

PART VII

THE RIGHTS OF THE PATIENT

Chapter 22: Protection of the Patient

Chapter 23: The Patient's Property and Financial Affairs

Chapter 24: Rights and Disabilities of Patients

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Chapter 22

PROTECTION OF THE PATIENT

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22.01 Introduction

This chapter is concerned with the various ways in which the rights of patients can be protected and the quality of their care reviewed. One of the most distinctive features of the Mental Health (Amendment) Act 1982 is that it introduced a body known as the Mental Health Act Commission with various functions and powers which are set out below. The concepts behind the Commission are not new but date back to the eighteenth century. One of the principal

functions of the Mental Health Act Commission is the investigation of complaints. In this chapter other complaints agencies are examined, particularly the Health Service Commissioners. In addition, the power to hold enquiries and the default powers of the Secretary of State are described. Finally, there is a brief description of the NHS Health Advisory Service and the Development Team for Mentally Handicapped People, both of which are concerned with monitoring services provided for mentally disordered people.

A. THE MENTAL HEALTH ACT COMMISSION

22.02 Background

2.02.1 *Commissioners in Lunacy*

Since the eighteenth century there has been some independent body with authority to review the exercise of compulsory powers as well as the treatment and care of mentally disordered people. The Act for Regulating Private Madhouses 1774 (14 Geo. III c. 9) was the first statute to provide for a system of licensing of private madhouses by Commissioners in Lunacy elected by the Royal College of Physicians. A keeper of a madhouse who refused to admit the Commissioners forfeited his licence, but there was no authority for withdrawing a licence on grounds of ill-treatment or neglect of patients; Commissioners could only display their reports in the Censor's room of the Royal College (see para. 1.05.2 *ante*).

The Commissioners in Lunacy were unable to prevent the continuation of appalling conditions in private madhouses. They were replaced in the Madhouse Act 1828 (9 Geo. IV c. 41) by the Metropolitan Commission appointed by the Home Secretary; five of the fifteen Commissioners were physicians and most of the rest were Members of Parliament. The Commission was given the power to release any patient who was in their estimation improperly confined (see para. 1.05.3 *ante*).

The Lunacy Act 1845 (8 & 9 Vict. c. 100) appointed new Commissioners in Lunacy now accountable to the Lord Chancellor, with a full time inspectorate and central secretariat. The inspection, licensing and reporting functions of the old Metropolitan Commissioners were continued by the Lunacy Commissioners. However, the right of inspection was extended to cover all insane persons in whatever institution they were confined, and the Lord Chancellor could order special visits (including a visit to Bethlem) (see para. 1.05.4 *ante*).

22.02.2 *Board of Control*

The Lunacy Commission was reconstituted as the Board of Control under the Mental Deficiency Act 1913 and reorganised under

the Mental Treatment Act 1930. The Board originally had management functions as the central department responsible for the general supervision of mental health services; it was not until the advent of the National Health Service in 1947–48 that the Board's management functions in relation to services were transferred to the Ministry of Health. But the Board continued to have the duty to supervise the use of procedures as applied to individual patients: it scrutinised legal documents, provided authority for the continuation of orders, visited patients, and inspected hospitals. The Board had the power to discharge detained patients (see para. 1.06.2 *ante*).¹

The Mental Health Act 1959 abolished the Board of Control. The responsibility for maintaining the standard of services remained with the Ministry of Health and health authorities; the duty to scrutinise documents and otherwise ensure that compulsory powers were exercised lawfully rested with the professionals who signed the necessary documents and the hospital managers; and the power of discharge was vested in newly constituted Mental Health Review Tribunals.²

22.02.3 *The Mental Welfare Commission for Scotland*

The Mental Welfare Commission for Scotland was established under section 2 of the Mental Health (Scotland) Act 1960. The Commission is a body corporate which must consist of no fewer than ten Commissioners. Among the Commissioners appointed, there must be a minimum of three women, one lawyer and three medical practitioners.³ The policy of the Commission is not to have a majority of medical members.⁴

The Mental Welfare Commission is charged with the duty "generally to exercise protective functions in respect of persons who may, by reason of mental disorder, be incapable of adequately protecting their persons or their interests".⁵ The Commission's jurisdiction therefore includes all mentally disordered people who are incapable of protecting themselves, whether they are situated in a hospital, in residential accommodation or in the community.

In the exercise of these protective functions the Commission has a duty: (i) to make inquiry into any case where there may be ill-treatment, deficiency in care or treatment or improper detention or where the property of a person may, by reason of mental disorder, be exposed to

¹ As to the history see the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954–1957*, Cmnd. 169, HMSO, London, paras. 725–734.

² *Ibid.*, paras. 735–784.

³ Mental Health (Scotland) Act 1960, s. 2(2); Mental Health (Amendment) Scotland Act 1983, s. 1.

⁴ Mental Welfare Commission (1975) *No Place to Go*, HMSO, Edinburgh.

⁵ Mental Health (Scotland) Act 1960, s. 4(1).

loss or damage; (ii) to visit regularly patients who are liable to be detained in hospital or who are under guardianship, and on such a visit to afford an opportunity, on request for a private interview (any visit must be made by, or must include, a medical practitioner who may examine the patient in private and may call for his medical records); and (iii) to bring to the attention of the hospital management or local authority the facts of any case to help secure the welfare of any patient.¹

The Mental Welfare Commission has the power to discharge patients who are detained or subject to guardianship,² and can advise the Secretary of State as to the discharge of restricted patients.³ It has the duty to visit patients detained for a specified period of time who have not appealed to the sheriff or have previously been visited by the Commission.⁴

The Mental Welfare Commission has the duty to published a report on its activities in 1985 and in every year thereafter.⁵

22.02.4 *The advent of the Mental Health Act Commission*

There was no consistent and uniform campaign for the re-establishment of some form of Commission for mental patients in England and Wales after the abolition of the Board of Control in 1959. MIND called for a Committee on the Rights and Responsibilities of Patients primarily with an advocacy function;⁶ the Royal College of Psychiatrists asked for a Commission on the Scottish model;⁷ and the Boynton Committee asked for a body to inspect and monitor closed institutions.⁸

The Mental Health (Amendment) Act 1982, consolidated in the 1983 Act, established the Mental Health Act Commission. But the decision to create a Commission in many respects was not a response to previous proposals. Instead it was a way to fashion a compromise on the question of whether decisions regarding consent to treatment should be made by a second doctor (as recommended by the Royal College of Psychiatrists) or by an independent authority (as recommended by MIND); indeed a major part of the Commission's work, quite unlike its predecessors, concerns consent to treatment. (See further para. 1.11.2 *ante*). It is highly likely that if a Commission had not been

¹ *Ibid.*, s. 4(2), (3), (4), (5).

² *Ibid.*, s. 43.

³ *Ibid.*, s. 4(2)(6B), added by the Mental Health (Amendment) Scotland Act 1983, s. 2.

⁴ *Ibid.*, s. 4(2)(bb), added as above.

⁵ *Ibid.*, s. 4(2)(6A), added as above.

⁶ L. Gostin (1975: vol. 1) *A Human Condition*, MIND, London.

⁷ R. Bluglass (July, 1981) *Towards a New Mental Health Act: Mental Health Commissions for England and Wales*, *Bull. Roy'l. Col. Psychiatrs.*, p. 130.

⁸ *Report of the Review of Rampton Hospital* (1980) Cmnd. 8073, DHSS, London, para. 4.7.

thought to be needed to resolve the intractable problems concerning consent to treatment that it would not have been established.

The new Commission maintains the traditional function of reviewing the way in which powers of detention are exercised. However, the function of inspecting conditions and services, and the power to discharge inappropriately detained patients is not vested in the Mental Health Act Commission as was the case with previous Commissions; these functions are now vested, respectively, in the Health Advisory Service (see para. 22.23 below) and the Development Team for the Mentally Handicapped (see para. 22.22 below), and in the Mental Health Review Tribunal (see Chapter 18).

22.03 Establishment of the Mental Health Act Commission

The Mental Health Act Commission was established in pursuance of section 56(1) of the Mental Health (Amendment) Act 1982 and continues under section 121(1) of the Mental Health Act 1983. The Mental Health Act Commission (Establishment and Constitution) Order 1983, S.I. 1983 No. 892, came into operation on 1st September 1983, and Article 3 of the Order (Functions of the Commission) came into operation on 30th September 1983; this gave the Commission one month to consider how it would carry out its powers and duties before it came fully into operation under the 1983 Act. The Mental Health Act Commission is a special health authority established under section 11 of the National Health Service Act 1977, amended by the Health Services Act 1980, Sch. 1, para. 31 (as to which see para. 2.16 *ante*).

22.03.1 *The Commission is under the jurisdiction of the Health Service Commissioner*

The Mental Health Act Commission has been designated by an Order in Council under section 109(d) of the National Health Service Act 1977 as an authority subject to the jurisdiction of the Health Service Commissioner.¹ Thus, like other health authorities, any of its activities or those of its members, can be investigated by the Health Service Ombudsman to determine if they amount to maladministration. (As to the Health Service Commissioner, see para. 22.17).

22.04 Constitution and Proceedings of the Mental Health Act Commission

The constitution and proceedings of the Commission are governed by the Mental Health Act Commission Regulations 1983, S.I. 1983 No. 894. (Unless otherwise specified, further references to regulations in this paragraph are to these regulations). Originally the

¹ S.I. 1983, No. 1114, Art. 2.

members of the Commission were divided into three regional groups, but in 1989 the Commission's Secretariat was centralised in Nottingham:

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22.04.1 *Membership*

The Mental Health Act Commission consists of members appointed by the Secretary of State for Social Services (acting jointly with the Secretary of State for Wales),¹ one of whom is the chairman (currently Sir Louis Blom-Cooper) and there is provision for a vice-chairman (reg. 2). The vice-chairman may be appointed by the Secretary of State for a specified period; but where no appointment is made, the Commission must elect one of their own members to be vice-chairman (reg. 6).² The term of office of the chairman and members is for a period, not exceeding four years, as specified by the Secretary of State on making the appointment (reg. 3); but they are eligible for re-appointment (reg. 5). They may resign at any time by giving written notice to the Secretary of State (reg. 5). Currently members are appointed for either two or four year terms; there are some ninety members consisting of doctors, lawyers, lay members, psychologists, social workers and nurses, with several specialist members such as academics or occupational therapists. The largest group is psychiatrists, in recognition of the large number of second medical opinions needed in respect of Part IV and section 118(2) of the Act (see paras. 20.20–20.22 *ante*).

22.04.2 *Central policy committee and other committees*

The Secretary of State must appoint a central policy committee consisting wholly of members; the Commission can, and has, co-opted other members to serve on the central policy committee. The central policy committee must perform on behalf of the Commission the following functions: (i) the function of submitting to the Secretary of State proposals as to the content of the code of practice which he must prepare and revise³ (see paras. 22.05 and 22.14 below); (ii) preparation

¹ As to pay and allowances for the chairman and members, see s. 121(11) and the National Health Service Act 1977, Sch. 5, para. 9. (As to payment of persons acting on behalf of the Commission for the purposes of certifying consent or giving second opinions, see para. 22.13 below.)

² At the time of writing the Commission the vice chairman is Professor Elaine Murphy.

³ See S.I. 1983, No. 892, Art. 3(2)(d).

of the biennial report of the Commission's activities (see paras. 22.08 below); and any other function which the Commission may require it to perform. These functions of the central policy committee must be performed in consultation with the Commission as a whole and, in practice, there is a good deal of inter-change of views between the Commission and its central policy committee. Apart from the central policy committee, the Commission may, and if so directed by the Secretary of State shall, appoint committees and sub-committees consisting wholly of Commission members (reg. 7). The Commission has a number of National Standing Committees dealing with such questions as Consent to Treatment, Complaints, Research and Information, etc.

22.04.3 *Meetings and proceedings*

The Commission must make Standing Orders for the regulation of their proceedings and business which must provide for at least one full meeting each year (reg. 8).

22.05 **Power of Secretary of State to Direct the Commission to Perform Functions on his Behalf**

Section 13 of the National Health Service Act 1977 authorises the Secretary of State to direct a special health authority to exercise on his behalf any of his functions relating to the health service as specified in the directions (see paras. 2.16–2.18 *ante*). Thus, like any other health authority, the Commission has to comply with directions given by the Secretary of State; but otherwise it is independent in the performance of its functions and in the advice it offers. Without prejudice to the generality of his powers to make a direction under section 13 of the 1977 Act, the Secretary of State **must** direct the Commission to perform on his behalf the following functions (s. 121(2))¹ which are each discussed elsewhere in the text:

- (i) **appoint registered medical practitioners** for the purposes of certifying a patient's consent to treatment and for providing second opinions under Part IV and section 118 of the Act (see paras. 20.20–20.22 *ante*);
- (ii) **appoint other persons (not being doctors)** for the purposes of certifying a patient's consent to treatment under section 57(2)(a) of the Act (see paras. 20.20 and 20.22 *ante*);
- (iii) **keep under review treatment given** to patients under Part IV of the Act, which relates to consent to treatment (s. 61) (see para. 20.26 *ante*);

¹ The Secretary of State has so directed the Commission in the Mental Health Act Commission (Establishment and Constitution) Order 1983, S.I. 1983 No. 892, Art. 3.

- (iv) **keep under review the exercise of powers and the discharge of duties** conferred by the Act relating to patients liable to be detained and to make arrangements to **visit and interview** such patients and to **investigate their complaints** (s. 120(1) (see paras. **22.09–22.11** below);
- (v) **submit proposals to the Secretary of State on a code of practice** which he is required to prepare and, from time to time to revise, under section 118(1) (see para. **22.14** below).¹

22.06 Review of the Care and Treatment of Informal Patients

The Secretary of State has the power (which he has not yet exercised) to direct the Mental Health Act Commission to keep under review the care and treatment, or any aspect of the care and treatment, in hospitals and mental nursing homes of patients who are not liable to be detained under the Mental Health Act 1983.² Note that when the Secretary of State makes such a direction the remit of the Commission will extend only to the care and treatment of mentally disordered persons who are patients in hospitals and homes, and not those living in the community.³ The Secretary of State can make such a direction only at the request of or after consultation with the Commission, and after consulting concerned bodies (s. 121(4)). (Note that, insofar as the code of practice is concerned the Commission already has the power to give guidance relating to informal patients; see para. **22.14** below).

For the purposes of reviewing the care and treatment of informal patients if so directed by the Secretary of State, any person authorised by the Commission can at any reasonable time visit and interview, and if a doctor, examine in private any patient; any such person can also

¹ Section 121(2) does not require the Secretary of State to direct the Commission to perform this function. But he has issued such a direction. The Mental Health Act Commission (Establishment and Constitution) Order 1983, S.I. 1983 No. 892, Art. 3(2)(d). The Code of Practice was laid before Parliament in December 1989 pursuant to s. 118(4) of the Act.

² The Secretary of State can, with Treasury approval, make provision for payment of persons carrying out the functions specified in s. 121(4) (s. 121(6)).

³ By contrast see the powers of the Mental Welfare Commission (Scotland), discussed at para. **22.02.3** above.

require the production of and inspect any records relating to the patient's past or present treatment as a patient (s. 121(5)).¹

22.07 Review of Decisions by Managers to Withhold Patients' Correspondence

The one power that the Commission has in its own right and which is not a delegated power exercised on behalf of the Secretary of State, is the power to review the decision of the managers to withhold correspondence sent by or to a special hospital patient. Since the Commission is reviewing a power technically which is exercised on behalf of the Secretary of State as manager of the special hospitals, it would be inappropriate for the Commission to exercise a purely delegated authority.

By section 121(7), if a valid application is made, the Commission must review any decision made by a person authorised by the hospital managers to withhold a postal packet (or anything contained in it) under section 134(1)(b) or (2); the Commission has the power to direct that the postal packet should not be withheld and the managers must comply with the Commission's direction (s. 121(8)). (See further para. 24.36 *post*).

22.08 Duty to Publish Reports

The Commission must in the second year after its establishment² and subsequently in every second year publish a report on its activities. Copies of every report must be sent by the Commission to the Secretary of State who must lay a copy before each House of Parliament (s. 121(10)).

22.09 General Protection of Detained Patients

The Mental Health Act Commission, on behalf of the Secretary of State (see para. 22.05 above), must keep under review the exercise of powers and the discharge of duties conferred or imposed by the Mental Health Act relating to the detention of patients and patients liable to be detained (s. 120(1)). This is a broad remit covering all powers and duties relating to the detention of patients or detained patients. In paras. 22.09.1–22.09.2 below there is a brief examination of the scope of the powers and duties of the Commission which can be exercised in pursuance of section 120(1). Section 120(1)(a) and (b) place specific duties on the Commission to visit and interview detained patients and to investigate complaints; these duties are examined at paras. 22.10–22.11 below.

¹ Section 121(5) only applies to patients in a mental nursing home. The Secretary of State already has power conferred on him by s. 17 of the National Health Service Act 1977 to make such a direction in respect of the Health Service.

² The First Biennial Report of the Commission was laid before Parliament on 22 October 1985 and published as H.C. 586.

22.09.1 *To review the exercise of powers and the discharge of duties relating to the detention of patients*

The Commission has a duty to review the exercise of powers and the discharge of duties conferred or imposed by the Act relating to the detention of patients. This jurisdiction is not limited to compulsory admission under Part II of the Act (see Chapter 11) but to any power or duty relating to detention under the Act including the doctor's (s. 5(2)) or nurse's (s. 5(4)) holding power (see paras. **10.04–10.05 ante**); warrants to search for and remove patients (s. 135, see para. **21.16 ante**); removal of mentally disordered persons found in a public place (s. 136, see para. **12.02 ante**); and the taking and re-taking of patients liable to be conveyed or detained (ss. 137, 138, see paras. **21.17–21.18 ante**).

The Commission should seek to ensure that the statutory procedures necessary before compulsory powers of removal, conveyance or detention are exercised are fully complied with. This does not give Commission members the power to substitute their judgement for that of the persons authorised to complete the necessary documents relating to the detention of patients. For example, the approved social worker and registered medical practitioners making an application and recommendations under Part II can exercise their discretion so long as they act lawfully and within the reasonable boundaries of professional practice (see para. **7.14 ante**); this would similarly apply to the exercise of any other power to detain patients such as the holding power. What the Commission must do is to examine whether the procedures prescribed in the Act are carried out. Since the day-to-day responsibility for reviewing the lawfulness of detention procedures rests with the hospital managers, the Commission's main task is to ensure that the managers devise and maintain procedures for their review, and to monitor the way in which managers carry out their tasks—for example, by holding spot checks to see whether documents held by the managers are lawful in all respects and that the necessary records are kept. (As to the role of the managers see para. **6.04 ante**).

The Commission's formal remit extends to Part III of the Act which relates to patients concerned in criminal proceedings or under sentence (see Chapters 14–16). Nothing in these powers should be construed as giving the Commission the authority to interfere with the sentencing powers of the Court under Part III of the Act. But the Commission could examine, for example, whether there are any problems with the use of remands to hospital (s. 35 or 36, see paras. **14.14–14.15 ante**) or interim hospital orders (s. 38, see para. **14.16 ante**) or whether regional health authorities are giving the courts the necessary information as to the availability of hospital beds (s. 39 see para. **15.09 ante**). The Commission does have the power to review the exercise of powers of the Home Secretary under Part III (see paras. **15.11–15.21 ante**). The Commission cannot interfere with the Home Secretary's exercise of

discretion. But the Commission must ensure that he acts lawfully and, without unreasonable delay.

22.09.2 *To review the exercise of powers and the discharge of duties relating to patients liable to be detained*

The Commission has a duty to review the exercise of any power and the discharge of any duty imposed by the Act relating to patients liable to be detained. Note that the responsibility of the Commission extends to patients liable to be detained (e.g. on a leave of absence) even if not actually detained in hospital. This is a wide ranging provision. The responsibilities of the Commission extend well beyond reviewing the procedures relating to compulsory admission and detention. The Commission can examine any power or duty specified in the Act which affects patients liable to be detained—for example, the power to grant a leave of absence (see para. 11.13 *ante*), the administration of treatment under Part IV (see paras. 20.17–20.28 *ante*), the removal and the return of patients (see Chapter 19), the managers' duty to give information (see paras. 6.07–6.08 *ante*) or to refer patients' cases to tribunals (see para. 6.09 *ante*). An interesting question arises as to whether the Commission has jurisdiction to review the exercise of powers which are not expressly conferred in the Act but are necessarily implied. If all of the Commission's various powers were to be examined together, including the power to investigate complaints (see para. 22.11 below), it could properly take a broad view of its remit. This would include treatment and restraint administered to detained patients which is necessarily implied in the 1983 Act (see Chapters 20 and 21 *ante*), and probably does come within the remit of the Commission.

The Commission expressly does not have the power to review the work of the Court of Protection (see paras. 23.01–23.13 *ante*) (s. 120(7)).

The work of the Commission also does not extend to the examination of services provided to patients. The duty to inspect and report on general services is a function of the Health Advisory Service and the Development Team for the Mentally Handicapped (as to which see paras. 22.22–22.23 below).

22.10 Duty to Visit and Interview Detained Patients

As part of its general duty to protect detained patients, the Commission must visit and interview in private patients detained in hospitals (defined at para. 3.02 *ante*) and mental nursing homes (defined at para. 5.02 *ante*) (s. 120(1)(a)). The Commission seeks to visit regularly (at least annually) hospitals and mental nursing homes where patients are detained, with more frequent visits to special hospitals. The duty to visit and interview patients is one of the more important functions of the Commission as it allows wide scope in hearing about their problems and seeking to resolve them, for example, by speaking with the managers or responsible professionals or by referring them to other bodies.

22.10.1 Confidentiality

There is no **statutory** duty on the Commission to respect the confidentiality of personal information obtained in the course of interviews or investigations. But as a matter of professional ethics such information generally should not be used or disclosed without the patient's agreement. Commissioners may also have a common law responsibility to respect confidentiality. (As to confidentiality, see paras. 20.30 to 20.34 *ante*).

22.11 Duty to Investigate Complaints

As part of its general duty to protect detained patients, the Commission must investigate complaints. There are two kinds of complaint which the Commission has jurisdiction to investigate which are dealt with in paras. 22.11.1 and 22.11.2 below (s. 120(1)(b)). Both categories, taken together, place a duty on the Commission to investigate any complaint about any matter which occurred in a period (current or past) during which the patient was detained. There is considerable overlap between the two categories but the essential distinction to be drawn in as follows: **section 120(1)(b)(i)** concerns **any** matter which affects a patient during a period of detention whether or not that matter involves the exercise of statutory powers—this category appears to be all inclusive; **section 120(1)(b)(ii)** concerns only the exercise of powers or the discharge of duties specifically conferred or imposed by the Act in respect of a patient who is or has been detained.

22.11.1 *Complaints about matters that occur while a patient is detained*

The Commission must investigate any complaint made by a person in respect of a matter that occurred while he was detained in a hospital or mental nursing home (s. 120(1)(b)(i)). The complaint need not be about the exercise of powers or the discharge of duties under the Act so long as it relates to a time (current or past) when the patient was detained under the Act. A complaint might concern alleged maltreatment, loss or misappropriation of personal property, clothing, food, privacy, noise on the ward, visits from relatives or friends, access to a telephone, writing paper etc.

Any complaint in this category and which does not fall within section 120(1)(b)(ii) (see next paragraph) must first be made to the hospital managers. The Commission must investigate the complaint if the patient considers that the managers did not deal with the complaint satisfactorily.

22.11.2 *Complaints about the exercise of powers or the discharge of duties conferred or imposed by the Act*

The Commission must make arrangements to investigate any complaint directly concerning the exercise of the powers or the discharge of duties conferred or imposed by the Act in respect of a person who is or has been detained (s. 120(1)(b)(ii)). Such a complaint must relate to a power or duty specified in the Act which affects or has

affected the patient during a period when he was detained. A complaint under section 120(1)(b)(ii) can be made directly to the Commission without first being referred to the managers.

In *R. v. Mental Health Act Commission ex parte Smith*,¹ the court reviewed a case in which the Commission considered that certain complaints made by a detained patient were not within its jurisdiction because the matters did not relate to “the exercise of powers or duties conferred or imposed by the Act.” The court expansively interpreted s. 120(1)(b)(ii): “Any complaints arising out of the exercise of the power to detain, manage and control, and the duty to treat, are complaints about the discharge of duties under the Act in respect of which the [Commission] has jurisdiction. . . . Management, control and treatment all form part of the package of compulsion which is the essence of s. 3 detention.” Consequently, the Commission had jurisdiction to investigate not only complaints about the patient’s initial detention and consent to treatment, but also complaints about inappropriate detention in a secure unit and inadequate care.

22.11.3 *Complaints made by a Member of Parliament*

Where a Member of Parliament asks for the investigation of a complaint which falls within section 120(1)(b)(ii) (see para. 22.11.2 above), the results of the investigation must be reported to him (s. 120(3)).

22.11.4 *The discretion not to investigate a complaint*

The Commission can decide not to investigate, or to discontinue investigating, any complaint or any part of a complaint where it considers that it is appropriate to do so. Further, any arrangements made by the Commission in respect of the investigation of complaints may exclude matters from investigation in any circumstances the Commission specifies (s. 120(2)).

22.11.5 *Overlap with other complaints bodies*

The Commission has a broad discretion as to which complaints it will take up and how it will conduct its investigation. The Commission is entitled to investigate any complaint that falls within its jurisdiction. But it can in the first instance refer a complaint to any other body which it considers is more appropriate to deal with a particular matter. For example, if the Commission considers that the matter concerns the proper management and administration of the hospital it can refer it to the hospital managers (cases falling only within section 120(1)(b)(i) must first be dealt with by the managers, see para. 22.11.1 above). (As to the managers, see paras. 6.01–6.13 *ante*). If the Commission considers that the matter is one purely of mal-administration and the managers have already investigated the case, it can be referred to the Health Service Commissioner or, in the case of special hospital patients, an M.P. can refer it to the Parliamentary Commissioner. If the Com-

¹ Q.B.D. *The Times*, 18 May 1998, CO/1925/97 (Transcript: Smith Bernal).

mission considers it a matter purely of clinical judgment it can refer the complaint to be dealt with under existing arrangements for handling complaints relating to clinical judgment. (As to complaints procedures, see paras. 22.15–22.17 below).

It is not intended that the Commission should replace or duplicate the work of other bodies who are able to help patients with their problems such as the hospital managers (see paras. 6.01–6.13 *ante*), Community Health Councils (see paras. 2.27–2.31 *ante*), voluntary organisations or a constituency M.P. However, there is likely to be some overlap in practice.

22.11A Case Study

Since the establishment of the Mental Health Act Commission, it has had to make challenging decisions on a range of medico/legal issues. The following case study, together with the Commission's findings, is instructive for the student of mental health law. Identifying data are omitted to protect the patient's confidentiality.

B.F., an adult patient with mental handicap and epilepsy from brain damage at birth, was detained under s. 3 of the Act "for treatment." A complaint was filed by a voluntary organisation on behalf of his mother. The complaint related primarily to the level of medication administered over a 4–5 year period and his ability to consent.

22.11A.1 Jurisdiction

Issue: Does the Commission have jurisdiction under section 120(1) (b) (ii) to investigate a complaint relating to the exercise of the RMO's clinical judgement as to the nature and extent of the medications appropriate to his patient's condition? The Commission found it did not have jurisdiction.

The jurisdiction of the Commission to investigate complaints is set out in sections 120(1) (b) (i) (complaints about matters that occur while a patient is detained) and 120(1) (b) (ii) (complaints about the exercise of powers or the discharge of duties conferred or imposed by the Act). (See paras. 22.11.1–22.11.2 above).

Subsection (i) refers to complaints "made by a person." The language, therefore, appears to limit the jurisdiction to complaints made by, or on behalf of, the patient. The Commission took the view that a complaint on behalf of the nearest relative would not trigger its jurisdiction under subsection (i). Subsection (i) contains overarching language which allows the Commission to investigate "[any] matter that occurred while he was detained." There is nothing within the statute itself which would bar the Commission from investigating under subsection (i) any aspect of treatment, including clinical judgement. Notably, the Mental Health Act does not expressly prevent the Commission from investigating matters of clinical judgement as is the case with the Health Service Commissioner (see para. 22.17.2 below). Had the complaint been made by the patient, then, the Commission would theoretically have had the jurisdiction to examine whether the level of

medication was so consistently high as to be outside the boundaries of ethical professional practice.

The Commission viewed the complaint as one falling within subsection (ii) which limits its jurisdiction to "the exercise of powers or the discharge of duties conferred or imposed by this Act." This language clearly gives the Commission the jurisdiction to investigate a complaint relating to the validity of consent obtained under the Act. In B.F.'s case, the Commission could not find in the medical records any Form 38 indicating he had consented, or Form 39 indicating that a second opinion had been obtained as required under section 58(3). (See paras. **20.21.3 ante** and **B. 55 post**).

However, the Commission took the view that the aspect of the complaint relating to the extent of medication did not fall within its jurisdiction. The jurisdictional question is determined by understanding whether the administration of treatment to a detained patient is a power provided under the Mental Health Act. The Commission argued that the power to treat arises under common law; since section 58(3) is expressed as a prohibition rather than as a power, the effect is to "repeat the common law requirement of consent as a statutory duty and to impose a further duty as to the certification of that treatment." The exercise of the consent and certification requirements falls within the Commission's jurisdiction; but the nature and quality of treatment is in the exercise of the RMO's clinical judgement.

The Commission's decision is scholarly and persuasive, but not binding in law. There are legal arguments on the opposite side. It is unclear whether the power to treat an incompetent patient does arise under the common law. The common law allows treatment with the patient's consent, or, where consent is withheld or incapable of being given, in cases of necessity. (See paras. **20.10, 10.13, 10.16 ante**). While it is true that section 58(3) is framed in the negative, treatment given in the absence of consent or necessity would have to be founded upon a power given in the Act rather than at common law. That being the case, the Commission would have scope to widely construe its jurisdiction to examine the nature or purpose of the treatment. This is particularly so since the Act contemplates that, for incompetent patients, treatment can be given only if it is likely to alleviate or prevent a deterioration of his condition. Interpreted expansively, this could indicate that the power to treat is provided under the Act, and open the question of clinical judgement to review by the Commission.

The Commission took the view that the nature and quality of the treatment raised the question of "clinical judgement" so was outside its remit. First, as has been suggested, the Act does not expressly bar the review of clinical judgement. Second, the RMO's response to the Commission in B.F.'s case indicates that there may not have been a genuine exercise of individual clinical judgement. The RMO's report to the Commission indicates: on a locked ward, there was a relative

shortage of staff; the level of security was low; there was a high level of risk to staff and patients; the main means of coping with the ward was by medication; and that if moderate doses of a drug were ineffective, the general ward set up required use of higher doses of drugs, if need be in combination. This suggests that there may have been no clinical discretion exercised as to the best therapeutic interest of the individual patient.

Whether the Act provides jurisdiction for the Commission to investigate matters of treatment and clinical judgement in response to a complaint by the nearest relative is ultimately a matter for the courts. Yet, there are strong public policy arguments for the Secretary of State and Parliament to consider in favour of a more expansive interpretation of the jurisdiction of the Commission. Had B.F. been competent to make a complaint on his own behalf, he could have had the benefit of a full, thoroughgoing investigation by the Commission. The Mental Health Act, by making "fine" distinctions between complaints made by individuals and by others, has placed the incompetent patient in an invidious position. A person, simply by reason of his incompetence, should not have fewer rights than those who are competent. Arguably there is a stronger need for safeguards for the incompetent person.

22.11A.2 Confidentiality

Issue: Are matters contained in the medical records confidential to the hospital, staff, and patient so they could not be imparted to the nearest relative? The Commission decided that the record was confidential.

The complainant in B.F.'s case was the nearest relative. The Commission found that B.F. was not competent to make the complaint. The Commission saw a right of confidentiality which belongs to the hospital, the staff, and the patient against third parties (see paras. 20.30-20.32, 22.10.1. *ante*). Accordingly, the Commission has no authority to breach confidentiality by revealing to the nearest relative information obtained from the hospital records or from the RMO.

The nearest relative of an adult has no authority to act on the person's behalf (see para. 20.11 *ante*). Further, the specific powers given under the Act do not provide such authority. Section 24 of the Act empowers a nearest relative to cause a doctor to visit the patient and inspect his records for the purpose of advising as to the possibility of discharge (see para. 8.03 *ante*). The nearest relative, exercising this power for a *bona fide* reason, can obtain relevant medical information from the doctor to make an informed judgement on whether to exercise a discharge order. The Commission takes the view that section 24 does not entitle the nearest relative to obtain information from the Commission for use for other reasons.

It is to be noted that, unlike the Health Service Commissioner (see ISSUE No. 2

para. 22.17.5 below), the Mental Health Act Commission has no duty to make a report to the complainant (unless he is a Member of Parliament—see para. 22.11.3 above). Arguably, the Commission's powers and duties after investigation of a complaint are left undefined so that it can proceed in any appropriate manner. The Commission, in practice, acts in various ways by making representations, giving advice, or by persuasion.

The Commission's decision has a bearing on future complaints. There is an ethical, if not a common law, duty to respect confidences in the course of investigating a complaint (see para. 22.10.1. above). Confidentiality, however, is a doctrine which is intended to benefit the patient, and not necessarily to shield the hospital or health professional from effective independent review. The public policy question raised again here is whether the rights and welfare of an incompetent patient are adequately being protected. The incompetent patient cannot realistically claim access to information in the medical record. Who will safeguard the incompetent patient's interests, if the nearest relative concerned with his care is denied effective access to information? The Commission would quite understandably argue that they would be the independent guardians of the interests of the patient. But, failing to make a full report to the complainant could undermine public confidence in the system.

The Health Service Commissioner has a statutory duty to provide reports to the complainant in order to ensure a fair and open complaints procedure. In the Mental Health Act, Parliament either overlooked this issue or decided by its silence not to require a report. But, there is nothing in the Act which prevents the Commission from providing a report in each case showing that the complaint was investigated fully and fairly.

22.11A.3 *Appropriateness of Investigating a Complaint*

Issue: Is it "appropriate" within section 120(2) for the Commission to resolve all of the complex questions raised by the complaint? The Commission decided it was not appropriate in this case.

Section 120(2) provides that the Commission need not undertake or continue an investigation where it does not consider it "appropriate" to do so. This is a matter within the discretion of the Commission. The Commission took the view that the investigation would involve complex questions of fact, and expert assessment of the patient's condition and the appropriateness of medications during extended periods. This would necessitate an adequate hearing or inquiry which the Commission does not have the powers or personnel to undertake.

The Mental Health Act Commission provides the principal safeguard for patients detained under the Act. If its jurisdiction, powers, or

resources are insufficient to exercise this safeguard effectively in all cases, there is a strong case to strengthen its ability to do so.

22.12 Power to Visit and Interview Patients and to Require the Production of Records

22.12.1 *Access to patients and their records by members of the Commission carrying out the duty to protect detained patients*

In order to assist the Commission in carrying out its general duty to protect detained patients under section 120 (see para. 22.09 above), the Commission has specific powers of access to detained patients and to their records (s. 120(4)). It may at any reasonable time:

- (a) visit and interview and, if the person is a registered medical practitioner, examine in private any patient in a hospital or mental nursing home; and
- (b) require the production of and inspect any records relating to the detention and treatment of any person who is or has been detained in a hospital or mental nursing home.¹

Hospital managers must grant members of the Commission access to detained patients and their records. (As to obstruction of a member of the Commission, see para. 22.12.4 below).

22.12.2 *Access to patients and their records extends to members of the Commission and other persons appointed by the Commission for the purposes of certifying consent to treatment or giving a second opinion*

The power to visit and interview, and (if the person is a registered medical practitioner) to examine in private, any detained patient extends to medical members of the Commission and to doctors appointed by the Commission for the purposes of certifying consent to treatment or providing second opinions under Part IV or section 118(2) of the Act (see paras. 20.20–20.21 *ante*); the power to visit and interview also extends to the non-medical members of the Commission for the purposes of certifying consent to treatment under section 57(2)(a) (see para. 20.20 *ante*). Persons authorised for any of these purposes can also require the production of and inspect any records relating to the **treatment** of that patient (s. 119(2)).²

Thus any member of the Commission who is giving a second opinion

¹ Section 120(4) applies only to access to detained patients and their records in a **mental nursing home**. The Secretary of State already has power under s. 17 of the National Health Service Act 1977 to direct **health authorities**, and he has done so in HC(83)19.

² Section 119(2) applies only to mental nursing homes. See also HC(83)19, and the preceding note.

or is certifying that the patient has consented to treatment has the right to interview and (if he is a doctor) to examine the patient in private. Since the functions to be carried out concern only the patient's **treatment** there is no entitlement to see the patient's records relating to **detention**. (As to general power of **Commissioners** to see records relating to detention, see para. 22.12.1 above).

22.12.3 *Records to be kept for five years after patient leaves hospital*

Any records relating to the detention and treatment of a patient in a hospital or mental nursing home which are required to be made under the Mental Health (Hospital, Guardianship, and Consent to Treatment) Regulations 1983, must be kept for a period of not less than five years after the person to whom they relate ceases to be a patient in that hospital. (Note that even if a detained patient becomes informal, the five year period only begins once he leaves the hospital). Thus, the records of patients must be kept for a period of time so that they are available for those authorised to carry out the functions of the Commission.¹

22.12.4 *Obstruction*

Anyone who without reasonable cause obstructs an authorised person in the exercise of his functions by preventing him from visiting, interviewing or examining a patient in private, or who without reasonable cause refuses to produce or allow an authorised person to inspect the patient's records commits an offence (s. 129; see para. 25.05 *post*). (As to persons authorised on behalf of the Commission to have access to patients and their records see paras. 22.12.1 and 22.12.2 above).

22.13 **Payment of Persons Appointed by the Commission**

The Commission has the power to appoint registered medical practitioners and others for the purposes of certifying consent to treatment and giving second medical opinions under Part IV, section 118 and section 57(2)(a) of the Act (s. 121(2)(a), see para. 22.05 above). The Secretary of State has the power, with Treasury approval, to pay people appointed for these purposes remuneration, allowances, pensions or gratuities (s. 119(1)). (As to the power of people appointed by the Commission to visit and interview patients and to examine their treatment records see section 119(2), and para. 22.12.2 above).

¹ Nursing Homes and Mental Nursing Homes Regulations 1984, S.I. 1984 No. 1578, Art. 7(10).

22.14 Code of Practice

22.14.1 *Scope and content of the code*

The Mental Health Act Commission must advise the Secretary of State concerning the preparation, and periodic revision, of a Code of Practice (s. 118(1), see para. 22.05 above). (The Secretary of State must publish the code which is for the time being in force (s. 118(b)). The publication of a Code of Practice proved to be a time consuming task. The Commission issued a draft Code of Practice in December 1985.¹ A further draft was circulated for comment on 27 August 1987.² The Code was laid before Parliament in December 1989 pursuant to s. 118 (4) of the Act, and subsequently published by the Department of Health and Welsh Office in May 1990.³ A revised and consolidated code was laid before Parliament in May 1993 and was subsequently published in August 1993.

The Code does not impose any legal duties beyond those already in the Act (paras 1.1, 1.2 of the Code). However, the Code sets out broad professional and ethical principles, as well as detailed guidance, which courts are bound to take cognizance of. Accordingly, the Code does not impose a direct legal duty, but is probative in setting a legal standard of care in court proceedings.

Paragraph 1.3 of the Code sets out the foundational principles behind the Code. These include respecting individuality and diversity in social/cultural/ethnic/religious backgrounds; meeting needs within the limits of available resources; delivering treatment in the least restrictive and segregated facilities; promoting the right to self-determination, personal autonomy and responsibility; and discharging any order under the Act as soon as it is no longer necessary.

The Code of Practice provides detailed guidance to statutory authorities, managers, and professional staff in hospitals, mental nursing homes, and social services authorities. The Commission took a wide view of its terms of reference in drafting the Code. The guidance is not restricted to the exercise of powers or the discharge of duties under the Act. Much of the Code is also equally applicable to informal patients.⁴ By providing guidance for good practice in the treatment and management of mentally disordered persons, the Code sets a generally applicable standard of care.

Overall, the Code attempts a delicate balancing of rights, needs, and resources. A mentally disordered person's legal rights under the Act

¹ Mental Health Act 1983: Section 118, *Draft Code of Practice*. See H.C. (85) 32.

² MHC 42.

³ The original Code of Practice was issued with Circular EL (90) P/85, LASSL (90) 5, WHC (90) 38. This has been replaced by NHS Management Executive HSG (93) 45, 2 September 1993.

⁴ Department of Health and Welsh Office, Code of Practice: Section 118 of the Mental Health Act 1983, EL (90) P/85, para. 4.

must be respected. Consistent with this "rights-based" philosophy is the requirement to inform patients and their relatives of their rights, and to do so with sensitivity to their social/cultural/ethnic characteristics, as well as their linguistic and sensory difficulties. The Code at several stages adopts the human rights doctrine of the least restrictive alternative, suggesting that patients should be treated and cared for in the least restrictive, controlled, and segregative environment that is consistent with their needs.

An ongoing tension is apparent throughout the Code between this "rights-based" approach founded on the ethical principles of autonomy and respect for persons, and a "needs-based" approach founded on the principle of paternalism. Respecting the wishes of patients is followed only until the point at which professionals regard it as harmful to the person's health and the safety of others.

A further tension in the Code is apparent in the concern for cost and available resources. The Code makes clear that rights and needs are to be met only within the confines of limited resources. Thus an undertone of rationing both services and rights exists in the Code.¹

The Code was revised in 1993, with a particular concern on the part of the Department of Health being to emphasise that the 1983 Act allows compulsory admission in the interests of the patients' own health and that dangerousness is not a prerequisite of detention. (See paras. 7.14.3A and 11.01(iii) *supra*.)²

22.14.2 *Treatments which give rise to special concern*

The code of practice must, in particular, specify any forms of medical treatment (see definition, s. 145(1) and para. 20.02 *ante*) in addition to psychosurgery and sex hormone implant treatment (see s. 57, para. 20.20 *ante*) which in the opinion of the Secretary of State give rise to special concern. The Commission may take the view, for example, that this applies to certain forms of behaviour modification (see para. 20.08 *ante*), unmodified electro-convulsive therapy (see para. 20.06 *ante*) or restraint or seclusion of a specified force or duration.

Treatments which are listed in the code of practice as giving rise to special concern are not treated in exactly the same way as treatments specified for the purposes of section 57. Treatments listed in the code as giving rise to special concern should not be given unless: (i) the patient has consented to the treatment or plan of treatment; and (ii) a

¹ The Preface to the Code, for example, makes clear that where "adopting the recommendations of the Code would have significant resource implications, it is recognised that this can only be done as resources permit."

² For a more detailed look at the genesis of the First Code of Practice under s. 118 published in 1990, see P. Fennell, "The Mental Health Act Code of Practice" (1990) 53 M.L.R. 499-507 and M. Cavadino, "Commissions and Codes: A Case Study in Law and Administration" (1993) *Public Law*, 333-345.

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written certificate is given by a registered medical practitioner appointed by the Commission (not by a doctor and two other persons as required in section 57) that the patient is capable of understanding the nature, purpose and likely effects of the treatment and had consented to it. The registered medical practitioner must also certify that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, it should be given (s. 118(2)). (As to the duty of the Commission to appoint registered medical practitioners, on behalf of the Secretary of State, for the purposes of section 118(2), see para. 22.05 above).

22.14.3 *Consultation required before preparing or altering the code*

Before preparing the code of practice or making any alteration in it the Secretary of State must consult such bodies as appear to him to be concerned (s. 118(3)).

22.14.4 *Negative resolution of Parliament*

The Secretary of State must lay copies of the code of practice and of any alteration in the code before Parliament. If either House of Parliament passes a resolution requiring the code or any alteration in it to be withdrawn, the Secretary of State must withdraw the code or the alteration. Where he withdraws the code, he must prepare a code in substitution for the one which is withdrawn (s. 118(4)).

Either House of Parliament has forty days beginning with the day on which the code or alteration was laid before the House to pass a resolution; but for these purposes no account is taken of any time during which Parliament is dissolved or prorogued or when both Houses are adjourned for more than four days (s. 118(5)).

22.14A **Commissioners' Duty to Act Fairly**

The Commission, in carrying out its various powers and duties under the Act probably has no duty to act judicially.¹ For example, the Commission is not obliged to hold hearings and take evidence before coming to a decision. But the Commission probably does have a duty to act fairly.

There is little clarity in the concept of the "duty to act fairly". But it does preclude actions which are arbitrary and unreasonable. Thus, the Commission should, in a thorough and careful way, seek to obtain relevant information necessary for an equitable and informed decision. This means giving interested parties an opportunity to discuss matters

¹ See *R. v. Mental Health Act Commission ex parte W.* discussed at paras. 20.20.3-20.20.3A ante reported *sub. nom. R. v. Mental Health Act Commission, ex parte X* (1988) 9 BMLR 77.

which are directly and clearly relevant to them. For example, patients should have the opportunity to discuss potentially adverse decisions pertaining to their competency and consent; and the RMO should have the opportunity to discuss decisions which implicitly question his clinical judgment. This does not require discussion of all matters with all parties, but only discussion which is reasonably likely to shed additional light on the Commission's decisionmaking.

22.14B Disclosure of Commission Reports

Part of the responsibilities of Mental Health Act Commissioners is to file reports on such matters as the patient's capacity to consent and the appropriateness of treatment. There is no specific requirement under the Act for the Commission to disclose reports in response to a request by a patient who is the subject of them or by his representative. The court in *R. v. Mental Health Act Commission ex parte W.*¹ in *obiter* said that in its judgment there is no general obligation to disclose reports. (As to the facts and holding of *W* see para. 20.20.3 above.) The court gave two reasons. First, "the subject of the reports is *ex hypothesi* a person suffering from a mental disorder, and in many cases it would therefore be undesirable for him to read the contents". Second, the court said if there were an obligation to disclose "it might well inhibit the candour of the Commissioners who are making the reports."

The court did recognise that there may be circumstances where justice demanded that the Commission should make the disclosure, as occurred in the case of *W*. Stuart-Smith LJ concluded that: "Save where it is so ordered by the court disclosure of the reports should remain a matter of discretion on the part of the Commission."

It is suggested that the Commission should operate, to the fullest extent possible, in an open and frank manner with patients and their representatives. It will seldom be the case that the honest disclosure and discussion of the patient's condition and consent to treatment will be detrimental to the patient or that it will impede the commissioners' work. Full exchange of information among the patient, RMO, and Commission will usually enhance the therapeutic relationship and the effectiveness of the Commission.

¹ *The Times*, May 27, 1988 reported *sub. nom. R. v. Mental Health Act Commission, ex parte X* (1988) 9 BMLR 77.

22.14B

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B. COMPLAINTS PROCEDURE

22.15 Introduction

One of the major functions of the Mental Health Act Commission is to investigate complaints (see para. 22.11 above). But to fully understand the Commission's powers and duties to investigate complaints it is important to have an understanding of the other major ways in which complaints can be investigated. The Commission does not replace existing bodies which investigate complaints and, as a general rule, if any complaint squarely falls within the remit of another complaints body it will be referred to that body in the first instance. This section discusses internal complaints procedures within the Health Service conducted on behalf of the hospital managers, and the role of the Health Service Commissioner. Inquiries and default powers are also discussed, together with the feasibility of individual enforcement of statutory duties. Finally, there is a brief discussion of the way services are monitored by bodies which are independent of the health authority responsible for providing services—*i.e.* the Health Advisory Service and the Development Team for Mentally Handicapped People. (As to the Parliamentary Commissioner, see para. 3.12 *ante*. As to disciplinary matters against doctors and nurses in respect of their professional obligations, see paras. 6.14 and 6.18 *ante*; as to complaints in special hospitals, see para. 3.12 *ante*.)

22.16 Health Service Complaints Procedure

22.16.1 Background

In 1971 a committee chaired by Sir Michael Davies was set up to inquire into the procedures which should be followed in dealing with complaints and suggestions about hospital and community-based health services. The Davies Committee issued a report in 1973 making two major recommendations: the first was for a uniform written code of practice for dealing with complaints, and the second was for the establishment of investigating panels in each Health Service region to investigate complaints involving clinical judgment.¹ In 1976 the DHSS issued a draft circular and code of practice which incorporated many of the recommendations of the Davies Committee²; a consultative document was issued in 1978.³

The Davies Committee recommendations regarding investigating panels were omitted from the 1976 code of practice. Instead, the Department invited the Select Committee on the Parliamentary Commissioner for Administration (which includes the Health Service

¹ DHSS (1973) *Report of the Committee on Hospital Complaints Procedure*, HMSO, London.

² DHSS (1976) *Draft Circular on Health Service Complaints Procedure*; DHSS (1976) *Draft Code of Practice for Handling Suggestions and Complaints*.

³ DHSS (1978) *Handling Patients' Complaints: Consultation Document*. HN(78)39.

Commissioners in its remit) to undertake a review of the present jurisdiction of the Health Service Commissioners for England, Wales and Scotland, having regard to the recommendations of the Davies Committee. The Select Committee unanimously recommended in December 1977 that the Health Service Commissioner's jurisdiction should extend to reviewing complaints concerning clinical judgement.¹ However, there were deep reservations within the medical profession and successive governments were unable to implement the recommendation of the Select Committee.

In April 1981 the DHSS issued Health Circular HC(81)5 establishing a uniform written code of practice for the investigation of complaints within the Health Service other than those relating to family practitioner services which are covered by the service committee procedures. The Circular includes guidance on investigating complaints relating to the exercise of clinical judgement by hospital medical staff; the provisions were adopted from a proposal made by the Joint Consultants Committee of the British Medical Association.

22.16.2 *Hospital Complaints Procedure Act 1985*

The Hospital Complaints Procedure Act 1985 (s. 1(1)) places a duty on the Secretary of State to give each health authority in England and Wales directions² for the purpose of establishing a procedure for dealing with complaints made by, or on behalf of hospital patients or former patients; and for publicising the complaints procedure in each hospital.

Directions given under the Hospital Complaints Procedure Act 1985 do not preclude an investigation by the Health Service Commissioner of any complaint which is within his jurisdiction (s. 1(2)). (As to the jurisdiction and powers of the Health Service Commissioner see para. 22.17 below.)

The Department of Health and Social Security on 11 June 1986 issued a consultative document which sets out a suggested complaints procedure from which a direction and accompanying guidance would be drawn.³ The directions, which have statutory force, were issued in June 1988.⁴ The Directions on Hospital Complaints Procedures are described below.

22.16.3 *Informing patients of procedures*

Health Authorities must publicize the complaints procedure as an essential part of improving public perceptions. Publicity could

¹ *First Report from the Select Committee on the Parliamentary Commissioner for Administration Session 1977-78: Independent Review of Hospital Complaints in the National Health Service*, paras. 26-48, HMSO, London.

² Such directions are given under the National Health Service Act 1977, s. 17. See para 2.18 *ante*.

³ DHSS (1986) *Hospital Complaints Procedure Act 1985*, DA (86) 14.

⁴ Directions on Hospital Complaints Procedures, HC(88)37, HN(FP)(88)18, Annex A.

include admission booklets with information on the complaints procedure issued to patients; leaflets explaining the procedure and including a reference to the Health Service Commissioner and notices to community health councils. The complaints procedure should also form part of the training and further education of staff.

22.16.4 *A designated officer*

Each Health Authority must appoint a designated officer for each hospital such as the Unit General Manager. The designated officer can assist in dealing with informal complaints. He is also the recipient of formal complaints made by, or on behalf of, patients. The designated officer is accountable for investigation of formal complaints other than those relating to clinical judgement, serious incidents involving harm to a patient, disciplinary proceedings, physical abuse of patients, or other criminal offences. The designated officer should not be denied access to records which are necessary for the investigation of formal complaints.

2.16.5 *Who can make a complaint?*

Any patient or former patient at the hospital is eligible to make a complaint. If the patient has died or is otherwise unable to act for himself a complaint can be made by a close relative, friend, or a body or individual suitable to represent him. The designated officer must be satisfied that, when the patient is capable, the complaint is made with his knowledge and consent.

22.16.6 *Form of complaint*

A complaint can be made orally or in writing. Where a patient is unable to make a formal complaint in writing the designated officer should ensure that a record of the complaint is made and ask the complainant to sign it.

22.16.7 *Time Limits*

Complaints should be made as soon as possible, usually within three months of the incident. The designated officer has discretion to extend the recommended time limit for good cause.

22.16.8 *Investigation of complaints*

The designated officer must ensure that he has full information about the incidents complained about. This may involve a preliminary interview. The designated officer, in liaison with the appropriate senior officers, should circulate details of the complaint to relevant staff for their comments, and seek to agree a reply. The complainant and other relevant persons must be kept informed of progress at all stages.

Where the complaint carries a threat of litigation the designated officer should seek legal advice as to how the investigation might proceed to minimise the risk of prejudicing any legal proceedings. The possibility of litigation should not prevent investigations necessary to uncover faults in procedures and/or prevent a recurrence.

When an investigation is completed the designated officer must complete a report and send a letter detailing the results to the complainant and other relevant persons. The letter should be informative both as to the reasons for any failure in service and any steps taken to prevent a recurrence, and should contain an apology where appropriate. If the complainant remains dissatisfied he should be advised to refer the matter to the Health Service Commissioner unless it is outside the Health Service Commissioner's jurisdiction, or the matter will be the subject of litigation.

22.16.9 Further action for certain complaints

The designated officer does not have specific authority to deal with the following kinds of complaint, and must bring them to the attention of his senior officer or where appropriate to the Regional Medical Officer without delay:

- (i) *Clinical judgement* – a separate complaints procedure is used for complaints about the exercise of clinical judgement which is discussed at para. 22.16.12 below;
- (ii) *a serious untoward incident* involving harm to the patient;
- (iii) *disciplinary proceedings* – where the actions of a doctor or nurse may be investigated by a relevant professional body (see paras. 6.14 and 6.18);
- (iv) *physical abuse of patients*;
- (v) *a possible criminal offence*.

22.16.10 Monitoring complaints

Health authorities must monitor arrangements for handling complaints, including trends and appropriate actions taken. The designated officer should provide anonymous summaries for the health authority.

22.16.11 Complaints within the jurisdiction of other statutory authorities

Section 1(2) of the Hospital Complaints Procedure Act 1985 provides that nothing in the directions shall preclude investigation by the *Health Service Commission* (see para. 22.17 below).

Section 120(1) of the Mental Health Act empowers the Mental Health Act Commission to investigate any complaint which a detained patient thinks has not been dealt with satisfactorily by the hospital managers (see para. 22.11 above).

The District General Manager must be consulted where it appears that a criminal offence may have been committed. Where the allegation is serious and substantial the police must be notified immediately (see para. 12.04 ante).

22.16.12 *Complaints relating to the exercise of clinical judgement*

Complaints relating to the exercise of clinical judgement are investigated according to a three stage procedure.¹ In the first stage the complaint is examined by the consultant responsible for the patient's treatment. The consultant may seek to resolve the case by a discussion with the complainant which will be recorded in the hospital records. If the risk of subsequent legal action is significant, the district administrator is informed. If the complainant is dissatisfied with the reply which results from the first stage, he may renew his complaint either to the hospital managers or to the consultant who will report to the Regional Medical Officer (RMO). A second stage complaint must be in writing. During the second stage the Regional Medical Officer, in light of discussions with the consultant and (only where necessary) with the complainant, has discretion to refer the case to a second medical opinion under stage three.

The procedure at the third stage is intended for complaints of a substantial nature but which are not, in the light of legal advice, likely to be the subject of more formal action either by the health authority or through the courts. The third stage is intended for use as an alternative to the procedures established for informal investigations provided in HM(66)15, although it does not replace those procedures. (see para. 22.18.1 below).

Under the third stage, arrangements are made by the RMO for the case to be considered by two independent consultants in the appropriate speciality who are nominated by the Joint Consultants Committee. At least one should be a doctor working in a comparable hospital in another region. The two doctors will meet the complainant which will be in the nature of a "medical consultation". The complainant can be accompanied by a relative or personal friend and, if he wishes, by his general practitioner. After the consultants have met with the patient they will prepare a confidential report to the RMO.

The district administrator will, on completion of the review by "second opinions", write formally to the complainant. Where clinical

¹ Memorandum of an Agreement for Dealing with Complaints relating to the Exercise of Clinical Judgement by Hospital Medical and Dental Staff (First issued as part of HC(81)5, HC(88)37, Annex B.

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matters are concerned he will follow the RMO's advice regarding the comment that would be "appropriate".

22.17 The Health Service Commissioners

22.17.1 *Bodies and matters subject to investigation*

The Health Service Commissioners for England and Wales may investigate certain complaints concerning a "relevant body"—*i.e.* regional, district or special health authorities and family practitioner committees.¹ (For a description of these bodies see paras. 2.06–2.17 *ante*). A Health Service Commissioner may investigate: (1) an alleged failure in a service provided by a relevant body, or (2) an alleged failure of such a body to provide a service which it is a function of the body to provide, or (3) any other action² taken by or on behalf of the body where a complaint is made by or on behalf of any person that he has sustained injustice or hardship in consequence of maladministration.³ "Maladministration" was deliberately left undefined, with the Ombudsman left to work out his own caselaw. The term includes corruption, bias and unfair discrimination, misleading the public, failure to notify him of his rights, losing or mislaying documents, unreasonable delay, unreasonable failure to explain a decision or the dilatory and superficial handling of complaints. In fine, any kind of administrative shortcoming may amount to maladministration. But it does not include the reasonable exercise of discretion, even if an unfair decision was taken.

22.17.2 *Matters not subject to investigation*

The Health Service Commissioners cannot conduct an investigation, *inter alia*, in respect of any of the following matters: where the person aggrieved has or had a right of appeal, reference or review before a tribunal, or a remedy in a court of law;⁴ where the complaint concerns the diagnosis of illness or the care or treatment of a patient which was in consequence of the exercise of clinical judgment; where the complaint is against a family practitioner committee; or where the matter has been, or is, the subject of an inquiry by the Secretary of State.⁵

¹ National Health Service Act 1977, s. 109; Health Services Act 1980, s. 1(7), Sch. 1, para. 72. Any special health authority established after April 1, 1974 is only subject to the jurisdiction of the Health Service Commissioner if there is an appropriate designation. Those which are designated include the Bethlem Royal Hospital and the Maudsley Hospital Health Authority (see para. 2.17 *ante*); the Rampton Hospital Review Board (see paras. 3.05.2 and 3.06.2 *ante*); and the Mental Health Act Commission (see para. 22.03.1 above).

² "Action" includes failure to act. National Health Service Act 1977, s. 120(1).

³ *Ibid.*, s. 115.

⁴ However, a Commissioner may conduct an investigation if satisfied that in the particular circumstances it is not reasonable to expect the complainant to resort to an appeal, tribunal review or court action. *Ibid.*, s. 116(1).

⁵ *Ibid.*, s. 116.

22.17.3 *Making a complaint*

A complaint may be made to a Health Service Commissioner by any individual or by any body of persons except, *inter alia*, by a local authority.¹ Where the aggrieved person has died or is unable to act for himself the complaint can be made by his personal representative, a family member or some suitable person or body to represent him.²

Complaints must be made in writing by or on behalf of the aggrieved person not later than one year from the day the matters alleged in the complaint came to his notice. But the Health Service Commissioners have a general discretion to investigate a complaint made outside of the time limit if they consider it reasonable to do so.³

The complaint must first be brought to the notice of the relevant body and that body must have been afforded a reasonable opportunity to investigate and reply to the complainant.⁴

22.17.4 *Procedure on investigation*

A Health Service Commissioner must afford the relevant body and any person alleged in the complaint to have taken or authorised the action complained of an opportunity to comment. The investigation must be conducted in private, but otherwise the procedure is determined by the Health Service Commissioner.⁵

The Commissioner has the same powers as the High Court in respect of the attendance and examination of witnesses and the production of documents.⁶ If any person without lawful excuse obstructs the Commissioner or any of his officers in the performance of his functions, he commits an offence.⁷

22.17.5 *Reports*

The Health Service Commissioner must send a report of the results of his investigation, *inter alia*, to the complainant, the relevant body, and to any person alleged in the complaint to have taken or authorised the action. The Commissioner's report is not binding on the authority.⁸

¹ *Ibid.*, s. 111(1).

² *Ibid.*, s. 111(2).

³ *Ibid.*, s. 114(1).

⁴ *Ibid.*, s. 112(a). But this requirement must be disregarded if the complaint is made by an officer of the relevant body on behalf of the aggrieved person, and the officer is authorised to make the complaint; the Commissioner must be satisfied that the requirement in s. 112(a) should be disregarded (s. 112(b)).

⁵ *Ibid.*, s. 114(2), Sch. 13, paras. 1 and 2.

⁶ *Ibid.*, s. 114(2), Sch. 13, para. 8.

⁷ *Ibid.*, s. 114(2), Sch. 13, paras. 12-14.

⁸ *Ibid.*, s. 119.

C. INQUIRIES AND DEFAULT POWERS

22.18 Investigation of Serious Complaints

22.18.1 *Informal investigations*

Any complaint which cannot be satisfactorily dealt with under HC(81)5 (see para. 22.16 above) can be made the subject of an informal inquiry. Informal inquiries are provided for in HM(66)15, which is concerned with the investigation of serious complaints. The health authority can appoint one or more members of the authority to make an investigation and report back. (This can be done at a regional, as well as district health authority level). The complainant, accompanied by a friend if he wishes, can be present at the informal investigation and should be allowed to be heard. An equivalent right to be heard is vested in the person against whom the complaint is made.

22.18.2 *Independent inquiry established by a Health Authority*

In a small number of cases which are so serious that they cannot be satisfactorily dealt with by way of an informal investigation (see preceding para), the regional or district health authority has discretion to refer the case for independent inquiry. Generally, an independent lawyer or other competent person from outside the hospital service, should conduct the inquiry, or preside over a small committee set up for the purpose, whose membership should be independent of the authority concerned and should include a person competent to advise on any professional or technical matters. The complainant and persons who are the subject of the complaint should have an opportunity of being present throughout the hearing, of cross-examining witnesses and of being legally represented.¹

22.19 Formal Inquiries Established by the Secretary of State

22.19.1 *In connection with the Mental Health Act*

The Secretary of State for Social Services may cause an inquiry to be held in any case where he thinks it advisable to do so in connection with any matter arising under the Mental Health Act 1983 (s. 125(1)). The person appointed to hold the inquiry may by summons require any person to attend to give evidence or to produce any documents under his custody or control; and may take evidence on oath. The Secretary of State can require a local authority to pay the costs of the inquiry if the local authority is a party to the inquiry (s. 125(2)).²

¹ HM(66)15.

² See the Local Government Act 1972, s. 250(2), (5). The Tribunals and Inquiries Act 1971 applies to an inquiry held under s. 125 of the 1983 Act to the extent provided for in the Tribunals and Inquiries (Discretionary Inquiries) Order 1975, S.I. 1975 No. 1379, art. 3, Sch., Pt. I, para. 39.

22.19.2 *In connection with the National Health Service Act*

The Secretary of State may cause an inquiry to be held in any case where he thinks it advisable to do so in connection with any matter arising under the National Health Service Act 1977. The person appointed to hold the inquiry may by summons require any person to attend to give evidence or to produce any documents under his custody or control; and may take evidence on oath.¹ Where the Secretary of State causes such an inquiry to be held, the costs incurred by him must be paid by the local authority or party to the inquiry as he may direct.²

22.20 **Default Powers of the Secretary of State****22.20.1** *Local Social Services Authority in default*

If the Secretary of State for Health is satisfied that any local authority have failed without reasonable excuse to comply with any of their duties which are social service functions as defined under s. 15(2) of the Local Authority Social Services Act 1970, he may make an order declaring the authority to be in default with respect to the duty in question.³ An order may contain such directions for ensuring that the duty is complied with within a specified period as appear to the Secretary of State to be necessary. The directions are enforceable by mandamus on the application of the Secretary of State. It is not anticipated that the Secretary of State will resort to the default power without first having carried out an investigation to ensure that the authority is in default of its duty and without having sought to resolve the matter by directions under the Local Authority Social Services Act 1970, s. 7A. As Baroness Hooper, then Parliamentary Under-Secretary for the Department of Health put it during the Lords debate on the provision, "It will only be after these processes have been exhausted and work with the authority through the Social Services Inspectorate has failed to secure any improvement in the situation that the use of default powers will be considered."⁴

This default power does not apply in relation to Social Services functions which result from the discharge of duties under the Children Act 1989, which has its own default mechanism in s. 8A.

22.20.2 *Health Authority in default*

The Secretary of State for Health has the power to declare a NHS trust, a regional, district or special health authority, or a family health services authority⁵ to be in default. He may do so if he is of opinion, on complaint or otherwise, that the body has failed to carry

¹ National Health Service Act 1977, s. 84(1), (2).

² *Ibid.*, 84(5).

³ Local Authority Social Services Act 1970, 1.7D as inserted by the National Health Service and Community Care Act 1990, s. 50.

⁴ Hansard, H.L. Debs. Vol. 519, col. 103.

⁵ *Ibid.*, s. 85(1); Health Services Act 1980, s. 1(7), Sch. 1, para. 65, National Health Service and Community Care Act 1990, s. 66(1), Sch. 9, para. 18(7) and Sch. 10.

out any function conferred or imposed on it under the National Health Service Act 1977 or Part I of the National Health Service and Community Care Act 1990; or if in carrying out those functions the body failed to comply with any regulations made under the Act. The Secretary of State must first make such inquiry as he may think fit.¹ When a default order is made, the members of the body must forthwith vacate their office, and the order must provide for the appointment of new members of the body in accordance with the relevant statutory provisions.²

22.21 Individual Enforcement of Statutory Duties

It was held in *Southwark London Borough Council v. Williams*³ that where an Act makes an obligation, and enforces it in a specified manner, performance cannot be enforced in any other manner. Thus, where the statute gives the Secretary of State the power to hold an authority in default (see para. 22.20 above) the courts are extremely reluctant to enforce the statutory obligation themselves.⁴ However, the existence of the remedy of complaint to the Secretary of State under his default powers would not exclude an application to the courts for a remedy of damages or injunction when an authority failed to perform its statutory duty and that failure was caused by a decision which was *ultra vires* or by an act of malfeasance, even perhaps by an act of nonfeasance.⁵

It is extremely rare for the Secretary of State to make an order holding an authority in default and it is difficult to envisage any circumstances where he would do so in response to a complaint that an authority failed in its obligations towards an individual client.

In sum, it is clear from the caselaw that where a person has suffered as a result of the failure of an authority to carry out its statutory duties, resort should first be made to the Secretary of State asking him to consider holding an inquiry and then exercising his default powers. If the Secretary of State wholly disregards the facts demonstrating an unreasonable failure to carry out the authority's statutory duties, consideration should be given to seeking a remedy in the courts, for

¹ *Ibid.*, s. 85, as amended by the National Health Service and Community Care Act 1990, s. 66(1), Sch. 9, para. 18(7) and Sch. 10.

² *Ibid.*, s. 85(2).

³ [1971] Ch. 734, [1971] 2 All E.R. 175, C.A. See *Doe d Bishop of Rochester v. Bridges* (1831) 1 B. & Ad. 847 at 859.

⁴ See *Thornton v. Kirklees Metropolitan Borough Council* [1979] Q.B. 626, [1979] 2 All E.R. 349, C.A. (since the Housing (Homeless Persons) Act 1977 prescribed no special remedy it was assumed that a civil action for damages for breach of statutory duty would lie); *Wyatt v. London Borough of Hillingdon* (1978) 76 L.G.R. 727, C.A. (since the remedy for breach of the Chronically Sick and Disabled Persons Act 1970 was provided by the Minister's default powers, there could be no claim for breach of statutory duty before the courts). See further para. 4.08.5A *ante*.

⁵ *Meade v. London Borough of Haringey* [1979] 2 All E.R. 1016, [1979] 1 W.L.R. 637, C.A. See also *Padfield v. Minister of Agriculture, Fisheries and Food* [1968] 1 All E.R. 694.

example, by way of judicial review. If the courts were not prepared to consider the matter in such a context the aggrieved person would be left without any effective remedy, and it is to be assumed that Parliament did not have this intention when creating a default power.

22.21.1 *Inadequacy of resources*

In *R. v. Secretary of State for Social Services, West Midlands R.H.A. and Birmingham A.H.A. (Treasury)*, *ex parte Hincks*¹, four patients claimed damages from the Secretary of State for a failure to provide an efficient health service. Mr. Justice Wien stated that "it is impossible to pinpoint anywhere a breach of statutory duty on the part of the Secretary of State. . . . It all turns on the question of financial resources. If the money is not there then the services cannot be met in one particular place". It is clear that one of the most significant limitations on enforcement of statutory duties is financial; according to *Hincks* a duty may be enforceable only to the extent that Parliament has made resources available.

The difficulty faced by any individual seeking to enforce a statutory duty is illustrated by the hypothetical case of a mentally disordered person recently discharged from hospital who is entitled to receive after-care services under section 117 of the 1983 Act (see para. 4.08 *ante*). If the local social services authority and district health authority fail to provide reasonably adequate after-care services there are no realistic means of enforcement: there exists a default power but it is unlikely ever to be exercised; further the courts would be extremely reluctant to intervene because a statutory remedy through the Secretary of State was created in the statute and because the defaulting authority will claim that its reason for defaulting was based upon financial considerations. One could well argue that the decision in *Hincks* was over-simplistic and that if Parliament created a binding responsibility, minimally, it should be reflected in the overall spending priorities of responsible authorities.

22.21.2 *Refusal of treatment for a medical condition: Role of ethical committees and consultants*

In *R. v. Ethical Committee of St. Mary's Hospital ex parte Harriott*² a consultant, in light of the advice of the hospital ethical committee, refused a patient treatment for infertility with in vitro fertilization. This is one of the first cases seeking judicial review of a decision to refuse NHS treatment for an illness. Schiemann, J held that an ethical committee, which was a non-statutory body, was a forum for discussion among professionals. If the committee refuses to give advice or does not have a majority view, the courts cannot compel it to give advice or to embark upon a particular investigation. An ethical

¹ *The Guardian* January 25, 1979; *The Lancet* (1984), No. 8413, p. 1224.

² [1988] Fam Law 165; *The Times* October 27 1987.

committee also does not have any duty to act judicially or to hear representatives.

Consultants may have a duty to act fairly in making a decision whether to provide or refuse treatment. But in the instant case the patient, albeit belatedly, did have the opportunity to put information in front of the consultant and health authority.

D. MONITORING SERVICES

22.22 Development Team for Mentally Handicapped People

In February 1975 Barbara Castle, then Secretary of State for Social Services, in a speech to the National (now Royal) Society for Mentally Handicapped Children, announced a number of initiatives to monitor the implementation of the 1971 White Paper, *Better Services for the Mentally Handicapped*:

- (1) The establishment of the **National Development Group** for the Mentally Handicapped. The Group's remit was to advise the Secretary of State in the development of departmental policy and strategy for its implementation. The Group was wound up at the end of 1980.¹
- (2) The intention to establish a **Development Team for Mentally Handicapped People**. The Team was subsequently established in 1976 with the remit to monitor services and to offer advice and assistance to health authorities and local authorities in the planning and operation of their services for mentally handicapped people.

The Development Team took over the functions previously performed by the Hospital (now Health) Advisory Service (see next para.) in respect of services for mentally handicapped people in England. The H.A.S. continues to have responsibility for mental handicap services in Wales. The Team's reports to individual authorities are rarely made public, and it was only comparatively recently that members of the Team were excused from signing the Official Secrets Act.² However, the Team's annual reports are published and make detailed proposals about service development.³

¹ The NDG produced a series of publications on various aspects of planning and running services. *Pamphlets 1-5* (1976, 1977); *Helping Mentally Handicapped People in Hospital* (1978); *A Checklist of Standards* (1980).

² The Secretary of State made the announcement that the Team would no longer be required to sign the Official Secrets Act in July 1983 following a series of disclosures of the team's reports in *The Guardian*.

³ National Development Team for the Mentally Handicapped: *First Report* (1978); *Second Report* (1980); *Third Report* (1982); *Fourth Report* (1985). DHSS, London.

22.23 Health Advisory Service

DHSS Circular HM 70/17 announced the formation of a non-statutory body, the Hospital Advisory Service, which was changed to the Health Advisory Service by HC(76), in 1976. The remit of the H.A.S. concerns the management of patient care in hospitals and in community health services with particular reference to the elderly and mentally ill. The objective is to help to maintain, and within available resources, to improve the standards of management and of the organisation of patient care (excluding matters of clinical judgment) in hospital and community health services in England.

Investigations may be initiated by the H.A.S. or upon invitation by particular authorities. Its reports are confidential and are sent with recommendations to the Secretary of State and the authorities concerned. The H.A.S. also makes an annual report to the Secretary of State which is published.

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E. ADVOCACY

22.24 Introduction

The Disabled Persons (Services, Consultation and Representation) Act 1986¹ is a significant landmark in the advocacy and consumer movement for disabled people. Disabled people have sought a voice in the decisions that are made about their lives within the health and social services.² An advocate can be defined as a representative whose function it is to secure services, rights, and dignity for the disabled person. An effective advocate must be independent of the authority providing services; this is necessary in order to avoid a conflict of interest. Self advocacy is when the disabled person acts on his own behalf to secure these services, rights and respect. Having an expectation or entitlement to assessment or services is often not enough. The Chronically Sick and Disabled Persons Act 1970 caused a revolution in services for people with disabilities. Section 2 created a mandatory duty to provide practical assistance and facilities for disabled people in their home, for recreation, travel, leisure, meals and communication. There have also been mandatory duties to provide prevention, care and after care services for mentally disordered people (see paras 4.07, 4.08 *ante*). Yet, duties in these and other areas have not been enforced to the extent needed to meet the needs of disabled people.

The Disabled Persons (Services, Consultation and Representation) Act 1986 is intended to improve the effectiveness of, and the coordination of resources in, the provision of services for people with mental or physical handicap and for people with mental illness; to provide for the assessment of their needs; and to establish rights to consultation and representation for such people.³

A critical aspect of advocacy or self advocacy is access to full and accurate information upon which to assess needs and assert rights. Representatives under the 1986 Act are given no greater access to information or documents than the disabled persons themselves are given; but, there has been an opening of relevant meetings to representatives (see para 22.25.2 below), and to the general public. In this

¹ References to sections in paragraphs 22.24–22.27 are to the Disabled Persons (Services, Consultation and Representation) Act 1986 unless otherwise specified. The Act does not come into force until the Secretary of State specifies. The following sections had come into force as of July 1987: sections 4 (except paragraph b), 8(1), 9, 10, 16, 17, 18. The Disabled Persons (Services, Consultation and Representation) Act 1986 (Commencement No. 1) Order, S.I. 1987 No. 564; (Commencement No. 2) S.I. 1987 No. 729.

² See Sang B & O'Brien J (1984) *Advocacy: The UK Experience*, Kings Fund: London; *Guidelines for One-to-One Advocacy in Mental Handicap Hospitals* (1985) Advocacy Alliance: London; *Advocacy Information Pack* (1985) Good Practices in Mental Health: London.

³ See Bingley W & Mitchell P (1986) *Disabled Persons (Services, Consultation and Representation) Act 1986: Handbook for Voluntary Organisations*. MIND/RADAR: London.

regard, several new "freedom of information" statutes have contributed to the consumer movement in Britain—the Local Government (Access to Information) Act 1985 and the Health Service Joint Consultative Committees (Access to Information) Act 1986. These statutes provide greater public access to the meetings, and documents, of Joint Consultative Committees, and of principal councils and their committees and sub-committees.

22.25 Representation

22.25.1 *Appointment of an authorised representative*

An "authorised representative" is a person appointed by or on behalf of a disabled person (s. 1(1))¹. The authorised representative acts in a voluntary capacity and will not be paid or receive expenses from public funds. The Act enables regulations to be made by the Secretary of State (s. 1(2)). It envisages that disabled adults who are physically and mentally capable will appoint their own authorised representative. A disabled child under the age of sixteen cannot make an appointment himself (s. 1(3) (a)). If the child is in the care of a local authority, a representative can be appointed by the authority (s. 1(3) (b)); if he is not in the care of a local authority, a representative can be appointed by the parent or guardian (s. 1(3) (a)).

A disabled person who is unable to make an appointment because of a mental or physical incapacity, can have an authorised representative appointed by the local authority (s. 1(3)(c)), or by a voluntary organisation approved by the authority (s. 1(4) (b)). In making the determination whether a disabled person is incapable of making an appointment, the local authority can obtain a medical opinion (s. 1(4) (a)), or consult other persons (s. 1(4) (c)). The authority must also provide for a review of cases where the disabled person has been found incapable of making an appointment.²

The Act is silent as to the nature or degree of incompetency necessary before a local authority can make an appointment for a disabled adult. It is suggested that the authority should allow any disabled person who wishes to make his own appointment to do so, unless there is overwhelming evidence of incapacity. Such an approach would maximise the ability of the disabled person to control his own fate, which is the overriding purpose of advocacy.

The 1986 Act specifically specifies that a nearest relative (see paras.

¹ Disability includes mental as well as physical disability (s. 16).

² The Minister of State specified that the Act does not impose "a compulsory duty on local authorities to set up arrangements for appointing representatives for people unable to act . . . That should be left to a local decision in light of local priorities." *Hansard*, H.C., vol. 100, No. 143, col. 1314.

8.01–8.04 ante) under the Mental Health Act 1983 may, if appointed, also act as the authorised representative of the disabled person (s. 1(6)).

22.25.2 *Rights of an authorised representative*

A local authority must permit an authorised representative, if requested by the disabled person, to represent his interests in connection with the provision by the authority of social services¹ and to accompany the disabled person (otherwise than as his representative) to any meeting or interview held by the authority (s. 2(1)). But the authority is not obliged to allow the representative to attend a meeting or receive information if the authority is satisfied that it would be likely to be harmful to the interests of the disabled person. (The authority must have regard to the express wishes of the disabled person when making that determination) (s. 2(4)). Authorised representatives are given an important right to visit the disabled person at any reasonable time and interview him in private when he is living in any one of a wide range of specified forms of accommodation including a health service hospital (see Chap. 3), Part III accommodation (see para. **4.05 ante**), a residential care or mental nursing home (see Chap. 5), and any place where a person under guardianship is required to live (see para. **11.07.5 ante**).

22.26 **Assessment of Needs of Disabled Persons**

In any case where the local authority is to assess the needs of a disabled person for his suitability for statutory services, it must afford an opportunity to him or his authorised representative to make representations (orally and/or in writing) as to his needs (s. 3(1)). The disabled person also has a right to a written statement of the authority's decision specifying: the needs accepted by the authority and the services it proposes to provide to meet those needs; or explaining the decision, particularly giving reasons for a decision, not to provide services (s. 3(2) (3)). If the disabled person or his authorised representative is dissatisfied with the statement, he may make further representations, which must be reconsidered; a new written statement of reasons for the decision must then be made by the authority (s. 3(4) (5)). Assistance must be given during the assessment procedures if either the disabled

¹ The social services, to which the authorised representative can act in relation, are any services provided under "welfare enactments", viz—Part III of the National Assistance Act 1948; section 2 of the Chronically Sick and Disabled Persons Act 1970, schedule 8 of the National Health Service Act 1977 (see paras. **4.04–4.08 ante**). The Secretary of State for Social Services may at a *future date* provide for the rights of authorised representatives to be extended to take in services provided by local health authorities and other services provided by local authorities (s. 2(7)). One notable omission, for example, is after care services under s. 117 of the Mental Health Act.

person or authorised representative is unable to communicate by reason of disability (s. 3(7)).

22.26.1 Disabled persons leaving special education

The Act has special provisions for disabled persons leaving special education (s. 5(5) (6)). The local education authority (LEA) must seek information from the social services authority as to whether a child with a statement under the Education Act 1981 is disabled at the first annual review after his fourteenth birthday; the LEA must inform the social services authority eight months before the disabled person's presumed date of ceasing further education either at school or a further education college so long as he is under nineteen at that time; and the social services authority must undertake an assessment within five months of this notification unless the person, or if under sixteen, his parent or guardian, ask them not to do so (s. 5).

The local education authority must keep under review the expected leaving dates of disabled children identified under section 5 both while they are in school and in further education (s. 6).

22.26.2 Persons discharged from hospital

Where a person is to be discharged from hospital¹ after having received in-patient treatment for mental disorder for a continuous period of six months or more, the hospital managers (see paras. 6.01–6.13 *ante*) must inform the following authorities in the place where the person intends to reside as soon as reasonably practicable after the date is known: the district health authority (unless the managers are that authority); the local authority; and the appropriate local education authority if the person is under the age of nineteen (s. 7(1)).

Where a person liable to be detained under the Mental Health Act is discharged² by a Mental Health Review Tribunal after a continuous period of in-patient treatment for six months or more, the managers must give written notification to the authorities listed above as soon as reasonably practicable (s. 7(2)).

Where a health or local authority receives notification that a patient is to be discharged from hospital as above, they must make arrangements (unless requested otherwise by the patient) for an assessment of the needs of the patient with respect to the health and social services they are required to provide (s. 7(3), (4)). The health and local authority

¹ The requirement to make an assessment does not apply to a patient being transferred to another hospital where he will be an in-patient (s. 7(8)).

² This only includes an order for "immediate discharge" which appears to exclude a delayed or deferred discharge by a tribunal, at least until the time it is about to take effect (see paras. 18.09 and 18.14A *ante*).

making the assessment are required to cooperate with each other (s. 7(5)).

22.27 Reports to Parliament on Community Care

The Secretary of State for Social Services is required to annually lay before Parliament a report containing the following: information appropriate to the development of health and social services in the community for persons who are mentally ill or mentally handicapped who are not resident in hospitals; and information on the numbers of persons receiving in-patient treatment for mental illness or mental handicap.