

## Vulnerability and the law: A practitioner's perspective

### *The Human Rights Act 1998 and its impact on the medical treatment of vulnerable people*

1. The Articles I consider are Articles 5 and 2 by reference to two particular cases and a procedural point on strike out after the advent of the Human Rights Act 1998

#### Article 5: deprivation of liberty

2. The MHA 2007 had in mind the need to comply with the European Convention on Human Rights when drafting the new legislation, precisely because Article 5(4) is engaged in every situation where a person faces detention because of their mental condition.
3. There exists a “handover” from the MHA to the MCA in relation to adult incapacitated persons who cannot consent to their detention – the so – called Bournwood patients. The safeguards for such patients are contained in the MCA 2005.
4. One of the cases defining detention for the purposes of Article 5(4) arises in the context of a MHRT hearing in relation to a Bournwood patient. The same judge, Munby J was involved in the case of PS –v- Sunderland.
5. JE –v- DE (by his litigation friend, the Official Solicitor) Surrey County Council and EW [2007] MHLR 39:

Facts: following a stroke in 2003, DE became blind and had a significant impairment of his short – term memory. It was likely that he did not have the capacity to decide where he wanted to live. After some respite care in a care home, DE moved in with a long term friend, JE and they married. After about 2 months, JE indicated that she could not cope and, indeed, left DE out on the street. DE was returned to a care home. DE repeatedly said he wanted to return to live with JE.

The issue was whether or not DE was being deprived of his liberty by being kept in the care home, it being common ground that he did not have capacity to decide where he wanted to live.

Decision: There are 3 elements to consider to determine whether an adult has been deprived of his liberty within the meaning of Article 5:

- (1) an objective element: is there confinement in a particular restricted space for a length of time which is not negligible. The key factor is whether the person is or is not free to leave. This is tested by determining whether those treating and managing the person exercise complete and effective control over the person's care and movements. A physical barrier is not necessary and the presence of the person on a locked or lockable ward is not determinative.
- (2) a subjective element: the person has not validly consented to the confinement. Such consent would require capacity. The lack of objection from a person without capacity cannot lead to an inference of consent.
- (3) State - imposed: for Article 5 to be engaged, the deprivation of liberty must be imputable to the State.

6. In this case, the emphasis was on what was factually occurring in order to establish that there was a detention. The learned judge focussed on the evidence of what someone would do if DE tried to leave and live with JE, what DE and his partner JE were told as to what the care home would permit and how it could be backed up by police intervention.

#### Article 2: right to life

7. Whether people subject to detention are treated differently than those not on a section for the purposes of Article 2.
8. The question is in what circumstances is Article 2 of the Convention, the right to life, engaged, remembering, of course that Article 2 encompasses the requirement on the State to take appropriate steps to safeguard life.
9. In the case of *Savage –v- South Essex Partnership NHS Foundation Trust*, at first instance [2006] EWHC 3562(QB) Mrs Justice Swift found that for Article 2 to be engaged in relation to a patient detained in hospital pursuant to the Mental Health Act 1983 section 3, where the relevant allegations were allegations of clinical negligence, the failures in care must amount to at least gross negligence of a kind sufficient to sustain a charge of manslaughter.
10. The learned Judge saw no difference in principle between how a voluntary patient and an involuntary patient should be regarded by the law: there may be no difference in the nature and severity of the conditions afflicting the two patients, their treatment may be the same and the clinical issues and judgements for clinicians will be similar in nature, both patients are being treated within the same State health system, governed by the same regulations and standards that have been identified as being regarded as necessary to meet the State's obligations under Article 2. Mrs Justice Swift regarded the position of the involuntary patient to be more similar to that of a voluntary patient than someone also subject to detention in, say a prison, or on a locked ward.
11. The case was appealed to the Court of Appeal, Sir Anthony Clarke, Master of the Rolls giving the judgement.
12. The critical point addressed by the CA was whether a person detained under a section should be treated differently so far as Article 2 was concerned than someone in prison. The Court decided that both prisoners and patients subject to the MHA are under the control of the state in a way in which ordinary patients are not (regardless of their illness and treatment being similar). In simple terms, not expressed in this way by the judges, patients not subject to the control of the State can "vote with their feet" whereas those subject to a section cannot.
13. Thus, as the MCA protects the interests of those who are peculiarly vulnerable by their lack of capacity, with safeguards in respect of a deprivation of their liberty, the *Savage* case requires particular consideration of those who are peculiarly vulnerable by reason of their incarceration, either in prison or by being subject to a MHA section.
14. In order to establish a breach of Article 2 with respect to someone who is subject to the provisions of the Mental Health Act, the test is that the Trust knew or ought to have known of the existence of a real and immediate risk to the life of the person from self harm and that it failed to take measures within the scope of their powers, which, judged reasonably, might have been expected to avoid that risk.

15. The third case I want to draw your attention to because it demonstrates how the passing of the HRA 1998 can be used to resist strike out in circumstances where the question of a duty of care is, on previously decided case law, adverse to the claimant. The argument is that the passing of the HRA makes the previous legal position uncertain, sufficiently uncertain so as to justify a trial on the facts to determine whether or not a duty of care arose.
16. This mechanism of using the HRA to challenge the established common law first arose (successfully at least) in the case of *JD & Ors –v- East Berkshire HA* in the Court of Appeal [2003]EWCA 1151. Despite the apparent definitive ruling of the House of Lords in *X –v- Bedfordshire* [2005] UKHL 23 that a duty of care could not be owed to a child who was subject to care proceedings, the Court of Appeal reached the “firm conclusion” that the decision in *Bedfordshire* could not survive the Human Rights Act so as to prevent a child challenging the decision to take them into care. The reasoning was that where child abuse is suspected the interests of the child are paramount and given the obligation of the local authority to respect a child’s Convention rights, the recognition of a duty of care to the child on the part of those involved should not have a significantly adverse effect on the manner in which they perform their duties.
17. In the context of suspected child abuse, breach of a duty of care in negligence will frequently also amount to a violation of Article 3 or Article 8. The difference, of course, is that those asserting that wrongful acts or omissions occurred before October 2000 will have no claim under the Human Rights Act. The Court held that this could not constitute a valid reason of policy for preserving a limitation of the common law duty of care which was not otherwise justified. On the contrary, the absence of an alternative remedy for children who were victims of abuse before October 2000 militates in favour of the recognition of a common law duty of care once the public policy reasons against this had lost their force.
18. This approach was referred to though not expressly adopted, in the case of *AK –v- Central & North West London Mental Health NHS Trust & Anor* [2008] EWHC 1217 so as to afford a mentally ill person the right to challenge the provision of aftercare services under section 117 of the MHA 1983. The established position was that contained in the case of *Christopher Clunis*, the person, you recall, who had killed *Jonathan Zito*, and which had set the precedent that a duty of care in the exercise of a statutory duty was excluded in all cases.
19. What the Honourable Mr Justice King decided was that there at least had to be an argument over whether a duty of care was owed or not and that *Clunis* could not be regarded as “the final chapter on the destiny of claims such as the present”. Hence, he held that the Master had been wrong to strike out the claim on the basis that no duty of care was owed, notwithstanding that the establishment of such a duty might be “fraught with difficulty”.
20. Which brings me, rather conveniently, to where I came in. There is no doubt that the impact of what happened to *Jonathan Zito* at the hands of *Christopher Clunis*, and the inquiry that followed it, have shaped the development of mental health legislation from the last century to this and has had a lasting impact. Equally, it appears, the right of the mentally ill to challenge failures in care provided to them has increased, by reason of the operation of the Human Rights Act.
21. Given the view of mental health lobbyists regarding the risk of the overuse of community orders and the risk that community orders will not result in real and meaningful help for those with mental disorder, perhaps that’s a fair exchange.

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