

The Consequences of Acting Unlawfully

*Kris Gledhill**

The Mental Health Act 1983 provides for detention and also for treatment which would otherwise be an assault. As such, it allows for interference with the fundamental rights to liberty and to self-determination. Particularly as it does so in the context of a branch of medicine which is often highly subjective, it is hardly surprising that litigation is occasionally resorted to by those affected who wish to challenge the legality of what is occurring to them.

The framework for this litigation has developed, spurred on in particular by the growth of public law and human rights law. As a result, mental health professionals have to be familiar not just with the court-machinery which is central to the Mental Health Act 1983 (which provides for the Mental Health Review Tribunal to determine the legality of the ongoing detention of a patient, and refers the issue of the displacement of a nearest relative to the county court) but also with the courts which deal with questions of public law (in particular the Administrative Court) and the civil litigation courts.

Public Law

The last quarter of the Twentieth Century saw a significant growth of public law, with an increased jurisdiction assumed by the High Court to intervene in the decisions of inferior courts and decision-makers by way of the process of judicial review. Mental health law was caught in this trend; for example, decisions of Mental Health Review Tribunals¹ but also decisions of mental health professionals to “section” or renew the detention of a patient² were subject to challenge by way of judicial review.

Mental health law has been at the forefront of the further invigoration of public law in the era since the Human Rights Act 1998 was ushered in on 2 October 2000. The first declaration of incompatibility to stand was made in relation to the powers of a Tribunal under ss72 and 73 of the

* *Barrister specialising in public law, particularly mental health and prison law; editor of Mental Health Law Reports and Prison Law Reports; regular lecturer on mental health and prison law.*

1 *Encouragement was given to use judicial review rather*

than the statutory method of special case stated under s78(8) of the Mental Health Act 1983: see Bone v MHRT [1985] 3 All ER 330.

2 *R v Hallstrom ex p W (No 2), R v Gardner ex p L [1986] QB 1090.*

1983 Act³ and two further declarations have so far been made⁴. In addition, the first action taken by a Minister to amend a primary statute by way of delegated legislation in the form of a Human Rights Act Remedial Order was also a mental health matter.⁵

Judicial Review Since the Human Rights Act 1998

The further growth of challenges to the legality of decisions made in a mental health law context can be traced to three major developments arising from the Human Rights Act 1998. The first is the development of the test for intervention by way of judicial review. Traditionally, a judicial review would only succeed if there were significant procedural defects in the decision-making process or the decision was irrational (the so-called *Wednesbury* unreasonableness test⁶); however, the courts now have to be more willing to examine the merits of a decision which interferes with fundamental rights guaranteed under the European Convention, by reviewing not just whether a decision maker exercised a rational judgment but also whether a proportionate balancing decision was reached⁷.

The second development is linked and is the extended scope of fact-finding (and hence evidence in the course of hearings) in judicial review proceedings. The case which made plain that this was necessary in order to comply with the requirements of Article 6 of the European Convention, the right to a fair trial in relation to civil rights, was *R (Wilkinson) v Broadmoor and Others*⁸. In essence, the ruling here was that where fundamental rights are involved, the courts do not simply review the rationality of a decision but make their own judgment, including determining as between competing medical opinions as to whether a particular form of treatment would breach Articles 2, 3 and 8 of the Convention (which would require the doctors to attend and be cross-examined). This was necessary to provide compliance with the right to a fair trial under Article 6.

The case of *Wilkinson* was an interlocutory appeal on a point of practice, namely whether it was necessary for doctors to attend to give evidence. It has been applied in practice in the case of *R (N) v A Hospital and Others*⁹. In this case, a High Court judge made the determination on contested evidence of whether a particular course of treatment should be allowed in light of the patient's rights under Article 3 and Article 8, which turned on issues of the correct diagnosis of the patient's condition and whether forced depot medication was in a patient's best interests. Although in upholding the decision the Court of Appeal¹⁰ noted that live evidence would not always be essential, the jurisdiction of the court to make the contested decision is clear.

The same fact-finding jurisdiction has been used in another mental health law context, namely the issue of whether a nearest relative had objected to an application being made to admit a patient

3 *R (H) v London North and East Region Mental Health Review Tribunal* [2002] QB 1, [2001] Mental Health Law Reports 48

4 The regime for the release of life sentence prisoners transferred to hospital under ss47 and 49 of the 1983 Act (*R (D) v Secretary of State for the Home Department* [2003] Mental Health Law Reports 193 – see now s295 Criminal Justice Act 2003) and the absence of a provision to allow a patient to change his or her nearest relative under s29 of the Act (*R (M) v Secretary of State for Health* [2003] Mental Health Law Reports 348

5 *The Mental Health Act 1983 (Remedial) Order 2001*, SI 2001 No 3712

6 *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223

7 *R (Daly) v Secretary of State for the Home Department* [2001] 2 AC 532

8 [2002] 1 WLR 419, [2001] Mental Health Law Reports 224

9 [2003] Mental Health Law Reports 138

10 [2003] 1 WLR 562, [2003] Mental Health Law Reports 157

under s3 of the 1983 Act¹¹ and it has also been used in different contexts, such as whether a search warrant was lawfully executed¹².

The third development has been the growth of challenges by one public law body to the decisions of another public law body, particularly challenges to decisions of Mental Health Review Tribunals by hospitals and after-care authorities. This is a consequence of the need to accord appropriate weight to the fact that a Tribunal is a judicial body which, to comply with Article 5(4) of the Convention, has to have the power to order the release of an unlawfully detained psychiatric patient. The issue of lawfulness here includes the question of whether the merits of the need to detain are made out.

Prior to the Human Rights Act 1998, if the mental health professionals believed that a decision to discharge a patient was wrong, they were able to arrange for the patient to be re-sectioned if they felt that the criteria were met¹³. Indeed the duty to make an application if it were thought appropriate, under s13 of the 1983 Act, could be said to require such an application. However, the situation has had to be revisited pursuant to the duty imposed on the courts under s3 of the 1998 Act to strive to interpret legislation so that it is compatible with Convention rights, which has required that previous authorities be revisited despite the common law's adherence to the doctrine of precedent. The new position is that a Tribunal decision is to be respected and allowed to stand unless it can be shown that there was information of which the Tribunal was not aware which puts a significantly different complexion on the case (such as the patient reneging on an undertaking to take medication or a deterioration in the patient's condition)¹⁴.

As a result of these developments, the Administrative Court's case load in relation to challenges to the lawfulness of decisions in the mental health context has seen a significant growth.¹⁵

Habeas Corpus

One of the other consequences of the growth of judicial review has been a diminution in the use of the remedy of Habeas Corpus, the remedy whereby a challenge to the jurisdiction to detain can be brought in front of the High Court. It was the remedy used in the leading case of *Re S-C*¹⁶, which involved a challenge to the right of the hospital to detain someone when the application was fundamentally flawed because the nearest relative objected. However, in *B v Barking, Havering and Brentwood Community Healthcare NHS Trust*¹⁷, which involved an allegation that the renewal of detention was fundamentally flawed, a differently constituted Court of Appeal suggested that judicial review should be the remedy sought. It is certainly possible to have judicial review cases heard speedily¹⁸ and the right to seek bail in the course of judicial review proceedings allows a detainee to be released in a short time-scale if the merits are clear.

11 *R (PG) v LB Ealing and Others* [2002] *Mental Health Law Reports* 140

12 *R (H) v Commissioners of Inland Revenue* [2002] *Police Law Reports* 350

13 *R v Managers of South Western Hospital ex p M* [1993] *QB* 683

14 *R v East London and The City Mental Health Trust ex p von Brandenburg* [2003] *UKHL* 58

15 A very simplistic approach is to look at the volume of cases in the *Mental Health Law Reports*: the 2002 and 2003 volumes are double the size of the 1999 volume.

16 [1996] *QB* 599

17 [1999] *1 FLR* 106

18 *The Administrative Court has a separate form, the N463, whereby an applicant for judicial review can seek an urgent hearing, and interim relief*

One of the controversial areas of the law of Habeas Corpus is the power of the High Court to review the sufficiency of evidence on the basis of which a person is detained¹⁹. In *R v Board of Control ex p Ruddy*²⁰, the High Court granted a writ of Habeas Corpus to secure the release of a person detained under the Mental Deficiency Act 1913 on the basis that the stipendiary magistrate who made the order did not have sufficient evidence that the patient had been “found neglected”, as required before a committal order could be made under the statute. A similar conclusion has recently been reached in *R (Kenneally) v Snaresbrook Crown Court*²¹, in which the release of a patient was ordered on the basis that the Crown Court judge had erred in finding that he had the jurisdiction to make a hospital order under s51 of the 1983 Act²², which requires that it be “impracticable or inappropriate to bring the detainee before the court”. The factual circumstances were that the patient was in the cells of the court, and it was his counsel’s request that s51 be invoked: however, the High Court held that the statutory language had to be construed restrictively, requiring a level of disablement such that it was inappropriate for the patient to be brought to court, and the judge had misdirected himself as to the law in using the power. There had been a parallel application for Habeas Corpus in case the time limit rules applicable to judicial review had caused a problem²³, though this was adjourned when permission to bring the judicial review proceedings was granted with a time extension of just under 4 years²⁴.

Both *Ruddy* and *Kenneally* involved what might be seen as procedural prerequisites for detention which were separate from the central medical question of whether the detainee suffered from a mental disorder of the necessary nature or degree. However, there is nothing in principle to prevent the jurisdiction of the High Court from being exercised in this regard. The Court has demonstrated that it is willing to review whether the prerequisites of the jurisdiction to detain are made out, and is willing to enter into the arena of medical disputes. Consequently, the existence of an “unsound mind” of the necessary nature or degree, established by adequate evidence²⁵ is a matter fit for judicial determination.

Those detained under the civil provisions of s3 of the 1983 Act are the subject of a public law decision which is open to challenge in the High Court; the right to apply to a Mental Health Review Tribunal is not an alternative remedy (it being a principle of judicial review that other avenues of appeal are exhausted first) because the Tribunal considers not the lawfulness of the original detention but the position of the patient at the date it meets. There is the practical fact that it might be possible to have a Tribunal consider the case more quickly than the High Court, which will have to allow time for the relevant medical evidence to be compiled and for the case to be listed.

19 See Sharpe, *The Law of Habeas Corpus*, 2nd Ed (OUP 1989) pp79–85; it is a jurisdiction clearly accepted in extradition cases

20 [1956] 2 QB 109

21 [2002] QB 1169, [2001] *Mental Health Law Reports* 53

22 s51(5) and (6) provide that if a transfer direction has been made in respect of a remand prisoner, it is impracticable or inappropriate to bring the detainee to court, and there is evidence from 2 doctors that the transferred prisoner is suffering from mental illness or severe mental impairment making detention in hospital for medical treatment appropriate, the court may make

a hospital order without convicting him if it is proper to do so; a restriction order may also be imposed.

23 Judicial review proceedings have to be commenced promptly and in any event within 3 months of the decision challenged: see CPR 54.5. However, the Court may extend the time limit if there is good reason for delay

24 See the note to the report of the case in [2002] *Mental Health Law Reports* 53

25 In other words, the criteria for deprivation of liberty under Art 5(1)(e) of the European Convention as interpreted in *Winterwerp v Netherlands* (1979) 2 EHRR 387, which is reflected in ss3 and 37 of the 1983 Act

In relation to those detained under a s37 hospital order by the Magistrates Court, there is a right of appeal to the Crown Court in the first instance, which has jurisdiction to examine the merits of the making of an order; the ruling of the Crown Court on appeal can be taken to the High Court. In relation to those detained under s37 by the Crown Court following a trial on indictment, the appeal route is to the Court of Appeal rather than by way of judicial review²⁶: the fact that there is a prospect of appeal on the merits supports the contention that the High Court, when it has jurisdiction by way of judicial review, should be willing to examine whether there is proper evidence that a person is of “unsound mind” so as to require detention.

Other Public Law Cases

In addition to the jurisdiction of the High Court in judicial review and habeas corpus cases, mental health practitioners should also be aware of other courts which may take decisions. In particular, the Family Division of the High Court has jurisdiction to make declarations as to the lawfulness or otherwise of treatment plans²⁷. It should also be noted that inquests are potentially of much greater significance in instances where there are deaths arising from inadequate care and treatment. Although the rules relating to inquests do not generally allow findings of neglect²⁸, the obligations which arise under Article 2 of the European Convention to investigate deaths which have occurred when a person is in the custody of the State mean that it is permissible to return a finding of systemic neglect (as opposed to neglect by an individual) when to do so will allow compliance with this procedural duty under Article 2 and reduce the risks of repetition of a death in similar circumstances: *R (Middleton) v HM Coroner*²⁹.

Private Law – Potential Tort Actions and Damages

Mental health law challenges to the lawfulness of a particular decision may also involve challenges framed in private law. The usual remedy available in such circumstances is a claim for damages, although injunctions to prevent or occasionally compel certain steps may be involved. (An injunction can be granted in judicial review proceedings, which can also include a claim for damages. Proceedings may be transferred from the Administrative Court to the Queen’s Bench Division of the High Court once the public law element of the claim has been determined³⁰.)

26 *The High Court’s jurisdiction by way of judicial review is excluded by s29 of the Supreme Court Act 1981*

27 *As a recent example of this, see In re W [2002] Mental Health Law Reports 411, in which it was declared that a psychopathically disordered prisoner was competent to refuse treatment in relation to various self-inflicted wounds which he was trying to make septic as part of a campaign to be transferred from prison to hospital.*

28 *R v HM Coroner for North Humberside and Scunthorpe ex p Jamieson [1995] QB 1*

29 *[2003] QB 581, [2002] Prison Law Reports 100.*

30 *See CPR 54.3(2), which indicates that a claim for judicial review may involve a claim for damages, though not as the only remedy; see also s31(4) of the Supreme Court Act 1981. CPR 54.20 provides that the Administrative Court may direct the transfer of a case. Note, however, that a transfer will not always occur and the judge may make an immediate assessment of any damages.*

1. False Imprisonment

False imprisonment is, in essence, detention without lawful authority. The House of Lords has confirmed that this is a tort of strict liability in the case of *R v Governor of Brockhill Prison ex p Evans (No 2)*³¹. The facts of this case are fairly stark. The prisoner was detained on the basis of an honest sentence calculation which was correct in law until the law was changed in *ex p Evans (No 1)*³², when the cases on which the governor had relied were effectively overruled. Because the legal theory is that the courts determine what the law has always been, in that they do not change the law just from the date of the judgment, the detention became unlawful, albeit retrospectively, and so damages were awarded at a level of £5000 for 59 additional days.

It follows that an action in false imprisonment is a possible consequence of detention in hospital without the cover of lawful authority. In mental health cases, lawful authority is provided by either the Mental Health Act 1983 or common law, so it is necessary to check whether the many requirements of the statute or common law have been complied with. There is scope for argument as to various of the specific requirements, but it should be noted that:

(i) s6 of the Act provides that a “duly completed” application is authority to convey to hospital within a set time and, on admission, is “sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of this Act”. Clearly, it is important that the application is duly completed, though there is an additional safeguard for hospitals in that s6(3) provides that an application which “appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendation is made or given or of any matter of fact or opinion stated in it”. There may be scope for argument about whether an apparently duly completed form which is not in fact duly completed amounts to detention “in accordance with a procedure prescribed by law” as required by Article 5 of the European Convention³³. The High Court is able to look behind the apparent due completion and grant habeas corpus if the form is inaccurate³⁴.

(ii) An admission order made under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 provides authority to convey to the hospital designated by the Home Secretary and to detain. (See also the place of safety powers of the Crown Court under Schedule 1 to the 1991 Act.) A failure to designate the appropriate hospital within the time scale set by the Act, namely 2 months, arguably takes away the jurisdiction to detain.

(iii) See also police powers under s135/136 of the 1983 Act, which have various procedural requirements which ought to be construed strictly as the right to liberty is involved.

31 [2001] 2 AC 19

32 [1997] QB 443

33 In *R(A) v Harrow Crown Court* [2003] Mental Health Law Reports 393, the High Court held that a hospital order which was *ultra vires* (and should have been an admission order) was valid until set aside – as an order of a superior court: *R v Cain* [1985] AC 46.

Further, as a substantially fair procedure had been followed before the erroneous order of similar effect was made, there was no breach of Art 5. However, the judge drew a distinction (at para 24) between the case of a court-ordered detention and an administrative act.

34 *Re S-C*

(iv) The common law allows detention in a situation of necessity of a person of unsound mind who is a danger to himself and others; necessity requires a manifest danger to the patient or others: see *Black v Forsey*³⁵.

In addition to the procedural requirements, there is the question of the substantive merits of the detention – ie, is the mental disorder such as to justify detention. The discussion above of the cases of *Rutty* and *Kenneally* applies in relation to the question of damages as well: the public law remedy which may result in an order for the release of the patient can be followed by a private law remedy in the form of damages.

The lawful authority to detain must be continuing. At this point, the issue of the merits becomes more important (though there are procedures to be followed, in particular compliance with s20 of the 1983 Act in relation to compulsory but non-restricted patients). For example, in *R v Riverside Mental Health Trust ex p Huzzey*³⁶, an error made by the managers in considering whether to uphold a barring order made under s25 of the Act following an application to discharge by a nearest relative (in that they considered the s3 test rather than the additional dangerousness criterion in s25) rendered false the detention between that time and the patient's release some 12 weeks later on the direction of a Tribunal, which in turn led a jury to award him £24000 in compensatory damages and £2000 in aggravated damages³⁷.

The issue of the merits of detention is usually dealt with by the Mental Health Review Tribunal, and two issues frequently arise. First: if the Tribunal orders discharge and the patient is soon re-sectioned, is that lawful? As explained above, the answer is basically not unless there has been a change in circumstances³⁸.

The second issue is what happens when a Tribunal orders a deferred discharge but conditions are not met, leading to the continued detention of the patient. As it stands, if the impasse is because a professional judgment stands in the way, there is little that can be done in domestic law to force the discharge through: so, when a community responsible medical officer refused to take a patient, the courts did not intervene³⁹; equally, when a social worker would not approve a hostel, the courts did not intervene with what was held to be a rational judgment⁴⁰. There has been a development in the law in that, in relation to the deferred conditional discharge of a restricted patient, the Tribunal is able to retain supervisory powers over the meeting of conditions and may modify them if it

35 1987 SLT 681. Note also there is a general common law power to detain to prevent a breach of the peace, and a now-statutory power to use reasonable force to prevent crime (s3 Criminal Law Act 1967); and necessity allows emergency medical treatment of incapable patients. The situation of patients covered by the case of *R v Bournemouth Community and Mental Health NHS Trust ex p L* [1999] 1 AC 458 should also be considered; the decision of the European Court of Human Rights on this situation is awaited.

36 (1998) 43 BMLR 167

37 see Jones, *Mental Health Act Manual*, 8th Ed, 1–293

38 This change in practice also has implications for the quality of reasons required by a Tribunal because those involved in the fresh process of sectioning the patient may not know what evidence was given to the Tribunal and why it discharged the patient: hence, the previous

view that the reasons of a Tribunal could be limited as they were given to an “informed audience” which know the evidence presented and the arguments made is no longer adequate. See *R (H) v Ashworth Hospital* [2003] 1 WLR 127, [2002] *Mental Health Law Reports* 314.

39 *R (K) v Camden and Islington Health Authority* [2002] QB 198, [2001] *Mental Health Law Reports* 24

40 *R (W) v Doncaster City Council* [2003] EWHC 193 (Admin): the judge granted permission to appeal, and one of the issues raised is whether a breach of the Convention deprives the detention of its lawfulness for the purposes of the tort of false imprisonment and, if so, whether it is the detaining hospital or the after-care authorities who are liable. The appeal is due to be heard in March 2004.

is not possible to persuade those involved to put the conditions into effect, though arguments remain as to whether this amounts to compliance with Article 5(4) of the Convention, the need for a Court to be able to order release if the merits of detention is not made out⁴¹. The European Court has held that the absence of powers to ensure that a deferred conditional discharge is put into effect without unreasonable delay amounts to a breach of the Convention⁴².

The issue of damages in this context is made plain by the fact that Article 5(5) of the Convention requires a right to compensation for those detained in breach of Article 5 of the Convention⁴³.

One final point to mention here is the effect of s139 of the Mental Health Act 1983, which in essence provides a defence for actions purportedly done under the Act in the absence of bad faith or the lack of reasonable care, except in relation to actions against the Secretary of State or a health authority or trust: the fact that this imposes a fault requirement for actions brought by those who are or are alleged to be mentally disordered in what is otherwise a strict liability tort may raise arguments under Article 14 (prohibition on discrimination). Although the more restrictive provisions of the predecessor of s139 was upheld in *Ashingdane v UK*⁴⁴, this was on the basis that there was not an improper breach of the right of access to a Court guaranteed by Article 6 of the Convention and it does not appear to have been argued that there was a breach of Article 14.

2. Assault

The cases of *Wilkinson* and *N* make it plain that detention under the Mental Health Act 1983 does not necessarily authorise the imposition of such treatment as the Responsible Medical Officer indicates should be administered. There are some statutory procedural hurdles to overcome in certain situations (including use of medication for more than 3 months): see ss56ff of the Act. However, even if the statutory pre-requisites have been met, including approval from the Second Opinion Appointed Doctor, the matter may be litigated if there is a proper argument that the proposed treatment is not authorised by the statute or is not in the best interests of the patient. It has always to be remembered that the fact that there is authority to treat against the wishes of the patient does not mean that it will necessarily follow: see, for example, para 16.11 of the Code of Practice issued under s118 of the 1983 Act.

Typically this sort of dispute will be based on arguments that the patient has been misdiagnosed, or that the nature or degree of the illness does not require a course of treatment as invasive as that proposed. The role of the Court is to ensure that Articles 3 and 8, and perhaps Article 2 in some circumstances, are respected: (i) Article 3 requires that treatment is convincingly shown to be a medical necessity; (ii) Article 8 requires that the treatment be a proportionate response⁴⁵.

The other issue which may arise in relation to treatment is whether a particular treatment is medical treatment for the purposes of the Act: in this regard, it should be noted that “medical treatment” is widely defined in s145 of the Act and that “treatment for mental disorder” can

41 *R (IH) v Home Secretary* [2003] QB 320, [2002] Mental Health Law Reports 87. This decision was upheld by the House of Lords ([2003] UKHL 59), which unfortunately declined to grapple with the important question of whether the community psychiatrist is a public authority and so bound by the Human Rights Act 1998 to act in a way which does not breach Article 5.

42 *Johnson v UK* (1999) 27 EHRR 296

43 This includes the failure to have a speedy review, as required by Article 5(4): see below.

44 (1979) 2 EHRR 387

45 See *Herczegfalvy v Austria* (1993) 15 EHRR 437 as applied in *Wilkinson* and *N*.

include treatment ancillary to the core treatment or designed to relieve the symptoms of disorder⁴⁶.

These issues can be litigated by way of judicial review or claims for assault and/or breach of the Human Rights Act 1998, all with interim injunctions likely to be sought.

3. Breach of Human Rights Act 1998

The Human Rights Act makes it unlawful for public authorities (a concept which is co-extensive with bodies amenable to judicial review) to breach Convention rights unless required to do so by a primary statutory provision: s6 Human Rights Act 1998. Section 7 of the Act allows action to be taken, and the remedies may include damages if such an award is necessary to afford just satisfaction to the Claimant. The case law in relation to this is currently being developed: as an example, see *R (KB and Others) v Mental Health Review Tribunal and Secretary of State*⁴⁷, in which damages were ordered for the majority of a number of claimants whose rights to a speedy Tribunal decision as guaranteed by Article 5(4) of the Convention had been breached (including some whose detention was upheld). This is a useful adjunct to claims phrased in false imprisonment (and may be the only claim if the courts decide that a detention which is unlawful in Convention terms but otherwise lawful in domestic law does not give rise to a claim in false imprisonment). Claims phrased in assault can also usually be supplemented by a claim for a breach of Articles 3 or 8, and claims for breach of Article 8 may be used in many areas⁴⁸.

4. Negligence and Other Torts

As a matter of presenting the complete picture, it should be noted that the law of professional negligence applies to the relationship between doctor and patient (and other professionals), and if damage is caused by a negligent failure in treatment, damages can be awarded. However, note that there is no duty of care arising directly from s117 of the Act if the doctor-patient relationship had not been formed⁴⁹. It is also possible that other torts will be made out on the particular facts: note, in particular, that torts such as misfeasance in a public office are developing. The mental health sphere is also one which involves information protected by confidentiality, and the Article 8 right to protection of privacy: a failure to maintain confidentiality may be actionable by way of the tort of breach of confidence⁵⁰.

46 See also the relevant case law, particularly *Reid v Secretary of State for Scotland* [1999] 2 AC 512; for example, in *B v Croydon Health Authority* [1995] Fam 133, tube feeding was authorised for someone who suffered from a personality disorder which caused her to self-harm.

47 [2003] *Mental Health Law Reports* 1 (for the argument on liability) and 28 (for the argument as to damages)

48 In *Wainwright v Home Office* [2003] 3 WLR 1137, the House of Lords held that it was not proper to use

the Convention to modify the common law and create a tort of breach of privacy: but it was noted that any gaps in protection offered by existing remedies in areas covered by Art 8 are now met by the claims available under the Human Rights Act 1998.

49 *Clunis v Camden and Islington Health Authority* [1998] QB 978

50 See as an example *Cornelius v De Taranto* [2000] *Mental Health Law Reports* 145 and, on appeal, [2001] *Mental Health Law Reports* 217. See also *Fenella Morris*, *JMHL*, July 2003.