PE1786/C
W. Hunter Watson submission of 9 March 2020

Petition PE01786 calls for an investigation into the reason for there having been no prosecutions for the offence of ill-treating a mentally disordered patient. As I pointed out in my previous submission, the petitioner was mistaken in his belief that there have been no prosecutions. Nevertheless, there have been remarkably few. In my previous paper in support of PE01786 I suggested that the reason for this may be there has been a general failure to appreciate that the forced treatment of patients can cause such distress that it constitutes inhuman or degrading treatment and hence ill-treatment. That is particularly true when the treatment in question had not been shown to be a medical necessity: see the judgment of the European Court of Human Rights in the case of Gorobet v Moldova. However, there is another reason for the dearth of prosecutions, namely that there is a general reluctance to prosecute medical practitioners. My experiences in representing three people who had complaints against the NHS certainly suggests that to be the case. The following is an outline of these cases.

Case number one

In this case I represented a man whose elderly mother, Mrs D, died only 18 days after entering a care home. Care home staff thought that the behaviour of Mrs D which they found objectionable might be caused by a urinary tract infection, a disorder from which Mrs D had suffered in the past and which had affected her behaviour then. As a consequence there was a request for Mrs D to be prescribed appropriate medication. A GP prescribed the antibiotic trimethoprim even though there were no symptoms of a urinary tract infection, not even a fever. Further, the GP prescribed the normal adult dose even though she should have prescribed only half the normal adult dose since she was elderly. Most seriously, the GP took no account of Mrs D's known renal impairment: trimethoprim is a nephrotoxic drug.

Mrs D's condition rapidly deteriorated after she was administered trimethoprim. The GP then prescribed that Mrs D be given an injection of diamorphine even though she was not in pain.

A Procurator Fiscal in Aberdeen had the circumstances surrounding the death of Mrs D investigated by the police and eventually he sent a report to the Crown Counsel. The Crown Counsel instructed that there should be no Fatal Accident Inquiry nor any other court action so there were no lessons learnt nor any prosecution.

Case number two

Mrs G was admitted to the Accident and Emergency Department of Aberdeen Royal Infirmary after collapsing while out shopping. She knew that she had suffered a slight stroke since something similar had happened to her once before. However, the consultant responsible for her care in hospital made a misdiagnosis. He thought that Mrs G had a brain infection which required to be treated without delay. Without her consent being sought, there was a device called a venflon inserted into a vein in Mrs G's arm. Mrs G's

reaction was to pull that device out since she is allergic to penicillin and hence could have been allergic to the antibiotic being administered to her. That reaction greatly concerned those treating her and a decision was made to resort to rapid tranquillisation. As a consequence, five people held Mrs G securely while a sixth person injected her with the antipsychotic drug haloperidol.

The following day she was given the CT scan which she had expected when admitted to that Accident and Emergency department. The scan confirmed that she had suffered a slight stroke.

With my assistance, Mrs G complained to Grampian Health Board about her treatment but the Board refused to apologise, claiming that the treatment had been "appropriate". I then complained to the Scottish Public Services Ombudsman on the behalf of Mrs D and the complaint was upheld (see "Case 200902396: Grampian NHS Board).

A complaint was also made to the police and that resulted in an investigation but not to anyone being charged even though Mrs G had been the victim of a serious assault. It would appear that assaults by medical practitioners who are treating patients without their consent are not normally prosecuted.

Case number three

Case number three concerns Mrs M. Without proper procedures having been followed, she was detained in a mental hospital on 12 September 2006. On 25 September 2006 there was an incident which resulted in the bruising of Mrs M's upper arms. A complaint was made to the Mental Welfare Commission, but its investigation consisted of no more than asking the hospital for an explanation of the bruising. Without asking Mrs M for her account of what had happened, the Mental Welfare Commission accepted the assurance from the hospital that the bruising had occurred as the consequence of a necessary restraint procedure. It should not have been so ready to accept that explanation. Annabel Goldie, MSP, wrote to the hospital on behalf of Mr M. A reply from the Operation Manager at the hospital stated "*I spoke to staff involved and they used Figure of 4 arms locks to secure Mrs Muir during this incident and to escort her to her room. This particular move does not require holds on the upper arm and staff did not recall using her upper arms so these injuries are not directly explained from this incident".*

Following the incident that resulted in the bruising, Mrs M was given intramuscular injections of Olanzapine and Lorazepam, a benzodiazepine. In response the complaint about this from Mr M, the Mental Welfare Commission stated it had been satisfied that the medication had been given for "therapeutic reasons" and, in response to a more general complaint from Mr M, it stated that "*We remain of the opinion that there are no issues of abuse, neglect or deficiency of care and treatment that the Commission should investigate ..."*

That statement from the Mental Welfare Commission should be contrasted with one from a consultant forensic psychiatrist who was critical of the decision to give an intramuscular injection of Olanzapine to Mrs M at the same time as an intramuscular injection of a

benzodiazepine. He expressed the opinion that "*The simultaneous use of Olanzapine and benzodiazepines in this way is contrary to guidelines and may constitute a deviation from the standard one might expect from a reasonable psychiatrist. The reason for this guidance is the risk of a very protracted period of deep unconsciousness".*

The guidance in the BNF is:

"*With intramuscular use. Blood pressure, pulse and respiratory rate should be monitored for at least 4 hours after intramuscular injection, particularly in those also receiving a benzodiazepine or another antipsychotic (leave at least one hour between administration of olanzapine intramuscular injection and parenteral benzodiazepines".*

That consultant forensic psychiatrist might have understated the risk. Michael Jackson died after being administered medication which could lower blood pressure, pulse and respiratory rates. The same fate could have befallen Mrs M. Either the Mental Welfare Commission was ignorant about such matters or it was covering up in an attempt to protect the consultant responsible for the care of Mrs M.

The Mental Welfare Commission stated it was satisfied that the medication was given for therapeutic reasons. It should not have been so easily satisfied because, almost certainly, these injections were given as rapid tranquillisation following the incident that caused the bruising on Mrs M's upper arms. If that were the case then that forced treatment was not a medical necessity and so, by the Gorobet v Moldova judgment, could constitute inhuman or degrading treatment and hence ill-treatment. This is simply one further example of a failure to hold to account health professionals responsible for the ill-treatment of NHS patients related to the non-consensual care. Perhaps the Public Petitions Committee should consider whether there might be a link between the non-consensual care and ill-treatment. Perhaps also the Mental Welfare Commission should be invited to comment on this petition.