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Criminal Law News

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The Poor Sick

Sally Ramage

Poverty and sickness have always been close partners, each causing the other. So attempts to relieve poverty have necessarily been associated with care of the sick poor and more recently this care was in the hope of restoring the working capacity of the individual. These two aspects of the relief of poverty were intertwined in England up to 1930 and used to be administered by *Boards of Guardians* under Poor Law powers.

Then the Local Government Act 1929 abolished the Guardians and transferred their duties and possessions ·to the Councils of Counties and County Boroughs. The other provisions of the Local Government Act 1929 had not been investigated but certain related matters were considered insofar as they concern the sick poor. In this study, Dr Ramage made references to the relations with Voluntary Hospitals and to the financial effects of the Act.

Development of the Poor Law and Public Health Medical Services

Until their closure in 1536 and 1539, the treatment of the sick and particularly the sick poor, was in the hands of the Monasteries. By

the 1535 the individual Parishes were made responsible for their poor.

1601 Poor Law Act

The first mention of special institutional accommodation for the Poor was made in the Poor Law Act of Elizabeth (1601). Overseers were appointed to control the paupers and were empowered to build convenient houses for the reception of the sick and impotent amongst them.

1662 Settlement Act

In 1662 the Settlement Act was passed in Britain. This was repressive and marked the beginning of a long period in which every effort was made do diminish the numbers of persons seeking assistance. Some provisions of the 1662 Settlement Act are still operative.

1832 Poor Law Amendment Act

The cost of Poor Relief had risen so much that a Royal Commission was appointed to investigate the problem in 1832 and then the Poor Law Amendment Act of 1832 was passed. The 1832 Act reorganised and reformed the Poor Law.

1847 Poor Law Board

A Central Authority was set up, named the Central Poor Law Committee (which was replaced by a Poor Law Board in 1847). Locally, new districts (Unions) were created, by combining parishes on the grounds of greater economy, extended operations and better classifications of paupers. Boards of Guardians replaced the former Overseers and were responsible to the Central Authority.

The Guardians were encouraged to build institutions, albeit of a 'deterrent type', and already doctors had been appointed to many of the existing workhouses to attend the sick.

1831 Central Board of Health

Following the investigation of an outbreak of cholera in 1831, a consultative central Board of Health was established under the Privy Council. This Board recommended that local boards of health should be formed to remedy obvious sanitary defects.

1846 Nuisance Removal Act

The Vaccination Act of 1841 conferred on the Guardians a primary duty of prevention medicine and the Nuisances Removal Act 1846 imposed on them the duties of Sanitation, making them the rural sanitary authorities. In 1838 the Poor Law Commissioners drew

attention to the charges on the poor rate, '*which are caused by nuisances by which contagion is generated and persons are reduced to destitution'*. It was urged that it was good economy for the administrators of the poor.

Mental health and learning disabilities

In 2013, the *Prison Reform Trust* and *Rethink Mental Illness* issued advice on mental health and learning disabilities in the criminal courts. Defence lawyers do represent clients with mental health conditions and learning disabilities, but recognising when individuals have these conditions and knowing how best to respond can be difficult. In 2009, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system recommended awareness training for all professionals involved in the criminal justice process. A new resource has been published which contains information useful for defence solicitors. The resource covers topics such as how to recognise when a client might have a mental health condition or a learning disability; disabilities and impairments such as autism, specific learning difficulties, and communication difficulties; the implications of these conditions for defendants; how to support vulnerable defendants in court; bail and remand decisions; sentencing options, and the Mental Health Act.

Criminal Procedure Rules 2013(CPR)

The Court of Appeal in *R* v K,[1] paragraph 6 underlined the importance of the Criminal Procedure Rules 2013, making it clear that the rules:

> *'[I]mpose duties and burdens on all the participants in a criminal trial, including the judge, and the preparation and conduct of criminal trials is dependent on, and subject to, these rules...'*

According to Thomas LJ in *R (on the application of the DPP) v Chorley Justices*[2] the introduction of the CPR has *'effected a sea change in the way in which cases should be conducted*'.

The rules define the full extent of the duties imposed by the CPR.
The nature of those obligations was described by the House of Lords in *Arthur J.S. Hall and Co. v Simons* (AP)[3] at 715:

> *'..[I]t is necessary to appreciate the extent of that duty and the extent to which the efficiency of our systems of criminal justice depends on it. The advocate's duty to the court is not just that he must not mislead the court, that he must ensure that the facts are presented fairly and that*

[1] [2006] EWCA Crim 724, [2006] 2 All E.R. 552.
[2] [2006] EWHC 1795.
[3][2000] UKHL 38, [2002] 1 AC 615.

he must draw the attention of the court to the relevant authorities even if they are against him. It extends to the whole way in which the client's case is presented, so that time is not wasted and the court is able to focus on the issues as efficiently and economically as possible.

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