

Chapter 3

HOSPITAL AND SPECIAL HOSPITAL SERVICES

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3.01 Introduction

There are three places where patients can receive treatment and care for mental disorder: a hospital, a residential home and a mental nursing home. This chapter examines the law relating to hospital services provided within the National Health Service. Chapters 4 and 5, which review services provided by local authorities and the independent sector, respectively, describe the law relating to residential accommodation and mental nursing homes.

A. HOSPITAL WITHIN THE MEANING OF THE MENTAL HEALTH ACT

3.02 Definition of Hospital

A hospital is defined in section 145(1) of the Mental Health Act as “(a) any health service hospital within the meaning of the National Health Service Act 1977; and (b) any accommodation provided by a local authority and used as a hospital by or on behalf of the Secretary

of State under that Act". A "health service hospital" is defined in the 1977 Act (s. 128(1)) as "a hospital vested in the Secretary of State under this Act".¹ This definition excludes all private hospitals or institutions whether conducted for profit or not. Private or charitable hospitals or institutions which admit mentally disordered patients are considered mental nursing homes and must be registered for the purposes of the Registered Homes Act 1984. (See paras. 5.01–5.09 *post*).

Mentally disordered patients may be admitted informally or compulsorily under the Mental Health Act to any health service hospital. The hospital need not have a special designation or direction by the Secretary of State to make lawful the reception of mentally disordered people.² The designation of local NHS hospitals as mental illness or mental handicap hospitals is for administrative purposes only; it does not prevent any patient from being admitted, irrespective of his classification under the Act. Further, mentally disordered patients can be, and increasingly are, admitted to psychiatric units of district general hospitals.

3.02.1 *Definition of Hospital for the Purposes of Compulsory Admission*

For the purposes of Part II (compulsory admission to hospital) and Part III (patients concerned in criminal proceedings or under sentence) any reference to a hospital also includes (except where otherwise expressly provided) a mental nursing home which is registered for the purposes of the Registered Homes Act 1984 to receive patients liable to be detained under the Mental Health Act (ss. 34(2), 55(5)).³ The mental nursing home must have the particulars of registration entered in the separate part of the register kept for the purposes of section 23(5) of the 1984 Act.⁴

¹ A "hospital" for the purposes of the 1977 Act (s. 128(1)) means, *inter alia*, any institution for the reception and treatment of persons suffering from illness, during convalescence or requiring medical rehabilitation. "Illness" includes mental disorder within the meaning of the Mental Health Act 1983.

² A primary recommendation of the *Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency 1954–1957* (Chairman: Lord Percy: 1957) Cmnd. 169, HMSO, London, paras. 18, 378–383, was that there should be no rigid legal designation of hospitals for particular groups of mentally disordered patients depending upon their legal or medical classification. See further 1.08.4 *ante*.

³ References to a "hospital" in Part V (tribunals), Part VI (removal and return of patients within the United Kingdom) and s. 134 (correspondence of patients) has the same meaning as in Part II (ss. 79(6), 92(1), 134(9)).

⁴ Mental Health Act 1983 (s. 34(2)). Section 23(5)(b) of the 1984 Act provides that, where it is proposed to receive in a mental nursing home patients who are liable to be detained under the 1983 Act, "the particulars of the registration must be entered by the Secretary of State in a separate part of the register". See further para. 5.02.1 *post*.

3.03 Hospital Under No Duty to Admit Mentally Disordered Persons

The hospital managers are under no duty to admit mentally disordered persons, even if they are the subject of a duly completed application for compulsory admission or if a court is minded to make a hospital order. (As to hospital managers see paras. 6.01–6.13 *post*). An application under Part II of the Act is sufficient authority for the managers to detain the patient in hospital, but does not require them to do so (s. 6(2)). Further, a hospital order under Part III cannot be made unless the court is first satisfied, on evidence of the medical practitioner who would be in charge of his treatment or some other person representing the managers, that arrangements have been made for his admission to hospital; the patient must then be admitted to that hospital within 28 days of the making of the order or the criminal proceedings lapse (s. 37(4)). This requirement applies to other orders made under Part III.¹ The managers also have the power to discharge patients, at any time, other than patients subject to a restriction order or direction.²

The implied discretion of the managers not to receive patients has sometimes resulted in them refusing to admit difficult or dangerous patients. In certain cases courts have been forced to sentence mentally disordered offenders to imprisonment.³ Thus, the Mental Health (Amendment) Act 1982 introduced a requirement on the appropriate Regional Health Authority to furnish information to the court as to hospitals at which arrangements could be made for the person's admission. (See paras. 15.08–15.09 *post*) This, however, does not alter the fact that managers retain the discretion to refuse to admit patients.

The Court of Appeal in *R. v. Harding*⁴ (per Lawton, J) has stated in *obiter* that, once a hospital order is made, anyone who obstructs the exercise of that order, or counsels or procures others to do so, might be guilty of contempt of court. The Court was faced with trade union pressure not to admit the offender to a regional secure unit. It said that putting severely mentally ill people into prison was a form of cruelty and imposed great strain on the prison staff. The Court reasoned that "it was clear that it was for doctors to decide who should be admitted to a mental hospital". This is only partly true: under the 1983 Act, although the consultant can give evidence on behalf of the managers, it is for the managers to decide whether a patient can be admitted; further, no hospital order can be made unless the court is satisfied that

¹ See, e.g., ss. 35(4), 36(3), 38(4). Note that, in practice, beds are under the control of a hospital consultant and decisions are not taken by the hospital managers. But the Secretary of State as the manager of the special hospitals does make more positive use of his discretion.

² Mental Health Act 1983, ss. 23(2)(a), 40(4), Sch. 1, Pt. 1, paras. 2 and 8.

³ See e.g., *R. v. Keegan* (1982) J. P. 695; *R. v. Gordon* (1981) 3 Cr. App. R. (S.) 352.; *R. v. Officer* (1976) *The Times*, February 20, 1976; *R. v. Brazil* (1975) *The Times*, October 29, 1975; *R. v. McFarlane* (1975) 60 Cr. App. R. 320, C.A.

⁴ *The Times*, June 15, 1983.

arrangements have been made for his admission (s. 37(4)). It could not be a contempt for the managers to exercise their discretion whether or not to make arrangements for the patient's admission. Further, since no hospital order could be made, the issue of obstruction of that order does not arise. The question of contempt might arise where the managers have made arrangements, and a court order properly made, but where the order is improperly frustrated within the 28 day period before the patient's admission to the hospital specified in the order.

The purpose behind the managers discretion to refuse to receive patients was that it would add to the general safeguards against the improper use of compulsory powers. Hospitals should be under no stronger obligation to admit patients under compulsory procedures than on an informal basis; they should judge the need for admission on medical and social grounds only.¹ It is clear, however, that this social policy was not intended to give managers a licence to refuse to admit patients because they may be difficult or awkward.²

3.03.1 *Where the Managers have no power to refuse admission*

The managers' discretion to refuse to receive patients does not apply where an order is made under section 5(1) of the Criminal Procedure (Insanity) Act 1964 following the return of a special verdict or a finding that the accused is under disability. (See further paras. 13.05 and 14.11 *post*). The order made by the court is that the accused be admitted to such hospital as may be specified by the Secretary of State; and the effect of the order is to grant sufficient authority for the person to be conveyed to the hospital within two months of the order and to be admitted as if under a hospital order with restrictions on discharge without limit of time (Sch. 1). There is no requirement for the court to be satisfied that arrangements have been made for the person's admission to a hospital. This follows from the fact that, following the appropriate verdict or finding, the sentence (a hospital order with restrictions) is fixed by law. The Home Secretary has been prepared, in practice, to direct a person's admission where the managers of an appropriate hospital have refused to admit a patient. The reason is that failure to admit the person to the hospital specified within two months of the order results in him being set free.

The managers do not appear to have discretion to refuse to admit patients in two other circumstances:

- (i) where the Home Secretary makes a transfer direction under Part III of the Act (ss. 47-53) (see para. 16.03 *post*); or
- (ii) the Secretary of State for Health makes a direction under

¹ See the Percy Report, referred to in Note 2 to para. 3.02 above, paras. 381-83.

² *Ibid.*, para. 383.

section 123 for the transfer of a special hospital patient to another hospital (see para. 3.08 below).

B. SPECIAL HOSPITALS

3.04 Definition of Special Hospital

The duty of the Secretary of State for Health to promote a comprehensive health service under the National Health Service Act 1977 includes in section 4 of that Act:¹

“a duty to provide and maintain establishments . . . for persons subject to detention under the Mental Health Act 1983 who in his opinion require treatment under conditions of special security on account of their dangerous, violent or criminal propensities”.

The hospitals established by the Secretary of State under this provision are referred to as special hospitals. The statutory definition of special hospital requires further elucidation as follows.

3.04.1 “For persons subject to detention”

Section 4 has traditionally been construed as proscribing the admission to, or residence of, patients in special hospitals who are not subject to detention under the Mental Health Act.² The language suggests that special hospitals can be maintained only for a purpose expressed in section 4. Admission of a patient known not to be liable to detention would be contrary to the object of the provision. The duty to maintain “establishments for persons subject to detention under the Mental Health Act 1983” is a question of fact, and is not a matter which can be the subject for the exercise of discretion by the Secretary of State.

There have been cases where informal patients have been kept for a time in the special hospitals—for example, after a Mental Health Review Tribunal has discharged the patient from being liable to be detained; continued residence in a special hospital was with the patient’s consent and for a period limited to finding accommodation in the community. This use of the special hospitals was not envisaged in the 1977 Act.

¹ The same definition is to be found in s. 128(1) of the 1977 Act and 145(1) of the 1983 Act. The definition of “special hospital” was formerly in s. 40 of the National Health Service Reorganisation Act 1973, and before that in s. 97 of the Mental Health Act 1959. Any institution provided under s. 97 of the 1959 Act is deemed to be provided under s. 4 of the 1977 Act (the 1977 Act, Sch. 14, para. 15(2)).

² See the *Report of the Committee on Mentally Abnormal Offenders* (Lord Butler; 1975), Cmnd. 6244, HMSO, London, para. 2.15.

There is another possible construction of section 4 which relies upon a less literal interpretation of the provision. Section 4 imposes a duty on the Secretary of State to establish special hospitals for certain purposes; this duty is included within his general duty as to the health service. A power to maintain an establishment for certain purposes may not necessarily preclude its use for other purposes related to the provision of health services. Thus, while there is a duty to provide special hospitals for detained patients in need of special security, this may not prevent the use of special hospitals for other purposes. On this view there would be no legal bar to the Secretary of State fulfilling his duty by providing facilities for the joint use of patients of the category envisaged in the statute and for other patients.

It is to be observed that, while special hospitals must be maintained for detained patients, it need not be for those who have been involved in criminal proceedings; nor do patients have to be subject to a restriction order or direction.

3.04.2 "Special security"

The term "special security" has been construed as meaning that it should not be less than that required for the most dangerous (category "A") prisoners.¹ "Security" in the context of a hospital providing treatment for mental disorder requires arrangements designed to prevent compulsorily detained patients from leaving the hospital (except with authorisation) and from causing harm to themselves, other patients or staff.² In practice, the security in the special hospitals is preserved by "a secure perimeter wall, locked wards, the constant vigilance of adequate numbers of well-trained staff, a system of procedures and checks properly communicated and carried out effectively and the constant review of procedures to ensure that they are at optimum efficiency".³ The security precautions, however, are not designed to prevent an organised and well planned attempt from outside to enable a patient to escape.⁴

Section 4 refers to "*treatment* under conditions of special security". Detention in a special hospital is regarded as therapeutic, not punitive; as with any other hospital the primary objective of the special hospitals is to provide treatment. The interests of security and those of treatment

¹ *Second Report of the House of Commons Estimates Committee: The Special Hospitals and the State Hospital*, Session 1967-68 (1968) HMSO, London, para. 8.

² *Report of the Review of Rampton Hospital* (Boynton; 1980), Cmnd. 8073, HMSO, London, para. 2.2.2.

³ DHSS (1981) *Working Party to Review Security Policies and Procedures in Special Hospitals*, paras. 20-23.

⁴ Working Party on Security in the Special Hospitals, Preliminary Report, reported in the Estimates Committee Report, referred to in Note 1 above, Annex 3, para. 21.

sometimes conflict, and reduced security may be a consequence of increased treatment and rehabilitation programmes.¹

3.04.3 "Dangerous, violent or criminal propensities"

A literal reading of section 4 would result in the conclusion that only patients who in the opinion of the Secretary of State require treatment under conditions of security on account of their "dangerous, violent or criminal propensities" can be admitted to, or reside in, special hospitals. The decision as to whether a patient has dangerous, violent or criminal propensities is a matter for the discretion of the Secretary of State.²

It is worth considering whether there would be grounds for judicial review of the decision of the Secretary of State concerning a person's admission to, or continued residence in, a special hospital. Three sets of factual circumstances might arise:

- (i) the Secretary of State may fail to exercise any judgment as to whether the person requires special security, in which case an order of *mandamus* would lie to compel him to form an opinion;
- (ii) the Secretary of State may form the opinion that the person does require conditions of special security. Where the statute affords an effectively unfettered discretion, the grounds for judicial review are narrow. The review will examine only whether the discretion was exercised in an arbitrary manner or for an unlawful purpose or if there was any evidence upon which the Secretary of State could reasonably form his opinion. Where evidence could reasonably be viewed either way it is for the Secretary of State to decide; the court will not substitute its discretion for that of the Secretary of State;³
- (iii) the Secretary of State may form the opinion that the person does not require conditions of special security but nevertheless agrees to his admission or continued residence. A special hospital research report observed that in 10% of its sample, patients were admitted to special hospitals in spite of the Secretary of State's view that they did not require conditions of special security. Further some 8% of the resident popu-

¹ For a discussion of the respective security roles of special and local hospitals see Ministry of Health (1961) *Special Hospitals: Report of a Working Party*, HMSO, London, paras. 23-27.

² Cf. *R. v. Davies*, Leeds Crown Court, transcript of hearing August 11, 1981.

³ As to the scope of judicial review of administrative actions see generally, D. Foulkes (1982; 5th ed.) *Administrative Law*, Butterworths, London, chap. 11; J. M. Evans (1980; 4th ed.) *De Smith's Judicial Review of Administrative Action*, Stevens, London; Gostin (1982) *Human Rights, Judicial Review and the Mentally Disordered Offender*, *Crim. L. Rev.* pp. 779-93.

lation of the special hospitals had been approved by the Secretary of State for transfer, also indicating that in his opinion they did not require conditions of special security.¹

In *Ashingdane v. Secretary of State for Social Services and Others*,² a patient's transfer from Broadmoor Hospital (recommended by the RMO and consented to by the Secretary of State for Social Services and the Home Secretary) was prevented by the Confederation of Health Service Employees who had maintained an absolute ban on admission to Oakwood Hospital of any patient subject to a restriction order or direction. The statement of claim against the Secretary of State³ was for breach of the statutory duty under the National Health Service Act (s. 3(1)) to provide hospital accommodation to meet all reasonable requirements. (The Secretary of State had the authority under section 99 of the Mental Health Act 1959 (now s. 123) to direct the transfer of special hospital patients.) (See further para. 3.08 below). The merits of the case were never reached because, in acting in pursuance of the Mental Health Act 1959, the Secretary of State had the protection of section 141 (now s. 139); leave to bring the action against the Secretary of State, therefore, was not granted by the High Court and its decision was affirmed by the Court of Appeal.⁴

3.05 Management

3.05.1 *The Secretary of State*

Under section 145(1) of the Mental Health Act the Secretary of State for Health is designated as the managers of the special hospitals. Thus, in addition to his general managerial responsibilities (*e.g.* finance, staffing, supplies and building), he has to exercise all of the functions given to the managers under the 1983 Act. (See further paras. 6.01–6.13 *post*.) The Secretary of State has delegated all these management responsibilities to the Special Hospitals Service Authority (see para. 3.05.2a below) which, acting on behalf of the Secretary of State, has direct control of, and managerial responsibilities for, the special hospitals; special hospitals are not administered locally by regional or district health authorities as are other NHS hospitals.

There continues to exist within the Department of Health the Special Hospitals Services Board (formerly the Office Committee for the

¹ S. Dell (1980) *The Transfer of Special Hospital Patients to NHS Hospitals*, Special Hospitals Research Unit (report no. 16), London. See also K. Clarke (Nov. 30, 1982) *H C Debs*; the same situation is reflected in figures given by Mr. John Patten, *H. C. Debs*, 23 July 1984. Cols. 416–437.

² Court of Appeal (unpublished) February 18, 1980.

³ The Kent Area Health Authority and COHSE were also joined in the action. The Court of Appeal granted leave to bring a claim against COHSE, but not against the authority.

⁴ Section 139(4) now excludes the Secretary of State and health authorities from the protection of s. 139. See further paras. 21.27 and 21.29.2 *post*.

Special Hospitals). The Board is not a corporate body and has no legal standing. It is chaired by the Under Secretary with medical, nursing and social work professional advisers. Its purpose is to advise the Secretary of State and the Special Hospitals Service Authority.¹

3.05.2 *Delegation of management functions: Background*

The Secretary of State for Health has power to direct a regional, district or special health authority to exercise on his behalf management functions relating to special hospitals.² The Secretary of State used to retain all management functions in relation to special hospitals.³ In 1981 he transferred his management functions for Rampton Hospital, following the recommendation of the Rampton Review Team (see para. 3.06.2 below). The Rampton Hospital Review Board (Establishment and Constitution) Order 1981⁴ provided for the establishment and constitution of a special health authority under section 11 of the National Health Service Act 1977 (see para. 2.17 *ante*) which was known as the Rampton Hospital Review Board. The Rampton Hospital Review Board was conceived as an experiment in good management for the special hospitals, and was disbanded on 30 June 1986. It was widely viewed as a successful experiment,⁵ and the Secretary of State replaced it immediately with the Rampton Hospital Board.⁶

In 1986, the Secretary of State delegated his management functions to special health authorities for all of the special hospitals: the Rampton Hospital Board, the Broadmoor Hospital Board⁷ and the Moss Side

¹ See further, Boynton Report referred to in Note 2 to para. 3.04.2 above, paras. 29.2-29.3; Hamilton (1985) *The Special Hospitals*, in L. Gostin (ed.) *Secure Provision: A Review of Special Services for Mentally Ill and Mentally Handicapped People in England and Wales*, Tavistock, London; MacCulloch (1982) *The Health Department's Management of Special Hospital Patients* in J. R. Hamilton and H. Friedman (eds.) *Dangerousness: Psychiatric Assessment and Management*, Gaskell, London.

² Section 98 of the 1959 Act which prevented the Secretary of State from delegating his functions to health authorities was repealed in the NHS Reorganisation Act 1973. As to delegation of functions see para. 2.18 *ante*.

³ See the recommendation for the transfer of responsibility (except for admissions) to health authorities in the *Regional Chairmen's Enquiry into the Working of the DHSS in Relation to Regional Health Authorities* (1976), DHSS, London, para. 217(e).

⁴ S.I. 1981 No. 727, amended by S.I. 1984 Nos. 692 and 693 (extending corporate life of Rampton Review Board to June 30, 1986) (*now revoked*). See further para. 3.06.2 below.

⁵ For a background and critique, see L. Gostin (1985), *Institutions Observed*, King Edward Hospital Fund, London.

⁶ The Rampton Hospital Board (Establishment and Constitution) Order 1986, S.I. 1986, No. 963 (revoked by the Boards for Special Hospitals (Abolition) Order 1989 (S.I. 1989, No. 947)).

⁷ The Broadmoor Hospital Board (Establishment and Constitution) Order 1986, S.I. 1986, No. 2004 (revoked by the Boards for Special Hospitals (Abolition) Order 1989 (S.I. 1989, No. 947)).

and Park Lane Hospitals Board.¹ These Boards exercised on behalf of the Secretary of State specified functions.²

The Special Hospitals Service Authority (SHSA) was established in July 1989, and was empowered to exercise such functions relating to the management of the special hospitals as the Secretary of State directed. The Department of Health relinquished all operational management functions for the special hospitals. The SHSA was delegated all the Secretary of State's management responsibilities including admission decisions, appointment of staff, personnel and other resources, professional services and managers' duties under the Mental Health Act. The SHSA also had responsibility to determine policies and set priorities for the provision and management of special hospitals within the strategic framework provided by the Secretary of State. The SHSA was abolished by the Special Hospitals Service Authority (Abolition) Order 1996 (S.I. 1996, No. 490) and a new management structure set in place for each hospital.

3.05.2A *Current management arrangements*

In 1996 three new special health authorities were established to manage the special hospitals by the Authorities for the Ashworth, Broadmoor and Rampton Special Hospitals (Establishment and Constitution) Order 1996, S.I. 1996, No. 488. This was to enable the special hospitals to operate as autonomous provider units within the commissioning arrangements for the NHS generally. Special health authorities were established instead of NHS Trusts because of practical and legal difficulties with applying that management structure to the special hospitals. Regulation 2 of the Ashworth, Broadmoor and Rampton Hospital Authorities (Functions and Membership) Regulations 1996 (S.I. 1996, No. 489) directs the authorities to exercise the Secretary of State's functions under the 1983 Act. The new special health authorities are accountable to ministers through the relevant Regional director of the NHS Executive and its Chief Executive. The idea is to develop closer integration between the special hospitals and the NHS in general whilst enabling ministers to retain the degree of central control necessary to ensure that essential requirements are met.³

¹ The Moss Side and Park Lane Hospitals Board (Establishment and Constitution) Order 1986, S.I. 1986, No. 2006 (revoked by the Boards for Special Hospitals (Abolition) Order 1989 (S.I. 1989, No. 947)).

² The Rampton Hospital Board (Functions and Membership) Regulations 1986, S.I. 1986, No 964; The Broadmoor Hospital Board (Functions and Membership) Regulations 1986, S.I. 1986, No. 2005; The Moss Side and Park Lane Hospitals Board (Functions and Membership) Regulations 1986, S.I. 1986, No. 2007 (*now revoked*).

The Rampton Hospital Review Board published four annual reports to the Secretary of State, the last being in October 1985. The Rampton Hospital Board also published annual reports.

³ 'High Security Psychiatric Services: Changes in Funding and Organisation' *NHS Executive*, June 1995, para. 5.10.

3.06 The Three Special Hospitals

The special hospitals have a resident population of approximately 1700 patients.¹ The special hospital system is organised on a national basis without specific geographic catchment areas; the admissions policy has regard to where a patient normally resides but this will not necessarily determine the special hospital to which he will be admitted. All special hospitals may admit patients classified under any of the four categories of mental disorder under the Act (s. 1), but each has for historical reasons developed differently; Broadmoor does not provide special services for patients with a primary classification of mental impairment. A brief description of the development of the special hospitals follows.²

3.06.1 Broadmoor Hospital

Broadmoor Hospital, situated in Crowthorne, Berkshire, was originally opened in 1863 as a criminal lunatic asylum run by the Home Office; management was taken over by the Board of Control in 1948, and by the Ministry of Health in 1959. A chronicle of Broadmoor has been published dealing with its development up to 1952.³ Broadmoor has been the subject of a number of official visits and reports⁴; earlier reports referred to overcrowding. The hospital has been rebuilt on site, and patients were transferred to Park Lane Hospital to reduce numbers.

3.06.2 Rampton Hospital

Rampton, situated in Retford, Nottinghamshire, was opened in 1910 as a criminal lunatic asylum owned by the Home Office; the management passed to the Board of Control and then to the Ministry of Health in 1959. A description of the functioning of Rampton prior to 1960 has been published.⁵ In 1971 a team from the Hospital Advisory

¹ Department of Health (1989) *Special Hospital Annual Statistics*, 1988.

² See generally, N. Walker and S. McCabe (vol. 2; 1973) *Crime and Insanity in England*, University Press, Edinburgh, pp. 11–15; Greenland (Pts. I–III; 1969–1970) *The Three Special Hospitals in England*, *Med. Sci. & Law*, vol. 9, p. 253 and vol. 10, pp. 93, 180; Hamilton (1985) referred to in Note to para. 3.05.1 above.

³ R. Partridge (1953) *Broadmoor: A History of Criminal Lunacy and its Problems*, Chatto & Windus, London. See also D. Cohen (1981) *Broadmoor*, Psychology News Press, London; Hamilton (1980) *The Development of Broadmoor 1963–1980*, *Bull. Roy. Coll. Psychiat.*, vol. 40, p. 130; L. Gostin (vol. 2; 1977) *A Human Condition*, MIND, London, chap. 8.

⁴ Estimates Committee, Report referred to in Note to para. 3.04.2; NHS Hospital Advisory Service (1975) *Report on Broadmoor Hospital*; All Party Parliamentary Mental Health Group (June 24, 1980) *Report of a Visit to Broadmoor Special Hospital*; *B v. the United Kingdom*, app. no. 6870/75, Report of the European Commission of Human Rights, adopted Oct. 7, 1981, paras. 174–81. (See further para. 20.29A *post*); Health Advisory Service and Social Services Inspectorate (July 1988) *Report on Broadmoor*.

⁵ Street and Tong (1960) *Rampton—A Special Hospital*, *Lancet*, ii, 143–45. For a more recent description of the Hospital, see *Report of the Review of Rampton Hospital* (Boynton; 1980) Cmnd. 8073, HMSO, London.

3.06.2

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Service prepared a report¹ and in 1973 the Elliot report was completed.² On May 22, 1979 the Yorkshire television film "The Secret Hospital" was screened, and contained serious allegations of ill-treatment of patients by staff. The allegations were referred to the Director of Public Prosecutions who arranged for a police investigation; a review of the "organisation, management and functioning" of the Hospital was also initiated. The Rampton Review Team (chaired by Sir John Boynton) reported in 1980 with the principal recommendation for the establishment of a Review Board.³ The Review Board was established in July 1981, and it was replaced in June 1986 with the Rampton Hospital Board. Rampton is now run by the Special Hospitals Service Authority (see paras. 3.05–3.05.2A above).

3.06.3 *Ashworth Hospital*

Originally there were two separate hospitals on the Merseyside campus—Moss Side and Park Lane—but upon its creation in October 1989 the Special Hospitals Service Authority received an instruction from the Department of Health to amalgamate these two hospitals because of management and other anomalies. The combined hospital is known as Ashworth Hospital. The history of the two hospitals is as follows:

Moss Side, situated in Maghull, Lancashire, was purchased by the Board of Control in 1914; taken over by the War Office and opened in 1919; it was re-opened in 1920 under lease to the Ministry of Pensions

¹ NHS Hospital Advisory Service (1971) *Report on Rampton Hospital*, summarised in Boynton, (referred to in preceding footnote), para. 3.3.

² *Report on the Organisational Problems and Staff Management Relationships at Rampton Hospital*, summarised in Boynton, para. 3.4, Appendix F.

³ The Boynton Report, para. 6.3.

for use as an epileptic colony. In 1933 it was re-opened as a state institution for mental defectives; ownership was vested in the Ministry of Health in 1946. It became a special hospital managed by the Ministry of Health in 1959, and was amalgamated with Park Lane Hospital in 1990.

Park Lane was the newest of the special hospitals and was built adjacent to Moss Side Hospital with which it shared some facilities. An advance unit with seventy male patients transferred from Broadmoor Hospital was opened in 1974; the first 100 beds were made available in September 1980, and it was completed with over 400 beds. It was amalgamated with Moss Side Hospital in 1990 and re-named as Ashworth Hospital.

3.07 Admission and Discharge

The statutory procedures for compulsory admission to, and transfer or discharge from, special hospitals are the same as for any hospital. This follows from the fact that special hospitals are included within the definition of hospital under the Mental Health Act, and particularly Parts II and III (see para. 3.02 above); special hospitals are not differentiated from other hospitals for these purposes. There are, however, additional provisions on admission¹ and transfer which, in part, apply exclusively to special hospitals.

3.08 Transfers

Without prejudice to any other provisions in the Mental Health Act with respect to the transfer of patients² the Secretary of State may direct the transfer of any patient liable to be detained in a special hospital to another special hospital or to a hospital which is not a special hospital (s. 123(1), (2)). Where a patient is transferred he will be detained in the hospital into which he is transferred as if the application for compulsory admission were an application to that hospital (s. 19(2)); regulations may be made under section 19(4) for the conveyance to their destination of patients directed to be transferred (s. 123(3)).³

The Secretary of State can give a direction for the transfer of a special hospital patient without regard to the requirements in regulation 7 of the 1983 Regulations. Regulation 7 requires, *inter alia*, the managers to be satisfied that arrangements have been made for the admission of the patient to the hospital to which he is being transferred within 28

¹ Applications for places in special hospitals are made directly to the hospital concerned, which seeks to apply the criteria in s. 4 of the 1977 Act. Where decisions cannot be reached at the hospital level, applications are referred to the Special Hospitals Service Authority. See para. 3.04 above and DHSS (1983) *Mental Health Act 1983: Memorandum on Parts I to VI, VIII and X*, paras. 266-71.

² That is, without prejudice to s. 19 (regulations as to transfer of patients).

³ See the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1983 No. 893, reg. 9.

days of the authority for transfer. The significance is that section 123(2) empowers the Secretary of State, if he is so minded, to override the managers of the hospital to which the patient is to be transferred, and to direct the patient's admission to that hospital. In practice, however, transfers from special hospitals are made only when a consultant makes a bed available in a local hospital. (See further para. 3.03 above)

3.08.1 *Discretion to transfer patients*

In *R. v. Secretary of State for the Home Department, the Special Hospitals Service Authority, and the Department of Health ex parte Pickering*,¹ a restricted patient detained at Ashworth Hospital sought leave for judicial review of a decision to transfer him to Broadmoor hospital. The patient claimed that the transfer decision was "arbitrary, perverse and unreasonable" because he was not consulted and that the transfer had no legitimate purpose. The Court of Appeal emphasised that the decision to transfer a patient is "pre-eminently" a matter for the advice of doctors, and that decisions in good faith based upon medical advice will be interfered with only in exceptional circumstances. The duty to act fairly does not require an invariable need to consult before making clinical decisions.² Mr. Pickering, the Court found, did not have a "legitimate expectation of consultation." He had not only eschewed previous suggestions of a transfer to a regional secure unit, but also expressed the view that he is ready for discharge. The Court, therefore, found that consultation would have been futile.³

The Court also declined to consider the Code of Practice as binding when it recommended that "individuals should be as fully involved as is practical, consistent with their needs and wishes, in the formulation and delivery of care." Consultation "depends on its own facts," said the court, and must be determined on a case by case basis.

Certainly a decision to transfer a patient is not immune from judicial review,⁴ but *Pickering* demonstrates that the choice of hospital regime made in good faith will seldom be overturned. (See para. 11.18.1 *post* for further discussion of the exercise of discretion in recommending transfer).

3.08.2 *Difficulty in effecting transfer to local NHS hospital*

Some two-thirds of releases from special hospitals are by way of transfer to allow rehabilitation by gradual relaxation of control over

¹ Transcript: Association of Official Shorthandwriters, 25 May 1990, per Leggatt, LJ.

² The Court of Appeal distinguished *Council of Civil Service Unions v. Minister for Civil Service* [1985] A.C. 374 at p. 401 (even if a person has no private law right to a benefit or privilege, if he has a legitimate expectation of it, the courts will protect his expectation under public law).

³ For further facts regarding Mr. Pickering's expectation of consultation that arose from an earlier tribunal hearing, see the decision of Roch J. in the same case. Transcript: Marten Walsh Cherer, CO/806/90, May 14, 1990.

⁴ See *R. v. Secretary of State for the Home Department, ex parte McAvoy* [1984] 3 A11 E.R. 417 (a decision to transfer a prisoner is susceptible to judicial review).

the patient.¹ Concern has been expressed about the difficulty of finding a local hospital bed for patients (particularly mentally handicapped patients) who no longer require treatment under conditions of special security. This resulted in a letter sent by the Secretary of State to Regional Health Authority Chairmen in November 1981 asking them to examine ways of arranging the transfer of appropriate patients into hospitals within their regions.

3.09 Application of Mental Health Act to Special Hospital Patients

The provisions of the Mental Health Act relating to patients while they are in hospital apply to special hospital patients just as they do to patients in other hospitals. The only provision in the Act which makes separate arrangements for special hospital patients is section 134 which regulates the correspondence of detained patients. (See further paras. **24.30–24.36** *post*)

3.10 Travelling Expenses of Visitors to Patients

The Secretary of State may, in accordance with arrangements made by him with Treasury approval, make payments to persons of such class as he may determine in respect of travelling expenses necessarily incurred by them in making visits to patients detained in special hospitals.²

3.11 Application of the Official Secrets Act

Prior to the establishment of the Special Hospitals Service Authority, special hospital staff were directly employed by the Department of Health and Social Security. As such they were persons who “hold office under Her Majesty” and were therefore subject to the Official Secrets Act. The Act prohibits the unauthorised disclosure of information; thus, prior authority had to be obtained before disclosure of any information about the special hospitals which had not already been made public.³

Now, professional medical, nursing and social work staff are employed within the National Health Service and are not subject to the Official Secrets Act. However, most administrative positions continue to be held by civil servants who are subject to the Act.

¹ S. Dell (1980) *The Transfer of Special Hospital Patients to NHS Hospitals*, Special Hospital Research Unit (report no. 16), London.

² Health Services and Public Health Act 1968, s. 66(1). The rate of payment determined is half the cost incurred in the use of public transport or a private vehicle at current Civil Service mileage rates.

³ DHSS (June 1981) *The Publication of Information about Special Hospitals* (unpublished). (For most purposes the responsibility for authorising publications was delegated to the heads of departments in special hospitals.)

3.12 Investigation of Complaints

The Department of Health has developed a set of principles for handling complaints in special hospitals which include the need to view complaints as part of a continuing therapeutic relationship; engage in a process of conciliation; treat complaints seriously and resolve them by mutual acceptance; and the rare use of an independent conciliator.

A consolidated set of procedures for handling patients' complaints in special hospitals was established in May 1989.¹ The hospital management team should issue an explanatory leaflet to all patients on admission, and to the relatives and friends of patients. The leaflet should be prominently displayed at all times. It should also be used in a continuing programme of training and management development for staff.

A complaints register, maintained by a Designated Officer, must be maintained at each special hospital. All complaints and the action taken on them should be recorded in the register. Complaints should normally be made, in writing, within three months of the incident, although the Designated Officer has discretion to allow a longer period for good cause.

Patients should make a complaint to the Charge Nurse, a member of the clinical team or to the Designated Officer. Friends, relatives, former patients or representatives (usually with the patient's consent) should refer complaints to the Designated Officer.

The Designated Officer, in consultation with the relevant head of department, should agree on the level at which the complaint will be investigated, such as at the charge nurse, department head or hospital management team level. If the seriousness of the complaint does not warrant a police enquiry (see below) the person assigned to investigate may require statements, should give patients the opportunity of recording their account of the facts and should be provided with access to all relevant documents. The investigating officer should talk with the patient(s) and relevant staff members to engage in a process of reconciliation.

A patient is entitled to have a friend with him to provide help and support, and a staff member may also have a friend, who could be a trade union representative or colleague.

Where internal reconciliation is unsuccessful, the hospital management team, exceptionally, may consider an independent conciliator who is agreed by all the parties.

The Designated Officer should be informed within 24 hours of non-resolution of a complaint or a decision that further enquiries are warranted. The hospital management team should satisfy itself that investigation of complaints and their resolution is prompt and effective,

¹ *The Handling of Patients' Complaints in Special Hospitals: Procedure*, May 9, 1989.

and it should direct other action if it is unsatisfied with the outcome of a complaint. Interested parties should be kept informed during the course of an investigation, and all parties should be informed in writing of the outcome.

In cases involving an allegation of ill-treatment, wilful neglect, corruption or interference with patients' property the matter should be referred to the police. Internal disciplinary action may be appropriate following police enquiries or if a complaint investigation warrants it.

3.12.1 *Other channels of complaint*

The special hospital complaints procedure is essentially for internal resolution of complaints. Nothing in this procedure affects the right of any appropriate person to raise a complaint with the Mental Health Act Commission (see para. 22.11 *post*), a Member of Parliament (see para. 3.12.2 below), the Health Service Commissioner (see para. 22.17 *post*) or any other interested individual or organisation.

3.12.2 *Parliamentary Commissioner*

Special hospitals used to be operated directly by a central government department, so that complaints concerning maladministration were dealt with by the Parliamentary Commissioner for Administration. His function is to investigate complaints referred to him by Members of the House of Commons from members of the public about alleged maladministration.¹ Complaints involving administration of any special hospital, therefore, used to be made to the Parliamentary Commissioner.²

Today, the Parliamentary Commissioner no longer has jurisdiction over the special hospitals because the special hospitals are within the National Health Service (see para. 22.17 *post*). However, any complaint alleging maladministration by the Home Secretary in respect of his powers over restricted patients³ or the transfer of patients from prison to hospital⁴ continue to be made to the Parliamentary Commissioner.

3.12A **Seclusion Procedure in Special Hospitals**

In July 1980 the European Commission of Human Rights adopted a report accepting a friendly settlement (under Article 28 of

¹ See Parliamentary Commissioner Act 1967.

² See *Seventh Report of the Parliamentary Commissioner for Administration for Session 1977-78* (August 1978), pp. 72-76 (visits to a Broadmoor patient).

³ See *First Report of the Parliamentary Commissioner for Administration for Session 1978-79* (December 1978), pp. 164-169 (refusal to discharge, and delay in discharging, restricted patients).

⁴ See *First Report of the Parliamentary Commissioner for Administration for Session 1982-83* (November 1982), pp. 65-74 (transfer of prisoner suffering from mental disorder).

the Convention) in the case of *A. v. the United Kingdom*¹. A patient at Broadmoor Hospital complained under Article 3 of the European Convention that he had been subjected to inhuman and degrading treatment during a period of seclusion which lasted for five weeks following his suspected involvement in a fire-raising incident on one of the hospital wards. The patient had only very limited opportunities for exercise or association; was deprived of adequate furnishings and clothing; and the conditions in the room were insanitary, inadequately lit and ventilated.²

The friendly settlement included an *ex gratia* payment to the applicant and a requirement that new working guidelines for the seclusion of patients at Broadmoor Hospital be introduced. Rooms used for seclusion have to be at least 4.7 square metres, and have natural lighting; an individual programme of care must be drawn up; patients must have suitable clothing and footwear, mattresses and bedding, and reading matter. Unless the patient's condition precludes it, he has to be allowed out of his room for toilet purposes, have at least 30 minutes exercise each morning and afternoon, and have visitors. Patients in seclusion are to be observed at irregular intervals not exceeding 15 minutes. A special record book should be maintained recording, *inter alia*, the start and ending time of seclusion, the reason for it, details of clothing, bedding, etc., and observations and reviews made.

The Commission, pursuant to Article 28(b), found that the friendly settlement had been secured on the basis of respect for human rights.

The Department of Health undertook a subsequent review of seclusion procedures in all of the special hospitals.³ The review team defined seclusion as "the supervised confinement of a patient specifically placed alone in a locked room for a period at any time of the day or night for the protection of self or others from serious harm."⁴

The Department of Health did not promulgate a policy on the use of seclusion following the review. Separate seclusion procedures still operate at each special hospital. However, the Department's review does state a set of principles. Patients should be secluded only where, based upon a professional judgement, there is a significant risk of physical injury to others which cannot be safely contained in any other way;⁵ and seclusion should be terminated as soon as possible.⁶

It is the responsibility of local managers to monitor the use of seclu-

¹ Application No. 6840/74, Report of the Commission, 16 July 1980.

² Further details of the parties' submissions are set out in the decision on admissibility. *Decisions and Reports of the European Commission of Human Rights*, vol. 10, p. 5. See also L. Gostin (April 1978) *Observations on the merits of Application No. 6840/74, European Commission of Human Rights*, MIND, London.

³ *Review of Special Hospitals Seclusion Procedures*. (April 1985).

⁴ *Ibid.*, para. 3.6.

⁵ *Ibid.*, para. 3.4.

⁶ *Ibid.*, Appendix 2.

sion, and to ensure that proper procedures are followed and full documentation is carried out.¹

3.13 Special Hospitals Research Unit

Research is carried out in each of the special hospitals by different disciplines, by individuals and through the Special Hospitals Research Unit. The latter was established in 1969 following the recommendation of the Estimates Committee. A case register² and a bibliography of research³ has been compiled by the Unit.

C. REGIONAL SECURE UNITS

3.14 Background

There are a group of patients whose needs fall between the services offered by local hospitals and special hospitals. These patients, because of their difficult and, at times, dangerous behaviour, require extra security which is not provided in local hospitals, but they do not require the degree of security found in special hospitals.

In recognition of this problem a Ministry of Health working party recommended in February 1961 the establishment of regional secure units⁴ *i.e.*, units maintained within each health region which would provide treatment under medium—secure conditions. A memorandum to regional boards in July 1961 recommended adoption of the working party's proposal, but not a single secure unit was established.

The idea was reintroduced in the interim Butler Report in 1974,⁵ which proposed secure units in each Regional Health Authority as a matter of urgency. The revised report of the working party on security in the NHS⁶ was published at the same time and made a similar recommendation. The Department of Health and Social Security agreed to fund these units from central government resources. Progress in

¹ *Ibid.*, Appendix 2. See further *Furber v. Kratter* (1988) *The Independent*, August 9, 1988, CO/559/88 where a patient in Moss Side Hospital claimed she was placed in seclusion for sixteen days in a room that was furnished only with a mattress. She alleged that she was denied any clothing and reading and writing materials, and that seclusion was "a punishment and to humiliate her, rather than a treatment".

² Special Hospitals Research Unit (1979) *Special Hospitals Case Register*, Report No. 15.

³ E. Parker (1981) *The Special Hospitals: Bibliography*, Report No. 17.

⁴ Ministry of Health (1961) *Special Hospitals: Report of a Working Party*. HMSO, London.

⁵ *Interim Report of the Committee on Mentally Disordered Offenders* (1974) Cmnd. 5698. HMSO, London.

⁶ *Revised Report of the Working Party on Security in NHS Psychiatric Hospitals*. (Glancy; 1974) DHSS, London.

developing regional secure units was agonizingly slow, but all regional health authorities now have plans for permanent accommodation and most regions have some unit in operation.¹

3.15 Management

Regional secure units have a catchment area which takes in an entire health region. Some regional health authorities have several units, each with a sub-regional catchment area. Funding for the units is essentially from the regional health authority.

Regional secure units are usually attached to existing mental illness or mental handicap hospitals, or district general hospitals. They are managed in the same way as the local or district hospital—*i.e.*, by the district health authority in whose area they are situated. (As to “the managers” see para. 6.01 *post.*)

¹ See contributions by R. Buglass and I. Treasendan, in Gostin (ed., 1985) *Secure Provision; A Review of Special Services for the Mentally Ill and Handicapped in England and Wales*, Tavistock, London.