Protecting the Suicidal Patient

Neil Allen[1]

Savage v South Essex Partnership NHS Foundation Trust [2007] EWCA Civ 1375

Introduction

Suicide prevention is said to be a key national priority for mental health services in England and Wales.[2] Nonetheless, over 1300 patients already known to those very services commit suicide every year;[3] an average of almost *four a day*. Around 450 take their own lives whilst, or soon after, receiving inpatient treatment.[4] Providing mental health care is an inherently risky business. Indeed, protecting mentally ill patients from themselves is often the very justification for depriving them of their liberty under the *Mental Health Act 1983*. But how far must public authorities go in safeguarding society's interest in preserving the sanctity of human life?

Article 2(1) of the European Convention on Human Rights 1950 provides that 'Everyone's right to life shall be protected by law'.[5] Ranked as one of the Convention's most fundamental provisions, it imposes both negative and positive obligations upon the State. Whilst the negative obligations require public authorities to refrain from the intentional and unlawful taking of life,[6] the positive obligations necessitate the taking of appropriate steps to safeguard the lives of those within its jurisdiction.[7] The latter requires the State to 'establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life.'[8]

This legal framework typically comprises of criminal, civil and disciplinary measures designed to deter those who would otherwise devalue the right to life. For example, suicidal patients may raise issues of individual and corporate criminal liability. Although attempted suicide is no longer unlawful,[9] it is an

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2 *The Department of Health aims to reduce the death rate from suicide by at least 20% by 2010 (National Suicide Prevention Strategy for England, Department of Health, 2002). This followed its White Paper, Saving Lives: Our Healthier Nation (1999) (Cm 4386).*

3 *See 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. This can be contrasted with the 92 suicides in prison custody in 2007 (Ministry of Justice announcement 1st January 2008).*

4 *Meehan J. et al., 'Suicide in mental health in-patients and within 3 months of discharge' (2006) 188 British Journal of Psychiatry 129 at 133. During the study period, an average of 180-190 patients per year died whilst receiving inpatient care and around 275 patients per year died within three months of being discharged from hospital.*

5 *Article 2(2) provides that deprivation of life is not unlawful where it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; or (c) in action lawfully taken for the purpose of quelling a riot or insurrection.*

6 *McCann and Others v United Kingdom (1996) 21 EHRR 97 at para 148.*

7 *LCB v United Kingdom (1999) 27 EHRR 212 at para 36.*

8 *R (on the application of Middleton) v West Somerset Coroner [2004] 2 AC 182 at para 2 per Lord Bingham of Cornhill.*

9 *Suicide Act 1961 s 1.*

offence to assist a patient to kill themselves.[10] Moreover, as I have argued elsewhere,[11] hospital Trusts may be prosecuted for corporate manslaughter where patients die as a result of gross systemic negligence. In terms of civil liability, the law of negligence may compensate a self-harming patient whose actions result from a breach of their clinician's duty of care.[12] A claim may also be brought under either the *Law Reform (Miscellaneous Provisions) Act 1934* or the *Fatal Accidents Act 1976*.[13] Finally, mental health practitioners are regulated by their respective professional bodies which are able to impose disciplinary sanctions.[14]

In addition to requiring such a comprehensive framework, the positive obligations in article 2 include two distinct duties; hereafter referred to as the 'investigatory duty'[15] and the 'protective duty'.[16] The former obliges[17] the State to adequately investigate death or near-death[18] and lies beyond the scope of this paper. The latter arises only in limited circumstances and requires public authorities to take steps to protect endangered life. The case of *Savage v South Essex Partnership N.H.S. Foundation Trust* considers the appropriate test to be used in determining whether this protective duty has been violated. After providing an overview of the case, I shall analyse its implications by drawing comparisons with the position at common law as discussed in *G v Central and North West London Mental Health NHS Trust*.[19]

The Facts and Judgments to Date

With the trial yet to have taken place, and permission to appeal having been given granted by the House of Lords, the reported judgments contain very little detail regarding the facts of the case. The day after voluntarily attending Runwell Hospital, Mrs Carol Savage was detained for treatment of her paranoid schizophrenia under section 3 of the *Mental Health Act 1983* ('MHA'). With a long history of mental illness, she was kept on an open acute psychiatric ward. It is alleged that, despite making a number of attempts to leave, she was left unsupervised on hospital grounds because she was considered to be at low

10 *Suicide Act 1961 s 2 prohibits the inciting, aiding, abetting, counselling or procuring of suicide. Where a person kills another pursuant to a suicide pact, s/he will be guilty of manslaughter under the Homicide Act 1957 s 4(1). Note that article 2 does not incorporate a 'right to death' according to Pretty v United Kingdom (2002) 35 EHRR 1 at para 39.*

11 *See N. Allen, 'Medical or managerial manslaughter?' in C. Erin and S. Ost (eds), The Criminal Justice System and Health Care (2007) Oxford University Press. Offences committed after 6th April 2008 must be charged under the Corporate Manslaughter and Corporate Homicide Act 2007 which endorses a direct liability approach to corporate culpability.*

12 *For a discussion on the extent to which their duty of care requires doctors to prevent suicide, see K. Wheat, 'The Law's Treatment of the Suicidal' (2000) 8 Medical Law Review 182. See also Corr v IBC Vehicles Ltd [2008] 2 WLR 499, HL, where a negligent employer was held to be liable for his ex-employee's suicide which occurred nearly six years after the breach of duty.*

13 *Sections 1 and 1A of the Fatal Accidents Act 1976 provide an exhaustive list of potential claimants. It remains to be seen whether article 2 of the ECHR will require that list to be expanded to include non-qualifying dependents (see Cameron v Network Rail Infrastructure Ltd (formerly Railtrack Plc) [2007] 1 WLR 163; [2007] 3 All ER 241).*

14 *Note the reform proposals in the White Paper, Trust, Assurance and Safety – The Regulation of Health Professions (2007) (Cm 7013). See also M. Brazier and E. Cave, Medicine, Patients and the Law (4th ed.) (Penguin, 2007) Chapter 1.*

15 *Sometimes referred to as the 'procedural' or 'adjectival' obligation.*

16 *Also known as the 'substantive obligation'.*

17 *See, for example, R (on the application of Amin) v Home Secretary [2004] 1 AC 653; R (on the application of Takoushis) v Inner North London Coroner [2006] 1 WLR 461; Emms, Petitioner [2007] CSOH 184; (2008) 99 BMLR 116; Shevchenko v Ukraine (2007) 45 EHRR 27; Dodov v Bulgaria (Application no. 59548/00) (unreported) 17 January 2008.*

18 *R (on the application of D) v Secretary of State for the Home Department [2006] EWCA Civ 143; R (on the application of JL) v Secretary of State for the Home Department [2008] 1 WLR 158; [2007] HRLR 39.*

19 *[2007] EWHC 3086.*

risk of suicide. One day she was able to escape, walking two miles to Wickford railway station before fatally jumping in front of an oncoming train. Substantial issues regarding the nature and adequacy of the hospital's management have been raised, with allegations focusing upon whether there was a failure to take reasonable measures to prevent the risk of suicide and absconsion.

It is not in dispute that the State's investigatory duty has been discharged as a coroner's inquest has been held and the deceased's family are able, if they so wish, to bring civil proceedings against the Trust. Neither has gross negligence been alleged. Instead, Anna Savage contends that the hospital staff have violated her mother's right to life under article 2.[20] As a preliminary issue, the Court of Appeal was asked to determine a matter of principle: what was the correct test to establish a breach of the right to life in these circumstances? The Trust submitted that it was necessary to prove at least gross negligence; whereas the claimant asserted that negligence, or something less, would suffice.

At first instance[21]

For Swift J. it was 'crucial' to consider 'the context in which the detention occurred.'[22] A distinction between custody and hospital deaths had been drawn in *R (on the application of Takoushis) v Inner North London Coroner*[23] when, in relation to the latter, it was further observed that there was 'an important difference between those who are detained by the state and those who are not.'[24] However, those distinctions were made in the context of the *investigatory* duty in article 2. They did not necessarily assist in determining whether different tests should be applied to detained patients and voluntary patients insofar as the *protective* duty was concerned. Often treated side-by-side, both groups may present analogous clinical issues necessitating similar therapeutic judgments. Indeed, Swift J. considered their similarities to be greater than those between a detained patient and a prisoner. To apply different tests might, therefore, result in defensive psychiatric practice.

In *Takoushis*,[25] Sir Anthony Clarke M.R. had endorsed the view[26] that 'simple negligence' resulting in a patient's death 'was not sufficient in itself' to breach the positive obligations in article 2, adding that the position 'is or may be different in a case in which gross negligence or manslaughter is alleged'. Perhaps constrained by precedent, Swift J. declared[27] that the proper test for establishing a violation of article 2 was 'at least gross negligence of a kind sufficient to sustain a charge of manslaughter'. In light of her Ladyship's earlier comments, this test would presumably have been applicable to both detained and voluntary patients. As gross negligence was never alleged, the judge made an order for summary judgment against the claimant.

On appeal[28]

The Court of Appeal seems to have been heavily influenced by the European Court of Human Rights' (ECtHR) decision in *Tarariyeva v Russia*[29] which, according to the Master of the Rolls, 'to some extent

20 *A claim under article 8 (respect for private and family life) was dismissed at first instance, and arguments concerning article 14 (discrimination) were advocated on appeal, although not ruled upon.*

21 *[2006] EWHC 3562 (QB).*

22 *Ibid at para 45.*

23 *[2006] 1 WLR 461.*

24 *Ibid at para 108.*

25 *Ibid at paras 95-96.*

26 *As per Richards J. in R (on the application of Goodson) v Bedfordshire and Luton Coroner [2006] 1 WLR 432 at 454. This view was largely based upon his interpretation of the investigation case of Powell v United Kingdom (2000) 30 EHRR CD362.*

27 *Ibid n 21 at para 48.*

28 *[2007] EWCA Civ 1375; [2008] HRLR 15.*

29 *(Application no. 4353/03) (unreported) 14 December 2006.*

maintained but to some extent blurred'[30] the distinction between custody and hospital cases. The case was 'of considerable interest'[31] as the State was held to be liable for a prisoner's death which resulted from the negligence of *hospital* staff. Although their Lordships understood the analogy drawn by Swift J., they considered the position of detained patients to be more akin to that of prisoners than to that of ordinary patients. The 'critical point' was that both groups were 'particularly vulnerable' and 'under the control of the state in a way in which ordinary patients are not'.[32] This was the case whether or not they were detained on a locked or unlocked ward. There was therefore no reason to afford those detained under the MHA 1983 any less rights under article 2 than those detained in prison or prison hospitals. Voluntary mental patients were vulnerable but in 'a rather different way' and whether or not a different test should apply to them, that was not the position at common law as the same duty of care was owed.

In a somewhat dramatic volte-face, the Court distanced itself from the 'probably obiter' comments it had made in *Takoushis*. Its previous reference to simple and gross negligence was not part of that decision, nor was the distinction drawn between detained and voluntary patients.[33] Thereby released from the shackles of precedent, the Court unanimously held[34] that it was not necessary to establish gross negligence or anything more serious. Instead, the *Osman* test[35] should apply in determining whether the positive obligation in article 2 had been breached. Thus, the claimant had to show that:

> *'… at the material time the Trust knew or ought to have known of the existence of a real and immediate risk to the life of Mrs Savage 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.'*

Elaborating upon these elements, the Master of the Rolls endorsed the view[36] that 'a real risk is one that is objectively justified and an immediate risk is one that is present and continuing'. This set a 'high test'. The appeal was therefore allowed and the action would proceed to trial. The judgment, however, concluded with the uncertain remark: 'While we would not prohibit [Ms Savage] from arguing at the trial for a lower test, we see no warrant for such a lower test …'

Comment

These proceedings are the first to identify the appropriate threshold for the protective duty in a medical negligence context. While the Court of Appeal's adoption of the *Osman* test is a welcome development, it is submitted that its reasons for doing so could have been clearer. I shall first contend that Mrs Savage's detention status was not relevant as the *Osman* test is applicable to any patient, detained or otherwise. Secondly, it will be noted that the scope of this test is qualified by its elements so as to severely restrict the circumstances in which public authorities are likely to violate their protective duty. Finally, the potential repercussions of the *Savage* proceedings for the law of medical negligence will be briefly considered.

(a) Unnecessary analogies and frail distinctions

The Court of Appeal's justification for rejecting the gross negligence threshold in favour of the *Osman* test appears to be that patients detained for treatment under section 3 of the MHA 1983 are in an

30 *[2007] EWCA Civ 1375 at para 20.*

31 *Ibid at para 25.*

32 *Ibid at para 32.*

33 *Ibid at para 9.*

34 *Ibid at para 35.*

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

36 *In re Officer L (Respondent) (Northern Ireland) [2007] 1 WLR 2135 at 2143 where the House of Lords adopted the same test as originally suggested by Weatherup J. in Re W's Application [2004] NIQB 67 at para 17.*

analogous position to prisoners. They are 'particularly vulnerable' and 'under the control of the state in a way in which ordinary patients are not'. It follows, presumably, that the *Osman* test would be equally applicable to those detained for assessment,[37] in emergency circumstances,[38] or under the temporary holding powers.[39] The logic might even extend to those informally deprived of their liberty under the forthcoming provisions of the *Mental Capacity Act 2005*.[40] Why should the protective duty in article 2 not extend to those recently discharged from detention for whom the risk of suicide is at its greatest?[41] What is the appropriate test for the vast majority of psychiatric patients who are not in detention?

The risk of defensive psychiatric practice in the face of such an arbitrary legal distinction seems not to have concerned the Court;[42] but referring to detention status is, in my view, unnecessary in the present context and may cause conceptual difficulties. As the Master of the Rolls rightly observed,[43] the European jurisprudence has extended the protective duty to those who are not in detention.[44] Indeed, domestic law has begun to follow suit.[45] Why should the presence of mental disorder make a difference?

Whilst the issue of detention status will be relevant to determining whether the protective duty has been breached,[46] it should not be used to circumscribe the types of patients to whom that duty is owed. This explains why the *Takoushis* distinctions were merely obiter. Consider *G v Central and North West London Mental Health NHS Trust*[47] where the patient had run out in front of a bus and tried to overdose on paracetamol before her voluntary hospital admission. Detention under section 3 of the MHA 1983 was considered to be unnecessary because she had agreed to have her liberty restricted on an informal basis, although there were short periods during which she was temporarily restrained.[48] If detention status was relevant, the *Osman* test might only apply during the hours of temporary detention whilst some other evidential test might apply to the remainder of her informal stay. The applicable legal test would therefore be dependent upon whether she was prepared to consent to the informal arrangements.

37 *MHA 1983 s 2.*

38 *Ibid ss 4, 135 or 136.*

39 *Ibid s 5.*

40 *Section 50 of the Mental Health Act 2007 inserts Schedule A1 into the Mental Capacity Act 2005 which will contain the procedural safeguards precipitated by the ECtHR's decision in HL v United Kingdom (2005) 40 EHRR 32. On the meaning of 'deprivation of liberty' see JE v Surrey County Council, re DE [2006] EWHC 3459 (Fam), [2007] 2 FLR 1150; Sunderland City Council v PS [2007] EWHC 623 (Fam), [2007] 2 FLR 1083. Salford City Council v GJ and others [2008] EWHC 1097 (Fam).*

41 *National Suicide Prevention Strategy for England: Annual report on progress 2006 (CSIP, April 2007) at p4. See also K v Central and North West London Mental Health NHS Trust [2008] EWHC 1217 (QB).*

42 *Ibid n 28 at para 33.*

43 *Ibid at para 26 which refers to Öneryildiz v Turkey (2005) 41 EHRR 20 at paras 69-73 and 107, Abdurrahman Kilnic v Turkey (unreported) 7 February 2005, and Ataman v Turkey (Application no. 46252/99) (unreported) 27 April 2006.*

44 *See also LCB v United Kingdom (1998) 27 EHRR 212; Mahmut Kaya v Turkey (1999) 28 EHRR 1; Mastromatteo v Italy (Application no. 37703/97) (unreported) 24 October 2002; Gongadze v Ukraine (2006) 43 EHRR 44.*

45 *See, for example, R (on the application of Dudley, Whitbread and Others) v East Sussex County Council [2003] EWHC 1093 (Admin) at para 28; R (on the application of Plymouth City Council) v County of Devon Coroner [2005] EWHC 1014 (Admin), [2005] 2 FCR 428; Van Colle and another v Chief Constable of Hertfordshire [2007] 1 WLR 1821; Smith v Chief Constable of Sussex [2008] EWCA Civ 39.*

46 *This conforms with R (on the application of DF) v Chief Constable of Norfolk Police, Secretary of State for the Home Department [2002] EWHC 1738 (Admin) at para 37 where Crane J. held that 'the requirement that the authorities knew or ought to have known of the risk will usually be satisfied much more readily in relation to a prisoner, than in relation to a member of the community in general'.*

47 *[2007] EWHC 3086 (QB).*

48 *Indeed she was detained under s 3 after her suicide attempt.*

(b) The Osman elements

Rather than referring to detention status, a clearer approach might be to rely upon the elements of the *Osman* test to prescribe the necessary trigger for invoking the protective duty. Thus, the duty will be owed to *any* identifiable patient whenever hospital staff are aware, or ought to be aware, of a real and immediate risk to that person's life. This degree of foresight sets a very high threshold which will not be readily satisfied.[49] For no question can be raised under article 2 unless the staff have such actual or constructive knowledge of the risk.[50] The nature of that risk will also be important because the patient must present an objectively justified risk *to life*; a risk of serious injury resulting from self-harm would not suffice, although this distinction may in practice be occasionally difficult to draw.[51] In addition, the real risk must be present and continuing at the time of the alleged violation; if its immediacy subsided before the expectation to take precautions arose, the necessary causal link will not have been established.

Contrast this clear formula with the line of judicial authority[52] which favours a variable threshold of risk, tailored to the particular circumstances of the case. It purports to water down the *Osman* elements for individuals whose lives have been put at risk by the actions of the State; for example, those in a 'special category of vulnerable persons' or those required by the State to perform certain duties on its behalf. Their enhanced status, it is said, entitles them to expect a 'reasonable level of protection' which is achieved by interpreting any risk as a 'real risk' and interpreting 'immediate' to simply mean 'present and continuing'. It is this 'lower test' which the Court of Appeal in *Savage* may have been referring to in its concluding remark, although it rightly saw no warrant for it. Indeed, it is submitted that the approach to be preferred is that endorsed by the House in *In re Officer L*: '… the standard is constant and not variable with the type of act in contemplation, and is not easily reached.'[53] Requiring the real risk to life to be immediate in the sense of being 'present and continuing' avoids frail distinctions, for example between those who may, or may not, be vulnerable, and is non-discriminatory in nature.

Returning to G, in the week before her suicide attempt at Baker Street Tube station, the patient absconded, withdrew money and bought a map of the infamous Beachy Head. She also preoccupied staff with discussions about the unit's suicide rate. Although no claim was brought under the *Human Rights Act 1998*, it is certainly arguable that there was a real and immediate risk to G's life at the time her consultant decided to continue with unescorted leave around hospital grounds. Moreover, the staff knew, or at least ought to have known, of that risk. In those circumstances, it is submitted that her informal detention status should not prevent the protective duty being owed, though not necessarily breached, in these circumstances.

49 *For a detailed analysis of the relevant considerations, see J. McBride, 'Protecting life: a positive obligation to help' (1999) European Law Review 43.*

50 *An example where such knowledge was held to be absent is R (on the application of Plymouth City Council) v County of Devon Coroner [2005] EWHC 1014 (Admin). See also Trubnikov v Russia (Application no. 49790/99) 5 July 2005, ECtHR.*

51 *Cf. The right to life, as preserved by the offence of gross negligence manslaughter, requires nothing short of a risk of death: R v Adomako [1995] 1 AC 171 at 187 and R v Misra and Srivastava [2005] 1 Cr App R 21 at para 52. See M. Brazier and N. Allen, 'Criminalising Medical Malpractice' in C. Erin and S. Ost (eds), The Criminal Justice System and Health Care (2007) Oxford University Press.*

52 *R (on the application of A) v Lord Saville of Newdigate [2002] 1 WLR 1249 at paras 28-31; R (on the application of DF) v Chief Constable of Norfolk [2002] EWHC 1738 (Admin) at para 38; R (on the application of Bloggs 61) v Secretary of State for the Home Department [2003] 1 WLR 2724 at paras 54-55 and 60-61; Van Colle and another v Chief Constable of the Hertfordshire Police [2007] 1 WLR 1821 at paras 75-77; Savage v South Essex Partnership N.H.S. Foundation Trust [2006] EWHC 3562 (QB) at paras 33-37 which were not disapproved of by the Court of Appeal [2007] EWCA Civ 1375 para 16; and Mitchell v Glasgow City Council [2008] CSIH 19 at paras 63-65.*

53 *[2007] 1 WLR 2135 at para 20.*

Satisfying the *Osman* elements serves only to trigger the State's protective duty. To establish its breach, the claimant must go on to prove that the authorities failed to do all that was reasonably to be expected of them to avoid the risk to life. The European jurisprudence embraces the principle of proportionality in this regard:

> *'…[B]earing in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities.'*[54]

Such a wide margin of appreciation aims to strike a fair balance between individual and community rights. It requires the Court to consider the precautionary options available to hospital staff, their likely effectiveness and the reasonableness of implementing them. This will take into account how difficult it may be to implement the precautions and the resources available. The protective duty, therefore, does not require staff to guard against *every* risk to life; in fact it would be impossible to satisfy such an absolute standard. Indeed, to do so may well threaten their therapeutic relationship with the patient.

Rather than applying a 'but for' test to determine whether the materialised risk could be said to be 'caused' by the State's actions or omissions, the test employed by the Court of Appeal mirrors the causative language used by the ECtHR in *Osman.*[55] Thus, the State will be liable if it fails to take protective measures 'which, judged reasonably, might be expected to avoid' the risk to life. With the *Osman* elements setting a high threshold for triggering the protective duty, this 'reasonable expectation' test for causation seems appropriately generous to claimants and conforms to European jurisprudence. Unlike the stricter test adopted in *Van Colle,*[56] which requires the measures to have had 'a real prospect of altering the outcome', it relinquishes the claimant from having to prove that matters would have turned out differently had the relevant precaution been taken. This ensures that the right to life is afforded real and effective protection in domestic law.

(c) Implications for the law of negligence

Were the House of Lords to adopt the *Osman* test and permit the *Savage* case to proceed to trial, assuming the *Osman* elements are satisfied so as to trigger the protective duty, the *human rights* issue will be whether her consultant failed to take measures within the scope of her powers which, judged reasonably, might have been expected to avoid the risk to life. This can be contrasted with the G case where the *negligence* issue was whether her consultant acted in accordance with a practice accepted as proper by a responsible body of practitioners skilled in the relevant field.[57] The common law duty of care can be seen to be covering much the same ground as the Convention right. Yet an alleged breach of the former will be determined according to the deferential *Bolam*[58] test whilst an alleged violation of the latter will call for

54 *Ibid n 35 at para 116; see also Keenan v United Kingdom (2001) 33 EHRR 38 at para 90; Akdogdu v Turkey (Application No. 46747/99) at para 45; Uçar v Turkey (Application No. 52392/99) at para 84.*

55 *In Dodov v Bulgaria ibid n 17 the ECtHR asked whether the public authorities did 'all that could have been required of them to prevent the life of the individual concerned from being, avoidably, put at risk'.*

56 *Ibid n 45 at paras 81– 83. This was used by the ECtHR in the context of article 3 in E v United Kingdom (2002) 36 EHRR 519 at paras 99-100.*

57 *Ibid n 19 at paras 87-9. G's consultant was held not to have been negligent.*

58 *Bolam v Friern HMC [1957] 1 WLR 582 at 587. The House of Lords in Bolitho v City and Hackney Health Authority [1998] AC 232 largely reaffirmed the Bolam test, stressing that only in rare cases will the courts be able to disallow an accepted medical practice.*

a greater degree of judicial scrutiny under the *Osman* test. Those claimants who do not begin proceedings within one year[59] might therefore lose this enhanced degree of Convention protection.

Adopting the *Osman* test is likely to exacerbate the recent tremors in the law of negligence.[60] The judiciary have begun to evolve the duty of care owed by the police so as to act compatibly with the Convention.[61] Whether the *Bolam* test provides the necessary degree of scrutiny must now be in doubt[62] as the contemporary view seems to be that compartmentalising human rights and negligence actions is not an acceptable way for the law to develop. Although the judiciary is not duty-bound to do more than the Strasbourg Court, it must certainly do no less.[63] Might this therefore be the beginning of the end for *Bolam?*[64]

Conclusion

Assessing the risk of suicide is an inherently unreliable exercise;[65] after all, 'psychiatry is not an exact science'.[66] This may explain why at their final point of contact with mental health services, immediate suicide risk was estimated to be low or absent for 86% of the deceased.[67] The cases of *Savage* and G vividly illustrate the potential for human error.

It has been argued that the protective duty is triggerable for all patients, regardless of their detention status, once the heavily qualified elements of the *Osman* test have been established. The margin of appreciation permitted by European jurisprudence in determining whether that duty has been breached should, it is hoped, discourage clinicians from engaging in defensive practice. In these early stages of articles 2's development into the health care setting, a careful legal balance must be struck between risk and liberty, between paternalism and self-determination. If suicide prevention is to be a national priority, obliging mental health services to take reasonable steps to protect life in limited circumstances would surely be a positive, and not unduly onerous, judicial development.

59 *Human Rights Act 1998 s 7. There is a discretion to allow late applications to proceed under s 33 where the Court considers it 'equitable' to do so.*

60 *The relationship between Convention and common law rights was considered in A v B and C [2002] 2 All ER 545 at para 4; and D v East Berkshire Community Health NHS Trust and others [2005] 2 AC 373.*

61 *See Smith v Chief Constable of Sussex Police [2008] EWCA Civ 39. Although the Court did not hear full argument on the issue, Rimer L.J. at para 45 considered it to be arguable that the positive obligations in article 2 should impact upon the development of the common law principles of negligence 'on the basis that where a common law duty covers the same ground as a Convention right, it should, so far as practicable, develop in harmony with it'.*

62 *Ibid at para 56 per Pill L.J. The ECtHR has held 'The Court must subject allegations of breach of [article 2] to the most careful scrutiny' (see Nachova and Others v Bulgaria (2006) 42 EHRR 43 at para 93; Angelova and Iliev v Bulgaria (Application no. 55523/00) (unreported) 26 July 2007 at para 91).*

63 *R (on the application of Ullah) v Special Adjudicator [2004] 2 AC at para 20.*

64 *See M. Brazier and J. Miola, 'Bye-bye Bolam: A Medical Litigation Revolution?' (2000) 8 Medical Law Review 85 and J. Miola. Medical Ethics and Medical Law: A Symbiotic Relationship (Hart Publishing, 2007).*

65 *The Department of Health has published guides to best practice in risk-assessment: 'Independence, choice and risk: a guide to best practice in supported decision-making' (DH, May 2007 for all N.H.S. services); 'Best practice in managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services' (DH, June 2007 for mental health services).*

66 *R (on the application of B) v Ashworth Hospital Authority [2005] 2 AC 278 at para 32 per Baroness Hale.*

67 *Avoidable deaths, ibid n 3 at p14.*