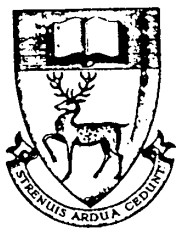
UNIVERSITY OF SOUTHAMPTON

FACULTY OF LAW



THE LAW AFFECTING PEOPLE WITH LEARNING DIFFICULTIES

Friday, 23rd September 1988

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THE LAW AFFECTING PEOPLE WITH LEARNING DIFFICULTIES

To be held at:

The King's Fund Centre, Albert Street, London NW1

Day 1: Friday, 23rd September 1988
9.30 a.m. - 4.30 p.m.

Half day: Friday, 28th October 1988
9.30 a.m. - 12.30 p.m.

On Day 2 please remember to bring course material and your name badge (for security reasons) with you

No further joining instructions will be issued for Day 2

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MAKING PROVISION FOR RELATIVES WHO HAVE A LEARNING DIFFICULTY

Introduction

The object of this very paper is to outline some of the things you should consider when deciding what you want to do now to assist any relatives or friends, who have learning difficulties.

When it comes to your property and your will you should obtain legal advice. This is not so as to give lawyers more work or money. It is because the law is complicated, because any brief summary as this cannot possibly mention all the possibilities and problems and because the law can change. However, you should approach a lawyer who is knowledgeable **not just** about this area of law **but also** who is knowledgeable about the lives, opportunities and practical problems experienced by people with learning difficulties. You may meet people who know experienced solicitors at various voluntary groups and you could take their advice. You can also suggest, to your solicitor, that he or she contacts the legal advisers to Royal Mencap who are experienced in this area and can provide useful documents to your solicitor.

Person and Property

It must be clear that our law deals with people and their property differently. What follows is mainly about property.

All parents may appoint guardians to look after their children should the parents die. But once children become adults they are responsible for themselves unless special laws are applied to them. For example, at 16 a child may decide which medical treatment to accept or reject. The test is of age. The adults who have learning difficulties as adults and not as children.

So parents cannot use their will to control what happens to any of their children once they become adults. However, they might make arrangements with their property which encourage certain arrangements. For example they might leave their house for the use of a particular child. That will enable that child to use that house but it cannot force him or her to live there. In many such cases such an arrangement will be all that is necessary. The relatives can also make arrangements with organisations like Mencap whereby they promise to visit and provide anniversary presents. And, when the Disabled Persons (Services Consultation and Representation) Act 1986 is fully implemented, relatives and relevant voluntary organisations may be involved in appointing advocates or representatives for people with learning difficulties.

If an adult needs direction, control or care then officials are going to have

have to decide which is going to be the most appropriate procedure. The individual's nearest relative (this is a technical legal term and will often not be the person closest to the individual) may take steps, with the social services department, to have a guardianship order made under the Mental Health Act 1983. This will give the person appointed guardian a few specified powers: to require the individual to live at a specified place, to attend specified places for training etc. or treatment and to require other people, for example a landlord or landlady, to allow specified people to have access to the individual where he or she is residing. This procedure may only be used with a relatively small number of people with learning difficulties.

There are proposals to change this area of law and have broader guardianship laws, with more checks and safeguards too, as has taken place in Commonwealth countries and in the USA. Hence, once again, the desirability of taking legal advice in each individual case.

The problem with property

Some people with learning difficulties, just like some other people, are regarded by our law as unable to look after their own property and money. When this happens a number of complicated and potentially expensive procedures come into operation and you need to be sure that these will produce the result you want.

But, it cannot be stressed enough, just because a person has a learning difficulty or mental handicap it does not follow that he or she is not able to own and administer his or her own property and money. Many problems could be avoided by emphasising the competence rather than the incompetence of the individual.

If the individual can own and administer property without the law about to be described being involved then so much the better. and cheaper. Relatives can and should make provision just as they would for any other relatives they are thinking of benefiting.

But how do they know whether the individual is able to own his or her own property? Well the Court of Protection, whose special job it is to look after the property and money of people who are mentally disordered, including people with learning difficulties, can only become involved where it is satisfied that the individual is "incapable, by reason of mental disorder, of managing his property and affairs."

The Court acts on medical advice but would consider other evidence. Relatives should then ask people providing health services or social work support to advise them whether the person they are concerned about fits within this definition. They could also ask that those people take steps to ensure that the individual learns about and understands and is able to look after his or her property. This will increase that person's choice, self-esteem, ability to look after him or herself and increase his or her legal rights.

The Court of Protection, the British Medical Association and the Royal College of Psychiatrists have produced guidelines about the meaning of this test of ability, to administer your own property. It is reproduced

and discussed in **Making the Most of the Court of Protection** (edited by David Carson, King's Fund Project Paper No. 71, available from the King's Fund Publishing Office, 2 St. Andrew's Place, London NW1 4LB, price £3.50).

Preventing Problems

Relatives who are still anxious that the person they are concerned with might be considered competent to manage his or her property now but might not be later, which could inconvenience their plans, could use some relatively new legislation and create an **enduring power of attorney.**

A power of attorney gives one or more people the right to make legal decisions on behalf of another person who will be bound by them. People going abroad for some time often given their bank manager or solicitor a power of attorney to pay bills and do other things on their behalf. What the person given the powers may do is specified in the document setting it up.

An enduring power of attorney is one that is made with special care, on special forms, because it will continue in force even though the person who made it becomes both mentally disabled and incapable of managing his or her property and affairs.

The individual must be competent at the time the power is created. So relatives could, during their own lives, invite the person they are concerned about to make an enduring power of attorney. They could seek supporting evidence of competence from doctors and social workers. Indeed, if still concerned about the individual's competence they can ask the Court of Protection to decide whether he or she actually is and that will determine the matter.

The enduring power of attorney document will then appoint one or more people who will be able to, if the individual does become incapable of managing her or her property and affairs, take over responsibility for those affairs. He or she will just have to give the Court notice of taking over, the Court will allow the individual and other relatives to comment and then, providing there is nothing improper, the enduring power of attorney will be registered. If the person who is now responsible for the property acts improperly the Court can intervene.

This approach has a number of advantages. Once set up the individual's property can be increased by a bequest in a relative's will. The individual is able to look after his or her property for so long as he or she is competent. The enduring power of attorney document can limit the powers given to the person who may take over and that person could be a friend or a special adviser such as banker or solicitor. This approach leaves much more control with the individual concerned. And, although some cost is necessarily involved, it will be much cheaper than using the other powers of the Court of Protection. (For a further discussion of enduring powers of attorney see the King's Fund report referred to above).

Your will

If money is left to any person with a disability it could give them problems. If they are left more than £3,000 then they will not be entitled, on current law, to supplementary allowance. Equally social services may be able to claim some of it to pay for the services that they provide.

If money or other property is left to someone who is unable to manage it because of a learning difficulty or mental handicap then anyone may apply to the Court of Protection. The Court will then appoint a receiver to manage that money and property. This may be more impersonal and the Courts charges a number of fees including for annual accounts.

A number of devices have been developed to try to get around these problems.

By making a trust you pass the legal ownership of the property to trustees but with a requirement that they use the property for the benefit of a particular person. However our law specifies that although the property actually belongs to the trustees the person who is to benefit will be treated as if he or she also owned it. Thus if more than £3,000 is involved there will be no entitlement to supplementary benefit.

A number of kinds of trusts have been developed to try to get around this but without real success. And whatever is set up might always be altered by another Act of Parliament.

Sometimes relatives give the money to someone they trust, for example a brother or sister, asking them to use it for the person specified. However, this is a trust! It will be caught by the rules. If everything is left to children who do not have learning difficulties then the will might be challenged for not making proper provision.

One method is to give money or property to a charity like Mencap and rely upon them to use that property for the advantage of people with learning difficulties. They cannot, because of the law, make specific promises about your particular relative. For example, having given them your house they cannot promise that it will be used for your relative although that might happen. Equally they cannot give your house to other relatives, say grandchildren, after the death of the relative you are anxious to make provision for.

Conclusion

This is a difficult area of law. You should seek legal advice for your particular plans; do not just adopt other people's solutions. But the way forward is to ask those providing services to ensure that your relative is capable to managing his or her affairs. Stress competence not incompetence.

The easiest way to solve a legal problem is to take it away. If the person is not incompetent then he or she can receive and deal with money just like the rest of us! By presuming incompetence - or not making people competent - we create their problems!

THE PROSECUTION OF PEOPLE WITH A MENTAL HANDICAP

[This was a discussion paper for a conference, of the same title, held in 1987]

Introduction

> The clerk whispered to the resident magistrate and then turned to the court and announced that the next case would be the last before lunch. Almost everyone left. A middle-aged man was charged with indecency. A police officer had spotted two men in an indecent act. One ran off. The other was ungainly and slow and easily caught. He pleaded guilty. His mother and sister sat in court, ashamed and worried. The police agreed the defendant was likely to have been a victim of the other man's advances. The solicitor argued that he was more sinned against than sinning. He had a mental handicap. He lived at home with his parents. The solicitor presented one doctor's report and apologised profusely that another had not arrived in time. The magistrate regretted that there were not two reports for then he could have made a hospital order. He adjourned the case. The mother and sister were still very worried. Perhaps they thought I was a newspaper reporter taking notes for publication instead of just being a researcher.

Should the police have bothered to prosecute? What good was done by it? Should his solicitor have tried to defend him in a way that almost sent him to a hospital? Could that hospital have done anything for his offending behaviour and might he have been kept there for longer than any prison sentence he could have received? Everyone was well-intentioned. But who gained, profited, learnt?

Criminal Liability

Most crimes involve some prohibited behaviour (called **actus reus**) and a state of mind (called the **mens rea**). Like everyone else, the person with a mental handicap can plead not guilty because he or she did not cause the **actus reus** or have the necessary **mens rea** to commit the particular crime. So if a defendant did not intend permanently to deprive someone of their property he or she cannot be guilty of theft which requires such a 'intention'. It does not matter whether this is due to the mental handicap or not. But if the **mens rea** is described as 'recklessness', as in the offence of causing criminal damage, or involves 'negligence', then the defendant can be guilty even though he or she did not intend to commit the offence. If they did the acts in a 'reckless' or 'negligent' manner then they have committed that crime. In deciding whether the defendant was reckless or negligent the courts consider what reasonable people would have known and would have done. So people with handicaps can be judged reckless and negligent by comparing their behaviour and knowledge with that of people without handicaps.(1)

Defences to criminal liability

If the **actus reus** and **mens rea** are proved then defences should be considered. There is no special or separate defence for having a mental handicap. But a number of defences might apply in a few cases.

Insanity can be pleaded as a defence to any crime. However it is used very rarely. If the defence is successful the defendant is found not guilty but detained at Her Majesty's pleasure in a hospital for a period with could exceed the sentence imposed on a defendant found guilty and sent to prison. The defence of insanity involves the McNaughten Rules (2). The defendant can be proved 'insane' if he or she is (i) suffering from a defence of reason which (ii) is due to a disease of the mind, and which either (iiia) leads him or her not to know the nature and quality of his or her acts, or (iiib) if he or she does know that then he or she does not know that they are wrong. A mental handicap might be treated as a 'disease of the mind' but learning difficulties would not automatically constitute a 'defect of reason' because the test is more about irrational thought processes than difficulty or slowness in using reason(3). So the insanity defence is of little practical relevance.

For diminished responsibility there must be proved such an abnormality of mind - which could involve degrees of mental handicap - that the defendant's responsibility can only be used by people charged with murder to reduce it to manslaughter. Judges have to impose life sentences for murder but have considerable discretion for manslaughter. Although psychiatrists give evidence about this defence the tests are more moral than clinical.

People with mental handicaps can, of course, use any of the other defences. Provocation only applies to murder to reduce it to manslaughter. Whilst the defendant must respond reasonably to the provocation a mental or social handicap can be taken into account(5). Being drunk or under the influence of drugs can only be a defence to a crime, like theft, which can only be committed intentionally. The drink and drugs would have the effect of removing the defendant's ability to intend the criminal behaviour. It is not defence to crimes like causing criminal damage which can be committed recklessly. Drunk people can be as reckless as anyone else. Being an automaton, in the sense of having no control over your body's acts, can be a complete defence to any crime. But it is difficult to prove. If the evidence suggesting automatism is a person's mental disorder or mental handicap then it will be treated as a defence of insanity rather than automatism(6).

Infancy, being under the age of 10 is a complete defence. Between 10 and 14 the prosecution must also prove that the child knew that what he or she was doing was wrong, like looking around furtively before taking something from a shop counter. These are chronological ages; 'intellectual age' is irrelevant to guilt or innocence. But, instead of being prosecuted, children may be taken into social services' care.

In 1975 the Report of the Committee on Mentally Abnormal Offenders(7) known as the Butler Report, recommended that where a defendant was found to have a severe mental handicap, or a mental handicap and lacked the **mens rea** for a crime, he or she should be found "not guilty by reason of

mental disorder"(8). The courts would then have a discretion to order what they thought was best for the innocent individual. The recommendation has not been acted upon.

The report's recommendation would continue the tradition of regarding people with mental disorders as somehow incapable of real crime, innocent people, having less responsibility than others. But these 'not guilty' people are still 'punished'. It may be called a hospital or treatment order but it is still a restriction of liberty for doing something wrong. That it is a hospital rather than a prison may not be an important distinction for the individual especially considering how long he or she may have to stay there.

An alternative approach would no longer presume people who have a mental illness or handicap are incapable of moral or criminal blame. We all usually have some control over our actions. We usually have some sense of danger, risk, right and wrong. We could punish each person - with or without a handicap - if he or she could or should have known about the wrongness of his or her acts and could have exercised more control. If a particular crime requires that it is committed intentionally then we could all, irrespective of handicap, be found not guilty if we did not have that intention. But if a crime is committed just be negligence or recklessness then we can all be guilty just by behaving in that way. The need for special defences can be avoided by more crimes requiring that they are committed intentionally or with an awareness of harmful consequences. If a person with a mental disorder means to harm someone, although that is due to a delusion, is it wrong to punish him or her for that desire to do harm? The finding of guilt or innocence should be entirely separate from deciding any punishment or disposal but these two points get mixed together when dealing with people with mental disorders.

Criminal behaviour

Many acts are criminal. But some crimes are treated as if 'not really criminal', for example exceeding the speed limits, misusing employers' stationery and telephones. We rely upon the police not to enforce all the law strictly. We also give prosecutors considerable discretion about which people should be prosecuted and when. Taking cases through the courts is expensive and labour intensive. The deterrence is often said to lie in being caught rather than in being prosecuted or punished. Cautions, warnings and social pressure may be all that is necessary to prevent re-offending. Or it may - at least - be as effective as the courts' punishments which are often ineffective in deterring re-offending. But, practical and sensible these alternatives may be, they do not allow the defendant a trial. The individual may wish to protest his or her innocence.

Similar things can happen in institutions where staff may seem to be deliberately blind to the offences that are committed within them. Taking property from other patients or damaging equipment, for example, is often referred to as naughty, irritating or 'problem behaviour'. But it is also criminal. Only the more serious offences lead to action. That could be prosecution, transfer to a more secure unit or a different treatment.

But what are we told and taught when our minor assaults and thefts are

ignored? Someone wanting attention learns to exaggerate or show off or learns how to get the attention which he or she may crave. by not acting, because the person has a handicap, we may be associating all people with handicaps as being less responsible, less complete citizens or as being like children - incapable of criminality.

Although it may not be considered a crime some official action is likely even if that is just a record of the behaviour. But this is ascribing guilt, blame and punishment or penalty without any outside investigation or trial. For example someone may be recorded as violent and irrational because of an incident. But, on investigation, the violence may have been justified and the reasons for it rational. The behaviour may be used to "associate" the individual with "abnormally aggressive or seriously irresponsible behaviour" which, under the Mental Health Act 1983, is grounds for detaining people with mental handicaps for more than 28 days(9). The protection of the Rehabilitation of Offenders Act 1974 is lost. It allows some people to treat their convictions as expunged, for certain purposes, after a certain time. Crimes that have been incapable of proof in a court may remain in manilla folders permanently.

The person may have a legal defence. This cannot be determined without some form of trial. Holding a trial could provide clinicians and managers with the quality evidence they need to make clinical and disciplinary decisions. It could reveal any institutional or managerial weaknesses that contributed to the incident. For example, a lack of privacy may contribute to sexual acts being treated as perfectly lawfully in private. The lack of facilities for keeping private property safe from theft might be revealed as a cause of frequent thefts. Providing an intensely boring setting might contribute to an individual's 'difficult behaviour' making it not only rational but moderate. Whilst this would not make the institution or its staff criminally liable it might produce grounds for civil litigation. And it could produce the evidence for a plea in mitigation. Even if guilty everyone is entitled to a plea in mitigation to get the most appropriate punishment or treatment - unless, of course, no trial is held. In whose interest is it to fail to treat crimes committed within institutions as crimes?

Investigating crimes

Most prosecutions are undertaken by the state via the police and Crown Prosecution Service. The vast majority of defendants, especially in the magistrates' courts, plead guilty. So the investigation of a crime usually leads to a **fait accompli** being presented to the courts. The courts decide the punishment but even there its powers are prescribed for each offence and influenced by guidelines and tariffs.

The police are entitled to ask anyone for information about a crime. We all have a social duty to reply but do not, generally, have any legal obligation to reply. But if we give false information we may become guilty of wasting police time. We may be invited to attend a police station but are under no obligation to go unless arrested. If arrested we must be told, as soon as practicable, that we have been arrested and the grounds for it. We would then be guilty of an offence if we resist arrest. The same must happen if a person voluntarily at a police station is prevented from leaving. If arrested somewhere other than a police station then a constable with reasonable grounds for believing that we

may present a danger to ourselves or others may search us. Wherever the arrest takes place we may be searched if a constable has reasonable grounds to believe we may have something concealed that we could use in escaping or something which would be evidence of the crime(10).

On arrival at a police station a custody officer must decide whether the police have sufficient evidence to charge us or whether we need to be detained to preserve evidence or get evidence by questioning us. The custody officer must tell us the grounds for detention and a written record must be made as soon as practicable. If we are unable to understand, are violent or in urgent need of medical attention, we need not be told. If we are detained then there must be regular reviews of whether the grounds for detention remain. Detention between 24 and 36 hours requires a superintendent's authority and between 36 and 96 hours a magistrates' hearing will be necessary where we will be present and may be legally represented. The custody officer must tell us, before questioning, why we are detained, tell us our rights to have someone informed of our detention, about our right to legal advice and right to consult the Codes of Practice. But our rights to inform someone and to get legal advice may be delayed for up to 36 hours by a superintendent if we are detained for a serious arrestable offence. Otherwise we might be able to interfere with the police investigation. The reasons for any delay must be recorded in the custody record. We are entitled to a copy of the custody record and may seek a copy up to a year after the event.

'Strip searches' can be ordered by the custody officer for articles we would not be allowed to keep. Superintendents may order intimate body searches for articles which might be used to assist in an escape. These are to be carried out by doctors although a superintendent may authorise a police officer where a doctor cannot or will not. Intimate body samples may only be taken on the authority of a superintendent and with the detained person's consent. Samples of other than urine and saliva may only be taken by doctors. Non-intimate samples may be taken to confirm or disprove our involvement in a crime and taken without our consent with the authority of a superintendent.

The Police and Criminal Evidence Act 1984 is now the main source of the law on the powers of the police when investigating a crime. Besides laying down rules it also requires the publication of codes of practice. Breaking a rule in a code of practice is not unlawful in the sense of being a crime but it will be taken into account and may lead to evidence against a defendant being rejected as unreliable or improper. It will also be a serious matter for the police officer who breaks the code because the Act specifies that disciplinary proceedings must be taken against him or her.

Confessions

There is a code of practice covering people with mental illnesses or handicaps. Amongst other requirements when a person with a mental handicap is arrested the custody officer must, as soon as practicable, inform an appropriate adult who is the nearest available relative or a person responsible for his or her care other than a police officer. That person must be told where the arrested person is, and why, and must be asked to come to the police station to see the individual. This must be done even if the police only suspect that the individual has a mental

handicap. The individual can only be interviewed in the absence of the 'appropriate adult' if a superintendent believes that delay will cause a risk of harm to others or serious loss of or damage to property. The arrested handicapped person has the same rights as other arrested people but the 'appropriate adult' may exercise the right to legal advice if the handicapped person does not(11).

Statements made by defendants and witnesses are an exceptionally important tool for the police in proving crimes before the courts. Most crimes are confessed to. But the courts can reject statements and confessions if they do not think that they have been made voluntarily. Without that confession or statement the prosecution case may be lost. Confessions made in breach of the codes of conduct made under the Police and Criminal Evidence Act 1984 may also be rejected.

Section 77 of the 1984 Act requires the courts to remind themselves or the jury that they should exercise special care before they accept that 'a confession by a person with a mental handicap, made in the absence of an independent person, is reliable. This is a special rule for people with mental handicaps. It is based upon the belief that people with mental handicaps are particularly susceptible to suggestion, for which there is some evidence, and a number of highly publicised cases such as that concerning Maxwell Confait(12).

Evidence

The House of Lords has also decided that juries should be warned before they convict someone, for example a carer, on the evidence of a person who has a mental handicap and a criminal record. However, they reversed earlier decisions to the effect that a person could not be convicted solely on the word of a person with a mental handicap without some corroborating evidence(13).

But we are all, to an extent, suggestible. Courtroom questions are largely designed to be such. The suggestibility of a person may be more related to the way he or she relates to people in authority than to any handicap. But our legal system tends to categorise people rather than scientifically investigate problems.

Court or hospital?

Rather than prosecute someone might decide that a warning or caution is sufficient. But if the person has a mental handicap then social services or the local health authority may be pressed to accept responsibility. Why prosecute if the individual will be supervised by care staff. But health and social services may not have legal powers to enforce this option.

Social services may, in certain circumstances take a child into care and exercise parental rights of control and direction. Whilst guardianship is possible, for adults, under the Mental Health Act 1983 it gives social services very limited powers.

Section 1 of the 1983 Act distinguishes between "mental impairment" and "any other disorder or disability of mind." "Mental impairment" means "a state of arrested or incomplete development of mind ... which includes

significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned ..." (For "severe mental impairment" the word 'significant' is changed for 'serious'.) People who are mentally impaired may be placed in guardianship and may, if other tests are satisfied, be detained in hospital for more than 28 days. But people who are not mentally impaired but have another disorder or disability of mind cannot be placed in guardianship and cannot be detained in hospital for more than 28 days.

If a person is detained without legal authority then he or she is likely to be unlawfully detained, which is both a civil wrong and a crime. A person placed in a hospital or hostel without active objection might be interpreted as consenting so there would be no unlawful detention. But minds can be changed at any time. The power to restrain is limited to preventing the commission of a crime. But if the individual did not object because of threats or inducements then any apparent consent might not be voluntary and therefore not real consent.

Court

If a defendant is severely mentally ill or handicapped the Court may have to decide whether he or she is "fit to plead". The test is whether he or she can understand the proceedings and advise lawyers in his or her defence. If the defendant is found to be unfit then he or she must be detained in a hospital as if he or she had been found guilty and placed under a hospital order with a restriction order of unlimited duration(14).

But any defence the individual might have does not get heard, at least until any resumed trial. The individual may be detained in a hospital longer than for any sentence available for the crime. And the individual is expected to advise lawyers about his or her fitness to plead even though the test of fitness to plead is he or her ability to advise lawyers.

An alternative procedure is available in magistrates' courts. Under section 37(3) of the Mental Health Act 1983 they can impose a hospital order on a person with a 'severe mental impairment' without convicting him or her provided they are satisfied that he or she performed the criminal act or omission. They could do this instead of finding him or her 'unfit to plead' and where they could not convict for absence of **mens rea**. This can also be done where an individual is so disordered as not to be able to exercise the choice of trial by Crown Court or magistrates' court (15).

Both magistrates' and crown courts can impose hospital orders under section 37 of the 1983 Act. It must be an imprisonable offence and the individual must be diagnosed as suffering from a mental impairment, mental illness or psychopathic disorder. The court must be satisfied that it is the most appropriate way of dealing with the case. The person is then detained in a similar way to someone detained under section 3 of that Act, but with reduced rights of appeal. Most importantly he or she can be discharged by the doctor in charge of treatment.

A crown court can also impose a restriction order and magistrates' courts

can refer cases to them for such orders. A restriction order can be for a specified period or of unlimited duration. During the period of restriction the individual cannot be discharged just be the responsible doctor. Each case is considered by a Minister of State at the Home Office. Whilst such individuals have a right of appeal to a Mental Health Review Tribunal they have special tribunals and the tests for discharge encourage conditional rather than absolute discharge.

Prisoners with a mental disorder can be transferred to hospitals for treatment in ways similar to hospital and restriction orders. Patients can be transferred between hospitals of different security but have no substantial rights to judicial review of their particular placement. Rights to treatment and care are essentially negative in form; the right not to be assaulted or negligently treated. However some litigation on a right to sufficient properly trained staff rationally organised may be developed from a recent Court of Appeal decision(16).

Courts are busy, daunting and mystifying places for most people. Although the court appearance is supposed to discourage re-offending little is done, outside of juvenile courts, to make it a learning experience. Perhaps courts should organise special sessions where special efforts are made to involve defendants and make the appearance a significant and comprehensible event. Defendants would still have a right of silence. Anything learnt by the courts might then be used for other defendants.

In many Commonwealth countries and in the USA there are guardianship laws where a person is appointed, after due process, to make certain decisions on behalf of people adjudged incapable of making apt decisions. In some cases the guardian is required to try to train the individual to become competent to make the decisions. Such laws in this country could make guardianship a more real alternative to hospital than at present and might provide a kind of structured probation option. However, it would be important to ensure that the criminal associations of one order were not popularly attached to a civil order.

(1) Elliott [1983] 1 WLR 939
(2) McNaughten (1843) 10 Cl. & Fin. 200
(3) Clarke [1972] 1 All ER 219
(4) Homicide Act 1957, section 2
(5) Raven [1982] Crim LR 51
(6) Sullivan [1983] 3 WLR 123
(7) Cmnd. 6244
(8) Para. 18.20
(9) See sections 1,3,7,37
(10) For this and the following paragraphs see, generally, the Police and Criminal Evidence Act 1984.
(11) See Interviewing Persons with Mental Handicaps and the Codes of Practice Stanley Hewitt, published by the author.
(12) See generally Police Interviewing of the Mentally Handicapped Tully and Cahill, The Police Federation.
(13) R v Spencer
(14) See generally Mental Health Law Brenda Hoggett, Sweet & Maxwell.*
(15) R v. Lincolnshire (Kesteven) Justices, ex parte O'Connor [1985] 1 WLR 335
(16) Wilsher v. Essex AHS

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PART IV

DETENTION

Duties of custody officer before charge

37.—(1) Where

(*a*) a person is arrested for an offence—

(i) without a warrant; or

(ii) under a warrant not endorsed for bail,

(*b*) a person returns to a police station to answer to bail

the custody officer at each police station where he is detained after his arrest shall determine whether he has before him sufficient evidence to charge that person with the offence for which he was arrested and may detain him at the police station for such period as is necessary to enable him to do so.

(2) If the custody officer determines that he does not have such evidence before him, the person arrested shall be released either on bail or without bail, unless the custody officer has reasonable grounds for believing that his detention without being charged is necessary to secure or preserve evidence relating to an offence for which he is under arrest or to obtain such evidence by questioning him.

(3) If the custody officer has reasonable grounds for so believing, he may authorise the person arrested to be kept in police detention.

(4) Where a custody officer authorises a person who has not been charged to be kept in police detention, he shall, as soon as is practicable, make a written record of the grounds for the detention.

(5) Subject to subsection (6) below, the written record shall be made in the presence of the person arrested who shall at that time be informed by the custody officer of the grounds for his detention.

(6) Subsection (5) above shall not apply where the person arrested is, at the time when the written record is made—

(*a*) incapable of understanding what is said to him;

(*b*) violent or likely to become violent; or

(*c*) in urgent need of medical attention.

(7) Subject to section 41(6) below, if the custody officer determines that he has before him sufficient evidence to charge the person arrested with the offence for which he was arrested, the person arrested—

(*a*) shall be charged; or

(*b*) shall be released without charge, either on bail or without bail.

(8) Where—

(*a*) a person is released under subsection (7)(*b*) above; and

(*b*) at the time of his release a decision whether he should be prosecuted for the offence for which he was arrested has not been taken,

it shall be the duty of the custody officer so to inform him.

(9) If the person arrested is not in a fit state to be dealt with under subsection (7) above, he may be kept in police detention until he is.

(10) The duty imposed on the custody officer under subsection (1) above shall be carried out by him as soon as practicable after the person arrested arrives at the police station or, in the case of a person arrested at the police station, as soon as practicable after the arrest.

(11) Where—

(*a*) an arrested juvenile who was arrested without a warrant is not released under subsection (2) above; and

(*b*) it appears to the custody officer that a decision falls to be taken in pursuance of section 5(2) of the Children and Young Persons Act 1969 whether to lay an information in respect of an offence alleged to have been committed by the arrested juvenile,

it shall be the duty of the custody officer to inform him, and if it is reasonably practicable to do so, his parent or guardian, that such a decision falls to be taken and to specify the offence.

(12) It shall also be the duty of custody officer—

(*a*) to take such steps as are practicable to ascertain the identity of a person responsible for the welfare of the arrested juvenile; and

(*b*) if—

(i) he ascertains the identity of any such person; and

(ii) it is practicable to give that person the information which subsection (11) above requires the custody officer to give to the arrested juvenile,

to give that person the information as soon as it is practicable to do so.

(13) For the purposes of subsection (12) above the persons who may be responsible for the welfare of an arrested juvenile are—

(*a*) his parent or guardian; and

(*b*) any other person who has for the time being assumed responsibility for his welfare.

(14) If it appears to the custody officer that a supervision order, as defined in section 11 of the Children and Young Persons Act 1969, is in force in respect of the arrested juvenile, the custody officer shall also give the information to the person responsible for the arrested juvenile's supervision, as soon as it is practicable to do so.

(15) In this Part of this Act—

"arrested juvenile" means a person arrested with or without a warrant who appears to be under the age of 17 and is not excluded from this Part of this Act by section 52 below;

"endorsed for bail" means endorsed with a direction for bail in accordance with section 117(2) of the Magistrates' Courts Act 1980.

Duties of custody officer after charge

38.—(1) Where a person arrested for an offence otherwise than under a warrant endorsed for bail is charged with an offence, the custody officer shall order his release from police detention, either on bail or without bail, unless—

(*a*) if the person arrested is not an arrested juvenile—

(i) his name or address cannot be ascertained or the custody officer has reasonable grounds for doubting whether a name or address furnished by him as his name or address is his real name or address;

(ii) the custody officer has reasonable grounds for believing that the detention of the person arrested is necessary for his own protection or to prevent him from causing physical injury to any other person or from causing loss of or damage to property; or

(iii) the custody officer has reasonable grounds for believing that the person arrested will fail to appear in court to answer to bail or that his detention is necessary to prevent him from interfering with the administration of justice or with the investigation of offences or of a particular offence;

(*b*) if he is an arrested juvenile—

(i) any of the requirements of paragraph (*a*) above is satisfied; or

(ii) the custody officer has reasonable grounds for believing that he ought to be detained in his own interests.

(2) If the release of a person arrested is not required by subsection (1) above, the custody officer may authorise him to be kept in police detention.

(3) Where a custody officer authorises a person who has been charged to be kept in police detention he shall, as soon as practicable, make a written record of the grounds for the detention.

(4) Subject to subsection (5) below the written record shall be made in the presence of the person charged who shall at that time be informed by the custody officer of the grounds for his detention.

(5) Subsection (4) above shall not apply where the person charged is, at the time when the written record is made—

(*a*) incapable of understanding what is said to him;

(*b*) violent or likely to become violent; or

(*c*) in urgent need of medical attention.

(6) Where a custody officer authorises an arrested juvenile to be kept in police detention under subsection (1) above, the custody officer shall, unless he certifies that it is impracticable to do so, make arrangements for the arrested juvenile to be taken into the care of a local authority and detained by the authority, and it shall be lawful to detain him in pursuance of the arrangements.

(7) A certificate made under subsection (6) above in respect of an arrested juvenile shall be produced to the court before which he is first brought thereafter.

(8) In this Part of this Act "local authority" has the same meaning as in the Children and Young Persons Act 1969.

Responsibilities in relation to persons detained

39.—(1) Subject to subsections (2) and (4) below, it shall be the duty of the custody officer at a police station to ensure—

(*a*) that all persons in police detention at that station are treated in accordance with this Act and any code of practice issued under it and relating to the treatment of persons in police detention; and

(*b*) that all matters relating to such persons which are required by this Act or by such codes of practice to be recorded are recorded in the custody records relating to such persons.

(2) If the custody officer, in accordance with any code of practice issued under this Act, transfers or permits the transfer of a person in police detention—

(*a*) to the custody of a police officer investigating an offence for which that person is in police detention;

(*b*) to the custody of an officer who has charge of that person outside the police station

(i) the custody officer shall cease in relation to that person to be subject to the duty imposed on him by subsection (1)(*a*) above; and

(ii) it shall be the duty of the officer to whom the transfer is made to ensure that he is treated in accordance with the provisions of this Act and of any such codes of practice as are mentioned in subsection (1) above.

(3) If the person detained is subsequently returned to the custody of the custody officer, it shall be the duty of the officer investigating the offence to report to the custody officer as to the manner in which this section and the codes of practice have been complied with while that person was in his custody.

(4) If an arrested juvenile is transferred to the care of a local authority in pursuance of arrangements made under section 38(7) above, the custody officer shall cease in relation to that person to be subject to the duty imposed on him by subsection (1) above.

(5) It shall be the duty of a local authority to make available to an arrested juvenile who is in the authority's care in pursuance of such arrangements such advice and assistance as may be appropriate in the circumstances.

(6) Where—

(*a*) an officer of higher rank than the custody officer gives directions relating to a person in police detention; and

(*b*) the directions are at variance—

(i) with any decision made or action taken by the custody officer in the performance of a duty imposed on him under this Part of this Act; or

(ii) with any decision or action which would but for the directions have been made or taken by him in the performance of such a duty,

the custody officer shall refer the matter at once to an officer of the rank of superintendent or above who is responsible for the police station for which the custody officer is acting as custody officer.

Detention after charge

46.—(1) Where a person—

(*a*) is charged with an offence; and

(*b*) after being charged—

(i) is kept in police detention; or

(ii) is detained by a local authority in pursuance of arrangements made under section 38(7) above,

he shall be brought before a magistrates' court in accordance with the provisions of this section.

(2) If he is to be brought before a magistrates' court for the petty sessions area in which the police station at which he was charged is situated, he shall be brought before such a court as soon as is practicable and in any event not later than the first sitting after he is charged with the offence.

(3) If no magistrates' court for that area is due to sit either on the day on which he is charged or on the next day, the custody officer for the police station at which he was charged shall inform the clerk to the justices for the area that there is a person in the area to whom subsection (2) above applies.

(4) If the person charged is to be brought before a magistrates' court for a petty sessions area other than that in which the police station at which he was charged is situated, he shall be removed to that area as soon as is practicable and brought before such a court as soon as is practicable after his arrival in the area and in any event not later than the first sitting of a magistrates' court for that area after his arrival in the area.

(5) If no magistrates' court for that area is due to sit either on the day on which he arrives in the area or on the next day—

(*a*) he shall be taken to a police station in the area; and

(*b*) the custody officer at that station shall inform the clerk to the justices for the area that there is a person in the area to whom subsection (4) applies.

(6) Subject to subsection (8) below, where a clerk to the justices for a petty sessions area has been informed—

(*a*) under subsection (3) above that there is a person in the area to whom subsection (2) above applies; or

(*b*) under subsection (5) above that there is a person in the area to whom subsection (4) above applies,

the clerk shall arrange for a magistrates' court to sit not later than the day next following the relevant day.

(7) In this section "the relevant day"—

(*a*) in relation to a person who is to be brought before a magistrates' court for the petty sessions area in which the police station at which he was charged is situated, means the day on which he was charged; and

(*b*) in relation to a person who is to be brought before a magistrates' court for any other petty sessions area, means the day on which he arrives in the area.

(8) Where the day next following the relevant day is Christmas Day, Good Friday or a Sunday, the duty of the clerk under subsection (6) above is a duty to arrange for a magistrates' court to sit not later than the first day after the relevant day which is not one of those days.

(9) Nothing in this section requires a person who is in hospital to be brought before a court if he is not well enough.

Children

52. This Part of this Act does not apply to a child (as for the time being defined for the purposes of the Children and Young Persons Act 1969) who is arrested without a warrant otherwise than for homicide and to whom section 28(4) and (5) of that Act accordingly apply.

PART V

QUESTIONING AND TREATMENT OF PERSONS BY POLICE

Right to have someone informed when arrested

56.—(1) Where a person has been arrested and is being held in custody in a police station or other premises, he shall be entitled, if he so requests, to have one friend or relative or other person who is known to him or who is likely to take an interest in his welfare told, as soon as is practicable except to the extent that delay is permitted by this section, that he has been arrested and is being detained there.

(2) Delay is only permitted—

(*a*) in the case of a person who is in police detention for a serious arrestable offence; and

(*b*) if an officer of at least the rank of superintendent authorises it.

(3) In any case the person in custody must be permitted to exercise the right conferred by subsection (1) above within 36 hours from the relevant time, as defined in section 41(2) above.

(4) An officer may give an authorisation under subsection (2) above orally or in writing but, if he gives it orally, he shall confirm it in writing as soon as is practicable.

(5) An officer may only authorise delay where he has reasonable grounds for believing that telling the named person of the arrest—

(*a*) will lead to interference with or harm to evidence connected with a serious arrestable offence or interference with or physical injury to other persons; or

(*b*) will lead to the alerting of other persons suspected of having committed such an offence but not yet arrested for it; or

(*c*) will hinder the recovery of any property obtained as a result of such an offence.

(6) If a delay is authorised—

(*a*) the detained person shall be told the reason for it; and

(*b*) the reason shall be noted on his custody record.

(7) The duties imposed by subsection (6) above shall be performed as soon as is practicable.

(8) The rights conferred by this section on a person detained at a police station or other premises are exercisable whenever he is transferred from one place to another, and this section applies to each subsequent occasion on which they are exercisable as it applies to the first such occasion.

(9) There may be no further delay in permitting the exercise of the right conferred by subsection (1) above once the reason for authorising delay ceases to subsist.

(10) In the foregoing provisions of this section references to a person who has been arrested include references to a person who has been detained under the terrorism provisions and "arrest" includes detention under those provisions.

(11) In its application to a person who has been arrested or detained under the terrorism provisions—

(*a*) subsection (2)(*a*) above shall have effect as if for the words "for a serious arrestable offence" there was substituted the words "under the terrorism provisions";

(*b*) subsection (3) above shall have effect as if for the words from "within" onwards there were substituted the words "before the end of the period beyond which he may no longer be detained without the authority of the Secretary of State"; and

(*c*) subsection (5) above shall have effect as if at the end there were added "or

(*d*) will lead to interference with the gathering of information about the commission, preparation or instigation of acts of terrorism; or

(*e*) by alerting any person, will make it more difficult—

(i) to prevent an act of terrorism; or

(ii) to secure the apprehension, prosecution or conviction of any person in connection with the commission, preparation or instigation of an act of terrorism.".

PART VI

CODES OF PRACTICE—GENERAL

Codes of practice

66. The Secretary of State shall issue codes of practice in connection with—

(*a*) the exercise by police officers of statutory powers—

(i) to search a person without first arresting him; or

(ii) to search a vehicle without making an arrest;

(*b*) the detention, treatment, questioning and identification of persons by police officers;

(*c*) searches of premises by police officers; and

(*d*) the seizure of property found by police officers on persons or premises.

OVERVIEW OF WAYS OF MANAGING THE PROPERTY AND AFFAIRS OF MENTALLY DISORDERED PERSONS

The aim of this diagram is to provide an overview and introduction to the many areas of law and problems involved. It is only a brief guide. It should not be relied upon too much because the categories and definitions are not as precise or complete as the following brief questions may suggest. Nevertheless they should act as a quick guide and checklist.

1. Is the client mentally disordered?

YES

- YES - 2a. Is he or she nevertheless still able to manage his or her property and affairs?

  NO

  - YES - 3a. Is he or she about to act in a way that will leave him or her with less money or property?

    NO

    - YES - 4a. Does he or she obtain a civil service or military pension?

      NO

      - YES - 5a. Does he or she obtain any social security?

        NO

        - YES - 6a. Are the client's finances and property relatively easy to collect together and administer and around £5,000 or less?

          NO

          Consider applying to the CoP for a receivership order. Note the medical and legal tests.

        - NO - Then approach the local DHSS to have an appointee appointed.

      - NO - Then ask the Paymaster General or Ministry of Defence to make it payable to someone else.

    - NO - Consider (a) applying for an emergency order from the Court of Protection, and (b) advising that other party that the client is mentally disordered so that the gift or contract may be invalid.

NO

- YES - 2b. Is there concern that he or she may become mentally disturbed?

  YES

  - YES - 3b. Does he or she want to and agree to having his or her property and finances reorganised so that he or she is likely to be able to manage even if mentally disordered?

    NO

    - YES - 4b. Does the client or someone else wish to create a trust for a trustee to adminster and 'own' the property?

      NO

      - YES - 5b. Does he or she wish to appoint someone to look after his or her property should he or she become mentally disordered?

        NO

        - YES - Then he or she should make an enduring power of attorney being careful to specify what he or she wants done.

        - NO - 6b. Then no action is appropriate although the client should be warned that if he or she becomes mentally disordered then any ordinary power of attorney will be invalid and an expensive application to the CoP may be necessary.

      - NO - Then make such arrangements but note that trust property often still belongs to the people it benefits when calculating their charges for Part III accommodation and supplementary benefit.

    - NO - Then make such arrangements. But also consider 4b.

- NO - Then no action seems necessary, though the client may wish to create an ordinary general power of attorney

PART I

APPLICATION OF ACT

Application of Act: "mental disorder"

1.—(1) The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.

(2) In this Act—

"mental disorder" means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind and "mentally disordered" shall be construed accordingly;

"severe mental impairment" means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "severely mentally impaired" shall be construed accordingly.

"mental impairment" means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned and "mentally impaired" shall be construed accordingly;

"psychopathic disorder" means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;

and other expressions shall have the meanings assigned to them in section 145 below.

(3) Nothing in subsection (2) above shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

Procedure for hospital admission

Admission for assessment

2.—(1) A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as "an application for admission for assessment") made in accordance with subsections (2) and (3) below.

(2) An application for admission for assessment may be made in respect of a patient on the grounds that—

(*a*) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

(*b*) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with.

(4) Subject to the provisions of section 29(4) below, a patient admitted to hospital in pursuance of an application for admission for assessment may be detained for a period not exceeding 28 days beginning with the day on which he is admitted, but shall not be detained after the expiration of that period unless before it has expired he has become liable to be detained by virtue of a subsequent application, order or direction under the following provisions of this Act.

Admission for treatment

3. (1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment) made in accordance with this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds that—

(*a*) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(*b*) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and

(*c*) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section.

(3) An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include—

(*a*) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (*a*) and (*b*) of that subsection; and

(*b*) a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (*c*) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

Admission for assessment in cases of emergency

4. (1) In any case of urgent necessity, an application for admission for assessment may be made in respect of a patient in accordance with the following provisions of this section, and any application so made is in this Act referred to as "an emergency application".

(2) An emergency application may be made either by an approved social worker or by the nearest relative of the patient; and every such application shall include a statement that it is of urgent necessity for the patient to be admitted and detained under section 2 above, and that compliance with the provisions of this Part of this Act relating to applications under that section would involve undesirable delay.

(3) An emergency application shall be sufficient in the first instance if founded on one of the medical recommendations required by section 2 above, given, if practicable, by a practitioner who has previous acquaintance with the patient and otherwise complying with the requirements of section 12 below so far as applicable to a single recommendation, and verifying the statement referred to in subsection (2) above.

(4) An emergency application shall cease to have effect on the expiration of a period of 72 hours from the time when the patient is admitted to the hospital unless—

(*a*) the second medical recommendation required by section 2 above is given and received by the managers within that period; and

(*b*) that recommendation and the recommendation referred to in subsection (3) above together comply with all the requirements of section 12 below (other than the requirement as to the time of signature of the second recommendation).

(5) In relation to an emergency application, section 11 below shall have effect as if in subsection (5) of that section for the words "the period of 14 days ending with the date of the application"there were substituted the words "the previous 24 hours".

Application in respect of patient already in hospital

5.—(1) An application for the admission of a patient to a hospital may be made under this Part of this Act notwithstanding that the patient is already an in-patient in that hospital or, in the case of an application for admission for treatment that the patient is for the time being liable to be detained in the hospital in pursuance of an application for admission for assessment; and where an application is so made the patient shall be treated for the purposes of this Part of this Act as if he had been admitted to the hospital at the time when that application was received by the managers.

(2) If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner in charge of the treatment of the patient that an application ought to be made under this Part of this Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished.

(3) The registered medical practitioner in charge of the treatment of a patient in a hospital may nominate one (but not more than one) other registered medical practitioner on the staff of that hospital to act for him under subsection (2) above in his absence.

(4) If, in the case of a patient who is receiving treatment for mental disorder as an in-patient in a hospital, it appears to a nurse of the prescribed class—

(*a*) that the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital; and

(*b*) that it is not practicable to secure the immediate attendance of a practitioner for the purpose of furnishing a report under subsection (2) above,

the nurse may record that fact in writing; and in that event the patient may be detained in the hospital for a period of six hours from the time when that fact is so recorded or until the earlier arrival at the place where the patient is detained of a practitioner having power to furnish a report under that subsection.

(5) A record made under subsection (4) above shall be delivered by the nurse (or by a person authorised by the nurse in that behalf) to the managers of the hospital as soon as possible after it is made; and where a record is made under that subsection the period mentioned in subsection (2) above shall begin at the time when it is made.

(6) The reference in subsection (1) above to an in-patient does not include an in-patient who is liable to be detained in pursuance of an application under this Part of this Act and the references in subsections (2) and (4) above do not include an in-patient who is liable to be detained in a hospital under this Part of this Act.

(7) In subsection (4) above "prescribed" means prescribed by an order made by the Secretary of State.

Guardianship

Application for guardianship

7.—(1) A patient who has attained the age of 16 years may be received into guardianship, for the period allowed by the following provisions of this Act, in pursuance of an application (in this Act referred to as "a guardianship application") made in accordance with this section.

(2) A guardianship application may be made in respect of a patient on the grounds that—

(*a*) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which warrants his reception into guardianship under this section; and

(*b*) it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received.

(3) A guardianship application shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include—

(*a*) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraph (*a*) of that subsection; and

(*b*) a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (*b*) of that subsection.

(4) A guardianship application shall state the age of the patient or, if his exact age is not known to the applicant, shall state (if it be the fact) that the patient is believed to have attained the age of 16 years.

(5) The person named as guardian in a guardianship application may be either a local social services authority or any other person (including the applicant himself); but a guardianship application in which a person other than a local social services authority is named as guardian shall be of no effect unless it is accepted on behalf of that person by the local social services authority for the area in which he resides, and shall be accompanied by a statement in writing by that person that he is willing to act as guardian.

Effect of guardianship application, etc.

8.—(1) Where a guardianship application, duly made under the provisions of this Part of this Act and forwarded to the local social services authority within the period allowed by subsection (2) below is accepted by that authority, the application shall, subject to regulations made by the Secretary of State, confer on the authority or person named in the application as guardian, to the exclusion of any other person—

(*a*) the power to require the patient to reside at a place specified by the authority or person named as guardian;

(*b*) the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training;

(*c*) the power to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved social worker or other person so specified.

(2) The period within which a guardianship application is required for the purposes of this section to be forwarded to the local social services authority is the period of 14 days beginning with the date on which the patient was last examined by a registered medical practitioner before giving a medical recommendation for the purposes of the application.

(3) A guardianship application which appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendation is made or given, or of any matter of fact or opinion stated in the application.

(4) If within the period of 14 days beginning with the day on which a guardianship application has been accepted by the local social services authority the application, or any medical recommendation given for the purposes of the application, is found to be in any respect incorrect or defective, the application or recommendation may, within that period and with the consent of that authority, be amended by the person by whom it was signed; and upon such amendment being made the application or recommendation shall have effect and shall be deemed to have had effect as if it had been originally made as so amended.

(5) Where a patient is received into guardianship in pursuance of a guardianship application, any previous application under this Part of this Act by virtue of which he was subject to guardianship or liable to be detained in a hospital shall cease to have effect.

Regulations as to guardianship

9.—(1) Subject to the provisions of this Part of this Act, the Secretary of State may make regulations—

(*a*) for regulating the exercise by the guardians of patients received into guardianship under this Part of this Act of their powers as such; and

(*b*) for imposing on such guardians, and upon local social services authorities in the case of patients under the guardianship of persons other than local social services authorities, such duties as he considers necessary or expedient in the interests of the patients.

(2) Regulations under this section may in particular make provision for requiring the patients to be visited, on such occasions or at such intervals as may be prescribed by the regulations, on behalf of such local social services authorities as may be so prescribed, and shall provide for the appointment, in the case of every patient subject to the guardianship of a person other than a local social services authority, of a registered medical practitioner to act as the nominated medical attendant of the patient.

Duty of approved social workers to make applications for admission or guardianship

13.—(1) It shall be the duty of an approved social worker to make an application for admission to hospital or a guardianship application in respect of a patient within the area of the local social services authority by which that officer is appointed in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him.

(2) Before making an application for the admission of a patient to hospital an approved social worker shall interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

(3) An application under this section by an approved social worker may be made outside the area of the local social services authority by which he is appointed.

(4) It shall be the duty of a local social services authority, if so required by the nearest relative of a patient residing in their area, to direct an approved social worker as soon as practicable to take the patient's case into consideration under subsection (1) above with a view to making an application for his admission to hospital; and if in any such case that approved social worker decides not to make an application he shall inform the nearest relative of his reasons in writing.

(5) Nothing in this section shall be construed as authorising or requiring an application to be made by an approved social worker in contravention of the provisions of section 11(4) above, or as restricting the power of an approved social worker to make any application under this Act.

Hospital and guardianship orders

Powers of courts to order hospital admission or guardianship

37.—(1) Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law, or is convicted by a magistrates' court of an offence punishable on summary conviction with imprisonment, and the conditions mentioned in subsection (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order or, as the case may be, place him under the guardianship of a local social services authority or of such other person approved by a local social services authority as may be so specified.

(2) The conditions referred to in subsection (1) above are that—

(*a*) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment and that either—

(i) the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition; or

(ii) in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and

(*b*) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section.

(3) Where a person is charged before a magistrates' court with any act or omission as an offence and the court would have power, on convicting him of that offence, to make an order under subsection (1) above in his case as being a person suffering from mental illness or severe mental impairment, then, if the court is satisfied that the accused did the act or made the omission charged, the court may, if it thinks fit, make such an order without convicting him.

(4) An order for the admission of an offender to a hospital (in this Act referred to as "a hospital order") shall not be made under this section unless the court is satisfied on the written or oral evidence of the registered medical practitioner who would be in charge of his treatment or of some other person representing the managers of the hospital that arrangements have been made for his admission to that hospital in the event of such an order being made by the court, and for his admission to it within the period of 28 days beginning with the date of the making of such an order; and the court may, pending his admission within that period, give such directions as it thinks fit for his conveyance to and detention in a place of safety.

(5) If within the said period of 28 days it appears to the Secretary of State that by reason of an emergency or other special circumstances it is not practicable for the patient to be received into the hospital specified in the order, he may give directions for the admission of the patient to such other hospital as appears to be appropriate instead of the hospital so specified; and where such directions are given—

(*a*) the Secretary of State shall cause the person having the custody of the patient to be informed, and

(*b*) the hospital order shall have effect as if the hospital specified in the directions were substituted for the hospital specified in the order.

(6) An order placing an offender under the guardianship of a local social services authority or of any other person (in this Act referred to as "a guardianship order") shall not be made under this section unless the court is satisfied that that authority or person is willing to receive the offender into guardianship.

(7) A hospital order or guardianship order shall specify the form or forms of mental disorder referred to in subsection (2)(*a*) above from which, upon the evidence taken into account under that subsection, the offender is found by the court to be suffering; and no such order shall be made unless the offender is described by each of the practitioners whose evidence is taken into account under that subsection as suffering from the same one of those forms of mental disorder, whether or not he is also described by either of them as suffering from another of them.

(8) Where an order is made under this section, the court shall not pass sentence of imprisonment or impose a fine or make a probation order in respect of the offence or make any such order as is mentioned in paragraph (*b*) or (*c*) of section 7(7) of the Children and Young Persons Act 1969 in respect of the offender, but may make any other order which the court has power to make apart from this section; and for the purposes of this subsection "sentence of imprisonment" includes any sentence or order for detention.

Judicial authorities and Court of Protection

93.—(1) The Lord Chancellor shall from time to time nominate one or more judges of the Supreme Court (in this Act referred to as "nominated judges") to act for the purposes of this Part of this Act.

(2) There shall continue to be an office of the Supreme Court, called the Court of Protection, for the protection and management, as provided by this Part of this Act, of the property and affairs of persons under disability; and there shall continue to be a Master of the Court of Protection appointed by the Lord Chancellor under section 89 of the Supreme Court Act 1981.

(3) The Master of the Court of Protection shall take the oath of allegiance and judicial oath in the presence of the Lord Chancellor; and the Promissory Oaths Act 1868 shall have effect as if the officers named in the Second Part of the Schedule to that Act included the Master of the Court of Protection.

(4) The Lord Chancellor may nominate other officers of the Court of Protection (in this Part of this Act referred to as "nominated officers") to act for the purposes of this Part of this Act.

Exercise of the judge's functions: "the patient"

94.—(1) [Subject to subsection 1A below] the functions expressed to be conferred by this Part of this Act on the judge shall be exercisable by the Lord Chancellor or by any nominated judge, and shall also be exercisable by the Master of the Court of Protection [, by the Public Trustee] or by any nominated officer, but—

(*a*) in the case of the Master [, the Public Trustee] or any nominated officer, subject to any express provision to the contrary in this Part of this Act or any rules made under this Part of this Act,

[(*aa*) in the case of the Public Trustee, subject to any directions of the Master and so far only as may be provided by any rules made under this Part of this Act or (subject to any such rules) by directions of the Master,]

(*b*) in the case of any nominated officer, subject to any directions of the Master and so far only as may be provided by the instrument by which he is nominated;

and references in this Part of this Act to the judge shall be construed accordingly.

[(1A) In such cases or circumstances as may be prescribed by any rules under this Part of this Act or (subject to any such rules) by directions of the Master, the functions of the judge under this Part of this Act shall be exercised by the Public Trustee (but subject to any directions of the Master as to their exercise)].

(2) The functions of the judge under this Part of this Act shall be exercisable where, after considering medical evidence, he is satisfied that a person is incapable, by reason of mental disorder, of managing and administering his property and affairs; and a person as to whom the judge is so satisfied is referred to in this Part of this Act as a patient.

General functions of the judge with respect to property and affairs of patient

95.—(1) The judge may, with respect to the property and affairs of a patient, do or secure the doing of all such things as appear necessary or expedient—

(*a*) for the maintenance or other benefit of the patient,

(*b*) for the maintenance or other benefit of members of the patient's family,

(*c*) for making provision for other persons or purposes for whom or which the patient might be expected to provide if he were not mentally disordered, or

(*d*) otherwise for administering the patient's affairs.

(2) In the exercise of the powers conferred by this section regard shall be had first of all to the requirements of the patient, and the rules of law which restricted the enforcement by a creditor of rights against property under the control of the judge in lunacy shall apply to property under the control of the judge; but, subject to the foregoing provisions of this subsection, the judge shall, in administering a patient's affairs, have regard to the interests of creditors and also to the desirability of making provision for obligations of the patient notwithstanding that they may not be legally enforceable.

Powers of the judge as to patient's property and affairs

96.—(1) Without prejudice to the generality of section 95 above, the judge shall have power to make such orders and give such directions and authorities as he thinks fit for the purposes of that section and in particular may for those purposes make orders or give directions or authorities for—

(*a*) the control (with or without the transfer or vesting of property or the payment into or lodgment in the Supreme Court of money or securities) and management of any property of the patient;

(*b*) the sale, exchange, charging or other disposition of or dealing with any property of the patient;

(*c*) the acquisition of any property in the name or on behalf of the patient;

(*d*) the settlement of any property of the patient, or the gift of any property of the patient to any such persons or for any such purposes as are mentioned in paragraphs (*b*) and (*c*) of section 95(1) above;

(*e*) the execution for the patient of a will making any provision (whether by way of disposing of property or exercising a power or otherwise) which could be made by a will executed by the patient if he were not mentally disordered;

(*f*) the carrying on by a suitable person of any profession, trade or business of the patient;

(*g*) the dissolution of a partnership of which the patient is a member;

(*h*) the carrying out of any contract entered into by the patient;

(*i*) the conduct of legal proceedings in the name of the patient or on his behalf;

(*j*) the reimbursement out of the property of the patient, with or without interest, of money applied by any person either in payment of the patient's debts (whether legally enforceable or not) or for the maintenance or other benefit of the patient or members of his family or in making provision for other persons or purposes for whom or which he might be expected to provide if he were not mentally disordered;

(*k*) the exercise of any power (including a power to consent) vested in the patient, whether beneficially, or as guardian or trustee, or otherwise.

(2) If under subsection (1) above provision is made for the settlement of any property of a patient, or the exercise of a power vested in a patient of appointing trustees or retiring from a trust, the judge may also make as respects the property settled or trust property such consequential vesting or other orders as the case may require, including (in the case of the exercise of such a power) any order which could have been made in such a case under Part IV of the Trustee Act 1925.

(3) Where under this section a settlement has been made of any property of a patient, and the Lord Chancellor or a nominated judge is satisfied, at any time before the death of the patient, that any material fact was not disclosed when the settlement was made, or that there has been any substantial change in circumstances, he may by order vary the settlement in such manner as he thinks fit, and give any consequential directions.

(4) The power of the judge to make or give an order, direction or authority for the execution of a will for a patient—

(*a*) shall not be exercisable at any time when the patient is a minor, and

(*b*) shall not be exercised unless the judge has reason to believe that the patient is incapable of making a valid will for himself.

(5) The powers of a patient as patron of a benefice shall be exercisable by the Lord Chancellor only.

Supplementary provisions as to wills executed under s.96

97.—(1) Where under section 96(1) above the judge makes or gives an order, direction or authority requiring or authorising a person (in this section referred to as "the authorised person") to execute a will for a patient, any will executed in pursuance of that order, direction authority shall be expressed to be signed by the patient acting by the authorised person, and shall be—

(*a*) signed by the authorised person with the name of the patient, and with his own name, in the presence of two or more witnesses present at the same time, and

(*b*) attested and subscribed by those witnesses in the presence of the authorised person, and

(*c*) sealed with the official seal of the Court of Protection.

(2) The Wills Act 1837 shall have effect in relation to any such will as if it were signed by the patient by his own hand, except that in relation to any such will—

(*a*) section 9 of that Act (which makes provision as to the signing and attestation of wills) shall not apply, and

(*b*) in the subsequent provisions of that Act any reference to execution in the manner required by the previous provisions of that Act shall be construed as a reference to execution in the manner required by subsection (1) above.

(3) Subject to the following provisions of this section, any such will executed in accordance with subsection (1) above shall have the same effect for all purposes as if the patient were capable of making a valid will and the will had been executed by him in the manner required by the Wills Act 1837.

(4) So much of subsection (3) above as provides for such a will to have effect as if the patient were capable of making a valid will—

(*a*) shall not have effect in relation to such a will in so far as it disposes of any immovable property, other than immovable property in England or Wales, and

(*b*) where at the time when such a will is executed the patient is domiciled in Scotland or Northern Ireland or in a country or territory outside the United Kingdom, shall not have effect in relation to that will in so far as it relates to any other property or matter, except any property or matter in respect of which, under the law of his domicile, any question of his testamentary capacity would fall to be determined in accordance with the law of England and Wales.

Judge's powers in cases of emergency

98. Where it is represented to the judge, and he has reason to believe, that a person may be incapable, by reason of mental disorder, of managing and administering his property and affairs, and the judge is of the opinion that it is necessary to make immediate provision for any of the matters referred to in section 95 above, then pending the determination of the question whether that person is so incapable the judge may exercise in relation to the property and affairs of that person any of the powers conferred on him in relation to the property and affairs of a patient by this Part of this Act so far as is requisite for enabling that provision to be made.

Power to appoint receiver

99.—(1) The judge may by order appoint as receiver for a patient a person specified in the order or the holder for the time being of an office so specified.

(2) A person appointed as receiver for a patient shall do all such things in relation to the property and affairs of the patient as the judge, in the exercise of the powers conferred on him by sections 95 and 96 above, orders or directs him to do and may do any such thing in relation to the property and affairs of the patient as the judge, in the exercise of those powers, authorises him to do.

(3) A receiver appointed for any person shall be discharged by order of the judge on the judge being satisfied that that person has become capable of managing and administering his property and affairs, and may be discharged by order of the judge at any time if the judge considers it expedient to do so; and a receiver shall be discharged (without any order) on the death of the patient.

Vesting of stock in curator appointed outside England and Wales

100.—(1) Where the judge is satisfied—

(*a*) that under the law prevailing in a place outside England and Wales a person has been appointed to exercise powers with respect to the property or affairs of any other person on the ground (however formulated) that that other person is incapable, by reason of mental disorder, of managing and administering his property and affairs, and

(*b*) that having regard to the nature of the appointment and to the circumstances of the case it is expedient that the judge should exercise his powers under this section,

the judge may direct any stock standing in the name of the said other person or the right to receive the dividends from the stock to be transferred into the name of the person so appointed or otherwise dealt with as requested by that person, and may give such directions as the judge thinks fit for dealing with accrued dividends from the stock.

(2) In this section "stock" includes shares and also any fund, annuity or security transferable in the books kept by any body corporate or unincorporated company or society, or by an instrument of transfer either alone or accompanied by other formalities, and "dividends" shall be construed accordingly.

Preservation of interests in patient's property

101.—(1) Where any property of a person has been disposed of under this Part of this Act, and under his will or his intestacy, or by any gift perfected or nomination taking effect on his death, any other person would have taken an interest in the property but for the disposal—

(*a*) he shall take the same interest, if and so far as circumstances allow, in any property belonging to the estate of the deceased which represents the property disposed of; and

(*b*) if the property disposed of was real property any property representing it shall so long as it remains part of his estate be treated as if it were real property.

(2) The judge, in ordering, directing or authorising under this Part of this Act any disposal of property which apart from this section would result in the conversion of personal property into real property, may direct that the property representing the property disposed of shall, so long as it remains the property of the patient or forms part of his estate, be treated as if it were personal property.

(3) References in subsections (1) and (2) above to the disposal of property are references to—

(*a*) the sale, exchange, charging or other dealing (otherwise than by will) with property other than money,

(*b*) the removal of property from one place to another,

(*c*) the application of money in acquiring property, or

(*d*) the transfer of money from one account to another;

and references to property representing property disposed of shall be construed accordingly and as including the result of successive disposals.

(4) The judge may give such directions as appear to him necessary or expedient for the purpose of facilitating the operation of subsection (1) above, including the carrying of money to a separate account and the transfer of property other than money.

(5) Where the judge has ordered, directed or authorised the expenditure of money for the carrying out of permanent improvements on, or otherwise for the permanent benefit of, any property of the patient, he may order that the whole or any part of the money expended or to be expended shall be a charge upon the property, whether without interest or with interest at a specified rate; and an order under this subsection may provide for excluding or restricting the operation of subsection (1) above.

(6) A charge under subsection (5) above may be made in favour of such person as may be just, and in particular, where the money charged is paid out of the patient's general estate, may be made in favour of a person as trustee for the patient; but no charge under that subsection shall confer any right of sale or foreclosure during the lifetime of the patient.

Lord Chancellor's Visitors

102.—(1) There shall continue to be the following panels of Lord Chancellor's Visitors of patients constituted in accordance with this section, namely—

(*a*) a panel of Medical Visitors;
(*b*) a panel of Legal Visitors; and
(*c*) a panel of General Visitors (being Visitors who are not required by this section to possess either a medical or legal qualification for appointment).

(2) Each panel shall consist of persons appointed to it by the Lord Chancellor, the appointment of each person being for such term and subject to such conditions as the Lord Chancellor may determine.

(3) A person shall not be qualified to be appointed—

(*a*) to the panel of Medical Visitors unless he is a registered medical practitioner who appears to the Lord Chancellor to have special knowledge and experience of cases of mental disorder;
(*b*) to the panel of Legal Visitors unless he is a barrister or solicitor of not less than 10 years' standing.

(4) If the Lord Chancellor so determines in the case of any Visitor appointed under this section, he shall be paid out of money provided by Parliament such remuneration and allowances as the Lord Chancellor may, with the concurrence of the Treasury, determine.

Functions of Visitors

103.—(1) Patients shall be visited by Lord Chancellor's Visitors in such circumstances, and in such manner, as may be prescribed by directions of a standing nature given by the Master of the Court of Protection with the concurrence of the Lord Chancellor.

(2) Where it appears to the judge in the case of any patient that a visit by a Lord Chancellor's Visitor is necessary for the purpose of investigating any particular matter or matters relating to the capacity of the patient to manage and administer his property and affairs, or otherwise relating to the exercise in relation to him of the functions of the judge under this Part of this Act, the judge may order that the patient shall be visited for that purpose.

(3) Every visit falling to be made under subsection (1) or (2) above shall be made by a General Visitor unless, in a case where it appears to the judge that it is in the circumstances essential for the visit to be made by a Visitor with medical or legal qualifications, the judge directs that the visit shall be made by a Medical or a Legal Visitor.

(4) A Visitor making a visit under this section shall make such report on the visit as the judge may direct.

(5) A Visitor making a visit under this section may interview the patient in private.

(6) A Medical Visitor making a visit under this section may carry out in private a medical examination of the patient and may require the production of and inspect any medical records relating to the patient.

(7) The Master of the Court of Protection may visit any patient for the purpose mentioned in subsection (2) above and may interview the patient in private.

(8) A report made by a Visitor under this section, and information contained in such a report, shall not be disclosed except to the judge and any person authorised by the judge to receive the disclosure.

(9) If any person discloses any report or information in contravention of subsection (8) above, he shall be guilty of an offence and liable on summary conviction to imprisonment for a term not exceeding three months or to a fine not exceeding level 3 on the standard scale or both.

(10) In this section references to patients include references to persons alleged to be incapable, by reason of mental disorder, of managing and administering their property and affairs.

General powers of the judge with respect to proceedings

104.—(1) For the purposes of any proceedings before him with respect to persons suffering or alleged to be suffering from mental disorder, the judge shall have the same powers as are vested in the High Court in respect of securing the attendance of witnesses and the production of documents.

(2) Subject to the provisions of this section, any act or omission in the course of such proceedings which, if occurring in the course of proceedings in the High Court would have been a contempt of the Court, shall be punishable by the judge in any manner in which it could have been punished by the High Court.

(3) Subsection (2) above shall not authorise the Master, or any other officer of the Court of Protection to exercise any power of attachment or committal, but the Master or officer may certify any such act or omission to the Lord Chancellor or a nominated judge, and the Lord Chancellor or judge may upon such certification inquire into the alleged act or omission and take any such action in relation to it as he could have taken if the proceedings had been before him.

(4) Subsections (1) to (4) of section 36 of the Supreme Court Act 1981 (which provides a special procedure for the issue of writs of subpoena ad testificandum and duces tecum so as to be enforceable throughout the United Kingdom) shall apply in relation to proceedings under this Part of this Act with the substitution for references to the High Court of references to the judge and for references to such writs of references to such document as may be prescribed by rules under this Part of this Act for issue by the judge for securing the attendance of witnesses or the production of documents.

Appeals

105.—(1) Subject to and in accordance with rules under this Part of this Act, an appeal shall lie to a nominated judge from any decision of the Master of the Court of Protection or any nominated officer.

(2) The Court of Appeal shall continue to have the same jurisdiction as to appeals from any decision of the Lord Chancellor or from any decision of a nominated judge, whether given in the exercise of his original jurisdiction or on the hearing of an appeal under subsection (1) above, as they had immediately before the coming into operation of Part VIII of the Mental Health Act 1959 as to appeals from orders in lunacy made by the Lord Chancellor or any other person having jurisdiction in lunacy.

Rules of procedure

106.—(1) Proceedings before the judge with respect to persons suffering or alleged to be suffering from mental disorder (in this section referred to as "proceedings") shall be conducted in accordance with the provisions of rules made under this Part of this Act.

(2) Rules under this Part of this Act may make provision as to—

(*a*) the carrying out of preliminary or incidental inquiries;

(*b*) the persons by whom and manner in which proceedings may be instituted and carried on;

(*c*) the persons who are to be entitled to be notified of, to attend, or to take part in proceedings;

(*d*) the evidence which may be authorised or required to be given in proceedings and the manner (whether on oath or otherwise and whether orally or in writing) in which it is to be given;

(*e*) the administration of oaths and taking of affidavits for the purposes of proceedings; and

(*f*) the enforcement of orders made and directions given in proceedings.

(3) Without prejudice to the provisions of section 104(1) above, rules under this Part of this Act may make provision for authorising or requiring the attendance and examination of persons suffering or alleged to be suffering from mental disorder, the furnishing of information and the production of documents.

(4) Rules under this Part of this Act may make provision as to the termination of proceedings, whether on the death or recovery of the person to whom the proceedings relate or otherwise, and for the exercise, pending the termination of the proceedings, of powers exercisable under this Part of this Act in relation to the property or affairs of a patient.

(5) Rules under this Part of this Act made with the consent of the Treasury may—

(*a*) make provision as to the scale of costs, fees and percentages payable in relation to proceedings, and as to the manner in which and funds out of which such costs, fees and percentages are to be paid;

(*b*) contain provision for charging any percentage upon the estate of the person to whom the proceedings relate and for the payment of costs, fees and percentages within such time after the death of the person to whom the proceedings relate or the termination of the proceedings as may be provided by the rules; and

(*c*) provide for the remission of fees and percentages.

(6) A charge upon the estate of a person created by virtue of subsection (5) above shall not cause any interest of that person in any property to fail or determine or to be prevented from recommencing.

(7) Rules under this Part of this Act may authorise the making of orders for the payment of costs to or by persons attending, as well as persons taking part in, proceedings.

Security and accounts

107.—(1) Rules under this Part of this Act may make provision as to the giving of security by a receiver and as to the enforcement and discharge of the security.

(2) It shall be the duty of a receiver to render accounts in accordance with the requirements of rules under this Part of this Act, as well after his discharge as during his receivership; and rules under this Part of this Act may make provision for the rendering of accounts by persons other than receivers who are ordered, directed or authorised under this Part of this Act to carry out any transaction.

General provisions as to rules under Part VII

108.—(1) Any power to make rules conferred by this Part of this Act shall be exercisable by the Lord Chancellor.

(2) Rules under this Part of this Act may contain such incidental and supplemental provisions as appear requisite for the purposes of the rules.

Effect and proof of orders, etc.

109.—(1) Section 204 of the Law of Property Act 1925 (by which orders of the High Court are made conclusive in favour of purchasers) shall apply in relation to orders made and directions and authorities given by the judge as it applies in relation to orders of the High Court.

(2) Office copies of orders made, directions or authorities given or other instruments issued by the judge and sealed with the official seal of the Court of Protection shall be admissible in all legal proceedings as evidence of the originals without any further proof.

Reciprocal arrangements in relation to Scotland and Northern Ireland as to exercise of powers.

110.—(1) This Part of this Act shall apply in relation to the property and affairs in Scotland or Northern Ireland of a patient in relation to whom powers have been exercised under this Part of this Act, or a person as to whom powers are exercisable and have been exercised under section 98 above as it applies in relation to his property and affairs in England and Wales [unless—

(*a*) in Scotland, a curator bonis, tutor or judicial factor has been appointed for him; or

(*b*) in Northern Ireland, he is a patient in relation to whom powers have been exercised under Part VIII of the Mental Health (Northern Ireland) Order 1986, or a person as to whom powers are exercisable and have been exercised under Article 97(2) of that Order.]

(2) Where under the law in force in Scotland [. . .] with respect to the property and affairs of persons suffering from mental disorder a curator bonis, tutor, [or judicial factor] has been appointed for any person, the provisions of that law shall apply in relation to that person's property and affairs in England and Wales unless he is a patient in relation to whom powers have been exercised under this Part of this Act, or a person as to whom powers are exercisable and have been exercised under section 98 above.

[(2A) Part VIII of the Mental Health (Northern Ireland) Order 1986 shall apply in relation to the property and affairs in England and Wales of a patient in relation to whom powers have been exercised under that Part, or a person as to whom powers are exercisable and have been exercised under Article 97(2) of that Order as it applies in relation to his property and affairs in Northern Ireland unless he is a patient in relation to whom powers have been exercised under this Part of this Act, or a person as to whom powers are exercisable and have been exercised under section 98 above.]

(3) Nothing in this section shall affect any power to execute a will under section 96(1)(*e*) above [or Article 99(1)(e) of the Mental Health (Northern Ireland) Order 1986] or the effect of any will executed in the exercise of such a power.

(4) In this section references to property do not include references to land or interests in land but this subsection shall not prevent the receipt of rent or other income arising from land or interests in land.

Construction of references in other Acts to judge or authority having jurisdiction under Part VII

111.—(1) The functions expressed to be conferred by any enactment not contained in this Part of this Act on the judge having jurisdiction under this Part of this Act shall be exercisable by the Lord Chancellor or by a nominated judge.

(2) Subject to subsection (3) [and (3A)] below, the functions expressed to be conferred by any such enactment on the authority having jurisdiction under this Part of this Act shall, subject to any express provision to the contrary, be exercisable by the Lord Chancellor, a nominated judge, the Master of the Court of Protection [, by the Public Trustee] or a nominated officer.

[(2A) The exercise of the functions referred to in subsection (2) above by the Public Trustee shall be subject to any directions of the Master and they shall be exercisable so far only as may be provided by any rules made under this Part of this Act or (subject to any such rules) by directions of the Master.]

(3) The exercise of the functions referred to in subsection (2) above by a nominated officer shall be subject to any directions of the Master and they shall be exercisable so far only as may be provided by the instrument by which the officer is nominated.

[(3A) In such cases or circumstances as may be prescribed by any rules under this Part of this Act or (subject to any such rules) by directions of the Master, the functions referred to in subsection (2) above shall be exercised by the Public Trustee (but subject to any directions of the Master as to their exercise).]

(4) Subject to the foregoing provisions of this section—

(*a*) references in any enactment not contained in this Part of this Act to the judge having jurisdiction under this Part of this Act shall be construed as references to the Lord Chancellor or a nominated judge, and

(*b*) references in any such enactment to the authority having jurisdiction under this Part of this Act shall be construed as references to the Lord Chancellor, a nominated judge, the Master of the Court of Protection or a nominated officer.

Interpretation of Part VII

112. In this Part of this Act, unless the context otherwise requires—

"nominated judge" means a judge nominated in pursuance of subsection (1) of section 93 above;

"nominated officer" means an officer nominated in pursuance of subsection (4) of that section;

"patient" has the meaning assigned to it by section 94 above;

"property" includes any thing in action, and any interest in real or personal property;

"the judge" shall be construed in accordance with section 94 above;

"will" includes a codicil.

Disapplication of certain enactments in relation to persons within the jurisdiction of the judge

113. The provisions of the Acts described in Schedule 3 to this Act which are specified in the third column of that Schedule, so far as they make special provision for persons suffering from mental disorder, shall not have effect in relation to patients and to persons as to whom powers are exercisable and have been exercised under section 98 above.

Correspondence of patients

134.—(1) A postal packet addressed to any person by a patient detained in a hospital under this Act and delivered by the patient for dispatch may be withheld from the Post Office—

(*a*) if that person has requested that communications addressed to him by the patient should be withheld; or

(*b*) subject to subsection (3) below, if the hospital is a special hospital and the managers of the hospital consider that the postal packet is likely—

(i) to cause distress to the person to whom it is addressed or to any other person (not being a person on the staff of the hospital); or

(ii) to cause danger to any person;

and any request for the purposes of paragraph (*a*) above shall be made by a notice in writing given to the managers of the hospital, the registered medical practitioner in charge of the treatment of the patient or the Secretary of State.

(2) Subject to subsection (3) below, a postal packet addressed to a patient detained in a special hospital under this Act may be withheld from the patient if, in the opinion of the managers of the hospital, it is necessary to do so in the interests of the safety of the patient or for the protection of other persons.

(3) Subsections (1)(*b*) and (2) above do not apply to any postal packet addressed by a patient to, or sent to a patient by or on behalf of—

(*a*) any Minister of the Crown or Member of either House of Parliament;

(*b*) the Master or any other officer of the Court of Protection or any of the Lord Chancellor's Visitors;

(*c*) the Parliamentary Commissioner for Administration, the Health Service Commissioner for England, the Health Service Commissioner for Wales or a Local Commissioner within the meaning of Part III of the Local Government Act 1974;

(*d*) a Mental Health Review Tribunal;

(*e*) a health authority within the meaning of the National Health Service Act 1977, a local social services authority, a Community Health Council or a probation and after-care committee appointed under paragraph 2 of Schedule 3 to the Powers of Criminal Courts Act 1973;

(*f*) the managers of the hospital in which the patient is detained;

(*g*) any legally qualified person instructed by the patient to act as his legal adviser; or

(*h*) the European Commission of Human Rights or the European Court of Human Rights.

(4) The managers of a hospital may inspect and open any postal packet for the purposes of determining—

(*a*) whether it is one to which subsection (1) or (2) applies, and

(*b*) in the case of a postal packet to which subsection (1) or (2) above applies, whether or not it should be withheld under that subsection;

and the power to withhold a postal packet under either of those subsections includes power to withhold anything contained in it.

(5) Where a postal packet or anything contained in it is withheld under subsection (1) or (2) above the managers of the hospital shall record that fact in writing.

(6) Where a postal packet or anything contained in it is withheld under subsection (1)(*b*) or (2) above the managers of the hospital shall within seven days give notice of that fact to the patient and, in the case of a packet withheld under subsection (2) above, to the person (if known) by whom the postal packet was sent; and any such notice shall be given in writing and shall contain a statement of the effect of section 121(7) and (8) above.

(7) The functions of the managers of a hospital under this section shall be discharged on their behalf by a person on the staff of the hospital appointed by them for that purpose and different persons may be appointed to discharge different functions.

(8) The Secretary of State may make regulations with respect to the exercise of the powers conferred by this section.

(9) In this section "hospital" has the same meaning as in Part II of this Act, "postal packet" has the same meaning as in the Post Office Act 1953 and the provisions of this section shall have effect notwithstanding anything in section 56 of that Act.

Warrant to search for and remove patients

135.—(1) If it appears to a justice of the peace, on information on oath laid by an approved social worker, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder—

(*a*) has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or

(*b*) being unable to care for himself, is living alone in any such place,

the justice may issue a warrant authorising any constable [. . .] to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.

(2) If it appears to a justice of the peace, on information on oath laid by any constable or other person who is authorised by or under this Act or under section 83 of the [Mental Health (Scotland) Act 1984] to take a patient to any place, or to take into custody or retake a patient who is liable under this Act or under the said section 83 to be so taken or retaken—

(*a*) that there is reasonable cause to believe that the patient is to be found on premises within the jurisdiction of the justice; and

(*b*) that admission to the premises has been refused or that a refusal of such admission is apprehended,

the justice may issue a warrant authorising any constable [. . .] to enter the premises, if need be by force, and remove the patient.

(3) A patient who is removed to a place of safety in the execution of a warrant issued under this section may be detained there for a period not exceeding 72 hours.

(4) In the execution of a warrant issued under subsection (1) above, [a constable] shall be accompanied by an approved social worker and by a registered medical practitioner, and in the execution of a warrant issued under subsection (2) above [a constable] may be accompanied—

(*a*) by a registered medical practitioner;

(*b*) by any person authorised by or under this Act or under section 83 of the [Mental Health (Scotland) Act 1984] to take or retake the patient.

(5) It shall not be necessary in any information or warrant under subsection (1) above to name the patient concerned.

(6) In this section "place of safety" means residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948 or under paragraph 2 of Schedule 8 to the National Health Service Act 1977, a hospital as defined by this Act, a police station, a mental nursing home or residential home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient.

Mentally disordered persons found in public places

136.—(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved social worker and of making any necessary arrangements for his treatment or care.

Provisions as to custody, conveyance and detention

137.—(1) Any person required or authorised by or by virtue of this Act to be conveyed to any place or to be kept in custody or detained in a place of safety or at any place to which he is taken under section 42(6) above shall, while being so conveyed, detained or kept, as the case may be, be deemed to be in legal custody.

(2) A constable or any other person required or authorised by or by virtue of this Act to take any person into custody, or to convey or detain any person shall, for the purposes of taking him into custody or conveying or detaining him, have all the powers, authorities, protection and privileges which a constable has within the area for which he acts as constable.

(3) In this section "convey" includes any other expression denoting removal from one place to another.

Retaking of patients escaping from custody

138.—(1) If any person who is in legal custody by virtue of section 137 above escapes, he may, subject to the provisions of this section, be retaken—

(*a*) in any case, by the person who had his custody immediately before the escape, or by any constable or approved social worker;

(*b*) if at the time of the escape he was liable to be detained in a hospital within the meaning of Part II of this Act, or subject to guardianship under this Act, by any other person who could take him into custody under section 18 above if he had absented himself without leave.

(2) A person to whom paragraph (*b*) of subsection (1) above applies shall not be retaken under this section after the expiration of the period within which he could be retaken under section 18 above if he had absented himself without leave on the day of the escape unless he is subject to a restriction order under Part III of this Act or an order or direction having the same effect as such an order; and subsection (4) of the said section 18 shall apply with the necessary modifications accordingly.

(3) A person who escapes while being taken to or detained in a place of safety under section 135 or 136 above shall not be retaken under this section after the expiration of the period of 72 hours beginning with the time when he escapes or the period during which he is liable to be so detained, whichever expires first.

(4) This section, so far as it relates to the escape of a person liable to be detained in a hospital within the meaning of Part II of this Act, shall apply in relation to a person who escapes—

(*a*) while being taken to or from such a hospital in pursuance of regulations under section 19 above, or of any order, direction or authorisation under Part III or VI of this Act (other than under section 35, 36, 38, 53, 83 or 85) or under section 123 above; or

(*b*) while being taken to or detained in a place of safety in pursuance of an order under Part III of this Act (other than under section 35, 36 or 38 above) pending his admission to such a hospital,

as if he were liable to be detained in that hospital and, if he had not previously been received in that hospital, as if he had been so received.

(5) In computing for the purposes of the power to give directions under section 37(4) above and for the purposes of sections 37(5) and 40(1) above the period of 28 days mentioned in those sections, no account shall be taken of any time during which the patient is at large and liable to be retaken by virtue of this section.

(6) Section 21 above shall, with any necessary modifications, apply in relation to a patient who is at large and liable to be retaken by virtue of this section as it applies in relation to a patient who is absent without leave and references in that section to section 18 above shall be construed accordingly.

Protection for acts done in pursuance of this Act

139.—(1) No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, or in, or in pursuance of anything done in, the discharge of functions conferred by any other enactment on the authority having jurisdiction under Part VII of this Act, unless the act was done in bad faith or without reasonable care.

(2) No civil proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court; and no criminal proceedings shall be brought against any person in any court in respect of any such act except by or with the consent of the Director of Public Prosecutions.

(3) This section does not apply to proceedings for an offence under this Act, being proceedings which, under any other provision of this Act, can be instituted only by or with the consent of the Director of Public Prosecutions.

(4) This section does not apply to proceedings against the Secretary of State or against a health authority within the meaning of the National Health Service Act 1977.

(5) In relation to Northern Ireland the reference in this section to the Director of Public Prosecutions shall be construed as a reference to the Director of Public Prosecutions for Northern Ireland.

Law and Sexuality of People with Learning Difficulties

Introduction
Many health authorities and social services departments have or are devising policies or guidelines on how their employees should respond to the sexuality of clients' with learning difficulties. Many are concerned about their legal liability. This paper seeks to help on these issues by isolating a number of critical questions that should be asked. They will not produce answers for individual questions but ensure that consideration is given to issues that the law holds dear.

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Do you owe a duty of care to the person with learning difficulties? The law of negligence only applies where there is a duty of care. Is the person in receipt of services which include supervision and/or assessment of needs or problems? If the individual is already a client of a service then a duty may be assumed. However if that service is, and appropriately is, limited to impersonal needs, such as being provided with a home help, a duty may not exist. If the person has a private contract for services then a duty will exist. Alternatively and additionally the classic test of the existence of a duty may be used: *Can you reasonably foresee that your actions - or those of the individual - or your inaction might cause harm to the individual or others?* If "yes" you owe a duty.

Could inaction be harmful? Liability is not limited to positive acts. Ignoring needs can create liability. Ignoring someone's problems in expressing or enjoying his or her sexuality, perhaps in a hope that they will go away or because frightened, inexperienced or untrained, will not avoid liability.

How old is the client? The law goes by biological age and does not use intellectual age. For it not to be a crime the individual must be over 16 to consent to heterosexual sexual acts and 21 to consent to male homosexual acts.

Has the client expressed his or her wishes? Prosecutors and courts, amongst many others, will be anxious to ensure that people with learning difficulties are not being exploited. So meeting the client's goals and accepting his or her values, rather than service goals or the values of individual members' of staff is less likely to be regarded as exploitative. *Who will benefit most from the proposed intervention, the client, the service, the client's family or staff?* Any other answer than "the client's" should cause concern, at least.

Is the client legally able to consent? Does he or she have an arrested or incomplete development of mind (brain damage whilst an adult may be excluded) which includes (a) severe impairment of intelligence and (b) severe impairment of social functioning? No intelligence quotients are legally prescribed. If "no" and of legally relevant age, not subject to duress, fear or fraud as to what is to happen but has been adequately informed, he or she can consent. If "yes": *Are active steps being taken to ensure that the client is no longer regarded as severely impaired in his or her social functioning?* If "no" then the client's interests and rights do not appear to be being protected or fostered. It may not be

possible to alter "intelligence" but "social functioning" can be and for so long as the client is regarded as severely impaired in them his or her legal and civic rights are limited.

Is there concern about the partner in any sexual activity? Criminal offenses are committed when certain employees have sexual intercourse with certain female clients. Disparities in ages and impairment cause concern to some but do occur within society. *Might the partner exploit the client?* If the client is unable to legally consent then the partner will be commit offenses if sexual touching takes place. There is a defence is he or she did not know and did not have reason to suspect that the other was "severely impaired." *Are there ways, without breaching confidence or defaming, of discouraging exploitation by advising partners that the other may be incapable of giving a legal consent?* If these are taken the partner may be helped and/or dissuaded by knowing that his or her defence will be lost as he or she now has knowledge and/or reason to suspect.

Does the client consent? Besides being having to be legally able to and free to consent the client must know what is being consented to and actually consent. *Has the client had explained to him or her, in language or by other form of communication, what it is proposed to achieve, the means, what will be experienced, the benefits and possible harms?* Using language or concepts which are beyond the our comprehension prevents us from consenting and so for clients. Explanations must be individualised, not standardised. The individual should be told as much as he or wants to know. *Has the client had sufficient experience of saying "no" and being respected?* If the client regularly consents to what is proposed then there is no consent. If the client consents for fear of repercussions then a criminal assault may be committed against him or her. *Has the client been protected against exploitation by having had experience of making decisions which are respected by service providers?* If "no" then the client's civic and legal rights are at risk and the services may not be fulfilling their duties to protect and habilitate.

Does the proposed action involve physical contact? If the client is touched then there may be trespass. Defenses to trespass are genuine consent and that it was social touching. Intimate touching will rarely pass as social, especially definitionally.

Does the service incite or cause clients' problems? Through failure to act, such as to explain which behaviour should take place in private, the service may cause clients to have problems and even contribute to crimes taking place. If clients have no private places and commit homosexual acts in public toilets that becomes a crime irrespective of age and capacity. Programming opportunities for privacy, a bedroom for an hour a week should also not suffice and, indeed, may pressurise people to do things they might not otherwise choose to do. Failure to advise, practically, about contraception and hygiene can, clearly, lead to problems. *Do staff undertake intimate acts upon members of the opposite sex?* If these acts take place outside that which is socially accepted and understood as related to hospitals and illness, moreso if they are for administrative convenience, they risk being interpreted as indecent assaults. *Does staff behaviour incite sexual behaviour?* Close contact with clients can lead to a degree of familiarity including physical contact that, outside that staff/client relationship, could be

interpreted as sexual by the client and produce expectations. If the acts are dependent upon the relationship, the staff would not act similarly to non-clients, then they demonstrate a belief that clients are different which, when dealing with emotional and sexual feelings, could be exploitative.

Are the staff adequately trained and supported by their employers. Employers can be vicariously liable for the civil offenses of their employees. Also, under the rule in *Wilsher* v. *Essex Area Health Authority* (C.A.) they can be directly liable if they have not provided sufficient properly trained staff and equipment. Failure to advise employees how to respond to clients' sexuality and support them in doing so could lead to direct liability if harm resulted to client or employee. *Are staff excused from responding to clients' problems, in sexuality or otherwise, because of their personal values?* If they are this will not provide a defence to not responding to clients' needs. There is no special legal protection, as with abortions, for staff employed in this area.

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PERMISSION OF
PROFESSIONAL NURSE

Patients injured through a nurse's mistake may be able to get compensation by suing for negligence. This Issues in Nursing article explains the law of negligence as it affects the profession, and discusses the separate concepts involved and how they can be applied in different situations.

NEGLIGENCE: Defining Responsibility

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The six tests

When dealing with cases of alleged negligence in nursing, the courts do not just ask "Was the behaviour negligent?" They go through a series of separate tests which, together, make up the law of negligence. It is most easily understood as six questions.

1. Did the nurse owe a duty of care to the injured person?
2. Did the nurse break the appropriate standard of care in the circumstances?
3. Did that breach of the standard cause the injuries?
4. Are the injuries of a kind that the courts compensate?
5. Were the injuries reasonably forseeable?
6. Did the injured person contribute to the happening of, or the extent of, the injuries?

Questions 1 to 5 must be answered "Yes." If not there is no legal liability. If question 6 is answered "Yes" then there has been contributory negligence, which means that the injured person's compensation will be reduced.

Court decisions are illustrative but it is dangerous to generalise from the facts rather than the law. Injecting a patient in the wrong place may break the standard of care in one case but not in another where, for example, there are special reasons such as an emergency.

The duty of care

Nurses only owe a duty of care to certain people, certainly to their patients and colleagues. But how do the courts decide who else nurses legally owe a duty of care? In *Towers v. Cambridgeshire Area Health Authority & Others* (unreported, March 9, 1982) an ambulanceman injured his back lifting a heavy patient. Anticipating a difficult lift, his colleague asked, two or three times, for help. One nurse took a drip but otherwise his requests were ignored. They began to lift. The colleague lost his grip and Mr Towers had to take the patient's weight. His back was injured.

Did the nurses owe the ambulance officers a duty of care? The trial judge said that nurses were not "primarily carriers" and there might be other claims upon their attention. So it did not matter how unreasonable or bad the nurses' behaviour was; they were not liable because they had no duty of care to the ambulance officers. The Court of Appeal disagreed. The trial judge had confused the second question about the standard of care with the first question about the duty of care. If a nurse had something more important to do then he or she would not be in breach of the *standard* but could still owe a *duty* of care to the ambulance officer.

The courts say we owe duties of care to our 'neighbours', people whom it is reasonably foreseeable may be affected by our actions and inactions. On this occasion it was reasonably foreseeable that these ambulance officers would have been affected by these nurses' behaviour. It may not be possible to imagine some of the people nurses owe duties to. Discharge a patient early and the relatives may harm themselves in trying to cope. Is that reasonably foreseeable? Is it reasonably foreseeable that a head injury patient will suffer further if not told to seek immediate attention if he or she begins to vomit? Many things are foreseeable. But it must be reasonable, not fanciful.

The standard of care

The judges decide who is owed a duty of care but the profession invariably decides the standard of care. The essential question is whether the nurse acted in a way that reasonably competent nurses would have done in those circumstances?

In *Walker v. South West Surrey D.H.A.* (unreported, June 17, 1982) a woman was giving birth. She said that she was injected with pethidine in the inner side of her right thigh. That fact was disputed, though both sides agreed that if it was true then it broke the standard of care. "No careful nurse or doctor would give an injection at that point unless there was some compelling reason to do so."

The standard is not what the best nurse or what most nurses or the average nurse would have done. It is about the reasonably competent nurse in that, if any, specialty. Expert witnesses may be called. They will be asked whether reasonably competent nurses would have done that. The test is not what the witness would have done. The test depends upon and reinforces professional standards. Certainly the courts reserve the right to declare professional practices and standards too low but that is a rarely applied reserve power.

The test recognises that standards should keep improving. What was reasonably competent once, say not knowing about adverse reactions to a new drug, will soon become unreasonable. The role of journals in spreading information about new standards can be crucial. Failure to read a journal could be the breach of standard.

"The test is the standard of the ordinary skilled man exercising and professing to have that skill. A man need not possess the highest expert skill: it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." That is known as the *Bolam* test. (*Bolam v. Friern H.M.C.* [1957] 1 W.L.R. 582, 586.) It has been restated many times by many courts. While it involved a doctor, the same principles would apply to a nurse. The test recognises differences of professional opinion. Provided a responsible body of professional opinion would support the action, the standard is met. Without differences of opinion there is no progress.

Causation

A patient in a psychiatric hospital had florid delusions about Christ, snakes, fires and said she had to die. She was diagnosed as having a "depressive illness with some paranoid features". She was to be nursed on the ward but not subjected to constant observation. She was noted as being potentially suicidal and likely to abscond. One day her husband gave a nurse a box of matches. He explained that his wife had given them to him saying that she might otherwise set fire to herself. This was not noted in the nursing records. The patient had periods of being very disturbed, shouted about fires, escaped from the ward but returned voluntarily. Her consultant concluded that she was in a psychotic state. He did not alter the nursing instructions. Then one day she seemed calmer, agreed to join in some activities but first went to the toilet, alone. There she set fire to her tee-shirt and burnt herself badly.

The patient claimed that both the doctors and the nurse were negligent. The doctors should have required constant observation. The nurse ought to have recorded the incident with the box of matches. The trial judge decided that the doctors were not negligent; reasonably competent doctors in that position would not have required constant observation. The matchbox incident, however, should have been recorded. Thus the nurse owed a duty of care to the patient and the standard of care had been broken. The nurse was therefore negligent, the trial court decided.

The Court of Appeal disagreed. (*Gauntlett v. Northampton Health Authority*, unreported, December 12, 1985.) The trial judge had confused the separate questions about breach of the standard of care and causation. The evidence was that if the consultant had known of the matchbox incident he would still not have required constant observation. The injuries would still have happened. The nurse may have behaved improperly but that did not cause the injuries. Many would link the matchbox incident and the subsequent burning but it is the effect on the

decision-makers that counts; ". . professional experience of dealing with people with disordered minds gives it a much less literal significance, as an indication of possible, or probable, future acts by the patient."

The causation rule in the law of negligence requires us to think twice. If the injuries would have happened anyway then some apparent causes might not be causes at all. (But disciplinary action could still be taken for the breach of the standard of care which, luckily, did not cause injury.) But this point must not be overstated. That several people cause somebody's injuries simply means that each is liable and the court will settle how much each should pay.

If the injuries would still have happened, but not so soon or so extensively, then those have been caused. In *Sutton v. Population Services Planning Programme Ltd.* (unreported, October 31, 1981) a nurse was working in a well-woman centre. When a patient complained of a lump in a breast she was supposed, it was agreed, to refer her to a doctor at the centre. She did not, and the patient subsequently had a mastectomy. Thus there was a duty of care and a breach of the standard of care. But, it was accepted, the doctor would not have found the lump, even with a mammograph. Did the nurse's breach cause the loss? The Court examined the steps likely to have been taken. The doctor would have referred to a specialist. The specialist would not have found anything but told the GP. The patient would have returned and repeated her complaint. The GP would have sent her to a specialist. The specialist would have found the lump, with or without a mammograph, and operated a few days later. The operation would have taken place about 10 weeks before it actually did take place and caught the cancer at an early stage. The patient would then have had a greater chance of survival for longer. Thus the nurse's breach of the proper standard did cause the loss.

Foreseeable losses

The courts will only compensate certain kinds of loss. This certainly includes injuries to the person and their finances. Pain, suffering and loss of amenities are covered. They will compensate recognised psychiatric disorders but are reluctant to compensate experiences such as sorrow and upset and not just because of problems of proof.

Recognised loss

A recognised loss or injury might nevertheless go uncompensated because the way it occurred was not reasonably foreseeable. This point is unlikely to arise frequently in nursing cases but it is possible. Say a mentally disordered patient leaves a hospital, through a nurse's breach of standard of care, and causes problems for a relative. Presuming the nurse owes a duty of care to the relative, he or she is unlikely to be liable if the loss or injury was, for example, to the relative's investment portfolio. That could be regarded as not reasonably foreseeable.

Contributory negligence

It is the plaintiff, the patient, who might be guilty of contributory negligence. If he or she is guilty, then the compensation will be reduced by the proportion by which the court thinks he or she is to blame. It includes both contributing to the cause or happening of the accident and contributing to the amount or extent of the injuries or losses by, for example, not seeking medical attention or disregarding advice. In *Patel v. Adyha* (unreported, April 2, 1985) a patient consulted her GP about back pains. His examination broke the standard of care. He should have discovered symptoms which would have led him to refer the patient to a specialist who would have diagnosed a tubercular condition with kyphosis. She deteriorated and, according to the judgement, her spine 'collapsed'. The doctor's lawyer argued that she should have sought further medical attention when her problems would have been noted and treated in time. But the Court of Appeal decided that it was perfectly understandable that she did not return to her doctor when she had been led to believe that there was nothing that could be done. However, if she had been "inviting disaster," if she had not acted as a reasonable person in her condition would have acted then, the Court implied, she would have been contributorily negligent.

Nurses take risks practically every day. Here, a way of assessing those risks is outlined, and a strategy put forward to aid decision-making – one that encourages appropriate risk-taking.

Taking Risks With Patients – Your Assessment Strategy

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Nurses make judgements, decisions. Nurses take risks. An elderly patient may be allowed matches in his bed despite the risk of fire. A mentally disordered patient may commit suicide while allowed the freedom of the hospital grounds. A patient discharged early may be unable to cope. There is a dignity and individuality in being able and allowed to take risks. In fact, taking risks is often a highly valued activity. But, despite the hope for and expectation of success, there is a risk of harm for the patient – and a risk of litigation, disciplinary action or professional inquiry for the nurse. Although risks may be frightening and worrying, risk-taking can be the essence of professional responsibility. This article outlines a way of assessing risks. It encourages risk-taking after careful analysis of the risk and, properly used, should prevent legal liability and professional censure if things should go wrong.

Making decisions

The method outlined below describes an approach to risk-taking. It does not take the decision away from nurses, nor provide easy solutions for individual cases. It does not tell nurses *what* to decide, rather it suggests a *way* of deciding. In view of the increasing pressure on resources and new care philosophies which encourage risk-taking and patients' rights, this framework could help in making decisions. Indeed, it might be used as the basis of a risk-taking policy which health authorities could adopt with a promise to support those staff who follow it. The framework is as follows:

1. Analyse whether the proposed action is best described as a gamble, a risk or a dilemma.
2. List all the possible kinds of benefits, for the patient, of acting.
3. List all the possible kinds of benefits, and knock-on benefits, for other people.
4. Analyse the likelihood of each of these benefits occurring.
5. Manipulate the risk by taking steps to make the benefits more likely to occur.
6. List all the possible kinds of harm, to the patient, of acting.
7. List all the possible kinds of harm, and knock-on harms, to other people.
8. Analyse the likelihood of each of these harms occurring.
9. Manipulate the risk by taking steps to reduce the likelihood of the harms occurring.
10. List any duties to risk.
11. Obtain the patient's informed consent.
12. Obtain the informed agreement of colleagues.
13. Assess whether 'the risk' should be taken.

Gamble, risk or dilemma?

Consider three different activities; gambling, taking a risk and facing up to a dilemma. Which is it that nurses do? Gambling is something that *may* be done (it does not have to be done) to gain a benefit where the act of gambling is often pleasurable. Taking risks involves deciding that the potential benefits of a proposed act outweigh the potential drawbacks. You may take risks because the potential benefits make it desirable. In contrast, facing a dilemma involves *having to act*, having to choose between options – each of which carries both potential benefits and potential harm. When facing a dilemma, something has to be done; doing nothing is, or soon will be, harmful.

Nurses' actions will often be better described as facing up to a dilemma rather than taking a risk. Merely calling it risk-taking is a disservice to both the nurses and their judges. Besides giving more credit and greater respect, we expect less and apply a lower standard when we know that a dilemma is involved. A situation requires quick thinking and action in the face of a dilemma. Who would argue with the questions: "We took a risk; can you say our decision was wrong?" and "We faced a dilemma; can you say our decision was wrong?"

Analysing decisions into gambles, risks and dilemmas is being truthful and honest, and fair judgements can be made. However, this article will refer to 'risk-taking' to avoid being repetitive.

The two sides to a risk

A risk can be divided into the *consequence* – the gain or loss, the benefit or injury that might occur – and the *likelihood* – the odds, the chance, the possibility, that it might occur. For example, there is a 10:1 risk (likelihood) the horse will win. There is a risk (consequence) I might lose £10 and a risk (consequence) I might win £100. Both senses of the word should be considered.

When the risk is of a dramatic injury or loss, like a patient's death or lifelong paralysis, we – quite naturally – get worried. But that is only one part of the risk. It is very easy to suggest that death is possible; it is possible every time we cross a road. A proper analysis of risk must consider the likelihood of each suggested outcome. A risk-taking scheme should ensure that the likelihood of each possible outcome is assessed separately. Epidemiological data may sometimes be used to describe statistically the chance but, if unavailable, words and concepts of possibility can be used. Precision may be impossible but that does not prevent clear thinking.

Benefits and losses

Another understandable tendency when taking risks is to concentrate on harms, injuries and losses. We tend to stress what may go wrong rather than what may succeed. When a child is returned from local authority care to its parents who then abuse it again, the press and media will concentrate on the risk of such abuse occurring. Little attention will be paid to the reasons for taking that risk, to the objectives of the exercise. However, if the decision was actually taken in terms of 'seeing if we can get away with it', then those who took that risk deserve the censure. The reasons or the objectives of taking risks should be clear and easily stated. Risks should be taken to achieve specific goals in the light of possible harms occurring: "We were trying to achieve . . . although, yes, we realised that these harms might occur."

Having goals and objectives for a patient or client is surely a central part of the nursing task. Some might argue that it is enough to justify the risk after the event, if and when it goes wrong. This is unwise. The reasons may show that it was a wise decision and that the same decision would be made again. That could be enough to show that the risk-taking did not cause, in legal terms, the loss suffered. (See the section on causation in the earlier article on the law of negligence – Carson, 1987.) But it could show enough carelessness to justify disciplinary proceedings. When a court or tribunal assesses the quality of a risk-taking *decision*, it

can only consider the information and reasons that were actually available at the time to the decision-maker. Disciplinary action should be concerned with poor decisions whether or not harm results.

Picture: NSPCC

The press pay little attention to the reasons for returning children to their parents if they then abuse them again.

The range of benefits and losses

A patient gets his wish to return home quickly. That is a benefit to consider in assessing the risk of early discharge. But it should not be limited to that. There could be benefits to other members of his family. It is not just the patient or client who may benefit or be harmed, but relatives and others. And it is not just the return home itself, but what it may lead to; for example, a reconciled marriage, preserved employment, pets not destroyed, skills maintained, accommodation retained. Risk-taking schemes should consider both the range of people who may be affected and the ways in which they may be affected. It should also consider the 'knock-on' effects. Somebody else may be able to use the vacated bed. Funds may be allocated to another desirable activity.

A duty to risk?

A reason for early discharge, for example, may be pressure on beds. The reason for allowing a client sharp tools may be a belief in the right to take risks or the need to show trust. These are not disreputable reasons. There are pressures on nurses from the government to make best use of scarce resources. There are care philosophies, such as normalisation, suggesting how nurses should behave and patients should be regarded. So, to an extent, nurses are being told or encouraged to take risks. Community care is a policy full of risks, although highly desirable. These duties should be acknowledged in risk-taking schemes and decisions. They are an important dimension affecting behaviour. Indeed, they may demonstrate that it is a dilemma rather than a risk. Judges should consider the duties to act in particular ways.

Sometimes care policies or goals sound empty or vague: "We believe our patients have a right to individuality, respect and a valued environment." But who doesn't? That policy may actually be empty, or there may be a series of documents or models which show what those proud goals mean in actual daily life. The more that these goals and policies can be converted into statements of what people will actually be doing, then the easier it will be to get them accepted as genuine and important duties in the risk assessment.

Manipulating risks

Risks do not exist in a vacuum. They can be manipulated. The risks involved in not asking a doctor to arrange an admission to hospital can be reduced by ensuring that the patient or an informal carer has a relevant telephone number and knows what signs to look for and how to respond. Just as the amount or likelihood of the harms can be reduced, so can the amount and likelihood of the benefits be maximised. Instead of having a vague objective for a patient of living in an ordinary house in the community, *specific* objectives could be cooking, washing and shopping for himself. The more things that could go right, the more justifiable the decision to risk.

It also becomes possible to re-analyse a risk as a dilemma. Moving someone from a large, rundown institution into an unfamiliar community is facing up to a dilemma. Nurses must do something. Staying there is not good enough, something must be done. Government or health authority policies, scarce resources, professional standards – all can make a risk better analysed as a dilemma.

Informed consent

Getting the patient's informed consent is good practice and it helps to show that the decision to risk was wise. The patient stands to gain or lose, and agrees with the decision. Similarly, colleagues' opinions would help to show that it was not just an individual's opinion.

The decision

No help can be given with the final decision. That is for the individual case and the individual nurse. But any decision to risk should be presented as a decision to obtain certain goals, for certain reasons, in the knowledge of the possibility of (and being prepared for) some harms.

Although this strategy does not solve individual cases, it could encourage more risk-taking. It emphasises the importance of accurately representing the risk and the benefits that could come from it. It discourages the overdramatising which may result from concentration on what might go wrong. It can lead to risk decisions being taken proudly rather than with a measure of shame and regret.

But, it may be objected, this long and detailed approach cannot be used every time a nurse has to decide whether a patient can, for example, go to the toilet unaided. Very true: it could often be impractical. It is an aid to decision-making, not a substitute. But, even if not used in detail, it could aid thinking about risks. What are the advantages of letting the patient go unaided? It encourages thought and responsibility. It justifies drawing the line when insufficient potential benefits can be demonstrated. It can help justify judgements when nurses are pressed to take decisions with which they disapprove. And it should encourage self-esteem through nurses realising the number of risk-taking judgements they make.

Reference
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