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Diplomatic immunity and the Mental Health Act 1983

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The UK, in common with all other countries party to the Vienna Convention on Diplomatic Relations, affords foreign diplomats a special status in law. Under the Diplomatic Privileges Act (1964) (DPA), accredited diplomats are accorded inviolability and cannot be detained compulsorily under any Act of Parliament, including the Mental Health Act 1983 (MHA).

A diplomat who is incapable of or unwilling to accept treatment by virtue of mental disorder "of a nature or degree which warrants his detention in a hospital", may require urgent admission "in the interests of his own health or safety or with a view to the protection of other persons", but this cannot be enforced by the usual procedure.

The only exceptional procedures stated in the MHA refer to the compulsory admission of Members of Parliament. It could reasonably be assumed that there are no other exceptions and certainly none are mentioned in the MHA (1959, 1983), in the Explanatory Memorandum (DHSS, 1983) or in the Code of Practice (Department of Health, 1989). Speller (1973, 1978), Bluglass (1983) and Gostin (1983, 1986) are equally silent on the subject. Jones (1985) states simply: "Diplomats and their families should not therefore be made subject to the provisions of this (MHA) Act". Therefore there appears to be no guidance in the standard texts and, when faced with an actual case, advice was sought from appropriate bodies.

The Mental Health Act Commission could not give any guidance "as the situation had not arisen previously". The Medical Defence Union, initially in the same position, later gave specific advice promptly, after first seeking a legal opinion. Only the Legal Department of the Foreign and Commonwealth Office were in the singular position of being able to give immediate and precise instructions on the procedure required by law. In brief:

> The inviolability afforded by the DPA can only be lifted by the State which the diplomat represents; in normal circumstances the State's consent must be obtained from the appropriate Head of Mission, usually an Ambassador, with whose agreement the provisions of the MHA can then be exercised. Irreversible and hazardous treatments would require his consent. In cases of extreme emergency, where immediate detention of the diplomat is the only way to protect human safety, such action would be justifiable on the basis of the inherent right of self-defence, or the duty to protect human life. In such a case the Foreign and Commonwealth Office should be informed immediately.
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> The Medical Defence Union advised that the consent of the Head of Mission should be sought in writing; and that the issue of breach of confidentiality should not present a problem to a doctor who was clearly acting in the best interests of the patient.

As this situation is likely to be uncommon, and particularly rare in NHS practice, the following case is reported. The advent of 1992 may render such situations less rare.

Case Report

A senior diplomat of a foreign mission in London was giving cause for concern and, under pressure from his family, saw a psychiatrist privately but refused help on the grounds of objection to private treatment.

Shortly after he was detained under Section 136 because of his behaviour in a public place but immediately released once his diplomatic status became known. He had expressed suicidal intentions and was known to own a handgun.

A further deterioration of behaviour led to an emergency admission to a local casualty department and the involvement of the psychiatric service. The casualty officer, an approved doctor and an approved social worker agreed that the patient was in urgent need of admission under Section 2 of the MHA.

The Foreign and Commonwealth Office conducted the delicate negotiations with the acting Head of Mission and verbal consent was obtained. Section 2 was implemented on the clear understanding that written consent from the Head of Mission would follow urgently.

In this case the issue of confidentiality did not arise as the Diplomatic Protection Group, the Foreign and Commonwealth Office and the Head of Mission had, fortunately, already been made aware of the situation before our involvement. However, clinical necessity forced us to rely on the consent of the acting Head, as the actual Head of Mission was not available at the time.

This was unsatisfactory to the professionals concerned, as it left an element of doubt as to their personal position in law, and having to rely on Section 139 MHA or common law for a defence.

Some weeks after discharge, the diplomat was found dead in his car with a bullet in his head.

Comment

Actions under the MHA violating diplomatic immunity could render the medical practitioner, and

others concerned, liable in law. It is unlikely that Section 139 MHA 1983 could be relied upon as a defence.

In a written opinion issued after the event, the solicitor to the health authority advised if "A person performing duties substantially corresponding to the duties performed by members of the Official Staff of an Envoy of a Foreign Sovereign, which in practice amounts to the person being accorded Diplomatic Status by the Foreign Office, then in such a situation that person is covered by the 1952 Act . . . is immune both from suit and legal process . . . you cannot sue him and he is totally immune so far as our laws are concerned . . . even if doctors wanted to admit such a person under a section . . . such a patient would be free to walk out at any time as if he were a totally informal patient. . . . As a matter of law you (the Health Authority) would not be immune from his issuing proceedings against you . . . he would have the normal rights as if he were a normal English citizen".

There is so far only one Court of Appeal decision relating to Section 139 MHA (*The Times,* 1985) and its interpretation must otherwise rely on case law relating to Section 141 MHA 1959. In Richardson v. LCC it was held that this section should be widely construed and Denning L.J. suggested that it gave protection even if the Act were misconstrued or actions taken without jurisdiction, provided there was no evidence of bad faith or lack of reasonable care. In the same case Parker L.J. would allow the statute to be misconstrued so long as it could bear that interpretation to the non-legal mind. However, in Buxton v. Jayne, Devlin L.J. said 'there are limits to which the plaintiffs can be expected to prove a negative'; and in R v. Runingham it was held that this section did not apply to informal patients (Speller, 1978).

In the view of Speller (1973) a medical practitioner who wrongfully detained a patient would lay himself open to an action for damages for false imprisonment, but it would be most unlikely that such an action would be brought, or if it were, that a successful plaintiff would be awarded more than nominal damages, provided the doctor acted reasonably and in good faith. The extension of the protection of the section to act in purported pursuance of the Act would cover a doctor who reasonably and in good faith wrongly believed a state of affairs to exist which, had it existed, would have entitled him, by virtue of the Act, to do what he had in fact done. But Section 141 MHA 1959 would not help him if his mistake had been, not as to the state of affairs, i.e. as to the relevant facts, but as to what the Act authorised him to do in that state of affairs which actually existed, i.e. as to law.

In a judgement delivered on 9 July 1985 (*The Times,* 1985) the Court of Appeal held that in considering under Section 139 MHA 1983 whether to grant an applicant leave to pursue a negligence claim against a medical practitioner, the correct test to be applied was whether on the material before the Court the complaint appeared to deserve fuller investigation and not whether the applicant had established a *prima facie* case against the doctor; a court was no longer required to be satisfied that the doctor had acted without reasonable care. The Court regarded the removal in Section 139 MHA 1983 of the wording "substantial ground for the contention that the person to be proceeded against has acted . . . without reasonable care", previously in Section 141 MHA 1959, as a change of substance. That left in issue only what Section 139 MHA 1983 requires to be demonstrated before leave should be granted and the Court considered this to be whether the complaint appeared to be such that it deserved fuller investigation, which would be possible if leave was granted.

In the opinion of a Mental Health Act Commissioner, a barrister, the doctor would have to rely on common law, provided he could justify that the circumstances warranted it. Therefore, unless the requirements of the DPA are fully met, it could be argued that the protection accorded by Section 139 MHA 1983 would not be applicable and a defence would have to rely on common law. Furthermore, ethical and legal issues of confidentiality also arise from the disclosure of clinical information to the Head of Mission or the Foreign and Commonwealth Office. The doctor can refuse to make any such disclosure, even though this may not be in the best interest of the patient. In practice, the problem can be surmounted by disclosing only the criteria of the MHA which are applicable to the Foreign and Commonwealth Office, who will then act as intermediaries with the Head of Mission. Nevertheless, this still implies the disclosure of sensitive information to third parties, one of whom is also in the position of being the employer. Again, in practice, the likelihood is that this information is already in their hands through other sources, e.g. The Diplomatic Protection Group.

Appendix

The following telephone numbers of the Foreign and Commonwealth Office will prove useful to clinicians who find themselves in the same situation: 071-273 3557/3561/5448. In practice, the best way of obtaining the necessary consent from the Head of Mission will be through the Foreign and Commonwealth Office.

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Audit in practice

Reading about . . . medical audit

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The volume of literature on medical audit and the broader field of quality assurance is expanding rapidly. Medical audit is now a requirement for all medical practitioners; therefore, to perform it, they need to know something about it. There is a multitude of articles written in the journals, especially the *British Medical Journal* and the *Journal of the Royal Society of Medicine*. However, in this paper I intend concentrating on some of the many books pertaining to this field which have been published recently.

Introducing medical audit

Medical Audit (Charles Shaw)

Charles Shaw is one of the leading authorities in the field of medical audit. He uses his considerable experience gained on both sides of the Atlantic to compile a very useful introductory book. He defines medical audit and quality assurance; he argues cogently for the widespread practide of audit, gives examples of the benefits of medical audit as it is already practised, explains how one sets up an audit programme, what methods to use and what subjects to audit. He discusses the considerable administrative issues such as resource implications, clinical databases, coding difficulties, inadequacies of existing medical record systems and issues of confidentiality.

Overall this is an excellent book which should be read by all clinicians practising audit, i.e. every doctor.

Hospital-Wide Quality Assurance (C. R. M. Wilson)

This is a Canadian book by an author who has widespread experience in the field, having set up a number of quality assurance programmes in Canadian hospitals. The discipline of quality assurance is far more