April 2009

Mental Health Focus

Welcome

Welcome to Hill Dickinson's Mental Health and Social Care Team's special edition newsletter.

A number of significant developments have been introduced into the field of mental health law from 1 April 2009, primarily the introduction of the new Deprivation of Liberty Safeguards and Independent Mental Health Advocacy service.

This update provides basic and essential tips and guidance with the new statutory provisions in mind, including where to seek further details. Information is also provided on issues affecting prisoners' mental health needs.

Feedback on the newsletter would be welcomed at:
healthnews@hilldickinson.com

If you would like further information on any of the issues addressed within this issue, please contact:

Sharon Thomas (née Wilson)
sharon.thomas@hilldickinson.com
0151 600 8249

Rebecca Fitzpatrick
rebecca.fitzpatrick@hilldickinson.com
0161 817 7296

Louise Wright
louise.wright@hilldickinson.com
0151 600 8112

Our Mental Health and Social Care Team have recently developed training packages for Mental Health staff and Mental Health Act Administrators. These cover the basics of the Act, documentation and case studies.

Comment from delegate "It was brilliant - more than we could have hoped for, just what we needed."

If you are interested in this training please contact:
Rebecca Fitzpatrick
0161 817 7296
rebecca.fitzpatrick@hilldickinson.com

Contents Page no.

Mental Health Bulletin

Injunction preventing disciplinary hearing granted by High Court	3
Independent mental health advocacy - a new statutory service	4
Court confirmation on the requirement for adequate risk assessment of vulnerable patients	6
The Deprivation of Liberty Safeguards - are your staff ready?	7
DoLS essential training for hospitals and care homes	9
DoLS essential training for supervisory bodies	9
Mental Health Prisoners	10

Hill Dickinson And AFTA Thought – A New Partnership Deprivation Of Liberty Safeguards

The training company AFTA Thought has sought to partner with Hill Dickinson in providing a unique model for delivery of training in DoLS for front line staff. This involves a combination of legal commentary, dramatic role play and interactive discussion. This is an extension of AFTA Thought's previously established model of delivering training for subjects such as safeguarding of vulnerable adults, Mental Capacity Act, looked after children and bullying and harassment.

A module has been developed by AFTA Thought and Hill Dickinson to deliver this training in a 3 hour session. A half day pilot session in January 2009 was held at Hill Dickinson's Liverpool office at St. Paul's Square involving invitees from local authorities, PCT's, NHS Trusts, Regulators and private hospitals.

The session was delivered by Mary Austin (AFTA Thought) and Sharon Thomas (nee Wilson), with a team of professional actors playing the roles of care home managers, patient's relatives etc.

Question and answer sessions at the conclusion of each case study were undertaken and afforded the opportunity to ask detailed questions about the safeguards, the application and interpretation of the safeguards and the links between MCA and DoLS.

At the conclusion of the training session comments made included:

"Good structured presentation"

"This format is a very impressive way of delivering this training"

"A really good session"

"Very thought provoking presentation"

"Roleplay excellent"

"Excellent insight into legalities"

"Day exceeded expectations"

"Really enjoyed the sessions, very informative, presenters very approachable"

"Extremely good seminar, gave me a lot of food for thought"

"Good Introduction, definitely made more sense as the sessions complemented each other"

In addition, many said that that they would see this training as benefiting their own and other organisations.

If you are interested in this format of DoLS training for your organisation, please contact:

Jamie, Curley
jamie.curley@hilldickinson.com
0151 600 8248.

Mezey -v- South West London and St George's Mental Health NHS Trust – injunction preventing disciplinary hearing, High Court (QBD) – 05/12/2008

The High Court has granted an injunction prohibiting an NHS Trust from imposing disciplinary sanctions on a consultant psychiatrist whose "one-off misjudgement" led to a man being killed. It was held that doctors, by the very nature of their work, are liable to make mistakes that have very serious consequences, but it does not follow that every such mistake deserves disciplinary action. Disciplinary action should not be taken in high-profile cases purely to show that the Trust is taking these matters seriously.

Facts

In 2004, following what was said to be a one-off misjudgement, Dr Mezey, a consultant psychiatrist, authorised unescorted "ground leave" for a one hour period for a patient with paranoid schizophrenia, with a history of violence. The patient subsequently absconded and murdered a total stranger the next day. Dr Mezey was suspended, but subsequently applied to, and won an order from, the High Court (confirmed by the Court of Appeal) staying her suspension pending the result of a disciplinary hearing. A full report into the matter was completed by the end of March 2008 and, whilst making some criticisms of Dr Mezey, found that she had not been at serious fault in any respect, and that her continuing employment by the Trust did not give any cause for concern. In light of the report Dr Mezey applied to the High Court for an injunction prohibiting the Trust from holding a disciplinary hearing and from continuing to exclude her from clinical work.

The decision

The Judge concluded that, in light of the March 2008 report, it would not be open to the Trust to impose any disciplinary sanction on Dr Mezey. Therefore a disciplinary hearing, at least in the form proposed by the Trust, would be inappropriate. The Judge emphasised that his decision should not be taken to belittle the tragedy of the victim and his family, or to ignore the fact that Dr Mezey made a misjudgement which had shocking consequences. By the nature of their work the misjudgements which doctors, like everybody else, sometimes make are liable to have very serious consequences. It does not follow that every such mistake or misjudgement deserves disciplinary action, or that disciplinary action has to be taken in a high-profile case in order to show that the Trust is taking matters seriously. In every such case a careful examination of the misjudgement in question is required, including an assessment of whether it reflects on the doctor's overall capability. Such an examination had occurred in this case.

Comment

The ruling emphasises the need for Trusts to focus their enquiries on the error or misjudgement itself rather than the consequences. Disciplinary action should not be taken in 'high-profile' cases simply because it is seen as the right thing to do in the eyes of the public, particularly if reports commissioned during the investigations indicate that disciplinary proceedings are not warranted. In each case Trusts must look at the misjudgement or error and, using all of the evidence available, ascertain whether the individual in question still has the necessary capabilities to carry out their role.

Graham Taylor
graham.taylor@hilldickinson.com

INDEPENDENT MENTAL HEALTH ADVOCACY – A NEW STATUTORY SERVICE

From 1 April 2009, 'qualifying patients' in England will be entitled to an Independent Mental Health Advocacy service under new statutory provisions introduced by s.30 of the Mental Health Act 2007. This service is designed to assist patients in understanding the provisions of the Mental Health Act 1983 (MHA 1983) to which they are subject, and to help safeguard their legal rights. Louise Wilson provides an overview of the provisions, and how they affect PCTs and mental health providers.

Who can be an IMHA?

The Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008 ("the Regulations") impose statutory requirements to consider when appointing persons to act as Independent Mental Health Advocates (IMHA) under Regulation 6. These requirements include:

1. A person must have appropriate experience or training or an appropriate combination of experience and training. The determination as to what constitutes appropriate experience or training would need to include consideration of:

- Previous experience working in advocacy, particularly mental health advocacy;
- Previous experience of working with people with mental health needs;
- Successful completion of the IMHA module of the National Advocacy Qualification.

This duty of ensuring the correct level of appropriate experience and training rests with PCT commissioners, even where IMHAs are provided by independent advocacy service providers. It is therefore advisable that any agreement between the PCT and the IMHA service provider includes a condition that all IMHAs meet the required level of appropriate experience and training.

2. The person must be of integrity and good character

- This must be evidenced by that person obtaining an enhanced criminal record certificate; or
- If an enhanced certificate is not required under s.113B (6) of the Police Act 1997, a criminal record certificate under s.113A Police Act 1997 should be obtained.

Which form of criminal record certificate is required depends upon the purpose for which the certificate is required.

3. The person must be able to act independently of any person who is professionally concerned with the patient's medical treatment.

4. The person must act independently of any person who requests that person to visit or interview the patient.

Again, it is important for the PCT to contract with the IMHA service provider with the condition that IMHAs meet the above criteria. Commissioners must take these issues seriously in order to ensure that patient and public confidence is not undermined.

Role of an IMHA

The role of the IMHA will complement the non-statutory Mental Health advocacy service already available to patients. However, specific roles and responsibilities of IMHAs will be introduced to provide statutory safeguards to patients outlined in s.130B MHA 1983. These include assisting patients in obtaining information relevant to:

- Provisions of the MHA 1983 the patient is subject to;
- Conditions or restrictions the patient is subject to under the MHA 1983 e.g. arrangements for s.17 leave;
- What (if any) medical treatment is being given to them, proposed for them or discussed in their case;
- Why that treatment is given, proposed or discussed;
- The authority for the provision of such treatment; and
- The patients' rights under the MHA 1983 in regard to treatment, and how those rights can be exercised. IMHAs can provide further assistance to qualifying patients in relation to:
- Accessing information, exploring options and making informed decisions in relation to their rights;
- Articulating their own views and representing them in exercising those rights.

Although in many respects the IMHAs' role is similar to that of the Independent Mental Capacity Adovocate (IMCA) introduced by the Mental Capacity Act 2005, it is much wider in relation to ongoing involvement.

Rights of IMHAs

IMHAs' rights are outlined within s.130B MHA 1983. These include:

- The right to visit and interview a qualifying patient in private;
- The right to interview the relevant professionals involved in the patient's care;
- The right to have access to records relating to detention or treatment, or in relation to s.117 aftercare, with the consent of the patient.

In situations where the patient lacks capacity (or is not Gillick competent if under 16) to consent, if the records are relevant to the IMHA being able to assist the patient, the holder of the records must allow the IMHA access.

>>>

Who is eligible for an IMHA?

Patients who are eligible for an IMHA are defined as "qualifying patients". These are patients who meet criteria under s.130C of the MHA 1983. For a patient to be defined as a qualifying patient, they must either be:

1. Liable to be detained under the MHA 1983 (including patients on leave of absence from hospital) except patients detained under s.4 (emergency admissions), s.5(2) or s.5(4) (doctors' and nurses' holding powers), s.135 (warrant to search for and remove a patient) or s.136 (mentally disordered patients found in public places); or
2. Conditionally discharged restricted patients; or
3. Subject to Guardianship under MHA 1983; or
4. A community patient (Supervised Community Treatment (SCT)).

In addition, patients who do not fall into the categories above may still be classed as qualifying patients if:

1. They are being considered for a s.57 treatment under Part 4 of the MHA 1983 (particular treatments requiring consent and a second opinion); or
2. Being considered for ECT (or any other treatment that may in future be covered) under s.58A of the MHA 1983, and the patient is under 18 years of age.

Duty to inform patients of their rights

Qualifying patients will have a right to be informed when they are entitled to an IMHA, and how such help can be obtained. This includes receiving written or verbal information as to the IMHA service available. This duty is placed upon the "responsible person" under the MHA 1983 which includes hospital managers, responsible clinicians, the local social services authority and approved clinicians.

The "responsible person" in each situation is dependant on following the provision which ascertains that a patient is a qualifying patient:

1. Detained and SCT patients – the managers of the hospital (in practice the Mental Health Act Administrators) are responsible for informing the patient as soon as practicable after the patient becomes liable to be detained, or becomes a SCT patient;
2. Guardianship patients – the local social services authority is responsible as soon as practicable after the patient becomes subject to Guardianship;
3. Conditionally discharged patients – the responsible clinician is responsible as soon as practicable after the patient is conditionally discharged;
4. Informal patients – the doctor or approved clinician who discusses the possibility of s.57 or 58A treatment first with the patient is responsible for informing the patient of the IMHA service during, or as soon as practicable after, that discussion.

In addition to referrals being made to the IMHA service by the "responsible person", commissioners should also ensure that the IMHA service facilitates self-referrals from qualifying patients. If a referral is made by the patient's nearest relative, responsible clinician or AMHP, IMHAs have a statutory duty to comply with any reasonable request to visit the qualifying patient under s.130B (5).

This will therefore mean it is essential that the IMHA service is structured to respond to referrals from all the different routes and provide minimal response times to these referrals.

Implementation of IMHA services

It is the responsibility of the relevant PCT to make arrangements for IMHA services. This is set out by s.130A of the MHA 1983 which places a duty upon the PCT (delegated by the Secretary of State) to make such arrangements as it considers reasonable for IMHAs to be available to help qualifying patients.

The NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 have been amended to set out the circumstances on which each PCT will be responsible for the commissioning of IMHA services. This is largely dependent on GP registration and residency of the qualifying patient. Therefore, these rules are broadly in line with existing PCT commissioning responsibilities in terms of specialist mental health services. In most cases, the PCT responsible for commissioning mental health care for a qualifying patient will be the same PCT who will provide access to the IMHA service.

Commissioning IMHA services

There are two ways in which PCTs can commission IMHA services:

1. From independent advocacy providers; or
2. By employing/engaging individuals directly to act as IMHAs.

However, it is advised that PCTs opt to commission IMHA services from independent advocacy providers to ensure the associated benefits and protection afforded by an independent organisation, such as greater assurance for patients of being genuinely independent, rather than being an individual employed by the PCT. In addition, independent advocacy providers will already have the appropriate experience and/or training as prescribed in the Regulations and are likely to have policies in place to deliver services effectively.

Conclusion

The introduction of a statutory mental health advocacy service is an additional safeguard to patients' legal rights introduced into the MHA 1983. This will mean patients will benefit from a patient orientated service encouraging participation in the decision-making process relating to their treatment. It is not intended to replace legal representation at Mental Health Review Tribunals etc. It is important that all relevant staff are aware of the new safeguard and inform patients appropriately.

Louise Wilson
louise.wilson@hilldickinson.com

ADEQUATE RISK ASSESSMENT OF VULNERABLE PATIENTS MUST BE PERFORMED TO ASSESS SUICIDE RISK

In December 2008 the House of Lords provided strong indications on the requirement for adequate risk assessment of vulnerable patients to be performed to assess whether a risk of suicide was present. Judgment was handed down in the case of Savage and South Essex Partnership NHS Foundation Trust, summarising the obligations of health authorities under Article 2 of the European Convention on Human Rights, which concerns right to life.

The Court of Appeal had previously held that reasonable steps should be taken to avoid a real and immediate risk of suicide where this was known or ought to have been known.

Facts

The case concerned a mental patient with a significant history of mental illness who was compulsorily detained under s. 3 of the Mental Health Act 1983 on an open acute psychiatric ward of an NHS hospital. After several attempts to leave during the preceding months, she absconded successfully and committed suicide. Her daughter brought an action against the Trust, claiming damages pursuant to s. 6, 7 and 8 of the Human Rights Act 1998 alleging that the deceased's right to life under Article 2 of the European Convention on Human Rights had been violated. The Trust requested confirmation, as preliminary issue, of the proper test to establish a breach under Article 2. At first instance, a declaration was made that the Claimant must prove the Trust had been guilty of gross negligence sufficient to sustain a charge of manslaughter, in accordance with previous decisions.

Following confirmation the Claimant could not satisfy this test, summary judgment was granted in favour of the Trust. The Claimant subsequently appealed to the Court of Appeal, where it was held that the relevant test to be satisfied was whether knowledge existed or ought to have existed concerning a real and immediate risk to life in the relevant circumstances, applying the principle previously established in Osman –v- the United Kingdom.

House of Lords decision

Baroness Hale confirmed that the appropriate trigger was a "real and immediate risk to life" about which the authorities knew or ought to have known at the time. The steps taken were to be proportionate and judged on the basis of relevant resources.

Lord Rodger confirmed positive obligations would include:

- The responsibility to employ competent staff trained to "a high professional standard";
- Adoption of systems of work capable of protecting the lives of patients;
- Appropriate supervision of patients.

Implications of the decision

The judgment by the House of Lords imposes an additional "operational" obligation on health authorities and their staff, namely to take care to perform adequate risk assessment of vulnerable patients to assess whether a risk of suicide is present in addition to existing, more general obligations under Article 2. Broadly speaking, emphasis is to be placed on saving a patient's life and employing a "common sense" approach in the circumstances.

On a practical level, Trusts should review and audit their risk assessment and observation policies to ensure that adequate and appropriate risk assessments are completed, with associated action. This includes for those vulnerable patients being cared for outside of a mental health trust, for example at A & E. A failure to do so by Trusts could leave the organisation vulnerable, not only to claims under the Human Rights Act, but to corporate manslaughter charges.

Catherine Clegg
catherine.clegg@hilldickinson.com

The "Deprivation of Liberty" Safeguards – are your staff ready?

New legal safeguards which form part of the Mental Capacity Act 2005 (MCA) came into force as of 1 April 2009 which aim to protect the human rights of vulnerable people in care homes and hospitals in England and Wales. From this date, it is unlawful for a care home or hospital to provide care to someone who meets the eligibility criteria for the DoLS Scheme, and whose care regime amounts to a "deprivation of liberty" without first having obtain specific authorisation. Obviously, this means it is vital to be aware of requirements for compliance with the legislation and how to implement appropriate policies. It is also necessary to understand the difference between what constitutes a "restraint" and a "deprivation of liberty".

Who is eligible under the scheme?

The scheme relates to a person who:

- Is 18 or over and present in England or Wales;
- Is suffering from a mental disorder (as defined by the Mental Health Act 1983);
- Lacks capacity to consent to admission to a hospital/care home but the care is deemed in their "best interest";
- Is not detained under the MHA or required to live in a specific place under the MHA; and
- An Attorney, appointed under a Lasting Power of Attorney, has not refused any part of the care regime on their behalf.

What is "deprivation of liberty"?

Deprivation of liberty depends on the circumstances of each individual case. As such, there is no one definition or checklist which can be used to identify if a deprivation of liberty is occurring. However, Court decisions at common law have identified a number of circumstances where patients may have been deprived of their liberty:

- Where restraint was used to admit a person to a hospital or care home when the person is resisting admission;
- Medication has been given forcibly, against a patient's will;
- Staff have exercised complete control over the care and movements of a person for a long period of time;
- Staff have taken all decisions for a patient, including choices concerning assessments, treatments, visitors and where they can live;
- The hospital or care home took responsibility for deciding if a person could be released into the care of others or allowed to live elsewhere;
- Where carers have requested that a person be discharged to their care and the hospital or care home staff have refused;
- The person has been prevented from seeing friends or family due to restricted access instigated by the hospital or care home;
- The person has been unable to make choices about what they want to do or how they want to live because the hospital or care home staff have exercised continuous supervision and control over them.

Action to take

For each person living in the hospital or care home who lacks capacity, you should consider whether:

- The care and/or treatment being provided removes their freedom to do what they want to do to the extent that they are being deprived of their liberty;
- Whether the suggested care and/or treatment is in the person's "best interests";

>>>

If yes, you need to consider whether the care or treatment can be provided in a way that does not affect their liberty (otherwise known as the "least restrictive alternative"). If the answer to this is no and there is no other way to provide care or treatment, you will need to carry out an assessment to decide whether the deprivation of liberty is justified. If the answer is yes, this will require authorisation.

Seeking authorisation

If you decide a deprivation of liberty will occur, you will need to apply to your "Supervisory Body" – the Primary Care Trust in the case of hospitals or local authority in the case of care homes – for a series of assessments to be performed and authorisation to be granted or denied, as appropriate.

The supervisory body is responsible for appointing appropriate assessors and ensuring they meet all the criteria.

Recent changes to provisions

Recent changes to the system have been introduced to allow supervisory bodies to enter into a number of shared operational and administrative arrangements to carry out their functions under the MCA effectively. These create the potential for PCTs to enter into formal "partnership arrangements" with a local authority under s. 75 of the National Health Service Act 2006. Practically speaking, these allow an assessor, who is an employee of the Primary Care Trust, to be covered by the indemnity/insurance of a local authority where they are performing an assessment for a local authority and vice versa. However, all local authorities and PCTs need to ensure confirmation of arrangements are provided within their own local insurance/indemnity arrangements. (If in doubt as to whether this is the case, you may wish to seek legal advice to confirm.) Subject to local arrangements being in place in time, local authorities and PCTs entering into these agreements will be able to carry out any of their functions on each others' behalf, including commissioning of assessments and authorisation of deprivations of liberty from 1 April 2009.

Record keeping

Hospitals and care homes need to keep detailed records as part of the MCA DoLS process. To aid with this, a number of standard forms have been developed. These can be accessed at the Department of Health website at http://www.dh.gov.uk/en/publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089772.

Transitional arrangements

Transitional arrangements apply for the month of April 2009 - the timescale for standard authorisation assessments is extended from 21 to 42 days and for urgent authorisations the period of 7 calendar days is extended to 21 calendar days.

Further guidance

There are also a number of guides available on the Department of Health website to assist in familiarising yourself with the new provisions, with separate guides for Primary Care Trusts and Local Authorities (OPG607) and Hospitals and Care Homes (OPG608) respectively, including an overview of the MCA DoLS process.

Catherine Clegg
catherine.clegg@hilldickinson.com

DoLS essential training

The Deprivation of Liberty Safeguards ("DoLS"), which form part of the Mental Capacity Act 2005, aim to protect the human rights of vulnerable people in care homes and hospitals in England and Wales and are intended to close the "Bournewood gap".

The DoLS may apply to anyone aged 18 or over, who lacks capacity to consent to their care/accommodation, suffers from a mental disorder (e.g. dementia or learning disability) and whose care regime amounts or may amount to a deprivation of liberty.

Hospitals and care homes - are you ready?

From 1 April 2009, hospitals or care homes that provide such care will have to apply for formal authorisation to deprive that person of their liberty. It is essential that hospitals and care homes are aware of their new responsibilities as managing authorities under the DoLS scheme, have appropriate policies in place and that staff are trained in accordance with the legislation.

DoLS training for hospitals and care homes

Hill Dickinson provides training on DoLS for all staff working within organisations where the new safeguards may affect them.

Specific topics include:

- Understanding the distinction between restriction and deprivation of liberty
- Who does DoLS apply to?
- The framework governing DoLS
- The assessments required
- The review procedure
- Legal implications of non-compliance
- Case studies and analysis
- Discussion

Available training packages

- Bespoke individualised packages for your organisation's needs
- Three hour overview seminar at your premises, for as many attendees as you wish

Supervisory bodies - are you ready?

It is essential that Primary Care Trusts, Local Health Boards and Local Authorities (LAs) are aware of their new responsibilities as supervisory bodies under the DoLS scheme, have appropriate policies in place and that staff are trained in accordance with the legislation.The government is also proposing to allow PCTs and LAs to enter into formal partnership arrangements under Section 75 of the National Health Service Act 2006 in relation to DoLS. Such an arrangement would mean that PCTs will be able to carry out any of the LA's functions under DoLS, on their behalf, including the commissioning of assessments and the authorising of deprivations of liberty, and vice versa.

DoLS training for supervisory bodies

Hill Dickinson provides training on DoLS for all staff working within organisations where the new safeguards may affect them.

Specific topics include:

- Understanding the distinction between restriction and deprivation of liberty
- Who does DoLS apply to?
- The framework governing DoLS
- Specific responsibilities of supervisory bodies and how to meet them
- The assessments required
- The review procedure
- Case studies and analysis
- Discussion
- How PCTs can enter into formal partnership arrangements with a LA under Section 75 of the
- National Health Service Act 2006

Available training packages

- Bespoke individualised packages for your organisation's needs
- Three hour overview seminar at your premises, for as many attendees as you wish

For further information please contact:

Liverpool
Sharon Thomas (née Wilson)
sharon.thomas@hilldickinson.com
0151 600 8249

Louise Wright
louise.wright@hilldickinson.com
0151 600 8112

Manchester
Rebecca Fitzpatrick
0161 817 7296
rebecca.fitzpatrick@hilldickinson.com

MENTAL HEALTH Prisoners

Be aware!

90% of the prison population have a diagnosable mental health problem, including serious personality disorders, psychosis, schizophrenia, suicidal and self harming behaviour and depression. 2% of remand prisoners will attempt suicide in any given week. It is therefore vital that prisoners' mental health needs are adequately assessed and provided for.

>>>

Identify mental health issues and vulnerable patients early

Where a prisoner required in-patient treatment this must be arranged as soon as possible (Prison Service Standard 22, "PSS 22"). Failure of the agencies involved to do this can lead to successful challenges in the Courts, whilst it may also put staff, patient and other prisoners at unnecessary risk. Case law, Public Inquiry reports and Coroners have also made it clear that those responsible for the care and welfare of detained individuals have a heightened level of responsibility for those individuals considered to be particularly vulnerable. For example, a prisoner who perhaps has a history of self harming, but who has not been diagnosed with a mental health problem, or a young offender who is serving their first term of imprisonment, who has received additional bad news such as the death of a close family member. Adequate risk assessment, monitoring and observations, all of which should be fully documented, are therefore crucial.

Risk of variety of legal proceedings

Where staff, patients and other prisoners are not adequately protected, this in certain cases may lead to adverse legal consequences such as:

- Prosecution of either the prison or PCT by the Health & Safety Executive;
- Criticism of a PCT/prison within the setting of a Coroner's Inquest;
- Public inquiry;
- Corporate manslaughter investigation;
- Personal injury litigation;
- Claims under the Humans Rights Act 1998;
- Involvement of the Prison Ombudsman.

Multi-disciplinary care: liaise with other agencies

There should be appropriate multi-disciplinary working between the PCT, where appropriate the relevant mental health Trust, the prison service and where necessary the Home Office/Ministry of Justice. Such joint working and sharing of information between agencies is essential to good quality care. Structures and systems should be put in place to make multi-disciplinary care more effective, including service agreements with local mental health services and agreements for sharing information between organisations.

Maintain patient confidentiality

Maintaining confidentiality of a patient's health records is important, although this can sometimes be difficult to achieve within a prison setting. It is therefore important to have clear policies and practices agreed between the PCT and prison service about disclosure of information relating to a patient's mental health to prison service staff (see PSS 22 and the NHS Code of Practice on Confidentiality).

Consider hospital transfers: Secure early diagnosis and treatment

If a prisoner needs medical treatment for their mental illness and the prison setting is not a satisfactory environment for this to take place, a hospital transfer should be considered and if appropriate, arranged as a matter of priority. In these circumstances, prisoners should be moved to a more appropriate setting at the earliest opportunity. Failure to do so will make both the PCT and the prison service vulnerable to challenges by way of judicial review and under the Human Rights Act, which are hugely costly whilst also often attracting negative media attention and the interest of the Prison Ombudsman. Where agencies fail to act swiftly and the prisoner then seriously self harms or commits suicide, this again will prejudice the defence of a personal injury claim, or the defence of the PCT at the subsequent inquest or inquiry.

Mental Health Act 1983

A person cannot be treated under the Mental Health Act whilst in prison, even if an order for transfer to hospital has already been made. If there are serious concerns for the health, welfare and safety of a prisoner patient, whom the PCT feel requires detention under the Act, but there are difficulties in arranging the appropriate hospital transfer due to wider issues, the Trust should seek urgent legal advice. The definition of mental disorder has now been widened and means that certain prisoners will meet the criteria for detention in hospital (e.g. with personality disorder) when they did not before.

The Mental Capacity Act 2005

The Mental Capacity Act (MCA) applies equally to prisoners as to other members of the population in general. All prison healthcare staff should be familiar with the relevant provisions of the Act, and the contents of the Department of Health guidance "Seeking Consent: Working with People in Prison". A patient's capacity should be regularly reviewed, particularly where the patient has mental health issues. Where the patient lacks capacity, treatment or welfare decisions must be made on a best interests basis according to the checklist set out in the MCA 2005. Where there is concern or uncertainty about a patient's capacity or best interests and important treatment or welfare issues are at stake (e.g. a patient refusing life sustaining treatment, or refusing food and water, who is considered to be particularly vulnerable), legal advice should be sought urgently.

The MCA & Independent Mental Capacity Advocates

The MCA created a new role called the Independent Mental Capacity Advocate (IMCA). IMCAs should be available where appropriate, to prisoners. An IMCAs involvement will be required where the patient prisoner lacks capacity to make a decision either about serious medical treatment or long-term accommodation in hospital (not as part of detention under the Mental Health Act 1983) or care homes, in the community.

s.117 duty

S.117 of the Mental Health Act 1983 required the relevant PCT to provide aftercare to patients who have previously been detained under certain provisions of the Act and will apply to some patients at the point of their release from prison. PCTs together with their partner social service departments should therefore plan well ahead to meet this statutory duty, so that appropriate community care services are made available to the patient upon their release. Where a prisoner patient has particularly complex mental health needs, a detailed care package including provision of supervised accommodation may be required. Failure to assess adequately and provide such service will open up the PCT to the possibility of a successful judicial review challenge on an emergency basis.

Observation, care and management of patients at risk of self injury

Prisoner patients must wherever possible be protected from harming themselves where the drive for self injury is a result of mental disorder for which they are receiving care and treatment. Where there exists concern that this may be an issue, risk assessments and care plans should set out what the risk is, what measures are required to manage the risk safely and any special observations that are required to ensure the patient's safety.

Rebecca Fitzpatrick
rebecca.fitzpatrick@hilldickinson.com

About Hill Dickinson

Hill Dickinson offers a comprehensive range of legal services from offices in Liverpool, Manchester, London and Chester, and its associated firm Hill Dickinson International has offices in London, Singapore and Greece. Collectively the firms have over 150 partners and a complement of more than 1000 staff.

Hill Dickinson is a major force in insurance and is well respected in the company and commercial arena. The firm's marine expertise is internationally renowned and it has one of the largest marine practices in the UK. The firm has an award winning property practice and is widely regarded as a leader in the fields of commercial litigation, employment, intellectual property, NHS clinical/health related litigation and private client.

For further details please contact:

Allan Mowat
Head of Health Services and
Head of Healthcare Team
0151 600 8298
allan.mowat@hilldickinson.com

Sharon Thomas (née Wilson)
Partner
sharon.thomas@hilldickinson.com
0151 600 8249

Rebecca Fitzpatrick
Associate
0161 817 7296
rebecca.fitzpatrick@hilldickinson.com

Hill Dickinson LLP:

Liverpool Office
No.1 St. Paul's Square
Liverpool
L3 9SJ

T: +44 (0)151 600 8000
F: +44 (0)151 600 8001
DX 14129 Liverpool

Manchester Office
50 Fountain Street
Manchester
M2 2AS

T: +44 (0)161 817 7200
F: +44 (0)161 817 7201
DX 14487 Manchester 2

London Office
Irongate House
Duke's Place
London EC3A 7HX

T: +44 (0)20 7283 9033
F: +44 (0)20 7283 1144
DX 550 City of London

Chester Office
34 Cuppin Street
Chester
CH1 2BN

T: +44 (0)1244 896600
F: +44 (0)1244 896601
DX 19991 Chester

Singapore Office
8 Shenton Way #44-05
Singapore 068811

T: +65 6576 4747
F: +65 6576 4748

Hill Dickinson International:

Greek Office
2 Defteras Merarchias St.
Piraeus, 185 35
Greece

T: +30 210 428 4770
F: +30 210 428 4777

London Office
Irongate House
Duke's Place
London EC3A 7HX

T: +44 (0)20 7283 9033
F: +44 (0)20 7283 1144
DX 550 City of London