



# the columns

## correspondence

### Serious incident inquiries have a role

Sir: the irrationalities identified by Szmukler (*Psychiatric Bulletin*, January 2000, **24**, 6–10) suggest that serious incident inquiries serve a role well beyond the need to explain how – or even why – something ‘untoward’ happens. Inquiries are, in fact, attempting to answer questions about fear, stigma, morality and personal responsibility, areas where rational inquiry has a poor record of satisfactory results. The folly of applying rational tools to irrational material becomes clearer when one considers the different perspectives and expectations of the agencies involved. To psychiatrists, inquiries are a quasi-legal form of local service audit, with powers to drive change far in excess of what may rationally be expected from a single case study. For the bereaved they serve a propitiatory role, the inquiry process helping families to make sense of the powerful emotions that accompany homicide. To the public at large, they provide a superficial way to soothe a fear that has troubled us since antiquity, and even more so in our individualistic, comfort-driven culture: ‘it could happen to me for no reason’. The idea of a ‘methodical’ investigation of the causes of such a natural but irrational fear renders it more manageable. To the Government, inquiries into the minutiae of local service provision provide welcome distraction from the simple fact that the psychiatric services generally have always been neglected.

The common theme of these irrationalities is the fear of mental illness. Many have suggested solutions to the problems of inquiries themselves (Eastman, 1996; Buchanan, 1999), but until we address the stigma-driven emotional responses that propel the current serious incident culture, or at least attempt to identify them, it seems that all shall lose and none shall have prizes.

### References

BUCHANAN, A. (1999) Independent enquiries into homicide. *British Medical Journal*, **318**, 1089–1090.

EASTMAN, N. (1996) Enquiry into homicides by psychiatric patients; systematic audit should replace mandatory enquiries. *British Medical Journal*, **313**, 1060–1067.

**Mark Salter**, Consultant Psychiatrist, Homerton Hospital, Homerton Row, London E9 6SR

### Children’s consent to medical treatment

Sir: Moli Paul, in his letter (*Psychiatric Bulletin*, January 2000, **24**, 31), refers to Section 133 of the Mental Health Act 1993 (he in fact refers to Section 10(2) of the Act which we assume to be a typographical error) which deals with the informal admission of patients, including children, under the Act. He then analyses the guidance in the 1999 Mental Health Act Code of Practice.

The 1999 Mental Health Act Code of Practice has a number of functions, which include providing essential reference guidance on practice and giving guidance on how the law, whether contained in statute or case law, should be applied.

The Code correctly summarises the law in relation to treating a child, that is any person under the age of 18, without their consent (code para. 31.12). The Code refers to the leading case in this area, *Re: W*, (1992) which states that the refusal of a child to be treated cannot override a consent to treatment by either the court or someone with parental responsibility. The court in *Re: W* went on to emphasise that the child’s refusal:

“... is a very important consideration in making clinical judgements and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.”

Be that as it may the court, or person with parental responsibility, can and will continue to ‘trump’ the child’s refusal in certain circumstances, even if the child has capacity. The most striking recent example of this was in July 1999 when a judge overrode the wishes of a 15-year-old girl who refused to consent to a heart transplant (*Re: M*, 1999). The judge’s decision was based on the objective of seeking what was best for the child.

Dr Parkin suggests that there are inconsistencies between good clinical

practice and the guidance in the Code. It would be more accurate to say that there are inconsistencies between the current law and good clinical practices. The foreword to the Code acknowledges that the Mental Health Act is increasingly out of date. Unfortunately, the Government, in the proposed reform of the Mental Health Act (1999) has not adopted the recommendations of the expert committee in this area. The Committee recommended that there should be a “threshold of 16 years for the presumption of capacity to make treatment decisions i.e. to both accept and refuse treatment” and in the case of children from 10–16 years old there be a rebuttable presumption of capacity.

Dr Paul refers to the Code’s guiding principles which provides that a patient should be treated in such a way as to promote to the greatest practicable degree the patient’s self-determination and personal responsibility, consistent with their own need and wishes (Code para. 1.1). In practise this means that, insofar as is practicable, the patient’s treatment wishes will be respected, but when not practicable their own treatment decisions will be overridden, by using the Mental Health Act.

The difficulty with this discussion is the inter-relationship between the provision of non-consensual medical treatment for mental disorder and the provision of medical treatment without consent. The former can be provided without consent and subject to certain safeguards under the Mental Health Act. The latter in the case of adults depends on an assessment of capacity. If capable an adult cannot be given medical treatment without their consent. If incapable the doctrine of necessity applies and treatment can be given if the treatment is in the patient’s best interests (*Re: F*, 1990). In the case of a child even if the child has capacity their refusal to be treated can be overridden. This is the position as stated in *Re: W*.

The Mental Health Act abridges a patient’s autonomy. As the Act is not age specific this will encompass children. Children do not have complete autonomy in the field of medical treatment, as is reflected in the common law. Code guidance has to incorporate guidance on statute and the common law. The general