A CRITICAL ANALYSIS OF RABONE AND ANOTHER V PENNINE CARE NHS FOUNDATION TRUST, EXAMINING HOW THE JUDGMENT OF THIS CASE COULD AFFECT THE RELATIONSHIP BETWEEN ARTICLE 2 OF THE EUROPEAN CONVENTION ON HUMAN RIGHTS AND NEGLIGENT PSYCHIATRIC CARE.

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Abstract

This paper considers the law surrounding the 2012 Supreme Court decision in the case of *Rabone v Pennine Care NHS Foundation Trust (Rabone)*, which concerns an informal psychiatric patient who committed suicide following permitted leave from an NHS Hospital.[2] This case exposed and reduced the disparity in the liability taken over patients formally detained under the Mental Health Act and informal patients who are not. Through consideration of the current law surrounding psychiatric patient care, this piece aims to analyse the effect the decision in *Rabone* may have on the application of Article 2 of The Convention on Human Rights when negligent psychiatric care occurs. Further, this piece will explore the idea that *Rabone* may increase the class of people owed this duty and the consequences this could have on individuals and care facilities.

Keywords: psychiatric care, medical negligence, human rights law

Introduction

Law and policy surrounding the care of psychiatric patients has been passed to provide a strictly regulated framework of guidance for practitioners which includes protection from negligent care. The law relies on the concept that effective care can save the lives of those at risk of committing suicide due to their mental illnesses. In 2001 the World Health Organisation reported that up to 60 per cent of those with depression can recover with a proper combination of antidepressant drugs and

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[2] *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2

psychotherapy. However, nearly two-thirds of people with a known mental disorder do not seek help from a healthcare professional.[3] Proper treatment can ensure that the number of psychiatric patients who recover continues to rise and can assist in encouraging greater utilisation of the care available.

In the field of mental health care attempted suicide is a common problem.[4] Personal reports of the impact proper care can have on successful avoidance of suicide help to build an understanding of its importance in saving the lives of those at risk. The media, once a facilitator of stigmatizing those with mental illness, has moved some way towards inclusivity by providing a positive forum for people who have experienced mental illness. For example, in an interview with the Guardian, one person explained their past struggles and how the care they received was the catalyst for their recovery.[5] This article provides an example of the improvements successful treatment can offer to a patient's life and how proper care can help to reduce suicidal ideas and actions. UK courts can rule on and compensate the families of those who commit suicide following negligent psychiatric care and, in doing so, can set precedents which can help to improve treatment for future patients. It is the positive potential impact of effective psychiatric care on patients' lives which makes the continuing development and scrutiny of the law which governs it so important.

This article aims to ascertain what effect *Rabone v Pennine Care NHS Foundation Trust (Rabone)*, will have on the application of mental health and human rights legislation to informal patients. In this context, an informal patient is one who has been admitted to hospital voluntarily and is therefore not under compulsory detainment. Overall, it will seek to conclude the consequences of this case for the relationship between negligent psychiatric care and the application of Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (henceforth ECHR).[6]

[3] World Health Organisation 'World Health Report- Mental Health: New Understanding, New Hope' (2001)
[4] Mats Samuelsson, et al. 'Psychiatric care as seen by the attempted suicide patient in Journal of Advanced Nursing' (2000) 32(3) JAN 635, 636
[5] Elena Cresci, 'The day the NHS saved my life: I was sectioned after trying to kill myself: Sarah Lamb, as told to Elena Cresci' *The Guardian* (26th January 2016)
[6] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) 1953, Art 2

1 A History of Policy and Law Reform in Relation to Mental Health Care

Before the 1950's, mental health care largely consisted of detainment where medical professionals pursued methods such as strait jackets, force-feeding and padded cells.[7] Mental health care was regulated by the Mental Treatment Act (1930), but it was evident that change was needed. In 1953 almost half of National Health Service (NHS) beds were occupied by 'mentally ill or mentally deficient' patients and the cost of their care was increasing.[8] A 1957 report from the Royal Percy Commission called for mental health to be treated in the same way as a physical illness and for psychiatric hospitals to operate more like the functioning of an 'ordinary' hospital, this paved the way for the first Mental Health Act in 1959 (the 1959 Act).[9] The 1959 Act directed that a hospital does not have to be a designated mental health hospital to admit and treat those with mental disorders. This saw the commencement of a standard of care required for all health care professionals who may care for mentally ill patients even in non-psychiatric hospitals as there was no longer any 'statutory reason for regarding the mental health services as a separate entity'.[10] This began to remove the disparity between psychiatric care and that of physical illnesses, as recommended by the Royal Percy Commission.[11]

Admissions made a noticeable move towards voluntarism during this temporal period with 75% of admissions in 1957 being voluntary.[12] Despite this, it was still recommended by the Commission's report that compulsory powers should be retained within legislation. This would be primarily designed for patients who were unable to fill out their own applications for admission.[13] Section 25(2) and s26(2) of the 1959 Act outlined the times at which observation or treatment may be delivered without the consent of the patient. The application of these powers creates debate over their morality. It is often argued that the 'disease' suffered by the patient distorts their values and understanding and that if they were behaving as the 'real them' they would consent to the treatment. Due to this it could be considered that treatment

[7] David Clark, *Administrative Therapy* (1st Edition, Tavistock, 1964) 4
[8] Mark Gould, 'Mental health history: taking over the asylum in Health Service Journal' [2008] HSJ
[9] Percy Commission, *Mental Illness and Mental Deficiency (Report)* (HC Deb 08 July 1957, vol 573, cols 35-103)
[10] HL Deb 4 July 1962, vol 241, col 1248
[11] Percy Commission (n 8) col 91
[12] Nicola Glover-Thomas, *Reconstructing Mental Health Law and Policy* (1st Edition, Butterworths, 2002) 24
[13] *Ibid*

without their consent be used to return them to the 'real them' and is therefore in their best interest.[14] However, this could be followed by the argument that it is impossible to know who the 'real them' is, especially if they have been suffering with a mental illness for some time and therefore it is difficult to know what they would consent to if they were of sound mind.[15]

A study conducted in 1990 concluded that compulsory treatment under section 26 is often used prematurely. Five to ten per cent of patients in the study initially refused treatment. Of them more than half agreed to the same treatment within seven days and of those that did not approximately half were permitted by a physician to refuse as the refusal was not medically unreasonable or it was in the longer term interest of the patient for refusal to be permitted.[16] This created an argument against the idea that compulsory treatment produces better results than a lack of compulsion when attempting to return the patient to their 'true self'.[17] Perhaps instead the same treatment could occur or be unneeded within the following 7 days, although this would still require the use of section 25 to detain for observation.

In 1957 the landmark case of *Bolam v Friern Barnet Hospital Management Committee (Bolam)* was heard, the decision of which shaped medical negligence and the standard of care expected of care professionals.[18] This case came just before the major changes of the 1959 Act and regarded a patient in a psychiatric institution who fractured his hip due to a fall during electro-convulsive treatment. The claimant argued firstly that the hospital did not do enough to restrain or drug him to avoid the injury, and secondly that they failed to warn him of this risk. The court held that a doctor is not negligent in providing treatment a certain way simply because another doctor may do it differently. The treatment method used must however be deemed appropriate by a body of doctors in the same field. In his guidance to the jury Lord McNair referred to the judgement of *Hunter v Hanley*[19] stating that:

> 'In the realm of diagnosis and treatment there is ample scope for genuine

[14] Imogen Goold and Jonathan Herring, *Great Debates in Medical Law and Ethics* (2nd Edition, Palgrave, 2018) 41-42
[15] *Ibid*
[16] Steven Hoge, et al. 'A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication in Archives of General Psychiatry' (1990) 47(10) AGJ 949
[17] Peter Bartlett, ''The Necessity Must be Convincingly Shown to Exist': Standards for Compulsory Treatment for Mental Disorder Under the Mental Health Act 1983 in the Medical Law Review' (2011) 19(4) MLR 514
[18] *Bolam v Friern Barnet Hospital Management Committee* (1957) 2 All ER 118 (QB)
[19] *Hunter v Hanley* [1955] SLT 213 (First Div) [217]

> difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men'.[20]

Hunter concerned the appeal of a jury decision in which a doctor was found not to be negligent following guidance from the judge that 'the test to be applied was whether there had been such a departure from the normal and usual practice of general practitioners as could reasonably be described as gross negligence'.[21] In the case the argument from the claimant was that a medical professional should not be in a special position with regards to negligence and that fault should be the foundation for negligence to be held, hence all that should be required to find liability is proving a breach of a duty to take reasonable care.[22] The defence argued that the circumstances for which a duty of care existed often varied and that the practice carried out by the doctor was a long-recognised one and did not vary enough from the standard practice as to constitute a breach. The court in this case stated that a doctor may be found to be negligent if they took actions which no other doctor of ordinary skill would take if employing reasonable care.[23]

Mental Health Law Reform

A clearer criterion was needed for the exercising of compulsory powers and for care of a patient than was provided in the 1959 Act for many reasons.[24] One example of this is that the 1959 Act failed to specify whether a legal order to detain a psychiatric patient also empowered doctors to provide treatment against the person's wishes.[25] While it was acknowledged that the 1959 Act had benefitted the mentally ill greatly, it was suggested in a debate in the House of Commons that there were shortcomings that needed to be addressed.[26] This need was met when reform of the 1959 Act came in 1983. The Mental Health Act 1983 (henceforth MHA) removed age limitations on compulsory admission for treatment so that the patient is only required to be suffering with a mental disorder of a degree for which it is appropriate action. This amendment was welcomed in the debate.[27] The Act's rules for compulsory admission for

[20] *Bolam v Friern Barnet Hospital Management Committee* (n 17) [121]
[21] *Hunter v Hanley* (n 18) [213]
[22] *Ibid* [216]
[23] *Ibid* [217]
[24] Marian Barnes et al. *Sectioned: Social Services and the 1983 Mental Health Act* (1st Edition, Routledge, 1990) 19
[25] Graham Connolly, 'The Mental Health Act' (*Ashton Hospital Pharmacy Services*, 19 January 2017)
[26] Mental Health (Amendment) Bill [Lords] Deb, 22 March 1982, vol 20, col 707
[27] *Ibid* col 708

observation or treatment otherwise remained as in the 1959 Act through Sections 2 and 3, respectively, and still faced similar concerns as previously discussed. It was a point of concern during the House of Commons debate that the reform of the Act did nothing to prevent those with capacity who refuse to consent to treatment from being treated against their will, suggesting that the requirement for the opinions of two doctors was not enough to combat the dangers of imposing treatment in this scenario.[28] It was considered later in the debate that correct precautions would need to be enforced to ensure the two opinions needed to detain a patient were made by two truly independent professionals.[29] The reform of the 1959 Act was generally welcomed throughout the debate.

The intention to approach mental health in a way which did not require psychiatric ward admission was one of the incentives for the new Act. It was hoped that the new legislation would create a clearer structure for psychiatric patient care, particularly for safeguarding their rights. The 1983 Act also made improvements to the requirement for aftercare and reducing the number of people sectioned under the Act, which is defined as being committed compulsorily to a psychiatric hospital for treatment or observation.[30] Section 117 outlined those eligible for aftercare and what should be done to prevent their condition deteriorating. This showed progress in enhancing the rights of the mentally ill, which reflected the main aim of the new legislation, to bring psychiatric care in line with that of physical patients.[31] The 1983 Act also created a power for nurses of 'prescribed class' to restrain a patient for up to six hours if they believed there to be a valid reason to.[32] This broadened the range of medical staff who could intervene to prevent an informal patient from absconding and committing suicide, making protection of 'at risk' individuals easier. The six-hour time frame for which a nurse could restrain a patient allowed time for decisions to be made regarding their longer-term care. This helped provide a solution to the problem that arose when a patient was a risk to themselves, but the relevant professionals were not available to complete formal detainment.[33] This created opportunities for doctors to be consulted and for the patient to be observed before a formal decision was made over a longer detainment, increasing the consideration and care taken over the patient's

[28] *Ibid* col 710
[29] *Ibid* cols 720-721
[30] Mental Health Act 1983 (MHA 1983) s 2; s 3
[31] Barnes (n 23) 51
[32] MHA 1983, s 5(4)
[33] Tommy Dickinson, 'Section 5(4) of the Mental Health Act 1983: the art of applying the Act for the British Journal of Nursing' (2007) 16(20) BJN 1272, 1272

wellbeing.

The 1983 Act included few restrictions on compulsory treatment of detained psychiatric patients, stating that consent shall not be required for certain treatments if they are given under the direction of the approved clinician.[34] Gardiner and Lidz interviewed past involuntary patients and found that around half of them did not find their detention justified when they regained capacity and of those who did, very few felt grateful because of the coercive nature of their detention.[35] This reflects the argument that the Act allowed the application of compulsory treatment to be carried out too easily, showing that some of those who lose capacity may later feel the system has let them down. An example can be found in the case of *MH v United Kingdom* in which the European Court of Human Rights held that the detention of a woman with Down's Syndrome, and her inability to appeal this detention due to a lack of capacity, was a violation of her human rights.[36] They held this despite the state's argument that the current law was correctly applied based on the patient's mental capacity. The governing legislation itself could not be amended by the court but a violation of her Article 5(4)[37] human right was held to have occurred as there were ineffective safeguards in place to allow the patient to appeal her detainment.[38]

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) released a document containing their standards for facilities which deprive people of their liberty.[39] This document outlines that patients should be given the right to refuse treatment whether they are admitted voluntarily or not and that this should only be deviated from in exceptional circumstances.[40] The case of *Re F (Mental Patient Sterilisation)*[41] came before these standards were published, but it demonstrates that the definition for 'exceptional circumstances' has remained vague throughout the history of mental health care, making it difficult to enforce guidance such as the CPT's. The decision was made in the case that a

[34] MHA 1983, s 63
[35] William Gardiner and Charles Lidz, 'Gratitude and Coercion between Physicians and Patients' (2001) 31(2) PA 125
[36] *MH v United Kingdom* App no 11577/06 (ECHR, 22 October 2013)
[37] ECHR 1953 (n 5) Art 5(4) is "the right to 'take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful'."
[38] *MH v United Kingdom* (n 35) 87
[39] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *The CPT standards*, CPT/Inf/E(2002) 1 - Rev. 2010
[40] *Ibid* 31
[41] *Re F (Mental Patient Sterilisation)* [1990] 2 AC 1 (HL)

sterilisation procedure could be carried out on a mentally ill woman whom medical professionals believed not to have the ability to deal with pregnancy or a baby. It was held by the court that it was within the 'best interests' of the patient and hence they could do so without her consent due to her inability to understand the implications of the procedure.[42] A two-stage test was developed to determine a patient's best interests; firstly, whether the treatment was consistent with a reasonably competent body of medical opinion and secondly, whether it the best option available. This case helped shape the principle of necessity in deciding when a circumstance was 'extreme' and relied on High Court judgements to decide whether this type of procedure could be carried out without consent. However, this left a question over how far necessity could be applied, proving the difficulty in defining whether a circumstance was 'exceptional'. The Mental Capacity Act 2005 introduced clearer provisions for the mentally ill to choose who may make decisions for them when they lose capacity; helping to reduce the burden on medical professionals.

The MHA was amended in 2007 due to reduced number of hospital beds and an even greater emphasis on care in the community.[43] These amendments broadened the definition of 'mental disorder' to be 'any disorder or disability of the mind'. It introduced an appropriate medical treatment test to attempt to alleviate the confusion mentioned above about when a treatment is acceptable for a person. This stated that it must be based on the treatment's ability to serve a therapeutic purpose rather than its probability of success.[44] As well as this, new safeguards were put in place regarding the consent to treatment rules, such as the introduction of an option for patients to make a prior decision to refuse electro-convulsive treatment, even if they were to later lose capacity.

The development of mental health law and reform of the MHA has helped to ensure that the law governing psychiatric care adapts over time and works to protect those who are undergoing treatment. The ability to detain a person who is in danger due to their mental health or because they lack the capacity to consent to treatment has been put in place by the MHA in order to protect those at risk to themselves and ensure care professionals have the opportunity to treat them. However, this does place a burden on psychiatric care professionals to ensure these powers are only

[42] *Ibid* 7
[43] Paul Barber et al. *Mental Health Law in England and Wales: A Guide for Mental Health Professionals* (3rd Edition, Sage, 2017) 3
[44] *Ibid* 5

utilised when it is in the best interests of the patient. These laws have a place in understanding the significance of *Rabone* and its potential effects on future cases relating to improper psychiatric care.

2 The Impact of Human Rights and Negligence Law

Human Rights Law

Many cases concerning treatment under mental health legislation are heard in the European Court of Human Rights. This means the development of human rights law has an important impact on the care of psychiatric patients in the UK. *Rabone* considers the obligation of professionals under the ECHR Article 2, right to life. This is often referred to as absolute right which means it 'cannot be infringed by any public authority, however necessary such an infringement may be perceived to be'.[45] Despite this there are situations in which this does not apply to the state, for example where force is necessary such as the armed forces and the police. This indicates that it is a qualified right which means it may be interfered with to protect others' lives or the public interest. Article 2 is key because it imposes a positive duty on care professionals to preserve the lives of those they care for. The Convention rights were ratified into UK legislation in the Human Rights Act 1998 (HRA), which became effective from October 2000. The Act makes it unlawful for any public body to act in a way which is incompatible with the Convention rights. Courts must therefore interpret legislation in a way which does not infringe on a person's rights. This meant patients could now enforce their human rights in UK courts rather than the European Court of Human Rights in Strasbourg, making claims more accessible.

An operational duty has been applied in precedent under Article 2 to specific situations, such as prisoners who risk harm to themselves or others[46], immigrants being detained[47] and military conscripts.[48] Article 2 has also purported claims in relation to formal psychiatric patients, who have been detained under the MHA,[49] such as in the case of *Savage v South Essex Partnership NHS Foundation Trust.*[50]

[45] Geoffrey Dickens and Philip Sugarman, 'Interpretation and knowledge of human rights in mental health practice in British Journal of Nursing' (2008) 17(10) BJN 664
[46] *Edwards v UK* (2002) 36 EHRR 487; *Keenan v UK* (2001) 33 EHRR 913
[47] *Slimani v France* (2006) 43 EHRR 49
[48] *Kilinc v Turkey* App no 40145/98 (ECHR, 7 June 2005)
[49] Mental Health Act (1983) s2; s3
[50] *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74, [2009] 1 All ER 1053

This case concerned a woman who committed suicide after absconding from a South Essex NHS Hospital where she had been formally detained under the MHA. It was found that Article 2 imposed a duty on the state to protect patients and that this included protection from self-harm and suicide because care providers assume a responsibility for their detained patients. This responsibility and duty of care over formal patients was evident from this precedent but until *Rabone* it had not been applied to informal patients. The judgement of *Rabone* could therefore have a significant effect on the application of the ECHR by extending the class of patient owed this duty beyond those defined in *Savage.*

The development of the HRA and the increased accessibility to making a claim began to impose greater responsibility on health care professionals to manage suicide risk in order to protect the Article 2 right. This opened the door for future challenges when suicide occurred whilst under the care of a public authority. It has been legislated that an individual can legally take their own life.[51] Despite this, it is often the case that the existence of a mental illness in a patient creates an argument for their incapacity to make that decision and therefore their Article 2 right must be protected until they can.[52]

Dickens and Sugarman interviewed psychiatrists to understand the knowledge and application of the HRA in mental health practice.[53] They hoped to establish whether clinical teams were properly implementing statutory and local devices to protect their patients' human rights and, when necessary, to justify their partial restriction. The findings confirmed that the implementation of the HRA had an impact on suicide prevention strategies and increased emphasis on risk assessment, however there was also a clear need for regular training to ensure effective care for those at risk.[54] Meeting this need is vital to ensuring the rights imposed by the HRA are being protected when patients are in the care of psychiatric professionals.

The human-rights approach to mental health care provokes strong arguments against compulsory treatment. Many believe that a person should be allowed to decide what

[51] Suicide Act 1961, s1
[52] Mohammad Shaiyan Rahmen and Nadya Wolferstan, 'A Human Right to be Detained? Mental Healthcare after 'Savage' and 'Rabone' in The Psychiatrist' (2013) 37(9) The Psychiatrist 294
[53] Geoffrey Dickens and Philip Sugarman, 'Protecting human rights in psychiatric care: the St Andrew's human rights project in Psychiatric Bulletin' (2007) 31(2) PB 52
[54] *Ibid* 54

happens to their own body and self. This is supported by Article 8, which outlines a person's right to a private life. However, these arguments are often vulnerable to the claim that a rights-based method leaves 'revolving door' patients who can be left in unacceptable circumstances, unable to receive the help they require.[55] In cases such as these, it can be argued that intervention, even if without the patient's consent, would be in line with a mental health practitioner's primary obligation to help.[56] It is a continuing debate whether the potential benefits of compulsory treatment can justify the restriction of a person's liberty.

The Tort of Negligence

The care given to psychiatric patients is subject to the law of tortious negligence. To establish a case for negligence there are three inter-related steps: that a duty of care is owed, that it has been breached, and that the breach is both the legal and factual cause of the damage. The first part of this, the duty of care, was first established in *Donoghue v Stevenson* as the neighbour principle which specifies that a person can owe a duty of care to anyone who is closely and directly affected by their act and who they reasonably should have foreseen the consequence for.[57] This was later expanded into the 3-Stage *Caparo* test to establish if there is a duty, the stages are: whether it is reasonably foreseeable that the claimant will suffer damage; whether there is sufficient proximity between the claimant and defendant; and whether it is fair, just and reasonable to impose a duty.[58] Where mental health law is concerned, it was established in *Bolam* that a duty of care exists between a doctor and their patient.[59] This has been held to extend to all health care professionals and hence can apply to psychiatric patient care.[60]

It is then necessary to show a breach of this duty by establishing whether the defendant acted as a reasonable person would and whether they considered all the circumstances they should have when deciding how to act. This principle has also been developed through *Bolam* which established the test for a reasonable doctor, stating that their actions must be within the realm of those that would be taken by a

[55] Andrew Molodynski, et al. 'Coercion and compulsion in community mental health care in British Medical Bulletin' (2010) 95 BMB 105, 113
[56] *Ibid m*
[57] *Donoghue v Stevenson* [1932] AC 562 (HL)
[58] *Caparo Industries plc v Dickman and others* [1990] 2 AC 605 (HL) [609]
[59] *Bolam v Friern Hospital Management Committee* (n 17)
[60] Andy Young 'Review: the legal duty of care for nurses and other health professionals in Journal of Clinical Nursing' (2009) 18(22) JCL 3071

reasonable person with the skills required of a doctor.[61] This was later expanded in *Bolitho v City & Hackney Health Authority* where guidance was given for an objective judicial standard that could be applied to prevent professionals governing themselves.[62] This made the court, and not the medical professional, the arbiter of medical breach.[63] The likelihood and seriousness of potential harm is then weighed up against the practicality of avoidance and social utility of the activity to determine whether reasonable care has been taken in deciding how to act.

Where tortious liability is concerned, it will then need to be proven that there is a causal link between the breach of care and the damage to the claimant. This must first be proven factually which requires proof the damage was caused by the breach itself or by many factors of which the breach was a contributing one and uses the 'but for' test to establish a link. It is within this part of the negligence test that it has been proven that one must take their victim as they find them.[64] This is important in mental negligence cases as professionals must accept their patients with the psychological illnesses they have, and it cannot be a defence for provision of a lower standard of care. It must then be legally proven which requires proof there were no intervening acts between the breach and the damage and that the damage itself was not too remote to be reasonably foreseeable. These steps for proving negligence have been developed through case law and apply to the standards placed on medical professionals when deciding how to treat psychiatric patients to work in their best interests and care for them adequately.[65]

3 The Supreme Court and Rabone v Pennine Care NHS Foundation Trust

The Facts of the Case

Rabone concerns an action brought by the parents of Melanie Rabone (M) who in 2005 was admitted informally to Stepping Hill Hospital under the control of the Pennine Care NHS Foundation Trust following a suicide attempt. On 7 March she was diagnosed with a severe episode of a recurrent depressive disorder. On 14 March M was assessed as having shown 'sufficient signs of recovery to be allowed

[61] *Bolam v Friern Hospital Management Committee* (n 17*)*
[62] *Bolitho v City & Hackney Health Authority* [1997] 3 WLR 1151 (HL)
[63] Rachael Mulheron 'Trumping Bolam: A Critical Legal Analysis of Bolitho's "Gloss" in Cambridge Law Journal' (2010) 69(3) CLJ 609
[64] *Smith v Leech Brain & Co Ltd* [1962] 6 QB 405
[65] Kirsty Horsey and Erika Rackley, *Tort Law* (5th Edition, Oxford University Press, 2017)

overnight leave', she was then discharged on 18 March.[66] M's condition failed to drastically improve, and she was admitted to the Accident and Emergency department on 31 March due to further self-harm; readmission to the hospital was advised but no beds were available. A second attempt on her own life occurred on the 11 April. A doctor noted she suffered from 'Severe depressive episode' and 'High risk DSH (deliberate self harm) and suicide'.[67] At this stage M agreed to be informally admitted to the hospital, although doctors noted she would have been assessed for detention under the MHA had she attempted to leave. She was under continuous 15-minute observation and she was prescribed drugs. The full Mental State Examination carried out on her admission found her to be of moderate to high suicide risk. In the days that followed nursing reports showed that M's mood was lifting however her parents contacted the hospital expressing concern over her condition, despite this M was granted 2 days home leave. The following day, the 20 April, M committed suicide whilst on this home leave; she was aged 24.

M's parents brought an action for damages against the Trust for a breach of Article 2 of the ECHR and for negligence under the Law Reform (Miscellaneous Provisions) Act (1934). The Trust admitted negligence in allowing overnight leave and agreed to pay £7,500 in settlement along with costs. However, the claimants continued to pursue a claim under the HRA, and hence under the Convention rights, for which the trust denied liability. The court at first instance held there must be a clear distinction between formal and informal patients when imposing a positive Article 2 obligation. They stated that in this case it should not be imposed as M was an informal patient who had capacity to make her own decisions over her treatment and hence no obligation existed.[68]

The case was then heard in the Court of Appeal where the appeal was dismissed on similar grounds, stating that 'the remedy for clinical negligence, even where a "real and immediate" risk of death has been disregarded, is an action in negligence'.[69] However, the court did conclude that if a duty had been held to exist then the trust would be in breach of it. The claimants appealed again to the Supreme Court, where the appeal was allowed. The existence of an operational duty under Article 2 was

[66] *Rabone (in his own right & as Personal Representative of the Estate of Rabone) and another v Pennine Care NHS Trust* [2009] EWHC 1827 (QB) 5
[67] *Ibid* 8
[68] *Ibid* 59
[69] *Rabone (in his own right and as personal representative of Melanie Rabone, deceased) and another v Pennine Care NHS Trust* (2010) EWCA Civ 698 64

held to exist for two reasons. Firstly, the threat to life was imminent, and secondly the vulnerability of M was enough to give rise to a duty without the need for control over her.[70] An assumption of responsibility had therefore been formed. Lord Dyson stated in his judgement that:

> 'if the trust had refused to allow her to leave, she would not have insisted on leaving. This demonstrates the control that the trust was exercising over Melanie'.[71]

The Significance of Rabone

Before *Rabone*, judicial precedent had already defined that in the event of a patient committing suicide there could be a claim in negligence if the actions of a medical care team had failed to protect the life of someone at risk. However, it had also been generally understood that a positive obligation to protect life under human rights law could only be applied when a patient had been formally detained through the MHA. As the ruling in *Rabone* narrows the disparity between the level of care offered to patients who have and have not been detained under the MHA, then in theory *Rabone* could establish a broader application of Article 2 for vulnerable individuals.[72] It has been argued that once the right has begun to apply to informal psychiatric patients it may also give rise for the operational duty to apply to vulnerable non-psychiatric patients when a care team have failed to protect their right to life. Beyond this it could even be possible to apply it to those individuals living in community care, which is long term care provided in the community rather than an institution. It would be possible to apply it this way as there is nothing to suggest a hospital setting is necessary if a person need not be detained as an extra level of control will be less likely to be required.[73] Although this helps to achieve the same standard of care for all psychiatric patients it increases the disparity between psychiatric and physically unwell patients, working against the intentions of the Royal Percy Commission when advising on the reform of the 1959 MHA.[74] This intention was helping psychiatric ailments to be treated in the same manner as physical ones are.[75]

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[70] *Rabone v Pennine Care NHS Foundation* (n 1) 105
[71] *Ibid* 34
[72] Nigel Poole QC, 'Rabone v Pennine Care NHS Foundation Trust – Claiming Damages under the Human Rights Act' (*Kings Chambers*, 2012) 15
[73] *Ibid* 11
[74] Percy Commission (n 8)
[75] George Szmukler, et al. ''Rabone' and four unresolved problems in mental health law in The Psychiatrist' (2013) 37(9) The Psychiatrist 297, 301

A key consequence from the creation of a similarity between informal and formal psychiatric patients is that a wider range of claims will lead to an Article 2 inquest, which is a judicial inquiry into an incident where a state's Article 2 obligation is considered. This will occur as there will be wider grounds on which state agents may be in breach of their obligations under this Article right, because the status of the victim, as a formal or informal patient, will be irrelevant. This will be likely to increase the granting of public funding for such inquests.[76] Post *Rabone* this could mean an inquest may be required for any suicide victim who had contact with care facilities running up to their death if the facility should have reasonably foreseen the real and immediate risk. Although this is a tenuous estimate of the effect, it could be argued that the expansion of this obligation could mean an enormous rise in potential claims. Basis for this argument can be found in a study which discovered that between 44 and 51 percent of the suicides investigated had been in contact with services within the last 7 days.[77]

However, Lord Dyson's judgement in *Rabone* suggested that M's status as an informal patient was only one of form, not substance*;*

> 'In reality, the difference between her position and that of a hypothetical detained psychiatric patient, who (apart from the fact of being detained) was in circumstances similar to those of Melanie, would have been one of form, not substance.'[78]

This statement suggests that *Rabone* will not create a new precedent for informal patients as M's status as an informal patient was only based on form. This is because she had voluntarily been admitted and in terms of severity of suicide risk and illness, she could be regarded to be the same in substance as a formally detained patient. For this reason, the case of *Rabone* could be argued as more of an anomaly to the rule set out in *Savage*, which outlines that formally detained patients are owed a duty under Article 2, rather than creating a new status of patients to whom the operational duty can be applied. If this were to be the case, then although the difference between formal and informal patients would still become increasingly vague, it would be more of a test of decision-making capacity of a patient and risk to themselves rather than

[76] Poole (n 72) 17
[77] Healthcare Quality Improvement Partnership 'National Confidential Inquiry into Suicide and Safety in Mental Health annual Report' (University of Manchester, 2018)
[78] *Rabone v Pennine Care NHS Foundation Trust* (n 1) 34

simply whether or not they are detained. This would ensure the correct level of care would be taken over all 'at risk' patients, not just those formally detained under the MHA. This argument reflects a case by case approach by the courts on the future of mental health negligence cases in respect of the application of an Article 2 operational duty.[79] Following these arguments it remains to be seen in future cases whether the decision in *Rabone* would create a new category of patients to which an Article 2 duty is owed or if it would simply allow those who have voluntarily been admitted, and hence avoided MHA detention, to be assessed on a case by case basis.

The Article 2 operational duty has been applied lightly since its inception and the criteria for proving a 'real and immediate risk' have always been strict. This is due to the pressures, costs and complexities in running services such as custody units in police stations or mental health facilities.[80] One of the experts in the case of *Rabone* assessed the risk of M's suicide as low to moderate (but nevertheless, significant), this was held to be enough to create a real risk.[81] In *Re Officer L*, it was found that a risk could be substantially immediate if it was 'present and continuing'.[82] Based on this, it was possible to find that the risk of M's suicide was immediate when she left for home leave and continued until her death, therefore this could be substantially immediate.[83] This application could reduce the strict nature of the test and could therefore increase the amount of cases brought against these facilities under this criterion for an Article 2 duty.

Both the expanded category of the application of the Convention right and the loosening of the real and immediate risk criterion could lead to an increase in court cases regarding a facility's failure to protect life, whether there was an element of control or not. It is likely that this rise in claims could increase the cost of legal fees for these facilities and the complexity of providing care for those at risk.

The Potential Effects

The main potential effect *Rabone* may have is on the future of Article 2 applications.

[79] Adam Wagner, 'Hospital had human rights duty to protect voluntary patient from suicide, rules Supreme Court' (*UK Human Rights Blog*, 8 February 2012)
[80] Matthew Hill 'Analysis - Rabone and the rights to life of voluntary mental health patients – Part 2/2' (*UK Human Rights Blog*, 14 February 2012)
[81] *Rabone v Pennine Care NHS Foundation Trust* (n 1) 35
[82] *Re Officer L* [2007] UKHL 36
[83] *Rabone v Pennine Care NHS Foundation Trust* (n 1) 41

The possibility that it has created an equivalence between the operational duty owed to detained and voluntary psychiatric patients means that a larger scope of claims could be brought against hospital trusts. In this way, *Rabone* has already begun to influence claims. Firstly, *Rabone* was applied in the case of *R v HM Coroner for the County of Kent* in which a 14-year-old died of a methadone overdose.[84] Prior to his death the deceased's psychiatric struggles were known to the local social services and it was felt by his family that these services missed many opportunities to prevent the death. Although the court held that an Article 2 inquest into the death should not be carried out, they also considered that there was 'no doubt' that the case entered the potential territory of an operational duty under Article 2.[85] In this way, *Rabone* is already beginning to extend the scope of an Article 2 duty, as the deceased in this case was not under the control of services yet the duty was still capable of existing. It was only upon further consideration of whether a real and immediate risk existed that no duty was found.

More recently, the Queen's Bench Division have considered applying the *Rabone* principles in *R v HM Assistant Coroner for the City of Sunderland* which may extend *Rabone* even further as it concerns the suicide of a patient who, although they had spent time in hospital for their psychiatric illness, was on a community care regime to allow her to live at home.[86] The coroner declined to engage an Article 2 inquest into the death and the family of the deceased sought judicial review. This was based on a failure of the coroner to consider all the factors laid out in *Rabone*. These factors were vulnerability of the victim, real and immediate risk of suicide and degree of control over the deceased. Instead the coroner only focused on the level of control community care provided. The decision of the court was not to quash the coroner's decision but to remit the case back to the coroner for them to further consider based on all the mentioned factors. It is currently unclear if an Article 2 inquest has since been engaged by the coroner based on the new statements but if so then this case could confirm that *Rabone* has opened the door for the extension of the scope of an Article 2 operational duty to those in community care who are in contact with services.[87] A claim would therefore be possible even if there is no element of control

[84] *R (on the application of) v HM Coroner for the County of Kent (North-West District) & Others* [2012] EWHC 2768 (Admin)
[85] *Ibid* 44
[86] *R. (on the application of Lee) v HM Assistant Coroner for the City of Sunderland* [2019] EWHC 3227 (Admin)
[87] Josie Baker 'Article 2 Inquests—possibility of an extension of the operational duty' (*Clyde & Co*, 10 December 2019)

over the patient, hence increasing pressure on psychiatric services to offer effective care.

This increase in claims may cause trusts to develop and improve their services to those at risk. Risk identification has been conceived as a key factor in the prevention of suicide in those who have contact with services. The potential for this increase in claims could give rise to an improvement in the way facilities investigate this risk in each patient they care for, which would create a better standard of care. However, in 2009 there were only 84 deaths out of 120,000 admissions in England that were due to suicide of in-patients, including those on periods of trial home leave.[88] This means that one suicide occurs amongst 1400 admissions. Due to the rarity of a suicide amongst the huge amount of patients being admitted to hospitals, the cost of increasing measures for suicide risk identification in every patient could be substantial for trusts in order to attempt to identify that one person, and even then they may fail. This identification is unnecessary in cases such as *Rabone* where a patient has been admitted because of an already apparent suicide risk. Therefore, the effect *Rabone* will have on risk identification is likely to be minimal as it was not the basis for negligence in M's care, however it remains an area which facilities must continue to monitor and improve to prevent further patient suicides.

The application of the Article 2 duty to informal patients, as well as formal, and the focus instead on the 'real and immediate' risk of a patient's suicide may create an uncertainty which would not only be confusing for patients but also for medical professionals who may be uncertain of their liabilities at any given time.[89] This could result in a stricter approach to care application, with a patient more likely to be detained under the MHA because informal hospitalisation will become less attractive.[90] A psychiatric care professional may more frequently turn to the option of detention for fear of being negligent in failing to do so. This is especially true given that, as in *Rabone*, experts in court can often overestimate the likelihood of suicide in a patient and therefore the question arises as to whether the identification of risks which exist in practice can ever satisfy the requirement of the Article 2 duty for 'real

[88] Szmukler (n 75) 300
[89] John Fanning, *New Medicalism and the Mental Health Act* (1st Edition, Bloomsbury, 2018) 70
[90] Nicola Glover-Thomas, 'Decision-Making Behaviour under the Mental Health Act 1983 and Its Impact on Mental Health Tribunals: An English Perspective in University of Manchester Research: Laws' (2018) 7(2) Laws, MDPI 1, 12

and immediate'.[91] Due to this an increased use of detention under the MHA could occur so that medical professionals can more clearly establish their liabilities and duties to a patient. This would reduce the risk of suicide occurring following a negligent decision to allow a patient to leave the hospital when there is a lack of formal detainment. Following this, patients may be less likely to seek care for their mental illness through fear of a likely detention. However, it can be argued that in a climate where inpatient bed numbers are reduced and well-established home treatment teams exist, admission will continue to be a last resort and *Rabone* will not create an increase in its use.[92] Additionally, as decisions to grant home leave are made with reasonable risk-assessment then the case is unlikely to give rise to an increase in claims which would not have warranted a case prior to *Rabone*.

Rabone marked a turning point for the care of informal psychiatric patients and created a stricter code of security and care for those at risk and under the care of a trust.[93] This may influence practices within hospitals when caring for informal patients. The case reduces the disparity between the care of formal and informal patients, which has the potential to increase the group of psychiatric patients to whom an operational duty to protect life is owed. This has already been seen in claims brought before the court and may increase the number of claims.

Conclusion

The case of *Rabone* reflects the most severe consequence that negligent psychiatric care can have on vulnerable patients, as it results in death. It is of utmost importance that the best care be provided to avoid these circumstances. For this reason, the courts must apply the law effectively to incentivise the best care practices, protect the mentally ill and compensate their families if an unlawful death occurs that breaches an individual's human rights due to negligent care. The importance of the Supreme Court's decision in *Rabone*, and the impact it will have on future claims of a similar nature, have been discussed in this report.

Before *Rabone*, liability for negligent care which causes the suicide of a patient followed the rule set out in *Savage* and relied on their status as a detained patient

[91] Szmukler (n 75) 301
[92] Barry Williams, 'Will Supreme Court Ruling on Obligations Affect our Practice? In Mental Health Nursing' (2012) 32(2) Mental Health Nursing (Online) 3
[93] Christian Duffin, 'Ruling may see more nurses assigned to suicide watch in Mental Health Practice' (2009) 12(5) MHP 4

under the MHA. This meant that the family of an informal patient, who had not been detained, could make a claim in negligence, but an Article 2 operational duty could not be applied.[94] Application to formal patients, along with prisoners at risk to themselves or others,[95] immigrants who have been detained,[96] and military conscripts,[97] has meant that this operational duty required the state service to have control over the individual. This drew a distinct line between those to whom a duty to protect life was owed and those who had enough autonomy over their decision-making for the state service to not be liable for their death. However, this left a class of vulnerable people who were unprotected by this Article 2 duty; patients who had voluntarily been admitted to hospital for their condition for fear of being formally detained if they refused. This meant, as described by Lord Dyson in *Rabone*, that their status as an informal patient rather than a formal one was only one of form, not of the substance of their vulnerability, leaving them equally as at risk due to their psychiatric condition but less likely to make an effective human rights claim.[98]

Rabone was the first time the UK courts had applied the duty to this form of patient and the effects of this have the potential to be seen in future claims of a similar nature. As discussed, the cases of *R v HM Assistant Coroner of Kent*[99] and *R v HM Assistant Coroner for the City of Sunderland*[100] consider the judgement in *Rabone* and its ability to extend the application of the operational duty. They show that claims may increase where there has been a possible breach of the duty to protect a patient's life, even when the level of control over the patient is lower due to their lack of detainment. The reduction in the disparity between the duties owed to formal and informal patients could create a pressure on facilities to prioritise suicide risk identification in all patients. Given the large numbers of patients that hospitals care for, increasing the need to gauge the suicide risk of each could be costly and time consuming. Due to the rarity of suicide in this huge scope of patients it proves to be a difficult task to find those at risk and protect their Article 2 right.[101] However, with the suicide risk already being evident in the case of *Rabone*, it will be more likely to highlight the ability to claim when an error occurs, rather than suggest that there is currently an abundance

[94] ECHR 1953 (n 5) Art 2
[95] *Edwards v UK*; *Keenan v UK* (n 45)
[96] *Slimani v France* (n 46)
[97] *Kilinc v Turkey* App no 40145/98 (n 47)
[98] *Rabone v Pennine Care NHS Foundation* (n 1) 34
[99] *R (on the application of) v HM Coroner for the County of Kent (North-West District) & Others* (n 84)
[100] *R. (on the application of Lee) v HM Assistant Coroner for the City of Sunderland* [2019] (n 86)
[101] Szmukler (n 75) 297

of errors in risk identification methods.

Rabone will not create an instant need for reform of legislation such as the MHA or relative legislation, but it could have an effect on the application of the current law and on those who have lost a family member through ineffective care. By potentially increasing the class of patients to whom an operational duty is owed, it opens the door for further potentially successful claims to proceed against hospitals. Although this could prove beneficial to those who suffer the loss of a family member following negligence of a care team, it could begin to put additional financial stress on the public health service. It would require those services to increase their risk identification procedures or more readily detain people under the MHA in order to protect themselves from these possible claims, which could see both positive and negative effects for the individuals in their care. Although it could allow patients access to the correct treatments through detention and a higher likelihood of suicide risk detection, it is also possible that it could deter people from seeking help from services out of fear of a more probable detention.

The case of *Rabone* exposes a significant gap in the law regarding liability for the death of a psychiatric patient due to negligent care, in that those who had not been formally detained under the MHA were not owed an operational duty to protect their life under Article 2 of the ECHR. The decision by the Supreme Court in *Rabone* to allow such a duty to exist is important for the future of mental health negligence cases and their relationship with human rights law, as it allows the application of the latter to be based more on whether a 'real and immediate' risk existed, and whether it was negligent of the hospital or care provider to fail to identify it. This has the potential to increase the amount of claims that could be brought against services for failing to prevent a suicide, and the status of a patient as a formal or informal patient will have less weight on their ability to be successful in this claim. Although, as discussed, this does have the potential to create both positive and negative impacts on the services themselves, and on their patients. *Rabone* has already begun to show significance in later cases. Its ability to increase the class of patients to whom an Article 2 duty is owed can allow claims to exist based more on the treatment received by a patient, and how well it has protected their right to life, rather than their official status. This will make it more possible for trusts to be held accountable for truly negligent care which will only improve the protection of patients overall.