What is a hospital?

David Hewitt[[1]](#footnote-1)

**1. Introduction**

*Leslie Nielsen as Doctor Rumack*: This woman has got to be taken to a hospital.

*Elaine:* A hospital? What is it?

*Dr. Rumack:* It’s a big building with patients, but that’s not important right now.[[2]](#footnote-2)

One hesitates to cross swords with the estimable Leslie Neilson, both because he is estimable and

also because, in this moment from a classic funny film, he gave a plain answer to what is, when all’s

said and done, a tricky question.

In the context of detained patients, the question has excited a great deal of deliberation, and it

continues to cause concern and, occasionally, real problems for mental health practitioners.

It’s also a question that the next Mental Health Act seems unlikely to resolve.

A number of possible answers have been proposed. Though most are perfectly sensible and, to

varying degrees, helpful, none resolves the question entirely. The purpose of this paper is to

consider those answers and to identify the merits and demerits of each.

**2. Definition**

It is necessary to examine the definition of ‘hospital’ that appears in current law and the proposed

definition under a new Mental Health Act.

**2.1 The current law**

On the face of it the Mental Health Act 1983 (‘MHA 1983’) has a comprehensive answer to the

question. It states: ‘“hospital” means –

(a) any health service hospital within the meaning of the National Health Service Act 1977;

and

(b) any accommodation provided by a local authority and used as a hospital or on behalf

of the Secretary of State under that Act.’[[3]](#footnote-3)

It is, perhaps, unhelpful for the 1983 Act to provide a definition that simply refers to another

definition. The National Health Service Act 1977 (‘NHSA 1977’) says:

‘ “hospital” means –

(a) any institution for the reception and treatment of persons suffering from illness;

(b) any maternity home; and

(c) any institution for the reception and treatment of persons during convalescence or

persons requiring medical rehabilitation;

and includes clinics, dispensaries and out-patient departments maintained in connection with

any such home or institution, and “hospital accommodation” shall be construed accordingly.’[[4]](#footnote-4)

It might be thought that the word ‘institution’ is highly significant. Sadly, that is not so. The New

Shorter Oxford English Dictionary defines it as:

‘7. A society or organization, esp. one founded for charitable or social purposes and freq.

providing residential care; the building used by such a society or organization.’[[5]](#footnote-5)

This definition is provided here only for the sake of completeness. It takes an abstract approach

and doesn’t deal in mere bricks and mortar. It fails to suggest any differentiation between ‘the

building’ used to house detained patients that is a discrete unit on a plot of its own and one that

is part of a much larger medical ‘campus’. As we shall see, the two forms of building are different

things and their differences are of considerable importance.

It is regrettable that, despite two lengthy statutory definitions, we cannot now be sure what

‘hospital’ means. In fact, that uncertainty has been caused by the definitions, and by the fact that

they have remained unaltered despite significant changes in the way mental health services are

configured.

**2.2 The Draft Mental Health Bill**

The position is unlikely to be very different under the next Mental Health Act. The Draft Mental

Health Bill published in September 2004 tells us that

‘“Hospital”, except in Parts 6,[[6]](#footnote-6) 10[[7]](#footnote-7) and 12[[8]](#footnote-8) and sections 161(2) (c),[[9]](#footnote-9) 172(2),[[10]](#footnote-10) 280(1)[[11]](#footnote-11) and

301(1),[[12]](#footnote-12) means –

(a) any health service hospital within the meaning of the National Health Service Act 1977 (c. 49),

(b) any accommodation provided by a local authority and used as a hospital by or on behalf of

the appropriate authority under that Act,

(c) any other establishment –

(i) which is an independent hospital (within the meaning of the Care Standards Act 2000

(c. 14)) in respect of which a person is registered under Part 2 of that Act, and

(ii) in which medical treatment is or may be provided to persons who are subject to the

provisions of Part 2[[13]](#footnote-13) or 3[[14]](#footnote-14) of this Act.”[[15]](#footnote-15)

This definition is the same as the one that appeared in the Draft Mental Health Bill published in

June 2002.[[16]](#footnote-16)

There is nothing in the various Government publications that preceded the Draft Bills to indicate#

Which deals with ‘Examination, Assessment and

Treatment’ why it was thought desirable to perpetuate the old definition of ‘hospital’ or

unnecessary to depart from it.[[17]](#footnote-17)

**3. Confusion**

If there is confusion as to the true meaning of ‘hospital’ it is a comparatively recent phenomenon.

As Professor Eldergill notes, at one time the position was very clear:

“Previously, all hospitals within a district had the same hospital managers, the local District

Health Authority. If it was necessary to move a patient from the psychiatric ward of the local

District General Hospital to a surgical ward, following a suicide attempt, the patient remained

detained in the same hospital by the same managers. Consequently, no legal formalities had to

be observed. Likewise, if a secure psychiatric unit was on the same site, but set apart from the

District General Hospital, permitting the patients to wander the hospital grounds, or taking them

to the general hospital for dental treatment, involved no legal formalities. The patient had not

left the hospital where he was liable to be detained so no formal leave of absence was

required.”[[18]](#footnote-18)

However, in 1990 there came the National Health Service and Community Care Act (‘NHS & CCA

1990’), which fostered the creation of NHS trusts to manage hospitals (and, as we shall see,

amended the statutory definition of ‘the managers’), but made no change to the meaning of

‘hospital’.[[19]](#footnote-19)

The result was that more than one NHS trust might now be responsible for different parts of a

single site, a site that was previously thought of as – and called – a hospital.

Eldergill has said:

“The position now is that different floors of a General Hospital may be managed by different

NHS trusts. For example, the local General Hospital NHS Trust may manage the first and

second floors, and also those wards on the third floor which admit patients for physical

conditions. The local Mental Health NHS trust may manage the open psychiatric ward on the

third floor, the secure unit set apart in the General Hospital grounds, and a number of wards

left on the site of the old asylum, situated some miles away. Worse still, some psychiatric wards

may be shared by two Mental Health NHS trusts, both having beds on the ward.”[[20]](#footnote-20)

As the MHAC has put it:

“‘Hospitals’ for the purpose of the Mental Health Act come in increasingly different shapes

and sizes.”[[21]](#footnote-21)

Professor Eldergill suggests that:

“[...] trying to apply the legal framework devised in 1983 for the detention, removal and

transfer of patients to this new managerial system has proved difficult.”[[22]](#footnote-22)

There is confusion, and, as has been noted, it is unlikely to be resolved by the new Mental Health

Act, which will probably replicate the existing definition of ‘hospital’.

**4. Competing concepts**

In order to answer the question ‘what is a hospital?’ and make sense of the confusion that came

with introduction of NHS hospital trusts, some commentators and practitioners have alighted

upon two competing concepts, concepts that appear be mutually exclusive.

The result has been a certain bifurcation in professional views, which the MHAC has summarised

as follows:

“When MHA 1983 was drafted, it was thought that each ‘hospital’ would have a single

managing body. It was not envisaged that one hospital could be divided into discrete units

each of which was managed by a different body. However, now that hospitals may not be

coterminous with managers, there is sometimes uncertainty as to what constitutes a hospital

[...] In general, there are two schools of thought, which see a ‘hospital’ as: [(a)] all the buildings

on a site defined by a single perimeter, even though some of those buildings may have

different NHS managers than others; or [(b)] only those buildings on a particular site that are

adjacent to each other and have the same NHS managers.”[[23]](#footnote-23)

The two schools of thought can, perhaps, be characterised as the ‘wide site’ concept and the

‘narrow site’ concept.

**4.1 The wide site**

The ‘wide site’ concept sees a ‘hospital’ as being defined by the largest boundary that fact or logic

will allow. Like the rhinoceros, the wide site hospital is a beast that is perhaps more easy to

recognise than to describe. However, where several clinical units inhabit a single site, which will

usually be defined by a continuous perimeter, they will constitute a ‘hospital’ even though they

are not all the responsibility of one NHS trust.

Adherents of the wide site concept might claim that it more truly reflects the intention of

Parliament in 1983 (or 1977), because it sees a ‘hospital’ as being comprised of all the clinical

facilities that inhabit a single site.

It is the wide site conception of a hospital that is favoured by the MHAC.[[24]](#footnote-24) However, it is worth

noting that the Commission is by no means adamant in its propagation of this view. It states:

“The MHAC is aware that its preferred definition of ‘hospital’ is not shared by some

commentators, and it does not insist that its preference is followed by NHS Trusts. However,

every Trust should be in no doubt as to the physical limits of the hospital(s) of which it is the

managers for the purposes of MHA 1983, and it should take legal advice where necessary.”[[25]](#footnote-25)

**4.2 The narrow site**

The ‘narrow site’ concept defines a ‘hospital’ by reference to its shortest logical boundary.

Therefore, in the case of clinical units on a single site, it would see each of those – or, at the very

least, each unit or group of units managed by a single NHS trust – as a discrete ‘hospital’.

Again, however, adherents of the narrow site concept might choose to claim it as the true inheritor

of the spirit of 1977 (or 1983), as it conceives of a ‘hospital’ as an entity under a single organ of

management. This is certainly so in the case of Professor Eldergill, who says:

“[...] the Act was drafted on the assumption that all of the wards on a single site would form a

single hospital managed by a single group of managers.”[[26]](#footnote-26)

Professor Eldergill prefers the ‘narrow site’ concept. He says:

“Although the idea that one institution can comprise two hospitals seems odd at first glance, it is

no different from a block of flats within which each floor has a different legal owner. The idea

only seems strange because for historical reasons such institutions are known by a single

name.”[[27]](#footnote-27)

His submission is:

“The context now requires that the term ‘hospital’ in section 145 means *that part* of an

institution which is vested in an NHS trust.”[[28]](#footnote-28)

“Where two or more NHS trusts manage different parts of an institution which is a hospital for

the purposes of the National Health Service Act 1977, each separately managed part is a hospital

for the purposes of the admission, detention and discharge provisions in the Mental Health Act

1983.”[[29]](#footnote-29)

It may be that in the first of these passages Professor Eldergill overstates the position somewhat.

The *contex*t may be less immutable than he suggests. The physical boundaries of a patient’s

confinement can only be governed by the provisions that permit him/her to be confined, and as we

shall see, different provisions in MHA 1983 now invoke different definitions of ‘hospital’.[[30]](#footnote-30)

Therefore, the context in which the word is used is not everywhere the same. However, and to

anticipate the chief conclusion of this paper, it would seem that the conclusion in the second of

these passages is broadly correct.

Richard Jones, after re-stating the views of Professor Eldergill and the MHAC, concedes that he

prefers the conception of ‘hospital’ that is here labelled the ‘narrow site’, because it is “consistent

with the scheme of” MHA 1983.[[31]](#footnote-31)

In order to understand the problem fully, and also if one wishes to resolve it, it is necessary to look

at its various manifestations; to consider each use of the word ‘hospital’ in MHA 1983 and the

context in which it is used, together with the practical effects of the competing definitions.

**5. Issues**

What follow are not the only uses of the word ‘hospital’ in MHA 1983, but they are among those

that are the most significant.

**5.1 The consequences of admission**

Under MHA 1983, a patient may be detained in the ‘hospital’, and only there. As far as an application

for ‘civil’ – that is, non-criminal – confinement is concerned, section 6(2) states as follows:

‘Where a patient is admitted [...] to the hospital specified in such an application [...], or, being

within that hospital, is treated by virtue of section 5 above as if he had been so admitted, the

application shall be sufficient authority for the managers to detain the patient in the hospital in

accordance with the provisions of this Act.’[[32]](#footnote-32)

With regard to patients committed to psychiatric detention by the criminal courts, section 40(1)

states

‘A hospital order shall be sufficient authority – [...] (b) for the managers of the hospital to admit

him at any time within that period and thereafter detain him in accordance with the provisions

of this Act.’[[33]](#footnote-33)

In order that a patient may be confined within the permitted boundary and given free movement

inside it, it is important to know the limits of the ‘hospital’ in which MHA 1983 authorises and

compels him/her to be detained.

*The wide site*

If the ‘wide site’ conception of the word were to be applied, ‘the hospital’ to which it would be

possible to confine a patient would have to be viewed expansively, and as consisting of all the land

and buildings contained within its largest conceivable boundary.

*The narrow site*

If the ‘narrow site’ concept were to be applied, it would only be possible to confine the patient to a

discrete unit, even where that unit was part of a larger medical campus. (It would, of course, be

possible under MHA 1983, section 19 (3) to ‘remove’ the patient to a second unit that was managed

by the same NHS trust as the first. However, the second unit would not be part of the same

‘hospital’ as the first, for the section 19 (3) power is to remove the patient ‘to any other such

hospital.’[[34]](#footnote-34))

*Discussion*

It will be noted that in MHA 1983, sections 6 (2) and 40 (1), the power to detain a patient in the

‘hospital’ is given to ‘the managers’. This is significant, for if one ignored the role of the managers

and attempted merely to divine the one true definition of ‘hospital’, the ‘narrow site’ concept

would be of equal force where the whole of a medical campus was within the management of a

single NHS body. In such circumstances – and particularly so where it bore its own distinct name

– a psychiatric unit within a general hospital managed by a single NHS trust would be a discrete

‘hospital’, and its tight bounds would mark the limits within which a patient might be detained and

beyond which s/he would require formal leave of absence.

However, it is to ‘the managers’ that the detention power is entrusted. Unlike the definition of

‘hospital’, that of ‘the managers’ has changed with the times.

As amended by NHS & CCA 1990,[[35]](#footnote-35) and also by a subsequent statutory instrument,[[36]](#footnote-36) MHA 1983,

section 145 states:

‘ “[T]he managers” means –

(a) in relation to a hospital vested in the Secretary of State for the purposes of his

functions under the National Health Service Act 1977, and in relation to any

accommodation provided by a local authority and used as a hospital by or on behalf

of the Secretary of State under that Act, the Health Authority or Special Hospital

Authority responsible for the administration of the hospital;

(bb) in relation to a hospital vested in a Primary Care Trust or a National Health Service

trust, the trust;

(c) in relation to a registered establishment, the person or persons registered in respect of

the establishment;

and in this definition “hospital” means a hospital within the meaning of Part II of this Act.’[[37]](#footnote-37)

It is submitted that this revised definition, and particularly the part contained in sub-section (bb),

is hugely significant. It identifies a hospital by reference to the physical responsibilities of the NHS

trust that manages it. The ‘hospital’ ends at the point where the trust’s writ ceases to run.[[38]](#footnote-38)

Sub-paragraph (bb) does not appear to contemplate the possibility that a ‘hospital’ will be ‘vested’

in more than one trust. There is, it is true, nothing to suggest that the discounting of this possibility

is to be inferred, nor that it was anything more than inadvertent. Furthermore, there seems to be

nothing to preclude the argument that a hospital may be vested in more than one trust. However,

‘vesting’ can only ever be the result of a precise legal process, and its consequences can be verified

objectively. A NHS trust would know if a hospital had been vested in it (and in another NHS

trust), and if it had been so vested, the NHS trust would probably know the precise physical

boundaries of the hospital for which it was now responsible.

Where two or more trusts share a single site, it is unlikely that all of the hospital that site comprises

can be said to be ‘vested’ in each of them, or that any one trust can be said to be seized of parts of

the site beyond those that have been vested in it. Therefore, although it may differ from the

intention of the 1983 legislators, this newer, more restricted definition of ‘hospital’ is by no means

illogical.

If the analysis set out in this section is correct, and the definition of ‘the managers’ means that ‘the

hospital’ in which a patient is detained is now to be regarded as synonymous with the NHS trust

detaining him/her there, it is hard to see how the ‘wide site’ concept can be preferred, at least for

the purposes of MHA 1983, section 6(2) or wherever in the Act powers in connection with the

‘hospital’ are provided for the use of ‘the managers’.

Whether the word ‘hospital’ – which must be assumed to have been intended in 1983 to have a

common meaning wherever it occurred in the Act – may now be given different, possibly

contradictory, meanings is open to dispute, but the possibility seems remote. However, there are

occasions when the use of the word ‘hospital’ in provisions of the MHA 1983 does not coincide

with a reference to “the managers”.

**5.2 Conveyance to the hospital**

MHA 1983 contains various powers to convey a patient to the ‘hospital’ in which s/he is to be

detained. Thus, in the case of a ‘civil’ patient, section 6(1) states:

‘An application for the admission of a patient to a hospital under this Part of this Act, duly

completed in accordance with the provisions of this Part of this Act, shall be sufficient

authority for the applicant, or any person authorised by the applicant, to take the patient and

convey him to the hospital [...].’

As far as offender patients are concerned, section 40(1) (a) states:

‘A hospital order shall be sufficient authority – (a) for a constable, an approved social worker

or any other person directed to do so by the court to convey the patient to the hospital

specified in the order within a period of 28 days [...].’

Unless those conveying the patient know what the ‘hospital’ comprises to which s/he may be

conveyed, they cannot know how far s/he must be carried and where on a particular medical

campus s/he may be deposited.

*The wide site*

If the ‘wide site’ concept is accepted, a patient need be conveyed only to the first boundary of the

overall hospital site, even if the physical limits of the mental health unit in which s/he is to be

confined lay some way inside that boundary.

*The narrow site*

The ‘narrow site’ concept would require that the patient were taken onto the hospital site and

deposited only at the door of the psychiatric unit. If s/he were to attain his/her liberty at an earlier

point, the only power of confinement that might be exercised over him/her would be the one

contained in MHA 1983, section 137 (1) and (2) (which deals with the ‘Provisions as to custody,

conveyance and detention’).

*Discussion*

On the face of it, there is nothing to preclude use of the ‘wide site’ concept in connection with

MHA 1983, sections 6(2) or 40(1)(a). In neither case is the power to convey provided for the use of

‘the managers’; indeed, it is clear that a wider range of statutory actors may exercise that power,

including some individuals whose authority doesn’t simply derive from the managers.

However, it is unlikely that the law would allow a multiplicity of definitions of the same word in

a single Act. Therefore, in view of the comments made in connection with the power to detain,[[39]](#footnote-39)

one is probably forced back onto the narrow site conception.

**5.3 Detention in the hospital**

The power to detain a patient under the civil provisions of MHA 1983 is also expressed in terms

of ‘a hospital’.

To some extent, MHA 1983, section 2(1) – which permits a patient’s admission to hospital for

assessment – replicates the power contained in MHA 1983, section 6 (2). It states:

‘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.’

The same is true of MHA 1983, section 3(1) – the power to admit a patient to hospital for

treatment – which states:

‘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.’

*The wide site*

Acceptance of the ‘wide site’ concept would mean that a patient would be regarded as being still

within ‘the hospital’ whenever he remained on the campus within which his psychiatric unit was

contained, and even though he had left the unit itself behind him.

Moreover, where he was first detained in a part of the hospital that did not provide mental health

care and treatment, he would also be regarded as having been admitted under section to that part

of the campus that provided psychiatric care. The two would be of a piece, and, because he was

simply swapping one part of ‘the hospital’ for another, his movement between them would be

possible without any degree of formality. This would impact upon the need to invoke the power of

transfer in MHA 1983, section 19[[40]](#footnote-40) or the power to grant formal leave of absence under section

17.[[41]](#footnote-41)

*The narrow site*

Adoption of the ‘narrow site’ conception of ‘hospital’ would mean that a patient detained in the

‘general’ part of a health care campus would not be regarded as having also been admitted to the

psychiatric part. The two would have to be seen as entirely discrete units, and the patient would

need formal leave or transfer in order to move to the psychiatric part while still subject to MHA

1983. For the reasons that follow, it is probably the narrow site concept that must prevail.

*Discussion*

Although they are not mentioned in MHA 1983, section 2 or 3, it is clear that the powers of

detention referred to there are to be utilised by ‘the managers’. MHA 1983, section 6(2), which has

been discussed already, [[42]](#footnote-42) states:

‘Where a patient is admitted [...] to the hospital specified in such an application [...], or, being

within that hospital, is treated by virtue of section 5 above as if he had been so admitted, the

application shall be sufficient authority for the managers to detain the patient in the hospital in

accordance with the provisions of this Act.’[[43]](#footnote-43)

Therefore, arguments made about detention under MHA 1983, sections 6(2) or 40(1) (b) would

appear to have equal force here. It would seem that one is forced to adopt the ‘narrow site’ concept

in this case, or at least to proceed as though it had been adopted. The same goes for admissions

pursuant to an ‘emergency application’ under section 4, which also give rise to a power to detain

that is governed by MHA 1983, section 6(2).

**5.4 Holding a patient in the hospital**

One of the greatest controversies about the meaning of ‘hospital’ has concerned the use of the

‘holding powers’ contained in MHA 1983, section 5(2) and (4).

Under MHA 1983, s 5(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.’

MHA 1983, s 5(4) states:

‘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.’

The authority provided by MHA 1983 section 5(2) may be used to detain ‘a patient who is an

in-patient in a hospital’. In such circumstances, the section states, “the patient may be detained in

the hospital.”[[44]](#footnote-44) It seems reasonable to infer that s/he may be detained only in the hospital in which

s/he is already an in-patient (whatever the extent of that ‘hospital’ might be).

The authority provided by MHA 1983 section 5(4) is for a patient’s detention within the ‘hospital’

in which s/he is ‘receiving treatment for mental disorder as an in-patient.’

These powers are of particular relevance in the case of a patient accommodated on a general

medical ward who appears to be suffering from mental disorder. If the two are not to be considered

part of the same ‘hospital’, a patient may not be moved from a general ward to a psychiatric ward

while remaining detained under MHA 1983, section 5. Neither may MHA 1983, section 19 be used

to transfer him/her to another ‘hospital’, for the relevant provisions in section 19(1)(a) and (2)(a)

apply only to ‘a patient who is for the time being liable to be detained in a hospital by virtue of an

application under this Part of this Act.’[[45]](#footnote-45) A patient who is subject to one or other of the holding

powers is not so subject ‘by virtue of an application’. Therefore, the only solution would appear

to be to apply for the patient’s substantive admission to the psychiatric unit under MHA 1983,

section 2 or 3 while s/he was still held on the general ward under section 5(2) or (4).

Professor Eldergill has suggested that it was at first assumed that a patient who nevertheless

remained subject to MHA 1983, section 5(2) or (4) might be moved from one hospital to another,

provided s/he was detained throughout the permitted 72-hour period by a single set of managers.[[46]](#footnote-46)

Now, however, when not just different medical units but different wards within those units might

be under different management, that assumption no longer holds good. There is, Professor

Eldergill suggests, a paradox, which can be summarised as follows:

(i) to allow movement without formality between different NHS trusts may perpetuate the

freedoms that existed before the NHS & CCA 1990, but it also contradicts the statutory

principle that the authority to detain a patient cannot be transferred to different hospital

managers; however

(ii) the prohibition of such movement “is inconsistent with the original statutory assumption,

expressed in section 145(1), that one institution equals one hospital.”[[47]](#footnote-47)

Therefore, Professor Eldergill submits:

“Patients detained on a general ward under section 5(2) may not be removed to a psychiatric

ward under section 19(3) if that ward is separately managed. Nor can the authority to detain

them be transferred to another NHS trust under section 19(1). [...] In extreme cases, their

removal may be justified under common law and recourse may be had to section 4.”[[48]](#footnote-48)

In fact, it is unlikely that use of the common law to transfer a patient from a psychiatric ward to

the ward in a ‘general’ hospital where s/he might receive treatment for a cardiac arrest (for

example) is confined to extreme cases. If, being capable, the patient is an adult who consents to

such a transfer, it will be lawful; the same will be true in the case of an incapable adult patient,

provided the treatment is in his/her ‘best interests’.[[49]](#footnote-49)

Professor Eldergill’s conclusion is doubtless correct, but for at least one reason that he does not

give. It is a reason that this paper has discussed already.[[50]](#footnote-50)

*The wide site*

It might be argued that on the strict wording of MHA 1983, section 5(2) or (4), the detention

permitted is detention in ‘the hospital’, and therefore that if the ‘wide site’ concept is adopted, a

patient detained under either of those provisions in the psychiatric part of a much larger hospital

site might be moved to the general part while still subject to MHA 1983, section 5(2) or (4), even

though the general part and the psychiatric part are managed by different NHS trusts.

Whilst superficially engaging, this analysis cannot withstand a detailed analysis of the full ambit of

the power. Although they are not mentioned in MHA 1983, section 5(2) or (4), it is clear that the

power of detention referred to there is to be utilised by ‘the managers’. As been stated,[[51]](#footnote-51) MHA

1983, section 6(2) states:

‘Where a patient is admitted [...] to the hospital specified in such an application [...], *or, being*

*within that hospital, is treated by virtue of section 5 above as if he had been so admitted*, the

application shall be sufficient authority for the managers to detain the patient in the hospital in

accordance with the provisions of this Act.’[[52]](#footnote-52)

Therefore, arguments made about detention under MHA 1983, sections 6(2) or 40(1) (b) would

appear to have equal force here. It would seem that one is forced to eschew the ‘wide site’ concept

in the case of patients detained in a hospital under MHA 1983, section 5(2) or (4).

*The narrow site*

On the basis of the foregoing, it must be assumed that the MHA 1983 powers of transfer will not

apply to a patient while s/he is detained under MHA 1983, section 5(2) or (4), and that, if they have

different ‘managers’, s/he may be moved from the psychiatric to the general part of a hospital only:

(i) once s/he has been detained under a substantive section of MHA 1983; (ii) if s/he is incapable,

in his/her ‘best interests’ under the common law doctrine of ‘necessity’; or (iii) if s/he is capable,

with his/her consent.

**5.5 Leave to be absent from the hospital**

A patient who is subject to MHA 1983 need not remain forever confined to the hospital to which

s/he is detained. Under section 17(1),

‘The responsible medical officer may grant to any patient who is for the time being liable to be

detained in a hospital under this Part of this Act leave to be absent from the hospital subject

to such conditions (if any) as that officer considers necessary in the interests of the patient or

for the protection of other persons.’[[53]](#footnote-53)

It is in connection with this provision that Richard Jones deals with the definition of ‘hospital’ at

most length. He states:

‘A particular difficulty has arisen where a single hospital site contains a psychiatric and a general

facility and the two facilities are administered by different NHS Trusts. In this situation, should

a detained patient who needs treatment for a physical disorder at the general facility be sent to

that facility under the authority of section 17 leave? As this Act was not drafted in

contemplation of NHS trusts, the answer to this question is not easy to determine.’[[54]](#footnote-54)

The question of whether it will be necessary to grant a patient leave to move from one ward,

managed by one set of managers, to another ward, managed by a different set of managers, even

though the two are on the same wide site, is not one that is created by MHA 1983, section 17, for

that provision is entirely permissive.

In fact, the question is raised as a result of MHA 1983, section 2 or 3 (or section 37), which, as has

been pointed out above, state that a patient may be detained in – but only in – the ‘hospital’ to

which an admission application is made. In that context, the provisions in MHA 1983, section 17

for the giving of formal leave to be absent from the hospital are the solution to this problem.

However, wherever a patient is detained under the Act, it becomes necessary to ask, not so much

when s/he must be granted leave, but how far s/he may venture without it becoming necessary at

all.

For the purposes of MHA 1983, the place within which the patient is detained is the ‘hospital’.

The narrower the confines of that place, the greater is likely to be the need for formal leave of

absence, granted under MHA 1983, section 17, for it is only with such leave that a detained patient

may leave ‘the hospital’.

*The wide site*

If the ‘wide site’ concept were adopted, a patient would not need formal leave to move within the

greater hospital site, even though the discrete unit in which s/he was detained only occupied a part

of that site and was managed by a NHS trust that did not manage the whole site.[[55]](#footnote-55) (However, s/he

would still require such leave if, in making his/her passage across the greater hospital site, s/he

would encounter a phenomenon for which none of the NHS trusts in whom various parts of that

site were vested was responsible in law. This would be the case, for example, where a detained

patient’s journey from a psychiatric ward to a newsagent’s stall, each of which were situated within

a single hospital site, would take him/her across a public road.)

Richard Jones has identified a flaw in the ‘wide site’ conception in so far as it is applied to MHA

1983, section 17. He states:

‘[I]f the patient moves from a part of the hospital that is managed by the NHS trust that is

detaining him to a part of the hospital that is managed by another NHS trust, the staff of that

other trust would not be authorised to detain him. This is because the application for the

patient’s detention would not have been addressed to the Hospital Managers of that other

trust.’[[56]](#footnote-56)

The MHAC has said that it accepts this argument ‘in part.’ However, it continues:

‘Even in a Trust that is a detaining authority, staff employed in capacities that are neither

nursing nor medical probably have limited powers of control over detained patients. The Act

does allow that any “officer on the staff of the hospital” (the definition of which encompasses

any employee of a detaining hospital) may take into custody and return an AWOL patient

under section 18(1), and may be authorised by a patient’s RMO to act as that patient’s escort

as a condition of leave (section 17(3)).’[[57]](#footnote-57)

This would not appear to address Jones’s specific point: what powers are to be enjoyed by doctors

and nurses employed, not by the detaining authority, but by the NHS trust that manages another

part of the same ‘hospital’ site? Are they ‘on the staff of’ the detaining ‘hospital’, as the ‘wide site’

concept would appear to imply, or can they utilise the take and return powers in section 18 only if

they have been expressly authorised to do so, as the ‘narrow site’ conception implies? The MHAC

does not answer this question, nor does it say which part of Jones’s argument it accepts (and which

it rejects).

*The narrow site*

As the MHAC has put it, the implication of adopting the ‘narrow site’ concept would be that:

‘[...] formal leave would be required under MHA 1983, section 17 for a patient to move from a part

of the hospital site that was managed by one NHS body to a part of the site that was managed by

another NHS body.’[[58]](#footnote-58)

*Discussion*

Clearly the question is not without practical significance: a Trust that adopted the wide site

concept might deny itself powers of control that it ought in fact and law to possess; whereas

inappropriate insistence on the narrow site conception might open a Trust up to judicial challenge.

The intricacies of the former situation have been discussed already.[[59]](#footnote-59) With regard to the latter

situation, a patient might have a cause of action against those who detained him/her if s/he were

prevented from going from one part of the greater hospital site to another solely because, on the

basis of the ‘narrow site’ test, s/he was thought to require formal leave of absence and his/her

mental state was not thought robust enough to warrant the granting of it.

This is the mirror image of the problem encountered under MHA 1983, sections 6(2) and 40(1) (b).

It concerns, not how closely a patient may or must be confined, but how far s/he may venture

without requiring formal leave of absence. However, and as has been indicated, in truth this

problem is created by MHA 1983, sections 2 and 3. That is important, because, unlike MHA 1983

section 6(2) or 40(1) (b), neither section 2 nor section 3 involves ‘the managers’. This means that the

word ‘hospital’ stands alone for the purposes of those sections. Therefore, the word is unqualified,

so that there is nothing to prevent its being given a wider definition. Nothing, that is, save the

general illogicality of having the same word defined in two different – possibly contradictory –

senses at different points in the same Act.

**5.6 The returning of a patient to the hospital**

Detained patients who go absent without leave (‘AWOL’) may be retaken and returned to the

hospital from which they have absconded. Under MHA 1983, section 18:

‘Where a patient who is for the time being liable to be detained under this Part of this Act in

a hospital –

(a) absents himself from the hospital without leave granted under section 17 above; or

(b) fails to return to the hospital on any occasion on which, or at the expiration of any

period for which, leave of absence was granted to him under that section, or upon being

recalled under that section; or

(c) absents himself without permission from any place where he is required to reside in

accordance with conditions imposed on the grant of leave of absence under that section,

he may, subject to the provisions of this section, be taken into custody and returned to the

hospital or place by any approved social worker, by any officer on the staff of the hospital, by

any constable, or by any person authorised in writing by the managers of the hospital.’[[60]](#footnote-60)

There are two aspects of this provision to which the definition of ‘hospital’ is relevant:

determining the point at which a detained patient becomes AWOL; and identifying the individuals

who may re-take him/her.

*The wide site*

Under the ‘wide site’ conception of ‘hospital’, a patient might be re-taken and returned there by a

larger number of staff, the pool of whom might include those from all units on a single site, even

if those units were managed by different NHS Trusts. However, there would be fewer cases in

which such a patient would be AWOL, as, if s/he wandered away from the psychiatric unit into the

grounds of a ‘general’ hospital that, though it was managed by a different NHS trust, was

contiguous with the grounds of the psychiatric unit, s/he would not have left the ‘hospital’ that

both units comprised.

*The narrow site*

The patient would be AWOL immediately s/he left the grounds for which the NHS trust that

managed the psychiatric unit was responsible. S/he could only be re-taken by someone ‘on the staff

of’ the psychiatric unit.

*Discussion*

The power to authorise persons to retake a patient who has gone AWOL is granted solely to ‘the

managers’, and so must be taken to be exercisable only by the NHS trust in which is vested the

premises in which the patient is liable to be detained.[[61]](#footnote-61)

However, there is nothing in MHA 1983, sec tion 18 to limit the substantive power to re-take a

detained patient to ‘the managers’: it may be exercised by, inter alia, ‘any officer on the staff of the

hospital.’ There is, of course, now some uncertainty as to what the word ‘officer’ means, and in

particular, whether it includes an employee who has no managerial involvement in his employer’s

affairs.[[62]](#footnote-62) That uncertainty apart, there is nothing in the wording of the statute itself to prevent a

wider conception of ‘hospital’ being adopted and a wider pool of possible patient-takers being

created. However, such a course would be inconsistent with the approach that, it would seem, must

be taken in respect of other manifestations of the word ‘hospital’. It has already been suggested

that it would be curious if contradictory definitions of the word were permitted to co-exist within

a single Act; it is surely the more so in the case of a single section of an Act.

**5.7 Transfer from the hospital**

The transfer of a detained patient from one hospital to another is dealt with in MHA 1983, section

19(1), which states:

‘In such circumstances and subject to such conditions as may be prescribed by the Secretary of

State –

(a) a patient who is for the time being liable to be detained in a hospital by virtue of an

application under this Part of this Act may be transferred to another hospital [...].’

Once a transfer has been effected in accordance with MHA 1983, section 19(1) (a), section 19(2)

provides:

‘(a) in the case of a patient who is liable to be detained in a hospital by virtue of an application

for admission for assessment or for treatment and is transferred to another hospital, as if the

application were an application for admission to that other hospital and as if the patient had

been admitted to that other hospital at the time when he was originally admitted in pursuance

of the application[.]’

(Where, in the case of hospitals that are incontrovertibly distinct, they are nevertheless under the

management of a single NHS trust, a detained patient may be transferred between them without

formality under MHA 1983, section 19(3).[[63]](#footnote-63) This possibility is considered in section 5.1, above.)

*The wide site*

Adoption of the ‘wide site’ concept would imply that a patient wouldn’t leave the ‘hospital’ – and

therefore would not need to be formally transferred under MHA 1983, section 19 – where all s/he

did was quit one ward or unit on a larger medical campus for another, even though the latter ward

or unit was managed by a different NHS trust than to the former.

*The narrow site*

The ‘narrow site’ concept would require that a transfer of the kind described above be made with

*formality, under MHA 1983, section 19.*

*Discussion*

Once s/he has been transferred to a new hospital under MHA 1983, section 19(1), a patient’s

detention is to be regarded as always having been in that hospital.[[64]](#footnote-64) Therefore, it is assumed, the

managers of the new hospital will find their authority to detain him/her in the same provision that

would have protected the managers from whom the patient has been received – in other words, in

MHA 1983, section 6(2). This, it will be recalled, permits ‘the managers to detain the patient in the

hospital in accordance with the provisions of this Act.’ However, in this context, the managers ‘in

relation to a hospital vested in a Primary Care Trust or a National Health Service trust’ is merely

‘the trust’.[[65]](#footnote-65) Therefore, to apply the argument that has been already advanced,[[66]](#footnote-66) whatever the

institution to which the patient has been transferred, it would seem that it is only the NHS trust

in which that institution is ‘vested’, and not a NHS trust responsible for another part of the site

on which that institution is situated, that might detain him/her thereafter. Once again, the ‘narrow

site’ concept must be introduced, even if only at arm’s length.

**5.8 Recommending that a patient be admitted to hospital**

There is one other use of the word ‘hospital’ that should be addressed. It is different to the other

uses described in this paper.

In section 12(3), MHA 1983 deals with the medical recommendations that must support an

application for a patient’s admission to hospital. The section states:

‘Subject to subsection (4) below, where the application is for the admission of the patient to a

hospital [...], one (but not more than one) of the medical recommendations may be given by a

practitioner on the staff of that hospital [...].’

This provision creates a conundrum that is, perhaps, the mirror image of those discussed above,

for the wider the concept of ‘hospital’ that one applies the more one reduces one’s room for

manoeuvre.

As to which concept of ‘hospital’ is to be preferred, the MHA 1983 Code of Practice is of no

practical assistance. All it says is:

“Where a Trust manages two or more hospitals which are in different places and have different

names [,] one of the two doctors making the medical recommendations may be on the staff of

one hospital and the second doctor may be on the staff of one of the other hospitals.”[[67]](#footnote-67)

In the situations discussed in this paper, the hospitals – insofar as the plural is the appropriate form

to use – are not in different places, but on the same site, and they are not managed by the same

NHS trust.

*The wide site*

The effect of MHA 1983, section 12(3) is to require at least one of the recommendations

supporting a patient’s detention to be provided by a medical practitioner who is not on the staff

of the hospital in which s/he is detained. Clearly, therefore, if one conceives of the hospital in

broad terms, one may reduce the pool of practitioners who may be called upon to assist.

*The narrow site*

If the hospital is conceived of as a small entity, the number of practitioners outside it – and therefore

not on its staff – will be that much greater than if one were to conceive of it as a large thing.

*Discussion*

As it is used in MHA 1983, section 12(3), the term ‘hospital’ is not linked to ‘the managers’, and

therefore, there would seem to be nothing to require the narrow reading of the former term that is

required by the up-dated definition of the latter term.

However, and as discussed before, it would seem to be unlikely that one and the same word might

have different, contradictory meanings at different places in the Act. The word ‘hospital’ must

probably be taken to mean the same wherever it appears. If so, the ‘narrow site’ concept will have

to prevail, and the larger will become the number of doctors who may provide the second

recommendation for a patient’s detention under MHA 1983.

**5.9 A specific hospital**

There is at least one situation to which the foregoing discussion is irrelevant. Under the Crime

(Sentences) Act 1997, when sending to a hospital a patient who is subject to restrictions, the Courts

or the Home Secretary may direct that s/he be detained in a *specific* unit or part of that hospital[[68]](#footnote-68).

This element of specificity goes beyond anything provided for in MHA 1983.

**6. Summary**

The argument advanced in this paper may be reduced to a number of propositions:

(a) It is now necessary to attempt to apply the Mental Health Act 1983 in situations very different

from those anticipated by the Act’s first framers.

(b) This is especially so when one is dealing with a provision that relates to ‘a hospital’.

(c) It is unhelpful to attempt to divine the true meaning of the word; the entity that was called ‘a

hospital’ in 1983 has, for the most part, ceased to exist.

(d) In any case, the task cannot be carried out in the abstract; one must define the word according

to the context in which it is used and with regard to the powers with which it is associated in a

particular case.

(e) The existing definition of ‘hospital’ does not correspond to modern practice.

(f) However, other terms – for example, ‘the managers’ – have been revised in to take account of

changed circumstances.

(g) Wherever the term ‘the managers’ is used in conjunction with ‘hospital’, the more restrictive

definition of that term introduced by the National Health Service & Community Care Act

1990 would seem to require that the ‘narrow site’ concept of ‘hospital’ be adopted. Therefore,

and must crucially:

(i) a patient who is subject to MHA 1983 may only be confined within the boundary that

marks the limit of the responsibilities of the NHS trust that confines him;

(ii) formal leave of absence will be required if s/he is to cross that boundary;

(iii) a patient who is subject to the section 5 holding power may only be moved within the

‘hospital’ managed by the Trust whose doctor or nurse applied that power to him/her.

(h) There is nothing in MHA 1983 to require adoption of the ‘narrow site’ concept of ‘hospital’

in cases where it is not qualified by mention of ‘the managers’, but it is unlikely that two

competing conceptions of the word could be allowed to co-exist in one statute.

**7. Conclusion**

Sadly, the definition of hospital that is provided by the Mental Health Act 1983 is neither more

clear nor more helpful than the one given by Leslie Nielsen in Airplane! However, as this paper has

attempted to explain, there was one respect in which his otherwise admirable reply got it wrong:

right now, the question is important.

If we base our argument on an attempt to divine the true meaning of “hospital” as it is used in

MHA 1983, we could go on arguing forever. It has not been revised in the light of significant

changes to the way mental health services are configured, and it is now hopelessly out of date.

However, some areas of MHA 1983 have been revised to take account of those changes. They

include the definition of ‘the managers’ in MHA 1983, s 145. The amendments to this definition

those were made in 1990, coupled with the failure to make such amendments to the definition of

‘hospital’, suggest that it was the government’s intention that, at least in so far as concerns the

power of detention (and the other powers specifically endowed upon ‘the managers’), they should

be exercisable by each discrete NHS trust in – and only in – the premises for which it was

responsible.

This paper has, perhaps, provided the least equivocal evidence for supposing that that is so.

As they wrestle with the competing conceptions set out here, mental health practitioners might

draw some small comfort from the fact that, no matter how wide their conception of a ‘hospital’, its

bounds could never approach the dimensions of those suggested by Sir Thomas Browne.[[69]](#footnote-69) He said:

“For the world, I count it not an inn, but an hospital, and a place, not to live, but to die in.”[[70]](#footnote-70)

1. Solicitor, and partner in Hempsons. The author would like to thank John Holmes, Bill Leason and Stephen Evans, who are also partners in Hempsons, for their very helpful comments on earlier drafts of this paper [↑](#footnote-ref-1)
2. Airplane! , 1980, dirs: Jim Abrahams, Jerry Zucker, David Zucker [↑](#footnote-ref-2)
3. MHA 1983, s 145(1) [↑](#footnote-ref-3)
4. NHSA 1977, s 128(1) [↑](#footnote-ref-4)
5. Clarendon Press, Oxford, 1993 [↑](#footnote-ref-5)
6. Which deals with the ‘Informal treatment of patients aged under 18’ [↑](#footnote-ref-6)
7. Which deals with the ‘Functions of Commission for Healthcare Audit and Inspection’ [↑](#footnote-ref-7)
8. Which deals with ‘Miscellaneous’ matters [↑](#footnote-ref-8)
9. Which deals with the ‘Transfer of patients from England and Wales’ [↑](#footnote-ref-9)
10. Which also deals with the ‘Transfer of patients from England and Wales’ [↑](#footnote-ref-10)
11. Which also deals with the ‘Transfer of patients from England and Wales’ [↑](#footnote-ref-11)
12. Which deals with the ‘Ill-treatment or wilful neglect of patients’ [↑](#footnote-ref-12)
13. Which deals with ‘Examination, Assessment and Treatment’ [↑](#footnote-ref-13)
14. Which deals with ‘Patients Concerned in Criminal Proceedings etc’ [↑](#footnote-ref-14)
15. Department of Health, Draft Mental Health Bill, September 2004, Cm 6305-I, cl 2(3); Department of Health, Draft Mental Health Bill: Explanatory Notes, September 2004, Cm 6305-II, para 32 [↑](#footnote-ref-15)
16. Department of Health, Draft Mental Health Bill, June 2002, Cm 5538-I, cl 2(3); Department of Health, Draft Mental Health Bill: Explanatory Notes, June 2002, Cm 5538-II [↑](#footnote-ref-16)
17. See, for example: Department of Health, Review of the Mental Health Act 1983: Report of the Expert Committee, November 1999; Department of Health, Reform of the Mental Health Act 1983: Proposals for Consultation, November 1999, Cm 4480 [↑](#footnote-ref-17)
18. Anselm Eldergill, Mental Health Review Tribunals: Law and Practice, 1997, London, Sweet & Maxwell, p 139 [↑](#footnote-ref-18)
19. See Eldergill, 1997, op cit, p 139 [↑](#footnote-ref-19)
20. Eldergill, 1997, op cit, p 139 [↑](#footnote-ref-20)
21. MHAC, Seventh Biennial Report: 1995–1997, 1997, London: The Stationery Office, para 10.10.2 [↑](#footnote-ref-21)
22. Eldergill (1997), op cit, p 139. See also: Richard Jones (2003), Mental Health Act Manual, eighth edition, London, Sweet & Maxwell, para 1–208 [↑](#footnote-ref-22)
23. MHAC, 1999, Issues Surrounding Sections 17, 18 and 19 of the Mental Health Act 1983, Guidance Note GN 1–99; accessible at

    www.mhac.trent.nhs.uk/s17.pdf . See also: MHAC, 1997, op cit, para 10.10.2; MHAC, Placed Amongst Strangers – Tenth Biennial Report: 2001–2003, 2003, London, The Stationery Office, para 9.40 [↑](#footnote-ref-23)
24. MHAC, 1999, op cit. See also: MHAC, 1997, op cit, para 3.4; MHAC, Eighth Biennial Report: 1997–1999, 1999, The Stationery Office, para 4.58; MHAC, 2003, op cit, para 9.40 [↑](#footnote-ref-24)
25. MHAC, 1999, op cit [↑](#footnote-ref-25)
26. Eldergill, 1997, op cit, p 139 [↑](#footnote-ref-26)
27. Eldergill, 1997, op cit, p 141 [↑](#footnote-ref-27)
28. Eldergill, 1997, op cit, p 141 (original emphasis) [↑](#footnote-ref-28)
29. Eldergill, 1997, op cit, p 141 [↑](#footnote-ref-29)
30. See, for example, para 5.1, below [↑](#footnote-ref-30)
31. Richard Jones, Mental Health Act Manual, 2003, eighth edition, London, Sweet & Maxwell, para 1–208 [↑](#footnote-ref-31)
32. MHA 1983, s 6(2) (emphasis added) [↑](#footnote-ref-32)
33. MHA 1983, s 40(1)(b) (emphasis added) [↑](#footnote-ref-33)
34. Emphasis added [↑](#footnote-ref-34)
35. NHS and CCA 1990, s 66(1) [↑](#footnote-ref-35)
36. The Health Act 1999 (Supplementary, Consequential, etc., Provisions Order 2000, SI 2000 No 90, Sched 1, para 16(3) [↑](#footnote-ref-36)
37. MHA 1983, s 145(1)(a) [↑](#footnote-ref-37)
38. The new Draft Bill contains provisions to much the same effect. See: Department of Health, Draft Mental Health Bill, September 2004, Cm 6305–I, cl 2(4) [↑](#footnote-ref-38)
39. See paragraph 5.1 [↑](#footnote-ref-39)
40. See paragraph 5.7 [↑](#footnote-ref-40)
41. See paragraph 5.5 [↑](#footnote-ref-41)
42. See paragraph 5.1 [↑](#footnote-ref-42)
43. MHA 1983, s 6(2) [↑](#footnote-ref-43)
44. Emphasis added [↑](#footnote-ref-44)
45. Emphasis added [↑](#footnote-ref-45)
46. Eldergill, 1997, op cit, p 140 [↑](#footnote-ref-46)
47. Eldergill, 1997, op cit, p 140 [↑](#footnote-ref-47)
48. Eldergill, 1997, op cit, p 141 [↑](#footnote-ref-48)
49. F v West Berkshire Health Authority and another (Mental Health Act Commission intervening) [1989] 2 All ER 545; Re T (Adult: Refusal of Medical Treatment) [1992] 4 All ER 649, CA, per Lord Donaldson MR; Re MB (Medical Treatment) [1997] 2 FLR 426, CA; R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 3 All ER 289, [1999] 1 AC 481 [↑](#footnote-ref-49)
50. See para 5.1, Discussion [↑](#footnote-ref-50)
51. See paragraph 5.1 [↑](#footnote-ref-51)
52. MHA 1983, s 6(2) (emphasis added) [↑](#footnote-ref-52)
53. MHA 1983, s 17(1) [↑](#footnote-ref-53)
54. Richard Jones, 2003, op cit, para 1–208 [↑](#footnote-ref-54)
55. See MHAC, 1999, op cit [↑](#footnote-ref-55)
56. Jones, 2003, op cit, para 1–208 [↑](#footnote-ref-56)
57. MHAC, 2003, op cit, para 9.42 [↑](#footnote-ref-57)
58. MHAC, 1999, op cit [↑](#footnote-ref-58)
59. See para 5.1 [↑](#footnote-ref-59)
60. MHA 1983, s 18(1) [↑](#footnote-ref-60)
61. See paragraph 5.1 [↑](#footnote-ref-61)
62. R (on the application of PD) v West Midlands and North West Mental Health Review Tribunal [2004] EWCA Civ 311, per Lord Phillips MR at paras 22–25 [↑](#footnote-ref-62)
63. As amended by NHS & CCA 1990, s 66(1) and Sched 9, para 24(2), and by The Health Act 1999 (Supplementary, Consequential, etc., Provisions) Order 2000, SI 2000 No 90, Sched 1, para 16(3) [↑](#footnote-ref-63)
64. MHA 1983, s 19(2)(a) [↑](#footnote-ref-64)
65. MHA 1983, s 145(1)(a) [↑](#footnote-ref-65)
66. See para 5.1 [↑](#footnote-ref-66)
67. Department of Health and Welsh Office, MHA 1983 Code of Practice, 1999, para 2.30 [↑](#footnote-ref-67)
68. Crime (Sentences) Act 1997 s.47. Also, see Home Office Circular 52/1997, paras 10–12 [↑](#footnote-ref-68)
69. 1605–1682 [↑](#footnote-ref-69)
70. Religio Medici (1647), part ii, 11 [↑](#footnote-ref-70)