Chapter 21

POWERS OF RESTRAINT, AND THE PROTECTION OF STAFF

21.01 Introduction

There is sometimes a need for those who care for mentally disordered people to exercise some degree of management and control. Yet, legal and other professional texts have seldom given guidance as to the rights and responsibilities of persons exercising force over mentally disordered people.[1] The questions are not only academic but have profound practical importance.

First of all, this chapter deals with the rights of any person to be free from the use of unauthorised force. The use of such force, without a lawful justification, can constitute a trespass to the person (battery, assault or false imprisonment). This is not only a civil wrong but is also a criminal offence. There are other specific offences—*e.g.* ill-treatment or wilful neglect of patients—which are provided for under the Mental Health Act (see paras. **25.02–25.05** *post*). The chapter then examines the various legal powers and justifications for the use of restraint—consent, the prevention of harm and the Mental Health Act. Finally, there is an examination of the scope of section 139 which provides certain protection from civil actions and criminal prosecutions for those purporting to act in pursuance of the Mental Heath Act.

21.01.1 *Practice pointers for the management of difficult or dangerous behaviour*

The Code of Practice (paras 18.1–18.30) gives detailed guidance on the management of difficult or dangerous behaviours. Patients themselves should not be labelled as difficult or dangerous. But persons in general health care, as well as psychiatric, settings may engage in behaviours which impede the ability of staff to provide beneficial treatment or even pose a risk to themselves or others. These behaviours include unreasonable refusals to participate in treatment programmes,[2] prolonged verbal abuse and threats, self injurious or destructive behaviour, including physical attacks on patients or staff. Difficult or dangerous behaviour can result from a person's mental condition, but environmental factors within the health care facility staff can contribute: boredom and lack of environmental stimulation and programme activity; overcrowding, lack of privacy, or excessive noise and stimulation, antagonism, aggression, or provocation by others; an unsuitable mix of patients; staff showing lack of sensitivity, respect or rewarding undesirable behaviour by attention.

Staff must be sensitive to the fact that health care facilities, particularly large, sterile institutions are not normal living environments. Disruptive behaviour can often be prevented by making the environ-

[1] One notable exception is B. Hoggett (1985) Legal Aspects of Secure Provision, in L. Gostin (ed.) *Secure Provision: A Review of Special Services for Mentally Ill and Mentally Handicapped People in England and Wales*, London, Tavistock.

[2] A refusal to consent to specific treatments should not, in itself, be regarded as difficult or obstructive behaviour.

ment more conducive to normal living; keeping patients fully informed; giving patients personal space, privacy, and a secure location for their clothes and possessions; providing sufficient opportunity for recreation and access to open space; providing separate places for recreation, quiet time, and visits; providing adequate facilities for telephones, writing letters, studying, etc.; providing structured activities for work, leisure and sports; having sufficient numbers of well trained staff; handling complaints fairly and quickly. The most effective way to prevent difficult behaviour is to develop a well thought out treatment plan, in consultation with the patient, and treating the patient with sensitivity, dignity, and respect.

Health authorities should have clear, written policies on the use of restraint. Physical restraint should be used only as a last resort and should be the least restrictive and obtrusive as possible. Restraint which involves either tying or hooking a patient (whether by means of a tape or by using a part of the patient's garments) to some part of a building or to its fixtures or fittings should never be used. Staff must make a balanced judgment between the need to promote an individual's autonomy by allowing him to move around at will and the duty to protect him from likely harm. In every case where the physical freedom of an individual is curtailed in his own interests, staff should record the decision and the reasons for it and state explicitly in a care plan under what circumstances restraint may be used, what form the restraint may take, and how it will be reviewed. Every episode of restraint must be fully documented and reviewed (Code of Practice, para. 18.9). Where non-physical methods have not, or will not, work, staff should use the minimal force necessary to control the situation without ever harming the patient. Controlling behaviour by medication should not be used for administrative convenience or because there are insufficient or untrained staff; medication should be used only under the careful supervision of a doctor for legitimate clinical purposes.

Any form of restraint lasting more than two hours should be reported to a designated senior manager. The manager should then interview and observe the patient at regular intervals. (As to the use of seclusion, see paras **3.12A** and **20.08A** *ante*).

A ward should not be locked because of administrative convenience or because of the lack of sufficient trained staff. The nurse in charge of the ward has discretion to lock the ward door for the safety of patients. The nurse should inform the RMO or nominated deputy, the line manager, other relevant staff and patients, giving adequate reasons; allow patients to leave if their behaviour would not endanger themselves or others; and keep adequate records of the action and reasons for it. Informal patients should not be detained against their will, but holding powers under section 5 could be considered. (See paras **10.03–10.05** *ante*).

Children in care cannot be placed in accommodations which restrict

their liberty for more than 72 hours without permission from the juvenile court. (Children Act 1989, s. 25. See para. **21.16A.2** *post*).

Patients should never be deprived of appropriate day time clothing with the intention of restricting their freedom of movement. Patients should also not be deprived of other rights, privileges, and aids for their daily being. The goal of mental health care is to ensure as normal and unrestricted a living environment as possible.[1]

A. LIABILITY FOR UNLAWFUL RESTRAINT

21.02 Trespass to the Person

21.02.1 *Battery and Assault*

The torts known as battery and assault are based upon the common law action of trespass to the person. Any direct and intentional application of force to another person without lawful justification is a battery. Reasonable fear or apprehension of the unjustified use of force is an assault. Trespass to the person is actionable *per se*; it does not require proof of actual injury. The slightest unwanted contact is a battery.[2] Trespass effectuates the common law's regard for personal self-determination; the force used may be intended for the individual's best interests but will still amount to actionable battery unless the person has lawful justification for the use of force.

A battery would result from any handling of a mentally disordered person by force unless it was justified, for example, by the person's consent. Setting aside for the moment whether there is lawful justification for the act, a battery would occur if a mentally disordered person

[1] For a comprehensive review of secure accommodation and the management of difficult or dangerous behaviour, see L. Gostin (1986) *Institutions Observed: Toward a New Concept of Secure Provision in Mental Health.* Kings Fund Publishing Office, London; L. Gostin (ed.) (1985) *Secure Provision: A Review of Special Services for the Mentally Ill and Mentally Handicapped in England and Wales.* Tavistock, London.

[2] *Cole v. Turner* (1705) 6 Mod. Rep. 149.

were physically controlled or restrained by any means—*i.e.* the application of personal or bodily force, mechanical restraints or sedation.

21.02.2 *False Imprisonment*

False imprisonment is another form of trespass to the person. It is the unlawful and total restraint of a person's liberty or movements, whether by constraining him from leaving, or compelling him to go to, a particular place. Confining a person in a hospital, a place of safety, a public place, or even one's own home[1] without lawful justification constitutes a false imprisonment;[2] so, too, is continuing to confine a person once the authority for detention has expired or has otherwise ceased[3]. The barriers used need not be physical as when a Commissioner in Lunacy dissuaded a patient on a trial leave of absence from leaving his office.[4] Usually when there is a false imprisonment there is also an assault or battery, but not, for example, where a person voluntarily enters a hospital ward which subsequently is locked. A person who is falsely imprisoned, in addition to bringing a claim in tort, has the remedy of *habeas corpus*, which will lie to obtain the release of any person unlawfully confined. (See further para. **17.07** *ante*).

In *Furber v. Kratter*[5] (an application for leave to commence proceedings under section 139 of the Act) the question arose whether a patient who was lawfully detained could bring an action for false imprisonment when she was secluded in a special hospital under inadequate conditions. Henry J rejected the proposition that "a lawful detention cannot be made unlawful by a change in the conditions of that detention to a harsher regime". He relied upon the dictum of Ackner LJ in the Court of Appeal in *Middleweek v. Chief Constable of Merseyside*[6] where he said that he could "conceive of hypothetical cases in which the conditions of detention are so intolerable as to render the detention unlawful and thereby provide a remedy to the prisoner in damages for false imprisonment. A person lawfully detained would . . . cease to be so lawfully detained if the conditions in the cell were such as to be seriously prejudicial to his health. . . ."

In *Hague v. Deputy Governor of Parkhurst Prison and others*; *Weldon v. Home Office*[7] the House of Lords disapproved Ackner LJ's statement in *Middleweek*, holding that a prisoner who is subjected to intolerable conditions of detention which are seriously prejudicial to health has

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[1] *Warner v. Riddiford* (1858) 4 C.B. (N.S.) 180.

[2] See W. Blackstone (1796) *Commentaries on the Laws of England* III, p. 127.

[3] See *Mee v. Cruickshank* (1902) 20 Cox 210; 86 L.T. 708 (confinement after acquittal or term of imprisonment has expired).

[4] *Harnett v. Bond* [1925] A. C. 669, H.L.

[5] (1988) *The Independent*, August 9, 1988, CO/559/88. Transcript: Marten Walsh Cherer. See further para. **21.25** below.

[6] (1984) [1990] 3 WLR 481 at 487; [1990] 3 All E.R. 662 at 668.

[7] [1991] 3 All E.R. 733.

both a public law remedy by way of judicial review and, if he sustains injury to health, a private law remedy in negligence, but no remedy for false imprisonment since an alteration in his conditions of confinement cannot alter the nature of his confinement or the fact that he has no liberty capable of deprivation. Lord Ackner accepted that his dictum in Middleweek was erroneous. Once a person is lawfully detained, English law recognises no concept of "residential liberty" which can be protected by an action for false imprisonment.

The authorities owe a duty of care to those whom they detain. In *H v. Home Office*,[1] as a result of a failure by the prison authorities to take adequate precautions a printout of the prisoner's convictions fell into the hands of other inmates, two of whom assaulted him in his cell. He was then, at his own request and for his own safety, removed from association with other prisoners under rule 43 of the Prison Rules 1964, as a result of which he was locked in his cell for 23 hours per day and had no opportunity to work, thus losing earnings. At first instance H was awarded £50.00 damages for the assault which had resulted from the negligence of the authorities, and £300 for the reduced quality of life consequent upon his segregation under rule 43. The plaintiff appealed on the grounds that the £300 was inadequate, and the Home Office cross appealed on the grounds that as a result of the House of Lords decision in *Hague* there could be no entitlement to damages in negligence in respect of segregation under rule 43.

Although the award of £50.00 in respect of the assault was upheld, the Court of Appeal granted the Home Office appeal against the damages for the segregation, holding per Balcombe LJ that "If the treatment complained of falls short of 'intolerable conditions', then there is only a remedy in damages if the plaintiff can establish malice on the part of some person for whose acts the Home Office is in the circumstances liable, so as to establish the tort of misfeasance in public office."

The reasoning in these cases ought to be equally applicable where an action is brought by a detained patient placed in seclusion without justification or in intolerable conditions.

As to seclusion in special hospitals, see para. **3.12A** *ante*.

21.02.3 *Direct Action*

Trespass to the person requires some direct action causing loss of liberty. A doctor certifying a person as of unsound mind under the Lunacy Act 1908 did "cause" the detention, even though it was a justice who made the order for detention.[2] A person who unlawfully compelled a patient on a trial leave of absence to go back to hospital

[1] CA judgment of 30 April 1992, *The Independent* 6 May 1992, The Times 7 May 1992, Transcript: Association.
[2] *De Freville v. Dill* (1927) 96 L.J.K.B. 1056.

would have "caused" the detention up until the time a person was admitted, but the subsequent detention of the person at various institutions would not be the direct consequence of the initial wrongful act.[1] It is likely that a modern court would hold that a person signing an application or medical recommendation in bad faith or without reasonable care would directly "cause" the patient's confinement, at least until those in charge of his care at the hospital had the chance to examine him and determine if he is fit to be discharged.

21.02.4 *Knowledge of the Restraint*

An important point in the mental health context is whether the person must know if his liberty is unlawfully restrained. A severely mentally handicapped or an elderly senile patient in hospital informally may not realise that he is being deprived of his liberty when locked in a room. In *Herring v. Boyle*[2] it was held that it was not false imprisonment if a child did not know he was being detained. That case cannot be regarded as conclusive for there was in any event, no evidence of actual restraint. Adoption of such a position would leave some severely mentally ill or mentally handicapped patients without a remedy were they to be unlawfully confined; this is particularly so if they were informally admitted and did not have the safeguards afforded by the Act. The preferred view is that of Atkin, L.J. in *Meering v. Graham-White Aviation Co.*[3]: ". . . a person can be imprisoned while he is asleep, while he is in a state of drunkenness, while he is unconscious, and while he is a lunatic". This was the view taken by the Court of Appeal in *L. v. Bournewood Community Mental Health NHS Trust*:[4] "a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving."

21.03 Criminal Offences

Assault, battery and false imprisonment are all also criminal offences. Generally, the definitions are the same in crime as in tort, except that consent as a defence in tort is probably wider than it is in crime.

21.03.1 *Offences under Mental Health Legislation*

Mental health legislation also provides for a number of specific offences which are examined in Chapter 25. Of particular relevance here is section 127 (ill-treatment of patients) and section 128 (assisting patients to absent themselves without leave) of the 1983 Act, and section 128 of the 1959 Act (sexual intercourse with patients).

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[1] *Harnett v. Bond* [1925] A.C. 669, H.L.
[2] (1834) 1 Cr. M. & R. 377.
[3] (1919) 122 T.L.R. 44, at 53–54.
[4] *The Independent* 5 December 1997, *The Times* 8 December 1997, Court of Appeal (Civil Division) (Transcript: Smith Bernal). See further para. **11.02A** *ante*.

21.04 Negligence

21.04.1 *Duty of care owed by those signing an Application or Medical Recommendation*

A person signing an application or a medical recommendation under Part II of the Act has a duty of care towards the patient. It follows that an action on the case for negligence (as opposed to trespass to the person) will lie where the professional does not exercise the standards of reasonable care that would be used by his fellow professionals.[1] (As to the traditional test of negligence, see para. **20.12.1** *ante*).

21.04.2 *Duty to protect third parties from risks posed by patients*

Mental health professionals and others who have a responsibility for managing or treating patients certainly owe a duty of care to protect the patient himself. An interesting question arises, however, whether a duty of care exists to protect third parties from risks posed by patients. Suppose a patient, whether detained or otherwise, is intentionally or negligently released and then harms a person in the community. Does the mental health professional owe a duty to protect that person in the community?

A duty of care is established by examining three criteria: foreseeability, proximity of relationship, and fairness.[2] The courts will inquire, firstly, whether the harm caused was reasonably foreseeable; secondly, whether there exists a close relationship between the party owing the duty and the person harmed; and, thirdly, whether in the circumstances it is fair, just, and reasonable to impose the duty. In understanding foreseeability and the proximity of the relationship, it is important to consider the person who is harmed. If the person comes within special, exceptional, or distinctive category of risk from the patient, it is more likely that a duty of care will be established. For example, if the mental health professional knew, or should have known, that the patient would cause harm to an identifiable person, as opposed to a general population placed at risk, then the case for a duty of care increases.[3]

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[1] *Harnett v. Fisher* [1927] A.C. 573; *De Freville v. Dill* (1927) 96 L.J.K.B. 1056. See also *Hall v. Semple* (1862) 3 F. & F. 337 and *Everett v. Griffiths* [1921] A.C. 631, H.L. where it was assumed, but not yet decided, that there was a duty to use reasonable care in signing certificates of insanity.

[2] *Caparo Industries plc v. Dickman* [1990] 2 A.C. 605, [1990] 1 All E.R. 568, per Lord Bridge.

[3] *Hill v. Chief Constable of West Yorkshire* [1989] 1 A.C. 53, [1988] 2 All E.R. 238 (In distinguishing *Hill* from *Dorset Yacht*, Lord Keith said: "Miss Hill was one of a vast number of the female general public who might be at risk from his activities but was at no special distinctive risk in relation to them, unlike the owners of a yacht moored off Brownsea Island in the foreseeable conduct of the Borstal boys."); *Palmer v. Tees Health Authority and Another* Q.B.D. 8 April 1998 (Transcript: V. Wason) (holding that a health authority owed no duty to a girl who was brutally murdered after the patient's discharge from outpatient care; the patient had informed the authorities that a child "would be murdered" but did not specify a particular child's identity).

The duty to protect was most famously recognized in the American case of *Tarasoff v. Regents of the University of California*[1] where a therapist was held liable for failing to protect his patient's girlfriend of the patient's intent to kill her.[2] Under *Tarasoff*, the duty to protect requires: (1) *foreseeability*—the therapist must have determined, or reasonably should have determined, that his patient poses a risk to another; (2) *a serious risk*—the risk posed to the third party must be genuine and not merely speculative or remote; and (3) *an identifiable victim*—the person endangered should be known to the patient and therapist.

Given the importance of foreseeability, proximity of relationship, and fairness, consider whether a duty of care would exist in the following cases:

What duty is owed to the patient himself to prevent him from harming himself?

Persons charged with the care and supervision of hospital or guardianship patients almost certainly have a duty to protect them from coming to foreseeable harm. For example, a nurse who negligently allows an obviously suicidal patient to remain unsupervised or to leave the hospital premises could face liability if the patient kills himself.[3] The relationship between the nurse and the patient is special and intimate and the nurse could reasonably forsee that a suicidal patient might take his own life.

A number of cases involving suicides by mentally ill persons detained in prison have reached the courts, presenting interesting issues of causation and duty of care. A case before the Queen's Bench Division, *Knight and others v. Home Office*,[4] dealt with the suicide of a mentally ill person detained in a remand prison pending his admission to hospital pursuant to a hospital order. Due to his violent tendencies, he had not been kept on an open ward, which would have allowed constant observation, but was held in a single cell, and observed every fifteen minutes. During one of these intervals, he hung himself. Pill J acknowledged that the prison authorities had a duty of care to protect a mentally ill patient against himself, but held that in this instance the duty had

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[1] 551 P.2d 332 (Cal. 1976).

[2] The case involved the murder of Tatiana Tarasoff, who was the former girlfriend of Prosenjit Poddar, a mentally-deranged patient of psychotherapist, Dr. Lawrence Moore. In therapy sessions Poddar conveyed to Dr. Moore his intent to kill Tarasoff. Dr. Moore did not warn Tarasoff or her parents, but instead asked the campus police to pick up Poddar. Although the police detained Poddar initially, he was later released on his recognizance after being advised to stay away from Tarasoff. Two months later, Poddar murdered Tarasoff.

[3] The issue of "control" over the patient would be relevant. Compare the situation where a nurse negligently allowed a detained patient to abscond, with the situation where the absconder was informal. Would it matter in the latter example whether the nurse was of the class prescribed for the purposes of s. 5(4)?

[4] [1990] 3 All E.R. 237.

been met. The judge stated that the duty of care in a prison hospital is not as high as that in a psychiatric hospital, as the latter specialises in treatment, and the former in detention. Accordingly, a prison that did not provide the same facilities in the prison hospital as would be expected in psychiatric hospitals was not negligent in its care of a mentally ill prisoner who committed suicide.

Breach of duty in regard to a suicide was found in *Kirkham v. Chief Constable of the Greater Manchester Police*.[1] The Court of Appeal upheld a finding of negligence on the part of the police when they failed to inform prison authorities of the known suicidal tendencies of a prisoner. The police, when arresting the deceased, assumed a responsibility "to pass on information which might affect his well-being". They failed in this duty, particularly in their omission to complete and submit a form designed to alert prison authorities of persons regarded as exceptional risks.

Although the divisional court in *Kirkham* found the element of causation met by a finding that on the probabilities, Mr. Kirkham would have been prevented from suicide had the prison authorities been informed, the Court of Appeal stated that merely showing that the omission materially increased the risk of a successful suicide attempt would be sufficient.[2]

Is there a duty of care to take reasonable steps to prevent a dangerous patient from causing harm to other patients?

The answer to this question depends on the foreseeability of the harm and the proximity of the relationship between the care taker and the person harmed. For example, in *Dorset Yacht*, the House of Lords held that officers in charge of borstal trainees should reasonably have foreseen that if they failed to exercise proper control or supervision that the boys might escape and cause damage to property. The harm in that case was foreseeable since the Yacht was moored on the very Island where the borstal trainees were detained.

Suppose that a patient, known to be violent, was left unsupervised so that the doctor knew, or should have known, that he would assault his fellow patients. Arguably the relationship between the doctor and other patients on the hospital ward is sufficiently special that there exists a duty of care to protect them against dangerous patients. Lord Morris in *Dorset Yacht* said:[3] "If someone is serving a sentence of imprisonment and consequently is not free to order his own movements . . . those in charge of the prison owed him a duty to take reasonable care from being assaulted by a fellow prisoner. . . ."

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[1] [1990] 2 Q.B. 283, [1990] 3 All E.R. 246, [1990] 2 W.L.R. 987.

[2] *R. v. HM Coroner for Birmingham, ex parte Secretary of State for the Home Department* (1991) 155 JP 107, also involved a prison suicide. But Watkins LJ held that the determination of breach of duty by prison officials is not the function of a coroner's jury.

[3] [1970] 2 All E.R. at 309.

Clearly, the care taker must have had the power to control the patient who caused injury. Further, the mere occurrence of harm by one patient to another does not of itself prove there was a failure of duty; there must be negligence.

What responsibility exists for negligently exercising a statutory function?

Could the hospital managers or the RMO be liable for negligently granting a patient a discharge or a leave of absence under the Mental Health Act? Here, the House of Lords in *Dorset Yacht* followed Lord Blackburn in *Geddis v. Proprietors of Bann Reservoir*:[1] "no action will lie for doing that which the legislature has authorised, if it be done without negligence, although it does occasion damage to anyone; but an action does lie for doing that which the legislature has authorised if it be done negligently."[2] However, it is clear that the exercising a discretion given by statute, a person is not liable for mere errors of judgment. The House of Lords, referring to *Holgate v. Lancashire Mental Hospital Board, Gill and Roberton*,[3] said that the release of a mental patient could result in liability only if it was "authorised so carelessly that there had been no real exercise of discretion."[4]

Does the patient's own unlawful violent act preclude his claim for damages arising from the health authority's negligence?

This was the question facing the Court of Appeal in *Clunis v. Camden and Islington Health Authority*.[5] Mr. Clunis, a mental patient with a history of serious violence, killed a stranger. He pleaded guilty to manslaughter on grounds of diminished responsibility. At the time of the killing, Mr. Clunis had been discharged from hospital where he had been detained under section 3 of the Act. Pursuant to section 117, the health authority had a duty to arrange aftercare in conjunction with the local social services authority. (See further, para. **4.08** *ante*). Mr. Clunis' case was that the health authority did not provide effective aftercare necessary to prevent his violent act. He claimed damages for himself because his mental condition worsened as a result of the killing, and he claimed indemnity against damages that he would have to pay to the victim's widow. The authority argued, however, that the maxim *ex*

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[1] (1878) 3 App. Cas. 430 at 455–56.

[2] *Dorset Yacht*, per Lord Reid [1970] 2 All E.R. at 301.

[3] [1937] 4 All E.R. 19.

[4] *Home Office v. Dorset Yacht Co. Ltd.*, per Lord Reid [1970] 2 All E.R. at 302. Compare with Lord Morris at 309: "I consider that in a comparable situation [to *Holgate*] a duty of reasonable care would be owed to those whose safety, as reasonable foresight would show, might be in jeopardy.")

[5] *The Independent* 9 December 1997, *The Times* 10 December 1997 (Transcript: Smith Bernal).

turpi causa non oritur actio[1] prevented the patient from recovering damages when his own actions were illegal and unconscionable.[2]

The Court of Appeal accepted the authority's argument, holding that, whether a person's claim is founded in contract or in tort, public policy "requires the court to deny its assistance to a plaintiff seeking to enforce a cause of action if he was implicated in the illegality. He must know, or be presumed to know, that he was doing an unlawful or wrongful act. While Mr. Clunis' responsibility was diminished by reason of mental disorder, he did know the nature and quality of his act or that what he was doing was wrong. Since Mr. Clunis was not found not guilty by reason of insanity, he must be taken to have known what he was doing and that it was wrong. Consequently, the court "ought not to allow itself to be made an instrument to enforce obligations alleged to arise out of the plaintiff's own criminal act. . . ."

[1] As to the origin of the maxim, see *Holman v. Johnson* (1775) 1 Cowp 341 ("A court will not lend its aid to a man who founds his cause of action on an illegal or immoral act.").

[2] The authority also argued (and the Court of Appeal agreed) that its statutory duty to provide aftercare does not give rise to a common law duty of care. See further para. **4.08.5A** *ante*).

B. CONSENT AS A JUSTIFICATION FOR THE USE OF RESTRAINT

21.05 The Elements of Effective Consent

Consent is usually a defence[1] to an action in trespass to the person. A patient may, for example, request a private room or seclusion (or "time out") as part of a general programme of behaviour modification (as to which see para. **20.08** *ante*). Consent can be given expressly, by words or writing; or it can be implied by gestures, conduct or the absence of any resistance to an act ordinarily expected in the course of a professional/patient relationship.

[1] Although consent, in an action in trespass, is often regarded as a "defence", the burden of proof is on the plaintiff. *Chatterton v. Gerson* [1981] Q.B. 432; [1981] 1 All E.R. 257.

21.05.1 *Consent must be to the actual act performed*

The elements which normally comprise legally effective consent have already been discussed in relation to medical treatment. (See paras. **20.11–20.16** *ante*) and have equal application here. However, there are a number of theoretical and practical difficulties particularly associated with consenting to have one's movements constrained which require discussion. The first is that consent must be to the actual act performed. The patient must be given sufficient information about what is to be done so as to allow him broadly to understand the nature and effect of the restraint. (See further para. **20.12** *ante*). A patient, by entering the hospital informally, may have implicitly agreed to reasonable restraint necessarily entailed in the operation of the hospital—for example, limiting visiting hours or locking the doors of a ward at night. The difficulty is that an informal admission does not require consent, but only the absence of an expressed objection. Further, the patient would have to be informed, in broad terms, of the hospital's internal rules and understand them.

21.05.2 *Consent must be given voluntarily*

Consent must be voluntarily given. Consent is vitiated if it is given by coercion or fraud. A person who admits to an act only because he believes that otherwise he will be compelled to accept does not submit voluntarily. Consent obtained by a show of authority—for example, a nurse commanding an informal patient to enter a seclusion room or to submit to a personal search—might be no consent at all.[1] The patient also cannot be medically induced into a physical or mental condition which would significantly undermine his capacity to consent voluntarily.[2] The threat of compulsory admission if an informal patient decides to leave the hospital could undermine the free choice of the patient.[3] However, if there were real grounds for the threatened action (*i.e.* the patient's condition actually came within the statutory criteria for compulsory admission) the patient's consent to the restraint might be upheld.[4] It is probably not enough for the patient to show that consent was given reluctantly,[5] or under the mistaken belief that the defendant was legally entitled to act as he did.[6] Whether a patient or prisoner can consent freely is a matter of fact in each case; there is no

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[1] See *Warner v. Riddiford* (1858) 4 C.B. (N.S.) 180.

[2] See *Beausoleil v. Soeurs de la Charité* (1964) 53 D.L.R. (2d.) 65 (A Quebec case where consent was vitiated because it was obtained by the imposition of a sedative and was given in words of defeat and abandonment of willpower.).

[3] Cf, *State v. Volschenk* (1968) 2 PH, H283(D) (South African case where the threat of malicious prosecution by a policeman was held to vitiate a woman's consent to sexual intercourse.).

[4] *Buckland v. Buckland* [1967] 2 All E.R. 300.

[5] *Freeman v. Home Office* [1983] 3 All E.R. 589, at 597, upheld on appeal [1984] 1 All E.R. 1036.

[6] *Latter v. Braddell* (1881) 50 L.J.Q.B. 448, 44 L.T. 369.

matter of law which would presuppose that a detained person, because of the institutional pressures upon him, could not give consent of his own free will.[1]

21.05.3 *Consent may be withdrawn*

Consent may be withdrawn by the patient at any time.[2] This may not be important in respect of medical treatment where it is, in practice, difficult to withdraw consent once the treatment is in the process of being administered. However, it often is possible to withdraw consent where the use of force is involved—for example, where the patient agrees to a period of seclusion but later asks to be let out.

21.06 The Incompetent Patient: Justification for Restraint in the Absence of Consent

The law's protection of the self-determination of the individual is founded almost entirely upon his ability to make a competent decision. Yet surprisingly little attention has been given by the courts or commentators to the most significant issues surrounding competency. What must the patient understand in order to be competent? It is generally thought that an understanding of the broad nature and effects of an act is sufficient to establish competency to consent to that act. (Competency is not an all-or-nothing concept but can vary over time and in respect of particular decisions.) If only a "broad terms" explanation of the act is required for consent to be "real", the corollary should be that a patient is competent if he understands that "broad terms" explanation.[3] This low threshold of competency would preserve the autonomy of mentally ill and mentally handicapped people by, wherever possible, upholding the validity of their consent.[4]

21.06.1 *The doctrine of necessity*

A more crucial question arises as to how a person can be constrained (if at all) if he is permanently unable to understand the broad terms of the act proposed. An illustration common to most

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[1] *Freeman v. Home Office* [1984] 1 All E.R. 1036, C.A. But see the American case of *Kaimowitz v. Michigan* (1973) 42 U.S.L.W. 2063. ("It is impossible for an involuntarily detained mental patient to be free of ulterior forms of restraint or coercion when his very release from the institution may depend on his cooperation with the institutional authorities and giving consent to experimental surgery.")

[2] But see line of cases suggesting that if a person enters into a contractual obligation to remain in a confined space, he may not be able to leave except in accordance with the terms of the contract. *Robinson v. Balmain New Ferry Co.* [1910] A.C. 295; *Herd v. Weardale Steel, Coal and Coke Co. Ltd.* [1915] A.C. 67.

[3] See Hoggett (1985) Legal Aspects of Secure Provision, in L. Gostin (ed.) *Secure Provision for Mental Patients: A Review of Special Services for Mentally Ill and Mentally Handicapped People in England and Wales.* London, Tavistock.

[4] See the low threshold required for consent of a mentally handicapped woman to sexual intercourse by the Supreme Court of Victoria in *Morgan* [1970] V.R. 337.

mental hospitals is whether the door can be locked to prevent the senile elderly patient from leaving the hospital; or whether a severely mentally handicapped patient can take part in a programme of behaviour modification which involves the administration of an aversive (*i.e.*, painful or unpleasant) stimulus or restraint?[1] The doctrine of "necessity" may, in certain circumstances, provide a justification for proceeding without consent.[2] Plainly, restraint that is immediately necessary to preserve life can be used where the person is non-volitional. Thus, if the senile patient referred to above was about to wander (unsupervised and unaware of the danger) onto a public road, a nurse could undoubtedly restrain him. The scope of the doctrine of necessity is uncertain and any case would probably turn on its own facts. Relevant considerations would include whether the person is likely to re-gain competency; whether the danger is serious and immediate; and whether the restraint used is necessary and not merely convenient. It is suggested that the doctrine of necessity would probably provide sufficient protection for the staff member who used reasonable force which was immediately necessary to prevent an incompetent patient from coming to any obvious and significant harm. However, the law at present does not provide sufficient guidance for staff in their day-to-day decisions in the management of disruptive, dangerous or wandering patients, who have no clear advance notice as to how such concepts as "immediate", "reasonable" and "necessary" might be construed by a court after the fact. (As to the "informal" admission of a patient who is unable to consent, see para. **11.02A** *ante*.)

21.07 Where Consent Is Not A Defence: Abetting Suicide or Mercy Killing

The overriding public policy interest of preventing crime is such that consent is not necessarily a defence to an unlawful act. The general principle is that it is unlawful to use such force that bodily harm is a probable consequence. A patient could not, for example, consent to a beating, even if he voluntarily entered into a fight with a member of staff or another patient.[3] It is a specific statutory crime to aid, abet, counsel or procure a suicide or attempted suicide;[4] and it is an offence to kill by consent. The motives in assisting a person in chronic pain to take his own life or mercy killing may be benign, but the patient's agreement will not provide a defence in crime. There is one case

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[1] The reader should appreciate that, where the use of restraint can be categorised as a medical treatment for mental disorder given to a patient to whom Part IV of the Act applies, the justification may be found under the Mental Heath Act. See further paras. **20.17–20.28** *ante*.

[2] See further Skegg [1974] A Justification for Medical Procedures Performed Without Consent, *L.Q.R.* vol. 90, p. 512; Williams (1978) Defences of General Application, (2) Necessity, *Crim. L. Rev.* 128; and para. **20.16** *ante*

[3] See *Attorney-General's Reference (No. 6 of 1980)* (1981) 73 Cr. App. R. 63.

[4] Suicide Act 1961, s. 2(1). It is no longer a crime to commit suicide (s. 1).

provided for in the Mental Health Act (*i.e.* the administration of psychosurgery or sex hormone implant treatments) where the consent of the patient alone cannot provide a justification for the treatment (s. 57). (See further para. **20.20** *ante*).

C. PREVENTION OF HARM AS A JUSTIFICATION FOR RESTRAINT

21.08 Prevention of Crime

The Criminal Law Act 1967 (s. 2) creates a category of more serious offences, termed arrestable offences, in respect of which a person is invested with specified powers of arrest without warrant. Section 3(1) provides for the use of force either in making an arrest or in the prevention of crime; a person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large. Unquestionably this would allow any private person to use reasonable force to prevent a crime which is actually in progress or is about to be committed; but it would not justify punishment of a person who has already committed an offence. It would, for example, allow a nurse to restrain a patient who is about to do imminent harm to other persons or the property; or to restrain a patient who has taken, or who is about to take, property belonging to another patient or to the hospital.

21.08.1 *Possession of an unauthorised offensive weapon*

Possession of an unauthorised offensive weapon in a public place is itself an offence under the Prevention of Crime Act 1953, s. 1. An offensive weapon includes those either made (*e.g.* a gun) or adapted (*e.g.* a broken bottle) for use in causing injury to the person. It can even include a kitchen knife or spanner if the intention is to use it for causing injury. Reasonable force could, therefore, be used to remove an item which a member of staff reasonably believes is to be used to cause injury.

21.08.2 *"Reasonable in the circumstances"*

Restraint used in the prevention of crime must be "reasonable in the circumstances". Reasonable force incorporates two concepts: the force must be **necessary** and it must be **proportionate** to the harm to be avoided. Only that force which is necessary to prevent an offence is justified. If the offence could have been prevented without the use of force, or by the use of lesser force, that course of action must be adopted. For example, if a patient can be verbally dissuaded from doing

violence, that must be attempted. Further, the **degree** and **duration** of the force must be proportionate to the harm to be prevented. For example, a nurse or doctor could not beat a patient or render him unconscious to prevent him from stealing property.[1] Nor could a patient be secluded or placed into mechanical restraints for a period long after the immediate danger has passed; the use of force must be the least necessary to bring the threatened harm to an end. It is possible that, in relation to minor offences (*e.g.*, stealing a spoon from the canteen), **no** force "reasonably" could be used. The member of staff must ask himself these questions: is it reasonable to use any force at all; what is the least amount of force which is necessary to accomplish the objective; when is the danger realistically over so that the force can be discontinued? The member of staff should seek to avoid or to minimise the use of force so as not to cause the patient any unnecessary injury; punishment, retaliation and excessive force can never be justified.[2]

21.08.3 *The making of "fine" judgements is not necessary*

The person exercising force, particularly in an emergency, is not expected to make a fine calculation: "Detached reflection cannot be demanded in the presence of an uplifted knife".[3] The concept of reasonableness is intended to prevent gross over-reaction—*i.e.*, to use force of such degree or duration which no reasonable person would be expected to use in the circumstances.

21.08.4 *Suicide is not a crime*

There are several difficulties with the right to prevent "crime", particularly as it relates to control within a mental hospital. Taking reasonable steps to prevent a person from taking his own life, as it is not a crime, may not be justified under this provision. What is the position of a nurse who takes the instruments of suicide from a mentally disordered patient or otherwise restrains him; or a doctor who medically treats a patient to save his life? Depending on the immediate circumstances of the case, the justification would probably be found either in the common law power of arresting the dangerous mentally ill person (see para. **21.11** below) or in the doctrine of necessity (see para. **21.06.1**

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[1] See generally, Criminal Law Revision Committee *(1965) Seventh Report*, Cmnd. 2659, para. 23.

[2] As to the question for the jury see *Reference under s. 48A of the Criminal Appeal (Northern Ireland) Act 1968 (No. 1 of 1975)* [1976] 2 All E.R. 937 at 947; [1977] A.C. 105 at 137, per Lord Diplock.

[3] Dictum of Justice Holmes in *Brown v. United States*, 256 U.S. 335 at 343; 41 S. Ct. 501. See also *Reed v. Wastie* (1972) *The Times*, Feb. 10; [1972] Crim. L. Rev. 221. ("In the circumstances one did not use jeweller's scales to measure reasonable force."); *Cockcroft v. Smith* (1705) 2 Salk. 642; 91 E.R. 541.

above). But note that in *Bryan v. Mott*[1] the court held that a person who had with him in a public place a broken milk bottle with the intention of using it to commit suicide was guilty of the offence of carrying a dangerous weapon. (See para. **21.08.1** above).

21.08.5 *An insane person cannot commit a crime*

A person who is insane within the meaning of the M'Naghten Rules (see para. **13.04** *ante*) cannot commit a crime. Rarely will a patient, even in a mental hospital, meet the M'Naghten criteria. Nevertheless the question arises whether a person restraining an insane patient from a dangerous act can use the 1967 Act to justify his behaviour. If the person restraining the patient knew him to be insane, or reasonably should have known, then the answer could be in the negative. Again, an alternative justification would surely uphold the right of a private person to prevent the insane patient from doing imminent harm to himself or others or to property. (See paras. **21.09–21.11** below).

21.09 Prevention of a Breach of the Peace

The common law powers of arrest for breach of the peace are preserved by the 1967 Act (s. 2(7)). A private person in whose presence a breach of the peace is being, or reasonably appears about to be, committed can use reasonable force to make the person who is breaching or threatening to breach the peace refrain from so doing.[2] At common law this is not only the right of every citizen but is also a duty.[3] There is a breach of the peace whenever harm is actually done or is likely to be done to a person or, in his presence, to his property; or where a person is in fear of being so harmed through an assault, an affray, a riot, unlawful assembly or other disturbance.[4] Thus, some harm (whether actual, likely or feared) is required. A patient whose words or behaviour are such that imminent violence is expected on a hospital ward would come within this definition; a nurse (or even a fellow patient) is entitled to take reasonable steps to make the person refrain from breaching or threatening to breach the peace.

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[1] (1976) 62 Cr. App. R. 71, D.C. Part of the hospital grounds where visitors were permitted to enter were held to be a public place in *R. v. Powell* [1963] Crim. L. Rev. 511, C.A.

[2] See *R. v. Howell* (1981) 73 Cr. App. R. 31, C.A. (where the power is exercised in the belief that a breach is imminent it must be established that it is an honest belief founded upon reasonable grounds).

[3] *Albert v. Lavin* [1981] 3 All E.R. 878; 3 W.L.R. 955, H.L.

[4] *R. v. Howell* (1981) 73 Cr. App. R. 31; *R. v. Chief Constable of Devon and Cornwall Constabulary ex parte Central Electricity Generating Board* [1982] Q.B. 458; [1981] 3 All E.R. 826, C.A.

21.10 Self-Defence

There is some disagreement as to whether (and to what extent) the common law right of self-defence survived the 1967 Act,[1] but an attempted resolution is beyond the scope of this text. Self-defence is sometimes referred to as a "private defence" because it is not restricted to defence of one's self. This would justify a nurse in going to the defence of a patient being assaulted by a fellow patient. However, an assault is a crime, and defending against it is the prevention of crime. It is probable that a court examining a case where force was used in defence of a stranger would adopt the language of prevention of crime[2] (see para. **21.08** above). Otherwise, the courts continue to deal with cases by reference to the common law of self-defence, and it is, therefore, useful briefly to state some of the basic principles. Self-defence can be used to ward off or prevent unlawful force and to avoid or escape from unlawful detention. The general principle is that the individual is justified in using such force as is "reasonably necessary" for defence. (See para. **23.08.2** above).[3] The nurse would be entitled to take all reasonable measures to ensure that he or she does not come to harm. As in the case of the 1967 Act, "general reasonableness" requires the use of force to have been necessary for self-defence and proportionate to the harm to be avoided. Courts used to speak of the "duty to retreat", particularly before using extreme force. However this common law duty has now been cast in *Julien*[4] as a "willingness to disengage": ". . . what is necessary is that he should demonstrate that he is prepared to temporise and disengage and perhaps to make some physical withdrawal". In *McInnes*[5] Edmund Davies L. J. said that the failure to retreat is one factor to be taken into account in deciding whether force was reasonable. The effect is that the question of "general reasonableness" is left to the jury.[6] Reasonable force can be used to defend oneself from an innocent aggressor such as a person who is insane under the M'Naghten Rules. This is of importance to a staff member protecting himself against an attack by a seriously mentally disordered person.

21.11 Restraining a Dangerous Mentally Ill Person

21.11.1 *Interaction between statute and common law: The older cases*

Lord Mansfield said in *Brookshaw v. Hopkins*:[7] "God forbid, too, that a man should be punished for restraining the fury of a lunatic, when that is the case". There is old authority that a person who is both

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[1] See Ashworth (1975) Self-Defence and the Right to Life, *Camb. L.J.*, vol. 34, p. 282; Harlow (1975) Self-Defence: Public Right or Private Privilege, *Crim. L. Rev.* 528.

[2] *Devlin v. Armstrong* [1972] N.I. 13, at 35–36.

[3] *Palmer v. R.* (1971) 55 Cr. App. R. 223, at 242, [1971] A.C. 814.

[4] [1969] 2 All E.R. 856; see *R. v. Bird (Debbie)* [1985] Crim L. Rev. 388.

[5] [1971] 3 All E.R. 295; [1971] 1 W.L.R. 1600; (1971) 55 Cr. App. R. 551, C.A.

[6] *Palmer v. R.* (1971) 55 Cr. App. 223, at 242. See *Brown v. United States* (1921) 256 U.S. 335.

[7] (1790) Lofft. 235, at 244, 98 E.R. 627.

a "lunatic" and "dangerous" may be restrained.[1] It appears as though the person must in fact be mentally ill;[2] a reasonable belief is probably insufficient.[3] The courts referring to this justification used the term 'lunatic'[4]. No definition of the kind or degree of unsoundness of mind has been offered, although the justification cannot be used in respect of those only with eccentric habits.[5] The definition of mental disorder under the Mental Health Act 1983, it is suggested, is too wide and is intended for other purposes. The basis for the restraint would appear to be that the person is "not in possession of his faculites",[6] and that would require serious mental illness. The person cannot be restrained on grounds of mental illness alone; there must be some danger to self or others.[7] The dangerous lunatic can be detained only until there is reasonable ground to believe the danger is over.[8]

The common law power to restrain the dangerous lunatic has been exercised concurrently with the statutory powers of compulsory admission and detention. Courts have stated *obiter* that they would not be prepared to discharge by way of *habeas corpus* a patient detained unlawfully under mental health legislation, if they considered him to be a dangerous lunatic.[9] It is to be doubted whether a modern court would allow the justification of arresting the dangerous mentally ill person. See para **21.11.2** below. It would be contrary to the policy of the Act to rely upon ambiguous common law powers where, for example, there is a specific statutory power for a nurse to hold a patient for six hours (see para. **10.05** *ante*). Further, since the power to detain a dangerous mentally ill patient is given under mental health legislation, subject to specific safeguards, it is inconceivable that the courts would allow detention outside the rubric of the legislation. Such detention would not have been envisaged or intended by Parliament, and the

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[1] *Scott v. Wakem* (1862) 3 F. & F. 327, 176 E.R. 147; *Symm v. Fraser* (1863) 3 F. & F. 859, at 880, 176 E.R. 391, at 400. The authorities are reviewed in detail in Lanham (1974) Arresting the Insane, *Crim. L. Rev.* 515. But Carson (1982) Detention of the Mentally Disordered, *Local Gov't Rev.*, vol. 146, p. 887, at 889 suggests that only those with a special status or skill such as a justice or doctor can rely on the justification.

[2] *Sinclair v. Broughton* (1882) 47 L.J. 170, 172. If the common law requires the person **at the time** to be dangerously mentally ill, what is the position of a person with some degree of mental disorder, but who is acting with a perfectly rational motive such as anger, jealousy, greed or hunger?

[3] *Fletcher v. Fletcher* (1859) 1 El. & El. 420, 120 E.R. 967.

[4] It was probably assumed in the older cases that **actual** mental disorder and dangerousness were clear concepts—either the person was a lunatic and dangerous or not; this clear dividing line surely does not exist. See *e.g.* Morse (1978) Crazy Behavior, Morals and Science, *S. Cal. L. Rev.* vol. 51, p. 527. The justification for arresting the mentally ill today should be viewed with some caution.

[5] *Fletcher v. Fletcher* (1859) 1 El. & El. 420, at 423, 120 E.R. 967, at 968. But the justification is applicable to those restraining a person with *delirium tremens*. *Symm v. Fraser* (1863) 3 F. & F. 859.

[6] *Fletcher v. Fletcher* (1859) 1 El. & El. 420.

[7] *Queen v. Pinder, ex parte Greenwood* (1855) 24 L.J.Q.B. 148.

[8] *Scott v. Wakem* (1862) 3 F. & F. 328.

[9] *Queen v. Pinder, ex parte Greenwood* (1855) 24 L.J.Q.B. 148; *Re Shuttleworth* (1846) 9 Q.B. 651 at 662 per Lord Denman.

judiciary could not reasonably use the older common law authorities as a justification.

21.11.2 *Common law right to detain superseded by mental health legislation*

The House of Lords in *Black v. Forsey*[1] (Scotland) reaffirmed that "the common law does indeed confer upon a private individual power lawfully to detain, in a situation of necessity, a person of unsound mind who is a danger to himself or others." The House of Lords cited secondary sources for this conclusion, but did not refer to the body of cases discussed in the foregoing paragraph. Lord Keith of Kinkel reasoned that: "Common sense and the protection of the public demand that such a power should exist, but a person exercising the power must be able to justify his action, if challenged, by proving the mental disorder of the detainee and the necessity of detention."

Commentators disagree about whether the same reasoning would apply to mental health legislation in England and Wales[2]. However, the English and Welsh Act displays a similarly coherent scheme for admission and detention of mentally disordered persons. Parliament's undoubted intent in enacting both pieces of legislation was to supply an exclusive and alternative scheme for detaining mentally disordered persons. The common law power of a health authority to restrain a mentally disordered person must be considered to be replaced by its statutory powers in England and Wales. This was the view taken by the Court of Appeal in *L. v. Bournewood Community Mental Health NHS Trust*:[3] "The right of a hospital to detain a patient for treatment for mental disorder is to be found in, and only in, the 1983 Act, whose provisions apply to the exclusion of the common law principle of necessity.

The issue of appeal in *Black v. Forsey* turned on whether the Mental Health (Scotland) Act 1984 comprehensively lays down the powers of hospital authorities to detain or whether there is any residual power. The House of Lords concluded that "the powers of detention conferred upon the hospital authorities . . . were intended to be exhaustive", and there is no "common law power to detain a patient otherwise than in accordance with the statutory scheme." "Any common law power of detention which a hospital authority might otherwise have possessed has been impliedly removed."

The House of Lords, while virtually ruling out any common law power to detain for hospital authorities, provided little guidance on the common law power to restrain a "lunatic" by a private person, i.e., a person who has no statutory authority to act on behalf of the health

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[1] Judgment given 25 May 1988. *The Times*, 31 May 1988, H.L.

[2] See Carson, Patients' Rights: Do Our Judges Care? *Health Service Journal* 9 June 1988.

[3] *The Independent* 5 December 1997, *The Times* 8 December 1997, Court of Appeal (Civil Division) (Transcript: Smith Bernal). See further para. **11.02A** *ante*.

authority. Clearly the Lords accepted that a private individual has the power to detain a person of unsound mind in a situation of urgent necessity. But the degree of mental disorder and the circumstances of necessity were hardly discussed.

Lord Griffiths helpfully rendered the opinion that on the facts of the case the patient's condition at the moment when he was about to be released from hospital was such that it would not have been appropriate for anyone to exercise the common law power to restrain a lunatic. The patient's doctor believed that he posed a serious threat to his wife when he discontinued his medication but there was no suggestion that he was imminently dangerous. The common law power, said Lord Griffiths, is "confined to imposing temporary restraint on a lunatic who has run amok and is a manifest danger either to himself or to others—a state of affairs as obvious to a layman as to a doctor. Such a common law power is confined to the short period of confinement necessary before the lunatic can be handed over to a proper authority." Lord Griffiths' observation should be regarded as the modern position on restraint of a seriously mentally ill person.

D. POWERS OF RESTRAINT UNDER THE MENTAL HEALTH ACT 1983

21.12 Introduction

The organisation of this section is designed to help conceptualise the numerous provisions in the Mental Health Act which authorise the use of force. **Before an application is duly completed** the Act does not grant any power to use force over the individual. Thus the person cannot be restrained for the purposes of interview or examination. If access is required to the home of a prospective patient (and his consent to entry to the premises cannot be obtained) an application by an approved social worker for a warrant to search for and remove him (s. 135(1)) is the usual lawful procedure. However, **after an application is duly completed** (*i.e.*, when it is founded upon the requisite medical recommendations) the Act provides authority for the person's conveyance to hospital (s. 6(1)). When the person is **actually admitted to the hospital on behalf of the managers** there is power to detain him in accordance with the provisions of the Act (s. 6(2)).

Any person authorised to be conveyed to any place or kept in custody or detained in a place of safety is deemed to be under "**legal custody**" (s. 137). If any such person escapes he can be retaken by specified persons (s. 138). Any person who is absent from the hospital without leave (or a guardianship patient absent without leave from a place at which he is required to reside can also be retaken (s. 18). If a patient who is liable to be retaken is in his own home, and is refusing entry to those authorised to recapture him, an application for a warrant should first be made under section 135(2) before entering the premises by force.

21.13 Restraint before an Application Under Part II is Duly Completed

21.13.1 *Gaining access to the patient for interview or examination*

The question arises whether there is any power to use reasonable force or even trespass implied in the approved social worker's duty to consider making an application (s. 13(1), (4)) or in the doctor's responsibility for considering the making of a medical recommendation. An application cannot be duly completed until those responsible for carrying out the statutory procedures have had an opportunity of personally seeing the prospective patient: the applicant must interview (s. 13(2))[1] and the doctor must make a personal examination (s. 12(1)).[2] Persons not wishing to be detained may sometimes refuse permission and, if in their own homes, may expel any intruders. There is certainly nothing in the statutory language which suggests the power to restrain the person or to force entry into premises for the purposes of interview or medical examination; nor is there any express corresponding duty on the person to make himself available for interview or examination.

21.13.2 *Trespass may not be committed for the purpose of interview or examination*

The only authority suggests that the person cannot unlawfully restrain the prospective patient or commit trespass for the purpose of making an application or recommendation under Part II of the Act. In *Townley v. Rushworth*[3] an emergency application under the 1959 Act (s. 29) was signed by the nearest relative, but not duly completed by the addition of the medical recommendation at the material time. The defendant was restrained by the doctor and police officers in his bedroom and an injection was prepared. The Queen's Bench Divisional Court reversed a conviction for assault on one of the police officers by the patient on the grounds that, before the application was duly completed, the persons had no statutory authority to restrain the defendant, but were trespassers; the statutory position is unchanged in the 1983 Act. The Court did not consider whether there was any justification for restraint of a mentally disordered person or right to forcibly enter premises under the common law.[4]

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1 [1] The applicant who is not an ASW has no specific statutory duty to interview. But any applicant must have seen the patient personally within fourteen days before the date of the application (s. 11(5)) or, in the case of an emergency admission, 24 hours before the date of the application (s. 4(5)). See Appendix E *post*.

[2] It is clear that the persons carrying out the procedures in Part II must personally see the patient before signing, and that falsely stating that the person had been seen is an offence (s. 126).

[3] (1964) 62 L.G.R. 95.

[4] At common law there does not appear to have been the right to trespass to gain access to the prospective patient. See *Anderdon v. Burrows M.D.* (1830) 4 C. & P. 210, 214 per Lord Tenterden (". . . although there may be difficulty in getting access to a party labouring under insanity; yet the proper course is, if access cannot be obtained, to apply to the High Authority, which has cognizance over such matters, to get the party taken up in order that he may be examined.")

21.13.3 *When an application is deemed to be duly completed*

It has been suggested that the Court in *Townley v. Rushworth* was wrong and that an application is "duly completed" when it is signed but not accompanied by the necessary medical recommendations; a signed application would enable the doctor to carry out his examination, if necessary by forcible entry into premises and physical restraint.[1] This interpretation, however, cannot be correct. The Act requires the application to be "founded on" a medical recommendation (s. 4(3)). Only an application "duly completed in accordance with the provisions of this Part of this Act" provides authority to convey a person to hospital (s. 6(1)). Any signed, but medically unfounded, application could not be regarded as duly completed and could not authorise the person's conveyance to hospital. The suggestion that a signed application alone would authorise a medical examination by force has no support in the Act; indeed an unfounded application does not appear to have any effect whatsoever. If Parliament had desired a signed application alone to have an effect which abridged the freedom of the individual it is to be expected that the Act would have expressly so provided.[2]

21.13.4 *Licence to proceed from the gate to the door of a dwelling house*

It should be observed, however, that in the absence of a locked gate or notice, any citizen has an implied licence to proceed from the gate to the front or back door of a dwelling-house if he had, or reasonably thought he had, legitimate business with the occupier. A person seeking to make an application or medical recommendation under Part II of the Mental Health Act clearly has legitimate business with the occupier. Thus, if the occupier is met in the drive-way there would be an implied licence to be on the land which could only be rebutted by an unequivocal expression withdrawing the licence.[3]

21.13.5 *Other methods of gaining access to the patient for interview or examination*

There are several ways that an applicant or doctor might seek access to a prospective patient for the purposes of considering making an application or a medical recommendation:

(*i*) **By warrant to search for and remove patient**—Section 135(1) was intended for situations where a forcible entry is required to remove a patient "with a view to the making of an

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[1] Lanham (1974) Arresting the Insane, *Crim. L. Rev.* 515, at 521–22.

[2] See *Morris v. Beardmore* [1980] 2 All E.R. 753, at 762; [1981] A.C. 446, H.L. (Entry into private premises is not assumed unless expressly provided for in the relevant Act.)

[3] *Snook v. Mannion* [1982] R.T.R. 321, [1982] Crim. L. Rev. 601.

application. . . ." (See further para. **21.16.1** below). The provision covers only those who are ill-treated, neglected or not kept under proper control or, if living alone, are unable to care for themselves. These criteria would include most, but not all, of those whose mental disorder would justify compulsory admission under Part II of the Act.

(*ii*) **By entry and inspection of premises**—It would be unwise to rely on the power of the approved social worker under section 115 to enter and inspect premises to justify forcible entry and restraint for the purposes of making an application. (As to section 115 see para. **4.09.1** *ante*). This provision does not provide authority for restraint or removal. Further the provision can be exercised only upon specific grounds ("reasonable cause to believe that the patient is not under proper care") and at "reasonable times" (presumably not late at night).

(*iii*) **By Consent to enter premises by co-owner**—The owner, or co-owner, of a premises is entitled to allow entry to another person.[1] There is no reason why a person who has ownership of a premises should not be entitled to allow an approved social worker and/or doctor entry for the purposes of making an application or recommendation under Part II. However, the prospective patient could not be constrained within his own home and forced to submit to interview or examination. There is even authority for the proposition that a wife who is **co-occupier** can give licence to enter premises which could not be revoked by the husband.[2] Although it may be doubtful whether any occupier could give licence for entry, the special nature of the wife's occupancy under the Matrimonial Homes Act 1967 may alter the situation.

21.13.6 *Obstruction of person seeking to interview or examine*

Section 129 makes it an offence for "any person who without reasonable cause" refuses to allow interviewing or examination by any person authorised under the Act or who otherwise obstructs any such person in the exercise of his functions; a local social services authority may institute proceedings for such an offence (s. 130) (see further para. **25.05** *post*). The language is arguably wide enough to include an unreasonable refusal to submit to a social work interview or medical

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[1] See *Slade v. Guscott* (July 28, 1981) C.A. 78/06556 (unreported). (A wife who is a co-owner of a house may give permission to enter the house, and the person will not be a trespasser, notwithstanding that the husband purports to refuse permission.)

[2] *R. v. Thornley* (1980) 72 Cr. App. R. 302; [1981] Crim. L. Rev. 637. See also *Jones and Jones v. Lloyd* [1981] Crim. L. Rev. 340 (where a guest leaves a party and then gets into difficulty, any host would be presumed to have authorised the guest to bring the police back into the house).

examination for the purpose of making an application for compulsory admission to hospital. However, it would be difficult successfully to prosecute a person for refusing to submit to psychiatric examination or social work interview; the prosecution would have to prove the refusal was unreasonable and would have to show that the language, particularly in sub-section (1)(*b*), was not limited to obstruction by a third party.

21.14 Restraint after an Application under Part II is Duly Completed

21.14.1 *Custody and conveyance to hospital*

The legal position of the applicant **after** the application has been duly completed is much improved. An application for admission to hospital under Part II is sufficient authority for the applicant, or any person authorised by him, to take the patient and convey him to hospital. The authority to remove to hospital expires after fourteen days from the date when the patient was last examined by a practitioner giving a medical recommendation; the corresponding period for an emergency application is 24 hours from the date of the medical examination or the application, whichever is earlier (s. 6(1)). The words "take and convey" suggest a power to use reasonable restraint for the purpose of removing the person to hospital. Any person required or authorised to be conveyed to any place is deemed to be under "legal custody" (s. 137(1)). If any person under legal custody escapes, he may be retaken by the person who had legal custody immediately before the escape or by any constable or approved social worker (s. 138(1)(*a*)), but only within the fourteen day or 24 hour period, whichever applies. (As to custody, conveyance and re-taking of patients see further paras. **21.17–21.18** below).

A number of authorities are likely to be involved in conveying patients to hospital, including the local authority, ambulance service and police. These authorities should publish joint policies and procedures for clear lines of communication and record keeping. Guidance to conveying personnel is important. Those conveying patients have a professional and personal obligation to do so in the most humane and least threatening way, while ensuring that no harm comes to the patient. (As to the ASW's role in this regard see para. **7.23** *ante*).

21.14.2 *No power to trespass for the purpose of conveying a person to hospital*

The court in *Townley v. Rushworth* (appeared to have assumed that, once the application had been "duly completed", there would have been a power to enter the premises by force. However, the language "take and convey" or the fact that the person is under "legal custody" does not of itself indicate that trespass can be committed for the purpose of removing a person to hospital. In the context of trespass

for the purposes of obtaining a sample of breath following a road accident, Lord Emund-Davis spoke of "the basic assumption of the common law that powers created and conferred by the law will be lawfully exercised".[1] Entry into private premises should not be assumed unless expressly provided for in the statute. Indeed in reaching their decision, the House did not seem unduly concerned that the provisions of the Act were being rendered unworkable in a significant number of cases.[2]

21.15 Restraint following Admission to Hospital

The act of actually admitting the patient to hospital is significant.[3] Where a patient is admitted within the statutory period, only then does the duly completed application provide sufficient authority for the managers to detain the patient for a period allowed by the Act (s. 6(2)). A person liable to be detained may be retaken if he escapes or is absent without leave by an approved social worker, any officer on the staff of the hospital, any constable or any person authorised in writing by the managers (ss. 138(1)(*b*), 18(1)).

21.15.1 *Constraint of a detained patient within the premises of the hospital*

If an informal patient is locked in a room, placed in seclusion or prevented from leaving the hospital without lawful justification it is a false imprisonment (see para. **21.02.2** above). However, under what circumstances can a compulsorily detained patient be imprisoned or otherwise restrained? Deprivation of liberty does not authorise all forms of "lesser" constraints within the hospital premises or the withdrawal of ordinary rights.[4] Any restraint of a detained patient in hospital, if the Act is to be used as a justification, must be based upon what the Act says or necessarily implies.

The Act allows the managers to detain patients "in accordance with the provisions of this Act" (ss. 6(2), 40(1)(*b*)). But those provisions refer only to the length of detention and methods of release, and are silent in respect of the control that may be exercised over the patient within the hospital. There are a few provisions regulating a patient's activities within the hospital—notably the regulation of medical treatment (Part IV) and correspondence (s. 134); indeed the fact that the

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[1] *Morris v. Beardmore* [1980] 2 All E.R. 753, at 762; [1981] A.C. 446.

[2] See Balley and Birch (1974) Recent Developments in the Law of Police Powers, *Crim. L. Rev.* 484, 547, at 554–57.

[3] It is to be noted that, before admission can take place, the hospital managers must agree to receive the patient. See further para. **3.03** *ante*.

[4] See *R. v. Hull Prison Board of Visitors, ex parte St. Germain and Others* [1979] 1 All E.R. 701, 716, per Shaw L.J. (A prisoner remains "invested with residuary rights appertaining to the nature and conduct of his incarceration".)

Act expressly seeks to control certain aspects within the hospital indicates that, where it is silent, there is no specific intention to authorise the use of compulsion. The Act expressly gives authority for the patient's detention in hospital and for his recapture (ss. 18, 138). Surely it could not be unlawful for a member of staff to use reasonable force to prevent a detained patient from leaving the confines of the hospital. The issue is whether there is anything that can be inferrred from the language of the Act to suggest that Parliament intended to go further and alter the common law rights of patients while in hospital. The House of Lords in *Pountney v. Griffiths*[1] said that compulsory detention necessarily involves the exercise of "control and discipline". It is suggested that the control and discipline must be reasonably related to the objects of the Act—*i.e.* health, safety or medical treatment. There could not be authority for the use of force for purposes not intended by the Act such as for revenge or punishment. Further, the use of force even for proper purposes probably must be reasonable in the circumstances; excessive or unnecessary force could not be justified. (However, hospital staff are not required to make "fine" judgments about the use of force in cases of emergency, and courts are likely to construe such concepts as "reasonable" in favour of hospital staff. See further para. **21.08.3** above).

21.16 Warrant to Search for and Remove Patients

21.16.1 *Neglected Persons (s. 135(1))*

An approved social worker (ASW) is entitled to make application to a justice of the peace for a warrant to search for and remove a neglected person. It must appear to the justice, on information on oath laid by the ASW, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder has been, or is being, ill-treated, neglected or kept othewise than under proper control or, being unable to care for himself, is living alone.[2] The person must be in a place within the jurisdiction of the justice. The justice may issue a warrant authorising a constable to enter any premises specified in the warrant in which the person is believed to be and, if thought fit, to remove him to a place of safety with a view to making an application under Part II or of other arrangements for his treatment and care (s. 35(1)). The constable may enter the premises by force if necessary, but must be accompanied by an ASW and by a registered medical practitioner (s. 135(4)).

Observe that the patient need not be named in the warrant

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[1] [1975] 2 All E.R. 881, at 888; [1975] 3 W.L.R. 140.

[2] The expression "found neglected" in the criteria for the making of a reception order under the Mental Deficiency Acts was discussed in *R. v. Board of Control and Others, ex parte Rutty* [1956] 2 Q.B. 109 (physical neglect, or such complete disregard of the person's welfare that he may be said to have been abandoned). The context was the abandonment of a child and therefore is not fully on point.

(s. 135(5)); the power to remove the patient applies only if it is thought fit; and he must be kept only for the purposes specified and not merely to confine him.

A person removed to a place of safety may be detained there for a period not exceeding 72 hours (s. 135(3)).[1] **"Place of safety"** means residential accommodation provided by a social services authority, a hospital, a police station, a mental nursing home or residential home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient (s. 135(6) as amended by the National Health Service and Community Care Act 1990, Sch. 10.). Only in exceptional circumstances should a police station be used as a place of safety; if it is used the patient should remain there for no longer than a few hours while an ASW makes the necessary arrangements for his removal elsewhere, either informally or under Part II of the Act.[2]

21.16.2 *Patients liable to be taken or retaken (s. 135(2))*

The appropriate statutory procedure where unauthorised entry is required **after** an application has been duly completed is for an application to be made for a warrant to search for and remove the patient under section 135(2). Any constable or other person (including an applicant) who is authorised under the Act to take a patient to any place, or to take into custody, or retake a patient liable to be taken or retaken, may apply to a justice of the peace for a warrant authorising a named constable to enter the premises and remove the patient. It must appear to the justice, on information on oath laid by the constable or other authorised person, that there is reasonable cause to believe the patient is to be found on the premises; and that admission to the premises has been refused or that refusal is apprehended. The warrant gives authority to a constable accompanied by a registered medical practitioner and any person authorised to take or retake the person, to enter the premises, if need be by force, and remove him (s. 135(2), (4)).

21.16.3 *Distinction between warrant issued under section 135(1) and (2)*

The distinction between a warrant issued under section 135(1) and (2) should be carefully noted. Sub-section (1) is on oath laid by an ASW who must reasonably suspect that a person is 'neglected' and is not yet liable to be taken or retaken; it authorises the person's removal to a place of safety for the purpose of making an application or providing care or treatment. Sub-section (2) is on oath laid by a con-

[1] A person who escapes while being taken to or detained in a place of safety cannot be retaken after the expiration of 72 hours from the time he escapes or the period during which he is liable to be detained, whichever expires first (s. 138(3)).

[2] DHSS (1983) *Mental Heath Act 1983: Memorandum*, para. 291.

stable or other authorised person who need not suspect neglect because the person is already liable to be taken or retaken; it is for the purposes of removing the person to hospital or place where he is liable to be detained for the period authorised by the Act.

21.17 Custody, Conveyance and Detention

Any person required or authorised under the Mental Health Act to be conveyed[1] to any place or to be kept in custody or detained in a place of safety or any place to which he is taken by direction of the Home Secretary in the interests of justice or for the purposes of any public enquiry is, while being so conveyed, detained or kept, deemed to be in legal custody (s. 137(1)).[2] A constable or any other person required or authorised to take a person into custody or to convey or detain him, has all the powers, authorities, protection and privileges which a constable has within the area for which he acts as constable (s. 137(2)). A constable has, in particular, a specific power to require other persons to assist him in the exercise of his duties[3]; this power is thus extended to other persons acting under the provisions of section 137(1).

21.18 Retaking Patients Escaping from Custody

If any person who is in legal custody escapes[4] he may be retaken, in any case, by the person who had his custody immediately before the escape, or by any constable or approved social worker (s. 138(1)(*a*)). If at the time of escape he was detained in hospital under the Act,[5] he may also be retaken by any officer on the staff of the hospital, or by any person authorised in writing by the managers (ss. 138(1)(*b*), 18(1)).[6]

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[1] In s. 137 "convey" includes any other expression denoting removal from one place to another (s. 137(3)).

[2] This would include, for example, a person conveyed to hospital following the completion of an application for admission under Part II (s. 6(1)), or an order under Part III (s. 40(1)), while being removed or returned within the U.K. (Part IV) or taken to a place of safety (s. 135(1) or s. 136).

[3] *R. v. Brown* (1841) Car. & M. 314. See generally *Halsbury's Laws of England* (4th ed; 1981), Police, vol. 36, Butterworths, London, paras. 319–331, and the Police and Criminal Evidence Act 1984.

[4] Escape is to be distinguished from absence without leave from hospital or guardianship. See s. 18 and para. **11.14** *ante*. A patient absent without leave is not, for that reason alone, deemed to have escaped from legal custody. Therefore, additional limitations are placed on the ability of police constables to retake such patients. *D'souza v. Director of Public Prosecutions* [1992] 4 All ER 545, HL. See para. **12.03.2** *ante*.

[5] As to patients detained under Part III see s. 40(4), Sch. 1, Pt. 1, paras. 2 and 4.

[6] If a guardianship patient escapes from the place he is required by his guardian to reside he may be retaken by any constable, any officer on the staff of a local social services authority or by any person authorised in writing by the guardian or a local social services authority (s. 138(1)(*b*), s. 18(3)).

21.18.1 *Time limit for retaking patients*

A patient liable to detention or subject to guardianship may **not** be retaken after the expiration of 28 days beginning with the first day of escape (ss. 138(2), 18(4)). This time limit does not apply in the case of a patient subject to a restriction order or an order or direction with the like affect; such a patient can be retaken at any time the restriction order is in force (s. 138(2)). In computing the period of 28 days during which a hospital order constitutes authority for conveyance and admission to hospital, time spent at large by a patient who escapes from legal custody is excluded (s. 138(5).[1]

If a patient having escaped from legal custody is at large and liable to be retaken on the day on which the authority for his detention or guardianship will expire unless renewed, the authority will remain in force until the expiration of the period during which he can be retaken (*i.e.*, 28 days from the time of the escape); if he returns within the last week of that period, the authority will expire at the end of one week beginning with the day of his return (ss. 138(6), 21).

21.18.2 *Inducing or assisting in an escape*

It is an offence to induce or knowingly to assist a person to escape (s. 128(2)). (See para. **25.04.2** *post*) However, the **patient** who escapes does not thereby commit an offence.[2]

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[1] Section 138 applies, *inter alia*, to patients while being transferred between hospitals as if they were liable to be detained in the hospital (s. 138(4)). For greater detail reference should be made to s. 138(4).

[2] See *R. v. Criminal Injuries Compensation Board, ex parte Lawton* [1972] 3 All E.R. 582 at 584; [1972] 1 W.L.R. 1589 at 1592, D.C.

E. SEARCH OF PATIENTS AND THEIR PROPERTY

21.19 General Inspection of a Patient's Room

An issue of particular importance to nursing and other hospital staff is whether patients can be searched.[1] A court might consider that a general inspection of a patient's room for the purposes of observing whether it is clean or the bed is made is something that the patient has impliedly consented to when he was admitted to hospital. So long as his body or chattels were not touched it is doubtful whether the patient would have any cause of action in tort or crime. However, any search of the patient himself or his personal possessions, in the absence of a lawful justification, would be a trespass to the person.

The Code of Practice (paras 25.1–25.4) recommends that authorities have an operational policy on searching of patients and their belongings. Searches must be lawful and clearly justified, never routine. The patient's consent should be sought. The Unit General Manager (or a delegated senior member of the staff) should be consulted if the patient withholds consent to the search. Staff carrying out searches should respect the person's dignity and privacy and use the minimum force and intrusion necessary. Personal searches should be carried out by a staff member of the same sex. The patient should be informed where his belongings are being kept in the event they are confiscated.

21.20 Search for Dangerous Articles

Guidance in HC(76)11 states that staff have authority at common law and by virtue of section 3(1) of the Criminal Law Act 1967 to take reasonable measures to prevent a patient from keeping in his possession articles of potential danger (*e.g.* matches, weapons, alcohol, tools, explosives, etc.). This probably overstates the nurse's powers in law. There are no specific powers of search given to private persons, including a nurse. To justify forcible search it would have to be argued that the search constituted no more than the use of reasonable force for an authorised purpose—*i.e.*, the prevention of crime or in self-defence. Search (unless it was unreasonably intrusive) could be considered to be a "reasonable" use of force if it were both necessary and the least restrictive or least harmful means of preventing a crime. Prevention of crime suggests that it is on the point of being committed, and not simply that there is a future risk. Thus, if there were reasonable grounds to believe matches were about to be used to set fire to the ward or a rope to be used to strangle a fellow patient, a search might well be justified. On the other hand a general concern that a mental patient should never be in possession of matches or alcohol would be

[1] See Meacher (June 24, 1982) *H. C. Debs.*, Special Standing Committee, 19th sitting, cols. 707–721; *Review of the Mental Health Act 1959* (1978) Cmnd. 7320, HMSO, London, paras. 7.12–7.16.

unlikely to give rise to a justification for search of an informal patient. The test would be whether there were reasonable grounds to believe a crime was about to be committed and whether a search was necessary and the least invasive means of preventing a crime.

21.21 Search for Stolen Property

It is doubful whether a patient could be searched for stolen goods. If a person is reasonably suspected of this he can be arrested. The person must then be taken before a justice or to a police station as soon as as reasonably possible. The police or justice has the power in these circumstances to search.[1]

21.22 Search for an Offensive Weapon

It is probable that in a case where the nurse has reasonable ground for believing that a patient is in unauthorised possession of a dangerous weapon such as a gun, he can make a search. The possession of an unauthorised offensive weapon in a public place is a crime (see para. **21.08.1** above), and it would be surprising if a court did not uphold the hospital's right to take reasonable steps to prevent patients from possessing such weapons. A court could consider a search under the principle of self-defence where there were reasonable grounds for believing that the weapon was going to be used. There is no requirement for the person to wait for the weapon actually to be used before defending himself. Again, the search would have to be shown to be a reasonable and necessary measure in self-defence.

21.23 Summary

In sum, search of a patient (whether detained or informal) could probably be justified if it were the least invasive use of force necessary to prevent a crime. This would not authorise a "fishing expedition" or a routine search of patients, for example, simply to establish whether there is any risk of future harm. Since search is a personal affront to dignity, there must be particular and individual grounds for the belief, and the crime must be imminent. It is common practice on some hospital wards to search a patient's clothing, for example, to discover whether he has taken a prescribed drug or whether he is in possession of alcohol. Absent the patient's consent, such a search cannot be regarded as lawful.

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[1] As to the duty of the private person making an arrest see *John Lewis & Co. v. Tims* [1952] A.C. 676. See also *Brazil v. Chief Constable of Surrey* [1983] *Crim. L. Rev.* 483 ("blanket" searches of all prisoners are not permitted—search is an affront to personal dignity and reasons must be given).

21.24 Power to Search Detained Patients

It has been suggested that "insofar as those in charge of a **detained patient** may do whatever is necessary for his well-being or for the safety of others, a search without his consent, *e.g.*, for a knife or for drugs would clearly be justified".[1] Again this probably over-estimates the extent of legal powers of search. Nowhere in the Act is there any express provision regarding search of detained patients. It can, however, safely be assumed that if there is a reasonable belief that the person has in his possession an instrument with which he intends to abscond (*e.g.* a key or a rope), it can be seized. The Act appears to allow, at least by implication, the reasonable use of force, including where necessary search, to prevent an escape. So too would the Act probably allow search if there were reasonable cause to believe a detained patient was in possession of a potentially dangerous item such as a knife or gasolene, even if there were no immediate risk of it being used. The foregoing appears to be within the powers of "control and discipline" of detained patients as contemplated in *Pountney's* case (see para. **21.15.1** above). Yet there is considerable doubt whether "control and discipline" would extend to general or routine search. It is suggested that search of detained patients could take place where there is some particular ground to believe the patient is in possession of items which cause a potential danger to health or safety which could possibly include a search for drugs (perhaps even of the prescribed kind) or alcohol. Yet there would be no ground for systematic or routine search where no such reasonable ground existed.

21.24.1 *Power to conduct routine, suspicionless searches of special hospital patients*

The Court of Appeal in *R. v. Broadmoor Special Hospital Authority and another ex parte S, H, & D*,[2] upheld a Broadmoor Hospital policy authorizing "random and routine searches of patients with or without their consent."[3] While the Mental Health Act does not expressly authorize patient searches, the Court relied on the implied power to control and discipline detained patients. The hospital managers have a power to compulsorily admit and detain patients. And, more importantly, special hospitals detain patients "under conditions of special security on account of their dangerous, violent or criminal propensities." (s. 4, see para. **3.04** *ante*). Given this statutory context, Broadmoor could show that a policy of routine searches without cause

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[1] Spellers Law Relating to Hospitals and Kindred Institutions (1978; 6th ed., J. Jacob, ed.) Lewis, London, p. 133, n. 1 (emphasis added).

[2] 142 SJ LB 76, *The Times*, 17 February 1998 (Transcript: Smith Bernal).

[3] The court found that, although Broadmoor's policy was contrary to the Code of Practice, the Code was not mandatory but only an expression of "best practice." See para. **21.19** above.

was "a self-evident and pressing need."[1] The power to search was necessary for a safe therapeutic environment for patients, staff, and visitors. Accordingly, an individual patient's therapeutic needs may have to give way to the wider interest in safety and security.

The Court of Appeal did not indicate whether the power to routinely search detained patients extended beyond special hospitals. Arguably, the patients' needs for treatment would outweigh the need for security outside the unique context of a special hospital.

[1] Steyn LJ in *R. v. Home Secretary, ex p. Leech* [1994] Q.B. 198, [1993] 4 All E.R. 539 CA, at 212E–F, adopted a rigorous test that Broadmoor had to show "a self-evident and pressing need" for the power for which it contended.

F. PROTECTION OF STAFF

21.25 Substantive Protection Against Litigation

Section 139 of the 1983 Act provides both a substantive and procedural protection against litigation in respect of any act purporting to be done in pursuance of the Act or any regulations or rules made under the Act.[1] Sub-section (1) provides for the substantive protection: no person is liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings in respect of any such act unless it was done in bad faith or without reasonable care. The substantive protection may not be important in respect of those actions which have want of good faith or reasonable care as part of the cause of action such as in an action for negligence. However, section

[1] The protection is afforded also in respect of anything done in the discharge of functions conferred by any other enactment on the authority having jurisdiction under Part VIII of the 1983 Act (management of property and affairs of patient).

139(1) can be an absolute bar to proceedings where these elements are not part of the claim[1] such as in an action for breach of statutory duty[2] or for battery based upon an intentional act performed with a benevolent motive. In *Kynaston*[3] the court decided whether, in considering the discharge of a restricted patient, the Home Secretary acted in bad faith or without reasonable care; there was no further requirement to consider whether he had acted lawfully in detaining a patient whom the RMO said was not mentally disordered.

The Court of Appeal in *Winch v. Jones*[4] considered the test to be applied in deciding whether to give leave to proceed under section 139(1). The Court noted that there was a significant change in substance from the Mental Health Act 1959 (s. 141) to the 1983 Act. In particular, Parliament no longer required "substantial ground" for the contention that the person to be proceeded against acted in bad faith or without reasonable care. Parliament intended, said Sir John Donaldson, M.R., that no one should be prevented from making a valid claim that he had suffered by reason of negligence or bad faith in the exercise of powers under the Act.

Section 139 is intended to strike a balance between the legitimate interests of the applicant to access to the courts upon any claim which is not frivolous, vexatious or an abuse of process, and the equally legitimate interest of the respondent not to be subjected to the risk of harassment by baseless claims. Donaldson, M.R. rejected the three alternative tests that the person establish a "*prima facie* case", whether the litigant is "vexatious", and whether there is "a serious question to be tried." The latter test (which is used in cases of judicial review) comes closest to the one that should be adopted.[5] The test to be applied in deciding upon leave under section 139 is:[6]

Whether, on the material immediately available to the court . . .

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[1] *Kynaston v. Secretary of State for Home Affairs and Another* (1981) 73 Cr. App. R. 281, at 285, [1982] J.S.W.L. 104, C.A., per Lawton L.J. ("When considering whether to give leave under section 141(2) the High Court does not have to be satisfied that there are substantial grounds to support the cause of action upon which the claim is based. . .", but only whether the person acted in bad faith or without reasonable care.)

[2] *Ashingdane v. Secretary of State for Social Services and Others* (Feb. 18, 1980) unreported—Transcript by the Association of Official Shorthandwriters, 1979 A No. 2514, C.A., per Bridge L.J. (Even if, apart from s. 141, there would be liability for breach of statutory duty, leave to bring proceedings will not be given unless the person to be proceeded against acted in bad faith or without reasonable care.) See further para. **3.04.3** *ante* and para. **21.29.2** below.

[3] *Kynaston v. Secretary of State for Home Affairs and Another* (1971) 73 Cr. App. R. 281. See C. Ash (March 12, 1981) Letter, *N.L.J.*, 131, 297.

[4] [1985] 3 W.L.R. 729, C.A.

[5] Parker, LJ observed, "If it is right that somebody who wishes to bring proceedings against a local authority should be given leave on showing that there is reasonable suspicion that the authority has committed something wrong, then I see no reason why those who apply for leave under section 139(2) of the Mental Health Act 1983 should be under any greater disability." [1985] 3 W.L.R. at 737.

[6] [1985] 3 W.L.R. at 736.

> [which can include material furnished by the proposed defendant] the applicant's complaint appears to be such that it deserves the fuller investigation which will be possible if the intended applicant is allowed to proceed.

The Court of Appeal later made clear that the purpose of section 139 is not only to protect staff against frivolous claims; it is also to protect against mere error. In making an application for admission for emergency assessment or providing a medical recommendation, social workers or doctors are immune from liability even if they were wrong, provided they acted in good faith and with reasonable care.[1]

The test established in *Winch v. Jones* is highly permissive. If the case raises a legitimate claim which should be further pursued in a full trial, leave should be granted. It is not for the court to hold a full dress rehearsal of the claim and the defence on an application for leave. Donaldson, M.R. observed that at the stage at which leave is sought the "applicant may well have reasonable suspicions that there has been a failure to exercise reasonable care, but quite unable to put forward a prima facie case in the absence of discovery."[2]

Parker, L.J. elaborated on this important point by suggesting *in obiter* that the applicant's evidence should "never" be subjected to cross examination in an application for leave. "Any such attempt would be to convert the application for leave, which ought to be a relatively short affair, into a full scale trial; and that is not the purpose of this subsection."[3] He goes on to suggest that there should be no trial on affidavits. The purpose is to see whether the evidence before the judge adds up to the answer: "if this allegation were tried out, there is no realistic possibility that the case might succeed."[4]

The permissive test in *Winch v. Jones* was applied by Henry J in *Furber v. Kratter*[5] where leave was granted by the High Court for actions in negligence and false imprisonment in relation to the seclusion of the applicant in a special hospital in inadequate conditions. (As to seclusion, see para. **3.12A** *ante*). The Secretary of State argued that there was no chance of succeeding in the negligence claim because no damages would lie in the absence of physical or mental injury. Henry J refused to so rule because damages might be recoverable for discomfort and suffering or loss of amenity.

The Secretary of State also argued that the false imprisonment claim would not succeed because "if a person is imprisoned in a place where

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[1] *James v. Mayor and Burgesses of the London Borough of Havering* (Transcript: Association) 12 February 1992, C.A. Farquharson LJ.

[2] [1985] 3 W.L.R. at 735.

[3] [1985] 3 W.L.R. at 737.

[4] *Ibid.*

[5] (1988) *The Independent*, August 9, 1988, CO/559/88. (Transcript: Marten Walsh Cherer).

he is lawfully so imprisoned, then . . . a variation in conditions of confinement cannot constitute the tort of false imprisonment at common law".[1] However, Henry J preferred the holding of the Court of Appeal in *Middleweek v. Chief Constable of Merseyside*,[2] that if the conditions of detention are so intolerable the detention may be unlawful and provide a remedy in damages for false imprisonment. "A person lawfully detained in a prison cell would . . . cease to be so lawfully detained if the conditions in that cell were such as to be seriously prejudicial to his health if he continued to occupy it. . . ."

Henry J observed that "doubtless I have power to give leave in respect of one cause of action and not in respect of another". But, adopting the highly permissive test in *Winch*, he would not limit the legal ways in which the applicant can put her case at the trial. He also granted leave to proceed against nursing staff, as well as the responsible medical officer, because each member of the clinical team may bear some responsibility for his or her individual actions.

21.25.1 *Mistake of fact: Performing an act without actual authority*

The words "want of jurisdiction" and "purports to act" suggest that section 139 will protect a person who performs an act without actual authority conferred by the statute, so long as he had a reasonable belief that he was performing an authorised act. The standard formulated by Brightman L.J. in *Ashingdane*[3] was: "An act is purported to be done in pursuance of the statute if the statute authorises the doer to perform an act of that type and the doer intended to perform such an authorised act". An illustration of this principle would be a nurse who restrains a patient whom she reasonably, **albeit wrongfully**, believes to be compulsorily detained. She would appear to be protected if she acted in good faith and with reasonable care.[4] Lord Justice Bridge in *Ashingdane* said the language "clearly propounds a subjective not an objective test. If a person is acting honestly with the intention of performing in the best way he knows how, the statutory functions or duties which are cast upon him, then it seems to me he is acting in purported pursuance of the statute".

21.25.2 *Mistake of Law*

What if the person who purports to act under the statute is mistaken as to the law? For example, the police officer knows that an application for emergency admission is made but no medical recommendation is signed (there is no mistake of fact); but he wrongly believes

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[1] *R. v. Board of Visitors of Gartree Prison, ex-parte Sears* (1985) The Times, March 20, 1985.

[2] (1985) *The Times*, August 1, 1985.

[3] See footnote to para. **21.25** above.

[4] See *Shackleton v. Swift* [1913] 2 K.B. 304.

that the Act allows him to forcibly enter premises and convey such a person to hospital. What if a doctor forcibly treats an informal patient honestly believing that section 62 allows it in cases of emergency? (Section 62 does not, strictly speaking, apply to informal patients see para. **20.27** *ante*). A practitioner may be acting in good faith when imposing treatment with the erroneous belief that it was lawful to proceed without consent. Could a person be mistaken in law and still act with reasonable care? Apparently the answer is yes. In *Richardson v. L.C.C.*[1] the court said: ". . . provided the statute could, in the mind of that person, who is not a lawyer, reasonably be thought to bear that construction, it cannot be said that he has acted without reasonable care". If this construction is correct section 139 would not merely impede an action for battery where the doer reasonably thought he was legally entitled to act, but it could bar such an action.[2]

The way for a prospective plaintiff to bring a claim alleging a mistake of law under the 1983 Act is by way of judicial review. The Court of Appeal in *Ex parte Waldron* decided that section 139 does not apply to proceedings for judicial review (see para. **21.31** below). Moreover, one of the important consequences of that result, which was of "comfort" to Ackner, L. J., was that it would provide some remedy where a person was subject to compulsory admission because of an understandable misapprehension of the law.[3]

21.26 Procedural Protection against Litigation

Sub-section (2) provides the procedural protection against litigation.[4] No civil proceedings can be brought against any person in any court in respect of any act purporting to be done in pursuance of the statute, regulations or rules without leave of the High Court; and no criminal proceedings can be brought against any person in any court in respect of any such act except by, or with the consent of, the Director of Public Prosecutions.[5]

21.26.1 *The burden of proof*

The onus is on the person seeking to bring the action to get the necessary leave or consent before the action can be taken. This is

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[1] [1957] 1 W.L.R. 751, at 761.

[2] It is probably because of this consequence that Professor Williams and Mr. Hodgson, members of the Butler Committee, suggested that s. 141 needed general reconsideration, but in any case should be qualified by making it clear that the protection does not extend to mistakes of law. *Report of the Committee on Mentally Abnormal Offenders* (1975) Cmnd. 6244, HMSO, London, para. 3.59, n. 26.

[3] [1985] 3 WLR at 1103.

[4] As to applications for leave to institute proceedings under s. 139, see R.S.C. Ord.32, r. 9. Guidance for magistrates is to be found in the observations of Lord Widgery in *R. v. Bracknell J.J., ex parte Griffiths* [1975] 1 All E.R. 900, 903, D.C.

[5] In relation to Northern Ireland the reference to the DPP is construed as a reference to the DPP for Northern Ireland (s. 139(5)).

the major protection intended by Parliament for members of staff.[1] In *Carter v. Commissioner of Police for the Metropolis*[2] it was held that the burden was on the applicant to satisfy the judge that leave should be given. *Carter* was decided under the Mental Health Act 1959. It is still true, under the 1983 Act, that the applicant has the burden to produce some evidence to show he has legitimate claim. Yet, the substantive change from the 1959 Act (s. 141) to the 1983 Act (s. 139)[3], together with the new test established in *Winch* (see para. **21.25** above), casts significant doubt on the rest of the holding in *Carter*. The court in *Carter* said that the judge has to consider the whole case on the strength of the evidence and the inherent probabilities. It is not sufficient to show a conflict of evidence. Further, Cairns, L. J., probably wrongly, implied that it was open for the defendants to be cross-examined on their affidavits.[4]

Under section 139 of the 1983 Act the applicant must only show that there is evidence which, if elaborated upon by discovery and at a full trial, might conceivably succeed. Only if the applicant's affidavits are "totally refuted by incontrovertible evidence" should leave be denied.[5] Thus, while the applicant continues to have the burden of coming forward with some credible evidence, he does not have the burden of proof by a preponderance of evidence (or by any other standard) at the hearing for leave. An application for leave is intended only to ascertain whether there is some serious claim, and not to become a trial in its own right.

21.26.2 *Proceedings instituted without leave are a nullity*

Proceedings instituted without the required leave or consent are a nullity.[6] Further, a person who acts in pursuance of the statute cannot waive (either expressly or by implication) the protection afforded by section 139. The provision does not create a personal immunity which is capable of being waived, but imposes a fetter on the court's jurisdiction which is not so capable.[7] There are no longer any specific grounds which the court must apply in giving leave;[8] the requirement to show bad faith or lack of reasonable care now applies only in relation to the substantive proceedings.

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[1] See *Winch v. Jones* [1985] 3 W.L.R. at 736.
[2] [1975] 2 All E.R. 33, [1975] 1 W.L.R. 507, C.A.
[3] It is to be emphasized that, in examining the burdens placed upon the applicant, the court relied heavily upon previous decisions construing the now deleted phrase "substantial ground."
[4] [1975] 2 All E.R. at 38.
[5] *Winch v. Jones* [1985] 3 W.L.R. at 737.
[6] *Pountney v. Griffiths* [1975] 3 W.L.R. 140, [1975] 2 All E.R. 881, at 888, H.L.
[7] *Ashingdane*, per Brightman, L.J.,
[8] Cf. *Mental Health Act 1959*, s. 141(2) (repealed).

21.27 Where Section 139 does not apply

Section 139 does not apply to proceedings for an offence under any other provision of the Mental Health Act which can be instituted only by or with the consent of the Director of Public Prosecutions (s. 139(3)).[1] Section 139 also does not apply to proceedings against the Secretary of State[2] or a health authority within the meaning of the National Health Service Act 1977.[3] It is to be observed that acts of local social services authorities performed in pursuance of the Act[4] continue to remain within the scope of section 139.

21.28 Appeals

The Court of Appeal has jurisdiction to hear appeals against the granting or refusal of leave by the High Court,[5] but no appeal lies to the House of Lords from the refusal by the Court of Appeal of leave to appeal to the House.[6]

21.29 Acts Done in Pursuance of the Statute

The language of section 139 potentially can be construed quite widely. It does not protect specified categories of litigant—*e.g.*, hospital staff or those making applications or medical recommendations under the Act. Rather section 139 provides protection to any person purporting to carry out certain acts. For example, it would protect from an action for false imprisonment a police officer who purports to act under section 136 to remove a mentally disordered person from a public place. It would similarly protect a person who has made an application (or even a person authorised by him such as a police officer or ambulance driver) who uses force to convey a mentally disordered person to hospital (see s. 6(1)). Further, section 139 is not merely a fetter on a mentally disordered patient's right of access to the courts but would apply to anyone bringing an action against a person purporting to act in pursuance of the Mental Health Act. If a nurse were to use force to prevent a third party from obstructing him in carrying out his functions

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[1] The consent of the DPP is required for proceedings in respect of the offence of ill-treatment of patients (s. 127(4)). It is also required in respect of the offence of unlawful sexual intercourse with women patients (s. 128 of the 1959 Act).

[2] As to the meaning of "Secretary of State" see para. **2.03** *ante*.

[3] Under s. 128(1) of the 1977 Act (as amended by the Health Services Act 1980, Sch. 1, para. 77(*b*)), a health authority means a Regional, Area, District or Special health authority or a Family Practitioner Committee. See further Chapter 2 *ante*.

[4] See *e.g.*, functions of local authorities in appointing approved social workers (s. 114), arranging visits to certain patients (s. 116) or providing after-care services (s. 117).

[5] See *e.g. Re Shoesmith* [1938] 2 K.B. 637, [1938] 3 All E.R. 186, C.A. Since an order of a judge refusing an application under s. 139(2) is an interlocutory order, no appeal lies against such an order without the leave of the judge of the Court of Appeal. *Moore v. Metropolitan Police Comr.* [1968] 1 Q.B. 26, [1967] 2 All E.R. 827, C.A.

[6] *Whitehouse v. Board of Control* [1960] 3 All E.R. 182n, [1960] 1 W.L.R. 1093, H.L.

under the Act, arguably, he could be protected by s. 139[1]. A court would probably be guided by the general principle enunciated by Lord Edmund-Davies in *Pountney*: Acts done in carrying out the "statutory purposes" would be protected. "That must surely involve a right to control, its nature and extent depending upon all the circumstances. . . ."[2] A further illustration of the potentially wide scope of section 139 is the hypothetical case of an approved social worker or ambulance driver who, in the course of transporting a person to hospital under section 6(1), runs into a pedestrian. Would the pedestrian have to obtain leave of court or the consent of the DPP before bringing civil or criminal proceedings?

21.29.1 *Acts expressly or impliedly provided for in the statute*

The courts should construe very narrowly any substantive or procedural barrier against having recourse to the courts for the rectifying of wrongs.[3] Undoubtedly section 139 extends to acts which are specifically and expressly provided for in the statute, such as the signing of an application or medical recommendation under Part II or the management of a person's property and affairs under Part VII. In *Pountney v. Griffiths* the House of Lords held that hospital orders are made where the person warrants detention in hospital for medical treatment, "and that necessarily involves the exercise of control and discipline".[4] The House quoted Lord Widgery C.J. with approval:[5] ". . . where a male nurse is on duty and exercising his functions of controlling the patients in the hospital, acts done in pursuance of such control, or purportedly in pursuance of such control, are acts within the scope of section 141, and are thus protected". Section 139 appears, then, to cover not only acts expressly provided for in the statute, but also acts of members of staff in their day-to-day control of individual patients.

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[1] In *Pountney* the applicant claimed that the nurse pushed the relative who was refusing for the moment to allow the nurse to remove the patient from the visitors room. If the relative brought a private prosecution, would he have to obtain leave? Compare this with the actions of a nurse who restrains a person whom he reasonably believes to be assisting a detained patient to escape.

[2] [1975] 2 All E.R. 881, at 886.

[3] *Pyx Granite Co. Ltd. v. Minister of Housing and Local Government* [1959] 3 All E.R. 1, at 6, [1960] A.C. 260, at 286; *Pountney v. Griffiths* [1975] 2 All E.R. at 886–7 and cases cited therein; *Ashingdane*, per Bridge L.J. (s. 141 "is to be given no wider ambit and effect than is necessary to enable it to achieve its essential purpose").

[4] [1975] 2 All E.R. at 888. The House emphasised that the scope of s. 141 extended only to express provisions in the Act, and that it was unnecessary to imply anything. It assumed that, if the patient warranted compulsory admission for treatment, acts done which are an "obvious part of the patient's treatment" are expressly provided for. It is suggested, however, that the House was referring to acts it considered to be necessarily implied, and this has been the construction adopted by courts in subsequent cases such as in *Ashingdane*.

[5] *R. v. Bracknell Justices, ex parte Griffiths* [1975] 1 All E.R. 900, at 903, [1975] 2 W.L.R. at 294.

21.29.2 *Decision taken by staff collectively*

The question posed in *Ashingdane* was whether the protection afforded by section 139 extends to decisions of policy taken by nurses collectively in relation to the treatment of classes of patient. The case involved a Broadmoor patient whose transfer was prevented by a ban initiated by the Confederation of Health Service Employees. An action was brought against the Secretary of State and the Kent Area Health Authority for breach of statutory duty and against COHSE officials for acting unlawfully in causing such a breach. The Court of Appeal per Bridge L.J. held that the powers of the Secretary of State and health authority were all to be found under the 1959 Act, and it did not matter that the breach complained of was a duty to provide hospital accommodation under the National Health Service Act 1977. Since their good faith was never challenged the action was barred by section 141. The Court rejected the argument that anything which is done which frustrates the policy and objects of the Act, cannot be an act in pursuance of the statute:[1] ". . . if a statutory authority is acting in good faith in what it believes to be the proper manner of discharging its statutory responsibilities, then the fact that it is subsequently held to have been acting in a way which contravenes the statute to the point of frustrating its policies and objects cannot lead to the conclusion that the original acts in good faith were not in purported pursuance of the Act". In determining that COHSE was not protected against proceedings the Court adopted the formulation of Brightman L.J.: ". . . the immunity conferred by section 141 is confined to an act done by a person to whom authority to do an act of that type is expressly or impliedly conferred by the relevant statute or regulations". A decision "to ban the admission of a whole class of patients, even if taken in the best of faith, is not a decision which is within the express or implied authority of nurses to take under the Act".

21.30 Application of Section 139 to Informal Patients

Since the vast majority of patients are in hospital on an informal basis it is important to determine whether section 139 applies to the acts of hospital staff in their day-to-day management of informal patients.[2] This depends upon whether there are any powers of control which are expressly given or necessarily implied in the Act. While there is certainly some power to control patients under the common law, the Act itself does not expressly confer such power. The House of Lords

[1] The court distinguished *Meade v. Haringey London Borough Council* [1979] 1 W.L.R. 637 and *Padfield v. Minister of Agriculture Fisheries and Food* [1968] A.C. 997, on the ground that in neither case was there a provision similar to s. 141.

[2] It is clear that to the extent to which the Act provides specific authority in relation to informal patients s. 139 does provide protection—for example acts relating to the management of the property or affairs of Court of Protection patients are clearly protected. A further example is giving psychosurgery to an informal patient under s. 57.

in *Pountney* did not specifically limit its decision to detained patients: the right of control, its nature and extent depends upon "all the circumstances and, in particular, on whether the patient was admitted voluntarily or (as in the present case) compulsorily detained".[1] However, the reasoning of the House is consistent only with a finding that the Act itself does not provide express powers of control over informal patients. The judgment turned upon whether there are express provisions in the Act for detention and control of patients. It is important to observe that the House did not refer to any provision of the 1959 Act which had any application to informal patients.

In *R. v. Runighian*[2] the Warwick Crown Court held that leave under section 141 was not required before commencing criminal proceedings in respect of an alleged assault of an informal patient. The Court said that acts done to such persons were not done in pursuance of the statute. The 1959 Act's main reference to informal patients was in section 5 (now s. 131), "a permissive section, which merely authorised their admission by private arrangement to hospitals or mental nursing homes for treatment". The question for courts which encounter this issue in future is whether s. 131 necessarily implies an authority to treat, care for or control informal patients on a consensual basis; and, if so whether such treatment, care of control is in pursuance of the Act.[3] It should be born in mind that other than in the marginal note to section 131 the expression "informal admission" is not to be found in the Mental Health Act. This suggests that the informal admission of a patient to hospital is not to be regarded as part of the Mental Health Act procedure, the patients admission being within the compass of National Health Service legislation.

21.31 Judicial Review

It was sometimes assumed that section 141 of the Mental Health Act 1959 applied to judicial review[4] and, in particular to *habeas corpus*.[5] The Mental Health Act 1983 specifically excludes health authorities

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[1] [1975] 2 All E.R. at 886.

[2] [1977] Crim. L. Rev. 361.

[3] In arriving at a decision courts should consider that mental hospitals are hospitals within the meaning of the National Health Service Act 1977 and are no different from any other hospital. See further para. **3.02** *ante*.

[4] See Judicial Review—The Mentally Ill (Feb. 26, 1981) *N.L.J.* 217–18 (The *N.L.J.* leader wrongly assumed that *Kynaston* involved an application for judicial review) This was probably an erronous view since, under the 1959 Act, the courts did not consider section 141 when hearing applications for judicial review. See e.g. *R. v. Secretary of State for the Home Department, ex parte Powell* (Dec. 21, 1978) D.C. reproduced in L. Gostin & E. Rassaby (1980) *Representing the Mentally Ill and Handicapped*, London, MIND (application for judicial review based upon breach of rules of natural justice).

[5] The issue of whether section 139 applies to habeas corpus was emphatically decided by Ackner, LJ in *Ex parte Waldron* [1985] 3 W.L.R. at 1097: the court and all the parties to the case accepted without reservation that there is no need to obtain leave under section 139 before making an application for *habeas corpus*.

and the Secretary of State from the protection of section 139, so it is clear they are subject to judicial review in the ordinary way.

The question still remained whether section 139 applied to judicial review of actions purportedly taken under the Act by other bodies such as social services authorities, or individuals such as doctors, social workers or nearest relatives.

The Court of Appeal in *Ex parte Waldron*[1] expressly decided for the first time that section 139 of the Mental Health Act 1983 does not apply to judicial review. The issue for the Court of Appeal was whether an application for leave to apply for judicial review constitutes "civil proceedings" within the meaning of section 139(1). The Court reiterated the principle that Parliament must explicitly state its intention to limit the court's jurisdiction for judicial review.[2] Section 139 does not provide the clear and explicit words that are necessary to exclude jurisdiction of the court to grant the remedy of *certiorari*. On the contrary, the words "civil proceedings" unless specifically defined, are apt only to cover civil suits involving claims in private law proceedings. The words are not apt to include proceedings for judicial review.[3]

There is a strong public policy justification for the decision not to limit the court's jurisdiction in proceedings for judicial review. In *Ex parte Waldron*, the patient was compulsorily admitted to hospital for treatment under section 3 of the Act because of her doctor's view that she would not take her medication if not under compulsion. The day after her admission the RMO granted her a leave of absence from hospital on condition that she take her medication. Waldron did not allege that her doctor acted negligently or in bad faith, but that he misconstrued the criteria for admission (see **21.25.2** above). She brought proceedings, not to seek damages, but to review the lawfulness of the compulsory admission. If the patient was required to obtain leave to proceed under section 139, it would have barred any effective review of the compulsory admission decision; that decision was a result, not of negligence or bad faith, but of a reasonable misconstruction of a public official's powers. "This would have disclosed a serious inadequacy in the powers of the courts to protect the citizen from an actual loss of liberty arising out of a serious error of law."[4]

Glidewell LJ addressed an important issue which was not specifically answered in *Waldron*. In what circumstances would judicial review of a decision under the 1983 Act be appropriate? As a general proposition, judicial review "will go only where there is no other equally effective and convenient remedy."[5] The question arises whether an aplication to

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[1] [1985] 3 W.L.R. 1090, C.A.
[2] See *R. v. Medical Appeal Tribunal* [1957] 1 Q.B. 574, 583 *per.* Dennis L.J.
[3] [1985] 3 W.L.R. at 1101, *per* Ackner L.J.
[4] [1985] 3 W.L.R. at 1103, *per* Ackner LJ.
[5] *R. v. Hillingdon London Borough Council, Ex parte Royco Homes Ltd.* [1976] Q.B. 720, 728.

a Mental Health Review Tribunal and the case stated procedure in section 78(8) of the Act is an equally effective and convenient remedy. Clearly it is not where the essence of the claim is that the decision for compulsory admission is unlawful. Tribunals can only hear applications in respect of persons already liable to be detained. They must decide the case as they find it on the day of the hearing. Tribunals have no jurisdiction to decide the very question sought to be tried in a court—*viz*, whether the compulsory admission itself was lawful.

21.32 Vicarious Liability of Secretary of State or Health Authority

As section 139 now does not protect the Secretary of State or health authorities against proceedings, the issue arises whether they can be held liable solely by reason of the actions of their employees. Where section 139(1) provides a substantive defence to an action so that employees are not held liable for their acts, it appears that no purely vicarious liability will lie.[1] The Secretary of State or a health authority can still be held liable for their "non-delegable" duties or where section 141(1) does not bar an action against their employees.

This issue arose but was not settled in *Furber v. Kratter.*[2] The Secretary of State argued that if the High Court refused to grant leave against medical and nursing staff then the Secretary of State could not be vicariously liable for their actions because they could not be sued. Leave to proceed against medical and nursing staff was granted, so the issue of vicarious liability was never examined.

21.33 Access to the Courts under Article 6 of the European Convention on Human Rights

Article 6(1) of the European Convention on Human Rights provides that: "In the determination of his civil rights and obligations . . . , everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. . .". The European Court in the *Golder* case (judgment given Feb. 21, 1975) held that the right of access to a court constitutes an element which is inherent in the right stated by Article 6(1). In *Ashingdane v. the United Kingdom*[3] the European Commission found that it is essentially for the national courts to decide disputes as to whether the plaintiff can bring a civil rights claim. This much Mr. Ashingdane was able to do, albeit unsuccessfully, for the domestic courts decided he would have no claim by virtue of section 141 of the the Mental Health Act 1959. (As to the facts of the *Ashingdane* case, see para. **21.29.2** above).

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[1] *I.C.I. Ltd. v. Shatwell* [1965] A.C. 656, 686. See discussion in R. Heuston and R. Chambers (1981; 18th ed.) *Salmond and Heuston on the Law of Torts*, para. 173.

[2] (1988) *The Independent*, August 9, 1988, CO/559/88. (See further para. **21.25** above.)

[3] Report of the European Commission of Human Rights, May 12, 1983; Judgment of the European Court of Human Rights, May 28, 1985.

The problem with the Commission's decision lies in the wording of Article 6(1) which guarantees access to a court "in the **determination** of civil rights and obligations" (emphasis added). "Determination" suggests a hearing on the merits which no court was able to do because of the provisions of section 141 of the 1959 Act. Simply because it was a court which ruled that no claim at all could be brought by the applicant should not mean that there was a judicial determination under Article 6(1). The court's task in that case was merely to construe an Act of Parliament and not to "determine" his civil rights claim; it was the Act of Parliament itself which precluded a determination of his civil rights.

The question arises whether, by virtue of section 139(1), a patient has **no** civil right at all to sue in respect of certain acts. It appears that the Commission was of this opinion: "the applicant's claim of a breach of statutory duty was not a civil right which he had, whose determination required a fair hearing under Article 6 of the Convention". A member-state, it would appear, can withdraw entirely certain civil rights; and it need not provide a right of judicial review in respect of a civil right which the person never had. Whether the intent of section 139(1) was to deprive patients of certain civil rights or simply to limit access to courts in respect of those rights is an academic question and it is not a principle upon which a human right should turn. To be sure, the Commission suggests that if the withdrawal of rights towards a class of people were extensive or unreasonable, it might take a different view. But that does not assist the applicant who had a major civil right withdrawn without any determination of his competence to exercise the right in question, or a determination of the substantive justification for withdrawing the right in his particular case.

Despite the decision of the Commission against the applicant, it referred the case to the European Court of Human Rights. The European Court did not consider it necessary to determine whether the claims asserted by the applicant before the English courts related to a "civil right" because, even assuming they did, there was no violation of Article 6(1). The European Court noted that the applicant did have access to the remedies that existed within the domestic system. But the degree of access afforded must not be so limited as to reduce the very essence of the "right to a court". Further, restrictions on judicial access must be for a legitimate aim; and there must be proportionality between the means employed and the aim sought to be achieved. The European Court held that, on the facts of *Ashingdane*'s case, the very essence of his "right to a court" was not impaired and there was no transgression of the principle of proportionality.