RadcliffesLeBrasseur

BRIEFING

Number 40

Failure to Prevent Suicide

MENTAL HEALTH LAW

The possibility of a claim against a mental healthcare provider if there is a negligent failure to prevent self-harm or suicide arising because of the patient's psychiatric condition is well known. The National Patient Safety Agency will concentrate on this as one of its 4 key target areas.

The issue often comes into sharp focus at the time of an inquest into the suicide of a psychiatric patient. However, what steps have to be taken to prevent suicide? Where does the balance lie between the prevention of harm to themselves by disturbed patients on the one hand, and the provision of personal dignity and reasonable daily living conditions on the other?

The issue was considered in a recent case[1] relating to Wandsworth Prison. In that case the prisoner, who was suffering from schizophrenia, was recognised as being a significant suicide risk. Although all obvious means of self-harm were removed, he was allowed to keep his shoe laces. He was not provided with his usual psychiatric medication and was on no special level of observation. Sadly, the prisoner was able to hang himself using his shoe laces.

The jury Inquest initially returned a verdict that the deceased had taken his life while the balance of mind was disturbed. This was challenged in the High Court successfully. The Court ordered a fresh inquest on the basis that the Coroner should have allowed the jury to consider a potential verdict of neglect (otherwise known as "lack of care"). The Court felt that there was evidence of a failure to provide medical attention. There was also a causal link between the absence of the measures taken by the Prison for the prisoner's safety and his death such as to be capable of being considered for a verdict of neglect.

The seminal case on "lack of care" or "neglect" verdicts is Ex Parte Jamieson[2] where it was held that "lack of care" was the obverse of self neglect and that a "lack of care" verdict required a gross failure to provide sustenance, shelter or necessary basic medical care. The Court also held that there must be a clear and direct causal link between the conduct and the death. The Scott case is a useful illustration of circumstances that can potentially constitute such lack of care and the vigilance required.

Inquests

Formal enquiries or inquests can be traumatic for healthcare staff, particularly if they concern the death of a patient that is unexpected.

In recognition of this, RadcilffesLeBrassuer have developed a special inquest service to support healthcare staff. It includes :

1. Help with the preparation of Statements for enquiries or the Coroner.

- Protecting staff from making incriminating statements
- Managing the risk of a compensation claim
- Ensuring relevance and appropriateness

[1] See R –v- HM Coroner for Inner West London Ex Parte Scott 13.2.01
[2] See R –v- HM Coroner Ex Parte Jamieson (1994) Times Law Reports 28 April

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2. Advice and representation at interviews with statutory authorities such as the Health and Safety Executive or police.

3. A meeting with staff on your site to explain the legal process and in particular what is involved in attending Court for an inquest.

4. Witness training

5. Representation by a solicitor at the inquest to protect the interest of the healthcare provider and their staff.

6. Providing a full debrief report for the purposes of any subsequent claim and for risk management and quality assurance.

RadcliffesLeBrasseur
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For more information on Mental Health Law contact Andrew Parsons at RadcliffesLeBrasseur on 020 7227 7282, or email: andrew.parsons@rlb-law.com.

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Readers are advised to take specific advice before acting in reliance on the matters set out in this briefing.

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