First Do No Harm. Second Save Life?

Neil Allen[1]

Some 50,352 people killed themselves in England and Wales between 1997 and 2006.[2] Reducing this human toll of inner turmoil has long been a key national priority for health services.[3] But protecting us from ourselves is no easy task when the apparent benefits of escaping life outweigh the agony of having to endure it. Often it is too late for someone's suicidal ideation to come to the attention of the authorities. Sometimes, however, the risk to life is more readily apparent: on average, 1300 patients already known to mental health services commit suicide every year.[4]

Our moral and legal obligations surrounding suicide arguably stand poles apart. English law does not encourage good Samaritanism. Just as the priest and Levite walked past the wounded man on their way from Jerusalem to Jericho,[5] so too are we permitted to walk past the suicidal man from Jevington to Jarrow. To idly watch a rescuable suicidist leap from a cliff top might raise a moral eyebrow. But such omissions are perfectly lawful at common law[6] because foreseeing death does not trigger any duty of care to prevent it.[7] Yet such obligational divergence does not deter volunteers from preventively patrolling the infamous suicide spot of Beachy Head.[8]

The European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 is slowly realigning the moral and legal obligations of public bodies to protect life, with Article 2 imposing three duties upon the state. Firstly, a negative duty to refrain from taking life, save in prescribed exceptional circumstances. Secondly, a procedural obligation to investigate deaths for which it might bear some responsibility.[9] Finally, there is a positive obligation to take steps to protect our lives which is the exclusive focus of this paper.

1 *Barrister, University of Manchester and Young Street Chambers.* *The author would like to thank an anonymous referee and Dr John Coggon for their comments on an earlier draft.*

2 *Annual Report, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, University of Manchester (July 2009).*

3 *The Department of Health aimed to reduce the suicide rate by at least 20% by 2010 (National Suicide Prevention Strategy for England, Department of Health, 2002).*

4 *Avoidable Deaths: Five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, University of Manchester (December 2006) at pp14 and 32.*

5 *Luke 10: 30–32, Revised Standard Version of the Bible.*

6 *Smith v. Littlewoods Organisation Ltd [1987] AC 241, 271; Yuen Kun Yeu v. Attorney General of Hong Kong [1988] AC 175, 192.*

7 *Dorset Yacht Co. Ltd v. Home Office [1970] AC 1004, 1037–1038; Hill v. Chief Constable of West Yorkshire [1989] AC 53, 60; Mitchell v. Glasgow City Council [2009] 1 AC 874, 890.*

8 *See www.bhct.org.uk: June 2009 was their busiest month since 2004.*

9 *See R (on the application of JL) v. Secretary of State for Justice [2009] 1 AC 588; R (on the application of Allen) v. HM Coroner for Inner North London [2009] EWCA Civ 623; R (on the application of P) v. Secretary of State for Justice [2009] EWCA Civ 701.*

Savage[10] Circumstances

Carol Savage was one of 166 psychiatric in-patients who took their own lives in 2004.[11] The day after voluntarily attending Runwell hospital, she was detained for treatment under section 3 of the *Mental Health Act 1983* ('the 1983 Act') with a diagnosis of paranoid schizophrenia. Having made a number of attempts to leave the open acute psychiatric ward, checks on her whereabouts were prescribed for every 30 minutes. Believed to be at low risk of suicide, Mrs Savage was allegedly left unsupervised on hospital grounds, from which she was able to abscond, walking two miles to Wickford railway station before fatally jumping in front of a train.

With the coroner's jury having concluded that the hospital's preventive precautions were "inadequate", her daughter claimed that the trust had breached her mother's right to life by allowing her to escape. The House of Lords[12] therefore had to determine the test for establishing the circumstances in which a detained patient's suicide would violate Article 2. Substantive opinions were delivered by Lord Rodger and Baroness Hale, with whom Lords Walker, Neuberger and Scott concurred, the last handing down a short judgment.

Lord Rodger noted[13] that Article 2's positive obligation to protect life comprised three duties. The primary duty required the state to establish an effective system of criminal law to deter those who threatened life, backed up by law enforcement machinery to prevent, suppress and punish its breaches. Secondly, general protective measures may be required to secure the health and well-being of, for example, prisoners and patients ('the *Powell* duty'[14]). These complemented the primary duty and typically obliged the relevant authorities to recruit competent staff, maintain high professional standards, and put in place suitable systems of work so as to protect life. Thirdly, in appropriate circumstances, an operational duty to protect the life of a specific individual may be imposed which was "distinct from, and additional to"[15] that general duty ('the *Osman* duty'[16]).

Runwell hospital clearly owed the *Powell* duty to take general precautions which mirrored the position at common law. Failure to do so could amount to both negligence and a breach of Article 2. If these general steps were taken but some medical error nevertheless resulted in death, there may be liability in negligence but not under Article 2. With hospital authorities and their staff already subject to this general obligation, Lord Rodger could not see why they should not also be under the "usual complementary operational obligation"[17] to try to prevent a particular suicide. In fact, there was no valid reason for them not to. Priority had to be given to saving life in such critical circumstances; otherwise negligence and a violation of Article 2 could result.

Baroness Hale reached the same conclusion but covered "somewhat different ground along the way". The positive obligations generally required proper systems to be put in place. But in some circumstances a protective duty towards a particular individual was triggered, although not by ordinary medical negligence alone. There was "little doubt that it [was] right in principle" to apply the *Osman* test to

10 *The Court of Appeal consideration of the circumstances surrounding the death of Carol Savage ([2007] EWCA Civ 1375) was reviewed by the author in the Journal of Mental Health Law, May 2008 pp 93–100.*

11 *Ibid. n2 at p25.*

12 *Savage v. South Essex Partnership NHS Foundation Trust [2009] 1 AC 681. For commentary, see N. Allen, 'Saving Life and Respecting Death: A Savage Dilemma' (2009) 17(2) Medical Law Review 262 and N. Allen, 'Protecting the Suicidal Patient' (2008) Journal of Mental Health Law 93.*

13 *At [30] and [69].*

14 *Powell v. United Kingdom (2000) 30 EHRR CD362.*

15 *At [72].*

16 *Osman v. United Kingdom (1998) 29 EHRR 245.*

17 *At [65]-[66].*

patients detained under the 1983 Act. After all, the ECtHR had recognised the authorities' obligation to provide necessary healthcare to those detained and it was "difficult to distinguish between different classes of people deprived of their liberty by the state."[18] Indeed, more of their ordinary civil rights were deprived as compared with other forms of detainee. Thus, if the hospital authority knew, or ought to have known, of a real and immediate risk that Mrs Savage would commit suicide, Article 2 imposed an operational obligation on them to do all that could reasonably be expected to prevent it.

When to Save A Life

Article 2's positive limb is broad-shouldered. It applies to "any activity, whether public or not, in which the right to life may be at stake".[19] But, in principle, it falls within the state's margin of appreciation to choose the means for fulfilling its tripartite set of obligations.[20] English criminal law is expected to satisfy the demands of the primary duty, although not all threats to life are deterred; suicide being the obvious example.[21] In fact, criminalising all actions and omissions that put life at risk would no doubt violate other Convention rights.

The general duty is more practical than the primary duty and requires the state to make regulations compelling public authorities to adopt appropriate measures for securing high professional standards and the protection of life. It is undoubtedly owed in the sphere of public and private healthcare as regards the acts and omissions of health professionals.[22] That is to say, *all* hospital patients – detained or otherwise – are its beneficiaries. In the community, emergency services, including mountain and sea rescue facilities, similarly owe this duty to those whose lives are knowingly in danger. But it does not obligate any specific result. It may, for example, require a regulatory framework to be put in place for rescuing mountain climbers in distress; but it does not demand a deadline within which aerial ambulances must reach them.[23]

The operational duty can be far more onerous. Where others threaten the right to life, the ECtHR has recognised this obligation in a diverse range of circumstances: from policing,[24] detention release,[25] and domestic violence,[26] through to the management of dangerous activities[27] and even political journalism.[28] Where someone threatens their own right to life, Strasbourg has so far only had the opportunity to recognise the obligation being owed to prisoners[29] and army conscripts.[30]

But how far down the path of suicide prevention might the positivity of Article 2 be prepared to go? *Savage* acknowledged the duty being owed to psychiatric patients detained for treatment. Logic would

18 *At [101].*

19 *Furdík v. Slovakia (2009) 48 EHRR SE9 146, 157; Öneryildiz v. Turkey (2005) 41 EHRR 20 at [71].*

20 *Furdík ibid. at 157.*

21 *Suicide Act 1961 s1. Assisting suicide may also not be prosecuted on public policy grounds: R (on the application of Purdy) v. Director of Public Prosecutions [2009] 3 WLR 403 led the DPP to revise his policy.*

22 *See Dodov v. Bulgaria (2008) 47 EHRR 41 at [70], [79]-[83] and [87]; Byrzykowski v. Poland (2008) 46 EHRR 32 at [104] and [106]; Vo v. France (2005) 40 EHRR 12 at [89]-[90]; Tarariyeva v. Russia (2009) 48 EHRR 26 at [74]; Powell v. United Kingdom (2000) 30 EHRR CD 362, 364.*

23 *Furdík ibid n19.*

24 *Ibid n16.*

25 *Tomaši v. Croatia (Application no. 46598/06, 15 January 2009); Mastromatteo v. Italy (Application no. 37703/97, 24 October 2002); Bromiley v. United Kingdom (Application no. 33747/96, 23 November 1999).*

26 *Opuz v. Turkey (Application no. 33401/02, 9 June 2009).*

27 *Öneryıldız v. Turkey (2004) 41 EHRR 325; LCB v. United Kingdom (1998) 27 EHRR 212.*

28 *Gongadze v. Ukraine (2006) 43 EHRR 44.*

29 *Keenan v. United Kingdom (2001) 33 EHRR 913.*

30 *Kilnic v. Turkey (Application no. 40145/98, 7 June 2005); Ataman v. Turkey (Application no. 46252/99, 27 April 2006).*

extend it to those detained for assessment,[31] in emergency circumstances,[32] on a temporary holding basis,[33] and under the criminal provisions in Part 3 of the 1983 Act. Might it even extend beyond detention? That was the key issue in *Rabone v. Pennine Care NHS Trust*[34] which was the first reported mental health case to test the boundaries of the *Savage* decision.

Informal Patients

Melanie Rabone was informally admitted to a locked ward at Stepping Hill hospital suffering from depression. She was subject to 15 minute observations having attempted suicide three times in the previous seven weeks. With her mood appearing to lift, the psychiatrist granted her request for home leave. The following day she hanged herself from a tree in Lyme Park. The trust accepted negligence but denied any breach of her right to life.

Clearly the general obligation was owed by the trust: institutional precautions therefore had to be taken to protect patients from committing suicide. For example, competent staff had to be recruited, high professional standards maintained, and suitable systems of work put in place. Ms Rabone's psychiatrist was negligent. The medical treatment she received was fragmented and discontinuous. Staff had not been trained in the use of the trust's new care programme approach policy. Old forms were still being used. And no documented risk reassessment was undertaken before leave was granted, with no support plan having been put in place. Yet, according to Simon J., the general duty conferred by Article 2 had not been breached: the circumstances "fell far short of a failure to have a system for the assessment of risk of suicide in mental patients".[35] Clinical misjudgement and implementation of the system could be faulted; but not the system itself.

Could the operational duty have been owed to Ms Rabone who, it was held, was not deprived of her liberty? In *Savage,* Baroness Hale had deliberately left this question open.[36] Arguably Lord Rodger had not for "[a]ny auction in the comparative vulnerability of prisoners, voluntary patients, and detained patients would be as unedifying as it is unnecessary."[37] But Simon J. considered *Savage* to have drawn a distinction "between those who are detained and lack capacity, and those who are not detained and have capacity to consent or object to treatment". The House of Lords had "implicitly confined" the duty to compulsorily detained patients.

A growing body of empirical research suggests that some patients detained under the 1983 Act in fact retain capacity to consent to admission and treatment.[38] Conversely, many informal patients lack such capacity.[39] So to rely upon incapacity to justify the operational duty does not provide the answer to the *Osman* question. Nor, it is respectfully submitted, does the fact of being detained; otherwise the ECtHR

31 *Pursuant to s 2 of the 1983 Act.*

32 *Ibid. ss 4, 135 or 136.*

33 *Ibid. s 5.*

34 *[2009] EWHC 1827.*

35 *Ibid. at [81].*

36 *Ibid. n12 at [102].*

37 *Ibid. at [49]. His Lordship noted that in Powell, where the patient was not detained, the ECtHR might have recognised the operational duty, in well defined circumstances, to prevent a patient from committing suicide.*

38 *J. Bellhouse et al, 'Capacity-based mental health legislation and its impact on clinical practice: 1) Admission to Hospital' (2003) Journal of Mental Health Law 9; J. Bellhouse et al, 'Capacity-based mental health legislation and its impact on clinical practice: 2) Treatment in Hospital' (2003) Journal of Mental Health Law 24. See also, D. Okai et al, 'Mental capacity in psychiatric patients' (2007) 191 British Journal of Psychiatry 291.*

39 *D. Okai ibid.*

would not have recognised the duty being owed to suicidal army conscripts.[40] Thus, its scope cannot be limited *solely* to those deprived of their liberty by the state.[41]

Simon J. also rejected the assumption of responsibility approach: "All hospitals assume responsibility for the safety and treatment of patients; but that does not mean that the operational duty under Article 2.1 arises in relation to all patients. On the contrary, it is clear that it does not." Instead, the "important factor" was "the exercise of coercive powers over an individual who (by reason) [*sic*] of the exercise of such powers is particularly vulnerable". This was missing and so the duty could not be owed.

The 'coerced vulnerability' justification for recognising the operational duty is novel and reflects the growing realisation that "[i]n many respects human rights law is all about the protection of the individual from undue coercion".[42] Unfortunately, however, Simon J. does not expand upon it, save to say that "voluntary mental health patients can leave when they want, are not deprived of any Convention rights and have input in their own medical treatment". Szmukler and Appelbaum[43] have sought to particularise the concept of coercion by describing a "spectrum of pressures" ranging from persuasion, interpersonal leverage, and inducements or offers, through to threats and the use of compulsion. Why was Ms Rabone not subject to the necessary degree of coercion, bearing in mind that she would have been detained under the 1983 Act had she attempted to leave the ward? Would her comparative vulnerability with compulsorily detained patients not be as unedifying as it is unnecessary?[44]

Where life is threatened by others, the operational duty is capable of being owed in circumstances where the state is not exercising coercive powers. In *Mitchell v. Glasgow City Council,*[45] for example, a man repeatedly threatened to kill his next-door neighbour. Both were council tenants. The local authority convened a meeting with the aggressor, at which he lost his temper and became abusive. An hour later he killed the neighbour. The majority of the House of Lords asked the *Osman* question but decided that the duty had not been triggered because the local authority could not have known of any real and immediate risk to his life. Nothing was said or done on the day to alert them of any attack, let alone a risk of death.

Should the right to life be protected differently when life is threatened by one's own actions? Ms Kerrie Wooltorton suffered from personality disorder.[46] She had ingested antifreeze before accepting lifesaving dialysis on up to nine previous occasions. She swallowed it a final time, called the ambulance services and, it is reported, capacitously refused treatment, knowing that she would die. Did the consultant renal physician violate Article 2 by failing to take reasonable steps to avert the real and immediate risk to life? Would it make a difference if someone else had administered the poisonous substance if she was still refusing treatment?

40 *Ibid. n30.*

41 *See also Bulut v. Turkey (Application no. 51480/99, 3 July 2006) at [32].*

42 *G. Richardson, 'Coercion and human rights: A European perspective' (2008) 17(3) Journal of Mental Health 245. For the relevance of coercion to Article 5 see N. Allen, 'Restricting movement or depriving liberty?' (2009) Journal of Mental Health Law 19.*

43 *G. Szmukler and P.S. Appelbaum, 'Treatment pressures, leverage, coercion and compulsion in mental health care' (2008) 17(3) Journal of Mental Health 233. See also R. Wynn, 'Coercion in psychiatric care: clinical, legal, and ethical controversies' (2006) 10(4) International Journal of Psychiatry in Clinical Practice 247.*

44 *In relation to the inherent jurisdiction, vulnerability has been held to extend to those who are incapacitated "by reason of such things as constraint, coercion, undue influence or other vitiating factors" (Re SA (vulnerable adult with capacity: marriage) [2006] 1 FLR 867 at [79]). See M.C. Dunn et al, 'To Empower or to Protect? Constructing the 'Vulnerable Adult' in English Law and Public Policy' (2008) 28 Legal Studies 234.*

45 *[2009] UKHL 11.*

46 *C. Dyer, 'Coroner rules that treating 26 year old woman who wanted to die would have been unlawful' (2009) 339 British Medical Journal 4070; S.A.M. McLean, 'Live and let die' (2009) 339 British Medical Journal 4112.*

Conclusions

English law still has a long way to go in clarifying the circumstances in which public authorities will violate the right to life by failing to avert death. Rather than relying upon frail distinctions like detention and capacity, perhaps more thought should be given to the relationship between the general and operational duties of Article 2. Are they "distinct from" *or* "additional to" each other? Whether the source of the risk to life should affect the relevance of the operational duty must then be considered. Must the state do more to prevent threats from others than it does to prevent threats from oneself?

Even if concepts like coerced vulnerability are employed to justify the extension of the *Osman* duty to those not in detention, they only relate to the applicability of the duty. *Savage* recognised that the threshold for triggering that duty is high[47] which is hardly surprising. Indeed, the ECtHR is wary of imposing disproportionate burdens on public authorities.[48] But once that threshold is reached, establishing a breach of the duty is harder than establishing negligence.[49] Health authorities will therefore find that it is "not particularly stringent"[50] to establish a defence because other Convention rights must be taken into account in determining which steps it was reasonable to expect them to take.

It follows that the operational duty "should not persuade the professionals to behave any more cautiously or defensively than they are already persuaded to do by the ordinary law of negligence".[51] Therapeutic risks must be taken despite risks to life. Runwell hospital was thus "entitled, and perhaps bound, to allow Mrs Savage a degree of unsupervised freedom that did carry with it some risk that she might succeed in absconding."[52] Doctors must first do no harm. But saving life at all costs does not seem to come second.

47 *Savage ibid. n12 at [78] per Baroness Hale. See also Van Colle v. Chief Constable of the Hertfordshire Police (Secretary of State for the Home Department intervening) [2008] 3 WLR 593 at [66] per Lord Hope.*

48 *Osman ibid. n16 at [116]; Keenan ibid. n27 at [90]; Akdo du v. Turkey (Application No. 46747/99, 18 October 2005) at [45]; Uçar v. Turkey (Application No. 52392/99, 11 April 2006) at [84]; Renolde v. France (Application No. 5608/05, 16 January 2009) at [82].*

49 *Ibid. n12 at [99]. The House of Lords has yet to consider the appropriate standard of proof in this regard.*

50 *Ibid. at [41] per Lord Rodger.*

51 *Ibid. at [100] per Baroness Hale.*

52 *Ibid. at [13] per Lord Scott.*