Judgment delivered in *Rabone*

In an extension of human rights law, the Supreme Court has made it clear that all psychiatric patients admitted into a mental health unit and at risk of suicide should be given the same level of protection irrespective of their status under the Mental Health Act. On 8 February 2012 the court handed down its unanimous judgment in *Rabone v Pennine Care NHS Trust*. Determining that the NHS does owe an Article 2 “operational” duty to informally detained patients, the judgment has further expanded the scope of the NHS’ Article 2 responsibilities. This briefing assesses the scope of the duty and what this will mean in practice for trusts.

The legislative background

Article 2 of the European Convention on Human Rights provides that everyone’s right to life shall be protected by law. This means that a hospital has a duty to ensure that appropriate general measures are taken to protect the lives of patients in hospitals. As Lord Rodger in *Savage v South Essex Partnership NHS Foundation Trust* (2008) explained “this will involve, for example, ensuring that competent staff are recruited, that high professional standards are maintained and that suitable systems of working are put in place”. Where these basic standards are met, so too is the general Article 2 obligation.

In certain circumstances it is accepted that an additional operational obligation - namely a duty to actively take steps to prevent people from killing themselves, or protecting their lives, where there is a “real and immediate” risk to life - may be imposed on the state (including hospitals).
An “operational” duty for the NHS?

To date, the European courts have managed the balance by stating that the “operational duty” of the State arises out of the wider duty to protect individuals who are in a vulnerable position and for whom they are responsible, in particular prisoners and conscripts.

This is a new and developing area of law. Cases have extended the duty to the NHS where patients are at risk of suicide and now still further to include voluntary patients as well as detained patients.

**Savage v South Essex Partnership NHS Trust (2008)**

Let’s go back to the case of Mrs Savage who was detained under section 3 of the Mental Health Act 1983 for the purposes of treatment and for her own safety. Whilst receiving treatment, Mrs Savage managed to abscond from Runwell Hospital and jump under a train, killing herself. Her daughter sought compensation arguing that the trust had not provided enough care to protect her mother and was therefore liable for breaching her mother’s Article 2 right to life. The case was based on the premise that the hospital had failed to appreciate the risk this patient presented and failed to make sure adequate measures were in place to protect her life.

As the first time an English court had been asked to consider whether the Article 2 “operational” obligation extends to hospital authorities, the issue was referred to the House of Lords as a preliminary point of law. The House of Lords held that where a patient was **compulsorily** detained in a mental hospital, the trust owed a comparative duty to that owed by the state to a prisoner. In summarising, Lord Rodger (who provided the main judgment in the case) noted that:

1. health authorities are subject to an over-arching obligation to protect the lives of patients in their hospitals. This requires them to ensure that they employ competent staff trained to a high professional standard to deal with patients at risk;
2. there would be no violation of Article 2 (in any form) if the cause of death was negligence as opposed to a failure by the authority to do all that the Article required of it; and
3. if a member of staff knows, or ought to know, that a particular (detained) patient presents a “real and immediate” risk of suicide, the additional “operational duty” under Article 2 will arise. In these circumstances, the trust will be required to do all that can reasonably be expected to prevent the patient from committing suicide.

Although, unfortunately, it is not mentioned within the summary provided by Lord Rodger, it is clear from the remaining judgments (and subsequent commentary) that particular emphasis was placed on the fact that the individual had been **compulsorily detained** under the Mental Health Act 1983 and as such, was a vulnerable individual in the care of the state.

The question of whether a wider duty was owed to all mental health patients was deferred by their Lordships “for another day” (as per Baroness Hale at paragraph 102).

**Rabone v Pennine Care NHS Trust (2012) – Supreme Court**

Melanie Rabone (aged 24) suffered from symptoms of a depressive illness with known suicidal tendencies. After a failed suicide attempt on 11 April 2005, she agreed to an informal admission to hospital. Following several requests by Melanie, and despite the reservations of her mother, overnight leave for two days was granted on 19 April 2005. On 20 April 2005, having told her mother that she was going to visit a friend, Melanie took her life by hanging that afternoon. Melanie’s father brought a claim against the trust alleging, inter alia, breach of Article 2 obligations. The
trust admitted that the decision to grant leave was negligent, and a sum was paid to settle a negligence claim. It was argued that the Human Rights Act 1998 did not apply.

Expert evidence, accepted by the court, suggested that the risk of Melanie taking her own life could be as low as 5 per cent or as high as 20 per cent. The High Court and the Court of Appeal decided that no “operational duty” was owed to Melanie as she was not detained under the Mental Health Act 1983. The matter was appealed to the Supreme Court.

Supreme Court judgment
Of relevance to this briefing are two of the questions the court had to answer;

1. whether the operational obligation under Article 2 can, in principle, be owed to a hospital patient who is mentally ill, but who is not detained under the MHA; and

2. if the answer to (1) is yes, whether there was a “real and immediate” risk to the life of Melanie of which the trust knew or ought to have known and which they failed to take reasonable steps to avoid.

Can the operational obligation under Article 2 extend in principle to a hospital patient who is mentally ill, but not detained under the MHA?

The court accepted there was a need to determine whether or not the responsibility and potential duty to informal patients was akin to general negligence (but no Article 2 “operational duty”), or whether an operational duty arises. The judges identified the following factors as relevant when considering whether or not to impose an Article 2 “operational duty” on the state:

- an assumption of responsibility by the state for the individual’s welfare and safety (including by the exercise of control) – the paradigm example of which will be state detention of the individual;

- the vulnerability of the victim – in circumstances of sufficient vulnerability, the courts have been prepared to find a breach of the “operational duty” even where there has been no assumption of control by the state such as where the local authority fails to use its powers to protect a child known to be at risk of abuse; and

- the nature of the risk – is it an “ordinary” risk of the kind that individuals in the relevant category should reasonably be expected to take or is it an “exceptional” risk with a specific threat to life?

In determining who the informally detained patient is most appropriately compared to, Lord Dyson placed particular emphasis on the fact that, unlike the ‘ordinary’ patient requiring treatment for a physical condition, the psychiatric patient’s mental disorder is likely to mean that their “capacity to make a rational decision to end [their] life will be to some degree impaired. [They] need to be protected from the risk of death...”. When coupled with the state’s ability to temporarily detain psychiatric patients under section 5 of the MHA 1983, the hospital has the power, and thus the duty, to protect the informally detained patient from the specific risk of suicide. In this respect, Lord Dyson believed the patient’s position to be “analogous to that of the child at risk of abuse”.

Where then did this leave Melanie Rabone? According to the court:

- she had been admitted to the hospital because she was a real suicide risk;

- by reason of her mental state, she was extremely vulnerable;

- the trust assumed responsibility for her; and
It is clear that, if she had insisted on leaving the hospital, the authorities could and should have exercised their powers under the MHA to prevent her from doing so.

Thus, Melanie Rabone was owed an “operational duty” under Article 2 as:

“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. Her position was far closer to that of such a hypothetical patient than to that of a patient undergoing treatment in a public hospital for physical illness” (emphasis added).

The extent of the “operational duty”
What is the standard to be expected when the “operational duty” under Article 2 is engaged. The considerations for a trust at this point are twofold:

1. Is there a “real and immediate” risk of suicide?
   According to Lord Dyson, there was a “real” risk of suicide, not least because the experts agreed that “all ordinarily competent and responsible psychiatrists would have regarded Melanie as being in need of protection against the risk of suicide”. In respect of whether that risk was “immediate”, Lord Dyson believed that the phrase “present and continuing” would capture the essence of its meaning. In the present case, there was a real risk (put at 5 to 20 per cent) that Melanie would take her life during the two day period which existed when she left the hospital and continued during the period of leave. This was sufficient to make the risk present and continuing, and therefore immediate.

   Hindsight is, as always, a marvellous thing, and courts should be careful when deciding what the trust knew or ought to have known with the benefit of hindsight.

   It is clear that even if an Article 2 “operational duty” is prima facie owed, the courts will not automatically assume a breach has occurred. But since it is an “expanding area of jurisprudence” it would be fair to assume there will be more dispute and cases in the future.

2. If the answer to 1 is yes, has the trust taken “all reasonable steps” to prevent the suicide?
   Considering whether or not there had been a breach of the “operational duty” in Rabone, Lord Dyson concluded that “The standard demanded for the performance of the “operational duty” is one of reasonableness”. This will bring into account “consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available” and, particularly in this case, “a consideration of respect for the personal autonomy of Melanie”.

   In the context of the voluntary patient, the court emphasised the need to strike a balance between “the right of the individual patient to freedom and self-determination and her right to be prevented from taking her own life”. In this respect, reliance on expert evidence alone will not always suffice. In the present case, additional considerations included the fact that there appeared to have been “no proper assessment of the risks” before leave was granted and “no proper planning” for the care during the leave. This leaves open the question as to whether or not there would have been a breach had Melanie Rabone presented a lower risk of suicide and been sent home with a thorough care plan and risk assessment which included adequate safeguards.

4
The courts have made it clear that where obvious steps are not taken, the NHS will be in breach of its obligations. Thus, in Savage the trust could, and should, have increased observations when aware that there was a high risk of the patient absconding. Likewise, in Rabone, failing to take the obvious preventative measure of refusing permission for leave led to a breach of duty.

So where does this leave the NHS?

When and to which patients do we owe the extended “operational duty” to take specific steps to prevent patients taking their own life? What are the consequences of this case for the NHS?

1. For the vast majority of patients it is no change
   The judgment only applies to mental health patients otherwise no “operational duty” will arise under Article 2. Whilst there may be an “assumption of responsibility”, individuals will not normally be considered “vulnerable” and will be facing “ordinary” risks. Thus the individual who requires life-saving surgery, is aware of the risks of refusal, but chooses to leave regardless, will not be owed any “operational duty”. Likewise, the patient with a physical illness who undergoes surgery will accept the risks (of death) by way of the consenting process and can choose to avoid the risk by not going ahead.

   Of course the general obligations under Article 2 remain such as, for example, ensuring that competent staff are recruited, that high professional standards are maintained and that suitable systems of working are put in place. There should be no need to change your general clinical practice.

2. It should make no difference to our clinical care
   The standard of clinical care required remains the same and there is no need to change good clinical practice. Despite all the “ink” that this judgement will spill, we wonder whether, in fact, the judgment simply reminds those who deliver care to mental health patients of what is, in any event, good practice? The NHS and clinicians should be protecting patients at risk as is reasonable and appropriate.

   The principles of civil and clinical negligence still continue to apply as far as the treatment of patients is concerned.

   It is instructive to remember that in Melanie’s case, the health care trust admitted their care fell below a reasonable standard which the patient was entitled to expect and their own expert suggested that no reasonable psychiatrist would have granted her leave that weekend.

3. Where an individual is compulsorily detained under the Mental Health Act 1983
   Both the “general” and “operational” Article 2 obligations will be engaged as set out in the case of Savage (above). Any trust faced with a patient who they know (or ought to know) poses a “real and immediate” risk of suicide, must take appropriate steps to minimise that risk.

4. For informal patients, the decision in Rabone means we have to think and take care
   You could say the case muddies the waters a little. At least in some circumstances, an “operational” Article 2 obligation will be owed to the informally detained patient. Decisions will need to be taken on a case by case basis and will depend on the facts of each case.

   Unfortunately, the “circumstance-specific” attitude adopted by the court means that the Supreme Court in Rabone was not required to consider every eventuality. On first reading, much emphasis appears to have
been placed on the fact that Melanie was, in effect, a “prime candidate” for temporary detention under Section 5 MHA 1983.

If Melanie had insisted on leaving hospital, the authorities or clinicians (if they had acted appropriately) could and should have exercised their powers to prevent her from doing so (a fact admitted in the negligence action). It appears the duty rests on the clinicians based on the condition of the patient as is (or should be) apparent to them. One way to look at this might be to consider that the duty arises if the patient is “sectionable” and we could, should or would use our powers to detain.

5 What is a “real and immediate risk”?
In Rabone the court accepted that the risk of Melanie killing herself was between 5 and 20 per cent. In our view, the level of risk will not need to be very high. Melanie was accepted as being at a “high” risk of suicide, but we suspect that almost “any” identification of a potential suicide risk in the medical records is likely to lead to the suggestion that the NHS owes an Article 2 duty. Without doubt lawyers will be making that case.

Practitioners will need to pay close attention to the risk assessment of all patients, and not just those who are detained. This should be the case already. Attention will need to be paid to the risk of suicide. As things stand at present it may be worth considering that any real risk (as opposed to some “fanciful” risk or notion) could be considered “real and immediate” if it is a genuinely present and continuing risk as far as the particular patient is concerned.

Clear notes and a record of the risk assessment must be made with reasons and then the appropriate action plan to minimise the risk set out, put in place and carried through. Clinicians and trusts must be able to demonstrate that appropriate actions have been taken and plans carried through.

6 The narrowing of the difference between detained and informal patients
Consider these quotes from the judgement:

“… the differences between the two categories of psychiatric patient should not be exaggerated”

Lord Dyson

“There is no warrant, in the jurisprudence or in humanity, for the distinction between the two duties ….. [93] Article 2 begins ‘Everyone’s right to life shall be protected by law’ “

Lady Hale

Human rights law and duties the state owes to its citizens are new areas of jurisprudence. The judicial approach has moved and changed significantly in the last ten years and will no doubt continue to do so. It seems to us that the distinction between detained and informal patients is being eroded. This case represents another step in that direction.

It seems clear that there is a gradual expansion of the reach of Article 2 and as a result the responsibilities and liabilities of hospitals and health care staff. It seems that as this case is essentially determined “on its particular facts” then this leaves scope for more argument in the future with a view to extending the operational obligation still further to include additional categories of patients at risk.
Mental health patients in the acute setting

Patients with mental health issues frequently present at A&E with injuries from self-harm or following attempts to take their own life. In the first instance, health care providers will need to deal with the immediate and potential life-threatening physical problems. There may (or may not) be a referral to mental health in-reach services. Often there will be an admission into the acute hospital.

The case is not clear as to the duty owed to these patients. It may be that they are at a “real and immediate” risk, but is that necessarily something that staff in the acute hospital can deal with in the same way as mental health professionals?

*Rabone* did concentrate on the mental health care setting and so there may be scope to argue that patients are not owed such a duty outside that environment. We suspect, again, much might turn on the facts of any given case, and the assessment of both the mental health and physical risks to the patient.

It will, perhaps, be a case for future litigation if a patient at risk succeeds in taking their own life following admission to an acute setting or following the granting of section 17 leave to a patient to receive treatment in an acute setting for a physical problem.

We can foresee arguments framed by lawyers assisting families to extend the scope of the “operational duty” under Article 2 to include the acute setting and potentially any patient who might have been identified at risk.

Concluding remarks

The case certainly paves the way for more litigation and claims against the NHS. In conclusion, we feel the following points are worth thinking about:

- The case is not authority for the proposition that voluntary patients should not be given home leave.
- In most cases, we cannot stop patients exercising autonomy and making choices, nor should we.
- As the law develops, following this case, it is likely there will be a requirement for more detailed NHS investigations and reports.
- We foresee increasing and more sophisticated arguments made on behalf of families for Human Rights Inquests with all the attendant implications for investigation, time, and costs. It is likely coroners will need to consider the facts of cases and the arguments of lawyers much more closely and accede to more requests to hold more detailed inquests (possibly with juries) to satisfy the requirement to provide proper and independent investigation on behalf of families and to determine whether there has been a breach of the Article 2 “operational duty”.
- As the case seems to rely on an approach based on “each case on its own facts” we feel this provides much more scope for argument and damages claims. We can foresee more litigation.
- We wonder whether the approach adopted by the court in this case might lead clinicians to adopt a more cautious approach and detain people under section more readily if they perceive any risk? Alternatively, it may be the case that there will be a greater reluctance on the part of trusts to admit patients informally and leave them for management in the home/community environment; after all, the case is based on the patient being in a mental health care environment under the direct control of the NHS. Of course that
approach would lead to the argument that the “operational duty” should be extended to cover all those identified at risk.

Case law

Savage v South Essex Partnership NHS Trust (House of Lords)
Savage v South Essex Partnership NHS Trust (Mackay J)
Rabone v Pennine Care NHS Trust (Supreme Court)
Rabone v Pennine Care NHS Trust (Court of Appeal)

Legislation

Human Rights Act 1998