by reason of the s3 admission. What did change, however, was the criteria to be applied, because the Tribunal had to consider the situation of the patient on the day it met, and so the s3 criteria had to be applied despite the application having been made when the patient was under s2.

The position relating to a s3 patient placed on aftercare under supervision ("ACUS") is different: this was decided in *R (SR) v Mental Health Review Tribunal* [2006] Mental Health Law Reports 121. The patient applied to the Tribunal whilst detained under s3, but was placed on a supervised discharge under s25A shortly before the hearing: the Tribunal was then cancelled. SR challenged this, arguing that it should have proceeded as fixed and have considered the supervised discharge criteria[43]. The judge dismissed this challenge. He held that a fresh application was needed if the patient changed status to that of an ACUS patient. There were several reasons for this, namely there were different time limits in s66(2) MHA for the making of an application (which started as of the date of the s3 order or of the ACUS order), the Tribunal having jurisdiction might be different if the patient moved when placed on ACUS, and the "responsible authority" (on whom the application was served, who was responsible for providing reports to the Tribunal and who is a party to the proceedings) differed according to whether the patient was detained or subject to ACUS. Further, the natural meaning of the statutory language as to the discharge of an ACUS patient in s72(4A) – "where application is made to a … Tribunal by or in respect of a patient who is subject to after-care under supervision" – properly required the patient to be so subject at the time of application.

41 *The provisions of s25Aff are deleted by s36 MHA 2007; there are transitional provisions retaining the regime until May 2009 for patients already subject to aftercare under supervision – see The Mental Health Act 2007 (Commencement No 6 and Aftercare under Supervision: Savings, Modifications and Transitional Provisions) Order 2008 (SI 2008/1210)*

42 *See s77(2) MHA: there is one right to apply to a Tribunal during any period giving rise to a right to apply; s66 MHA sets out the rights to apply, including when a patient is placed on s2 and when a patient is placed on s3 or a s3 order is renewed under s20.*

43 *Former s72(4A) MHA 1983.*

How does this case law apply if the s3 patient is placed on a CTO before a Tribunal hearing? The rationale in *SR* has some application: the time limits in s66 MHA are different and there may be different responsible authorities[44]. (Of course, there are different time limits in relation to a patient under s2 and a patient under s3, and it is possible for a patient to be transferred between hospitals at any stage, which will change the responsible authority.) But there are various other features to consider. For example, (i) the tribunal task in relation to a community patient is also set out in s72(1) MHA 1983 (not in a separate subsection, as in the case of an ACUS patient); s72(1) simply refers to an application being made and then sets out tests according to the status of the patient, and so the point arising from the language of s72(4A) does not apply; (ii) the s3 order applicable at the date of application remains in place, being suspended rather than ended, in contrast to an ACUS order, which represented a cleaner break from the s3 detention[45]; and (iii) the CTO ends if the s3 order "ceases to have effect" (s17C(c) MHA), so a decision by the Tribunal that the s3 is not justified ends the CTO. It is also to be noted that the duty of managers to refer a case under s68 applies in relation to a community patient as from the date the detention of the patient commenced, suggesting that there is a continuum of compulsion in different forms rather than a complete break, as happened under the ACUS regime.

One suspects that this is a point that might have to be determined at some stage in the future, and the Upper Tribunal's endorsement of a concession made should not be taken to determine the position.

44 Indeed, if a patient detained in England is placed on a CTO in Wales, then a different Tribunal may have jurisdiction: but there are provisions allowing transfer – r5(3)(k) TPR, or r23 of the Welsh Rules in the vice versa situation.

45 If an ACUS patient deteriorated, consideration had to be given to whether a fresh sectioning process should be followed.

Between a Rock and a Hard Place

Paul McKeown[1]

Lewisham LBC v Malcolm
[2008] UKHL 43

The Facts

Courtney Malcolm was diagnosed with schizophrenia in 1985. Over a period of five years, he was admitted to hospital on ten occasions, two of which were compulsory detentions under the *Mental Health Act 1983*. However, his condition was stabilised by medication. Throughout the period, Mr Malcolm held down employment, including a position in a housing office.[2]

In February 2002, Mr Malcolm rented a flat from Lewisham London Borough Council under a secure tenancy for the purpose of section 79 *Housing Act 1985*. He was entitled to exercise the right to buy, which he applied to do in March 2002. The purchase had still not been completed in 2004 when the material events took place.

In 2004, Mr Malcolm had compliance problems with his oral medication, and it was reported that "he became dysfunctional at work, eventually, simply sitting at his desk. He was losing weight, not sleeping or eating."[3] Mr Malcolm was placed on depot medication in July 2004.

During the period of his medication problems, Mr Malcolm secured a mortgage offer and was due to complete the purchase on 26 July 2004. However, on 22 June 2004, Mr Malcolm sub-let the flat on an assured short-hold tenancy which was in breach of his tenancy agreement. Furthermore, by vacating the property, Mr Malcolm lost his secure tenancy by virtue of sections 79(1) and 81 of the *Housing Act 1985*. Once a secure tenancy ceases, it cannot subsequently once more become a secure tenancy.[4]

The Local Authority, Lewisham LBC, exercising its function of managing its housing stock, served a notice to quit upon Mr Malcolm and commenced possession proceedings.

In his defence, Mr Malcolm argued that he was disabled within the meaning of the D*isability Discrimination Act 1995* ('DDA'), the reason why the Council were seeking possession was related to his disability, and unless the Council could show justification, the Court was precluded from making a possession order against him.

At first instance, the judge granted a possession order. Her principal reason for doing so was that the DDA was not engaged where all security was lost and there was no discretion for the court to exercise. However, she also made findings of fact in case she was wrong. Firstly, she concluded that Mr Malcolm was not disabled within the meaning of the DDA as she was unable to say that his illness had a substantial effect upon his ability to carry out day-to-day activities. Secondly, the decision to sub-let was a planned decision, closely linked to his proposed purchase, not an irrational act caused by his illness.

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2 *an indication that Mr Malcolm most probably understood the consequences of sub-letting his tenancy.*

3 *Per Baroness Hale, Judgement, para 49*

4 *Section 93(2) Housing Act 1985*

The Court of Appeal[5] allowed the appeal, dismissed the possession proceedings and declared that the notice to quit and possession action constituted unlawful discrimination contrary to Part III of the DDA. They found Mr Malcolm was a disabled person within the meaning of the Act, there was an "appropriate relationship" between the Council's actions and his illness, that his treatment had been less favourable than that of other people to whom that reason did not apply, and (by majority) the fact that the landlord did not know of the disability did not preclude a finding of discrimination.

The Law

As a consequence of sections 79(1), 81 and 93 *Housing Act 1985*, Mr Malcolm's tenancy ceased to be secure within the meaning of that Act. Therefore, he was no longer protected by section 84 *Housing Act 1985* which prohibits the making of order for possession of a dwelling let under a secure tenancy unless one of the grounds in Schedule 2 of the Act applies. Consequently, putting to one side the DDA, Lewisham LBC had an unanswerable claim for possession of the dwelling.

Mr Malcolm sought to defend the claim on the grounds that the actions of Lewisham LBC amounted to discrimination within the meaning of section 22(3) DDA[6] which states:

> *"It is unlawful for any person managing any premises to discriminate against a disabled person occupying those premises–*
>
> *(a)…*
>
> *(b)…*
>
> *(c) by evicting the disabled person, or subjecting him to any other detriment."*

Discrimination is defined in section 24 DDA as:

> *"(1) …a person ("A") discriminates against a disabled person if–*
>
> *(a) for a reason which relates to the disabled person's disability, he treats him less favourably than he treats or would treat others to whom that reason does not or would not apply; and*
>
> *(b) he cannot show that the treatment in question is justified."*

The same wording is used in section 5(1)[7] of the Act to define discrimination in the employment context, whilst section 20(1) uses this wording in the context of supply of goods and services.

Prior to *Malcolm*, the leading authority on the interpretation of disability related discrimination was the Court of Appeal decision in *Clark v Novacold*[8] which sought to interpret section 5(1) of the Act. The courts are required to identify a comparator to whom the treatment can be compared. In identifying the comparator, Mummery LJ set out two options in his judgment. A *broad approach* in identifying the comparators focused on the first three words of the provision, "for a reason". The expression, "which relates to the disability" are words added not to identify or amplify the reason, but to specify a link between the reason for the treatment and the disability which enables the disabled person to complain of their treatment.[9] The second option was for a *narrow approach* which uses the entire phrase "for a reason which relates to a disabled person's disability".

5 *[2007] EWCA Civ 763*

6 *Lewisham LBC v Malcolm originated prior to the amendments made by the Disability Discrimination Act 1995 (Amendment) Regulations 2003 SI 2003/1673 and the Disability Discrimination Act 2005. Therefore, all references to the legislation will be to its original format unless otherwise indicated.*

7 *Now section 3A(1)*

8 *[1999] I.C.R 951*

9 *Ibid, per Mummery LJ at p. 962*

Following the broad approach, if a disabled employee is absent on long term sick leave because of his disability, the comparator would be an employee who is not on long term sick leave. The comparator using the narrow approach would be an employee who is on long term sick leave but does not have disability. Mummery LJ stated in *Novacold*[10] that the correct approach for identifying the comparator was the broad approach.

Interestingly, Mummery LJ handed down what appears to be a conflicting judgment in *S v Floyd and EHRC*[11]. This case involved a landlord who sought possession on the grounds of rent arrears. It was alleged that the cause of the rent arrears was the tenant's lack of mental capacity. The lack of mental capacity was a disability and the "reason" for the possession claim was a reason related to the disability. It was therefore argued that the possession claim was an unlawful act. In rejecting this argument, Mummery LJ states at paragraph 48:

> *"It is not immediately obvious (a) how the 1995 Act could provide a basis for resisting a claim for possession on a statutory mandatory ground or (b) how a landlord would be unlawfully discriminating against a disabled tenant by taking steps to enforce his statutory right to a possession order for admitted non-payment of rent for 132 weeks. The 1995 Act was enacted to provide remedies for disabled people at the receiving end of unlawful discrimination. It was not aimed at protecting them from lawful litigation or at supplying them with a defence to a breach of a civil law obligation. Like other anti-discrimination legislation, the 1995 Act created statutory causes of action for unlawful discrimination in many areas, such as employment, the provision of goods, facilities and services and the disposal and management of premises, but it did not create any special disability related defence to lawful claims of others, such as a landlord's claim for possession of premises for arrears of rent. The legislation is not about disability per se: it is about unlawful acts of discrimination on a prohibited ground, i.e., unjustified less favourable treatment for a reason which relates to the disabled person's disability."*[12]

Whilst prior to *Malcolm*, *Novacold* remained the leading authority, here there was conflicting Court of Appeal authority, which on the facts aligned itself more favourably with the facts which existed in *Malcolm*.

If it is established that the actions are regarded as potentially discriminatory under section 24(1)(a), potentially they can be justified under section 24(1)(b) DDA. However, there is an exhaustive list of justifications in section 24(3) DDA including, inter alia, treatment necessary not to endanger the health or safety of any person, and that the disabled person is incapable of entering into an enforceable agreement. It was common ground that none of these would apply in *Malcolm*.[13]

However, section 5(3)[14] DDA meant that, in the employment context, the actions are justified if they are both material to the circumstances of the particular case and substantial. In other words, it is open for an employer to raise any justification which satisfies this criterion.

The Decision

The House of Lords unanimously upheld the appeal, although they were far from unanimous in their reasoning for doing so.

10 *Ibid, p.964*

11 *[2008]EWCA Civ 201*

12 *A point noted by Lord Scott in Malcolm at para 37 of the Judgment*

13 *Per Baroness Hale, Judgment, para 60*

14 *Now section 3A(3)*

The Lords upheld[15] a long established meaning of 'disability' as a physical or mental impairment that has a substantial adverse effect on an individual's ability to carry out normal day-to-day activities. 'Substantial' means "more than minor or trivial".[16]

There was unanimity in that knowledge of the disability is required for there to be a claim under the DDA although the Lords differed as to the extent of that knowledge. Lord Bingham, with Baroness Hale in agreement[17], stated that "knowledge, or at least imputed knowledge, is necessary."[18] Lord Scott however, in agreement with an earlier Court of Appeal judgment[19], considered that the disability must play a motivating part in the mind, whether consciously or subconsciously, to establish discrimination.[20]

There was unanimous agreement that Lewisham LBC's actions did not relate to Mr Malcolm's disability. Lord Bingham stated that "relates to" denotes "some connection, not necessarily close, between the reason and the disability"[21], whilst Baroness Hale stated that "[t]he connection between the disability and the reason must not be too remote"[22]

By a majority of 4:1 (Baroness Hale dissenting) the Lords found that the correct comparator in disability related discrimination is a person who to whom the underlying reason still applies. In other words, the Lords preferred the *narrow approach*. However, there was disagreement as to the extent to which this comparison should apply. Lords Scott[23] and Brown[24] found that *Novacold* was wrongly decided. Lord Bingham, whilst not explicitly overruling *Novacold*, found it hard to accept that it was "rightly decided". [25] Lord Neuberger limited himself to the premises provisions of the DDA.[26]

There was unanimous agreement that the DDA provided a defence, where there would otherwise be none, the Lords' reasoning being that the courts would not give legal effect to unlawful acts. However, Lord Bingham stated that he "would not expect such a defence, in this field, to be made out very often."[27]

Comment

This decision, whilst made in the context of housing, potentially has a huge effect on the application of disability discrimination legislative provisions as it effectively neutralises any indirect disability discrimination claim. The controversial part of the judgment relates to the comparator to be used in a claim for disability related discrimination. Lord Neuberger stated:

> *"This appeal raises a number of points relating to the scope and the meaning of the provisions of Part III of the* Disability Discrimination Act 1995 *("the 1995 Act") insofar as they apply to "Premises". In particular, the competing arguments appear to require a choice to be made between two interpretations of the definition of discrimination in section 24, one of which (supported by the appellant, the London*

15 *Dissenting, Baroness Hale upheld the finding at first instance that Mr Malcolm was not a disabled person within the meaning of the Disability Discrimination Act. Whilst "it would seem very surprising if a person with chronic schizophrenia, who needed regular anti-psychotic medication if he was to live a normal life in society, did not fall within the definition of disabled within the Act....the judge did correctly direct herself on what the Act required...I am not convinced that she applied the wrong test, or that no judge who applied the right test could have reached the conclusion she did." (Judgment, para 67)*

16 *Goodwin v Patent Office [1999] ICR 302, EAT*

17 *Judgment, para 86*

18 *Ibid, para 18*

19 *Taylor v OCS Group Ltd [2006] ICR 1602*

20 *Judgment, para 39*

21 *Ibid, para 10*

22 *Ibid, para 83*

23 *Ibid, para 34*

24 *Ibid, para 112*

25 *Ibid, para 15*

26 *Ibid, para 139*

27 *Ibid, para 19*

> *Borough of Lewisham) would give the anti-discrimination provisions of section 22 an unattractively restrictive effect, and the other of which (supported by the respondent, Mr Courtney Malcolm) would give those provisions an extraordinarily far-reaching scope."*[28].

It is apparent that the Lords were caught in a difficult position as judgment either way would have had a major impact on anti-discrimination law. The Lords were required to balance the interests of private law rights against the interests of disabled people not to be treated less favourably.

What appears to underpin the majority judgments is the fact that the *Novacold* interpretation would effectively have meant entrenchment of the disabled person's tenancy. Disabled persons could not be evicted if the reason had some causal connection to the disability.

The apparent problem highlighted by *Malcolm* is the limited grounds of justification contained in section 24(3) DDA.[29] This could be the reason why *Novacold* remained unchallenged for 9 years and has not caused difficulty in practice. Disability related discrimination in the employment field can be justified if "the reason for the failure is both material to the circumstances of the particular case and substantial."[30] As such, there are many circumstances where an employer can justify otherwise discriminatory actions. Each case must be judged on its facts with regard to the Code of Practice.[31] In practice, the justification point is a low threshold and "there is considerable leeway afforded to employers when the issue of justification is under scrutiny."[32] Evidence can also be found in a housing context. In *Manchester City Council v Romano*[33] the Court Of Appeal found that the tenants had not been unlawfully discriminated against because the landlord's actions were objectively justified by the need not to put the health of a neighbour at risk.[34]

The problem in the housing context is that there is an exhaustive list of justifications contained within section 24(3) which, inter alia, includes treatment necessary not to endanger the health and safety of any person, or that the disabled person is incapable of entering into an enforceable agreement. As sub-letting and rent arrears could not fit into this list, a tenant would always succeed.

The decision in *Malcolm* was unavoidable given the legislative framework. Whilst Baroness Hale set out a strong argument that Parliament intended the broad interpretation to be used,[35] the Court was not going to give a judgment which would allow people to effectively breach their tenancy agreement and have a cast iron defence, thus infringing the lawful rights of others. The consequences could have potentially seen some tenants living rent-free. Parliament's implicit approval of *Novacold* can be attributed to the fact it was made in an employment context, and therefore the problems had not materialised. It is from this point of view whereby we can understand Lord Scott's statement:

> *"Parliament must surely have intended the comparison…where the directed comparison is in identical terms, to be a meaningful comparison in order to distinguish between treatment that was discriminatory and treatment that was not."*[36]

The decision in *Malcolm* could have been limited to the housing provisions of the DDA. Only two of the

28 *Ibid, para 119*

29 *These views were expressed by Michael Connelly, 'The House of Lords narrows the meaning of disability related discrimination', Emp. L.B. [2008] 1*

30 *Section 3A(3) Disability Discrimination Act 1995 as amended*

31 *Clark v Novacold [1999] IRLR 318*

32 *O'Hanlon v Commissioners for HM Revenue and Customs [2006] IRLR 840 per Elias J para 43*

33 *[2005] 1 W.L.R 2775*

34 *Sections 24(2) and 24(3)(a) DDA*

35 *Judgement, paras 77–80*

36 *Ibid, para 32*

five Lords expressly overruled *Novacold*, and therefore it was arguable that it still applied in the employment context. Lord Neuberger left the door open to such argument at paragraph 158:

> *"It would, on the face of it at least, be very surprising if section 24(1)(a) had a different meaning from the effectively identical worded section 5(1)(a), but it would not be an impossible conclusion. While the 1995 Act has a single definition of "disability" which is generally applicable, it has three effectively identical definitions of "discrimination", each of which applies in different fields (employment, goods facilities and services, and premises). The combination of the contrast between section 5(3) and section 24(3), and the fact that the wider construction of section 5(1)(a) has been assumed to be right for some years – perhaps together with other factors, such as subsequent parliamentary approval – could conceivably justify the decision in Novacold being correct as to the effect of section 5(1)(a), despite the conclusion I have reached as to the meaning of section 24(1)(a)."*.

Spencer Keen suggests[37] that support for this proposition could be found in the UK's compliance with Council Directive of 27 November 2000 establishing a General Framework for Equal Treatment in Employment and Occupation 200/78/EC. The Framework Directive requires member states to protect disabled employees from both direct and indirect discrimination. He argues that since the UK courts are required to give a purposive interpretation to the DDA 1995 so it complies with the Framework Directive, a claimant could argue that the *Novacold* interpretation of the DDA 1995 is the only interpretation consistent with providing protection against indirect discrimination in accordance with the Directive.

However, such argument now appears dead following the decision of the Employment Appeal Tribunal (hereafter 'EAT') in *The Child Support Agency (Dudley) v Truman*[38]. In their judgment, the EAT stated that the wording of sections 24(1)(a) and 3A(1)(a) are identical and therefore it would "seem surprising if the comparator in one provision was different from that in the other."[39] Further, the EAT concluded that justification could not impact on the question of who is the appropriate comparator for the purposes of unlawful justification.

It is noted that the Framework Directive was not raised in *Truman* and potentially there is still scope for argument. However, it appears that under the current legislation, the *narrow approach* will be adopted in all fields unless a there is a further ruling from the House of Lords.

Lawyers need to be creative in the use of the reasonable adjustment provisions of the DDA.[40] Many claims of disability related discrimination in the employment context could also be brought as a 'reasonable adjustment' claim as employers will be required to take appropriate action in respect of employees with disabilities. In the context of goods, facilities and services, claims generally relate to a failure on the provider to make reasonable adjustments in any event. The comments in *Malcolm* relating to knowledge should not have an impact as Sedley J confirmed in *Roads v Central Trains Ltd*[41] that the duty to make adjustments in a services context is anticipatory and therefore knowledge of the disability is not required.

In relation to the premises context, it has been suggested[42] that the draft European Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability

37 *Spencer Keen, 'Discrimination: Blame it on the dog', 158 NLJ 1216*

38 *UKEAT/0293/08/CEA*

39 *Ibid, per His Honour Judge Peter Clark, para. 22*

40 *Sections 4A and 21*

41 *[2004] EWCA Civ 1541*

42 *Robert Latham and Catherine Casserley, 'Disability-related discrimination claims after Lewisham LBC v Malcolm', Legal Action, September 2008*

age, sexual orientation contains obligations in relation to both indirect discrimination and the duty to make reasonable adjustments. Therefore, it is argued that, if finalised in its present form, it is likely to require changes to the current provisions in the UK, particularly in relation to premises.

In the longer term, it is likely that Parliament will remedy the narrow interpretation. The proposed single *Equality Bill*[43] may counter the effect of *Malcolm*. As suggested above, it is arguable that the true problem with disability related discrimination is the restricted justification defences available in the housing context, whilst employment context offers employers' unrestricted justification defences. The Government has stated that it wants to "replace these different justification defences with a single 'objective justification' test which would require that the conduct in question is a proportionate means of achieving a legitimate aim."[44] However, if the wording of disability related discrimination remains unchanged, the courts will need to re-interpret the legislation, although hopefully they will be able to do so without the all or nothing approach the current legislation seems to demand.

43 Referred to in the Queen's Speech on 3 December 2008.

44 The Equality Bill – Government Response to Consultation, Government Equalities Office, July 2008, Chapter 11.12

"She took no reasoning": Enticing Someone into a Public Place

David Hewitt[1]

McMillan v Crown Prosecution Service
[2008] EWHC 1457 (Admin)

A police constable acted lawfully when he physically escorted a woman from a private garden to a public footpath and then arrested her for an offence that could only be committed in a public place.

Introduction

This case has implications for the use of section 136 of the *Mental Health Act 1983*, under which a person in a public place who appears to be suffering from mental disorder may be arrested by a police constable and taken to, and detained for up to 72 hours in, a place of safety, such as a police station or a hospital.[2]

Although it is frequently used, the section 136-power is rarely the subject of legal proceedings, and quite often, the best guidance as to its limits may be found in cases that have nothing to do with mental health.[3] One such case suggests that a practice commonly thought to be dubious may in fact be perfectly lawful.

It is hard to find authoritative statistics on section 136. Data collected by the Mental Health Act Commission (MHAC) suggest that between 2002/3 and 2003/4, the power was used 4,450 times, with patients detained either in hospital or in a police station.[4] More recent figures, however, suggest much greater usage. The Independent Police Complaints Commission (IPCC) has calculated that in 2005/6, patients detained under section 136 were held in police cells alone on 11,517 occasions. (The greatest use would appear to be in Sussex, where there were 277 such patients per 10,000 people in police detention. The lowest was in Cheshire and in Merseyside, where the proportion was one patient per 10,000 detainees.)[5]

Recently, a great deal of attention has been given to the places of safety to which patients apprehended under section 136 are taken.[6] There is also concern, however, that on occasions, police constables keen to use the

1 *Solicitor and partner in Weightmans LLP; Visiting Fellow, Law School, University of Northumbria.*

2 *MHA 1983, section 136. See also: Department of Health, 2008, Mental Health Act 1983 Code of Practice, paragraph 10.12 et seq; Department of Health, 2008, Reference guide to the Mental Health Act 1983, paragraph 30.16 et seq.*

3 *See, for example: David Hewitt, New perspectives on the Mental Health Act, Solicitors Journal, vol 152 no 44, 18 November 2008, page 13.*

4 *Mental Health Act Commission, 2006, In Place of Fear? Eleventh Biennial Report, 2003–2005, TSO, paragraph 4.165 and figure 76.*

5 *Maria Docking, Kerry Grace and Tom Bucke, September 2008, Police Custody as a "Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983, Independent Police Complaints Commission, IPCC Research and Statistics Series: Paper 11, pages 10 & 11. Also see 'The use of section 136 to detain people in police custody', Maria Docking, in this issue of the Journal of Mental Health Law.*

6 *See, for example: Paul Bather, Rob Fitzpatrick and Max Rutherford, September 2008, Police and mental health, Sainsbury Centre for Mental Health, Briefing 36; Royal College of Psychiatrists, 2008, Standards on the use of Section 136 of the Mental Health Act 1983 (2007), College Report CR149; Maria Docking et al, op cit.*

removal power have enticed a person into a public place. The MHAC, for example, says it has "heard of several […] instances where s136 has been used to detain a person who has been asked or made to step outside of their home (or another private property) by police."[7] The Social Services Inspectorate (SSI) has suggested that this is so in a "significant minority" of section 136 cases.[8] For its part, the MHAC adds:

> *"[A]t a meeting with one London-based social services authority […] we noted that its audit showed that 30% of s.136 arrests were recorded as having been made at or just outside the detainee's home. Police officers were 'inviting' people out of their homes, or arresting them for a breach of the peace and 'de-arresting' them once outside to then invoke s.136 powers."*[9]

The IPCC study found evidence to the same effect, and notes:

> *"It was stated that this was generally done because officers were either: concerned about the welfare of the individual; did not feel they had time to wait for a warrant to be obtained under section 135 of the Mental Health Act 1983 (in order to lawfully detain someone in a private premise); and did not feel they had any alternative options for detaining the individual."*[10]

But if this practice is widespread, Richard Jones says it is unlawful,[11] a conclusion he draws from the case of *Seal v Chief Constable of South Wales Police*.[12] There, police were alleged to have arrested a man for breach of the peace in his own home, and to have then detained him under section136 "as a result of what happened in the street" outside. Passing judgment, Baroness Hale wondered, *obiter*, how the man could be said to have been "found in a place to which the public have access".[13] That case might not, however, represent the whole story.

The facts

The latest case came in the form of an appeal by Mary McMillan against her conviction for being drunk and disorderly in a public place. In Sunderland, in the early hours of a midsummer morning, two police constables had seen Ms McMillan in the street, waving her arms about and obviously drunk. When they told her to go home she did so, but a short time later the constables found her outside a house, shouting at the front door. The house belonged to her daughter and this time, Ms McMillan did not heed the suggestion that she go home. One of the constables, PC Spackman, went into the garden of the house, where he noted signs that Ms McMillan was intoxicated. She was shouting and swearing, although not towards the constable. He took hold of her arm and led her from the garden onto the pavement beyond. Because she had continued to shout and swear, the constable then arrested Ms McMillan for being drunk and disorderly in a public place.

The appeal judges noted that at first instance, the magistrates had accepted that:[14]

- At the front door, PC Spackman had tried to calm Ms McMillan down by warning her as to her behaviour, but she "took no reasoning".

7 *Mental Health Act Commission, 2008, Risk, Rights, Recovery: Twelfth Biennial Report, 2005–2007, TSO, paragraph 4.63.*

8 *Social Services Inspectorate, 2001, Detained: Inspection of compulsory mental health admissions, paragraph 6.8.*

9 *Mental Health Act Commission, 2008, op cit.*

10 *Docking et al, 2008, op cit, page 18.*

11 *Richard Jones, 2008, Mental Health Act Manual, Sweet & Maxwell, eleventh edition, paragraph 1-1253.*

12 *Seal v Chief Constable of South Wales Police [2007] UKHL 31; [2007] 4 All ER 177. See further: David Hewitt, Protection from what? The nullifying effect of section 139, Journal of Mental Health Law, November 2007, page 224.*

13 *Seal v Chief Constable of South Wales Police [2007] UKHL 31, per Baroness Hale at [60].*

14 *Judgment, at [4] (unless stated).*

- She came away from the door without force or struggle.
- The constable told her that he wanted to sort out the problem without an arrest.
- Although he took firm hold of her arm, it had not been against her will; there were steps in the garden and he wanted to steady her for her own safety.
- Ms McMillan continued shouting and swearing on the path and was warned several times about her behaviour.
- The pavement on which Ms McMillan was arrested was a public place.[15]
- The constable's intention in leading her there was to speak to her in the street.

The issue

The issue in this case was whether PC Spackman had acted lawfully when physically taking hold of Ms McMillan and leading her from the garden to the public footpath. At first instance, it had been the basis for a submission of no case to answer and an application to exclude the constable's evidence, both of which failed.

The appeal judges accepted that the disorderly behaviour on which the conviction was founded had to be limited to that on the public footpath, because the garden was a private place.[16] For Ms McMillan, however, it was argued that from the moment PC Spackman took her arm and led her from the garden, he was assaulting her, and that when she shouted and swore, she was not acting in a disorderly manner, but in protest at a continuing assault of which she was the victim.[17]

Both the magistrates and the appeal court accepted that the question of whether the constable's actions had amounted to an assault was to be answered by reference to *Collins v Willcock* [1984] 1 WLR 1172,[18] which suggested that:

(a) consent is a defence to assault, and most of the physical contacts of ordinary life are impliedly consented to by all who move in society and so expose themselves to the risk of bodily contact;

(b) alternatively – and preferably – there is no assault where physical contact is of a kind that is generally acceptable in the ordinary conduct of daily life;

(c) in either case, the test is whether the physical contact went beyond generally acceptable standards of conduct.

The judgment

In a judgment with which Mr Justice Penry-Davey agreed, Lord Justice McKay LJ said that the magistrates had been entitled to find that by taking Ms McMillan by the arm and leading her from the garden to the public footpath, PC Spackman was indeed acting within the bounds of what was generally acceptable.[19]

15 *Judgment, at [1] & [15].*

16 *This appears to be consistent with R v Edwards (1978) 67 Cr App R 228, a case decided under the Public Order Act 1936, and also with R v Leroy Lloyd Roberts [2003] EWCA Crim 2753 and R v Bogdal [2008] EWCA Crim 1, which were decided under section 139(7) of the Criminal Justice Act 1988 and section 3(1) of the Dangerous Dogs Act 1991 respectively. (See also: Director of Public Prosecutions v Fellowes (1993) 157 JP 936.)*

17 *Judgment, at [8].*

18 *See, in particular, Goff LJ at pp 1177 & 1178.*

19 *Judgment, at [11].*

It was clear that the magistrates were satisfied that the constable had hoped to achieve a "negotiated conclusion" and had therefore decided not to arrest Ms McMillan in the garden, perhaps for an offence under section 5 of the *Public Order Act 1936*. Furthermore, they had rejected the suggestion that the purpose of moving her from there was to justify an arrest for an offence that could only be committed in a public place.[20]

Finding that PC Spackman had not assaulted Ms McMillan, and therefore dismissing her appeal, McKay LJ said:

> *"In my judgment, in acting as he did, the [constable][,] who had had in mind the steepness of the steps in the garden and had wanted [in his own words] 'to steady her for her own safety'[,] can properly be said to have acted in conformity with 'generally acceptable standards of conduct.'"*[21]

Discussion

It is, of course, dangerous to compare cases from different areas of law; from different jurisdictions, indeed. There are, however, very few cases on the interpretation and use of section 136 of the *Mental Health Act 1983* and if we are to form a mature view of the limits and possibilities of that power, we are forced to look elsewhere.[22] That, in fact, is a sensible approach, for experience suggests that whether they are brought under the *Public Order Act 1936*,[23] the *Criminal Justice Act 1988*,[24] the *Road Traffic Act* of the same year[25] or the *Dangerous Dogs Act 1991*,[26] the precipitating facts of many cases are colourably the same: someone has been arrested in a public place for an offence that can only be committed there.

The circumstances in which Mary McMillan came to be arrested do not seem exceptional and for good or ill, the actions of PC Spackman do not seem unusual. For present purposes, indeed, they resemble the approach reported by the MHAC, the SSI and the IPCC, and condemned by Richard Jones.

When considering the lawfulness of that approach, it seems that a great deal will depend on why a police constable took the action he or she did. If the court can be persuaded that he or she went no further than what is "generally acceptable", it seems that an enticement – or even force – that persuades a mentally disordered person to quit a private place for a public will be eminently lawful.

20 *Judgment, at [12].*

21 *Judgment, at [13].*

22 *David Hewitt, 2008, op cit.*

23 *R v Edwards (1978) 67 Cr App R 228.*

24 *R v Leroy Lloyd Roberts [2003] EWCA Crim 2753; Harriott v DPP [2005] EWHC 965 (Admin).*

25 *David Lewis v Director of Public Prosecutions [2004] EWHC 3081 (Admin); May v Director of Public Prosecutions [2005] EWHC 1280 (Admin).*

26 *R v Bogdal [2008] EWCA Crim 1; Director of Public Prosecutions v Zhao and Zhao, QBD (Admin), 30 June 2003, Owen J.*

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