SAVING LIFE AND RESPECTING DEATH – A SAVAGE DILEMMA

Savage v South Essex Partnership N.H.S. Foundation Trust (MIND and others intervening)

[2009] 2 WLR 115 (HL)

Introduction

In 2004, Mrs Carol Savage was one of 165 who took their own life whilst receiving treatment as a psychiatric in-patient.¹ With the trial yet to take place, few facts are presently known. The day after voluntarily attending Runwell Hospital, she was detained for treatment under section 3 of the Mental Health Act 1983 ('the 1983 Act') with a diagnosis of paranoid schizophrenia. Having made a number of attempts to leave the open acute psychiatric ward, checks on her whereabouts were prescribed for every 30 minutes. Believed to be at low risk of suicide, Mrs Savage was allegedly left unsupervised on hospital grounds from which she was able to flee, walking two miles to Wickford railway station before fatally jumping in front of a train. A coroner's jury concluded that the preventive precautions in place were 'inadequate'. And her daughter, Ms Anna Savage, claimed that the hospital had breached her mother's right to life by allowing her to escape.

A preliminary ruling was required to determine the proper test for establishing a breach of Article 2 of the European Convention on Human Rights 1950 ('ECHR'). A stark choice had to supposedly be made between two, mutually exclusive, lines of authority emanating from the European Court of Human Rights ('ECtHR'). One related to deaths in custody ('the *Osman/Keenan* approach'); the other to deaths resulting from medical negligence ('the *Powell* approach'). According to the former, where the authorities know, or ought to know, of a real and immediate risk to life, they must do all that can reasonably be expected of them to avert that risk. The Strasbourg court had originally devolved this obligation upon law enforcement agencies, requiring them to take preventive operational measures to protect those in the community whose lives were threatened by the criminal actions of third parties.² However, its scope had been extended to protect those in prison whose lives were put at risk through self-harm.³

The second line of authority stemmed from the admissibility decision in *Powell v United Kingdom*.⁴ The parents of a child with Addison's disease contended that Article 2 was violated by a hospital authority's failure to act promptly to avert his risk to life. The ECtHR

¹ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Annual Figures* (University of Manchester 2008) table 5. Available at: [http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiryannualfigures/annual_suicide_figures_\(1997-2005\).pdf](http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiryannualfigures/annual_suicide_figures_(1997-2005).pdf)

² *Osman v United Kingdom* (1998) 29 EHRR 245.

³ *Keenan v United Kingdom* (2001) 33 EHRR 913.

⁴ (2000) 30 EHRR CD362.

did not exclude the possibility that the acts and omissions of hospital authorities could, in certain circumstances, engage their responsibility under the positive limb of Article 2. However, the *Osman* line of reasoning could not be sustained. The justiciable issue related to the procedural aspect of the right to life which was entirely different, in terms of both its context and scope. The state's obligations would thus be discharged if adequate provision had been made for securing high professional standards among health professionals and the protection of patients' lives. Death resulting from errors of medical judgment or negligent co-ordination would not violate Article 2. More than mere negligence was required.

The circumstances in *Savage* therefore presented something of a hybrid. Which approach should apply to self-inflicted deaths occurring in psychiatric detention? At first instance, Swift J endorsed the reasoning in *Powell* and decided it was necessary to establish 'at least gross negligence of a kind sufficient to sustain a charge of manslaughter'.⁵ Distancing itself from previous *obiter* remarks, the Court of Appeal⁶ preferred the *Osman/Keenan* approach and this was unanimously upheld by the House of Lords.⁷ Thus, where there was a real and immediate risk of a (detained) patient committing suicide, Article 2 imposed an operational obligation on hospital authorities to do all that can reasonably be expected of them to prevent it.

Protecting the Right to Life

Crucially, the Appellate Committee held that the two mooted approaches related to different aspects of Article 2 which were 'not alternative but complementary'.⁸ There was 'not a hint' in the European jurisprudence that only the *Powell* approach could ever apply to the acts and omissions of hospital staff. Whilst Strasbourg may, on that occasion, have rejected the *Osman* test, 'this does not mean that the court would also have ruled out an operational duty ... to prevent a patient from committing suicide'.⁹ In fact, the decision provided 'no guidance' on the present issue.¹⁰ Thereby unencumbered by precedent, the House was free to determine the matter afresh.

Article 2 was said to comprise of three different duties upon the state.¹¹ Firstly, a negative duty to refrain from taking life, save in prescribed exceptional circumstances. Secondly, there was a procedural obligation to properly and openly investigate deaths for which the state might bear some responsibility.¹² It was not in dispute that both were satisfied in the present case as Mrs Savage had taken her own life and a coroner's inquest had been properly held.

⁵ [2006] EWHC 3562 (QB) at [19].

⁶ [2007] EWCA Civ 1375. For commentary, see N Allen, 'Protecting the Suicidal Patient' (2008) *Journal of Mental Health Law* 93.

⁷ [2009] 2 WLR 115.

⁸ *Ibid* at [17] (Lord Rodger). Similarly, at [9] Lord Scott did not accept 'the starkness of the contrast'.

⁹ At [55] (Lord Rodger).

¹⁰ At [58].

¹¹ At [76] (Baroness Hale).

¹² This aspect of article 2 was considered in *R (L (A patient)) v Secretary of State for Justice (Equality and Human Rights Commission intervening)* [2008] 3 WLR 1325 where the House of Lords held that the procedural obligation also arises where a prisoner's suicide attempt nearly succeeds and leaves him with (lasting) serious injury.

Rather, it was the nature of the third duty that was in dispute. Substantive opinions were delivered by Lord Rodger and Baroness Hale, with whom Lords Walker, Neuberger and Scott concurred, the latter handing down a short opinion. All agreed that the *Osman/Keenan* approach should be followed but they covered ‘somewhat different ground along the way’.¹³

The positive obligation in Article 2 obliged the state to take steps to protect the lives of those within its jurisdiction. It did so in three respects.¹⁴ The primary duty required the state to establish an effective system of criminal law to deter those who threatened life, backed up by law enforcement machinery to prevent, suppress and punish its breaches.¹⁵ But the obligation could be more demanding and wider in its scope. General protective measures may, secondly, be required to secure the health and well-being of prisoners and patients for instance (the *Powell* approach).¹⁶ These would complement the primary duty and oblige the relevant authorities to, for example, recruit competent staff, maintain high professional standards, and put in place suitable systems of work so as to protect life. Thirdly, in appropriate circumstances, an operational duty to protect the life of a specific individual may be imposed which was ‘distinct from, and additional to’ the general obligations (the *Osman/Keenan* approach).¹⁷

The difficulty was in defining when and why the two approaches should come into play. So far as suicidal prisoners were concerned, the basis for imposing both obligations was that ‘[p]ersons in custody are in a vulnerable position and the authorities are under a duty to protect them’¹⁸ which ‘was only stating the obvious’.¹⁹ The duties were similarly imposed upon states that had conscripted young people into their armed forces. In short, prisoners and conscripts were under the state’s control and placed in situations involving a heightened risk of suicide.²⁰ Could the same be said of psychiatric hospitals?

There was no dispute that Runwell Hospital owed a general obligation to take precautions to prevent the mentally ill from committing suicide. In determining which measures would be appropriate to that end, account had to be taken of their patients’ vulnerability. But ‘[a]ny auction in the comparative vulnerability of prisoners, voluntary patients, and detained patients would be as unedifying as it is unnecessary.’ Those detained were vulnerable ‘not only by reason of their illness which may affect their ability to look after themselves, but also because they are under the control of the hospital authorities.’²¹ There was nothing new in this as the Convention obligation simply reflected the position at common law.²² Thus, a failure to take such general steps could result in a claim, both for a breach of Article 2 and in negligence. If this duty was satisfied, but some medical error nevertheless resulted in death,

¹³ At [104] (Baroness Hale).

¹⁴ Lord Rodger at [26] perceived it as starting with ‘a high-level general duty and working down to an operational duty’.

¹⁵ See *Osman* (n2) at [115].

¹⁶ At [30] and [69] (Lord Rodger).

¹⁷ At [72] (Lord Rodger).

¹⁸ At [27], citing *Salman v Turkey* (2000) 34 EHRR 425. See also *Keenan* (n3) at [90]-[91].

¹⁹ At [28]. The same reasoning extended to other types of detainees; see *Slimani v France* (2004) 43 EHRR 1068 (administrative detention centre).

²⁰ At [39].

²¹ At [49].

²² At [47] (Lord Rodger).

there may be liability in negligence but not under Article 2.

With hospital authorities and their staff already subject to the general duty, Lord Rodger could not see why they should not also be under the 'usual complementary operational obligation' to try to prevent a particular suicide in appropriate circumstances. In fact, there was no valid reason for them not to.²³ Priority had to be given to saving life in these critical circumstances. A failure to do so would therefore result in liability both in negligence and under Article 2. Baroness Hale reached the same conclusion. The positive obligations generally required proper systems to be put in place. But in some circumstances a protective duty to a particular individual was triggered, although not by ordinary medical negligence alone. There was 'little doubt that it is right in principle' to apply the *Osman* test to patients detained under the 1983 Act. For the ECtHR had recognised the authorities' obligation to provide necessary health care to those deprived of their liberty and it was 'difficult to distinguish between different classes of people deprived of their liberty by the state.'²⁴ Indeed, they were deprived of more of their ordinary civil rights than other detainees. Baroness Hale was therefore undeterred from following 'the clear thrust' of the European jurisprudence.

The Threshold for Intervention

The threshold for triggering the operational duty is high.²⁵ Given the seriousness of its violation, this is perhaps hardly surprising. Indeed, it will be harder to establish a breach than it is to prove negligence.²⁶ Rarely has it been shown that a public authority knew, or ought to have known, of a real and immediate risk to an individual's life.²⁷ The *Osman* test is said to be 'clear and calls for no judicial exegesis',²⁸ but perhaps a little academic tangency might be forgiven.²⁹

There must first be a risk to life, not just to limb; a distinction often difficult to draw.³⁰ Jumping in front of an oncoming train evidently puts life at risk. Can the same be said of

²³ At [65]-[66].

²⁴ At [101].

²⁵ At [78] (Baroness Hale). See also *Van Colle v Chief Constable of the Hertfordshire Police (Secretary of State for the Home Department intervening)* [2008] 3 WLR 593 at [66] (Lord Hope).

²⁶ At [99]. The House of Lords has yet to consider the appropriate standard of proof in this regard.

²⁷ At [100] where reference was made to *Younger v United Kingdom* (2003) 33 EHRR CD 252 (police did not know that their prisoner was a suicide risk). For an example of the threshold being reached, see *Tomašić and Others v Croatia* (Application No. 46598/06, 15 January 2009) in which, having been released from prison, a man with personality disorder killed his former partner and daughter before committing suicide.

²⁸ *Van Colle* (n25) at [30] (Lord Bingham).

²⁹ For a detailed analysis of the relevant considerations, see J McBride, 'Protecting life: a positive obligation to help' (1999) *European Law Review* 43.

³⁰ 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, 187; *R v Misra and Srivastava* [2005] 1 Cr App R 21 at [52]. See M Brazier and N Allen, 'Criminalising Medical

wrist-cutting? Or a paracetamol overdose? Or crossing the road? Might it not even be argued that the inevitability of death itself creates a risk to life from the moment of birth, if not before?³¹ The ECtHR has been careful not to interpret Article 2 in such a way as to impose impossible or disproportionate burdens on the authorities.³² It recognises that modern societies are difficult to police. That human conduct can be unpredictable. And that conflicting priorities and limited resources may affect operational choices. Thus, not every claimed risk to life will trigger the *Osman* obligation: only those that are both ‘real’ and ‘immediate’.

Predicting someone’s risk to themselves or to others is an inherently unreliable exercise.³³ After all, ‘psychiatry is not an exact science’.³⁴ Any deprivation of physical liberty carries with it a risk of suicide.³⁵ But rarely will it be real and immediate. For example, on the day Mark Keenan committed suicide, there was no particular indication that he was likely to make an attempt on his life, despite his self-harming tendencies. The risk was real but not immediate.³⁶ In many situations, the risk of serious injury may be foreseen but not that of suicide.³⁷ Our inability accurately to predict risk was strikingly illustrated by the National Confidential Inquiry’s findings: at their final point of contact, immediate suicide risk was estimated to be low or absent for 86% of those already known to mental health services who committed suicide.³⁸

If such a risk to life does exist there must, secondly, be the requisite degree of knowledge. The authorities must be aware, or ought to be aware, of the risk at the time. Not sooner; nor

Malpractice’ in C Erin and S Ost (eds), *The Criminal Justice System and Health Care* (OUP, Oxford 2007).

³¹ In *LCB v United Kingdom* (1998) 27 EHRR 212 the applicant sought, unsuccessfully, to rely upon her father’s exposure to radiation as a basis for invoking her rights under article 2.

³² *Osman* (n2) at [116]; *Keenan* (n3) at [90]; *Akdoğan v Turkey* (Application No. 46747/99, 18 October 2005) at [45]; *Uçar v Turkey* (Application No. 52392/99, 11 April 2006) at [84]; *Renolde v France* (Application No. 5608/05, 16 January 2009) at [82].

³³ See J Monahan, ‘Jurisprudence of Risk Assessment: Forecasting Harm among Prisoners, Predators, and Patients’ (2006) 92 *Virginia Law Review* 391. See also J Monahan and others, *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence* (OUP, Oxford 2001) where one in four of those considered to be in the highest risk category were not violent in the following year of the project. 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’ (London, Department of Health 2007 for all NHS 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’ (London, Department of Health 2007 for mental health services).

³⁴ *R (on the application of B) v Ashworth Hospital Authority* [2005] 2 AC 278 at [32] (Baroness Hale).

³⁵ *Tanribilir v Turkey* (Application No. 21422/93, 16 November 2000) at [74] and repeated in *Akdoğan v Turkey* (n32) at [47].

³⁶ *Keenan* (n3) at [98].

³⁷ See *Trubnikov v Russia* (Application No. 49790/99, 5 July 2005).

³⁸ *Avoidable Deaths: Five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, (Manchester, University of Manchester 2006) at p14.

later. This is said to be ‘a crucial part of the test’.³⁹ Despite its benefits, hindsight must be avoided. We must not look at yesterday through today’s eyes. Importantly, constructive knowledge will suffice, although its meaning is still being judicially explored. In *Van Colle*, for example, Lord Phillips identified two possible constructions. Either it could mean that the authorities ‘ought, had they carried out their duties with due diligence, to have acquired information that would have made them aware of the risk’. Or that they ‘ought to have appreciated on the information available to them’.⁴⁰ Whilst his Lordship preferred the latter, Lord Bingham went further:

[S]tupidity, lack of imagination and inertia do not afford an excuse to a national authority which reasonably ought, in the light of what it knew or was told, to make further inquiries or investigations: it is then to be treated as knowing what such further inquiries or investigations would have elicited.⁴¹

Their Lordships in *Savage* were not called upon to decide whether there was a risk to life that was real, immediate, and known to hospital staff. Even if this high threshold can be reached at trial, the health authority will find that it is ‘not particularly stringent’ to establish a defence;⁴² for other Convention rights must be taken into account in determining which steps it was reasonable to expect them to take. Thus, the *Osman/Keenan* approach ‘should not persuade the professionals to behave any more cautiously or defensively than they are already persuaded to do by the ordinary law of negligence’.⁴³ Although liberty has been deprived, and personal autonomy affected, the steps taken must be proportionate to the need to protect patients from themselves. Runwell Hospital was thus ‘entitled, and perhaps bound, to allow Mrs Savage a degree of unsupervised freedom that did carry with it some risk that she might succeed in absconding’.⁴⁴

When to Save Life

So the protective duty is owed to those detained for treatment under section 3 of the 1983 Act. It seems likely that it will also apply to patients detained for assessment,⁴⁵ in emergency circumstances,⁴⁶ and on a temporary holding basis.⁴⁷ Similarly for those deprived of their liberty under the criminal provisions in Part 2 to the Act. But how far down the path of suicide prevention should the Human Rights Act 1998 go? Will the operational obligation be owed, for example, by privately-funded care homes authorised to deprive liberty under the Mental Capacity Act 2005?⁴⁸ Or by hospital authorities that quarantine those with specified

³⁹ *Van Colle* (n25) at [32] (Lord Bingham).

⁴⁰ *Ibid* at [86].

⁴¹ *Ibid* at [32].

⁴² At [41] (Lord Rodger).

⁴³ At [100] (Baroness Hale).

⁴⁴ At [13] (Lord Scott).

⁴⁵ Pursuant to s2.

⁴⁶ Ss 4, 135 or 136.

⁴⁷ S5.

⁴⁸ Mental Capacity Act 2005 Sch A1 contains the procedural safeguards precipitated by the ECtHR’s decision in *HL v United Kingdom* (2005) 40 EHRR 32. By virtue of s64, it does not matter whether the detaining authority is a public authority or not.

diseases?⁴⁹ Might it even extend beyond the boundaries of detention? To ordinary hospital wards, accident and emergency departments, and general practitioner surgeries?

To illustrate the legal issues, imagine a policeman, psychiatrist, and law student, chatting on a cliff top.⁵⁰ They see a man, deeply engrossed in the *Medical Law Review*, about to walk over the edge to his death. Are they legally (as opposed to morally) obliged to warn him? The position at common law is simple. Pure omissions, without more, are not unlawful.⁵¹ No-one need be a good samaritan in the absence of a duty of care; and this will not arise through foreseeability of harm alone.⁵² The Human Rights Act 1998 is less straightforward. The law student would (hopefully) know that he is not duty-bound to act compatibly with Article 2 because he is not performing a function of a public nature.⁵³ The same could presumably be said of the policeman and psychiatrist were they on holiday at the time. But both, let us assume, are acting in the course of their employment.

At its highest level, the state's positive Article 2 obligation to protect life is likely to be engaged for it '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'.⁵⁴ The police force would owe a general obligation, derived from the primary duty, to protect the lives of those within its locality. But this is not person-specific. It merely requires general measures to be implemented: in the main, to employ and train competent staff, and to adopt appropriate systems of work. No breach of Article 2 could accordingly arise if such steps are taken.⁵⁵ However, the policeman and psychiatrist are aware of a real and immediate risk to this particular man's life. Unlike *Osman*, no criminal actions of a third party have created that risk. Unlike *Keenan* and *Savage*, his liberty is not being deprived. Would the operational duty be triggered in these circumstances?

This is likely to depend upon the relationship between the general obligation and the

⁴⁹ At the time of writing, as regulated by the Public Health (Control of Disease) Act 1984 ss37-38 and Public Health (Infectious Diseases) Regulations 1988.

⁵⁰ This is an adaptation of Lord Keith's illustration in *Yuen Kun Yeu v Attorney General of Hong Kong* [1988] AC 175, 192.

⁵¹ *Smith v Littlewoods Organisation Ltd* [1987] AC 241, 271 (Lord Goff).

⁵² *Dorset Yacht Co Ltd v Home Office* [1970] AC 1004, 1037-1038 (Lord Morris); *Hill v Chief Constable of West Yorkshire* [1989] AC 53, 60 (Lord Keith). A doctor who fails to intervene in an emergency may, however, face professional disciplinary proceedings for breach of para 11 of the General Medical Council's *Good Medical Practice* Code of Conduct. See generally M Brazier and E Cave, *Medicine, Patients and the Law* (4th ed Penguin 2007) at p156-157.

⁵³ Within the meaning of s 6(3)(b) of the 1998 Act. For commentary as to its scope, see S Palmer, 'Public Functions and Private Services: A Gap in Human Rights Protection' (2008) 6(3/4) *International Journal of Constitutional Law* 585.

⁵⁴ *Furdík v Slovakia* (2009) 48 EHRR SE9 at 157.

⁵⁵ Following *Smith v Chief Constable of Sussex Police (Secretary of State for the Home Department and others intervening)* [2008] 3 WLR 593, the police would also be immune from liability in negligence. For commentary, see C McIvor, 'The positive duty of the police to protect life' (2008) 24(1) *Professional Negligence* 27 and C McIvor, 'Police immunity and the legacy of *Hill v Chief Constable of West Yorkshire*' (2005) 21 *Professional Negligence* 201.

protective duty. Two schools of judicial thought are emerging, vividly illustrated by the recent decision in *Mitchell v Glasgow City Council*.⁵⁶ A man repeatedly threatened to kill his next-door neighbour. Both were council tenants. The local authority convened a meeting with the aggressor, at which he lost his temper and became abusive. An hour later he killed the neighbour. It was argued that the council had breached the deceased's right to life by failing to warn him of the risk. The majority of the House of Lords were content to apply the *Osman* test and held that no liability arose under Article 2. Its high threshold had not been met because the local authority could not have known of any real and immediate risk to the neighbour's life. Nothing was said or done on the day to alert them of an attack, let alone a risk of death.

From this perspective, the protective duty is portrayed as entirely distinct from the general obligation. A free-standing concept, self-supporting in nature. One that bites whenever the *Osman* elements are met. It follows that both our policeman and psychiatrist would accordingly be obliged to do all they can to avert the man's death. Failure to do so would violate his right to life. This would mark a radical departure from the common law stance.⁵⁷ It would mean, for example, that the police authorities would no longer enjoy complete immunity from suit. Life-threatening medical procedures could be scrutinised with the more judicatorial test of Article 2⁵⁸ rather than the somewhat deferential *Bolam*⁵⁹ test. The threshold may be high and the defence to a claim not particularly stringent to establish. But, as Spencer observes, much like Heineken beer (according to its advertisers), the *Osman* principle could refresh those parts of the civil law that tortious principles cannot reach.⁶⁰

The second, more cautious, school of thought is that of Lord Rodger who, in the minority, considered Article 2 to be 'fundamentally irrelevant'.⁶¹ Even if the Council had known of a real and immediate risk to the deceased's life, it would not have been under duty to avert it.⁶² The reasoning behind this stance is a little unclear. It may have been because the general and operational obligations were already owed by the police. Thus, to also subject the local authority to the rigours of the *Osman* test would be superfluous and contrary to public policy. Or, second, because the landlord-tenant relationship did not justify the duty. His Lordship noted, in this regard, that the Council had not in any way assumed responsibility for the tenant's safety.⁶³ The third reason may be more conceptual in nature. Lord Rodger may have

⁵⁶ [2009] UKHL 11.

⁵⁷ The relationship between Convention and common law rights was considered in *Kay v Lambeth LBC* [2006] 2 AC 465 at [28]. See also *R (on the application of Purdy) v Director of Public Prosecutions and Omar Puente and Society for the Protection of Unborn Children* [2009] EWCA Civ 92 from [50].

⁵⁸ The ECtHR has held 'The Court must subject allegations of breach of [Article 2] to the most careful scrutiny': *Nachova and Others v Bulgaria* (2006) 42 EHRR 43 at [93]; *Angelova and Iliev v Bulgaria* (Application No. 55523/00, 26 July 2007) at [91].

⁵⁹ *Bolam v Friern HMC* [1957] 1 WLR 582, 587. See M Brazier and J Miola, 'Bye-Bye Bolam: A Medical Litigation Revolution?' (2000) 8 *Medical Law Review* 85.

⁶⁰ See JR Spencer, 'Tort law Bows to the Human Rights Act' (2008) 67(1) *Cambridge Law Journal* 15.

⁶¹ At [67].

⁶² At [71].

⁶³ Lord Rodger at [69] gave examples of circumstances in which responsibility for another's safety might be assumed: to those in custody or otherwise under the control of the authorities;

perceived the protective duty to be parasitic upon the general obligation.⁶⁴ Thus, the former could not be owed in the absence of the latter.

Were this line of reasoning to be applied to our cliff top scenario, the police would be obliged to intervene but our psychiatrist would not for any or all of his Lordship's reasons. Either because it would be superfluous; or because she has not assumed responsibility for the stranger's safety; or because no general obligation was already owed. The situation may be different were the man to have absconded from her control, or been subject to supervised community treatment at the time.

When to Respect Death

Not too far down the path of suicide prevention will the Human Rights Act meet a capacious suicidist. Like Mrs Dianne Pretty, whose motor neurone disease prevented her from taking her life unaided.⁶⁵ Or Ms Debbie Purdy who, due to progressive multiple sclerosis, wanted to be able to end her life whilst physically able to do so.⁶⁶ According to Lord Scott, the state has no general obligation to prevent a person desirous of taking their own life.⁶⁷ Thus, the passport authorities are not obliged to confiscate those proposing a short stay with suicidal intent in Switzerland, Belgium, Luxembourg, the Netherlands or Oregon, U.S.A. Presumably, the publication of suicide manuals need not be prohibited either.⁶⁸

Are there circumstances, however, in which the protective duty might be triggered? After all, neither Article 2 nor Article 8, at present, confers a right to die.⁶⁹ In *Re Z*,⁷⁰ for example, Mrs Z was diagnosed with cerebellar ataxia and received extensive local authority support at home. Her husband informed them that she was going to travel to Zurich on 1st December 2004 to be assisted with suicide. The court hearing took place the day before. The risk to life was real. Arguably it was immediate and was known to exist. Would her right to life therefore have been violated by the local authority, or indeed by the court, if she was not prevented from leaving?

Such matters of life and death underline the reason why the defence to an alleged breach of the protective duty should not be too stringent to establish. In determining the expected steps an authority should take to avert death, regard must be had to personal autonomy and to other

the ill and those in need of care because of old age; those in Council sheltered accommodation or retirement homes; and those deprived of their freedom of movement or action.

⁶⁴ At [66] he stated: 'Authorities which are under these general obligations to persons in their care may also come under a distinct, additional, "operational" obligation to take special preventive measures to protect a particular individual in their care.'

⁶⁵ See *R (on the application of Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)* [2002] 1 AC 800; *Pretty v United Kingdom* (2002) 35 EHRR 1.

⁶⁶ See *R (on the application of Purdy) v Director of Public Prosecutions and Omar Puente and Society for the Protection of Unborn Children* [2009] EWCA Civ 92.

⁶⁷ At [11].

⁶⁸ See *Attorney-General v Able* [1984] QB 795.

⁶⁹ See *Pretty* (n65) at [39].

⁷⁰ [2004] E.W.H.C. 2817 (Fam).

Convention Articles. Positive obligations arise, for example, under Article 3 not to subject suicidists to inhuman or degrading treatment. Choices about managing one's death also fall, in principle, within Article 8. Providing life-saving medical treatment in the face of a capacitous refusal could interfere with the patient's physical and psychological integrity.⁷¹ In the absence of legislative intervention, therefore, the path of suicide prevention needs to be carefully negotiated.

Conclusions

The *Savage* decision reinforces the state's obligations to protect those it deprives of liberty. With the House of Lords having distinguished European jurisprudence, the *Osman/Keenan* approach was left pushing at an open door; one leading into Runwell Hospital's acute psychiatric ward. Requiring its staff to avert real and immediate risks to life was a sensible judicial development. It complements their common law obligations and protects vulnerable patients. All inpatient suicides are, in theory, preventable. Leave of absence, for example, could be forever denied. Sedative medication forcibly administered. Doors locked. And bed restraints used. But the sheer intensity of such restrictions is likely to do more harm than good. An important balance must therefore be struck between preventing death and promoting health; between the interlocking Convention rights of Articles 2, 3 and 8. As the House rightly acknowledged, therapeutic risks have to be taken in patients' best interests.

Through which other doors might the protective duty be allowed to venture? Significant implications for the law of negligence may arise were it to extend to general medicine on ordinary hospital wards. Public authorities providing services outside the hospital context are likely to continue to face challenges similar to that in *Mitchell*. The reach of the *Osman* principle will be tested. Its basis will be questioned. Will an individual's vulnerability ultimately justify the relevance of the protective duty?⁷² Must the authority have created or heightened the risk to life before it be held accountable for failing to avert death? Or must some form of assumption of responsibility be required? Proportionality will no doubt play its part in future developments but further analysis of the relationship between Article 2's general and operational duties may help to clarify the issues.

Life is sanctimonious; self-determination fundamental; respect essential. But these ethical principles are not always compatible. For to respect someone's capacitous decision to fatally determine themselves is to offend life's sanctity. Decriminalising suicide reinforced the primacy of personal autonomy in the face of which Article 2 must now carefully tread.

Neil Allen
School of Law
Centre of Social Ethics and Policy
University of Manchester

⁷¹ See *Pretty* (n65) at [63].

⁷² The vulnerable adults group extends beyond the remit of the Mental Capacity Act 2005 to include those who are incapacitated 'by reason of such things as constraint, coercion, undue influence or other vitiating factors' (*Re SA (vulnerable adult with capacity: marriage)* [2006] 1 FLR 867 at [79] (Munby J). See MC Dunn and others, 'To Empower or to Protect? Constructing the 'Vulnerable Adult' in English Law and Public Policy' (2008) 28(2) *Legal Studies* 234.