Mersey Care NHS
NHS Foundation Trust

# TRUST-WIDE CLINICAL POLICY DOCUMENT

## VICTIMS' RIGHTS

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| **Scope of this Document:** | **All staff working in a clinical or clinical support role** |
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| **Lead Author(s):** | **Head of Forensic Social Care / Nominated Officer** |

TRUST-WIDE CLINICAL POLICY DOCUMENT

**2017 – Version 1**

**Quality, recovery and wellbeing at the heart of everything we do**

Mersey Care NHS
NHS Foundation Trust

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## VICTIMS' RIGHTS

### Further information about this document:

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| Document name | **VICTIMS' RIGHTS AND SHARING OF INFORMATION POLICY** |
| Document summary | **This document contains guidance relating to victims' rights under the Domestic Violence, Crime and Victims Act (DVCVA) 2004 and Section 48 and Schedule 6 of the Mental Health Act 2007, relating to chapter 2 patients - (with effect from 3 November 2008).**<br><br>**Through this Policy, the service will enable victims to exercise their rights and will ensure that all relevant staff are aware of their responsibilities and are enabled to fulfil these as required by the MHA 2007 and DVCVA 2004.** |
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| To be read in conjunction with | **MCT Policy MH01: MHA 1983 Overarching Policy**<br><br>**Mental Health Act Code of Practice 2015 edition chapter 40**<br><br>**'The 'Victims' Code' - The Code of Practice for Victims of Crime. Ministry of Justice. 2013**<br>**Domestic Violence, Crime and Victims Act 2004**<br><br>**Section 48 and Schedule 6 of the Mental Health Act 2007** |
| **This document can be made available in a range of alternative formats including various languages, large print and braille etc** | |
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## Version Control:

| | | Version History: |
|---|---|---|
| Version 1 | Policy Group<br>Executive Committee | February 2017<br>March 2017 |

## SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

### SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

### EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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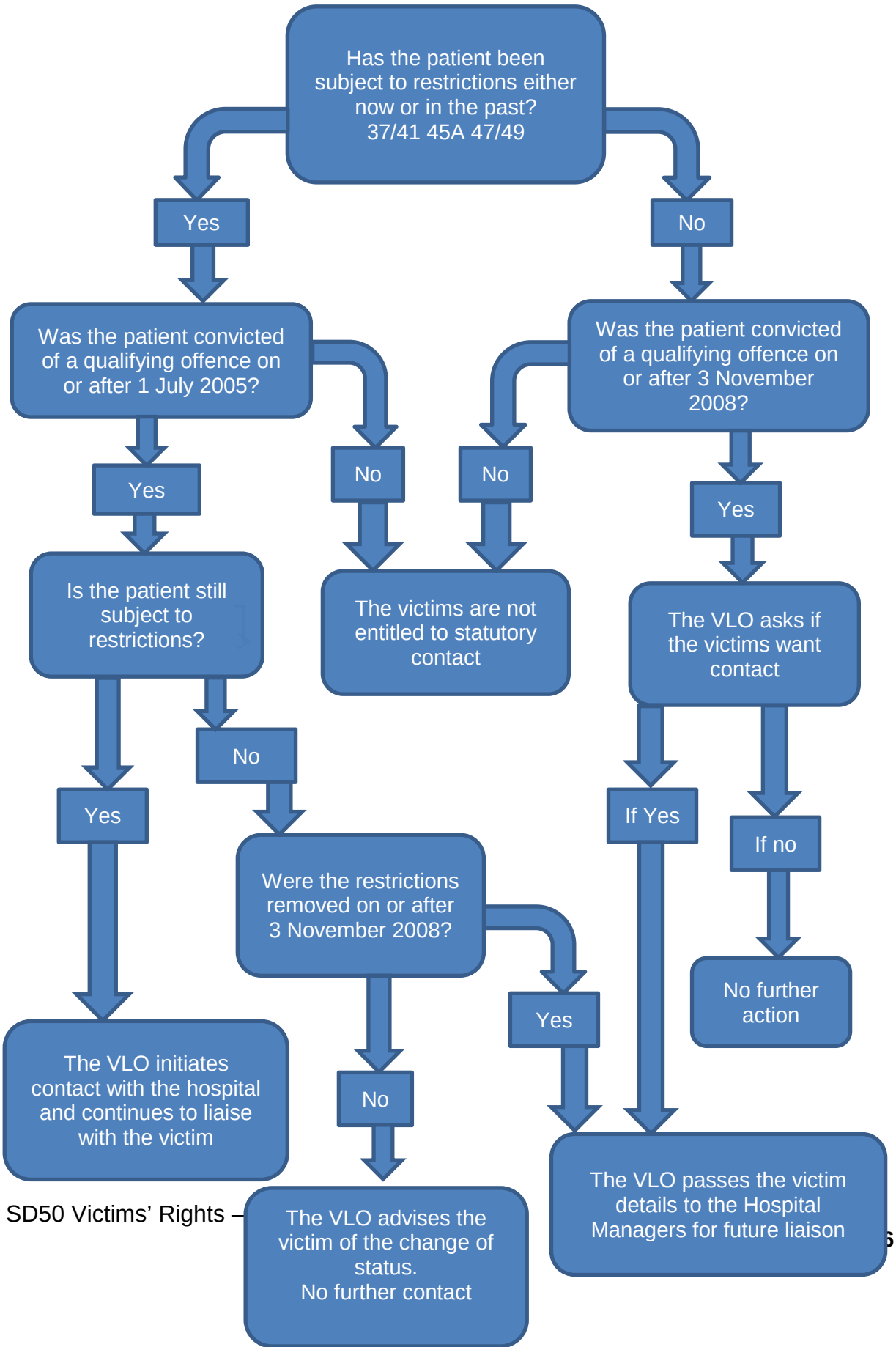
## 1. FLOWCHART – VICTIMS RIGHTS PROCEDURE

**(Modified version, taken from the Probation Circular 23/2008)**



## 2. INTRODUCTION

2.1 The purpose of this procedure is to provide information and guidance on the actions to be taken by Trust staff to meet the requirements of the Mental Health Act 1983 (as amended) and the Domestic Violence, Crime and Victims Act 2004 (DVCVA) as they relate to victims of crime and in relation to people considered to be potential victims.

2.2 The victims of specified violent and sexual offences (see sections 4.6 and 8) have certain rights to information about the offender. This includes offenders who are subject to the Mental Health Act 1983 (MHA) and are detained in hospital or subject to compulsion in the community. The victims also have rights to make representations about the release of the offender from detention under the MHA.

2.3 All hospital and community-based staff with a responsibility for the care and treatment of patients affected by this legislation, whether the patients are perpetrators of the crime or victims, must have a clear and structured response to any occasions where actions must be taken to comply with the MHA and DVCVA.

## 3. SCOPE OF PROCEDURE

3.1 The procedure applies to:

a) All patients in the Trust who have committed a specified violent or sexual offence and meet the criteria under the DVCVA

b) All patients in the Trust who have been a victim of crime that falls within the criteria of the DVCVA

c) All staff employed by or seconded to the Trust working in a clinical or clinical support role.

3.2 This procedure should be read in conjunction with the following Trust policies:

SD01: v2 Leave for inpatients who are either managed informally under section 131 of the Mental Health Act or under the general powers of the Mental capacity Act (Sections 5&6)
SD05: Service users missing from an inpatient area
SD21: v3 Corporate Policy and Procedure for the Care Programme Approach
HSS 12: Policy and Procedure for Care Programme Approach
SD46: Multi Agency Public Protection Arrangement (MAPPA)
HSS 05: Multi Agency Public Protection Arrangements (MAPPA) Protocol

SD-G3: Section 117 - Aftercare under the Mental Health Act 1983
MH01: MHA 1983 Overarching Policy
MH20: Mental Health Act Managers' Policy
HSS 14: Policy & Procedure for Patients Temporary Absence from Hospital

## 4. LEGISLATION AND GUIDING PRINCIPLES

4.1 Under the provisions of the DVCVA 2004 the victims of certain offenders (who are detained in hospital under Part 3 of the MHA as ***restricted patients*** or in the community subject to a conditional discharge) have rights to receive information. The victims also have rights to make representations about the conditions to which the

offender may be subject on their discharge from hospital. These victim rights in respect of restricted patients are not new. They came into force on 1 July 2005.

4.2 The MHA 2007 amended the DVCVA, extending these rights to the victims of ***unrestricted patients***. These new rights came into force on 3 November 2008. Section 9 of this policy provides more detail on identifying the patients within the Trust affected by the legislation.

4.3 The MHA 2007 placed new statutory duties on Hospital Managers (effectively, the Trust Board). These duties are outlined in section 5 below.

4.4 Any actions taken by Trust staff to meet the requirements of the MHA must be taken in accordance with the guiding principles in Chapter 1 of the MHA Code of Practice 2008. These principles are as follows:

4.4.1 **Purpose** Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm.

4.4.2 **Least Restriction** People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

4.4.3 **Respect** People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation, and any disability. They must consider the patient's view, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

4.4.4 **Participation** Patients must be given the opportunity to be involved, as far as practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

4.4.5 **Effectiveness, efficiency and equity** People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

4.5 The MHA Code of Practice includes guidance on the DVCVA and sharing limited information with victims (Chapter 40).

4.6 The Department of Health (DoH) has produced comprehensive guidance for clinicians and Hospital Managers, 'Mental Health Act 2007, Guidance on the extension of victims' rights under the Domestic Violence, Crime and Victims Act 2004:

*http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089407.pdf*

NOMS has also published the Victim Contact Scheme Guidance Manual, chapter 36 of which relates to mentally disordered offenders:

http://www.justice.gov.uk/downloads/offenders/probation-instructions/pi-48-2014-victim-contact-scheme-guidance-manual.doc

## 5. DUTIES

### 5.1 Chief Executive

The Chief Executive is responsible for ensuring that the Trust has policies and procedures in place and complies with its legal and regulatory obligations.

### 5.2 Accountable Director

The accountable director is responsible for the development of relevant policies and procedures and to ensure they comply with applicable standards and criteria. They are also responsible for trust wide implementation and compliance with the policy or procedure. The accountable director for this procedure is the Executive Director of Nursing.

### 5.3 Managers

Managers are responsible for ensuring policies and procedures are communicated to their teams / staff. They are responsible for ensuring staff attend relevant training and adhere to the policy or procedure detail. They are also responsible for ensuring policies and procedures applicable to their services are implemented.

### 5.4 Statutory Duties specified in the DVCVA and the MHA

To enable victims to exercise their right to receive information and to forward their representations on specified occasions, statutory duties fall upon:

a) **Providers of probation services**: to identify eligible victims and, with their consent, to pass on their details to Hospital Managers (in respect of unrestricted patients) or Victim Liaison Officers (in respect of restricted patients);

b) **Ministry of Justice**, **Mental Health Casework Section** (MHCS): where discharge is considered the Justice Secretary must inform the National Probation Service. MHCS caseworkers will liaise with Victim Liaison Officers;

c) **The First-tier Tribunal - Mental Health**: When victim liaison has been established, the tribunal service must inform the Victim Liaison Service of planned tribunals and the results of tribunals. The tribunal service will also receive representations from victims;

d) **Hospital Managers**: (defined in s.145 of the MHA) to give information to victims and to pass on any representations they make to clinicians or the tribunal service;

e) **Responsible Clinicians** (RC): to inform Hospital Managers if they are considering discharging relevant unrestricted patients and if they make certain decisions relating to those patients. They must also consider victims' representations when deciding what conditions to include in a CTO;

f) **Approved Mental Health Professionals** (AMHP): to consider victims' representations when considering a proposal for a Community Treatment Order (CTO); and

g) **NHS Bodies**: responsible for NHS patients placed in independent hospitals, when considering discharge, including patients subject to CTO.

## 6. ROLES AND RESPONSIBILITIES

6.1 **The Hospital Managers have the following responsibilities in respect of unrestricted patients**

a) To identify any patients who are 'Chapter 2 patients' (this term comes from the joint Department of Health / Ministry of Justice guidance and is a reference to Chapter 2 of Part 3 of the DVCVA). Chapter 2 patients may be detained in hospital under the MHA, be subject to a conditional discharge and residing in the community or be on a Community Treatment Order.

b) To keep records of victims who have asked to make representations and/or receive information.

c) To invite and pass on representations from victims to the RC and AMHP when discharge or a CTO is being considered.

d) To provide information to victims about patients discharged by the RC, hospital managers and Tribunal, including decisions not to renew detention or extend a CTO.

e) To decide whether to provide additional information to victims (i.e. proposals for leave, absconding or transfer to another hospital, all subject to the general principles of patient confidentiality).

f) To inform new Hospital Managers (the new detaining authority) where patients are transferred or assigned.

6.2 These responsibilities will be delegated to the MHA Administrators to carry out on a day-to-day basis. Responsible Clinicians and clinical teams must accept responsibility for identifying those patients who fall within the scope of the DVCVA and are thus known as Chapter 2, DVCVA patients. This information must be passed to the site MHA Office/Administrator.

6.3 **Responsible Clinicians have the following responsibilities:**

a) To inform the MHA Office in advance if they are considering discharging an unrestricted 'Chapter 2' patient, placing the patient on a Community Treatment Order (CTO) or varying conditions of the CTO. Any decision to discharge should not be unduly delayed for the purpose of allowing a victim to make representations.

b) To consider any representations made by the victim about the conditions to be included in a new CTO or one that is to be varied.

c) To inform the MHA Office of any other event about which the victim will have a right to receive information i.e. expiry of detention, decision not to renew detention or extend the CTO (where they relate to the victim), variation of the conditions of the CTO (where they relate to the victim) or revocation of the CTO.

d) To consider if additional information is to be made available to the victim.

e) To liaise with a Victim Liaison Officer (if he/she has made contact with the hospital on behalf of the victim). This may happen for restricted patients.

6.4 **Approved Mental Health Professionals** have the following responsibility:

When asked by the RC to agree an unrestricted Chapter 2 patient's placement on a CTO, to consider any representations from victims before agreeing to the proposed conditions to be included in the CTO.

## 7. SYSTEMS & RECORDING

7.1 Information about the status of patients under the DVCVA must be recorded on electronic clinical records and CPA documentation. Currently, there is no designate place within to record this information.

7.2 The RC must record the relevant information in the patient's record.

7.3 The RC must notify the MHA Office/Administrator of identified 'Chapter 2' patients.

7.4 The MHA Office must maintain a list of victims or VLOs who have a right to receive information or make representations and have made contact with the hospital to enact these rights. If the initial request for information is made to the RC or another clinical team member, the MHA Office must be informed.

## 8. DEFINITION OF KEY TERMS IN THE DVCVA

8.1 **Sexual or Violent offence:** falls within one of the following descriptions:

a) Murder, attempted murder or conspiracy to murder and any offence in Schedule 15 Criminal Justice Act 2003. This includes: manslaughter: kidnapping; false imprisonment; assaults under sections 18,20 or 47 Offences Against the Person Act 1861 (as amended); child cruelty; possession of a firearm with intent; burglary; robbery; affray; death by dangerous driving; and a wide range of sexual offences;

b) An offence which requires that a patient complies with the notification requirements of Part 2 of the Sexual Offenders Act 2003. This refers to a large number of offences set out at Schedule 3 which includes: rape; indecent assault; sexual offences involving children; and possession of indecent photographs of children;

c) An offence against a child within the meaning of Part 2 of the Criminal Justice & Courts Services Act 2000.

8.2 A **full list** of offences can be referred to by following the link to the Department of Health Guidance given at paragraph 4.6 of this procedure.

8.2.1 **Victim**: includes any person who appears to be, or to act for, the victim of the specified sexual or violent offence. It includes a victim's family in a case where the offence has resulted in the victim's death or incapacity and in other cases where the victim's age or personal circumstances make it appropriate to approach a family member in the first instance. It is the duty of the Probation Service to identify victims at the point of sentencing and commence the process of victim liaison. Contact with the hospital staff will usually be through the Victim Liaison Officer (VLO).

8.2.2 **Victim Liaison Officer**: the VLO works with the probation services and is usually the main conduit of information to and from victims. If a patient is unrestricted, the Hospital Managers may be required to maintain contact with the victim directly.

8.2.3 **Responsible Clinician/Community RC:** the RC is the approved clinician who has the overall responsibility for the care of the patient. A patient subject to a conditional discharge/Community Treatment order does not have a RC but instead has a supervising psychiatrist/CRC who has the same responsibilities under this policy as a RC.

8.2.4 **Approved Mental Health Professional:** the AMHP is a social worker or other professional approved by a local social services authority to carry out statutory functions under the MHA.

8.2.5 **Hospital Managers:** This term is defined in section 145 of the MHA. It is the organisation responsible for the operation of the MHA in a particular hospital, in this case, Mersey care NHS Trust. Hospital Managers have a number of statutory duties under the MHA. They can discharge an unrestricted patient from detention or a CTO. This specific duty is delegated to a committee known as the MHA Managers Committee. Other duties are delegated to Trust staff, and in particular, MHA Administrators in the Trust MHA Offices.

8.2.6 **Restricted Patients**
A restricted patient is subject to 'special restrictions' imposed by the sentencing court or the Secretary of State for Justice. The patient falls under Part 3 of the MHA having been detained in hospital following criminal proceedings. The special restriction is imposed to protect the public from serious harm. One of the effects of the restriction is that the patient cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice and only the tribunal can order a discharge without the Secretary of State's agreement**.** A restricted patient can be given an absolute or conditional discharge. The DVCVA provisions will continue to apply to Chapter 2 patients granted a conditional discharge.

8.2.7 **Unrestricted Patients**
A patient detained under Part 3 of the MHA, following criminal proceedings is not always subject to special restrictions. The court or the Ministry of Justice can make a decision not to impose restrictions on the section (e.g. s.37 or s.47). Other patients may have initially been given a restriction order but this has ceased at some point during the detention period in hospital (the section then becomes a notional s37, an unrestricted section).

8.2.7.1 The unrestricted Part 3 patient may be discharged by the Hospital Managers (in addition to the tribunal). The Secretary of State for Justice is no longer involved with the case, hence many of the duties under the DVCVA fall to the Hospital Managers and not the other bodies involved with restricted patients.

8.2.8 **First-tier Tribunal, Mental Health:** this is an independent judicial body (in effect, a court) which has the power to discharge a patient from detention in hospital, from a CTO, from a guardianship order or from a conditional discharge order. In relevant cases, the tribunal will receive representation from victims and also pass on information to victims. The tribunal service has issued guidance on victims' rights at tribunal proceedings.

*http://www.mentalhealthlaw.co.uk/Practice_Guidance_on_Procedures_Concerning_Handling_Representations_from_Victims_in_the_First-tier_Tribunal_(Mental_Health)*

8.2.9 **Domestic Violence, Crime and Victims Act 2004:** An Act that introduced new powers for the police and courts to deal with offenders, while improving support and protection that victims receive.

8.2.10 **Probation Services:**
The National Probation Service is a statutory criminal justice service that supervises high-risk offenders released into the community.

8.2.11 **MAPPA (Multi-agency Public Protection Arrangements):** MAPPA is a set of statutory arrangements to ensure the police, probation and prisons work together to manage a

defined group of dangerous offenders living in the community. A number of other agencies, including health trusts, have a duty to co-operate with MAPPA (this does not mean that patient information has to be disclosed). The Trust has a MAPPA policy, M8.

## 9. IDENTIFYING RELEVANT PATIENTS ("CHAPTER 2" PATIENTS)

9.1 **Restricted Patients**

Contact will be made with hospital staff (usually the SW or RC) by the Victim Liaison Officer (VLO). This should be the route of all communication. Contact will only be made if the victim has asked to be provided with information about the offender.

9.2 The clinical team responsible for a newly admitted restricted patient should apply the DVCVA criteria to identify if the patient is a 'Chapter 2' patient. If this is the case, the clinical team must notify the MHA Office and make an appropriate note in the patient's clinical record.

9.3 The MHA Offices will keep a list of Trust patients who are known 'Chapter 2' patients. The list can be manual or electronic. It is envisaged that the clinical record system will capture relevant data associated with the DVCVA and provide lists for use by clinical teams and the MHA Office.

9.4 The DVCVA provisions came into force for restricted patients on 1 July 2005.

They will apply if:

a) The offender was convicted on or after I July 2005 and

b) The offence is a listed sexual or violent offence and

c) For a sentenced prisoner, the sentence was 12 months or more and

d) The patient is detained under one of the following sections;

   i. MHA s.37/41 (hospital order with restriction this will include a restricted hospital order given under the Criminal Procedure and Insanity Act)

   ii. MHA s.45A (hospital direction and limitation direction)

   iii. MHA s.47/49 (transfer direction and restriction direction)

   iv. MHA, conditionally discharged patient

Refer to the flowchart.

9.5 The provisions of the DVCVA will continue to apply if the patient becomes an unrestricted patient on or after 3 November 2008. Refer to flowchart.

9.6 **Non statutory victims**

There are certain circumstances where Probation Trusts may exercise their discretion to offer the Victim Contact Scheme (VCS) to victims who do not statutorily qualify, where this seems appropriate in the Probation Trust's professional judgement.

The term 'discretionary contact' refers only to the discretion exercised to offer the victim contact under the VCS in the first place; non-statutory victims may otherwise

be offered the same service as statutory victims. (See the Victim Contact Scheme Guidance Manual 3.3)

9.6.1 If a non-statutory victim of an unrestricted patient wishes to receive contact under the VCS, the VLO should pass their contact details to the relevant hospital. The hospital manager and RC will then use their discretion to consider whether to pass information to the victim, and what information this should include.

9.7 **Unrestricted Patients**

The DVCVA came into force for unrestricted patients on 3 November 2008.
They will apply if:

a) The offender is convicted on or after I July 2005 and

b) The offence is a listed sexual or violent offence and

c) In the case of a sentenced prisoner, the sentence was 12 months or more and

d) The patient became subject to one of the following sections after 3 November 2008:

i. MHA s.37 (hospital order including an unrestricted order under CPIA),

ii. MHA s.47 (transfer direction)

iii. MHA notional s.37 (notional hospital order – starts when prison sentence ends)

iv. MHA s.17A (CTO – following a s.37 or notional s.37 if above criteria applies)

Refer to the flowchart

## 10. PATIENTS WHO ARE VICTIMS UNDER THE DVCVA

10.1 A patient in the Trust may be the victim of a relevant violent or sexual offence and be entitled to receive information about the offender. Contact will initially be made with the patient by the Victim Liaison Service following the court case.

10.2 Trust staff will offer support and guidance to the patient and offer to work with the VLO to gain an understanding of what information is to be shared with the patient. It is important that Trust staff are aware of the nature of the information being shared and when this is to happen in order to manage the care and treatment of the patient.

## 11. VICTIMS RIGHTS TO INFORMATION AND REPRESENTATION

11.1 Victims have two main rights in relation to Chapter 2 patients:

a) They have the right to receive information about any conditions to which the patient is subject when discharged from hospital, and

b) They have the right to make representations about conditions to which patients should be subject when discharged from hospital

c) The right to receive information in a format or language as requested

11.2 <u>The right to receive information</u>

11.2.1 **In respect of a restricted patient**

In cases covered by DVCVA 2004 concerning a restricted patient, NOMS MHCS will make contact with known VLOs, in order to pass on information about key stages in the offender's sentence, including:

a) when they are first transferred to hospital and become a restricted patient;

b) when the Secretary of State is considering a proposal for discharge, to request representations from the victim;

c) if the Secretary of State decides to discharge the patient;

d) the conditions of discharge relating to the victim or their family;

e) any variation of conditions of discharge relating to the victim or their family;

f) if the restricted patient is recalled for further treatment under the MHA 1983;

g) if the offender is absolutely discharged, resulting in the cessation of conditions and the removal of the offender's liability to be recalled to hospital;

h) when the patient's restrictions are lifted or expire;

i) if the prisoner is transferred to hospital under s.47 MHA 1983;

j) if a patient previously found unfit to plead is remitted back to Court to continue legal proceedings;

k) if a patient is to be remitted to prison.

11.2.2 There is no requirement to notify the VLO of any abscond or escape unless there is concern for the welfare of the victim. Usually, liaison with the VLO about absconds or escape will come from the responsible clinician.

11.3 <u>The right to receive information</u>

11.3.1 **In respect of an unrestricted patient (in hospital or on a CTO)**
If a victim has expressed a wish to receive information (and the provisions of the DVCVA apply) the VLO will contact the Hospital Mangers (via the MHA Office). There is no obligation on the Hospital Managers or Trust staff to try and establish contact with a victim. Once this contact has been made the DVCVA places statutory duties on the Hospital Managers and certain clinicians (see section 6).

11.3.2 The VLO will pass on the name and address of the victim to the Hospital Managers. The VLO will also inform the victim of the name and address of the hospital. The VLO will follow this step if a Chapter 2 restricted patient becomes unrestricted. The VLO has no further role with the victim of an unrestricted patient.

11.3.3 Victims of unrestricted patients are entitled to the same information, listed above, as the victims of restricted patients. However, this information will be provided at the discretion of the responsible clinician, and will be provided to the victim by the hospital directly. The statutory minimum of information that hospital managers will communicate to victims includes:

a. whether the patient is to be discharged;

b. whether a Community Treatment Order (CTO) is to be made, including allowing the victim to make representations about the conditions attached to the CTO;

c. what conditions of the CTO relate to the victim;

d. when the CTO ceases;

e. when authority to detain the patient expires;

f. when the offender is discharged, including allowing the victim to make representations about discharge conditions;

g. what conditions of discharge relate to the victim, and when these cease

11.3.4 The RC should pass this information to the MHA Office who will write to the victim.

11.3.5 RCs must also consider using their discretion to inform victims about a patient's leave of absence, absconding, or transfer to another hospital. The Department of Health guidance states "If a Chapter 2 patient is transferred (or in the case of a Supervised Community Treatment patient, assigned) to a new hospital whose Managers are different, it is likely to be appropriate to tell victims the name and address of the new Hospital Managers". A record of this decision should be written up in the clinical notes.

11.4 <u>The right to make representations</u>

If a victim wishes to make representations regarding the discharge of a restricted Chapter 2 patient they must do this through the VLO or directly to the tribunal service.

11.4.1 The MHA Office will inform the Tribunal if the patient being considered is a Chapter 2 unrestricted patient and there is a victim who wishes to make a representation. Any representations received will be forwarded to the RC.

If the victim wishes any part of the submission to be withheld from the patient this must be clearly specified, including the reasons for the request. Victims should be made aware that there can be no guarantee that the information will be withheld and that the expectation is that all documents will be disclosed to the patient. The decision to withhold information is taken by the tribunal; when information is withheld from the patient it will still be made available to the patient's legal representative.

11.4.2 The victim can apply to attend a hearing, at the discretion of the chairman of the tribunal.

11.4.3 Victims may also make written representations to Hospital Managers hearings, at which the patient may be discharged. The MHA office will write to the victim and will ascertain whether the victim wishes to make representations. The MHA office will pass any such representations to the RC and to the patient's legal representative. If the victim wishes any part of the submission to be withheld from the patient this must be clearly specified, including the reasons for the request. Victims should be made aware that there can be no guarantee that the information will be withheld

The MHA office is responsible for advising the victim of the outcome of the hearing. The victim is not entitled to a copy of the decision form.

11.5.1 **Responsible Clinicians Decisions**

RCs will contact the victim/s via the MHA office asking if they would like to make a representation on any of the following plans:

a) A plan to discharge the patient from a section; A plan to allow the section to lapse;
b) A plan to discharge on a CTO;
c) Conditions of a CTO that may be relevant to the victim;
d) Changes to the conditions of a CTO that may be relevant to the victim; the expiry of, revocation of or discharge from a CTO.

The MHA Office will provide a written letter to the victim/s (using approved templates) advising of the discharge/transfer/CTO (as appropriate.)
It is the responsibility of the RC, whenever possible, to give the above information (and relevant dates) sufficiently far in advance to allow victims to make representations, however, discharges should not be delayed purely to allow representations to be made.

11.5.2 If the RC is actively considering discharge onto a CTO, the RC must also pass the victim's representations on to the AMHP who is considering whether to agree to the proposed CTO.
RCs must consider any representations made by victims when deciding what conditions to include in a patient's CTO. Victims might, for example, want RCs to consider imposing a condition that the patient stays away from the area in which the victim lives. If victims make representations about conditions after a patient has already been discharged onto a CTO, RCs should consider whether the conditions ought to be varied as a result.
The DVCVA does not affect the rule in section 17B (2) MHA that RCs may only include conditions in a patient's CTO which they think are necessary or appropriate for ensuring the patient receives medical treatment, preventing risk of harm to the patient's health or safety or protecting other people.

11.5.3 There is a Code of Practice for Victims of Crime, published by the Stationary Office, October 2013. This explains how victims can opt into the Victim Contact Scheme and the services they are entitled to from a number of organisations:

https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime

## 12 DISCLOSING INFORMATION AND PATIENT CONFIDENTIALITY

12.1 The use and disclosure of patient information is governed primarily by the Data Protection Act 1998 and the Human Rights Act 1998. Additionally there is the NHS Code of Practice on Confidentiality (2003) and the MHA Code of Practice (2015) providing guidance on confidentiality. Ordinarily, information about a patient is not to be disclosed to a third party such as a victim without the patient's consent. However, it can be disclosed if other statutes permit this such as the DVCVA

12.2 The DVCVA requires RCs (on behalf of the hospital managers) to give victims who have asked to receive any further information which they think is appropriate in all the circumstances of the case.
This provides RCs with discretion to provide information intended to reassure victims. It is not intended to permit disclosure of any information which would otherwise be treated as confidential patient information.
For example, if there is a possibility that the victim(s) may come into contact with patients who are on leave, it may be appropriate for RCs to disclose to a victim that a patient has been allowed leave, without giving details about the timing or purpose of the leave, so that the victim knows the patient has not absconded.

In cases where the patient is competent and willing to consent to further information about their progress being given to the victim this can also be passed on if the victim wishes to receive it.

12.3 It is good practice to ensure the patient knows the effects of the DVCVA and what information may be disclosed. Regular discussions should take place between members of the clinical team and the patient and these should be documented in the patient's clinical record.

## 13 TRANSFERRING PATIENTS FROM PRISON TO HOSPITAL OR BETWEEN HOSPITALS

13.1 If a detained Chapter 2 patient is transferred to another hospital the RC will inform the receiving hospital of the patient's status under the DVCVA. This requirement is also applicable to CTO patients if they are assigned to a different hospital managed by another Trust.

13.2 Refer to section 11.3 of this procedure in respect of information which *may (not must)* be passed to the victim, usually through the VLO when a patient is transferred from one hospital to another.

13.3 When the MoJ transfer a restricted patient (who is subject to the provisions of the DVCVA) from prison to hospital, the MHCS caseworker will pass this information to the relevant offender manager who, in turn, will pass this to the VLO and ultimately, the Trust and RC. If at a later stage the patient is remitted to prison the MHCS caseworker will notify the VLO.

13.4 When the MoJ consent to the transfer of a restricted patient from one hospital to another hospital (and when the transfer proceeds) the MoJ will notify the VLO.

## 14 POTENTIAL VICTIMS

14.1 When conducting risk assessments of patients, RCs and care teams should identify individuals who may be at risk from the patient in the future. This could include family, friends, neighbours or others. This may include people who currently have contact with the patient or who wish to have contact in the future.

14.2 The RC and care team should consider whether the risk of harm is such that it warrants disclosure of information to the potential victim. In this case the risk assessment should ordinarily be discussed with the patient and consent sought to share information. There may be exceptional cases where it is considered inappropriate to discuss this with the patient. If consent to share information is withheld the RC should consider whether this information should be disclosed without the consent of the patient. Disclosure of information without the consent of the patient should only occur when it is considered necessary to prevent serious harm.

14.3 It would usually be preferable to share this information with a potential victim in person and then to follow this up with written information. The decision to disclose this information and the outcome of any meeting should be recorded in PACIS (&Rio)/Epex?) and marked as third party information.

14.4 On-going support should be offered to the potential victim by members of the care team, usually the social worker. (See the MHA Code of Practice 40.21)

14.5 Review of risks to potential victims should be considered at every CPA review and recorded in the minutes.

Guidance on confidentiality is provided at the following sources:

DoH Confidentiality NHS Code of Practice:
https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

DoH Confidentiality: NHS Code of
Practice - Supplementary Guidance: Public Interest Disclosures
November 2010
https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

Information Commissioner's Office
Data sharing code of practice:
https://ico.org.uk/for-organisations/guide-to-data-protection/data-sharing/

## 15 MONITORING OF PROCEDURE

15.1 An audit of this policy will be carried out every three years unless a need is identified sooner by the local Mental Health Law Governance groups.

## 16 TRAINING

16.1 The appropriate Governance Groups for each division of the Trust will determine what training is required to introduce this new procedure to Trust staff. Thereafter, the key principles of this Act will be raised in the Mandatory Mental Health Law training

## 17 CONSULTATION

17.1 Consultation has taken place across local, secure and specialist learning disabilities divisions of the Trust.

Mersey Care NHS
NHS Foundation Trust

# Equality and Human Rights Analysis

| |
|---|
| **Title: Victim Rights** |
| **Area covered: T*rus*t Wide Non Clinical Procedure** |

| |
|---|
| **What are the intended outcomes of this work?**<br>The purpose of this procedure is to provide information and guidance on the actions to be taken by Trust staff to meet the requirements of the Mental Health Act 1983 (as amended) and the Domestic Violence, Crime and Victims Act 2004 (DVCVA) as they relate to victims of crime and in relation to people considered to be potential victims.<br>The victims of specified violent and sexual offences (see sections 4.6 and 8) have certain rights to information about the offender. This includes offenders who are subject to the Mental Health Act 1983 (MHA) and are detained in hospital or subject to compulsion in the community. The victims also have rights to make representations about the release of the offender from detention under the MHA.<br>All hospital and community-based staff with a responsibility for the care and treatment of patients affected by this legislation, whether the patients are perpetrators of the crime or victims, must have a clear and structured response to any occasions where actions must be taken to comply with the MHA and DVCVA. |
| **Who will be affected?** Service users/patients/Carers/Staff |

## Evidence

| |
|---|
| **What evidence have you considered?**<br>The procedure contained within the document<br>The Equality and Human Rights Analysis of the related policies<br>SD01: v2 Leave for inpatients who are either managed informally under section 131 of the Mental Health Act or under the general powers of the Mental capacity Act (Sections 5&6)<br>SD05: Service users missing from an inpatient area<br>SD21: v3 Corporate Policy and Procedure for the Care Programme Approach<br>HSS 12: Policy and Procedure for Care Programme Approach<br>SD46: Multi Agency Public Protection Arrangement (MAPPA)<br>HSS 05: Multi Agency Public Protection Arrangements (MAPPA) Protocol<br><br>SD-G3: Section 117 - Aftercare under the Mental Health Act 1983<br>MH01: MHA 1983 Overarching Policy<br>MH20: Mental Health Act Managers' Policy<br>HSS 14: Policy & Procedure for Patients Temporary Absence from Hospital |
| **Disability (including learning disability)**<br>Protected under this policy |

| |
|---|
| **Sex**<br>Protected under this policy |
| |
| **Age** Protected under this policy |
| **Gender reassignment (including transgender** Protected under this policy |
| **Sexual orientation** Protected under this policy |
| **Religion or belief** Protected under this policy |
| **Pregnancy and maternity** Protected under this policy |
| **Carers** Protected under this policy |
| **Other identified** Protected under this policy |
| **Cross Cutting**<br>The purpose of this procedure is to provide information and guidance on the actions to be taken by Trust staff to meet the requirements of the Mental Health Act 1983 (as amended) and the Domestic Violence, Crime and Victims Act 2004 (DVCVA) as they relate to victims of crime and in relation to people considered to be potential victims. |

| **Human Rights** | **Is there an impact?**<br>**How this right could be protected?** |
|---|---|
| **Right to life (Article 2)** | Human Rights Based Approach Supported |
| **Right of freedom from inhuman and degrading treatment (Article 3)** | Human Rights Based Approach Supported |
| **Right to liberty (Article 5)** | |
| **Right to a fair trial (Article 6)** | Human Rights Based Approach Supported<br><u>The right to make representations</u><br>If a victim wishes to make representations regarding the discharge of a restricted Chapter 2 patient they must do this through the VLO or directly to the tribunal service. |
| **Right to private and family life (Article 8)** | Human Rights Based Approach Supported<br>**DISCLOSING INFORMATION AND PATIENT CONFIDENTIALITY**<br>The use and disclosure of patient information is governed primarily by the Data Protection Act 1998 and the Human Rights Act 1998. Additionally there is the NHS Code of Practice on Confidentiality (2003) and the MHA Code of Practice (2015) providing guidance on confidentiality. Ordinarily, information about a patient is not to be disclosed to a third party |

| | |
|---|---|
| | such as a victim without the patient's consent. However, it can be disclosed if other statutes permit this such as the DVCVA |
| **Right of freedom of religion or belief (Article 9)** | Human Rights Based Approach Supported |
| **Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)** | Human Rights Based Approach Supported |
| **Right freedom from discrimination (Article 14)** | Human Rights Based Approach Supported |

| Engagement and Involvement *detail any engagement and involvement that was completed inputting this together.* |
|---|
| N/A |
| |
| |

## Summary of Analysis

### Eliminate discrimination, harassment and victimisation

This procedure aims to provide awareness of and make clear duties that staff have in relation to victims of specified violent and sexual offences (see sections 4.6 and 8) Victims have certain rights to information about the offender. This includes offenders who are subject to the Mental Health Act 1983 (MHA) and are detained in hospital or subject to compulsion in the community. The victims also have rights to make representations about the release of the offender from detention under the MHA.

### Advance equality of opportunity

N/A

### Promote good relations between groups

N/A

### What is the overall impact?

No negative impact detected

## Addressing the impact on equalities

This procedure aims to provide awareness of and make clear duties that staff have in relation to victims of specified violent and sexual offences (see sections 4.6 and 8) Victims have certain rights to information about the offender. This includes offenders who are subject to the Mental Health Act 1983 (MHA) and are detained in hospital or subject to compulsion in the community. The victims also have rights to make representations about the release of the offender from detention under the MHA.

## Action planning for improvement

See below

## For the record

**Name of persons who carried out this assessment:**
Phil Appleton
George Sullivan

**Date assessment completed:**
06/03/2017

**Name of responsible Director:**
Director of Nursing and Patient Experience

**Date assessment was signed:**
March 2017

# Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

| Category | Actions | Target date | Person responsible and their area of responsibility |
|---|---|---|---|
| **Monitoring** | An audit of this policy will be carried out every three years unless a need is identified sooner by the local Mental Health Law Governance groups. | | |
| **Engagement** | Policy to be placed on the Trust website<br>Staff to be informed of their responsibilities via Safeguarding training. | | |
| **Increasing accessibility** | The right to receive information in a format or language as requested | | |

| **IMLEMENTATION PLAN FOR:**<br>**DATE:**<br>**AUTHOR:** | | | |
|---|---|---|---|
| | **Issues identified / Action to be taken** | **Lead** | **Time-Scale** |
| **1. Co-ordination of implementation**<br>• How will the implementation plan be co-ordinated and by whom?<br>*Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve any further issues that may arise.* | | | |
| **2. Engaging staff**<br>• Who is affected directly or indirectly by the policy?<br>• Are the most influential staff involved in the implementation?<br>*Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made.* | | | |
| **3. Involving service users and carers**<br>• Is there a need to provide information to service users and carers regarding this policy?<br>• Are there service users, carers, representatives or local organisations who could contribute to the implementation?<br>*Involving service users and carers will ensure that any actions taken are in the best interest of services users and carers and that they are better informed about their care.* | | | |

| | | | |
|---|---|---|---|
| **4. Communicating**<br>• What are the key messages to communicate to the different stakeholders?<br>• How will these messages be communicated?<br>*Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can also provide encouragement to those involved.* | | | |
| **5. Resources**<br>• Have the financial impacts of any changes been established?<br>• Is it possible to set up processes to re-invest any savings?<br>• Are other resources required to enable the implementation of the policy eg. increased staffing, new documentation?<br>*Identification of resource impacts is essential at the start of the process to ensure action can be taken to addess issues which may arise at a later stage.* | | | |
| **6. Securing and sustaining change**<br>• Have the likely barriers to change and realistic ways to overcome them been identified?<br>• Who needs to change and how do you plan to approach them?<br>• Have arrangements been made with service managers to enable staff to attend briefing and training sessions?<br>• Are arrangements in place to ensure the induction of new staff reflects the policy?<br>*Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy* | | | |

| | | | |
|---|---|---|---|
| **7. Evaluating**<br>• What are the main changes in practice that should be seen from the policy?<br>• How might these changes be evaluated?<br>• How will lessons learnt from the implementation of this policy be fed back into the organisation?<br>*Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justifying changes that have been made.* | | | |
| **8. Other considerations** | | | |