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Quantum—appeal—self-inflicted death of voluntary patient—obligation of NHS Trust—European Convention on Human Rights—whether breach of art.2—operational obligation—investigatory obligation—victim status—limitation

IN THE SUPREME COURT OF THE UNITED KINGDOM

ON APPEAL FROM HER MAJESTY'S COURT OF APPEAL (CIVIL DIVISION) (ENGLAND)

B E T W E E N :

(1) RICHARD RABONE
(In his own right and as Administrator of the Estate of Melanie Rabone, Deceased)

(2) GILLIAN RABONE
Appellants

-and-

PENNINE CARE NHS TRUST
Respondent

CASE FOR INQUEST, JUSTICE, Liberty AND Mind

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The issues

1. The Interveners are broadly supportive of the submissions made in the Appellant's Case in relation to the first issue, in particular the conclusions at paras 37-39, and make the additional submissions set out below.

2. The Interveners will also make brief submissions on the second issue (whether 'victim' status has been lost).

The Interveners' approach on this appeal

3. The Interveners will develop their submissions under the following headings:

   (1) The consequences of the Court of Appeal's ruling (para 4).

   (2) The prevalence and preventability of self-inflicted death among mentally disordered patients (para 5).

   (3) The artificiality of the distinction between informal patients and those who have been formally detained under the Mental Health Act 1983 (MHA) (paras 6-7).

(4) Positive obligations under the Convention (paras 8-50).

(i) The threshold requirement: whether Article 2 is 'applicable'.

(ii) Operational obligations under Article 2 and the balancing exercise.

(iii) Relevant factors in the balancing exercise.

(iv) Positive obligations in the healthcare sphere.

(5) Conclusions and submissions in relation to the first issue (para 51).

(6) Submissions on the second issue (paras 52-56).

(1) The consequences of the Court of Appeal's decision

4. The families the Interveners speak to whose loved ones have taken their own lives consistently say that what they want, above all else, is to find out exactly what happened and to ensure that lessons are learned for the future. If there is no operational obligation under Article 2 there is usually no requirement for an enhanced Article 2 investigation triggering a *Middleton*-type inquest in such cases. There will be little prospect of such an investigation through civil proceedings. There are strict limitations upon who may bring claims under the Fatal Accidents Act and, unless the deceased died with dependants, the claim will have little, if any, monetary value. Legal aid will not be given in those circumstances.

(2) The prevalence and preventability of self-inflicted death among mentally disordered patients

5. Informal patients are at as great a risk of self-inflicted death as formally detained patients (114 of 164 self-inflicted deaths a year, Annex 1, paras 3-4), and such deaths may be equally preventable (Annex 1, para 5). The death of an informal patient in the closed environment of a psychiatric hospital may require as much by way of investigation by the state in order to ascertain the facts of the death, to identify those who are responsible and for lessons to be learned as the death of a detained patient. Policy on suicide prevention does not distinguish in terms of category of psychiatric in-patient; the law does not distinguish between them in

relation to the common law duty of care and should not do so in terms of Article 2.

(3) The artificiality of the line that distinguishes the position of informal patients from formally detained patients;

6. The approach adopted by the Court of Appeal draws an artificial line between informal patients and formally detained patients, for reasons explained in Annex 1.

7. Patients who have not been formally detained are in theory free to leave and to refuse medical treatment. There may be an appearance of consent but that is often illusory as it has been given against a backdrop of the existence of formal powers to detain under the MHA and the knowledge that these could be used at any time. In some cases the patient may lack capacity to consent (Annex 1, paras 12-17). Informal patients may be subject to the same coercive and restrictive measures as detained patients (Annex 1, paras 18-22) which may amount to a *de facto* deprivation of liberty (Annex 1, para 23) and which certainly restrict their freedom of movement. These measures include locked doors on wards, highly structured activities, close levels of monitoring and observation, and the use of restraint and seclusion. This group is also disadvantaged by the lack of legal safeguards available to formally detained patients (Annex 1, para 24).

(4) Positive obligations under the Convention

8. We identify, below, the general principles governing the nature and application of positive obligations under the Convention before turning to consider the specific context of operational obligations in a healthcare context.

(i) The threshold criteria: whether a Convention Article is 'applicable'

9. In determining whether there has been a violation of a positive obligation in any given case, the European Court of Human Rights (the 'ECtHR') carries out a two stage exercise. First, it considers whether the Convention right in question is 'applicable'; if so, it determines whether there has been 'compliance' with the Article (as it does in relation to any allegation of the violation of a Convention right: see Karen Reid, 'A Practitioner's Guide to the European Convention on Human Rights', 3rd Edition, para I-072).

10. In determining whether the Convention right is 'applicable' the ECtHR considers whether the acts or omissions complained of fall within the 'ambit' of the Article: *Őneryildiz v. Turkey* [GC] (2005) 41 EHRR 20, para 74. That is a relatively low 'threshold' test: *ibid* para 71:

> This obligation must be construed as applying in the context of any activity, whether public or not, in which the right to life may be at stake, and *a fortiori* in the case of industrial activities, which by their very nature are dangerous.

11. In reaching that conclusion the ECtHR rejected the submission made by the Turkish Government that Article 2 was not applicable and that 'responsibility for actions that were not directly attributable to its agents could not extend to all occurrences of accidents or disasters and that the … applicability of Art. 2 should be … restrictive'. The ECtHR held that the factors the government relied upon for its submission that Article 2 was inapplicable were only relevant at the second stage, when the merits of the case were examined (para 73).

12. The ECtHR has since observed that the Grand Chamber's decision in *Őneryildiz* developed the concept of positive obligations it had established in *Osman v United Kingdom* (2000) 29 EHRR 245. In *Watts v United Kingdom* (2010) 51 EHRR SE 66, para 82, in the context of an argument that the closure of a care home put at risk the lives of its elderly residents, the ECtHR said:

> Although the Court originally explained that this positive obligation arose where there was a risk to life "from the criminal acts of another individual" (*Osman*), it has since made clear the positive obligations under art. 2 are engaged in the context of any activity, whether public or not, in which the right to life may be at stake.

13. In deciding whether Article 2 is 'applicable', the 'sphere of application of Art. 2 of the Convention cannot be interpreted as being limited to the time and direct cause of the individual's death' (*Dodov v Bulgaria* (2008) 47 EHRR 41, para 70). The ECtHR will examine the compliance of any acts or omissions which may be said to have been part of the 'chains of events' leading to the loss of life (*Dodov*, para 70).

14. The Interveners observe that those who are admitted to psychiatric hospital for medical treatment are at a significant risk of self-inflicted death, whether they are formally detained or informal patients. Informal patients are at as great a risk of self-inflicted death as formally detained patients and those deaths are equally preventable (Annex 1, paras 3-5). The admission, treatment and discharge of informal patients is therefore an activity in which 'the right to life is at stake' and Article 2 is applicable.

(ii) Operational obligations: the balancing exercise

15. Once satisfied that the conduct complained of falls within the 'ambit' of a Convention right, the ECtHR goes on to consider the merits of the claim ('compliance'). At this stage the ECtHR considers the State's compliance with both the primary substantive obligation (to put in place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life) and the operational obligation. This case is concerned only with the second obligation.

16. In certain "well-defined" circumstances, States may be under a positive obligation under Article 2 to take operational measures to protect an individual whose life is at risk[1]. At the merits or compliance stage, the ECtHR will consider whether the victim was at a real and immediate risk to his life; whether the authorities knew or ought to have known of that risk; and whether the authorities failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (the *Osman* criteria).

17. In determining whether the authorities have failed to take reasonable measures the Court conducts a balancing exercise that is indistinguishable from that it carries out when deciding if an interference with a qualified right, such as Article 8, is justified (see Karen Reid, para I-067)[2]. It carries out a global assessment, taking into account all the relevant factors, having regard to the fair balance that has to be

[1] *Osman v United Kingdom*, para 115

[2] The Court's approach applies to the so-called 'absolute' rights like Articles 2 and 3 as well as to the 'qualified' rights such as those under Articles 8-11. A further consequence of this approach is that the 'balancing exercise' is conducted only once, whether the obligation is said to arise under an absolute right (such as Article 2 or 3) or a qualified right such as Articles 8-11. If a breach of a positive obligation is found under, for example, Article 8(1), that is sufficient for the purposes of a finding of a violation: the Court does not then go on to consider the balancing exercise under Article 8(2) (*Storck v Germany* (2006) 43 EHRR 6, para 151).

struck between the general interest of the community and the interests of the individual[3]. The ECtHR has repeatedly emphasized that the operational obligation "must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities, so not every risk to life will give rise to a positive obligation of this kind" (*Osman*, para 116).

18. Relevant factors in the balancing exercise include 'the harmfulness of the phenomena inherent in the activity in question, the contingency of the risk to which the applicant was exposed by reason of any life-endangering circumstances, the status of those involved in bringing about such circumstances, and whether the acts or omissions attributable to them were deliberate' (*Őneryildiz*, paras 73 and 107). Other relevant factors in the balancing exercise include the rights and freedoms of the individual and of others as well as resource and policy considerations. Thus, for example:

    (1) Prison authorities will not be expected to adopt protective measures in the case of a patient at risk of self-inflicted death if those would disproportionately restrict the individual's autonomy (*Keenan*, para 91).

    (2) In the context of the prison authorities' obligations not to release dangerous individuals from prison, 'the merit of measures – such as temporary release – permitting the social reintegration of prisoners even where they have been convicted of violent crimes' are relevant (*Mastromatteo v Italy*, App. no. 37703/97, 24 October 2002, para 74).

19. See also *Osman* (paras 115-116) for the balance in a policing context and *Z v United Kingdom* (2002) 34 EHRR 3, para 74 in the child protection context.

20. The Interveners would make three observations:

    (1) The balancing exercise is carried out not at the admissibility stage but at the compliance stage. Whether policy or resource considerations are relevant in a given case, or what weight is to be given to them, will depend upon the

[3] *Rees v United Kingdom* (1986) 9 EHRR 56, para 37; *Sheffield & Horsham v United Kingdom* (1998) 27 EHRR 163, at 191, para 52.

context of the particular case[4]. These considerations do not operate as a bar to the imposition of the duty in the first place, by contrast with the 'fair, just and reasonable' test at common law (see, recently, *Mitchell v Glasgow CC* [2009] UKHL 11, [2009] 1 AC 874) which gives rise to issues under Article 13: see *Z v United Kingdom*, para 102.

(2) This would suggest that the ECtHR in healthcare cases like *Powell v UK* (no. 45305/99, 4 May 2000) is not applying an exclusionary rule but a balancing exercise: see further, below at para 46.

(3) The fair balance test is not to be equated with a threshold of 'gross dereliction or willful disregard of duty', a proposition rejected by the ECtHR in *Osman* (para 115) and emphasised by Lord Bingham in *Van Colle and Another v Chief Constable of Hertfordshire Constabulary* [2008] UKHL 50, [2009] 1 AC 225, para 30. That is not to say, however, that the gravity of the breach of duty is not relevant in the balancing exercise: the fact that failings on the part of state agents were deliberate (see *Őneryildiz*, para 73) or amounted to gross negligence is relevant.

(iii) Factors relevant to whether the operational obligation has been breached

21. A number of factors also weigh in favour of a finding of a breach. In conducting the balancing exercise the ECtHR has given prominence to three factors in particular. All may be present in a given case; in others only one will be present but may nevertheless be determinative. These factors include (although the Interveners do not suggest this list is exhaustive):

(1) The assumption of responsibility by the State, including the fact that control is exercised over the victim.

(2) The vulnerability of the victim or her membership of a vulnerable group.

(3) The nature and gravity of the risk to which the victim has been exposed.

(4) The gravity of the breach of duty (see para 21(3) above).

[4] See "Positive Obligations under the European Convention on Human Rights: A guide to the implementation of the ECHR", Human rights handbooks, No. 7, 2007 Council of Europe Jean-Francois Akandki-Kombe, pp. 17-20

22. We will consider the first three factors in more detail before turning to the specific context of the provision of healthcare services.

(i) Assumption of responsibility by the State, including the exercise of control

23. The ECtHR has found the State to be under an operational obligation in circumstances where it has assumed responsibility for the individual. In these circumstances the assumption of responsibility may also cause the individual to be vulnerable, but that is not necessarily the case.

24. The paradigm example of assumption of responsibility is where the State has detained an individual, whether in prison, in a psychiatric hospital or on immigration grounds. The operational obligations that the ECtHR has found to be owed to detainees under Articles 2 and 3 include the provision of appropriate medical treatment (*Tarariyeva v Russia* (2009) 48 EHRR 26), the provision of conditions of detention suitable to ensure the detainee's health and well-being are adequately assured (cell size, bedding, food, water, toileting facilities and the like) (*Kudła v Poland* [GC] (2002) 35 EHRR 11) and to take appropriate measures to protect against self-harm (*Keenan v United Kingdom*, (2001) 33 EHRR 913[5]). These obligations apply to all detainees but are particularly stringent in relation to detainees who are especially vulnerable by reason of their physical or mental condition[6].

25. Although some of these duties may also be categorized as arising under the State's negative obligation under Article 3 not to subject an individual to inhuman or degrading conditions[7], both positive and negative obligations are engaged in these

[5] Although no breach of the operational obligation under Article 2 was found, the ECtHR did find a breach of Article 3 and since then it has applied the same approach in a number of self-inflicted death cases, finding violations of Article 2 in a number of them, namely *Renolde v France* (2009) 48 EHRR 42, *Kilavuz v Turkey* App no. 8327/03, 21 October 2008 and *Jasinska v Poland* App no. 28326/05, 1 June 2010.

[6] Mental disorder (*Kudła v Poland* , *Keenan*), serious illness (*Tarariyeva*), disability (*Price v United Kingdom* (2002) 34 EHRR 53), age (see *Papon v. France*, App. No. 64666/01, 7 June 2001) or drug addiction (see *McGlinchey v United Kingdom* (2003) 37 EHRR 41)

[7] This is an area in which the boundaries between the positive and negative obligations under Article 3 are particularly difficult to determine. Detaining a person in unacceptable conditions of detention or without suitable medical treatment has been held to amount to a breach of the negative obligation not to subject an individual to inhuman or degrading treatment or punishment under Article 3 (e.g. *Aleksanyan v Russia* (2011) 52 EHRR 18). In Article 2 cases the failure to provide suitable medical care has been analysed as a breach of the State's positive obligations under Article 2 (*Tarariyeva*). In *Keenan* the ECtHR analysed the breach of Article 3 by reference to both positive obligations (see para 112) and negative obligations (para 115).

circumstances. The key feature is that by detaining them the State has assumed control of the individual and is, accordingly, responsible for their health and well-being. Thus in *Savage v South Essex NHS Trust* [2009] 1 AC 681, Lord Rodger observed that the fact Mrs Savage was a detained patient was relevant because she was 'under the control of the hospital authorities' (para 49).

26. However, detention is not the only mechanism by which State responsibility may be assumed. The victim may have been conscripted into the army[8], or may have died as the result of a particularly hazardous activity such as the planning of an armed police or military operation[9]; an environmental hazard that the State has caused or permitted to occur[10]; or the release of a particularly dangerous prisoner on probation[11]. In all these cases the State has either assumed control over the individual or has caused the life-threatening risk or permitted it to continue. The ECtHR will then treat the State as having assumed responsibility for the individual and an operational obligation will be owed.

27. In the context of informal patients, the state may assume responsibility by admitting them to hospital and (in many cases) thereafter exercising control over them. As we explain in Annex 1, at paras 18-22, an informal patient may in practice be subject to coercive measures such as locked wards, high levels of observations, seclusion and restraint. Her consent to admission may be in question, either because of the fear that she will be 'sectioned' if she ceases to co-operate or because the nature of her mental disorder puts her capacity in doubt. Whether she is *de facto* detained or not, many informal patients are subject to restrictions on their liberty falling within the meaning of Article 2 of Protocol No. 4 (liberty of movement within a State and freedom to leave).

(ii) Vulnerability of the victim/ membership of a vulnerable group

28. When finding an operational obligation to have been breached the ECtHR has repeatedly emphasized the vulnerability of the victim as a relevant consideration in its decision. For example:

[8] For which see the analysis of Lord Rodger in *Savage* at paras 34-38.
[9] *McCann v United Kingdom* (1996) 21 EHRR 97 (Death on the Rock case).
[10] For example, attacks by stray dogs: *Stoicescu v Romania*, App. No 9718/03, 26 July 2011, paras 48-63 (Article 8).
[11] *Maiorano v Italy* (2009) EHRLR 224

(1) Psychiatric patients: see *Herczegfalvy v Austria* (1992) 15 EHRR 437, para 82; *Renolde v France* (2009) 48 EHRR 42, para 84, 109.

(2) Prisoners, particularly those at risk of self-inflicted death or in need of medical attention due to illness or disability. We refer to para 25, above.

(3) Pregnant women denied the necessary medical treatment to enable them to take a decision whether to terminate a pregnancy: see *RR v Poland* (App no 27617/04, 26 May 2011), para 159.

(4) Elderly care home residents at risk to their life from a care home closure and transfer: *Watts v United Kingdom* (2010) 51 EHRR SE5, p. 90, para 88, 93.

(5) Children, particularly those at risk of sexual abuse: *Z v United Kingdom*, para 73. Although this was an Article 3 case, the same reasoning would follow under Article 2 if a child died in circumstances where the risk of death was known.

(6) Women at risk from domestic violence: *Opuz v Turkey* (2010) 50 EHRR 28; see paras 99, 159 and 160.

(7) Military conscripts (discussed in detail in both *Savage* and *R (Smith) v Asst. Dep. Coroner* [2011] 1 AC 1).

(8) Members of persecuted religious or other minorities: e.g. *Milanovic v Serbia* (App no. 44614/07, 14 December 2010).

29. Key to all of these cases is the particular vulnerability of the individual or the group to which they belong and that the State knows, or ought to know, that they are at a 'real and immediate risk' to their life (for Article 2) or that they are at such a risk of treatment crossing the threshold of another relevant Convention Article (notably Articles 3, 4 and 8). In circumstances of sufficient vulnerability the ECtHR has been prepared to find a breach of the State's positive obligation even in cases where there has been no assumption of control by the State, such as where a child is at risk of abuse (*Z v United Kingdom*) and where a woman is at risk of domestic violence (*Opuz v Turkey*).

30. The Interveners would observe that individuals suffering from mental disorder are more vulnerable than the general population to the risk of self-inflicted death (Annex 1, paras 3-5). Those who are admitted to psychiatric hospital are the most at risk; admitted at times of crisis, they are vulnerable not only by virtue of a greater risk of self-harm but also by the very nature of their illness. Their ability to make competent choices may be compromised. Once in hospital, they may agree to remain only because of their fear of being sectioned (Annex 1, paras 12-17) or be otherwise *de facto* detained (Annex 1, para 23). Their loss of autonomy may be as profound as that of a detained patient. They may be *more* vulnerable, because of the lack of legal safeguards governing their care and treatment compared to detained patients (Annex 1, para 24).

(iii) The nature of the risk to which the victim has been exposed

31. The ECtHR in *Osman* stated that 'not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising' (para 116). However it is not readily apparent precisely what risks to life fall into this category, notwithstanding the ECtHR's observation in paragraph 115 of *Osman* that those circumstances are 'well-defined'.

32. Operational obligations have been implied so as to require States to take specific measures to protect individuals from the following risks:

    (1) Criminal acts of third parties (i.e. non-State agents), e.g. *Osman*.[12]

    (2) Environmental pollution (*Őneryildiz*) and other risks to public health.

    (3) Acts of self-harm and self-inflicted death (*Keenan v United Kingdom*, paras 90-91).[13]

    (4) The consequences of naturally occurring disease (*Tarariyeva*).

33. Simply because a risk falls within one of these categories may not be sufficient, of itself, to determine whether it is one that gives rise to a positive obligation, even if

[12] See also *Opuz v Turkey*, *Kontrova v Slovakia,* App. No. 7510/04, 31 May 2007; *Edwards v United Kingdom* (2002) 35 EHRR 19, para 54; *Mastromatteo v Italy*; *Maiorano v Italy*.

[13] See also *Dodov v Bulgaria*, para 100; *Trubnikov v Russia* App no. 49790/99, 30 November 2005; *Renolde v France; Kilavuz v Turkey* App no. 8327/03, 21 October 2008; *Jasinska v Poland,* App no. 28326/05, 1 June 2010.

the other elements of the *Osman* test are satisfied. That may be because other relevant factors are absent – a lack of vulnerability or a lack of assumption of responsibility by the State. But it may be because of the nature of the risk itself.

34. It would appear that the nature of the risk to which the victim has been exposed may be relevant in (at least) two respects.

35. First, where the risk discloses a particularly grave underlying problem which the State ought to address, an operational obligation is more likely to arise. In *Opuz v Turkey* (2010) 50 EHRR 28, for example, in determining that there had been a breach of the state's operational obligation to protect the applicant (and her mother) from domestic abuse, the ECtHR took account of the fact that domestic violence is a general problem concerning all member states and continued (at para 132):

> Accordingly, the Court will bear in mind the gravity of the problem at issue when examining the present case.

36. The Interveners would observe that the prevalence of self-inflicted death among psychiatric patients, in particular hospital in-patients, discloses a problem of similar gravity (see Annex 1, paras 3-5). This would explain the approach taken by the ECtHR in relation to self-inflicted death, both in relation to detainees but also in other contexts. In *Haas v Switzerland*, App. No. 31322/07, 20 January 2011, the ECtHR held that States are obliged under Article 2 to take steps to prevent an individual taking his or her life if the decision is not freely made or if he lacks capacity to make it (paras 51, 54). Although relying upon *Keenan*, the decision is significant as the proposition is not limited to detainees but includes those who are informal patients or even those in the community.

37. Second, <u>in certain contexts</u> an operational obligation will only arise if the risk can be considered a special or exceptional one. In *Stoyanovi v Bulgaria*, App. no. 42980/04, 9 November 2010, the ECtHR rejected an application made by the family of a soldier who died during a parachute exercise. At paras 59-61 it drew a distinction between, on the one hand, risks which, although inherently dangerous, are nevertheless an ordinary part of military duties; and, on the other, ""dangerous" situations of specific threat to life which arise exceptionally from

risks posed by violent, unlawful acts of others or man-made or natural hazards". An operational obligation would only arise in the latter situation.

38. In drawing the distinction the ECtHR appeared to equate the role of soldiers to that of doctors (at para 61) which might suggest that one explanation for the approach of the ECtHR in healthcare settings, exemplified by *Powell*, is that those risks to life that are an inherent part of a doctor's everyday practice (for example, a patient undergoing emergency surgery) are, if they eventuate, less likely to lead to a breach of an operational obligation than 'dangerous situations of specific threat to life' such as the criminal acts of third parties.

39. Whether that inference is correct or not, the Interveners do not accept it applies to the self-inflicted death of a mentally disordered person, which the ECtHR has already held is a risk against which States must take protective measures, at least where the individual is detained or where there is doubt about the genuineness of their decision, considering *Haas*, above para 36. We return to this at para 48, below.

Discussion

40. The Interveners submit that support for the above analysis is to be found in the speeches of your Lordships in *Savage*, *Mitchell* and *Smith*, in particular in the speeches of the late Lord Rodger. As to *vulnerability* and *assumption of responsibility*, see *Savage*, paras 28 and 37; *Mitchell*, para 69; *Smith*, paras 118, 120-121, where Lord Rodger distinguished between 'vulnerable' new recruits and ordinary members of the armed services who could not be so described[14]. As to the *nature of the risk*, see *Smith*, paras 125-126 where Lord Rodger distinguished between 'ordinary' risks faced by soldiers on active service, against which the State could not be expected to protect, and others – such as heatstroke and friendly

[14] Lord Walker explicitly agreed with Lord Rodger on this point (para 131). Lord Mance was prepared to accept that there were circumstances in which an operational obligation could arise in the combat arena (para 217). Lord Hope did not agree with Lord Rodger that a new recruit was to be equated with a military conscript so that an operational obligation would arise on that ground alone (Lord Hope (para 102), although he did accept that there might be circumstances in which an operational obligation could arise (105D). Lord Phillips was not prepared to accept that an operational obligation could arise at all (para 84), although accepted that systemic breaches could lead to an Article 2 violation; Lady Hale and Lord Brown agreed with both Lord Rodger and Lord Phillips (para 137, 150).

fire - which it arguably could be expected to protect against; see also Lord Mance at para 218[15].

41. Against that backdrop the Interveners turn to the immediate issue of how these principles are to apply in the healthcare sphere.

(iv) Positive obligations in the healthcare sphere

42. The Court of Appeal in the case before your Lordships concluded that no operational obligation is owed in a hospital setting to a patient suffering from mental illness, even where there is a 'real and immediate' risk of death of which the relevant authorities are, or ought to be, aware (Judgment, para 63), applying the decision in *Powell* (see para 51). While the Court accepted that there were exceptional circumstances in which the courts would infer a positive obligation in such a setting, there had to be some additional element, such as the fact the individual was detained by the state (para 62). Detention makes a 'critical difference' (ibid).

43. The genesis for this ruling was the ECtHR case of *Powell v United Kingdom* (2000) 30 EHRR CD 362. *Powell* concerned a complaint by the parents of a 10-year-old boy who had died of Addison's disease, allegedly due to the failure of the doctors responsible for his care to ensure that this disease was promptly treated and diagnosed. The ECtHR rejected the submission that the Article 2 operational obligation identified in *Osman* could have been breached, observing that the issue before it was 'an entirely different one in terms of both the context and scope of the obligation', but adding the crucial words 'it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2'.

44. *Powell* establishes that, in an ordinary healthcare setting, provided the primary 'systems' obligation has been complied with, then errors of judgment or negligence on the part of the medical staff will not be sufficient <u>of themselves</u> to breach the operational obligation. That is uncontentious; the rationale for that

[15] Lord Hope disagreed, see para 103, as did Lord Phillips (para 84) and Lords Collins and Kerr (paras 309, 340). Lord Walker expressly agreed on this point (para 131); Lady Hale and Lord Brown having agreed with both Lord Phillips and Lord Rodger cannot be taken to have agreed or disagreed with Lord Rodger on this particular point.

distinction may well be that given in *Stoyanovi* in relation to serving soldiers (above, para 37).

45. What is less clear is how the issue in *Powell* is different 'both in context and scope' from *Osman* and in what 'certain circumstances' the operational obligation will arise in a healthcare context. The Interveners submit that the answers to the both questions lie in the analysis that we have set out above. The court must consider, first, whether Article 2 is applicable and then, second, whether the *Osman* criteria are met, which includes the fair balance test. The fact that death has occurred in a healthcare setting does not operate as an exclusionary rule but is a relevant factor in the balancing exercise. Indeed, in the absence of any countervailing factors it is a <u>determinative</u> factor against the finding of a breach. However, other countervailing factors can tip the balance the other way.

46. It is not in dispute that one of the 'certain circumstances' in which an operational obligation arises in a healthcare setting is the provision of medical care to detainees (above, para 25). The significance of detention for present purposes is not, however, detention *per se* but the assumption of responsibility by the state over the detainee coupled with the vulnerability of detainees as a group. These considerations outweigh the fact that death occurred as a result of failures in a healthcare setting.

47. But the State may assume responsibility for an individual without detaining them (e.g. conscripts). In any event, a person who is not detained may be so vulnerable that the State must take measures to protect them against certain risks (such as child abuse, domestic violence and – considering *Haas* – self-inflicted death, at least where the individual has not made a free or competent choice to end their life). So while detention is a <u>sufficient</u> factor that tips the balance in favour of a positive obligation arising, it is not a <u>necessary</u> factor. A combination of the relevant factors of vulnerability, assumption of responsibility, the nature of the risk and the gravity of the failure may also suffice.

48. In *Savage*, a combination of the first three factors was present. The particular vulnerability of formally detained mental patients was emphasized (Lord Rodger,

para 46, 49; Lady Hale, para 97[16]). It was relevant, moreover, that Mrs. Savage had been a detained patient (see Lord Rodger, para 46, 65; Lady Hale, para 97), although nothing in their Lordships' speeches suggest that detention was anything other than a relevant, rather than a necessary, factor. It is also apparent that the House considered the nature of the risk – self-inflicted death – to be one that the State was required to protect against. At paras 58-59 of his speech Lord Rodger contrasted the position in *Powell* and in *Savage* by reference to the differing nature of the risks and the reasonable steps that might be expected in the face of those risks. At para 65 Lord Rodger asked, rhetorically, 'What else would [the hospital] be supposed to do?' when confronted by a patient at a real and immediate risk of self-inflicted death than take reasonable measures to prevent it.

49. Lord Rodger therefore put the risk of self-inflicted death, and the expected response to that risk, firmly into the category of risks in respect of which the State owes an operational obligation – at least, in the context of a patient detained under the MHA. That is consistent with cases such as *Keenan* and *Haas*, discussed above. This is not a case like *Stoyanovi v Bulgaria* (above para 38).

50. That is not to say that the State is expected to take steps to protect against *every* risk of self-inflicted death, as Lord Rodger explains in *Savage* at para 25. Where the individual is not vulnerable (for example, a competent individual who has made a free choice to end his own life here or abroad) there is no obligation on the State under Article 2 to take protective measures, as *Haas* demonstrates. But where there are questions about whether the individual has freely chosen to take his own life or lacks capacity to do so, the state may be obliged to adopt protective measures.

(5) Interveners' conclusions and submissions on the First Issue

51. In the light of the above the Interveners can state their conclusions and submissions relatively shortly.

(1) The ECtHR does not apply an exclusionary rule akin to the approach of the common law of determining whether an operational obligation arises in a

[16] The other Law Lords agreed with the judgment of Lord Rodger and Lady Hale: see per Lord Scott, (para 1), Lord Walker (para 74), Lord Neuberger (para 105)

particular context. It applies a relatively low threshold test in determining whether Article 2 is applicable and then at the second, merits stage it balances the interests of the individual and countervailing State interests in establishing whether there has been a breach.

(2) That threshold is clearly crossed in the present context. Those who are admitted to psychiatric hospital for medical treatment are at a significant risk of self-inflicted death, whether they are formally detained or informal patients.

(3) Whether self-inflicted death is a risk against which the State may be expected to take operational measures under Article 2, even in a healthcare setting, will depend upon whether the individual was at a real and immediate risk of death of which the authorities were or ought to have been aware; and whether the authorities failed to take measures which, judged reasonably, might have been expected to avoid that risk.

(4) This 'reasonable measures' test involves a fair balance exercise. Factors that weigh against the finding of a breach include the fact that the death occurred in a healthcare setting where there has been no breach of its primary ('systems') positive obligation.

(5) Factors that weigh in favour of the finding of a breach include:

(a) The degree of control exercised over an informal patient may be as great as in the case of a formally detained patient. Their consent to admission and treatment may be vitiated by duress or lack of capacity. They may be placed in locked wards; subject to seclusion, restraint, high levels of observation, medical treatment against their will (if judged to lack capacity); they may be *de facto* detained.

(b) Mentally disordered individuals informally admitted to hospital are a particularly vulnerable group and are at a heightened risk of self-inflicted death. Their vulnerability is heightened by the lack of legal safeguards in relation to their admission and treatment.

(c) Self-inflicted death is a risk against which the State is expected to take protective measures where the individual is detained (*Savage*) or where there is doubt as to whether the choice is made freely or the individual lacks capacity (*Haas*).

(6) There are additional policy considerations that weigh in favour of recognizing an operational obligation in the context of informal patients, namely:

(a) In a policy context no distinction is drawn between deaths in a mental healthcare setting between formally detained and informal patients.

(b) There is no less need for an enhanced investigation where the patient who dies has been informally admitted rather than formally detained under the MHA.

(7) There are no policy factors weighing against recognition of that operational obligation. Hospital staff already owe a duty of care in this context and the test to be satisfied for breach of the operational obligation is a higher one, as the House of Lords recognized in *Savage*, namely the need for there to be a 'real and immediate risk' of death.

(6) 'Secondary' victims of Article 2 violations

52. In a number of cases the ECtHR has made awards of damages for non-pecuniary damages to relatives of the deceased arising out of violations of the *substantive* limb of Article 2, even where there has been no breach of the investigative obligation.[17]

53. In *Kontrova v Slovakia* 31 May 2007, the ECtHR awarded the applicant EUR 25,000 for non-pecuniary loss following its finding that the death of the Applicant's children at the hand of their father had been caused by a failure of the police to take protective measures, in breach of the operational obligation under Article 2. What is significant for present purposes is the Court's finding, in

[17] E.g. *Kontrova v Slovakia*; *Metin v Turkey*, App. No. 26773/05, 5 July 2011; *Servet Gündüz & Others v Turkey*, App. No. 4611/05, 11 January 2011; *Jasinska v Poland* (note at para 85 that the applicant specifically sought compensation for the non-pecuniary damage which *she* had suffered in respect of the failure to protect her grandson, who killed himself while in prison); *Golubeva v Russia* App. No. 1062/03, 17 December 2009 – compensation awarded to the applicant for the distress and frustration which she must have suffered (para 120); *Saoud v France* App. No. 9375/02, 9 October 2007.

addition, that the applicant's inability to obtain compensation for non-pecuniary damage in respect of this loss in domestic proceedings had amounted to a breach of Article 13.

> 64. It is the applicant's contention that she had no possibility of obtaining compensation for non-pecuniary damage. The question therefore arises whether Article 13 in this context requires that such compensation be made available. The Court itself will in appropriate cases award just satisfaction, recognising pain, stress, anxiety and frustration as rendering appropriate compensation for non-pecuniary damage. It has previously found that, in the event of a breach of Articles 2 and 3 of the Convention, which rank as the most fundamental provisions of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be available as part of the range of possible remedies (see *Keenan v. the United Kingdom*, no. 27229/95, § 130, ECHR 2001-III).
>
> 65. In this case, the Court concludes that the applicant should have been able to apply for compensation for the non-pecuniary damage suffered by herself and her children in connection with their death. From the above finding as regards the Government's preliminary objection, it follows that the action for protection of personal integrity provided her with no such remedy.

54. So the non-pecuniary loss in respect of which compensation must be available relates to both the victim (represented, domestically, by her estate) and to the victim's relative.

55. This approach has been adopted in a number of other cases[18].

56. If the ECtHR considers payment of such damages necessary to afford just satisfaction to the relatives, it would be inconsistent to hold that the payment of damages in domestic proceedings only in favour of the estate of the deceased could deprive them of their status as victims.

Conclusion

57. Accordingly, the Interveners submit that the Appeal should be allowed for the following among other

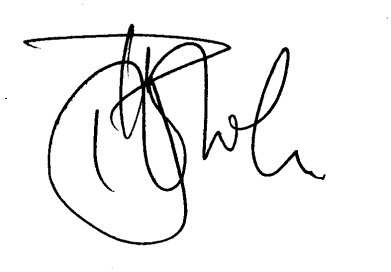
[18] See, for example, *Lutfi Demirci & Others v Turkey* (28809/05, 2 March 2010), see para 42; *Mizigarova v Slovakia* (74832/01, 14 December 2010), Paras 126, 129

REASONS

(1) An operational obligation under Article 2 may arise, and be breached, if psychiatric hospital staff fail to take reasonable measures within their powers to prevent the self-inflicted death of an informal mental patient who is at a real and immediate risk of death of which the authorities are, or ought to be, aware.

(2) Where there has been a breach of the operational obligation under Article 2 the victim's family members are entitled to be considered as 'victims' for the purposes of Article 34 and s 7 Human Rights Act and to receive adequate compensation for their non-pecuniary loss.

17 OCTOBER 2011



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