

case from *Paul* above is founded on the evidence at the inquest that brought to light no possibility of action that could be taken to prevent this type of death. The result might have been different if a plausible basis for protecting others in future had been suggested at the inquest.

■ **Children's Rights Alliance for England v Secretary of State for Justice and (1) G4S Care and Justice Services (UK) Ltd (2) Serco PLC (interested parties)**

[2012] EWHC 8 (Admin),  
11 January 2012

This is another case relating to the deaths of children in secure training centres (STC), who had been subjected to force by officers. The claimant submitted that the defendant should take positive steps to inform children, who were subject to restraint for particular purposes in STC over a specified period, that the restraint techniques were unlawful and they had legal rights to compensation. The court rejected the claim. It decided that this positive duty came about neither under the common law nor under articles 3, 6 or 8 of the convention.

The court also decided that the Children's Rights Alliance for England (CRAE) did not have standing under HRA s7 to make a claim solely to assert the convention rights of detainees. The claimant was not itself a victim for the purposes of HRA s7; however, the CRAE did have standing to make a challenge under the common law.

\* The text of this judgment is available in French only.

# Responsible authority statements for mental health tribunals



**Christopher Curran, Phil Fennell and Simon Burrows** describe the statutory requirement on the responsible authority to provide information and documents about patients for mental health tribunals in England.

## Introduction

The Care Quality Commission (CQC) report, *Monitoring the Mental Health Act in 2010/11* (December 2011), states that the:

... overall number of people subject to the Act as at 31 March rose by 5%, from 19,947 on 31 March 2010 to 20,938 on 31 March 2011.

Almost all of this increase was due to the overall rise in the number of people subject to a [community treatment order (CTO)]. ... the number subject to a CTO at 31 March 2011 rose from 3,325 to 4,291, an increase of 29.1% on the previous year (page 16).<sup>1</sup>

This demonstrates the increasing number of people subject to both inpatient and outpatient compulsion. By comparison, in 2009/10 the number of guardianship orders had decreased from 877 in March 2009 to 836 in March 2010.<sup>2</sup> Following detention under the Mental Health Act (MHA) 1983 (amended 2007) or discharge on a CTO or guardianship order, a patient has a statutory right to apply to a mental health tribunal (and if that right is not exercised the hospital may have a duty to refer his/her case to the tribunal anyway). As part of this appeal process, the body managing the detaining hospital – which the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 ('the Tribunal Procedure Rules') SI No 2699 refer to as the 'responsible authority' (RA) or detaining authority – must provide certain information to the tribunal (rule 1(3) states: "responsible authority" means ... in relation to a patient detained under the Mental Health Act 1983 in a hospital within the meaning of Part 2 ... the managers (as defined in section 145 of that Act)'). Unfortunately, compliance with this requirement in England, and the quality of the information provided, is inconsistent and may sometimes cause unnecessary delay for the patient appealing against his/her detention in hospital, a CTO (MHA 1983 s17A) or a

guardianship order (MHA 1983 s7).

This article identifies the information to be provided under Sections B and C of the 2008 *Practice Direction Health Education and Social Care Chamber mental health cases* ('the 2008 PD').<sup>3</sup> Sections B and C are particularly relevant; this article explains why, in addition to being a legal requirement, the provision of this information and documentation is very important to the tribunal's assessment and decision-making process and sets out the implications of non-compliance. Section B (information about the patient) identifies 18 specific points that must be addressed in the RA's statement, where that information is known to the RA. Section C (documents concerning the patient) identifies three categories of document (see below) which need not be supplied routinely, but must be provided if the tribunal so directs, whether in advance or at the hearing itself.

The Mental Health Review Tribunal Rules 1983 ('the MHRT Rules') SI No 942, which formerly applied in England and Wales, were replaced in November 2008 by discrete tribunal rules for each country. In England, the provision of information in mental health cases is governed by the Tribunal Procedure Rules r32(5) and by the 2008 PD.

## Relevant mental health legislation and guidance

Rule 32(6) of the Tribunal Procedure Rules requires the RA to provide information and documents specified in the 2008 PD. It is vital that those compiling the information required in the RA statement are aware of this as the information is required for all tribunal hearings. The *Reference guide to the Mental Health Act 1983* (Department of Health (DoH), September 2008) states that: 'The rules and Practice Directions must be followed by people involved in tribunal cases' (para 20.10).<sup>4</sup> The *Code of Practice. Mental Health Act 1983* (DoH, May 2008) and the above reference guide provide helpful information at paragraphs 32.10–32.21 and paragraphs 20.8–20.10 respectively.<sup>5</sup>



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## RA statement – Section B: information about the patient

The RA must provide all the information required under 2008 PD Section B (insofar as it is within its knowledge). Note: the letters 'RR' below refer to a regulatory requirement under the 2008 PD, which means the information must be provided by the RA before all tribunal hearings. These, along with the bold headings, have been inserted by the authors. The following, unless otherwise specified, are all regulatory requirements under the 2008 PD:

1.1) **RR RA statement:** *The statement provided to the Tribunal must, insofar as it is within the knowledge of the responsible authority, include the following information:*

a) **RR Patient's full name:** *the patient's full name (and any alternative names used in his patient records);*

b) **RR Patient's date of birth, age and usual place of residence:** *the patient's date of birth, age and usual place of residence [ie prior to admission];*

c) **RR Patient's first language:** *the patient's first language and, if it is not English, whether an interpreter is required, and if so in which language;*

d) **RR Interpreter:** *if the patient is deaf whether the patient will require the services of a British Sign Language interpreter, or a Relay interpreter [indicate if arrangements have been made, for example, ensure that the Tribunals Service has been notified in good time before the hearing date];*

[Paragraph 11(c)–(d) highlights the importance of noting any difficulties patients may have with English (or Welsh) due to either speaking a different language or having a sensory disability. These considerations are important from the point of view of article 6 of the European Convention on Human Rights (right to a fair trial) because they are intended to ensure a fair hearing. Primarily, however, they are designed to ensure that the tribunal is able to make proper arrangements for the hearing to take place speedily. It is essential that the tribunal knows that an interpreter is required for the hearing and for the examination by the tribunal member (medical) at some point before the hearing. A failure to forewarn the Tribunals Service of the need for an interpreter (for example, language or signing) could lead to avoidable delays and adjournments, waste valuable time and resources in hearing the appeal and create unnecessary stress for the patient.]

e) **RR Date of admission or transfer of the patient to the hospital:** *the date of admission or transfer of the patient to the hospital in which the patient is detained or liable to be detained, or of the reception of the patient into guardianship, together with details of the application, order or direction that constitutes the original authority for the detention or guardianship of the patient, including the Act of Parliament and the section of that Act by reference to which detention was authorised and details of any subsequent renewal of or change in the authority for detention;*

f) **RR Detaining hospital or guardianship address:** *details as applicable of the hospital at which the patient is detained or liable to be detained, or the place where the patient is living if received into guardianship;*

g) **RR Details of any transfers under MHA 1983 s19 or s123:** *details of any transfers under section 19 or section 123 of the Mental Health Act 1983 since the application, order or direction was made;*

[The information at subparagraphs (e)–(g) assists in providing a concise history of the patient's progress which might not be easily apparent from the reports.]

h) **RR Independent hospital:** *where the patient is detained or liable to be detained in an independent hospital, details of any NHS body that funds or will fund the placement;*

i) **RR MHA 1983 s117 aftercare – local social services authority:** *where relevant, the name and address of the local social services authority and NHS body having the duty under section 117 of the Mental Health Act 1983 to provide after-care services for the patient (or which would have it were the patient to leave hospital);*

[The information as subparagraph (i) can be important if the tribunal is considering discharge but is concerned about the adequacy of after-care arrangements.]

j) **RR Responsible clinician:** *the name of the patient's responsible clinician and the period which the patient has spent under the care of that clinician;*

k) **RR Care co-ordinator:** *the name of any care coordinator appointed for the patient; [It is helpful to indicate the individual's professional background.]*

l) **RR Nearest relative, except in the case of a restricted patient:** *except in the case of a restricted patient, the name and address of the patient's nearest relative or of*

*the person exercising that function, and whether the patient has requested that this person is not consulted or kept informed about their care or treatment;*

m) **RR Significant part:** *the name and address of any person who plays a significant part in the care of the patient but who is not professionally concerned with it;*

n) **RR Private guardian:** *where the patient is subject to the guardianship of a private guardian, the name and address of that guardian;*

o) **RR Deputy or attorney under the MCA:** *the name and address of any deputy or attorney appointed under the Mental Capacity Act 2005;*

p) **RR Registered lasting power of attorney:** *details of any registered lasting power of attorney made by the patient that confers authority to make decisions about his personal welfare, and the donee(s) appointed by him;*

q) **RR Registered enduring power of attorney:** *details of any registered lasting or enduring power of attorney made by the patient that confers authority to make decisions about his property and affairs, and the donee(s) appointed by him; [For example, once notified of the existence of a deputy or attorney, the tribunal may think that notice should be given under rule 33(e): 'Notice of proceedings to interested persons ... who, in the opinion of the tribunal, should have an opportunity of being heard.']] and*

r) **RR Advance decisions:** *details of any existing advance decisions to refuse treatment for mental disorder made by the patient. (Authors' emphasis throughout.)*

**Note:** If information is not available for any part of the RA statement, the authors strongly recommend that the MHA administrator does not simply enter 'N/A' or leave a blank space as that implies it is not applicable or has not been addressed, and not that there is or is not any pertinent information. It is more accurate to enter 'Not known' or 'Information is being sought'.

## Supervised community treatment/CTO

If the patient is subject to a CTO under MHA 1983 s17A or a guardianship order under MHA 1983 s7, the RA is required to provide an RA statement under the 2008 PD highlighted above.<sup>6</sup>

## Provision of the RA statement and Section C documents

The RA is required to provide a statement under Section B of the 2008 PD and, if directed by the tribunal, also under Section C. The information, documents and reports that the RA must provide are set out in 2008 PD paras 3, 7, 8(a)–(f), 11 and 12(a)–(c):

3) *The responsible authority must send a statement to the tribunal and, in the case of a restricted patient other than a conditionally discharged patient, to the secretary of state, so that it is received by the tribunal as soon as is practicable and in any event within three weeks after the responsible authority received a copy of the application or reference ...*

7) *If the patient is a community patient subject to supervised community treatment the statement to the tribunal must contain the reports specified in paragraph 8(f) below.*

8) *The information, documents and reports referred to above are:*

a) *the information about the patient set out at Section B below;*

b) *the documents concerning the patient set out at Section C below;*

c) *the clinician's report set out at Section D below;*

d) *the social circumstances report set out at Section E below;<sup>7</sup>*

e) *if the patient is an inpatient, the nursing report set out at Section F below;*

f) *the reports set out in Section H below [CTO].*

...

*Section B. Information about the patient [‘the RA statement’]*

*11) The statement provided to the tribunal must, in so far as it is within the knowledge of the responsible authority, include the following information [as defined at paragraph 11(a)–(r): see box].*

*Section C. Documents concerning the patient*

*12) If the tribunal so directs, copies of the following documents must be included in the statement provided to the tribunal if they are within the possession of the responsible authority ...*

a) *the application, order or direction that constitutes the original authority for the patient's detention or guardianship under the Mental Health Act 1983, together with all supporting recommendations, reports and records made in relation to it under the Mental Health (Hospital, Guardianship and Treatment) Regulations 2008;*

b) *a copy of every tribunal decision, and the reasons given, since the application, order or direction being reviewed was made or accepted; and*

c) *where the patient is liable to be detained*

*for treatment under section 3 of the Mental Health Act 1983, a copy of any application for admission for assessment that was in force immediately prior to the making of the section 3 application (authors' emphasis).*

These documents may not be requested by the tribunal in every case. Nevertheless, the RA should be prepared to make them available if directed, in order to avoid delays. Particularly in longer, complex cases, the tribunal may wish to have a detailed understanding of the background to the case which can be obtained from previous tribunal decisions and the original detention papers.

## Purpose of the RA statement

Besides being a statutory requirement under the Tribunal Procedure Rules and Section B of the 2008 PD, the RA statement provides the first impression of the patient to the tribunal.<sup>8</sup> The main purpose of the RA statement is to ensure that the tribunal, the patient and the legal representative have an authoritative and accurate biography of the patient. If the patient is subject to Ministry of Justice restrictions, the secretary of state must also receive a copy of the RA statement. It must include the patient's date of birth/age and usual place of residence. In addition, it must identify a number of ‘key players’, for example, the nearest relative, the responsible clinician and the care co-ordinator under the Care Programme Approach (CPA) (see box). It should also provide a chronology of the use of compulsion under the MHA 1983 and, where relevant, information about any advance decision refusing treatment or advance statement requesting it.

## Statement by the responsible/detaining authority

Based on the authors' recent tribunal experience in England, the delivery and quality of a number of RA statements remains variable following the introduction of the 2008 PD and continues to be inconsistent. For example, despite the fact that over three years has elapsed since the new regulations were implemented, it is the authors' experience that a number of MHA administrators acting on behalf of the RA incorrectly refer to the provision of ‘Part A statements’ (which no longer exist) and fail to comply fully with the current law. At times the statement provided by the RA solely relates to the MHRT Rules (now repealed) or it is a mixture of information required under the expired MHRT Rules and the 2008 PD. Worryingly, some MHA administrators show a limited understanding of the importance of the RA statement, and place insufficient weight on the obligation to provide this essential information. It is worth reiterating that it is a regulatory requirement to provide

the RA statement under the 2008 PD, be it for an inpatient detained under the MHA 1983, or for a patient subject to a guardianship order under section 7 or a CTO under section 17A.

The statutory requirement to comply fully with the 2008 PD is emphasised in the introduction to *Reports for mental health tribunals* (Tribunals Service, 2010).<sup>9</sup> The Deputy Chamber President Judge Mark Hinchliffe states that all those responsible for completing social circumstances/medical and nursing reports, including the RA statement, for mental health tribunals have a statutory requirement to comply fully with the Tribunal Procedure Rules and the 2008 PD. He says:

*Many people forget that proceedings before mental health tribunals are judicial, just like proceedings before courts ... Consequently, for those whose task it is to prepare statements and reports ... the duty to ensure that all the key details are included is absolutely fundamental.*

*... the Senior President of Tribunals has issued a Practice Direction, which has the full force of law and is legally binding. It spells out the minimum requirements ... for various types of report. Compliance is compulsory, and not optional (pages 2–3).*

This information must be served within the time specified in the 2008 PD. In MHA 1983 s2 cases (admission for assessment), the RA statement must be provided on the day of the hearing.

## Failure to comply with Tribunal Procedure Rules and 2008 PD

Where the RA statement is not provided or fails to fully comply with the 2008 PD, the tribunal may in certain circumstances decide to adjourn the case for a short time on the day in order that the MHA administrator may provide an RA statement (Tribunal Procedure Rules r5(3)(d)). This regrettably has the effect of slowing down the hearing process (with all that that involves in terms of impact on the patient, his/her family and legal representatives, health care professionals and the tribunal).

## Preparation of the RA statement

The 2008 PD clearly identifies what must be included in the RA statement. Senior health and social care managers should ensure that any relevant forms are up to date and in line with the 2008 PD, and that staff are fully aware of the regulatory requirements and receive regular MHA updates, training and access to formal legal support. RAs and MHA administrators and their managers should also ensure they are fully aware of the importance of providing an RA statement. If the MHA administrator is unclear about the law, the

tribunal's powers or how to compile this information, it is recommended that s/he liaises closely with his/her line manager and, if necessary, the NHS Trust/independent hospital legal adviser. MHA administrators are advised to be wary of 'cutting and pasting' extracts from any previous RA statements, in case they include outdated or incorrect information which may unintentionally mislead the tribunal.

### **Delay between patient's application and eventual hearing date**

If several weeks have elapsed since the submission of the first RA statement and if any of the requisite information has changed, it would be helpful (to the tribunal and the patient together with any legal representative) if the RA reviewed the statement and, if necessary, submitted an updated one; doing so on the day of the hearing is sufficient.

### **Mental Capacity Act 2005**

It is vital to provide the information about the Mental Capacity Act (MCA) 2005, lasting power of attorney, power of attorney and advance directives, because of the potential interface between the MHA 1983 and the MCA. The old MHRT Rules did not require this information, so adherence to the Tribunal Procedure Rules is important. In addition to dealing with any communication problems it is important to be aware of any issues relating to the patient's capacity, which may clearly inhibit his/her ability to take an active part in the tribunal hearing process. It would be useful if any such issues were clearly flagged up in the RA statement.

### **Layout and content of the RA statement**

The authors strongly advocate that the content of the RA statement adheres to the actual paragraph number and letters used in paragraph 11(a)–(r) of the 2008 PD. In that way the tribunal, the patient and his/her representative know whether all the regulatory requirements have or have not been fully addressed. It would assist the tribunal if any additional information was clearly differentiated, for example, by being written on separate sheets entitled 'Non-statutory information'. It is recommended that the RA statement is paginated, dated and signed by the MHA administrator on behalf of the RA.

### **Administrative issues Information for tribunal medical members**

One issue facing tribunal medical members (MMs) on CTOs is arranging to meet with the community patient in advance of a hearing. It would assist the tribunal and the MM if the RA provided a separate sheet with information that

includes telephone numbers and e-mail addresses for the patient's 'current' community psychiatric nurse (CPN)/social worker (SW)/care co-ordinator, community mental health team (CMHT) base (plus its full address and postcode) and community responsible clinician, in order that the MM may make the necessary arrangements to meet with the patient subject to the CTO and access his/her case notes (hard copy or electronic). It would also be helpful if the hospital/ward/CMHT telephone numbers were provided as the MM frequently arranges to examine the patient out of office hours.

### **Inpatient nursing care plan**

MHA administrators should remind ward nursing staff that it is a statutory requirement under Section F of the 2008 PD (Tribunal Procedure Rules r32(5)) that: 'A copy of the patient's current nursing plan must be appended to the report' (para 19). Unfortunately this useful information is repeatedly overlooked and thus absent from the inpatient nursing report.

### **Tribunal reports**

It would be helpful if the MHA administrator reminded mental health professionals attending the hearing to have a copy of their tribunal report at the hearing. In the authors' experience, report writers regularly attend without a copy of their own report.

### **Observation of a mental health tribunal hearing**

Tribunal Procedure Rules r38(1) provides that all mental health tribunal hearings must be held in private (unless the tribunal considers that it is in the interests of justice for the hearing to be held in public). However some individuals, such as newly-appointed tribunal members, are required to observe the tribunal process and others, such as mental health professionals and lawyers new to mental health law, understandably wish to observe a hearing as part of their professional development. Notwithstanding the hearing being conducted in private, requests to observe are regularly granted. It is a matter for the tribunal panel (rule 38(3)). The patient's views are sought, and provided s/he raises no objection, and there is sufficient space within the hearing room, permission is usually given, subject to the observer agreeing to comply with the *Guidance for the observation of tribunal hearings* (Tribunals Service, November 2009).<sup>10</sup> This guidance lays out specific criteria in recognition of the private and confidential nature of the proceedings. Ideally, the RA/MHA administrator should apply in advance of a hearing with any observation request.

### **Additional 'non-statutory information'**

Although not essential the following is useful to the tribunal:

- application or referral: an indication if the referral to a tribunal is by the RA or is a patient or nearest relative application;
- adjourned case: in an adjourned or complex case it is particularly helpful to provide the tribunal judge with a copy of the previous tribunal's decision (2008 PD Section C);
- previous tribunal hearings: ie, date and result of previous hearings;
- addendum reports: if an addendum report is provided on the day of the hearing the MHA administrator should remind the writer to have sufficient copies of the report. If addendum reports relate to a restricted patient, the writer should ensure this is delivered at least seven to ten days before the hearing date, in order that the secretary of state has an opportunity to comment, otherwise an adjournment may well be necessary;
- CTO conditions or requirements: if the patient is subject to a CTO it would be helpful if the MHA statutory papers were made available to the tribunal regarding any conditions or requirements. At the current time most tribunal reports commonly omit this important statutory information, contrary to the 2008 PD (Section H, para 24(h) for the responsible clinician report and paragraph 26(i) for the social circumstances report);
- MHA 1983 s17 leave of absence: ie, a record of recent periods of section 17 leaves of absence;
- CPA plan and MHA 1983 s117 after-care plan in embryo: the date of the last section 117/CPA meeting and a summary of the patient's current CPA plan.

### **Legal representatives and tribunal hearings**

If an RA statement is not provided for the tribunal hearing or does not fully comply with the regulatory requirements of the 2008 PD, the patient's legal representative should consider drawing the issue to the attention of the tribunal's administrative centre in Leicester at the earliest opportunity and request that arrangements are made for an RA statement compliant with the 2008 PD to be provided before the hearing date.

### **Comportment at tribunals**

The 2008 PD applies to a 'mental health case', as defined in rule 1(3) of 2008 Rules. While, in accordance with their overriding objective, mental health tribunals seek to be flexible and avoid formality, it is important to emphasise that they remain courts and must therefore determine appeals fairly and justly. Nonetheless, tribunals are conducted within a 'judicial

setting', and are not venues for a case conference or informal meetings. Most attendees are usually witnesses and when discharging the responsibilities of that role they are expected to conduct themselves appropriately at tribunal hearings. The most common lapses in professional etiquette include a failure to switch off mobile/smart phones (eg checking texts/emails), consuming beverages and chewing gum during the course of the tribunal hearing. Such behaviour, sadly witnessed all too often, can only reflect badly on the individual and hospital concerned and exhibits a discourteous attitude to the judicial process.

### Conclusion

MHA administrators are a valuable component of the mental health appeal process and may sometimes feel undervalued and under-resourced. They frequently deal with a number of tribunal hearings in any given week and it is essential that they receive appropriate support and advice. Compared with the provision of tribunal reports, the compilation of the RA statement and the provision of Section C documents may seem like a further chore of limited, if any, value. The authors have attempted to demonstrate that this is far from the case. Comprehensive information about the patient's circumstances, presented in accordance with the statutory requirements set out above, is essential to the tribunal's task of assessing the need for compulsion and applying the relevant law. Failure to provide a full RA statement presents the tribunal with an incomplete picture and may necessitate an adjournment of the appeal. This not only leads to an interruption of the proceedings on the day but also adds additional stress to the patient's tribunal experience. Adjournments (no matter for what length of time) are costly. They may cause an undesirable delay in what is, after all, the determination of a patient's appeal against his/her detention in hospital (or under a CTO or a guardianship order), and the restoration of his/her liberty. The Tribunal Procedure Rules and 2008 PD provide a mechanism for ensuring that all relevant material is put before the tribunal. In short, compliance with the RA statement is compulsory, not optional. It is a statutory requirement and as such attracts significant weight under the law.

1 See 'Part 2: Use of the Mental Health Act in 2010/11', pages 15–20, available at: [www.cqc.org.uk/sites/default/files/media/documents/cqc\\_mha\\_report\\_2011\\_main\\_final.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf). See also *In-patients formally detained in hospitals under the Mental Health Act, 1983 – and patients subject to supervised community treatment, annual figures, England 2010/11*, The NHS Information Centre for Health and Social Care,

October 2011, available at: [www.ic.nhs.uk/pubs/inpatientdetmha1011](http://www.ic.nhs.uk/pubs/inpatientdetmha1011).

- 2 *Local authority personal social services statistics. Guardianship under the Mental Health Act 1983, England, 2010*, The NHS Information Centre, Community and Mental Health, September 2010, available at: [www.ic.nhs.uk/webfiles/publications/mental%20health/guardianship/Guardianship\\_2010\\_v1.0.pdf](http://www.ic.nhs.uk/webfiles/publications/mental%20health/guardianship/Guardianship_2010_v1.0.pdf).
- 3 Available at: [www.justice.gov.uk/downloads/guidance/courts-and-tribunals/tribunals/mental-health/publications/PracticeDirection.pdf](http://www.justice.gov.uk/downloads/guidance/courts-and-tribunals/tribunals/mental-health/publications/PracticeDirection.pdf).
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- 5 Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084597](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597) and see note 4.
- 6 Christopher Curran, Dr Tony Zigmund and Catherine Grimshaw, 'Community treatment orders under the 1983 Mental Health Act', *Openmind*, March/April 2010, No 162, pp26–27.
- 7 Christopher Curran, Malcolm Golightley and Phil Fennell, 'Social circumstances reports for mental health tribunals – Parts 1 and 2', June and July 2010 *Legal Action* 30.
- 8 Phil Fennell, *Mental health law and practice*, second edition, Jordans, March 2011, pp333–334.
- 9 Available at: [www.mhrt.org.uk/Documents/Forms/ReportsGuidanceBooklet.pdf](http://www.mhrt.org.uk/Documents/Forms/ReportsGuidanceBooklet.pdf).

10 The mental health tribunal has produced helpful guidance on the protocol in respect of the categories of observers and how individuals should apply, see: [www.judiciary.sut1.co.uk/docs/tribunals/mhrt/guidance-obs-trib-hearings.pdf](http://www.judiciary.sut1.co.uk/docs/tribunals/mhrt/guidance-obs-trib-hearings.pdf).

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