medical negligence matters

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Some NHS Mental Health Trusts

and their staff are capable of providing excellent psychiatric help and other support to patients, yet many Trusts are under extreme financial pressure that have led them to trim the resources available. This comes on top of the underlying trend away from inpatient treatment to care in the community for mental health patients.

The reductions in funding and the general switch to a mix of inpatient and community care have unfortunately combined in a way that can be very detrimental to patients with severe mental health issues. Availability of mental health beds in hospitals has been squeezed, meaning even greater reliance on community-based care and upon effective co-ordination between the respective care providers.

My colleagues and I have seen increasing numbers of cases where the plight of mental health patients has been worsened either by the unavailability of a hospital bed or, when patients have consequently been treated in the community as a second-best option, by poor systems of communication between care providers. In some instances, there has been the tragedy of a potentially avoidable suicide.

Charities such as SANE and Mind want the NHS to give greater priority to mental health. We agree with them on that, which is why this newsletter is focused on mental health issues and the tragic consequences that can result from inadequate care.

With all best wishes,

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Concern over mental health care

There is rising concern about the structure and delivery of care for the mentally ill, particularly when this involves treatment and support both in hospital and at home in the community. In some disturbing cases covered in this newsletter, poor communication and co-ordination of treatment contributed to tragic outcomes. These cases have not been wholly exceptional, as a picture of deteriorating mental health care has been emerging.

BBC investigations revealed that around 1,500 mental health beds had been lost to cuts in recent years, meaning that many trusts had virtually no beds available for further patients that needed them. At the same time, the medical director of one London area NHS Trust claimed that mental health care provision in England was in crisis. Even the care and support minister Norman Lamb described the situation as unacceptable and needing improvement.

On the Today programme on BBC Radio 4 on 24 June the President of the Royal College of Psychiatrists talked about the Government "sleep walking into a car crash" with regard to mental health care.

NHS Trust medical director Dr Martin Baggaley has spoken about cases where individuals were transferred from south London as far as Somerset due to a lack of beds in the capital. Beds have been closed down nationally in a shift from inpatient care to care in the community, but this can deprive mental patients of the care they really need. Things are sometimes made worse by communications failings or inadequate responses to danger signs such as credible suicide threats.

Mental health charities have added their concerns about the apparent tendency for NHS cost savings to impact on mental health service quality. The chief executive of SANE pointed to the difficulty of finding an urgent bed for patients in severe mental distress compared to those with other serious medical conditions. Being denied a hospital bed can trigger the final feeling of rejection and despair that may precede a suicide bid.

Hard figures confirm what medical professionals and patient groups have suspected, as statistics show that mental health funding for NHS Trusts in England fell by 2 per cent in real terms over a two-year period. This may seem like a modest reduction, but the president of the Royal College of Psychiatrists asserted that small cuts have a disproportionately large effect on mental patient welfare. They can leave patients lacking community-based support in between the extremes of outpatient consultation and crisis response.

Another worrying feature of mental health provision is a shortage of dedicated care for under-18s that means some are treated on adult psychiatric wards. They and other patients need and deserve the right care and support in the most appropriate setting.

Damning inquest verdict after suicide tragedy

One case handled last year by our firm illustrated the vital importance of ongoing support and effective communication between NHS teams responsible for patients with mental health problems. It was heard by an inquest jury at Hove Crown Court in Sussex.

Patrick Whiting, who had previously attempted suicide, died a few days after discharge from a mental health unit. He suffered known mental health problems, including anxiety, delusions and psychotic depression. Mr Whiting had attempted to take his own life by plunging 30 metres onto electrified railway tracks near his home. He survived the fall and was admitted to hospital with spinal fractures and bruising.

Having been 'sectioned' under the Mental Health Act, Mr Whiting was transferred to a secure unit run by Sussex Partnership NHS Foundation Trust at Conquest Hospital, St Leonards. Following a short period of acute care, Mr Whiting was deemed sufficiently stable mentally for release from the unit, which had a beds shortage. He was sent back to his own home.

Daily support was arranged from Brighton Crisis Resolution and Home Treatment Team. The team's core interventions include relapse prevention and identification of triggers. However, soon after being returned home without his medication, Mr Whiting had shown the team a noose he had made with a dressing gown cord, but they did not confiscate it or arrange for his readmission to hospital. Three days later, he was found hanged at his flat.

The inquest was also told that, as Patrick Whiting's carer, his twin brother Andrew was given no copy of his treatment plan or care plan. Managers had made decisions to alter the treatment without consulting clinicians; also, hospital staff failed to note the deterioration in his mental health at the prospect of going home.

"The jury heard about several disturbing aspects to this tragic case, which had led the NHS Trust concerned to issue an apology to Patrick's family," said a solicitor from Attwaters Jameson Hill after the inquest. *"Patrick's brother Andrew, our client, had previously worked as a mental health nurse with the Sussex Partnership Trust and acted as his carer, yet he was neither consulted nor informed about his twin's progress in the weeks before his death. Ambiguity surrounded whether Patrick was on leave or being discharged. Either way, the home treatment team had grave concerns that he had left hospital too soon. His long-term mental health medication had been changed, but staff had not properly monitored its effectiveness, nor had adequate account been taken of a suicide note written by the patient when first admitted, nor of a shoelace found around his neck the day before discharge.*

"The jury's verdict in this case was absolutely damning. It referred to Patrick Whiting's 'death from hanging whilst suffering a mental health illness' and went on to say 'his discharge was premature and carried out in a confused manner. This resulted in Patrick Whiting having an unclear leave plan of which individuals had differing understandings. This also led to Patrick Whiting having incorrect quantities of medication. The care plan of 18th May 2012 identified Patrick Whiting as high risk and having a low threshold for readmission to hospital. An obvious deterioration in his mental health, exampled by Patrick Whiting admitting he had tried a noose, was not acted upon or communicated to his brother or other team members. Patrick Whiting should have been immediately readmitted to hospital on 20th May 2012 in accordance with that care plan.'"

Community care must be 'joined-up'

The consequences of the transition from caring for severely ill psychiatric patients in traditional asylums to 'care in the community' date back over several decades and are still being seen.

Mental health services are currently undergoing a period of substantial change with traditional community mental health teams being restructured into new specialist teams. Cuts in NHS funding are putting enormous strains on the system.

A key issue in caring for such patients is the sheer number and variety of professionals involved, including psychiatrists, community psychiatric nurses, social workers, occupational therapists, clinical psychologists and many others. Lack of communication between the professional carers can have severe consequences.

Two recent surveys give growing cause for concern. Firstly, The Royal College of Psychiatrists has found that mental health professionals are sending 'critically unwell' patients home because they cannot secure them hospital care due to a shortage of beds.

Secondly, a joint investigation by Community Care and BBC News found that NHS mental health trusts are 'sending a growing number of patients to out-of-area hospitals up to 300 miles from home as demand for hospital care outstrips local bed capacity. Social workers said being sent long distances for care was distressing for patients, damaged continuity of care and made it hard for families and care teams to visit. Leading charities have called the situation scandalous and a disgrace'.

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Meet our Medical Negligence team

Left to right:
Julie Carolan
David Kerry
Madeline Seibert
Karen Webster
Sarah Wealleans
James Sherwin
Mary Butt

Outsourced mental health care was lacking

Evidence that care for the mentally ill may be under-resourced and stretched to the limit emerged after two NHS Trusts agreed a six-figure settlement over the tragic death of a 56-year-old father-of-three from Cheshunt, Herts.

The recent settlement resulted from legal claims by our firm on behalf of the late James (known as Jim) Hughes's widow Julie and family, against Barnet and Chase Farm Hospitals NHS Trust and Hertfordshire Partnership University NHS Foundation Trust.

"This was a shocking case in which a family man took his own life," our medical negligence head David Kerry explains. *"His death occurred shortly after he was discharged from a hospital run by an NHS Hospital Trust that outsourced mental health treatment to a Partnership Trust.*

"My colleague, Solicitor Sarah Wealleans, successfully took up the case for Julie Hughes and her children. Actions were brought on behalf of the Estate and James's dependants and also under Article 2 of the European Convention on Human Rights, right to life, pursuant to the UK's Human Rights Act 1998."

Jim underwent jaw reconstruction surgery at Chase Farm Hospital in September 2009, needed as a result of radiotherapy 14 years earlier. He had no previous psychiatric history, but after surgery he suffered paranoia and hallucinations.

Post-operative recovery was also complicated by pneumonia and a wound infection, and through his 11-week admission Jim was depressed and fearful of being a burden on his family. Even after numerous requests by the clinical staff for psychiatric input, there was completely inadequate psychiatric support provided at the hospital.

"Despite James suffering from low mood/depression, a psychiatric assessment was delayed," says Sarah Wealleans. *"Then the care provided was wholly inadequate. There was a resulting failure to manage and treat his depression before he was discharged from hospital. Two days after discharge, he took his own life."*

It was Julie Hughes's contention that there was a woeful lack of any proper psychiatric support within the hospital. Those treating Jim had been particularly concerned about his mental state at the time of requesting a psychiatric referral, and his treating consultant had only ever made such a referral in two other cases during the previous ten years.

Her allegations of negligence included failure to ensure prompt psychiatric assessment and a subsequent lack of communication between the psychiatrist and Jim's family, the clinicians and nursing staff treating him. No plan was put in place to manage Jim's depression and the opportunity for further psychiatric referral was missed.

"Concerns expressed by Julie Hughes should have been explored with her and documented," Sarah Wealleans adds. *"If properly understood, these would have prompted more diligent investigation into James's psychiatric symptoms. He should not have been discharged from hospital without a proper mental health assessment.*

"The claim was settled on a 'global' basis but the settlement rightly took account of James's pain and suffering, funeral expenses, a bereavement award, financial and service dependency and damages for breach of human rights. The systemic failure raised a claim under the Human Rights Act, as the risk of suicide in depressed patients is a clear one and there is an operational duty to provide proper psychiatric support."

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Coroner cited patient supervision and continuity failings

In a case we are currently dealing with, the Coroner in Suffolk recorded a narrative verdict that our client's husband *"took his own life while the balance of his mind was disturbed, in circumstances where there was a deficiency in the record keeping and significant failures to provide continuity and an appropriate level of supervision in his ongoing care"*.

The Coroner further commented: *"There is also a picture that we got of a system in a sense under some strain because of the lack of resources in particular in terms of the home treatment team."*

In this case our client's husband had been discharged from a psychiatric unit and was being cared for in the community. The Coroner's remarks clearly support our contention that there are significant failures, generally, in the care of psychiatric patients. This case is ongoing.

Our Madeline's specialist expertise is confirmed

A medical negligence partner at our firm, Madeline Seibert, has just had the second of two important professional credentials confirmed, giving clients total reassurance about her status in this important area of law.

Following a strict assessment, Madeline maintains her membership of the Law Society's Clinical Negligence Accreditation Scheme for another five years. This comes after her membership of the Action Against Medical Accidents (AvMA) Referral Panel was extended for a further term.

Lawyers applying for the Clinical Negligence Accreditation Scheme must have been handling medical negligence work on behalf of claimants for several years. They must have completed a minimum of 36 relevant cases during the previous three years, of which a significant proportion must have reached specific advanced stages of the legal process. Applications must be supported by case reports. Madeline comments.

"There is certainly more to applying for Accreditation than ticking a few boxes. To me, the effort is worth it, to prove to clients that we take this area of law seriously and have demonstrated to our peers that cases have been expertly handled."

In her work with Attwaters Jameson Hill, Madeline takes on a wide range of medical negligence cases, including surgical error, misdiagnosis and substandard nursing and midwifery care, with a particular interest in claims involving injuries to mother or baby during pregnancy or labour. She also represents families at Inquest and handles high-value fatal accident claims, including preventable suicide cases.

Our Department Head, David Kerry, is also a Panel Member on the AvMA and Law Society Clinical Negligence panels. Further, he is a fellow of APIL and an APIL Accredited Clinical Negligence Specialist. David emphasises that membership of such panels is a recognition of the expertise that is needed to handle clinical negligence claims, which can often be very complex and which require a clear understanding of the medical issues and law involved.

contact us...

If you need help or advice about a medical negligence issue, contact our highly experienced and sympathetic team based at our Harlow office. Our range of other legal services is offered by our other offices in Hertford, Ware and Loughton.

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