A human right to be detained? Mental healthcare after 'Savage' and 'Rabone'

Mohammad Shaiyan Rahman,[1] Nadya Wolferstan[2]

The Psychiatrist (2013), **37**, 294–296, doi: 10.1192/pb.bp.112.040980

[1]National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Manchester University
[2]Hempsons Solicitors, London

Correspondence to Mohammad Shaiyan Rahman (mohammad.rahman2@nhs.net)

First received 25 Jul 2012, final revision 19 Nov 2012, accepted 23 Nov 2012

Summary The UK courts have recently considered the management of suicidal patients in the cases of Savage and Rabone. As a result of these judgments, the case law has extended significantly the responsibilities of mental healthcare providers. In this article we discuss the repercussions of these landmark decisions which are likely to have significant consequences for mental health service providers in the UK.

Declaration of interest M.S.R. is employed by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). NCISH had no role in the conception or preparation of this article. The views expressed here are those of the author and do not necessarily reflect those of the NCISH. N.W. acted as the legal counsel for the NHS mental health trust in *Rabone v. Pennine Care NHS Foundation Trust* (2012). The views expressed here are those of the author and do not necessarily reflect those of Hempsons (solicitors).

In the UK, as well as in other high-income countries, healthcare providers and clinicians are held responsible for providing competent, evidence-based assessment and treatment. Assessment and treatment of patients with mental disorders falls under the remit of the Mental Health Act 1983 (as amended in 2007), which has specific provisions for detaining patients against their will under certain circumstances. This detention power over a psychiatric patient raises human rights issues which must be balanced with the duty of care owed to individual patients. UK courts have considered the psychiatric management of suicidal patients in the landmark cases of Savage[1] and Rabone.[2] As a result of these judgments, the balance may have tilted away from patient autonomy. The repercussions of these decisions are likely to extend beyond psychiatric practice and have an impact on healthcare delivery in general.

In this article, we discuss the background of these developments and highlight the key clinical and legal implications for mental health and other healthcare settings in light of research evidence and national policies.

Background

Savage v South Essex Partnership NHS Foundation Trust[1]

The European Court of Human Rights has imposed obligations on the Council of Europe member states to protect the lives of prisoners, immigrants in detention and conscripts, recognising that the State has forced these vulnerable classes of people into places of danger where it assumes control over individuals. The UK courts extended this duty to protect life to detained mental health patients in the case of Savage[1] (Box 1).

In this case, the court found that the National Health Service (NHS) trust had failed to take measures to avoid the 'real and immediate' risk that the patient posed to herself. This failure was distinct from duties owed under the law of negligence. The additional duty arose owing to the patient's vulnerability and the hospital's overall control over her activities.

Rabone v Pennine Care NHS Foundation Trust[2]

In the case of Savage,[1] a clear distinction was drawn between voluntary and detained psychiatric patients, as control of the detained patient was seen as comparable with that of a prisoner. This distinction was removed in the case of Rabone[2] as the court found that the difference between the voluntary and detained patient was not substantial (Box 2).

Box 1 Case summary of Mrs Savage

The patient was a middle-aged woman with a history of mental illness since the 1970s. She had one previous detention under Section 3 of the Mental Health Act 1983, in 2001, when she escaped from the ward and was found walking between the cars on a main road. The reason for this action was never fully understood, but it was assumed to be suicidal. She was eventually discharged into the community where she held a part-time job. In early 2004, following a deterioration of her mental state, she was detained under the Mental Health Act in an open, acute psychiatric ward and eventually was given day leave to spend time with her family. After several attempts to abscond from the ward in the preceding months, she succeeded in her attempts and died by suicide by throwing herself in front of a train. Before her death, she made one ambiguous reference to suicidal thoughts behind the reasons for wanting to leave the ward.

https://doi.org/10.1192/pb.bp.112.040980 Published online by Cambridge University Press

Box 2 Case summary of Ms Rabone

The patient was a female in her mid-20s with a history of depression. In March 2005, she attempted suicide and was admitted into hospital as a voluntary patient. Within 2 weeks, she made sufficient recovery to be discharged into the community, to go on holiday abroad with her family. Following a further attempt at cutting her wrists, she agreed to voluntary admission and was diagnosed with severe recurrent depressive disorder. She made one further suicidal attempt in April 2005 while an in-patient, and was considered to be at a risk of suicide. Following her request for home leave, she was assessed at a ward round with members of her family present. The treating consultant psychiatrist gave her 2-day leave over the weekend. On the second day, she died by suicide.

After Ms Rabone's death, the family's and NHS' experts agreed that the decision to send her on leave was negligent, and the family had previously accepted compensation for this negligent care. However, the parents argued that the NHS had additional duties under the Human Rights Act 1998 to protect the patient's life. Under the same law, they also sought additional compensation as victims. The newly formed UK Supreme Court, in its first medical case, agreed.

Implications for clinicians and mental healthcare providers

A doctor has a duty of care to his patient and has ethical and legal obligations which require him to act in their best interests. In addition to the individual doctor's responsibility, NHS trusts can be held responsible for the clinicians employed by them. Furthermore, as a government organisation, the NHS has duties relating to patients' human rights. Therefore, NHS trusts can be held responsible under common law negligence and the Human Rights Act 1998 for the actions of the doctors working within them.

In the case of Rabone, the NHS argued that existing regulatory systems satisfied the hospital's duty (as a government organisation) to protect lives in a case of clinical negligence. It relied on the decision of *Powell v UK*,[3] a case that examined the failure to diagnose Addison's disease in a child. In the Powell judgment, the European Court of Human Rights held that an error of clinical judgement alone did not amount to a breach of human rights. In the case of Rabone, the NHS had admitted negligence and argued that it had already settled the family's claim and that there was no need for a further compensation under the Human Rights Act 1998. These arguments were rejected by the UK Supreme Court. We analyse the legal arguments and discuss certain clinical implications of these rulings.

Risk assessment and prediction of fatal outcomes

In the cases of Savage and Rabone, the courts have drawn distinctions between the roles of the healthcare system and of the individual clinicians in addressing the risk posed by patients, which are in addition to the standards for negligence claims. To be considered compliant with Article 2 of the European Convention on Human Rights, a healthcare organisation must put in place policies and procedures which are aimed at providing high-quality care and safeguarding patients' safety. These may include recruiting competent staff, facilitating the maintenance of high professional standards of practice, and implementing procedures aimed at reducing the number of deaths by suicide within the organisation.

In addition to organisational safeguards, in the case of Rabone the court established a new test of the individual clinician's responsibility to mitigate 'real and immediate' risk. Lord Dyson described 'real' risk as a 'substantial or significant risk and not a remote or fanciful one' (paragraph 38). Furthermore, a risk need not be imminent to be 'immediate' but it needs merely to be 'present and continuing' (paragraph 39). A high degree of risk does not have to be present as long as the risk can be perceived as a continuing threat to the health and safety of the patient. The wording of the judgment suggests a requirement of a degree of 'foresight' on the part of clinicians and emphasises the need for 'proper risk assessment', indicating that a risk assessment tool may have to be used (paragraph 107).

There is some support from meta-analysis and population-level studies that systematic, population-wide prevention strategies are likely to reduce suicide in the general population[4] as well as in mental health services.[5] However, it does not follow that prediction is necessary for prevention. Applying population-derived risk factors to predict individual risk is likely to provide inaccurate estimation of risk,[6,7] even for those patients who are considered to be at a high risk of suicide.[8,9] It is worthwhile to note that the National Institute for Health and Care Excellence guideline for longer-term management following self-harm suggested the use of risk assessment tools only as an adjunct to the clinical assessments as they were not considered sufficiently precise to be used as predictive tools.[10]

Whereas validated tools can help guide clinical decisions,[11] most of the psychiatric risk assessment tools that proliferated in the NHS over the past two decades are perceived to have limited utility and validity.[12] They may take significant time to complete[13] and their usefulness in routine clinical practice has been frequently questioned.[13,14] Furthermore, owing to the inherent trade-off between sensitivity and specificity of any assessments or tools, trying to provide restrictive care for all 'truly' suicidal patients is likely to increase the number of patients who are 'falsely' designated as high risk and receive restrictive care,[6–10] perhaps unethically so.

In summary, emphasis on 'real and immediate' risk which could be 'foreseen' is likely to encourage clinicians to adopt defensive medical practices, without any discernible benefits to the patients.

Capacity of voluntary patients

In assessing vulnerability, the court in *Rabone* considered the issue of capacity in voluntary patients. In this particular case, there was no formal capacity assessment, as detention under the Mental Health Act in England and Wales does not require consideration of mental capacity (cf. the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003).[15] Mental capacity is determined by applying the principles of the Mental Capacity Act 2005. The patient was admitted voluntarily but the court felt that 'she

https://doi.org/10.1192/pb.bp.112.040980 Published online by Cambridge University Press

might well lack the capacity to make an autonomous decision to take her own life' (paragraph 105). The judgment seems to indicate that by simply having a mental illness, such as depression, patients are more likely to lack capacity and decision-making power. This contrasts with the guidance provided by the *Code of Practice* for the Mental Capacity Act where there is a presumption of capacity.[16] Research also suggests that a significant number of voluntary patients admitted to psychiatric in-patient units have decision-making capacity.[17]

The Supreme Court recognised that autonomous individuals have a right to take their own life if that is what they truly want, but from the cases of Savage and Rabone it appears that the presumption of capacity is reversed if the individual has a history of mental illness. The abandonment of the presumption of capacity may further stigmatise this vulnerable group.

Increase in litigation and compensation

In the UK, the parents of an adult child cannot obtain financial compensation for bereavement under the law of negligence. In the case of Rabone, the patient's parents could only recover additional compensation for their distress and anguish by obtaining a declaration of breach of human rights. In practical terms, the Rabone decision is likely to inflate awards for negligence claims related to the suicide of a vulnerable patient. Furthermore, there are no potential limits to those who can claim under the Human Rights Act 1998, as long as a potential 'victim' can establish a close link with the deceased. At the time of unprecedented squeeze on financial resources within the healthcare sector, this development is unlikely to be beneficial to mental health services.

Conclusions

The European Convention on Human Rights has introduced additional legal principles which sit outside the UK common law, including the right to life (Article 2) and the right to liberty (Article 5), which may conflict and compete in healthcare context. Developed in the aftermath of the Second World War, these laws were designed to safeguard individual freedom and dignity. Ironically, there now appears to be an enforceable human right to be detained.

The two judgments discussed are likely to encourage defensive practice and increase the number of claimants against the NHS and the compensation paid out. They also leave clinicians in limbo about the capacity of patients and risk assessment when they are under the care of a mental healthcare provider. The judgment in the Rabone case has already had an impact on the accident and emergency services, where an NHS trust was criticised for not assessing a vulnerable young man who self-presented, and then left the department before a review could be carried out and died by suicide.[18] We believe that this trend is likely to grow.

About the authors

Mohammad Shaiyan Rahman, Clinical Research Fellow, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), Centre for Mental Health and Risk, Jean McFarlane Building, University of Manchester, Oxford Road, Manchester. **Nadya Wolferstan**, Partner, Hempsons Solicitors, London.

References

1 *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74.

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

3 *Powell v United Kingdom* (2000) 30 EHRR CD 362.

4 Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, et al. Suicide prevention strategies. *JAMA* 2005; **294**: 2064–74.

5 While D, Bickley H, Roscoe A, Windfuhr K, Rahman S, Shaw J, et al. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997–2006: a cross-sectional and before-and-after observational study. *Lancet* 2012; **379**: 1005–12.

6 Kapur N. Evaluating risks. *Adv Psychiatr Treat* 2000; **6**: 399–406.

7 Rose G, Khaw T-H, Marmot M. *Rose's Strategy of Preventive Medicine*. Oxford University Press, 2008.

8 Large M, Sharma S, Cannon E, Ryan C, Nielssen O. Risk factors for suicide within a year of discharge from psychiatric hospital: a systematic meta-analysis. *Aust NZ J Psychiatry* 2011; **45**: 619–28.

9 Large M, Smith G, Sharma S, Nielssen O, Singh SP. Systematic review and meta-analysis of the clinical factors associated with the suicide of psychiatric in-patients. *Acta Psychiatr Scand* 2011; **124**: 18–29.

10 National Institute for Health and Clinical Excellence. *Self-Harm (Longer Term Management)* (CG133). NICE, 2011.

11 Department of Health, National Risk Management Programme. *Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*. Department of Health, 2007.

12 Hawley CJ, Littlechild B, Sivakumaran T, Sender H, Gale TM, Wilson KJ. Structure and content of risk assessment proformas in mental healthcare. *J Ment Health* 2006; **15**: 437–48.

13 Hawley CJ, Gale TM, Sivakumaran T, Littlechild B. Risk assessment in mental health: staff attitudes and an estimate of time cost. *J Ment Health* 2010; **19**: 88–98.

14 Large MM, Nielssen OB. Probability and loss: two sides of the risk assessment coin. *Psychiatrist* 2011; **35**: 413–8.

15 Lyons D. New mental health legislation in Scotland. *Adv Psychiatr Treat* 2008; **14**: 89–97.

16 Department for Constitutional Affairs. *Mental Capacity Act 2005 Code of Practice*. TSO (The Stationery Office), 2007.

17 Owen GS, Szmukler G, Richardson G, David AS, Hayward P, Rucker J, et al. Mental capacity and psychiatric in-patients: implications for the new mental health law in England and Wales. *Br J Psychiatry* 2009; **195**: 257–63.

18 *E (as PR of the estate of M Deceased) v St George's NHS Trust, Wandsworth Teaching Primary Care Trust and South West London Mental Health Trust* (2012) LTLPI 3/5/12.

https://doi.org/10.1192/pb.bp.112.040980 Published online by Cambridge University Press