

**The Arms of the Infinite?
The Liability of Mental Health Professionals for the Violent Acts of their Patient**

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Abstract

The article reviews the clinical and legal obligations faced by those with responsibility for the clinical management of potentially violent mentally disordered offenders. Responsibility for violent patients is now a mainstream issue for all mental health practitioners who as part of their professional practice will be expected to have at least a working knowledge of the principles and practice of risk assessment and management. With civil litigation growing for health care negligence there is a pressing need to educate mental health professionals about their legal rights and responsibilities towards violent patients.

The primary ethical and legal responsibility of mental health professionals is to their patients. However, the law also requires practitioners to exercise reasonable care in responding to clients' threats against third parties and, under strictly limited circumstances, protect them from harm.

In general, the law does not require workers to warn third parties but permits warnings if the clinician deems them necessary. Case law does not nullify the practitioner's ethical obligation to protect client confidentiality under most circumstances.

Keywords: Violence, Risk, Accountability, Law, Ethics, Mental Health Act.

Background

Before the Mental Health Act 2007, detained patients had a Responsible Medical Officer (consultant psychiatrist) in charge of their care. In addition, there could be several junior doctors. Now there will be a Responsible Clinician in charge of their care, with other Approved Clinician(s) also involved. Neither the Approved nor Responsible Clinician has to be a doctor and the following staff can qualify as Approved Clinicians: nurses, social workers, psychologists, occupational therapists and doctors.

It is currently unclear whether the courts will impose what could be extended liability on Responsible Clinicians. The question is whether mental health professionals should be held liable in negligence when their patients commit crimes. Should this liability extend to victims and their families as well as clients and if a patient is discharged, for how long should a Responsible Clinician remain liable for his or her subsequent behaviour?

Although there is little case law to assist in deciding these questions, there are strong arguments based on legal and ethical principles as well as public policy for limiting the liability of mental health practitioners. Many of them spring from two ethical dilemmas at the heart of mental health law: to what extent should a mental health professional be entitled to restrict the liberty of a patient in the interests of others and to what extent should one adult be responsible for the acts of another? (Adshead 2000; Hale 2010).

Working with Assaultative Offenders – Clinical Duties

Assaultative behaviours are not just dangerous for the individual; they are also dangerous for other people. Dangerousness here refers not just to the nature of the behaviours but also to the degree of victimisation (Prins 2005). Ethical and legal considerations also take on a

much greater prominence with assaultive offenders (Young 2003). For example, when an assaultive offender discloses a re-offence to a therapist the legal and ethical ramifications are qualitatively different from those involved when an alcoholic or even a drug addict reports a relapse. In the case of an assault relapse, such as threats to injure, there may be a duty of care to inform (protect) the third party at risk.

In terms of global review, the Court of Appeal last considered the duties of mental health professionals in respect of dangerous patients in *W v Egdell*: it held that practitioners could breach patient confidentiality in notifying a responsible authority of a risk posed by a patient and that they 'may have a duty to do so'. It did not, however, suggest that there was any duty to communicate directly with and protect a potential victim (Adshead 2000). The advice given to mental health practitioners by professional bodies goes no further than this. In the arguably analogous case of a patient with AIDS, both the GMC and NMC have stated that medical and nursing staff can disclose that information to a third party without the patient's consent where there is a serious identifiable risk of transmission to an identifiable victim (Jones 2003; Herring 2010).

The Law in the United States

The issue was considered by the Californian Supreme Court in the case of *Tarasoff v Regents of the University of California* (1976). The legal basis for much of the present tort law in relation to a patient's violent actions in the community is rooted in this much-cited case, which established the 'duty to protect' in the US. The basic facts of the case are as follows:

Tatiana Tarasoff was loved by a Mr Prosenjit Poddar, an Indian graduate student studying naval architecture at the University of California. The two young people knew each other, but did not have a close relationship, and it is unlikely that Ms Tarasoff was aware of Mr Poddar's infatuation and the depth of his feelings. Mr Poddar was depressed about his feelings for Ms Tarasoff. During his sessions with a University counsellor he told his therapist that he had fantasies of killing Ms Tarasoff. He also told someone else that he intended buying a gun, and this information was passed on to the therapist, who confronted Poddar about it. The therapist was alarmed and contacted the campus police. They interviewed Mr Poddar who denied any wish to harm Ms Tarasoff. Three weeks later Mr Poddar went to Ms Tarasoff's house and shot her. He pleaded insanity, went to hospital and after two years was released and returned to his native land (Jones 2003).

Ms Tarasoff's family sued for negligence, arguing that the university had failed to protect their daughter and, as a consequence, she had died. The Californian Supreme Court debated this twice having both concerns about the implications for public policy and being advised of professional concerns about patient confidentiality. They decided that there was a duty of care to both warn and protect third parties. The duty to warn should be given where there was an identifiable party at risk. The duty to protect could be carried out by the use of existing mental health legislation for civil commitment, or taking steps to use it.

Since the *Tarasoff* ruling in 1976 some US states have been willing to give a *wide* interpretation to the duty to protect. In one case, damages were awarded against a doctor when a patient burnt down a farm building, even though there was no identifiable victim, and no warning given by the patient (Simone and Fulero 2005).

Perhaps this is not surprising, considering that community care has had a longer history in the USA, than the UK, that such a legal framework has developed there in relation to violent incidents in the community (Dawson 2010).

English Law

Technically, these principles could be applied in English Law and the clinical duty *to warn and protect* extended to members of the broader public not just identifiable victims, as it has in some US states. When the English courts come to consider the question, as they surely will now that non-medical staff can take on lead clinical roles under the Mental Health Act, they will have to answer the question relying on the basic principles of clinical negligence: are the Responsible Clinician and patient or victim in a sufficiently proximate relationship, and if they are, are there any reasons of public policy that preclude or limit a duty of care?

It is perhaps instructive to consider the case of *Home Office v Dorset Yacht Co* [1970] AC 1004. Here, borstal boys who had been taken on a residential outing escaped due to the negligence of the warders. These young offenders then did considerable damage to neighbouring property and the Home Office was held liable for its employees' failure to control the offenders in their charge. Lord Diplock gave as a reason, the existence of a 'special relationship' between the prison officers, their charges and a distinct group of persons who were potential victims.

Proximity: Responsible Clinicians, Patients and their Victims

In the case of mental health professionals, patients and their victims is there an analogous 'special relationship' sufficient to justify the imposition of liability?

The first, and arguably the most closely analogous case, is that of the detained patient.

Under the Mental Health Act 1983 (as revised by the Mental Health Act 2007), a particular clinician is assigned responsibility for a patient. The Responsible Clinician has a substantial amount of information about and control over the patient and it seems reasonable to expect her or him to take steps to prevent behaviour in foreseeable dangerous ways. However, the question is more difficult when dealing with patients who have been discharged or who remain outpatients. When a patient has recently been discharged there may still be sufficient proximity, especially where the Responsible Clinician has the authority to discharge. Many patients, particularly those with a notable history of offending, are discharged by the Mental Health Review Tribunal or the statutory restrictions on them are lifted by the Ministry of Justice. While these decisions are based on medical and social care reports it is not the Responsible Clinician who orders the discharge and it is questionable whether a 'special relationship' exists in those circumstances.

Similarly, it is unlikely that a court would find a proximate relationship between a clinician and an outpatient but a Responsible Clinician might be obliged to warn the police, for instance, of the threatened risk to an individual by virtue of *W v Egdell* [1990].

However, it would probably be unreasonable to impose a duty of care on them to control a patient if they do not have statutory power to detain. The extent or size of the class of potential victims to whom a practitioner might owe a duty of care is uncertain. Also, a judge might be reluctant to find a duty of care to a third party if doing so might lead to a conflict of interest for the clinician and force them to choose between a duty of care to the patient and a duty of care to protect potential third party victims (Young 2003). Occasionally the courts have had to decide between opposing public interests and rule on which interest should be dominant and take precedence. The case of *Egdell* (concerning a breach of confidentiality by a doctor) was upheld on the grounds of public safety. In his judgement, Mr Justice Scott found that Dr. Egdell 'owed a duty not only to his patient but to the public at large'. He was however at pains to point out that 'Only in the most extreme circumstances could a doctor

(or nurse) be relieved from observing the strict duty of confidence imposed on by his relationship with his patient.'

When a patient identifies a proposed victim, the proximity of the relationship may be established, but it is doubtful whether a mental health professional can be held liable in respect of any potential but unknown victim of a patient. Support for this position comes from the decision of the House of Lords in *Hill v Chief Constable of West Yorkshire* (1988) when it was held that there was not a sufficiently proximate relationship between the police and a class of persons such as 'women' who were the potential victims of the Yorkshire Ripper. Therefore, relatives of victims of the Yorkshire Ripper had no claim against the police for any careless or ineffective handling of the case. The argument that the Ripper's thirteenth victim would not have died but for the negligence of the police investigation was therefore rejected. By contrast in *Osman v Ferguson* (2000) the court found the requisite 'special relationship' existed between the police and an identifiable victim. In that case a teacher formed an obsessive attachment to a pupil, committed a number of minor acts of criminal damage affecting his family and told a police constable that there was a danger that he might do something criminally insane. Finally, he shot and killed the pupil's father and was convicted and later detained in a mental hospital. Between these two instances it may be possible but quite difficult to identify a class of persons rather than just an individual to whom a duty may be owed, particularly if an attack is seemingly random. Potentially, this reasoning could exclude the health authority's liability.

Public Policy

The second criterion for the imposition of a duty of care is that it should not be negated by public policy. In *Osman*, despite the court finding that there was a 'special relationship', the police were not held liable. The court came to the same conclusion in *Hill* because it wished to avoid the adoption by the police of unduly defensive practices. It took the view that the imposition of a duty would 'not promote the observance of a higher standard of care and might divert resources from the investigation and suppression of crime'. A subsequent application to the European Court of Human Rights (EctHR) identified that this contravened Article 6. While the court appreciated that the rule was in place to ensure the effectiveness of the police, it had not been balanced with the rights of the public.

Public authorities act under statutory duties and their liability has been the subject of a wide range of cases for misfeasance. Since public money is involved in settling such claims it is also inevitable that policy is a major consideration in determining whether or not claims in negligence are possible. The decision will very often rest on the fact of whether or not it is fair, just and reasonable in the circumstances to impose a duty.

In this way the Court of Appeal would not accept that a health authority could be liable for the murder of a child by a psychiatric outpatient in *Palmer v Tees Health Authority and Hartlepool and East Durham NHS Trust* (1999) *Lloyd's Rep Med* 351. The facts were that the claimant's child had been abducted, abused and murdered by a psychiatric patient for whose care the health authority was responsible. The patient who had a history of violence, had threatened to murder an unidentified child. The claimant now suffered with psychiatric illness as a result of her child's murder and sought damages for negligence from the health authority, alleging that the defendants had failed to diagnose the real and foreseeable risk that the patient would cause serious injury to the child and failed to provide adequate treatment to prevent him from doing so (Mason 2000). The claim was struck out as showing no cause of action on the basis that the health authority owed no duty of care to either the child or her mother. The Court of Appeal ruled that it was at least necessary for the victim to be identifiable in order to establish proximity. The reasoning is very close to that in *Hill*.

Public Policy and the Approved Clinician

Considerations of public policy are equally pertinent for Approved Clinicians who, like many healthcare professionals, are acutely aware of the difficulties associated with defensive health practice (Hurley 2007). Those concerned with the civil liberties of the mentally ill may think it is already difficult enough to secure a patient's discharge without adding to the pressures on practitioners to continue their control over them. Some argue that liability in negligence is a means of shifting the burden of responsibility for the acts of violent patients away from individuals towards health authorities (Samuels 2008). However, in financial terms at least, the victims of crime and their families are provided for by the Criminal Injury Compensation Scheme (CICS).

As for increasing the accountability of clinicians and health authorities, given long-established complaints procedures, recent inquiries and intense media interest (Swinson et al, 2007) it is perhaps doubtful that an extension of tortious duties would have any significant effect.

The question of whether it is right for a claimant to recover damages in reliance on a blatantly criminal act was considered when the defendant made an application to dismiss the claimant's claim in *Clunis v Camden and Islington Health Authority*.

Here, the court ruled that the defendant Health Authority had an obvious duty of care 'to treat and to provide aftercare on discharge from hospital' for the claimant who had a long history of mental illness. The Court of Appeal would not accept that this duty extended so far that the defendants would be liable when Clunis stabbed another man to death and was convicted of manslaughter. A party claiming negligence based on an allegation that the defendant caused and/or failed properly to treat mental disorder, could in principle recover damages for self-inflicted harm, and was not precluded from doing so even if the harm resulted from harming others in a criminal manner (Herring 2010).

Standard of Care

If a duty of care is to be imposed on the Responsible Clinician the next question is what the standard of care might be. The usual Bolam test would require mental health professionals to act in accordance with a reasonable body of medical opinion (Young 2009a). This would involve practitioners carrying out a risk assessment on a patient in accordance with a reasonable body of medical opinion about such assessments and treating a patient accordingly (Woods and Kettles 2009). Legal argument would then centre on what a proper risk assessment should entail.

Currently, there is lively discussion in mental health practice about what form risk assessment should take, and what clinical (and actuarial) factors they should include (Webster and Hucker 2006; Woods and Kettles 2009). There are many risk assessment tools available across England and Wales and those in use vary from NHS Trust to NHS Trust. However, the NHS does make use of standardised risk assessment tools (especially within forensic mental health care services), and some of these tools are used by the Police and Probation Service (Maden 2007).

The Department of Health has issued guidance in this area (Department of Health 2007) and their 'principles and evidence for best practice' emphasise that risk behaviour does not occur in a vacuum, it always has a context and is invariably the result of a complex interaction between individuals and their environments and situations. To assume that dangerousness (or risk) are permanent features is to ignore the significance of context and making such assumptions produces a blinkered view of the patient and greatly oversimplifies the risk

assessment process. Behaviour and emotions need to be assessed and understood in connection with the thought, perceptions and interpretation an individual has about situations, other people and their own behaviour. Consequently, the assessment, reduction and management of risk behaviour should be broad based and multi-modal in its approach and the clinical decision-making process viewed as the central issue, rather than the 'prediction' itself (Department of Health 2007). This does not deny the process importance of attempting to make predictions about behaviour, but combines this with a process of explanation and understanding (Hanson 2005).

Also, non-clinical factors such as unavailability of healthcare records at weekends are probably as significant as clinical matters. Claimants might contend that more should have been done in terms of the information obtained, the variety of sources of information or the length of any period of observation (Samuels 2008). Ultimately it should be possible to establish a clinical standard of risk assessment as there is in the US and Canada (Monahan 1993 and Maden, 2005) and protocols may even be devised. This would put the emphasis on a clinical skill, which mental health care professionals can and do acquire through training and expertise, rather than on the ability to predict the future (Department of Health 2007).

Yet, it is questionable whether this standard of care would require mental health professionals to detain a patient who is assessed as dangerous. The Mental Health Act 1983 (as revised in 2007) imposes no such duty on practitioners. The purpose of the legislation is to allow mental health professionals to detain, not oblige them to do so. The Act was not conceived as a mandate for locking up dangerous people and only imposes a duty on Approved Mental Health Professionals (AMHP) to make the relevant application (Prins 2008). Most importantly, a patient may only be detained if the relevant statutory criteria are fulfilled and danger to others alone is neither a necessary nor a sufficient condition. If a patient has been assessed by an AMHP and doctors in accordance with the Act and is not detainable it would be wrong for both of them and the patient for some further common law duty to detain to be introduced.

The Chain of Causation

It must be remembered that any violent crimes are committed for reasons other than mental illness – substance misuse or emotional distress are just as significant factors (Woods & Kettles 2009). Consequently, the chain of causation from a patient's assessment to discharge to crime may be so long and convoluted that liability can no longer be imposed on the original mental health care providers.

In such cases, while it may be said that the crime would not have been committed had the patient been in hospital (although it might still have been), the discharge of the patient, negligent or otherwise cannot be the cause of the offence. Where there had been an intervening event, or the chain of causation is long, liability cannot be imposed. Otherwise detention in hospital might be justified solely for the purpose of preventing crime. Even if it can be shown that a patient committed a crime in a state of diminished responsibility it does not necessarily follow that it was caused by mental illness or an associated clinical failure. First, the tests in tort and in criminal law would concern the patient's state of mind at different times and, secondly, the tests themselves are different. For example, it is often the case that a defendant who successfully relies on a defence of diminished responsibility is not subsequently detained under the Mental Health Act 1983 (Hale 2010).

Conclusions

The mental health practitioner role has expanded and the increased professional autonomy brings increased legal risk (Young 2009b; Young 2010). A proactive and robust approach to

managing that risk is required. Where a patient is known to be violent and is under the supervision and control of the practitioner, or the appropriate authority, in circumstances in which it is reasonably foreseeable that the patient will cause injury should he or she escape, there is a strong argument that a duty of care will be owed to the victim. The extent of any liability based on this principle will of course depend on the exact facts of a case. In other words, it is likely that the Responsible Clinician does owe a duty to patients and their prospective identifiable victims. This duty however, is circumscribed: it may not extend to the whole community or oblige mental health practitioners to control patients they may not lawfully detain or treat. Also, where a clinical duty of care is imposed its focus should be clinical and on the establishment of a standard or risk assessment rather than on the prediction and prevention of crime.

Tarasoff-like scenarios reflect a conflict of public interests between the obligations of mental health professionals to their clients and the public at large. It is open to some doubt whether the courts, today, would seek to extend a Responsible Clinician's legal duty of care to identifiable or unidentifiable third parties. However, they might, if 'the right' case came before the courts. Arguably, community care reforms have vastly altered the 'map of the terrain' and the very nature of mental health/forensic care over the last decade and it could be argued that the law has not kept pace with developments. Also, there is now detailed guidance for mental health professionals (National Reference Group, 2010) and more sophisticated procedures in relation to risk assessment and discharge that might make it easier for the courts to justify the imposition of a duty.

The main implications of this are fourfold:

First, proper training for lead clinicians is required. Mental health professionals taking on the role of Responsible Clinician must be fully aware of their legal responsibility and all mental health practitioners require education in relation to information sharing and defensible risk decision-making and ensuring the needs and rights of mental health patients (Prins 2005 and 2007). Similarly, the public and the courts also need to be educated about what mental health professionals do as there is a constant risk of violence in society and a large part of it is not due to mental illness or its negligent treatment (Maden 2007).

Second, holding specific mental health professionals liable for all the crimes committed by the mentally disordered will not stop violent offending but may lead to the unwarranted detention and treatment of patients solely because of fears about their dangerousness and a decline in professional morale.

Thirdly, more research is needed to clarify exactly how practitioners balance risk and rights, particularly in complex cases involving 'imposed' recovery. The systemic issues and the value assumptions that health professionals often bring to their interactions with clients needs to be explored further. Not until we have serious debate about such issues will health services fully translate the current rhetoric of collaborative partnership into reality for health professionals and the clients they serve.

Fourth, is it fair for Responsible Clinicians to have to take ultimate responsibility given today's emphasis upon team working and multi-disciplinary decision-making?

The clinical duty to potential third party victims does not necessarily correspond to the professional duty set out in the relevant codes of ethics of the professions or, indeed, the moral duty or moral views that any individual may hold. Case conference decisions also influence the treatment programme, so perhaps there needs to be formal corporate decision-making/governance (with a signed agreement) in certain clinical cases e.g. those involving restricted patients and potential liability to named victims or specific groups of individuals.

Ultimately, the crucial issue might not be whether a possible legal duty is imposed but the perceived threat of legal proceedings and public concern when things go wrong.

Cases

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