Mental Health Commission acts to protect rights of patients at psychiatric facility in Kilkenny

Department of Psychiatry at St Luke's Hospital, Kilkenny, pleaded guilty to and was convicted of certain breaches of the 2001 Mental Health Act

Monday 25 February 2019: The Mental Health Commission has today welcomed a decision by Kilkenny District Court to convict the HSE of a number of charges relating to breaches of the 2001 Mental Health Act. The breaches occurred at the Department of Psychiatry at St Luke's Hospital, Kilkenny.

The Department of Psychiatry at St Luke's Hospital, Kilkenny pleaded guilty to four charges:

> 1: They contravened a condition of the registration of the said premises whereby they failed to implement a programme of maintenance to ensure that the premises met the needs, privacy and dignity of the resident group and failed to ensure adherence to the regulations.
>
> 2: They failed to comply with the rules governing the use of seclusion and mechanical means of bodily restraint in that the seclusion facilities at the said premises were not furnished, maintained and cleaned in such a way that ensured that patients' inherent rights to dignity and privacy were being respected.
>
> 3 & 4: They failed to comply with the rules governing the use of seclusion and mechanical means of bodily restraint in that the seclusion register for patients was not signed by a consultant psychiatrist responsible as required by the law.

Summing up the case and referring to a comment that the Assistant Inspector of Mental Health Services for the Mental Health Commission, Martin McMenamin, said when referring to the state of the facility at the time of the inspection, Mr Judge O'Shea said it ran "contrary to everything a hospital should stand for".

The Commission initiated legal proceedings against the HSE, the registered proprietor of the Department of Psychiatry in St Luke's, following an inspection in November 2018, which found critical risks. The inspection team found a series of issues that were non-compliant.

In his statement of evidence to the court, Assistant Inspector of Mental Health Services for the Mental Health Commission, Martin McMenamin, said the team found certain parts of the premises were "grubby" and dirty, they found pungent odours, ligature points and exit corridors used to store large inappropriate items. "There was an extremely pungent heavy odour…The strength of the smell was enough to repel the inspection team from the immediate area. It was later reported by the Clinical Nurse Manager that the origin of the smell was a used colostomy bag."

He gave further evidence of hair and hardened food and other dirt on the floor of the unit's seclusion room, along with fluid stains on the room's walls and windows. He also gave evidence of dirty toilets, unemptied waste bins and grimy floors in a number of rooms.

"I have spoken before about there being a legacy of disrespect for mental health patients in some cases, and the conditions found in this unit on this particular day suggest no other explanation," said Chief Executive of the Mental Health Commission, John Farrelly.

"It is not acceptable that our inspectors found such a dirty seclusion room on day one of their inspection and returned to find it in the same state on day four. The Commission has worked with many service providers over the years to improve conditions and many have achieved great results. However, no arguments about lack of staffing or resources offer any excuse for what we found in Kilkenny in November.

Mental Health Commission Chairman, John Saunders, said, "As a regulatory body, it is entirely unacceptable to find conditions that you would have expected to find in a Victorian workhouse in a mental health service in Ireland in 2019. Let me state again, the vast majority of service providers are doing a good job, but where we find conditions such as those found in this case, we must take action. We must ensure patients are treated in appropriate facilities."

The HSE also pleaded guilty to the fact that a consultant psychiatrist had not signed the register to demonstrate that he/she had supervised the initiation and order of seclusion. "A consultant's signature is required to ensure that there is appropriate oversight. When this does not happen, it is not acceptable and must stop," said Mr Farrelly.

ENDS

Issued by Murray on behalf of the Mental Health Commission.

Notes to the Editor:

About the Mental Health Commission

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

To operate an in-patient mental health service in Ireland, the service must be registered as an 'approved centre' with the Mental Health Commission. Upon registration, the service must comply with regulations made under the Mental Health Act 2001. Failure to comply with regulations may result in enforcement action including: corrective and preventative action plans, an immediate action notice, a regulatory compliance meeting, registration conditions, removal from the register (closure) and prosecution.

About seclusion:

Seclusion is defined as placing or leaving a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving. The Commission has an oversight role to ensure that restrictive practices are only used where strictly necessary and that any physical restraint or seclusion is undertaken safely and in line with specified rules and codes of practice. Any practice which compromises a person's liberty should be the safest and least restrictive option necessary to manage the immediate situation. It must be proportionate to the assessed risk and employed for the shortest possible duration.

Contact Communications Department
Dave Williams Mob: 087 419 7140
Siobhan Bigley Mob: 086 839 5861