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 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.

Background

Savage v South Essex Partnership NHS Foundation Trust

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 (Box 1).

Savage v South Essex Partnership NHS Foundation Trust

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 (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. The UK courts have considered the psychiatric management of suicidal patients in the landmark cases of Savage and Rabone. 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.

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

Mohammad Shaiyan Rahman, Nadya Wolferstan

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 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

In the case of Savage, 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 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.
2 of the European Convention on Human Rights, negligence claims. To be considered compliant with Article
the individual clinicians in addressing the risk posed by
In the cases of Savage and Rabone, the courts have drawn
implications of these rulings.
arguments were rejected by the UK Supreme Court. We
family’s claim and that there was no need for a further
judgement alone did not amount to a breach of human
NHS had additional duties under the Human Rights Act
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 responsi-
bility, NHS trusts can be held responsible for the clinicians
employed by them. Furthermore, as a government organisa-
tion, 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, 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 as well as in mental health services.
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, even for those patients who are
considered to be at a high risk of suicide. 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.
Whereas validated tools can help guide clinical
decisions, 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. They may
take significant time to complete and their usefulness in
routine clinical practice has been frequently questioned.
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, 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). 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

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**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 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.
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 stigmatisate 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.

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