Mental Health News

August 2008

Capsticks

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More criticism ahead at inquests

A new Court of Appeal case means that mental healthcare providers are more likely to face more critical decisions at inquests.

In our winter issue, we referred to the impact of the December Court of Appeal Savage decision which significantly reduced the threshold on neglect verdicts, to make them much more likely in the future. In that case, the test of neglect (for a detained patient) was whether or not the hospital knew of a "real and immediate" risk and failed to do anything about it. The Court of Appeal overturned the High Court in that case, which had said that before there could be a neglect verdict, the fault would have to reach the threshold for gross negligence "sufficient to sustain a charge of manslaughter".

Now, there has been another case, in a different context, that will enable much more critical verdicts in the future in a healthcare context. Capsticks' Inquest team has already noticed that some Coroners are increasingly asking witnesses whether they think that there is fault, or an error, and then asking whether they think it amounts to a serious error, and whether it amounts to a failure. It is essential that witnesses appreciate this is the line of questioning they may face, because per the leading case of Jamieson, (for informal patients) to secure a neglect verdict there has to be a failure that is "gross". At a recent Capsticks Inquest a consultant, in answer to such, said that there were shortcomings, which he later referred to as "suboptimal care", but rejected the suggestion that it amounted to a failure to provide care. The Coroner had to accept that.

Line of enquiry greatly fortified

Much recent publicity has been given to a recent Inquest involving the death of a British soldier in Iraq. He died of heat exhaustion where it was found that there was a failure to look after him (i.e. of systems), "death was caused by a serious failure to recognise and take appropriate steps to address the difficulty that he had in adjusting to the climate". Readers may be aware that under Rule 24 and Rule 36 the Coroner's verdict has to keep within very well-defined boundaries. One of the Rules states that, "no verdict shall be framed in such a way as to appear to determine any question of civil liability".

In other words, when the Coroner used words such as "serious failure", that amounted to a finding of neglect and one which was, in effect, determining liability. The Secretary of State for Defence said that the Coroner's decision should be quashed for this reason.

The Court decided that a Coroner finding that a failure was a "serious one", did not determine a civil liability question. He was entitled to say that the authorities, by their actions or in-actions, amounted to a serious failure. Thus, the verdict was allowed.

What does this mean?

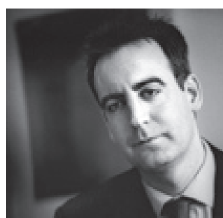
What this means is that Coroners' Courts are going to be invited, in a narrative verdict, to make comment upon matters in a way that, if it does not determine liability, gives a very clear steer in that direction.

The direction of travel in Inquest cases, means that providers are far more likely to be in receipt of critical decisions which, in turn, may encourage compensation claims being brought on the basis of alleged neglect. Readers will recall the Middleton case, *(see MH Newsletter 6/08)*, which said that the broad circumstances leading to death and systems can be examined with greater scrutiny. When one adds to this the Savage case, that lowers the bar for a finding of neglect, it is clear that at Mental Health Inquests, providers must be ready to address the issues in Savage and the new neglect test, as well as an outcome recording "serious failure".

This also means that clinicians and managers, particularly those responsible for systems, will face tougher questions. The impact upon staff morale of bad publicity and the impact upon reputation will need to be considered when preparing for difficult Inquests.

Capsticks' Inquest team can help protect your organisation's reputation, give the support that staff need and minimise unjustified critical verdicts.

For further information and advice please contact Robert Wilson, Philip Hatherall or Ashley Irons.



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Healthcare evidence at prison inquests

R v HM Coroner, Northamptonshire & Others ex p Warren, 2008

Capsticks' Inquest team regularly represents those providing healthcare services in prisons at Inquests. A recent prison suicide case illustrates how clinical issues arise, not only in prison.

B committed suicide in the segregation unit of the privately operated Rye Hill Prison. Its clinical services were provided under contract by the private sector.

The Prison Ombudsman said the investigation had demonstrated "individual and systemic failures of disturbing proportions", which included existing healthcare arrangements.

Although B had showed no signs of mental illness up to one week before his suicide, he then behaved bizarrely – stripping naked and walking around the exercise yard reciting the Lord's Prayer and saying that he was ready to die. The Healthcare Manager spoke to a consultant forensic psychiatrist who said that he might be suffering from psychosis and suggested anti-psychotic medication. There was no dispute that B was significantly mentally disturbed by this time.

The Judge held, "that such an event can occur in prison, must be something that medical and other support systems in place should generally pick up, identify and deal with, so far as is practicable, so that the person is protected. If he is not protected and suffers harm (e.g. suicide) the failure to prevent harm or death should be investigated under Article 2 by an Inquest". In turn, this meant that the clinical arrangements in prison should be investigated.

The Judicial Review arose because the Coroner rejected the family's request for a consultant psychiatrist, instructed by their solicitor, to give evidence. The Coroner did so on the basis that he already had an independent report of an experienced investigator and the doctor proposed had no relevant experience of prison healthcare.

The Judge decided that he was not going to compel the Coroner to call that psychiatrist, but came close to it. He went on to say that an Inquest, without clinical evidence from an independent consultant psychiatrist and an independent GP, would not comply with Article 2, as they would both be able to comment upon healthcare systems.

Future picture

The implication of this case is that prison inquests are increasingly likely to become more lengthy than they are already and the Coroners will be under some pressure to allow independent clinical evidence to be called. This in turn means that PCTs and mental health trusts (and private providers) will need to consider, in each case, whether there is an issue upon which they, too, should call evidence.

Although the Judge in this case said he was not setting a precedent and his decision was confined to the facts of his case, it is hard to see how this case will not be quoted by any party seeking to call an independent medical witness.

Capsticks' Philip Hatherall, Rob Wilson and Ashley Irons have all represented trusts at prison inquests.

Currently, Ashley Irons has a case which has been adjourned, where the Coroner turned down the request from a family to have their nominated psychiatrist prepare a report and give evidence at the Inquest. They had even suggested that the Inquest might adopt such a report as its own! Here, the Coroner said that he had considerable experience of Inquests and was unlikely to be assisted by a psychiatrist's report. Nevertheless, if it was sent to him, he would read it but it would not form part of the evidence at the Inquest unless the provider was given a similar opportunity.

Please consult Capsticks' Inquest Team for further information or advice.

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Private doctors can recommend admission

Mental health private providers will be pleased that their own doctor can be one of the two doctors who can recommend admission to hospital under the Mental Health Act.

Under the MHA, s.12 and the Code at 4.1, regarding admission of a patient to a private hospital, "neither medical recommendation can be provided by a doctor and the staff of the hospital". This will change as at 3rd November 2008.

The new Code, under the MHA 2007 and the Mental Health (Conflicts of Interest) Regs. 2008, has changed the picture.

The new Code at 7.8 states, "where the patient is to be admitted to an independent hospital and the doctor providing one of the medical recommendations is on the staff of that hospital, the other medical recommendation must be given by a doctor who is not on the staff of that hospital". The Regulations at 4.2 also state that there will only be a "potential conflict of interest" where both medical recommendations are made by doctors who are both employed by the hospital.

Capsticks has checked with the authors of the Code and the above is indeed what is intended, notwithstanding the absence of any publicity upon the subject. This will help private providers a great deal, as they will now only have to provide one medical recommendation from elsewhere, when considering whether a patient is to be detained under the MHA.

For further information please contact Ashley Irons or Francis Lyons.

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Autism & Asperger's Syndrome: guidance pending

The DoH has been asked how services to people with autism and Asperger's Syndrome will be improved in the coming years, in light of the Healthcare Commission putting in new standards and criteria, upon which providers of learning disability care will be assessed.

The Secretary of State for Health, Ivan Lewis, has responded by saying the department document "Putting People First" contains "an ambitious and radical programme for independent living for all adults with support needs, including people with autism and Asperger's Syndrome".

The goal is maximum choice and control over the support services they receive, with a particular focus on disabled children to give them the best start in life possible. It is said that local commissioners have access to increasing resources for social care and this should lead to improvements.

The attention given to those with autism has been further increased by an announcement on 7th May, by Ivan Lewis, that a census will be taken to identify adults with autism in the community - with the intention of informing future healthcare planning.

Separately, guidance is being prepared by NICE on the initial recognition, referral and diagnosis of autism spectrum disorders – amongst both children and adolescents. One of the concerns of the National Autistic Society is that their own research said that 63% of adults with the condition are isolated or ignored (their report "I Exist"). One of the issues is that the Guidance should include adults as well as those younger. It is likely that this prompted, in part, the ministerial announcement above.

Contact Ashley Irons or Lindsay Gee for further information.

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Concurrent detention

R v Homerton University Hospital ex p M 2008 C/A

Concurrent detention issues can arise when there is uncertainty over the validity of one section and another is put in place in the meantime. In one JR it was held that two could run side by side. This case supports that ability.

M was detained under s.29.4. Readers will know that s.29 is the section that allows an RMO to prevent a Nearest Relative (NR) for applying for a discharge. This is when someone is seeking discharge of a patient, who is in great need of treatment and who will not have it, save when being detained.

She challenged the Trust's decision to detain her under s.3 at the same time. Hospitals often face challenges to decisions to displace NRs.

M had been bedridden for 3/4 years and her anorexia nervosa left her weight life-threateningly low. Both she and her NR mother were in denial about the seriousness of it, claiming she suffered only from food intolerance and/or pernicious anaemia. The NR was also known to psychiatric services and both she and M had earlier attempted suicide.

M was originally admitted under s.2 and although she gained weight her mother said she would apply for a Discharge Order. However, before the s.2 expired, the Trust applied to displace the mother, on the basis that she was unreasonably objecting to the application, despite the fact that her daughter needed care and treatment (under s.29).

Following the usual procedure, the County Court made an initial Order displacing the mother, and then a further interim Order was made. During the course of this, the Trust made an application under s.3. At a subsequent MHRT, it was held that the s.3 criteria had been met. Before the final hearing, M was transferred to a specialist unit. In the meantime, the mother took no steps on the s.29 application and there was never a final displacement Order. Instead, the application was to challenge two concurrent detention regimes at the same time.

The Court of Appeal said there was nothing in the Act that prevented a hospital from detaining a patient under s.3, whilst the displacement proceedings under s.29 continued.

The hospital did not have to await the outcome of that, and there was no reason why two separate detentions could not run concurrently, nor did such "amount to a disproportionate and unjustified interference with her Article 8 rights".

There was no breach of the European Convention of Human Rights because the safeguards under s.2 and s.3 were available to proper review (i.e. by MHRT). Specifically, the extension of detention under s.29.4 was compatible with the Convention.

This was not a case of false imprisonment or an irrational act of authorities. Both M and her mother could have insisted that the s.29 application be dealt with in the County Court, but chose not to do so. Furthermore, M could have applied to an MHRT but had not done so.

Contact Ashley Irons or Francis Lyons for more information.

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CSCI Restraint report

The Commission for Social Care Inspection (CSCI) has been accused of unfairly exaggerating concerns over the use of restraint in care homes for the elderly.

The implications of this report affect many of those in long-term care. The relevance for readers of this newsletter is that it reflects the competing interests between liberty and duty of care. Furthermore, if liberty is to be restricted in some way, what amounts to the minimum necessary to keep a resident safe?

The report entitled “Rights, Risks and Restraints” was designed to prompt debate on the various forms of restraint, having regard to both the Mental Health Act and the European Convention on Human Rights. It looks at restraint in terms of excess medication and CCTV, as well as physical restraint. CSCI admitted that it had found “no simple solutions”, when grappling with the balance between protecting residents and keeping any infringement of their human rights to a minimum.

The Registered Nursing Homes Association’s Chief Executive said that CSCI had failed to grasp an opportunity to work with long-term care providers in finding practical answers to these complex issues. Mr Ursell said, “On the one hand the Regulator says that care home residents must be allowed to take risks. On the other hand, when risks are taken and something goes wrong, the poor care workers get the blame.”

Capsticks is often asked about restraint related issues, in the context of Bournewood, for those patients or residents who do not have capacity and acquiesce in what is requested of them but who, on the other hand, would not be allowed to leave, as they would come to harm.

The dividing line between restraint and deprivation of liberty is far from fixed. The Code of Practice to the Mental Capacity Act gives examples of where liberty can be restricted to keep someone safe, without the measures taken amounting to deprivation of liberty. The MHA 2007 provides detailed safeguards for this category of patient.

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Certificate in Clinical Risk and Claims Management

Birmingham

This course, which will take place in Birmingham, is based on Capsticks’ extremely successful Diploma in Clinical Risk and Claims Management which has been running in London since 1993.

The Certificate comprises selected highlights of the six day diploma course and runs over three days. There is no exam, but attendees will receive a certificate confirming succesful completion of the course.

Who should attend?

- Risk managers
- Claims managers
- Board members responsible for claims and risk
- management

The Certificate course will introduce you to best practice in claims management and provide the practical skills required to:

- Avoid claims
- Reduce legal costs by greater understanding of
- the claims process
- Comply with the requirements of the NHSLA

Expert guest lecturers will include a representative from the NHSLA, the Department of Health, a senior clinician and a manager working in the Health Service.

Risk management
Day 1 Monday 29th September 2008

Clinical negligence
Day 2 Monday 27th October 2008

Litigation process/medico-legal emergencies
Day 3 Monday 24th November 2008

Course fee: £500 + vat for the whole course

Venue: Maple House, 150 Corporation Street, Birmingham, B4 6TB

Places on the seminars are limited, so please book early to avoid disappointment.

For more information, please visit
www.capsticks.com

Mental Health Seminars

For further information on these seminars contact the Capsticks Events team on 020 8780 2211 or visit www.capsticks.com/seminars

The Mental Capacity Act: the Practical Consequences One Year in

Thursday 18th September 2008
Maple House, 150 Corporation Street **Birmingham** B4 6TB

This seminar will aim to consider the impact of the MCA since its introduction in October 2007. As well as case studies we will consider:

- Applications before the new Court of Protection
- How patients have used the Act
- The effectiveness of staff training on the MCA and areas which require further training
- The role of policies to assist in implementation of the Act
- Common problems encountered in interpreting Advance Decisions, and Powers of Attorney

Risk in Mental Health: Are you Ready for the New Changes

Wed 29th October 2008, Maple House, 150 Corporation Street, **Birmingham** B4 6TB

Wed 19th November 2008, Capsticks Solicitors, 77/83 Upper Richmond Road, **London** SW15 2TT

This interactive seminar will discuss:

- Duties of care – the Courts' view
- Forseeability – responding to risk
- Learning lessons from compensation claims – avoiding repetition
- Corporate manslaughter
- New inquest neglect threshold
- Investigations – Healthcare Commission, HSE, SUI, MAPPA, homicide
- Tips on giving evidence

Mental Health Forum 2008

Wednesday 10 - Thursday 11 September 2008
City of Manchester Stadium, **Manchester** M11 3FF

Panel discussion: navigating legal and regulatory challenges in the provision and delivery of mental health services with Ashley Irons, Partner

- Overview of the Mental Health Act: Implications and challenges
- Establishing systems to mitigate risks
- Examining the interface between the Mental Health and Mental Capacity Acts
- What the Corporate Manslaughter Act will mean in practice for staff and the organisation

Further details: **www.hsj-mentalhealthforum.co.uk**

Implementing the Mental Capacity Act in Health and Social Care: Moving Forward

Tuesday 23 September 2008
4 Hamilton Place, **London** W1J 7BQ

Implementation of the act: legal issues and update with Ashley Irons, Partner

- Giving effect to living wills and avoiding liability
- Consent on behalf of an adult – when is a lasting power of attorney valid?
- Defining lack of capacity and best interests
- Permitted "restraint" – Bournewood and duties of care
- Linking mental health patients and proposed Bill

A Practical Guide to Implementing the New Mental Health Act in Practice

Wednesday 15 October 2008
4 Hamilton Place, **London** W1J 7BQ

Legal issues and implications in practice with Ashley Irons, Partner

- New Mental Health Act 2007 and Code of Practice - changes since 1983
- Linking with the Mental Capacity Act 2005 and its Code of Practice
- Admission, discharge and recall: a new regime
- Compulsory treatment in the community
- Restraint: duties of care and liberty issues
- Treatability: has it really gone?

Risk and Patient Safety 2008

Tuesday 25 - Wednesday 26 November 2008
Church House, **London** SW1P 3NZ

Legal workshop with Majid Hassan, Partner

- Lessons from claims and recent cases

For further information on any of these events, please visit **www.healthcare-events.co.uk**

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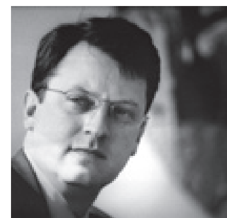

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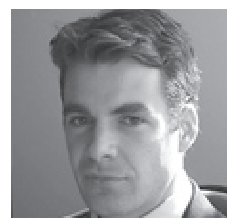

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The healthcare business inside out