



**‘Train the Trainers’
on the Mental Health Act, 2001**

PHASE 1

**EXCELLENCE IN
MENTAL HEALTHCARE RECORDS**

TRAINING MANUAL

DAY 2

Mental Health Commission
in
conjunction with

La Touche Bond Solon Training

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Welcome

Welcome to our training programme in ***Excellence in Mental Healthcare Records***. We hope that you enjoy the training course and learn a great deal!

The training has been designed to provide you with a clear insight into the professional and legal aspects of good recording practices. You will be looking at your professional guidelines on records, the typical pitfalls in creating records, and good practice principles. You will also be learning about the new Statutory Forms issued by the Mental Health Commission under the Mental Health Act, 2001.

The materials for the training consist of the course materials, practical exercises, group exercises and plenary sessions.

You will be learning by doing and will receive feedback and support from your peers and the trainers.

I wish you every success with the course.

Caroline Conroy, Solicitor
Managing Director
La Touche Bond Solon Training

This manual aims to provide accurate authoritative information and comment on the subject it covers. It is offered to delegates on the understanding that La Touche Bond Solon Training is not in business as legal advisers. Independent legal advice should be sought.

The aims and objectives are to:

1. To understand the functions of records
2. To learn the components of good record keeping
3. To identify the pitfalls and learn how to avoid them
4. To learn how to create, maintain and enhance best practice standards in record creation
5. To understand the legal implications of your records
6. To understand the procedural requirements involved in documenting the Statutory forms required under the Mental Health Act, 2001

My Concerns about my records and documentation

Exercise 1

Please break into pairs and make a note of what you want to be covered during the day. We will then hear from the group as a whole what you want covered and put this onto the flip chart. Your trainer has an agenda but in addition will do their best to cover all the points you wish to be included during the day.

Exercise 2

The definition of a

1. Record is.....

2. Clinical record is.....

3. Care plan is.....

4. Policy is.....

5. Guidelines is.....

Documentation

Records and documentation created by mental health professionals include the following;

- **Record** – as defined by the Freedom of Information Acts 1997 and 2003 “any memorandum, book, plan, map, drawing, diagram, pictorial or graphic work or other document, any photograph, film or recording (whether of sound or images or both), any form in which data are held, any other form (including machine-readable form) or thing in which information is held or stored manually, mechanically or electronically and anything that is a part or a copy, in any form, of the foregoing or is a combination of two or more of the foregoing and a copy, in any form, of a record shall be deemed, for the purposes of this Act, to have been created at the same time as the record.”

- **Clinical (patient) records**

Include paper records including files, case notes, letters, reports, continuation sheets, diaries, post – IT notes, computer print outs, electromagnetic records including discs, servers and databases

Audio-visual records including films, tapes, videos and CDs

Photographs, x-rays, microfiche

- **Care Plans**

Good practice demands a clearly delineated treatment plan for each new patient is created in which the patient and carers are participant partners. The clinician /patient relationship is recognised as a partnership where the treatment is open, informative and transparent.

- **Policies, Protocols and Guidelines**

Policy - plan of action that governs mental health service activity and which employees are expected to follow

Protocol - written plan specifying the procedures to be followed in providing care in defined situations (Protocols specify who does what, when and how)

Clinical Guidelines - systematically developed statements that guide action to assist practitioners and patients’ decisions about appropriate health care for specific clinical circumstances

- **Reports** – provision of information in report format such as Professional Reports, Critical Incident Reports, Medication Error Reports, Near Miss reports

Function of Records

The **function** of clinical records is twofold:-

Communication

- Assessing patient status (patient's physical, psychological and social well-being)
- Evaluating patient care given
- Ensuring continuity of care
- Ensuring effective team communication

Patient Assessment

Record should clearly show the present history, past history, patient's concerns/history, medication history, physical examination findings

Plan of Care

Record should show patients' problems, planned interventions, investigations ordered, consent given, treatment/medication ordered

Patient Progress Notes

Outline of updates on care plans, all referrals/consultations, all results obtained, patients' response to treatment

Patient Discharge Plan

Outline of instructions & information given to patient/next of kin, discharge letters & prescriptions

Protection

To fulfil evidentiary requirements (35/40% of medical negligence cases are indefensible due to documentation issues)

Your Mental Healthcare Records

If a health professional were to be asked “Why do you maintain records?” it is inevitable that the answers would be varied and wide ranging. From the replies received a consistent theme would emerge which might well be summarised in the following response: **“To facilitate the care, treatment and support of the patient or client.”**

There is no doubt that record keeping is an integral part of care. If a situation were to arise where the health professional was responsible for the total delivery of care and the case-load was such a size that every detail relating to each patient could be remembered in its entirety, then possibly there would be no need to keep the records. In reality the situation is very different. Care should be shared between a number of health professionals and the notes provide an effective means of communication between them. It could be argued that if a health professional failed to record a significant event and thus did not communicate with a colleague, who then proceeded to act in a way, which was detrimental to the patient, this would constitute professional misconduct. In addition, case-loads are of such a size that no health professional could hope to remember all the detail from contact to contact and the records therefore become an important “aide memoir” for the professional.

Amidst the demands and pressures of the busy working day it is all too easy to see record keeping as a chore that gets in the way of the real work which is the hands-on task of direct contact with the patient/client. Such a view is clearly wrong. From what has already been said there can be no doubt that record keeping is in fact an integral part of care. In planning the day, the health professional will allocate a time both for direct contact and for writing up what has taken place. It is the two together which represent the total commitment to the client. There is a real danger that when record keeping is seen as a chore to be fitted in whenever possible that the notes will fall short of the standard expected of a professional. Either the entries will be routine and meaningless or they will not convey a complete picture of what has taken place.

Health professionals are often uncertain of just how much to write. An effective task is to ask *“If I were coming to this patient cold, for the first time, what would I need to know?”* This will provide a useful yardstick against which to judge the relevance of individual entries. Imagine for a moment that for some reason you are prevented from returning to work. From the patient’s point of view this should make no difference to the care received. Your colleague will look at your notes, and continue to look after the patient without having to ask any questions. Care would be seamless continuum. If the records do not allow this to happen, why bother?

Of course what has been said so far is only part of the story. The notes are clearly a tool, which enables health professionals to discharge their duty of care, but they also perform another function, which is their evidential role. Long after the professional has finished with them they may be required to respond to a complaint or for use at an enquiry/tribunal or for the purposes of litigation. The difficulty here will be that while the claimant will remember everything in great detail, the health professional will remember little or nothing. It is hardly surprising, that it may be months or even

years before the issue is raised. For the patient or client the experience will have been important and very often they will have relived and retold the events in great detail and all the circumstances will be firmly fixed in memory. For the health professional, on the other hand, unless there was something very unusual or untoward the detail will be forgotten or at best merged into the background of a busy case-load.

A civil action is a dispute between two parties - someone has to win and someone will have to lose. The judge will determine the case on the **balance of probabilities**. In other words, he will ask himself who has the best evidence and whom does he believe. Faced with a claimant who on oath remembers everything and a health professional who, remembers little or nothing, the judge has little option but to find for the claimant. While there is little doubt that the patient or client genuinely believes the accuracy of his or her recollection, in reality it may not be wholly accurate. The memory is fallible. With the passage of time, and in retelling, events will have been edited and rationalised. There is nothing sinister in this - it is simply the way the memory functions. All of us will have childhood memories and believe we remember events, which took place with clarity. If it were possible to match that recollection against the reality of what occurred there would be discrepancies. It is exactly the same with claimants but in the absence of any evidence to contradict what is said their version of events will prevail. The only way in which the presumption that the claimant is right can be overcome is with **records**. If there is a contradiction between what is remembered and what was recorded in the contemporaneous record written, at or about the time the events took place, it is usually the records, which are preferred. It is not putting it too strongly to say that whether a case is won and lost will depend on the quality and detail of the record. *It is therefore important that there is sufficient information in the notes to enable the health professional when giving evidence to reconstruct precisely what happened.*

There is another aspect of record keeping which needs to be borne in mind. Long before witnesses are seen or statements/reports exchanged, the notes will have been read and studied and a view will have been taken about the professionalism or otherwise of the writer. If the notes are clearly unprofessional, it is a very short step to suggest that the same lack of professionalism extended to the case and treatment of the client or patient. Everything, which is written in the course of your work, has the potential status of a legal document and may one day see the light of day in court/tribunal. If the records are maintained in a sloppy way it will be difficult if not impossible to retain professional credibility.

In the Supreme Court decision in **Collins v MWHB & O'Connor (1999)** members of the Supreme Court when addressing the question of general practitioner's negligence addressed the question of records and held that a GP must keep adequate and proper records of patients. *They added that good records ensure both good and ongoing patient care and good medico-legal and risk management practice.*

It is clear then that as part of the duty of care of healthcare professionals to patients the Irish Courts recognise the **importance of proper recording**.

Against that background, it must be tempting to practise defensively and to write with litigation and lawyers in mind. If that happens there is a danger that the entries become stylised, verbose and possibly even convey a different message from that

intended. The cardinal rule must be to keep entries simple and accurate. If there is a tension between the two uses to which the records are put, this should not influence the way entries are written. First and foremost they are a tool to assist the health professional when caring for and supporting the patient or client and records will be used, and entries made with that purpose paramount. If records are viewed in that way it follows that the only considerations, which should dictate how and what is recorded are the professional ones set out earlier. Do not look to the lawyers but rather to your own profession when making entries in the records. The acid test must surely be “Can I justify what I have written?” or put another way “Will the profession endorse what I have done?” If records are professionally maintained **for the purpose of patient care** they will be more than adequate for use in court.

Facts, Assumptions, Opinions

Fact

A fact is information seen or heard. It is **objective** in nature.

An assumption/inference

A statement about the unknown based on the known.

Opinion

A subjective view that should be based on facts

Opinion

Because

Fact

Most Common Deficiencies in Clinical Records

- Handwriting (print)
- Initials
- Failure to sign entries
- Failure to identify status of recorder
- Altering entries of another
- Altering your original entry
- Tipp-ex, destruction, deletion
- Dates, late entries, timing of entries
- Documenting for someone else
- Lack of records
- General file untidiness
- Ambiguous entries
- Complaints
- Abbreviations and personal grading systems
- Jargon, derogatory remarks
- Using pencil
- Not in chronological order
- Other healthcare professionals not referred to or identified
- Nursing and care plan decisions not documented
- Note of advice given not documented
- Patient's details not on all pages
- Documenting too early
- Not using headed notepaper and putting in extra pages that are not chart pages

Guidelines on Clinical Records

- Quality of record should ensure that **continuity of care is always guaranteed**
- Complete records contemporaneously (note time of event and time of recording (24 hour clock))
- Frequency of recording – must be sufficient to show **accurate** picture of patient at all times
- Avoid late entries, if required do not squeeze in
- Do not predate entries
- All healthcare professionals encouraged to read each other's entries
- Avoid subjective comments or if necessary explain, record the facts
- Do not alter, delete or destroy any original record
- Record must provide evidence of planning and provision of care
- Record must be up to date, accurate and unambiguous
- Write notes clearly and legibly
- Request others to rewrite record if unclear
- Ensure record is permanent and capable of photocopying
- Avoid initials
- All entries must be signed off and recorder clearly identifiable by name and status
- Students and assistants entries must be counter-signed
- Maintain register of sample signatures and keep it up to date
- Record must be made in chronological order, explain any variance
- Identify names and status of other healthcare professionals involved
- Identify when other professionals contacted and any advice given
- Avoid abbreviations, make acceptable list for organisation

- Use only acceptable official grading systems
- Record all advice given to patient
- Record any decisions made
- Be systematic by maintaining all patients records together and having patient's name and record number on every page of the record
- Use care plans to assist
- Supervise standards of recording by those in positions of responsibility
- Regularly audit standards of recording

Additional Pointers

Prescription Writing

Must be

- Accurate
- Appropriate
- Unambiguous

Any advice given including details of foreseeable risks must be documented

Abbreviations

- Abbreviations should be kept to a minimum in clinical records and must only be used in the context of care
- References must be approved locally
- To be avoided in transfer or discharge situations

Retrospective Notes

Record the date and time the entry is made date and time the entry refers to.

Narrative Case Notes – Guidelines

- Keep sentences short
- Use big words sparingly
- Be simple and direct
- Notes must be legible
- Avoid broad generalities
- Minimise confusion
- Be specific
- Identify purpose of the notes
- Avoid jargon
- Watch abbreviations
- Distinguish facts from opinion
- Is the note clear and objective?
- Is it relevant?
- Support your professional opinions?
- Are you following best practice?
- Does the record convey a high respect for the client?
- Evidence of a treatment plan?
- Evidence of classifiable diagnosis?
- Evidence of periodic review?
- Think before you write!!
- Put line under the end of each entry

Professional Reports

- Have a front page with the title of the case
- Have a contents page with page numbers (if report exceeds 8 pages)
- Identify who you are
- Detail the purpose of the report
- Have a brief summary at the beginning for quick reference by the reader
- Have an introduction where you clearly define the issues you are addressing in your report
- Give all background information/history where relevant
- State the facts of the case, as you know them
- Provide information on any examination or investigations you carried out yourself
- Give your professional opinion based on the facts and any published research, standards or guidelines available
- Have a conclusion, which summarises the main points of the case and your opinion
- Make sure to distinguish between facts, information reported to you and your professional opinion
- Do not stray from your area of expertise
- Convey a high respect for the client?
- Use simple, clear, plain English
- Explain any technical or medical terms, if report is for the layperson
- Use a glossary if you refer to many technical or medical terms
- Keep the report as short as possible but include all relevant information
- Any published material referred to or consulted in the preparation of the report should be included in the appendices
- Re-read the report and ensure you are satisfied with your conclusions
- Ask a colleague to read the report and comment on it.
- Keep a copy for yourself on file

Professional Guidelines

1. Nurses

For nurses specifically the Fitness to Practice Committee of **An Bord Altranais** has increasingly identified concerns about standards of recording among the nursing profession. Accordingly An Bord Altranais have issued guidelines entitled **Recording Clinical Practice Guidance to Nurses and Midwives 2002**

The aim of the document is to provide user-friendly guidelines on what is expected from nurses in relation to documenting care to patients.

These guidelines offer assistance to all healthcare practitioners on best practice in effective recording of good patient/client care.

In 1995 in an address to the Dept. of Nursing Studies UCD **Mr. Justice Dermot Kinlen** of the High Court gave the following advice to nurses:

- Keep up to date and be sure of competence
- Document all patient care carefully
- Take all complaints seriously and take immediate action
- Follow all hospital policies and guidelines
- Follow guidelines from An Bord Altranais
- Ensure your employer knows and authorises your nursing activities

2. Psychiatrists

GMC Good Medical Practice 2001

In providing good medical care practitioners must keep clear, accurate, legible and contemporaneous patient records, which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or treatment prescribed.

3. Doctors

The Irish Medical Council's Guide to Ethical Conduct & Behaviour 2004

It is in the interest of both doctors and patients that accurate records are always kept. These should be retained for an adequate period and eventual disposal may be subject to advice from legal and insurance bodies.

4. Psychologists

Code of Professional Ethics

Professionals should be acutely aware of the need for discretion in the recording and communicating of information, so as to prevent it from being misinterpreted or used to the detriment of others. Appropriate action includes, but is not limited to: not recording information which could lead to misinterpretation and misuse; avoiding conjecture; clearly labelling opinion; and, communicating information in language that can be understood clearly by the recipient of the information.

5. Social Workers

Code of Ethics of the Irish Association of Social Workers

The social worker, having taken into account the right of others, will provide clients with full information, including access to records pertaining to work on their behalf.

6. Speech and Language Therapists

Code of Ethics of the Irish Association of Speech and Language Therapists

Speech and Language Therapists should maintain adequate records of professional services on each client and ensure that the contents of these files remain confidential.

7. Occupational Therapists

Code of Ethics of the Association of Occupational Therapists of Ireland

Members shall respect confidentiality of all client information at all times. Members shall maintain comprehensive, contemporaneous, accurate and up to date records of all professional activities in relation to the client. These will include the nature, extent, duration, and outcome of Occupational Therapy intervention and liaison.

The prime purpose of records is to facilitate the care, treatment and support of a client. A written record of professional intervention, advice given and outcome of decisions taken is a requirement of good practice. The implications of the Freedom of Information Act, 1997, should be considered. Subjective opinion and/or emotional comment should be avoided, or clearly identified if considered to be required in notes. Requests from individuals on the basis of the Freedom of Information Act, 1997 should be adhered to according to local and national policy. Provisions must be made for the secure and confidential storage and disposal of records, with reference to local procedures.

Eastern Regional Health Authority Mental Health Services – Occupational Therapy – Guidelines for Documentation May 2001

Guidelines on Good Practice and Quality Assurance Mental Health Services, Department of Health & Children 1997

Clinical Review

“During care in hospital, some special considerations apply which need stressing. All patients who have been admitted involuntarily should have their clinical condition reviewed on a daily basis, and as soon as it is deemed appropriate, this status should be changed to voluntary. In all cases newly admitted patients should be clinically reviewed on a daily basis and the results of such review, clinical and otherwise, be documented in the case notes. All entries by professional staff on clinical documentation should be dated with time of entry and signed legibly and in full. The designation of the professional staff member should also be recorded. Initials, of themselves, are not acceptable and specimens of signatures opposite the printed name should be maintained on a register of clinical staff. There should also be written policy on the care of patients’ case notes and other personal patient documentation stating who is responsible for their maintenance, who has access to them and specifying the regulations governing the transfer of clinical records or their contents to other agencies. Case records should contain clearly and, for each admission, name, address, date of birth, gender, religion, telephone number, next of kin, admission date and time, legal status, marital status, occupation, allergies, drugs taken prior to admission, name of referring general practitioner and other referral agent, discharge date and final diagnosis on discharge. Case notes should be kept in a satisfactory condition with correspondence and investigation reports correctly filed in chronological order and copies of previous discharge summaries readily available. Social work, psychology and occupational therapy and other professional progress notes should be completed by such staff and be easily accessible in patients’ care records.

The case record in regard to each patient should contain information on the history of the illness for which the patient is being treated, the personal history of the patient, the family history of the patient, the diagnosis of the patient’s illness, classification of the patient, particulars of medical examination on reception, particulars of any material change in the mental condition of the patient, particulars of any occurrence in relation to the patient including accidents, date of discharge, assessment prior to discharge. In the case of death, particulars of cause of death should be recorded”

It should be noted that the same principles, as outlined above, apply not only to hospital care but to community care as well.

Accountability & Documentation

Inadequate Records

- ▶ Render it impossible to determine the standard of your work
- ▶ Make good work practices look bad
- ▶ Make bad work practices look worse

Good records are the first line of defence in a legal challenge

Ask yourself the following:

- Are your records a help or hindrance?
- How could the records act as a help to you?
- How could the record act as a source of hindrance to you or someone else?

Accuracy and Adequacy

Accurate notes are far from being the same as **adequate** notes

- The context of the note is a critical element of patients' notes and mere accuracy is an element of the need for a holistic adequacy
- The key to adequate records is that the information explains and rationalises key decisions
- Be mindful of the possibilities the future holds for the information to be read by many other people
- The clearer the notes are the easier it will be to prove the intention and level of care behind what was written

Accountability

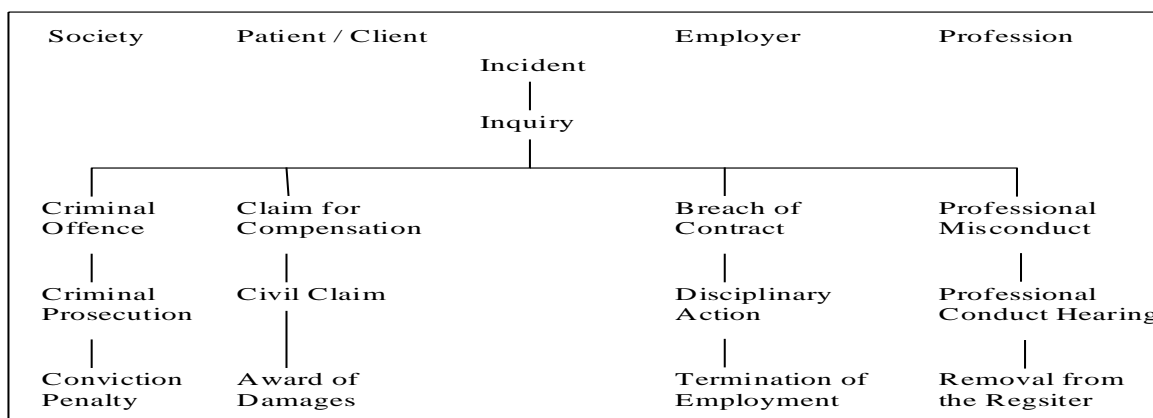
The concept of accountability is one, which is familiar to all nurses and healthcare professionals. It is a word, which they all know and use and forms part of their working day vocabulary. While the term is in constant use, many would have problems defining it.

The reality of the situation is that each mental healthcare professional is, on a personal level, answerable and can be called to account. Once that premise has been accepted, the inevitable and consequent enquiry, which must flow from that is the question, to whom and how is that accountability discharged.

The second part of that question is perhaps the easiest to address since the arena in which these issues must ultimately be debated is the legal one of the courts. Having said that, it follows that when issues are reviewed it will be done with the wisdom of hindsight. This will be the case because the law is, by its very nature, reactive and is invoked after the event. The normal sequence is that something will have happened to trigger an investigation and this will raise, in its wake, questions of accountability. When the professional appears before a court or inquiry his/her acts and omissions will be weighed in the balance and the question to be addressed in that forum is “when your acts and omissions are so weighed, will you be found wanting?” Only the professional can answer that. The legal system does not, as a general rule, permit an individual or body to put hypothetical questions to the judges or courts. There is no mechanism that will enable a health board or indeed the individual to go to the court and seek what amounts to a decision in advance. It is only when a real case is presented that the judges will deliberate and deliver judgement. Obviously a decision in a particular case will be helpful when it clarifies the law and gives an indication of the way the courts are thinking. It is for this reason that case law and precedent play such an important role in the legal system. The practical effect for individuals may well be that they find themselves in the position where they will have to make a decision, live with it and hope that the courts will ultimately support them.

We have now placed accountability into its legal context but the first part of the question still remains unanswered and that is to ask to whom the mental healthcare professional is accountable.

On analysis it will be found that there is not one single individual or body who can exercise a total claim on the professional. There are, in all probability now four groups or bodies to whom he/she is answerable. In the first place he/she must, in the widest possible sense, be answerable to society. Perhaps, and more importantly from her perspective, he/she must be accountable and answerable to the client or patient. Equally, he/she will be answerable to his/her employer and last but certainly not least, he/she will also be accountable to his/ her profession. Having established that a professional can be accountable in four quite separate and distinct respects, we need next to examine how that is done in practice.



This diagram indicates the four groups, which have been identified as those to whom the mental healthcare professional is accountable. It is prompted by the incident because that is the trigger that will set the process in motion. There may or may not be an inquiry. The healthcare professional is accountable to society through the criminal law and if this avenue is to be pursued, it will be argued that the individual has fallen short of what society accepts and demands of someone in that position and if a health care professional is found wanting then ultimately, following conviction, he/she faces a penalty. It must be borne in mind that in criminal law the healthcare professional, as an individual, is personally accountable. No professional body or employer or insurer can indemnify the individual against consequences of a criminal act. All those supporting the individual can do is to ensure that he/she is given the best possible defence but following conviction the professional stands alone.

Fortunately, however, prosecutions in the field of health care are rare. When they do occur, they are the subject of much interest both at a professional level and to society at large through the media. Members of the public have a particular interest in cases involving health care and all prosecutions are guaranteed to generate a great deal of discussion and comment. They do so because when they occur, they are still regarded as exceptions. It is far more likely that the healthcare professional will be called to account by the patient or client and the diagram indicates that the route open to them to pursue their remedy is the civil law. What the patient seeks is compensation, or to use the technical term, damages. This is important because civil law is not about punishment. It is an attempt to put the injured party back, in monetary terms, in the position he/she would have been in if he/she had not been wronged.

Damages are therefore, as a general rule, purely compensatory. Although the client might well wish to sue the healthcare professional on a personal basis, he/she will need to be practical and since he/she will have no idea whether or not the professional has the money to meet the claim, will in practice, direct his/her claim not at the health care professional but at their employer. This is because the law takes the view that the healthcare professional, in the course of his/her work, is the representative of his/her employer. For this reason the employer is therefore vicariously liable for any acts or omissions committed by his/her employees while working on the employers behalf. It therefore follows that although there will be a civil claim alleging negligence and seeking damages or compensation, that action will not be directed at

the healthcare professional but at the employer and it is the employer who will have to meet the cost. If that claim succeeds, there will be, as the diagram indicates, an award of damages.

Equally, an employer may not be very happy about what has happened and the route open to him is to look to their disciplinary procedure. Any action, which is taken by the employer, will be on the basis that the healthcare professional is in breach of contract. They may allege that their employee's behaviour is totally unacceptable and that the healthcare professional is in breach of contract so gross that it has undermined the relationship of trust that ought to subsist between employer and employee. The ultimate sanction under this procedure is termination of employment or dismissal. Then, too, the profession concerned may wish to review what has happened. The perspective here will not be the same as that of the employer since their concern is that there has been misconduct or, put another way, breach of contract. Employers cannot determine whether or not the professional's behaviour constitutes professional misconduct. This must be a matter for the profession itself. If the case proceeds, the actions of the individual member will be reviewed at a professional conduct hearing. The questions to be addressed in that forum will be whether the individual is a safe practitioner and has he/she maintained a professional standard? If the answer to either one of those questions is no, then of course the professional's own registration and the right to practise is at risk. It will be seen from what has been said that an individual working in this field could in effect be tried four times. The decision to call the health care professional to account by one of the parties does not preclude any of the others wishing to exercise their right in the same way.

When there is a common interest and common purpose by all of the above-mentioned groups, the issues of accountability are not a major problem for the mental health professional. However when the interests of each of those parties do not match or coincide, this will cause real problems for the individual who may in effect feel himself/herself pulled in different directions. Whenever there is inherent tension between the interests of those parties, its resolution remains the responsibility of the healthcare professional. At the sharp end the healthcare professional delivering care is faced with problems and issues on a day-to-day basis and must make decisions. Ultimately, each and every decision made in the course of his/her work is subject to review. With increasing awareness of the law and a tendency in society at large to litigate, mental healthcare professionals feel that while at work they are already on the road to the courts! It is important to keep this fear of the law in perspective and to remind healthcare professionals that no lawyer can tell them what to do. The role of the legal advisor is to provide legal support and advice.

Ultimately in reaching any decision, due weight will be given to the law, morals, ethics and professional standards where a healthcare professional is faced with these competing claims and will come to the conclusion that, although he/she is aware of the laws' requirements, he/she needs to act in another way. That in itself should not pose an undue problem provided that the mental health professional knows exactly what he/she is doing and why, and that he/she is, and will be, prepared to justify that later. There is no doubt that as long as the individual concerned acts in a professional way, the lawyers will be able to mount an appropriate and robust defence. The real danger is that if health care professionals become preoccupied with the law and legal

issues, it could reach the situation where they begin to regard themselves as mini lawyers and put those considerations before their normal professional responsibilities. It is then that things could go badly wrong. The paramount consideration for the health care professional is to act professionally and to be able to prove that this is what has been done.

Guidelines for the Completion of Incident/Near Miss Form

- The member of staff involved/witnessing the incident/near miss should complete the form.
- Begin documentation as soon as possible after the event and ensure that a full and contemporaneous report is made in the appropriate clinical record (clinical incidents).
- Document actions taken to manage the incident and/or ameliorate the effects of the incident. If more than one person is injured or affected in the same incident, a separate form should be completed for each.
- If an incident has not been observed but it is relevant to client care then this must be made clear e.g. the patient/visitor states.....
- Details on the form should be accurate, factual and should not contain opinions or apportion blame.
- Only use abbreviations that have been approved by your organisation.
- Do not use correction fluid or make a wrong entry difficult to read.
- Correct any errors by putting a line through them and attaching your signature.
- Ensure that additions to existing entries are individually dated, timed, and signed. Recognisable signatures are essential – PRINT YOUR NAME adjacent to your signature if necessary.
- The 24 hour clock should be used when documenting evidence.
- Complete the relevant section of the form in relation to Risk Rating in accordance with your assessment of the Incident (refer to Protocol for the Rating and Investigation of incidents).

Management of Records

It is important that records are kept accurately, correctly filed and archived in accordance with good practice principles. Every organisation should have a record management and retention policy.

All records should be maintained and stored in a manner where they are easily retrieved. This must be balanced with the need for confidentiality. Poor standards of recording, failures to maintain records and the consequences of such failures have been highlighted in previous reports of the Inspector of Mental Health Hospitals (Department of Health & Children, 2001).

Because of the implications of the Statute of Limitations Act, 1957 records need to be maintained for various lengths of time depending on the status of the patient/client involved. **The Policy for Health Boards on Record Retention Periods** published by the National Freedom of Information Liaison Group (Health Boards) October 1999 gives useful guidance on record retention policies. All healthcare facilities should have in place a system for the safe storage of past and current records and should refer to this Policy for guidance on their own internal policies. Managers and administrative staff have a responsibility to ensure that systems are in place to support practitioners in their clinical work. Confidentiality of course is of paramount importance in determining questions of record management.

It is recommended that original forms under the Mental Health Act 2001 should be kept on the patient's clinical file. If that is not possible, then a photocopy of any such form should be kept on the patient's clinical file, to enable inspection by the Tribunals. The same rules in relation to retention of these forms will therefore apply, as would apply to the patient's file.

Access to Records

Generally the records belong to the owner of the material on which the record was created or to the person who created the record. Patients do have a right to access their records, which derives from two sources. Firstly the courts give that right to patients who wish to access their own records. Secondly statutes have been enacted which enable patients to see information held on them and to have it amended or deleted without resorting to the courts.

Methods by which patients can access their records

1. By Direct Request

2. Freedom of Information Act, 1997 & 2003

- *The Freedom of Information Act, 1997 (the “Act”) was enacted on 21 April 1997. Most public bodies became subject to its provisions on 21 April 1998. A list of public bodies, who are or will be subject to the Act, is set out in Schedule 1.*
- The aim of the Act is:

To ensure that the activities of public bodies are transparent by stipulating that their records are available to members of the public. There are obviously legitimate concerns in relation to some categories of information that public bodies may possess. To counteract these concerns, the Act exempts a number of categories of information from disclosure.

Broad Principles of the Act

The Act is derived from the following broad principles:

- decisions by public bodies should be more open to public scrutiny, thus providing greater appreciation of the issues involved in policy decisions and stronger public ownership and acceptance of decisions made;
- groups and individuals who are affected by decisions of public bodies should have the right to know the criteria used in making those decisions;
- every individual should have the right:

- to know what information is held in government records on him or her personally subject to certain exemptions to protect key interests
 - to inspect files held about or relating to him or her
 - to have inaccurate material on file corrected
- citizens, as shareholders in public bodies, should have the right to examine and review the deliberations and process of public bodies

“Record” - The Act defines “record” in an extremely wide manner as including:

“any memorandum, book, plan, map, drawing, diagram, pictorial or graphic work or other document, any photograph, film or recording (whether of sound or images or both), any form in which data are held, any other form (including machine-readable form) or thing in which information is held or stored manually, mechanically or electronically and anything that is a part or a copy, in any form, of the foregoing or is a combination of two or more of the foregoing, and a copy, in any form, of a record shall be deemed, for the purposes of this Act, to have been created at the same time as the record.”

(i.e. records in any format, including e-mail and hand written notes (clinical charts, professional notes) fax, photograph, video or tape recording.)

Part III- Relevant Exemptions

- S. 20 - Deliberations of Public Bodies
- S. 21 - Functions and Negotiations of Public Bodies
- S. 26 - Information Obtained in Confidence
- S. 27 - Commercially Sensitive Information
- S. 28 - Personal Information

3. Data Protection Acts 1988 and 2003

Data protection is the safeguarding of the privacy rights of individuals in relation to the processing of their personal data. Data protection law places obligations on health providers and others who keep personal information.

Data protection applies whether the information is held in electronic format, i.e. on computer or in manual or paper based form.

Principles of the Legislation

Personal information should be:

- Obtained and processed fairly i.e. that the person who provides it must know the purposes for which it will be used and the persons to whom it will be disclosed
- Relevant and not excessive
- Accurate, complete, up to date and well organised
- Held only for as long as necessary
- Devoid of irrelevant, derogatory, prejudicial statements
- Purpose specific
- Held securely
- Accessible to the person or someone on his behalf on a reasonable basis
- Whenever it is reasonable and practicable to do so personal information held about a client should be collected directly from the client rather than 3rd parties

Separate requests may be made under the FOI Act and DP Act. Each will be dealt with separately.

Informed Client Consent

The consent of the client should be the guiding principle when obtaining personal information. Such consent should be informed and meaningful. Care should be taken when collecting personal information to ensure the client understands:

- what information is being collected
- why the information is being collected
- who within the agency will have access to the information
- how the information will be used
- the consequences of not providing the information
- what 3rd parties disclosure are contemplated
- the fact that there is a statutory obligation to collect the information
- that he or she can have access to the information once collected
- the identity of the organisation collecting the information

Client's Entitlement to Personal Health Information

A client is entitled to:

- Have access to his personal information irrespective of how it is kept
- Know the sources of the information
- Know the purpose for which it is held
- Know to whom it is intended to be disclosed
- Have any personal information on him corrected, amended or blocked to make it consistent with the principles set out above

Can Access be Refused?

Access is refused only if:

- Providing access would pose a serious threat to the life or health of any individual including the requestor
- That access would have an unacceptable impact on the privacy of other individuals
- It is required or authorised by law

Clients' Rights Under The Data Protection Acts

Data must be processed under the following principles:

- Information is obtained and processed fairly
- Kept only for one or more specific and lawful purposes
- Used and displayed only in ways compatible with these purposes
- Kept safe and secure
- Kept accurate, complete and up to date
- That it is adequate, relevant and not excessive
- Retained for only as long as is necessary
- Give a copy of personal data to the person on request

4. Discovery

Discovery is the name given to the procedure whereby documentation is sought by either party from the other side, in the context of civil proceedings. Generally speaking, in civil matters one party is entitled to obtain those documents in the possession of the other party (or within their procurement), which are *relevant and necessary* for making their case at trial. Discovery is effectively a two- stage process. Firstly, one party will write to the other side seeking voluntary discovery of the documents which they want sight of. If the other party is not forthcoming, then a motion can be brought to court compelling the other side to make discovery on the basis that the documents are relevant and necessary. If the Court agrees that they are relevant and necessary then an order for discovery is made.

The second stage is where affidavit of discovery is made. This will be made by the party, who is producing the documentation, which is requested. This affidavit will list out all the documents they have in their possession. However, the affidavit is divided into those documents, which are available for inspection, and those documents which are in the party's possession but which are not available for inspection due to being privileged.

Once the affidavit of discovery is furnished, the other party will have a right to inspect and get copies of those documents available for inspection and reasonable opportunity must be provided to allow this to happen. If one wishes to challenge the claim of privilege made over certain documents the parties will have to bring a motion to court to settle this matter.

Legal Privilege

Legal professional privilege is specific to communications emanating from legal advice and litigation. The public interest is said to lie in the preserving of the integrity of the litigation process by protecting the confidentiality of the relationship between lawyer and client. Legal privilege covers communications between lawyer and client, client and third party or lawyer and third party where these communications were in preparation of contemplated litigation. The privilege also applies between communications between lawyer and client for the purposes of giving legal advice. Legal privilege has been deemed not to attach to a legal document such as a lease or a will created following legal advice, since this is not a "communication" for the purposes of litigation or legal advice.

A significant exception to legal professional privilege was created in respect to expert reports in personal injury cases. Under Rules of the Superior Courts and by virtue of SI 391 of 1998, in High Court personal injury proceedings, the parties must exchange all reports and statements prepared by experts whom they intend to call as witnesses.

The rules of the Superior Courts provide that any party may apply to court for an order directing any other party to make discovery on oath of the documents which are or have been in his possession or power. The court may order an affidavit to be filed listing all the documents in the party's possession relating to the matters in question. The order may relate to a person not a party to the action who may appear to the court to have relevant documents in his possession.

Hospital records will usually be asked for discovery in two instances:

Inter-party discovery, where a patient takes legal action against the hospital. The patient's Solicitor may ask the hospital for discovery of documents relevant to the patient.

Non-party discovery, where a patient is a party to legal proceedings, which do not involve the hospital. Either party may seek discovery of relevant medical records.

Voluntary Discovery

The first step in discovery is for the party seeking it to write to the Health Board asking for voluntary discovery of the records. If the patient or Health Board does not consent to release the records, they can refuse to do so, in which case the party seeking the discovery can apply to the court for an order for discovery.

Documents

Documents include but are not limited to:

- Any written documents
- Photographs and x-rays
- Video and audio-tapes
- Electronic/computerised information.

5. Search Warrant

Compliance with a search warrant is required by law and record personnel are advised that they should advise their supervisor of any official demand for access to records. The warrant must be specific regarding the records required.

6. Requests for Information by the Gardai

Where a client or patient has authorised Gardai to have access to his records this may be supplied. Other request without the client's authorisation will only be supplied where legally authorised by a Court Order or Search Warrant.

7. Mental Health Services Inspector Order

The 2001 Act established the Office of the Inspector of Mental Health Services. The Act provides that the Inspector visits and inspects every Approved Centre at least once a year. It also provides for the Inspector to carry out a review of mental health services and furnish a written report to the Mental Health Commission once a year. The Inspectors overall duty is to ensure compliance with the Mental Health Act, 2001.

The Inspector has the power to:

Visit and inspect at any time any Approved Centre where mental health services are being provided and to be accompanied by any consultants he thinks appropriate

- Require the production of any information, records or documentation needed for the carrying out of his functions
- Require a person to attend before him who may have information or documents relevant to an inspection
- Where necessary take evidence on oath

8. Mental Health Tribunal Order

It is important to point out that under the Mental Health Act, 2001, decisions as to detentions of patients will now be automatically reviewed by Mental Health Tribunals. The main function of the Tribunals will be to review the detention of patients detained involuntarily and some decisions concerning psychosurgery and transfers to the Central Mental Hospital. In order to facilitate their work the Tribunals have extensive powers including the power to direct individuals to attend and give evidence and to compel the production of documentation. The Tribunal must either affirm or revoke an admission or renewal order and to do so it must be satisfied that that the patient is suffering from a mental disorder and that the proper procedures have been complied with. Even if there has been a failure to comply with the procedures then the order may still be affirmed if the failure does not affect the substance of the order and does not cause an injustice.

9. Subpoena

It is generally accepted that it is better for all concerned if healthcare professionals attend court voluntarily rather than as the result of a witness summons (in criminal cases) or subpoena (in civil cases) but, if solicitors are allowed to gain the impression that they are unwilling to attend court and will refuse to do so, they will be tempted to make use of these devices to compel attendance at court.

Increasingly, however, subpoenas are used by solicitors, as a means of protecting themselves from liability for costs of cancelled hearings when key witnesses fail to turn up at court. In such circumstances solicitors should contact the witness in question beforehand, preferably by means of an explanatory letter or telephone call, to explain why a subpoena is to be issued.

Where it is necessary to issue a subpoena to compel attendance of the witness it should also be remembered that the solicitors who have requested the subpoena be issued are responsible for the expenses of the witness in attending to give evidence. In the case of both general practitioners and hospital doctors, this can include the cost of providing a locum for a whole day.

The subpoena is a court order, which may require the witness to bring any relevant documentation in their possession to court.

Statutory Forms under the 2001 Act

The Mental Health Act 2001 specifies a number of forms that must be used in relation to the involuntary admission and treatment of patients.

These forms reflect content and format designed by the Mental Health Commission after widespread consultation with Stakeholders.

There are 18 Statutory forms in total and they cover the processes below:

It should be noted that these forms are for sample purposes only and not for use.

It should also be noted that while the forms have been colour coded, best practice would require that you be aware of the titles of the forms and the sections of the Act that the forms apply to, rather than relying on colour to identify them.

- Applications
- Recommendation
- Admission Order
- Renewal Orders
- Revocation order
- Transfer orders
- Treatment orders
- Tribunal Decisions /Extensions

Applications

Form 1

Application (To a Registered Medical Practitioner) By A SPOUSE OR RELATIVE for a Recommendation for Involuntary Admission of an Adult (to an Approved Centre)

Form 2

Application (To a Registered Medical Practitioner) by AUTHORISED OFFICER for a Recommendation for Involuntary Admission of an Adult (to an Approved Centre)

Form 3

Application (To a Registered Medical Practitioner) by a MEMBER of the GARDA SIOCHANA for a Recommendation for Involuntary Admission of an Adult (to an Approved Centre)

Form 4

Application (To a Registered Medical Practitioner) by a MEMBER of the PUBLIC for a Recommendation for Involuntary Admission of an Adult (to an Approved Centre)

Recommendation

Form 5

Application by a Registered Medical Practitioner for Involuntary Admission of an Adult (to an Approved Centre)

Admission order

Form 6

Involuntary Admission Order for up to 21 days

Renewal order

Form 7

Renewal Order by Responsible Consultant Psychiatrist

Tribunal Decisions

Form 8

Decisions of the Mental Health Tribunal

Form 9

Decision of the MHT to extend the Period of an Admission or Renewal Order by up to 14 days

Transfers

Form 10

Notice of Patient Transfer to another Approved Centre (other than the Central Mental Hospital)

Form 11

Proposal by the Clinical Director to Transfer Patient to the Central Mental Hospital

Form 12

Notice of Transfer of a Patient to the Central Mental Hospital

Admission Order for Voluntary Patient

Form 13

Certificate & Admission Order to Detain a Voluntary Patient (Adult)

Revocation Order

Form 14

Revocation of an Involuntary Admission or Renewal Order

Treatment without consent

Form 15

Proposal to Perform Psychosurgery Involuntary Patient (Adult)

Form 16

Treatment without Consent Electroconvulsive Therapy Involuntary Patient (Adult)

Form 17

Treatment without Consent Administration of Medicine for more than 3 Months Involuntary Patient (Adult)

Form 18

Treatment without Consent Administration of Medicine for more than 3 Months (Child)

Note: Forms 1-7, 10-13 and 15 will trigger a Tribunal hearing. The others will not.

Administration and Procedural Issues

Various definitions contained in the new Act should be noted and observed:-

“Approved Centre” – A centre which has been registered in accordance with Sec 64 of the Act, and run by a person who is the “registered proprietor thereof”.

“Voluntary Patient” – a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order.

“Patient” – a person in respect of whom an involuntary admission order (referred to in the Act as “an admission order”) has been made, the order only being made once a consultant psychiatrist is satisfied that the person is suffering from a mental disorder.

1. Procedures for Submitting Forms to the Mental Health Commission

Section 16 (1) (a) –

“Where a consultant psychiatrist makes an admissions order or a renewal order, he or she shall, not later than 24 hours thereafter –

(a) send a copy of the order to the Commission,”

All the documentation (i.e. the application, recommendation, order, transfer, proposal, notice or revocation) must be made:

“in a form specified by the Commission”.

The definition of “give” envisages the sending of documents by electronic means and is consistent with the right of the MHC to receive the documents by electronic means.

Section 2 (1) -

“Give” is defined under the Act as:

“includes send, whether by post or electronic means, and cognate words shall be construed accordingly”.

The MHC specifies that all completed forms are faxed to the MHC accompanied by the MHC fax cover sheet for expedience in order to meet tight deadlines. When forms are faxed to the MHC, it is necessary to ensure that the acknowledgement of fax form is collected from the sender’s machine and placed onto the patient’s clinical file (best practice being to wait by the machine till the acknowledgement is received.) If fax is not received, the MHC will put alternative arrangements in place.

- It is important to stress that when faxing an admission order, the application and the recommendation forms are included so therefore always ensure that all

forms are sent on to the MHC where there is a requirement that more than one be sent.

- The sending of a facsimile copy of the completed form (i.e. the application, recommendation, order, transfer, proposal, notice or revocation) instead of a copy is consistent with the obligations to send a copy under the Act.

“Copy” is not defined in the Act, and a fax can constitute a copy as long as the MHC does not specify otherwise. The original of each form must be held at the approved centre in the patient’s health records.

- To avoid any possibility of error or fraud, the MHC must insist on having the original completed form containing the original handwriting available for inspection if they so request it.
- A supply of forms will be made available by the Mental Health Commission to all personnel who require them. A supply of forms will be made available to all centres and if more are required the Mental Health Commission can be contacted.
- A form, whether photocopied, downloaded or carbonated, will become an original when it is completed in original handwriting and is signed. The original is the form which has original signatures on it.
- It is the MHC’s intention that in the future persons required to complete the forms may do so by downloading a form from Mental Health Commission website and then completing it. There is nothing in the Act, (technology permitting) which would prevent this from being acceptable.
- Similarly to the use of downloaded forms, the use of a good quality photocopy of a blank form is not in breach of the Act, so long as the use of a photocopy of a blank form is consistent with “the form specified by the Commission”.
- The main issues are that the form is properly and satisfactorily completed as far as the MHC is concerned, is legible, and that the **original completed form is available** to MHC if required by it, a tribunal, or a court of law.
- When completing a form, if you are concerned about lack of space, it should be emphasised that what is required is a summary. All supporting information, to include the referral letter and discharge letter, should be contained in the patient’s clinical file, and this will be available to staff and the tribunals.
- **It should be noted that it is one’s duty to check forms on receipt, and this duty remains as it is, when dealing with forms under the Mental Treatment Act 1945. The standard best practice of checking forms and acting accordingly will not disappear purely because a new Act is in operation.**

Interpretations of time

Section 11 (h) of the Interpretation Act 1937 (“the 1937 Act”) provides:

“Section 11 (h) periods of time. Where a period of time is expressed to begin on or be reckoned from a particular day, that day shall, unless the contrary intention appears, be deemed to be included in such period, and, where a period of time is expressed to end on or be reckoned to a particular day, that day shall unless the contrary intention appears, be deemed to be included in such period”

“Day”

There is no definition of “day” within the 1937 Act. “Day” had been defined in other legislation as:

“A period of 24 consecutive hours commencing at midnight”.

This definition may provide you with some guidance as to how it might be interpreted by the courts.

This needs to be considered when determining time periods under the 2001 Act e.g. Section 15 which provides that an admission order shall remain in force for a period of 21 days. If an order is made late on a particular day then that will constitute day one of that period with day two commencing after midnight on that day.

“Month”

Section 19 of the schedule to the 1937 Act provides:

“The word “month” means a calendar month”

What are the Potential Legal Consequences of Errors in Completion of the Necessary Forms?

Under Section 18 of the Act, where an admission order or a renewal order has been referred to a tribunal, the tribunal shall review the detention of the patient concerned and if satisfied that the patient is suffering from a mental disorder and that the necessary stated procedural requirements (which would include the proper completion of the necessary forms) have been complied with, shall affirm the order, or if not so satisfied, revoke the order and direct that the patient be discharged from the approved centre concerned.

Therefore, failure to comply with the stated procedural requirements can result in the admission or renewal order being revoked. There is however a provision under Section 18(1)(a)(ii) which allows the Tribunal to affirm an order, despite a failure to comply with the stated procedural requirements, provided that the failure does not affect the substance of the order and does not cause an injustice. The procedural requirements that the Tribunal needs to be satisfied have been complied with are:-

- a. an application for a recommendation for involuntary admission to be in a form specified by the Commission
- b. a recommendation of involuntary admission to be in a form specified by the commission
- c. the taking into custody of a person by a member of An Garda Síochána (where applicable)
- d. the admission order to be in order
- e. the renewal order (where applicable) to be in order
- f. the provision of information to the patient

If unhappy with the Tribunal's order, a patient, under Section 19 of the Act, is allowed to appeal to the Circuit Court but only on the grounds that he or she is not suffering from a mental disorder. If the patient can show to the satisfaction of the Court that he or she is not suffering from a mental disorder then the Circuit Court shall revoke the order. If satisfied that the patient is indeed suffering from a mental disorder then the Circuit Court shall affirm the order.

No appeal lies against an order of the Circuit Court other than an appeal on a point of law to the High Court.

What other legal remedies are available to a patient?

If unhappy with a Tribunal order, patients will not be confined to the appeal process allowed for under the Act but will still be able to avail of the options that were used by patients under the 1945 act when challenging their detention such as:-

- Judicial Review Proceedings – a Court application seeking to challenge the manner in which a decision was made ie., the fairness of the procedures invoked, rather than seeking to appeal the decision.

- Habeas Corpus applications – a procedure whereby the legality of the detention of any person may be examined by the High Court and if required the release of that person ordered.
- Inquiry pursuant to Article 40.4 of the constitution – a constitutional provision which allows a citizen to apply to the High Court to enquire into their detention in order to ensure that the person is being detained in accordance with the law.
- Negligence proceedings – a case that would be taken by a plaintiff against a defendant, alleging that the defendant owed the plaintiff a duty of care, that the defendant breached that duty by failing to meet a standard of care required by law, and that the defendant’s breach of duty caused the plaintiff to suffer injury or harm for which the plaintiff seeks compensation.

However a patient’s ability to take these forms of proceedings has been limited by section 260 of the Mental Treatment Act 1945 (and will be by Section 73 of the 2001 Act when it is enacted), which specifies that civil proceedings cannot be instituted in respect of acts done in pursuance of the Acts, unless leave has been obtained from the High Court in advance and the High Court are satisfied that there are “substantial grounds” (1945 Act), or “no reasonable grounds” (2001 Act), for contending that the person against whom the proceedings are to be brought, acted in bad faith or without reasonable care.

The constitutionality of Section 260 of the 1945 Act was recently challenged in the High Court in a case of **Blehein v Minister for Health and Ors** which was a judgment of Judge Carroll of the 7 December 2004. She found that the limitation of access to the courts on two specified grounds constitutes an impermissible interference by the legislature in the judicial domain and thereby found it to be unconstitutional.

It is likely that the same reasoning would apply to Section 73 of the 2001 act, given the similarities. The case is currently under appeal to the Supreme Court.

It has also been held in the UK that it is no longer necessary to seek the leave of the Court before instituting Judicial Review proceedings, the UK Act containing a similar provision.

What can we learn from previous Irish and UK cases, as to what kind of documentary or procedural errors could give rise to a patient taking the types of proceedings referred to above?

O’Dowd v North Western Health Board – 1983 1 ILRM

In this case the plaintiff sought leave, in the High Court, to sue the defendant under sec 260 of the 1945 Act, alleging that he was admitted on foot of forms that were deficient. Leave was granted in the High Court but refused on appeal in the Supreme Court on the basis that there were no substantive grounds to show that the admitting doctors acted “without reasonable care”.

Bailey v Gallagher 1996 2 ILRM

In this case the Plaintiff was granted leave to sue the defendant, the Supreme Court finding that there were substantial grounds for contending that the plaintiff's detention was due in part to a want of "reasonable care" on the part of the defendant, where the plaintiff was admitted on foot of a GP's certificate which was over seven days old, the Act specifying that the examination by a GP should be within seven days of admission.

Melly v Moran and Ors. 1998 SC

In this case the Plaintiff sought leave under Section 260 to sue the defendants alleging irregularities in completion of the forms required to detain him. In the course of their judgment the Supreme Court said:- "Any deprivation of liberty can only be justified if done in accordance with law... The plaintiff has established substantial grounds for contending that there was a want of reasonable care in the filling out of the form by the doctor and by the hospital authorities in accepting it as sufficient".

Blehein v St. John of God Hospital and The Attorney General SC 31/05/2002

In this case the plaintiff sought leave under sec 260 of the 1945 Act to sue the defendants, challenging his detention on a number of grounds. One of his grounds was that one of the GPs' certificates was more than seven days old. He did not succeed on this ground in the High Court, or on appeal, in the Supreme Court. There were a number of examinations referred to, the most recent of which was the day before his detention, and it was held that "...the intention of the legislature... is to ensure that no person should be detained in a mental institution on foot of an out of date medical examination and that the relevant examination should be an up to date one."

He also challenged his detention on the grounds that the order providing for his reception and detention was made more than 12 hours after he was first detained. The Supreme Court in this instance referred in detail to the nursing report and medical notes from the hospital. Judge McGuinness commented that it was difficult to be certain of the meaning of the hand-written notes, some of which were very difficult to decipher but at the same time held that there was not sufficient evidence before the Court to establish that the order for detention was made outside the statutory twelve hour period.

The plaintiff also sought to challenge the GPs' certificate on which his detention was based. The court held in this instance "...The onus is on the medical practitioners to carry out an examination and complete the certificate. It is not for the receiving hospital to go behind this...". Judge McGuinness went on to say "On the face of it this form was in order and, as stated, above, it was not necessary for the Respondents (ie the hospital) to go behind the certificates of the registered medical practitioners."

These cases highlight the necessity to be careful in the completion of forms and the observance of various procedural requirements and show the effect that failure to comply can have, in calling into question the legality of the patient's detention.

UK Cases under the Mental Health Act, 1983

The procedural requirements under the UK Act are quite different, however there are two UK cases where the issue of the implications of incorrectly completed forms are addressed.

R v Managers of South Western Hospital and Another ex parte M 1993 QB

In this case the applicant brought an application for a writ of habeas corpus (an application for release from unlawful imprisonment) against the hospital managers on the basis that her detention was unlawful because the social worker, when dealing with the application to admit the applicant to the hospital, and completing the necessary form, arranged for the applicant's mother to be interviewed as the applicant's "nearest relative" (which is required under section 11(4) of the English Act), when she did not qualify as a "nearest relative" as she was resident outside the jurisdiction, and noted her consent to admission as the "nearest relative" on the form. The applicant's "nearest relative" in accordance with the Act was his uncle who did in fact consent to his admission. The applicant's application was dismissed on the basis that while the hospital managers lacked authority to detain a patient as section 11(4) had not been fulfilled, that since the application as stated on its face, stated facts which if true constituted compliance with section 11(4), that the detention of the applicant was not therefore unlawful. The hospital managers were entitled to rely on Section 6(3) of the English act which specifies that "Any application for the admission of a patient under this Part of this Act which appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application nor any such medical recommendation is made or given or of any matter of fact or opinion stated in it" It was therefore held that the detention was not unlawful.

However the following case held differently and disapproved the 1993 decision in R v Managers of South Western Hospital ex parte M.

Re SC (Mental Patient: Habeas Corpus) 1996 1 FLR

In this case the applicant succeeded in an application for habeas corpus when it was shown that the admission had been made on foot of an application for admission for treatment which was made by a social worker which recorded the patient's mother as his "nearest relative" and recorded her consent when the social worker in fact knew that the "nearest relative" was the patient's father and that he was not consenting. The hospital argued that they were entitled to rely on an application, which appeared, on the face of it, to be in order, under sec 6(3) of the Act. It was held by the Court of Appeal that the application for admission and detention of the patient was not a lawful application by reason of the provisions of sec 11(4) which prohibited such an application by an approved social worker if the "nearest relative" of the patient had notified the social worker that he had objected to it. The fact that the admitting hospital had been entitled to rely on an apparently valid application, under sec 6(3), could not operate to turn an unlawful detention into a lawful detention.

It was held that since there had never been jurisdiction to detain the patient in the first place that habeas corpus was the appropriate application and it was granted. By doing so the two Judges who gave judgments in this case, disagreed with the findings of the Judge in the 1993 case detailed above. They held that it was perfectly possible that the hospital managers were entitled to act on an apparently valid application, but for that the detention to be in fact unlawful.

How helpful, are these cases to the Irish situation?

The procedural provisions under the English Act are quite different. However, from these and from previous Irish cases, it is clear that procedural errors, of sufficient degree, will call the legality of a patient's detention, into question.

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Action steps

Please get into pairs. Please note what you will do as a result of what you have learnt today. Write down what you will do.

DELEGATES NOTES

DELEGATES NOTES