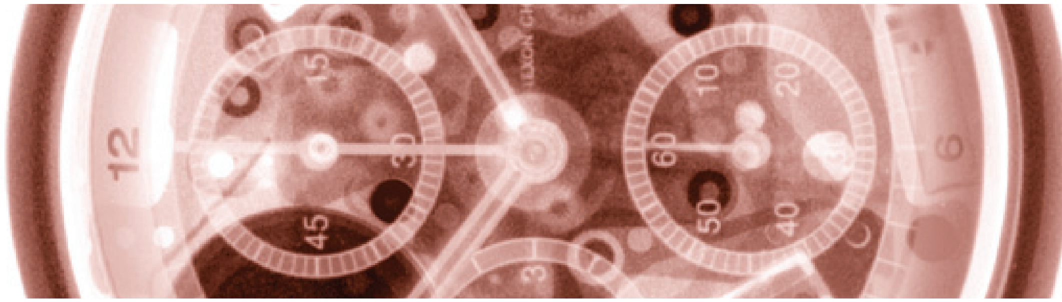


Capsticks
The Healthcare Business Inside Out

Mental Health News

FEBRUARY 2009

Liability for suicide

Savage v South Essex Partnership NHS Trust House of Lords

When is a hospital responsible for the suicide of a patient under Article 2, European Convention of Human Rights?

The duties of care to patients in the mental health and acute sectors have just been extended and will be quoted in future negligence claims:

In a Judgment that expressly applies to mental health patients, the House of Lords said:-

1. Under Article 2, all hospitals have an over arching obligation to protect the lives of patients.
2. Hospitals must employ competent staff who are trained to a high professional standard.
3. And must adopt systems of work which will protect the lives of patients.
4. Introduced a new "*operational*" obligation on hospitals and their staff.

This arises where staff know, or ought to know, that a particular patient presents a "*real and immediate*" risk of suicide – they must do all they reasonably can to prevent the patient from committing suicide.

The case concerned is a mental health patient who absconded from hospital and committed suicide (it was found that the precautions taken by the hospital were inadequate). But the majority of the Law Lords appeared to intend this ruling to apply to all patients in both the mental health and the acute sectors.

Hospitals must check their procedures to ensure their policies comply with this ruling.

The patient suffered from paranoid schizophrenia (readers will recall that the Court of Appeal decision was reported in our mental health newsletter 12 months ago). She had been detained under s.3 in an open acute psychiatric ward and had made numerous attempts to leave and, having finally succeeded, jumped in front of a train and was killed.

The family brought proceedings for compensation based on a breach of Article 2. The High Court Judge said that in order to be in breach of Article 2 there had to be "*. . . at least, gross negligence such as would be sufficient to sustain a charge of manslaughter*", so the claim was dismissed. The Court of Appeal reversed that decision and said that the "gross negligence test" was too high and that what mattered is whether the Trust knew, or ought to have known, of the existence of "*. . . a real and immediate risk to life*". In this case, the court felt that the Trust had failed.

In the December House of Lords Decision, the leading Judgment, by Baroness Hale, expressly limited her decision to the specific facts of that detained patient, and said that a mental health patient, whether detained or informal, was entitled to the same standard of duty of care. She pointed out that a real and immediate risk "*has rarely been shown*". She also pointed out that the steps taken must be proportionate. She acknowledged "*. . . keeping her absolutely safe from physical harm, by secluding or restraining her, or even by keeping her on a locked ward, may do more harm to her mental health. In judging what can reasonably be expected, the Court has also taken into account the problem with resources. The facilities available for looking after people with serious mental illnesses are not unlimited and the healthcare professionals have to make the best use they can of what they have*" (para. 100).

The reference to resources is important because it is often the complaint of providers that they are judged as if resources were unlimited when the reality is the reverse.

Secondly, she acknowledges that hospitals have to balance many factors in managing risk. Patients cannot be secluded just because there is a risk of absconding. Nor can they be continually observed - a paranoid patient may even become a greater risk, as Courts have appreciated in the past. Leave of absence cannot be banned just because there is some risk. It all depends on an assessment of the degree of risk. Courts are reluctant to criticise hospitals provided they see recorded a full risk assessment that sets out risks and benefits of different ways of managing a patient. Hospitals are not expected to guarantee 100% safety, but they are expected to take all reasonable steps to manage forseeable harm and to record this process.

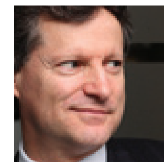
Of interest in the same Judgment, it was said that if a health authority puts in reasonable systems, and a member of staff negligently does not follow them, for example, a nurse leaving his post whilst the patient took up the opportunity to commit suicide, the nurse could be liable for a breach of Article 2. However, the reality is that the hospital under the principle of vicarious liability would be responsible for any consequences.

Another issue concerns corporate manslaughter, because this "*operational obligation*" is very much one that is imposed on managers and it remains to be seen whether this case will be quoted in any later manslaughter prosecution.

For example, a hospital risk assessment states that some wards have potential ligature points and recommends changes. Lack of funds means nothing has been done for a year. If there is a suicide, the hospital will have to justify its allocation of resources in the face of a recognised risk. This may not be easy, as the higher the risk, the higher the priority it deserves.

The House of Lords did not make it 100% clear as to whether this decision was really intended to apply to the acute sector, but that certainly seems to be the implication from the Judgment of Lord Roger, with which his colleagues agreed.

For further information contact Ashley Irons or Philip Hatherall.



Ashley Irons
Partner
020 8780 4866
ashley.irons@capsticks.com

Funding for Alzheimer's Care refused

In a case heard recently but involving pre-National Framework eligibility criteria, Green v South West Strategic Health Authority, North Somerset PCT and others, a PCT's decision that an Alzheimer's patient was not eligible for fully-funded NHS continuing care in her care home was subject to judicial review.

The Strategic Health Authority at independent review had upheld the PCT's decision. The patient however claimed that this decision was unlawful because the criteria on which it was based did not follow the primary health needs test, as established in Coughlan and Grogan (a case in which Capsticks' Lindsay Gee acted for the Care Trust). The patient was unsuccessful in her application: the Judge stated that decision-makers must consider the whole of the individual's care needs, and that the SHA's criteria had to be read as a whole and in the light of the Department of Health's supplementary guidance following Grogan.

On this basis the decision was compatible with the primary health needs approach. We frequently find that the diagnosis of Alzheimer's is regarded by patients as automatically warranting fully-funded NHS continuing healthcare: it is useful to have this public reminder that this is not accurate, but that instead such eligibility is based on appropriate assessments of need.

Habeas Corpus

N v SW London & St George's Mental Health Trust C/A 7.8.08

The Court of Appeal dismissed the Habeas Corpus application brought by a patient and took exactly the same view as Capsticks' Ashley Irons did when receiving a call from the clients to ask whether detention was lawful or not. Amongst other things, this demonstrates how important it is for clients to have immediate and expert advice.

N was detained under s.3 with bipolar-affective disorder and schizo-affective disorder. She had originally been admitted under s.2, Mental Health Act (MHA). N needed an operation at a DGH and, shortly before this was interviewed by an ASW and psychiatrist. She did not cooperate with the interview and brought it to an abrupt halt. Both decided that she should be detained under s.3 (MHA) in response to which N applied for Habeas Corpus. She said that there had been no proper interview or assessment and, therefore, the detention was unlawful.

This was the situation as described to Ashley Irons on the telephone who said that provided that a genuine attempt at an interview had taken place, the detention could not be unlawful when it was terminated abruptly by the patient, and where there were grounds to conclude that she had a disorder requiring immediate treatment (see s.12+13 MHA).

The High Court said that the statutory process had been followed. The Court refused to hear oral evidence about the nature of the interview and the examination, which N alleged provided an insufficient basis for a detention determination. She wanted the psychiatrist and social worker to be cross-examined.

The Court of Appeal supported the High Court Judge in saying that there would only be oral evidence, where "*it was absolutely necessary to resolve an issue*" that the Court could not determine otherwise. In support, the Court of Appeal quoted two earlier Capsticks' cases!

The Court of Appeal went further and said that there was not "*an inherent flexibility*" in s.13.2 entitling the Judge to decide that the interview and examination had been sufficient (s.12.1). In other words, a patient could not avoid an interview / examination by not co-operating and then avoid being detained!

Capsticks' Lindsay Gee conducted the successful Defence on behalf of the Hospital Trust.

Contact Lindsay Gee to discuss the issues in this case.

Lindsay Gee
Consultant
020 8780 4703
lindsay.gee@capsticks.com

Neglect test

Bailey v Ministry of Defence C/A

B had been a patient in a hospital managed by the MOD and brought a claim for damages for brain injury said to be caused by the neglect of the MOD, which included a period of lack of care and a failure to resuscitate. Mental health practitioners are not immune from neglect claims and, here, the Court of Appeal was asked to try and pin down the causation test.

In other words, there may be fault, but can it really be said to have led to the final outcome, or were there other features that did so, that were not the product of any lack of care? They said that it was enough for the Claimant to establish, on the balance of probabilities, that the lack of care "made a material contribution, namely something greater than negligible, to the weakness of her condition". To put it the other way around, if the injury was the product of matters that were not the fault of the Defendant, then the damages claim would fail. Readers may feel this is less than crystal clear.

As advised in earlier newsletters, criticism by Coroners is increasing through the use of narrative verdicts, and this is a case that is likely to be quoted when neglect is an issue.

Contact Philip Hatherall, Rob Wilson or Ashley Irons for further information.

Philip Hatherall
Partner
020 8780 4717
philip.hatherall
@capsticks.com

Trust fine reduced

R v Guy's & St Thomas' NHS Trust C/A

Although not in a mental health context, the reduction in a fine following the death of a baby has implications for fines that may be imposed for corporate manslaughter.

In this case, a baby died because of a technician's error in nutrition given to a baby and where there had been a similar error in the past. The Trust appealed against the fine of £75,000 successfully, which the Court of Appeal reduced to £15,000.

They held that the fine did not take into account that the task had been properly delegated to the technician, who had been properly trained. Secondly, the Judge failed to take account of the detriment to the public, in imposing a fine that would in turn seriously impact upon its ability to serve the public. The fine equated to the cost of 2.5 staff salaries for the year and to impose a fine of that, was bound to have an adverse effect.

The theoretical deterrent effect of a fine needed to be balanced against the impact that the fine would have on the provision of healthcare.

It will be interesting to see whether this argument will also have the same effect if there is a fine under the Corporate Manslaughter Act, as a public body will always be able to argue that a fine reduces its ability to serve the public. Secondly, will private providers benefit from the same consideration – especially when patient funding comes entirely from PCTs? We can be sure this case will be quoted when the first corporate manslaughter prosecution comes along.

For further information contact David Firth, or Ashley Irons.

David Firth
Partner
020 8780 4785
david.firth@capsticks.com

Liability for s.117 injury

R v Kensington & Chelsea ex p AK

Does a trust have any liability for an s.117 patient who jumps from a secondfloor window in his B&B accommodation and suffers catastrophic injuries?

AK had a long history of mental illness, including numerous suicide attempts. AK brought a damages claim, saying that there was neglect and that he should have been placed in more appropriate hospital accommodation to keep him safe.

The High Court Master struck out the claim on the basis that the trust had no liability. However, this was reversed by a High Court Judge.

The central issue centred on the *Clunis* case. Readers will recall that the victim in that case was randomly chosen and that, as such, the relevant aftercare bodies had no direct duty of care to the victim (no "*proximity*" to create a commonlaw duty of care to that victim).

Here, AK argued that his situation was different and that, anyway, *Clunis* should not be cited to avoid liability that otherwise would exist.

The High Court felt that there was a far closer relationship between the defendants and AK than there was with the defendants in the *Clunis* case (where he picked a victim at random at Finsbury Park tube station).

In passing, the Judge said that this would require gross negligence to be established (notwithstanding the Savage case) as regards Article 2. The Judge held that AK's claim under Article 2 was bound to fail.

However, the Judge felt that AK had an arguable case under Articles 3 & 8 and therefore allowed AK's appeal.

Readers will understand that this case does not determine AK's case, as the trial will take place next year. What is of direct concern to PCTs, and other health providers, is that where a patient is discharged and is in the community under s.117, the relevant aftercare bodies might have a liability where harm is foreseeable. In this case there was a history of suicide attempts.

It has always been the case that Courts have been most reluctant to extend the responsibilities under s.117, to make aftercare bodies liable for whatever mishap may occur. This is on the basis that as a matter of public policy, there has to be a limit by aftercare bodies to the duty owed members of public, for whom they have no direct duty of care.

It is clear that this is a developing area of law and that the direction of travel is likely to broaden the opportunities for a successful claim in the future.

For further information contact Francis Lyons or Ashley Irons.

Francis Lyons
Solicitor
020 8780 4865
francis.lyons@capsticks.com

Who pays – PCT or LA?

St Helen's BC v Manchester PCT C/A

Capsticks are regularly consulted by PCTs as to whether they are responsible for funding, or whether the responsibility should be that of the local authority (LA).

Here the LA appealed a decision that it was responsible to pay for P's care in a home that required 24-hour attention. P suffered from dissociative identity disorder and the LA had paid for this care for many years, but decided that the services she needed were not those that Social Services should fund. Best interests proceedings were started on P's behalf and the Trust commissioned a continuing healthcare assessment and other reports.

The PCT decided that the needs were not primarily health and that, except for physiotherapy, it should not fund P's care.

The LA's challenge to this decision in the High Court failed.

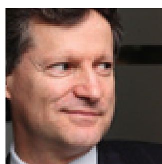
The Court of Appeal held that as the delegate of the Secretary of State, the PCT was the primary decision-maker. The determination of whether P's needs were primarily for health derives from the NHS Act 2006 sections 1-3. It was a decision to be taken by or on behalf of the Secretary of State. The structure required recommendations from a multi-disciplinary team, on which there was Social Service expertise and membership.

The Trust's expert panel then had to decide whether the prime needs were health or social care.

The NHS Act was the dominant Act when compared with the National Assistance Act 1948, in that if a person's care needs were not primarily healthcare, they would be social care.

This case is therefore an important one and will be referred to whenever disputes arise as to who pays.

For further information and advice please contact Lindsay Gee or Ashley Irons, who are both regulary consulted on funding issues and disputes.



Ashley Irons
Partner
020 8780 4866
ashley.irons@capsticks.com

Capsticks seminars and events

Deprivation of Liberty Safeguards in Health and Social Care

Thursday 05 March 2009, 76 Portland Place, London

Deprivation of Liberty: legal issues and update with Ashley Irons, Partner

- Current UK and European case law on Deprivation of Liberty
- When keeping someone safe = Deprivation of Liberty?
- Capacity and best interests
- Restraint v duties of care conflict: overlap with the Mental Capacity and Mental Health Acts and common law
- How courts will distinguish between lawful and unlawful detention
- Reducing the risk of claims

For further information contact Healthcare Events on 020 8541 1399 or email naomi@healthcare-events.co.uk

Mental Capacity Act in Health and Social Care Moving Forward

Wednesday 29 April 2009, 4 Hamilton Place, London

Implementation of the Act: legal issues and update with Ashley Irons

- Giving effect to LivingWills 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

For further information contact Healthcare Events on 020 8541 1399 or email jayne@healthcare-events.co.uk

Deprivation of Liberty Safeguards - Update and the Experience So Far

Wednesday 13th May 2009, Central London

Thursday 18th June 2009, Maple House, 150 Corporation Street, Birmingham B4 6TB

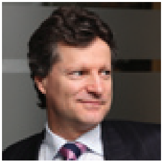
- Resolving assessment disputes
- PCT/Supervisory role
- When keeping someone safe = Deprivation of Liberty?
- Capacity and best interests
- Restraint v duties of care conflict: overlap with the Mental Capacity and Mental Health Acts and common law
- How courts will distinguish between lawful and unlawful detention
- Reducing the risk of claims

For further information contact the Capsticks Events team on 020 8780 4864 or email seminars@capsticks.co.uk

Mental Health Law contacts

David Firth
Partner
020 8780 4785
david.firth@capsticks.com

Philip Hatherall
Partner
020 8780 4717
philip.hatherall
@capsticks.com



Ashley Irons
Partner
020 8780 4866
ashley.irons@capsticks.com

Peter Marquand
Partner
020 8780 4705
peter.marquand
@capsticks.com

David Mason
Partner
020 8780 4701
david.mason@capsticks.com

Lindsay Gee
Consultant
020 8780 4703
lindsay.gee@capsticks.com

Rebecca Hunt
Solicitor
020 8780 4896
rebecca.hunt@capsticks.com

Francis Lyons
Solicitor
020 8780 4865
francis.lyons@capsticks.com

Capsticks Solicitors LLP

www.capsticks.com

London Office
77–83 Upper Richmond Road, London SW15 2TT
T +44 (0)20 8780 2211
F +44 (0)20 8780 1141
DX 59461 – Putney

Birmingham Office
35 Newhall Street, Birmingham B3 1PB
T +44 (0)121 230 1500
F +44 (0)121 230 1515