Neutral Citation Number: [2022] EWHC 260 (QB)

Case No: QB-2018-000526 and QB-2021-000914

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10 February 2022

Before :

MR JUSTICE JOHNSON

- -

Between :

(1) MARC TRAYLOR **(2) KITANNA TRAYLOR**	**Claimants**
- and -	
KENT AND MEDWAY NHS SOCIAL CARE PARTNERSHIP TRUST	**Defendant**

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- -

Sebastian Naughton and Rachael Gourley (instructed by Hodge Jones & Allen) for the Claimant Marc Traylor
Alison Gerry (instructed by Hodge Jones & Allen) for the Claimant Kitanna Traylor
Edward Bishop QC and Susanna Bennett (instructed by Bevan Brittain) for the Defendant

Hearing dates: 18 January 2022 – 24 January 2022

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Approved Judgment

Mr Justice Johnson:

1. On 8 February 2015 Marc Traylor suffered a psychotic episode. He threatened to stab his daughter, Kitanna Traylor. Police officers, and Marc Traylor's father, attended. In the early hours of 9 February, he stabbed Kitanna several times, causing serious injuries. He was shot three times by armed police officers. He was subsequently prosecuted for attempted murder. The jury found that he was not guilty by reason of insanity.

2. Marc Traylor brings a claim against Kent and Medway NHS Social Care Partnership Trust ("the Trust"). He says that the Trust was negligent in its treatment of his mental illness, and this caused what happened on 9 February 2015 and his resulting injuries. The Trust accepts that a decision on 3 December 2014 to discharge Marc Traylor from secondary psychiatric care "was not handled correctly" but denies other allegations of negligence. It also says:

   (1) Any breach of duty did not cause what happened on 9 February 2015. The cause of those events was Marc Traylor's decision to stop taking his medication.

   (2) Marc Traylor voluntarily accepted the risk that he might act as he did on 9 February 2015 because he stopped taking his medication, against medical advice.

   (3) Marc Traylor's claim must fail because the events on 9 February 2015 resulted from his own criminal acts.

   (4) Alternatively, any damages should be reduced on account of Marc Traylor's fault ("contributory negligence") when he stopped taking his medication.

3. Kitanna Traylor brings a separate claim against the Trust. She says that it failed to take positive steps to protect her right to life and her right not to be subject to inhuman or degrading treatment, and that these failings resulted in the events of 9 February 2015. The Trust responds that it was not required to take steps to protect Kitanna Traylor's Convention rights, and that in any event it acted compatibly with those rights. It says that even if it did act incompatibly with her rights, this was not the cause of the events of 9 February 2015. Accordingly, any damages should be limited to an award for non-pecuniary loss to reflect a breach of her Convention rights, rather than compensation for the injuries she sustained.

4. Directions were made for the two claims to be heard at the same time, and for preliminary issues to be determined (broadly whether the Trust is liable to each of the defendants, including questions of causation but not the assessment of damages). The issues requiring determination are:

   Marc Traylor's claim:

   (1) Whether, and in what respects, the Trust breached a common law duty of care owed to Marc Traylor.

   (2) Whether any established breach of duty caused the events of 9 February 2015.

   If so:

(3) Whether Marc Traylor voluntarily accepted the risks that flowed from the Trust's breach of duty.

(4) Whether Marc Traylor's claim is defeated on the ground of illegality.

(5) If the claim otherwise succeeds, by what proportion should Marc Traylor's damages be reduced on account of his contributory fault in not taking his medication.

Kitanna Traylor's claim:

(6) The scope of the Trust's obligations under articles 2 and 3 of the European Convention on Human Rights ("ECHR").

(7) Whether the Trust knew or ought to have known that there was a real and immediate risk to Kitanna Traylor's life or physical safety.

(8) If so, whether it took reasonable steps to avert that risk.

(9) If not, what, if any, heads of loss should be awarded.

5. At the outset of the trial I directed, with the parties' consent, that the evidence in each case would stand as evidence in both of the cases. Evidence was given by Marc Traylor, Nicole Traylor (Marc Traylor's wife) and Peter Traylor (Marc Traylor's father). Kitanna Traylor provided a witness statement which was not challenged, so she did not give oral evidence. Dr Marcos Pisaca, a consultant psychiatrist employed by the Trust, gave factual evidence for the Trust. Expert evidence was given by Dr Stephen Ginn, instructed on behalf of Marc Traylor and Kitanna Traylor, and by Dr Boris Iankov, instructed on behalf of the Trust.

The agreed facts

6. Most of the facts are not in dispute. The primary factual issues concern what was said between Dr Marcos Pisaca and Marc Traylor on 4 June 2014.

7. Marc Traylor was born on 4 September 1974. He has been married to Nicole Traylor since 1995. They have three daughters. Kitanna Traylor was born in 1998. Her sisters were born in 1995 and 2001. The family lived in Kent, apart from a period between 2004 and 2007 when they were in Cumbria.

8. In November 1994 Marc Traylor was convicted of dangerous driving and affray. When police officers sought to apprehend him, he threatened them with a knife.

9. In 1999 Marc Traylor threatened Nicole Traylor with a shotgun. The police were called. He was convicted and was sentenced to a community penalty.

10. In June 2002 police attended at the family home. Marc Traylor had kicked Nicole Traylor in the face causing bruising and swelling.

11. In July 2002 Marc Traylor was convicted of possession of what is described as "a small firearm". He was sentenced to a community penalty.

12. In October 2006, Marc Traylor was about to drive away from a pub after drinking all day. His mother took the car keys. He returned to the pub, grabbed a sword that was hanging on the wall, and smashed a window. He was convicted of affray and possession of a bladed article in a public place. There is a record that during the incident he said that he would "stab someone and kill the kids." He denied saying that.

13. In September 2008 Nicole Traylor reported previous incidents of violent attacks carried out by Marc Traylor, including "binding and gagging her, threatening her with knives, handcuffing her to the bed, taking her out to sea in a dinghy and then letting the air out whilst holding a knife to her throat." Nicole Traylor cannot swim.

14. On 29 October 2012 Marc Traylor made a 999 call to the police. He said that someone was trying to kill him and that he had just been poisoned. A community psychiatric nurse spoke to him. He attended at Kent and Canterbury Hospital. He was reviewed and discharged with arrangements for him to be seen the following day by the mental health crisis team. On 30 October 2012 Marc Traylor was seen by a community psychiatric nurse. He maintained that his wife was having an affair and that she and her partner were plotting to kill him. There was no rational basis for these fears. Nicole Traylor said that there had been 6 times in the last 20 years where something similar had happened. On these occasions Marc Traylor had taken possession of a knife so that he could defend himself. There was a strong history of mental illness in Marc Traylor's family. When the possibility of treatment was discussed, Marc Traylor said that he had never taken tablets and that he never would. He also refused voluntary admission to hospital for assessment.

15. Marc Traylor remained at home, but matters deteriorated, reaching a crisis point on 7 November 2012. He was assessed by a consultant psychiatrist. He was fixed on the idea that his wife was having an affair, that an attempt had been made on his life, and that it would happen again. He was detained under s2 Mental Health Act 1983. An entry in the notes says, "he didn't accept nor was going to accept his risperidone [antipsychotic medication] - he explained that he only planned to accept his medication one day prior to his tribunal "so that it looked good.""

16. In a report dated 14 November 2012 a differential diagnosis was made of morbid jealousy, paranoid personality disorder and persistent delusional disorder. Marc Traylor was discharged from hospital with medication on 23 November 2012, with ongoing input from the crisis team. Over the following days he claimed that he was taking the medication that had been prescribed. Nicole Traylor reported that he was improving due to the risperidone. Later, however, Marc Traylor said that he had not taken his medication during this period, and that he had stopped taking it as soon as he had been discharged from hospital.

17. In December 2012 Nicole Traylor reported that she had received threatening messages from Marc Traylor. The messages accused her of having an affair. On 28 December 2012 Nicole Traylor reported a text to the mental health crisis team in which Marc Traylor had said she should contact police "before he [the man with whom he thought she was having an affair] kills them all". Later that day, Marc Traylor climbed on to the roof of a hotel and claimed that two men were trying to kill him. Police were called. He was re-admitted to hospital pursuant to s2 of the 1983 Act.

18. On 29 December 2012 Marc Traylor assaulted a female member of hospital staff. He later explained that he did so to try and get the keys to the unit so that he could escape from people who were going to kill him. He was described as having a "very disturbed mental state". Six police officers were required to restrain him. He was transferred to another unit under s3 of the 1983 Act. There was a hearing before the First-tier Tribunal (Health, Education and Social Care Chamber (Mental Health)) ("the Tribunal") on 9 January 2013. Nicole Traylor presented evidence which she hoped would lead to a decision to discharge Marc Traylor. She said he would be better recovering at home. She described the family as a successful stable family "with no problems whatsoever". She said that Marc Traylor could return home without any significant stresses on him. After the hearing she said that she had "put in her papers to her solicitor so that Marc could be discharged and would not require another tribunal."

19. Marc Traylor was diagnosed with paranoid schizophrenia with morbid jealousy. Antipsychotic medication was started by depot injection on 25 February 2013. This is a slow-release form of administration, meaning that fewer injections are necessary, and adherence can be certain. Uncontested expert evidence suggests that it results in better outcomes than medication that is administered by tablet, even where compliance with the medication is assured. It also requires less resource (because it is only administered once a month). It also avoids an obvious risk associated with oral medication: that the patient may not take the tablets. Marc Traylor was engaged and compliant with medical staff whilst he was receiving antipsychotic medication during his admission.

20. On 28 February 2013 Marc Traylor's children, including Kitanna Traylor, were placed on a child protection plan. They were removed from the plan in November 2013 because it was thought that other agencies, including the mental health care team, could keep them safe.

21. A detailed risk assessment (running to 15 pages of mostly closely typed text) was carried out at some point between March and June 2013. It sets out the previous history of violence and convictions, the "definite" diagnosis of a major mental illness, specifically paranoid schizophrenia manifesting in the form of morbid jealousy syndrome, a "definite/serious lack of insight", and reports of refusal of medication from November 2012. Under the heading "risk formulation & scenarios" the document states:

> "Mr Traylor has presented with morbid jealousy with delusional intensity and risk behaviour over a long period of 20 years with the impression of psychopathic emotional responses.
>
> This places Mrs Traylor at risk from stalking, threats, repeated accusations, agitation, reported threats to life, reported hostage taking…
>
> Mr Traylor has also assaulted a member of his care team and this seems to be in the context of a deterioration in his mental health. Therefore, when he is unwell, the risk to people in his general vicinity is increased.…
>
> Mrs Traylor and her children at risk of psychological difficulties as a consequence of her husband/their fathers behaviour.

> As Mr Traylor has used both a knife and a gun in a threatening manner, there is a risk of death for Mrs Traylor…
>
> Whilst [detained in hospital] this risk is low, however once in the community then the risk to Mrs Traylor is high should her husband began to suffer from mental health difficulties…
>
> Signature risk signs involve:
>
> Persistent unrelenting accusations towards his wife
>
> Stalking behaviour towards his wife
>
> Wearing inappropriate clothing
>
> Abstract, bizarre text messages or notes to family members
>
> Insomnia…
>
> Early symptoms of deteriorating mental state would be enhanced by sleep deprivation. In relation to self neglect Mr Traylor's sister… has reported that when unwell there is evidence of self neglect, for instance, Mr Traylor impulsively arrived at her house, there was evidence that Mr Traylor had lost weight, was wearing inappropriate clothing for the weather and was anxious due to being convinced that he was being persecuted. Should Mr Traylor begin to behave in this manner, then a reassessment of risk should be undertaken…
>
> Mrs Traylor should be provided with access to a crisis team. In the past where she has been vulnerable from Mr Traylor, she has successfully managed to contact the police.
>
> To continue to monitor warning signs in relation to Mr Traylor's mental health deterioration and to ensure that she seeks support immediately should he become mentally unwell."

22. Marc Traylor was discharged on 26 June 2013 on a Community Treatment Order ("CTO"), on the condition that (among other things) he attend for administration of psychiatric medication as directed by his treating consultant psychiatrist, with ongoing input from a Community Care Worker.

23. A Discharge Summary psychiatric report dated 12 July 2013 states:

> "[Marc Traylor] has a history of non-compliance with his medication. This is significant as if he decides not to comply with his psychotropic medication, he is likely to have a relapse of his mental illness, thereby increasing his risk to self and others."

24. Marc Traylor was compliant with his depot injections (albeit he expressed a wish to try to manage his condition without medication). He was reviewed on 12 November 2013

and 18 December 2013 by Dr Aleksandra Szpak (a locum consultant psychiatrist). On 18 December 2013 Dr Szpak reported that Marc Traylor had asked about the length of time for which he would need to take the medication. He expressed the hope that the dose could be reduced. Dr Szpak assessed Marc Traylor's current risk level as "low" whilst he was adequately medicated and abstained from substance misuse. She recommended an extension of the CTO.

25. On 16 January 2014 Nicole Traylor spoke to the Trust's forensic psychiatry service and indicated that Marc Traylor wished to challenge the CTO. She said that Marc Traylor "has told [her] that he is going to come off medication with the help of his care team or not. Apparently, he would like to establish whether he can manage his illness without medication".

26. On 24 January 2014 Nicole Traylor served a notice stating that she wanted Marc Traylor to be discharged from the CTO. The continuation of the CTO was authorised.

27. On 29 January 2014 Marc Traylor was reviewed by Dr Szpak. She reported that Marc Traylor wished to come off his medication and manage his condition without it. The notes record:

> "Given the long term history of morbid jealousy (20 years) with the subsequent onset of florid psychotic symptoms of schizophrenic nature in late 2012, my recommendations are that he should continue the depot medications long-term."

The notes re-iterated that the risk remained low "whilst he receives appropriate treatment".

28. In a psychiatric report dated 13 February 2014, prepared for a hospital managers' hearing to consider the CTO, Dr Szpak reviewed Marc Traylor's mental health history, and wrote:

> "Should Mr Traylor be discharged from the [CTO], there is a potential risk that he would decide to reduce and eventually cease the pharmacological treatment, which puts him at significantly heightened risk of relapse. Recent information revealed makes it evident that such a plan may be considered by Mr Traylor in the nearest future.
>
> In considering the risks that Mr Traylor may present without appropriate treatment, clearly, without such treatment it would seem almost inevitable that his mental state and health will deteriorate to a point where his behaviour becomes driven by paranoid persecutory beliefs and concerns about his partner's unfaithfulness. This is likely to lead to chaotic behaviour where he is likely to put himself at risk (as evident prior to the last admission).
>
> As his mental state deteriorates, the risk to others will also increase. This may be as a result of him perceiving that others are involved in his persecution, specifically his wife. The

> presence of a morbid jealousy syndrome, combined with a schizophrenia-type psychotic illness, combined with poor insight and with extra stressors in terms of his partner's health difficulties, would almost inevitably lead to a very significant deterioration in mental state. In addition it has been recorded that Mr Traylor has kept implements such as knives and an axe in close proximity in order to feel safer from his perceived persecutors. He has a previous conviction in relation to the possession of an offensive weapon… I consider that Mr Traylor suffers from a mental disorder of both a nature and also a degree (recently reduced insight) which makes it appropriate and necessary that he receives treatment under the CTO conditions in the interests of his health, safety and the protection of others. I can confirm that appropriate treatment is available in the community setting at this stage.
>
> It is therefore important that any signs of relapse are addressed quickly and appropriately… Mrs Traylor is clearly committed to seeking help for her husband should he require it as soon as she notices any signs of relapse. She has often stated she is not prepared to allow her family to go backwards. Mr Traylor has given permission via his relapse plan for Mrs Traylor and other family members to make contact with services on his behalf should he be unable to recognise that he is becoming unwell.
>
> I do believe that the conditions of the Community Treatment Order can contribute positively to maintaining his stable mental health in the community. The legal framework allows for prompt interventions, including recall to hospital at early stages of relapse or disengagement, thus hopefully preventing full destabilisation, which would obviously take longer to treat and more importantly, increase the risk level in all the above mentioned contexts.
>
> I would therefore respectfully ask the Hospital Managers panel to uphold the Community Treatment Order and the current conditions."

29. A psychology report dated 14 February 2014 records that Marc Traylor was highly motivated to engage in work aimed at understanding the development of his illness and how to manage it. Both Marc Traylor and Nicole Traylor had positively engaged in therapy. On 24 February 2014 the notes record that Marc Traylor was hoping to be discharged from the CTO and "would like a trial period of not taking his depot medication".

30. On 10 March 2014 Marc Traylor reported that he wished to reduce his medication before stopping it. Nicole Traylor reported some concerns about this. The hospital managers' hearing took place on 20 March 2014. The CTO was upheld. These reasons were given:

> "After considering the reports and discussing with the professionals we were agreed that Marc still meets criteria for detention under a CTO inasmuch that he has a mental disorder of a nature which makes it necessary for his health that he receives treatment and the RC has the power of recall. We are convinced that he would stop taking his medication if discharged and does not have full insight, without the depot injection he would quickly deteriorate.
>
> We would like to recommend that before the expiry of the current CTO that consideration is given to reducing his medication under close monitoring."

31. On 15 April 2014 Marc Traylor was seen by Dr Szpak. She recorded that his mental state was stable, with no psychotic symptoms, that he had "insight" and that he wished to come off the medication completely at some stage. The decision was made to reduce the depot injection to 75 mg monthly (but with close monitoring so that the dose could be increased if there was a deterioration in his mental health). Dr Szpak recorded that Marc Traylor needed to be on antipsychotic medication long term.

32. In June 2014 Dr Szpak's locum position came to an end, and Dr Pisaca took up a substantive position with the Trust as a consultant psychiatrist. There was a handover meeting at the end of May 2014.

33. On 4 June 2014 Marc Traylor was reviewed for the first time by Dr Pisaca. The outcome of the meeting was that it was agreed that Marc Traylor would have one further depot injection the following day, and that he would thereafter take his medication orally. The contemporaneous notes of the review state:

> "Seen for a review with wife and care coordinator Carol Eccleshare.
>
> In remission with treatment that was recently reduced.
>
> Insightful and enjoying increased support from his wife and family that are now more aware of his mental health problems.
>
> Said he has benefitted from the input of our services and would like ongoing support.
>
> Agrees that medication has been beneficial to address his paranoid ideas but insisted that he would also like to have the opportunity to see how he does without medication now that he feels well. He agrees to have his next injection tomorrow but would like to come off it.
>
> We discussed his CTO and agreed in principle that after 1 year we should aim at a less restrictive way to manage his illness and improve his self management. We are going to meet again in 15 days to confirm decision.

> Even if he decides to come off his medication against advice, we have to allow him to take responsibility and the risks have been substantially mitigated with his engagement with services and increased awareness and support in his family.
>
> Our services are now in a position to intervene early [if] concerns are raised.
>
> Marc has agreed to go back on medication if he discontinues it and he experiences paranoid ideas.
>
> We discussed and agreed risperidone tablets to replace injection in a month's time.
>
> Mrs Traylor requested that Mark is given the opportunity to try oral and come off medication given the increased supervision he is under, what he has learned attending sessions with TGU and care coord and his increased insight.
>
> Paliperidone injection to be stopped after next inj tomorrow and replaced with risperidone oral tablets 4mg od nocte in a months time."

34. Dr Pisaca dictated a letter to the GP but did not send it at this point.

35. On 18 June 2014 Marc Traylor was again seen by Dr Pisaca. His father, Peter Traylor, was present. According to the notes, his father reported a major improvement in Marc Traylor's mood and involvement with the family. Marc Traylor agreed to take the medication and agreed that if he changed his mind and decided to come off the medication, he would inform the mental health clinicians so that he could be closely monitored. Both Marc Traylor and his father were said to be happy with this arrangement. The CTO was discharged. Dr Pisaca amended and sent the letter that he had previously dictated. It states:

> "I saw Marc with his wife and his care coordinator, Carol Eccleshare for a review at Laurel House. Marc's mental health problems have remained in remission with treatment; he showed good insight into his condition and told us that he has learned a lot about his illness, anger management and relationships in recent months. He told us that after a year he wanted to reduce and come off of his medication if possible. He told us that he knows his relapse indicators and he was prepared to receive treatment as required. We had a long discussion, including his wife who told us that she believes that now Marc will be safe if he tries to come off of his medication with the support of our services, herself and Marc's family who is now more aware of his mental health problem and supportive.
>
> I advised Marc to have his paliperdone injection due tomorrow to which he agreed. We also discussed alternative treatment with risperidone tablets to replace the injection in a month's time. We

> agreed to meet in 2 weeks time to discuss his CTO and dose of risperidone tablets;
>
> We met again for a follow up on the 18th of June. He came with his father who has noticed that Marc's mood has been brighter in recent days. Marc remained insightful and in remission.
>
> We agreed that the CTO was no longer needed.
>
> Treatment with paliperidone injection was discontinued. Marc agreed to continue treatment with risperidone 2mg od nocte starting in 2 weeks' time (when the next injection was due), I prescribed for 2 weeks.
>
> Marc can increase treatment to 4mg of risperidone od nocte in the case of paranoid ideas, agitation or other relapse signs.
>
> I discharged CTO."

36. Entries in the medical notes record that Marc Traylor was visited by members of the mental health care team on 4 July 2014, 7 July 2014, 16 July 2014, 17 July 2014 and 30 July 2014. Some of these were lengthy visits, lasting more than an hour. He said he was taking his medication. No concerns were raised. On 6 August 2014 Dr Picasa saw Marc Traylor, with Nicole Traylor present. There was a note of a report by Marc Traylor's father that he had deteriorated. Both Marc Traylor and Nicole Traylor denied any deterioration. Marc Traylor said that he was taking his medication but that he wanted to try to stop it. Dr Pisaca said that he should wait for at least 6 months before doing that. It was agreed that there would be a review in 6 months' time.

37. Marc Traylor was visited by members of the mental health care team on 28 August 2014, 10 September 2014 and 5 November 2014. On 3 December 2014 Carol Eccleshare carried out a review. Marc Traylor said that he felt well and that he wanted to be discharged from secondary care. Nicole Traylor said that she felt that he was much better. Carol Eccleshare decided that he should be discharged from secondary mental health care.

38. On 8 February 2015, Marc Traylor was at home during the day. Peter Traylor went to the house in the morning. He says he thought that Marc was behaving oddly and that he "wasn't right", but that Nicole disagreed. She thought he seemed fine for most of the day. He was painting some fence panels in the kitchen. At 9pm Nicole Traylor asked him if he wanted to watch television, and he said that he wanted to finish painting. An hour later Nicole Traylor saw him standing in the same position he had been in at 9pm and it was clear he had not done any painting and had been brooding. She kissed him goodnight and he said he would be up in a minute. Then, after Nicole Traylor went upstairs, he armed himself with two knives and went to Kitanna Traylor's bedroom. Kitanna Traylor's sister went to Peter Traylor's house to seek help. She said he needed to come around straight away because her father was having a psychotic episode. By the time Peter Traylor got there, police officers were in the house. Peter Traylor spoke to his son and tried to calm him down. He persuaded his son to put the knives down.

39. Peter Traylor gives the following account of what happened next:

> "a number of police armed with guns had arrived and were standing on the stairs behind me. I instructed Kitty to move further into the corner of the room by the radiator and asked the firearms police to stay back. Marc said that he was scared.
>
> A police officer then put a hand on my shoulder and Marc burst out saying 'don't hurt my dad'. He picked up the knives again and then as I turned to tell the officer to get back I felt a sharp pain in my head. I fell to the floor with the force of the pain. I heard three shots and the next thing I remember I was being carried downstairs before being taken to hospital. The police had attempted to taser Marc, but had hit me instead.
>
> I have since learned that the three gun shots that I heard were from when Marc was shot, once in the jaw and then a further two times in his stomach. Before he was shot he managed to stab his own daughter."

40. Kitanna Traylor sustained significant physical and psychiatric injuries.

41. Marc Traylor suffered a cardiac arrest and a hypoxic brain injury. He was tried for attempted murder and was found not guilty by reason of insanity. A hospital order was made with restrictions, under ss37 and 41 of the 1983 Act. Marc Traylor is wheelchair dependent, fed through a gastric tube, and has considerable ongoing physical needs, requiring 24-hour nursing care.

<u>The statutory framework</u>

Mental Health Act 1983

42. Sections 2 and 3 of the Mental Health Act 1983 provide for compulsory admission to hospital. By s2, a patient may be admitted to hospital and detained there for up to 28 days on the grounds that:

> "(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
>
> (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."

43. By s3, a patient may be admitted to hospital and detained there for up to 6 months on the grounds that:

> "(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and …
>
> (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment

> and it cannot be provided unless he is detained under this section; and
>
> (d) appropriate medical treatment is available for him."

44. A patient detained under s3 may be discharged from hospital under a CTO for a 6-month period, subject to extension. While the patient is subject to the CTO, the power to detain him under s3 is suspended. There is no power to treat a patient under a CTO without his consent unless he lacks capacity under the Mental Capacity Act 2005 - *Welsh Ministers v PJ* [2018] UKSC 66 [2020] AC 757 *per* Lady Hale at [16(iv)].

45. Discharge under a CTO is subject to a limited power to recall to hospital under s17E, if in the opinion of the responsible clinician:

> "(a) the patient requires medical treatment in hospital for his mental disorder; and
>
> (b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose."

or if the patient fails to attend certain examinations connected with the CTO. A recalled patient must be released within 72 hours unless the CTO is revoked (resulting in detention under s3) (ss17F, 17G).

46. By s17A(5), the following criteria must all be met for a CTO to be made:

> "(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
>
> (b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
>
> (c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;
>
> (d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) below to recall the patient to hospital; and
>
> (e) appropriate medical treatment is available for him."

47. A patient subject to s3 detention or to a CTO must be examined within the 2-month period before its expiry (ss20(3) and 20A(4)). If the mandatory conditions are still met, the s3 detention / CTO will be extended by a further 6 months. Otherwise, it expires.

48. Separately, there is a power for the responsible clinician, hospital managers, or nearest relative to discharge a patient from detention or from a CTO: s23. There are no conditions regarding the exercise of this power by the responsible clinician or hospital managers. A patient whose CTO is discharged ceases to be subject to s3 detention.

49. A patient may make an application to the Tribunal for review of decisions made under the Act, including of a decision to detain him under s3 or to make him subject to a CTO – see s66. Such an application must be made within 6 months.

50. If the patient does not apply for a review, the hospital managers must refer the patient's case to the Tribunal for review at the 6 month point: s68(2).

51. The Tribunal must discharge the patient if the relevant mandatory conditions are not met. Even if they are met, it may discharge the patient: s72(1).

52. A detained patient may (with some exceptions, and subject to certain requirements) be given medical treatment without their consent: s58(1)(b), s58(3)(b), s63.

53. A patient under a CTO may be given medical treatment for his mental disorder if:

    (1) He has capacity to consent to it and does consent to it: s64(2)(a).

    (2) A donee or deputy or the Court of Protection consents to it on his behalf: s64(2)(b).

    (3) He lacks capacity, but, either there is no need to use force, or there is no reason to believe that the patient objects: s64D.

    (4) He lacks capacity and the treatment is immediately necessary: s64G.

Insanity

54. The common law and legislative history of the defence of insanity is relevant to the Trust's reliance on the defence of illegality.

55. In the fourteenth century, proof of insanity was treated in the same way as self-defence: it resulted in a special verdict which gave rise to a right to a pardon (see A History of the Criminal Law of England, Sir James Fitzjames Stephen, 1883, vol 2 p151). By the sixteenth century, proof of insanity could result in an acquittal without the need for a pardon ((1506) YB Mich 21 Hen VII pl 16) and see Hale's Pleas of the Crown, 1800 vol I p28 and "The origin of insanity as a special verdict: the trial for treason of James Hadfield (1800)", Richard Moran, Law & Society Review, Vol 19 No 3 (1985).

56. By the eighteenth century, a jury could in such a case either find the defendant not guilty, or return a special verdict that the accused committed the act but at the time was not "compos mentis". In each case the verdict was treated as an acquittal and the defendant was released - see Sir Michael Foster's Crown Law, third edition (1792), s1 p279 and *Felstead v The King* [1914] AC 534 *per* Lord Reading at 540.

57. The Criminal Lunatics Act 1800 provided that in relation to certain offences (including murder) if the jury found the defendant to be insane at the time of committing the offence, then the court "shall order such person to be kept in strict custody… until His Majesty's pleasure shall be known." The rationale was public safety rather than punishment because "it may be dangerous, to permit persons so acquitted to go at large."

58. The Trial of Lunatics Act 1883 provides, by s2, for a special verdict where the jury finds that the defendant did the act charged but that the defendant was insane at the

time. The sidenote to the section states "Special verdict where accused found guilty, but insane at date of act or omission charged…" As originally drafted, s2 provided for a verdict of "guilty of the act or omission charged, but insane so as not to be responsible, according to law, for his actions."

59. In *R v Ireland* [1910] 1 KB 654 the Court of Criminal Appeal (relying on the word "guilty" in the special verdict) held that the special verdict amounts to a conviction on indictment so as to give rise to a right of appeal under s3 Criminal Appeals Act 1907.

60. In *Felstead* the House of Lords overruled *Ireland* and held that a special verdict under s2 of the 1883 Act results in an acquittal rather than a conviction. Lord Reading said (at 543):

> "It is unfortunate that [the word "guilty"] is there used, as it suggests the responsibility for a criminal act. If the requirement under the statute had been merely to find that the accused did the act, instead of that he was guilty of the act, there could have been no room for doubt that such a verdict was not a conviction, but was an acquittal."

61. The wording of the special verdict was changed by an amendment to s2 of the 1883 Act introduced by the Criminal Procedure (Insanity) Act 1964. This substituted "a special verdict that the accused is not guilty by reason of insanity." Where such a verdict is returned, then, by s5 of the 1964 Act, the court must either impose a hospital order under s37 of the 1983 Act (with or without restrictions under s41), or impose a supervision order within the meaning of schedule 1A to the 1964 Act, or make an order for the absolute discharge of the defendant. Such orders do not involve any element of punishment (see, in respect of orders under ss37/41 of the 1983 Act, *R v Fisher* [2019] EWCA Crim 1066 [2020] MHLR 103 *per* Hickinbottom LJ at [34]). There is no power to impose an order under s45A of the 1983 Act (which does include a penal element).

The evidence

Marc Traylor, Nicole Traylor, Peter Traylor and Kitanna Traylor

62. Marc Traylor: Marc Traylor explains that he does not believe in taking medication. His aim throughout his engagement with the Trust was to stop taking medication. He only remembers one meeting with Dr Pisaca. He told Dr Pisaca that he did not want the depot injections anymore, that he would like to stop them and have tablets instead. He was happy with Dr Pisaca's decision to take him off the CTO and prescribe tablets rather than depot injections. He never took the tablets. He threw them away when walking the dogs. Nicole Traylor did not realise that he was not taking the medication. He lied to people (including Nicole Traylor and those who came to see him after he was discharged to review his progress) and said that he was taking the medication, when he was not. He does not recall the events of 8-9 February 2015. He says that if Dr Pisaca had advised him to remain on the depot injections, then he would have accepted that advice.

63. Nicole Traylor: Nicole Traylor gives detail of the background history, which is not controversial. She said that as soon as Marc Traylor was admitted to hospital, he expressed a determination to appeal against his detention. She supported him in that.

She says that with hindsight she realises that she failed to recognise how ill he was at the time, or subsequently – she just wanted to get back to normal. She attended the appointment with Dr Pisaca on 4 June 2014. She says:

> "On 4 June 2014 Marc saw a new doctor, Dr Pisaca, at Laurel House, accompanied by me and his father as far as I recall. He requested again to be taken off the depot injection and both his father and I disagreed and expressed our concerns about this. I remember turning round to Marc and saying something to the effect of 'I'm sorry Marc, I don't believe now is the right time and I don't believe you are going to take your medication'. Dr Pisaca asked if we did not agree that Marc should be given a chance to try oral medication? I said I agreed but I didn't think this was the right time. I thought back to the appointment only six weeks ago where Dr Szpak was clear that he should be on these long term, which to me meant at least a year to 18 months, not 6 weeks after she had said that. Dr Pisaca stated that Marc's views should be respected and agreed to transfer Marc to oral medication, despite Marc's past history of not taking his oral antipsychotic medication. He also agreed to review the CTO, with a view to discharging this soon. This is what I remember of this appointment (and I recall both me and his father were there, although I understand that this is not reflected in the records)."

64. Nicole Traylor says that she expressed concerns about her ability to tell if Marc Traylor was deteriorating, that she does not think that she was best placed to support him and that whilst she appreciated the need for medication, she did not understand the potential risks. She agrees that a "relapse plan" had been put in place. This identified the signs that might indicate that Marc Traylor was becoming unwell and what should be done in that event (including, in certain instances, contacting the care co-ordinator or the GP or the Crisis Team).

65. Peter Traylor: Peter Traylor says that when Marc Traylor was admitted to hospital, Nicole Traylor was always keen to get him discharged (whereas the rest of the family thought that he needed close supervision). Peter Traylor only recalls one appointment that he attended with Dr Pisaca and Marc Traylor:

> "I said in front of Dr Pisaca that in my view he should not come off the medication, and I recall what Dr Pisaca said: he said Marc should be allowed if he thinks he is strong enough, and he should be allowed to come off it because it is his right. I got the impression that Nicole agreed with him. I said it is not right, it is alright now because he is on the medication, and I don't think he should come off the CTO. Dr Pisaca said Marc should be able to think for himself. Nicole said she can look after him, which seemed absolutely crazy to me. Marc said 'I will be ok, I am fine'. I believe that was the final meeting, to take him off the CTO."

66. Kitanna Traylor: The evidence of Kitanna Traylor was not challenged, so she did not give oral evidence and instead relied on her written statement. In the absence of any

challenge to the content of that statement, I accept her evidence in its entirety. In February 2015 she was 16 years old. She is now 23. She describes the erratic and sometimes violent behaviour of Marc Traylor when she was growing up. She says that he was a "Prepper" which is, she says, someone who prepared for doomsday. He used to hoard weapons, including a hunting knife, a double-sided sword, bows-and-arrows and axes. When he was admitted to hospital under the 1983 Act, he refused to accept that he might be mentally ill. He told Nicole Traylor "that she had to get him out of there." When he was released from hospital there were arguments between her parents about him having his injections, and it was clear that he did not want to have them. Later, when he moved to oral medication, Kitanna Traylor recalls her mother telling her father to take the tablets, and him saying that he had taken them. She is not now surprised that he did not take them – he had always been averse to any form of medication or hospital treatment. In the months leading up to February 2015 there were subtle changes in Marc Traylor's behaviour which Kitanna Traylor now realises were a sign that his mental health was deteriorating. Kitanna Traylor sets out the detail of the events of 8-9 February 2015.

Dr Marcos Pisaca

67. Dr Pisaca was appointed as a consultant psychiatrist in 2003. He is approved under s12(2) of the 1983 Act. He has worked for the Trust since 2007. At the time of these events, he was the lead consultant psychiatrist for the Canterbury & Swale Community Mental Health Team. In June 2014 he moved from Sittingbourne to Canterbury to support the local community mental health team as their permanent consultant, taking over from Dr Szpak who had been filling the position on a locum basis.

68. Dr Pisaca explains that he had a detailed discussion with Dr Szpak about Marc Traylor's history during a handover meeting in late May 2014. They agreed that Marc Traylor would be booked in to see Dr Pisaca during his first week in post. He read the notes and reports which set out the history in considerable detail. He was therefore fully aware of the background history. At the consultation on 4 June 2014 Marc Traylor asked to switch to oral medication and made it clear that, in the long term, he wished to come off medication entirely. Dr Pisaca says that he recommended that Marc Traylor continue with his depot injections, and he explained the risks of relapse. Marc Traylor listened to the advice but declined to continue on a depot injection and requested a change to oral medication. Nicole Traylor supported this decision. Dr Pisaca says that he recalls Nicole Traylor saying that she would watch Marc Traylor take his medication every day (saying she had a vested interest to do so), and that Marc Traylor agreed to this. Marc Traylor was adamant that he wished to switch to oral medication, and this was a decision he was entitled to make. After a detailed discussion, a plan was agreed. Marc Traylor would have one more depot injection (which would take place the following day) and would then switch to oral medication. If that was successful then it might later be possible to reduce, and in the longer term to cease, oral medication under close supervision. Dr Pisaca believed that Marc Traylor was being "open and honest" with him. He believed that he would take his medication.

69. Dr Pisaca says that he was alive to the risks of coming off depot medication, but the risk was balanced. He set out a detailed explanation of how he considered that the risks were adequately addressed. This included that Marc Traylor was well aware of the risks of non-compliance with medication, that support was in place both from the mental health team (who would continue to visit him regularly) and from an "aware and

vigilant family", and this would assist to detect any early signs of deterioration. Moreover, the medication changes could be reviewed at any time, or new medication decisions made depending on progress.

The expert evidence

70. The claimants rely on the expert evidence of Dr Stephen Ginn. The Trust relies on the expert evidence of Dr Boris Iankov.

71. Dr Ginn is a consultant in adult psychiatry. He became a consultant in 2014, initially taking up a locum position before appointment to a substantive post in 2017. He works as an inpatient consultant psychiatrist and is responsible for, amongst other matters, the assessment, diagnosis, management and treatment of patients under his care, including patients suffering from schizophrenia. He is approved for work under s12(2) of the 1983 Act.

72. The reports he made in these two cases were among the first reports he had written (and the report in Marc Traylor's case was the first report he had written). That does not in any way undermine his evidence. What is far more important is an expert's experience and expertise in the matters on which expert evidence is given, rather than the expert's experience in giving evidence. The fact that the expert does not have previous experience of writing reports or giving evidence in court is not a reason for impugning their evidence, so long as the witness understands the role of an expert, what is required by Part 35 of the Civil Procedure Rules and (in a clinical negligence case) the concept of a reasonable body of medical opinion (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582). Dr Ginn's reports do, on their face, comply with Part 35 of the Civil Procedure Rules. He makes the declarations that are required by CPR PD 35 paragraph 3.2(9). Although it is not clear from the text of his reports that he understood the nature of the *Bolam* test, it is clear from his oral evidence that he does so. I do not therefore see any reason to give less weight to his evidence on the grounds of his inexperience as an expert witness.

73. The experts were asked, when preparing a joint statement, to summarise their professional experience of considering to renew a CTO, preparing reports about CTOs, and sitting on Tribunals considering CTOs. In answer to each of these questions, Dr Ginn wrote "regarding my experience please refer to my report dated 3 May 2021 paragraph 1.1.1 onwards." In fact, as he agreed when giving oral evidence, his report does not provide any information of his experience in relation to CTOs. He accepted, in cross-examination, that he has no such experience.

74. This raises two problems with his evidence more generally. First, this case concerns the management of a patient who had been on a CTO and, in particular, his management at the point a CTO is discharged. Dr Ginn has no relevant experience of working in this context. Second, the correct answer to the questions that were asked was "none." It would have been easy to say so. Dr Ginn's explanation is "I work full time and… there were two reports to do in a very short period of time and at the time it seemed reasonable to concentrate on those questions and to direct you to my report that I had done before." I do not consider that this adequately explains what has here happened. For these reasons I treat Dr Ginn's evidence with some caution.

75. Dr Iankov is a consultant psychiatrist who is approved under s12(2) of the 1983 Act. He is currently working at HMP Five Wells, but prior to that he worked as a general adult psychiatrist working in community and inpatient settings. He is a medical member of the Tribunal. He has substantial experience of managing patients who are on a CTO. On one issue (when Ms Gerry questioned him about whether the conditions for making a CTO continued to be satisfied in June 2014) I was left with the impression that his responses may not have sufficiently acknowledged the possibility for a range of opinion, but that was an isolated feature. On the whole his evidence was careful, well-reasoned and convincing.

76. In their written reports, and joint statements, the experts agree that, as from 4 June 2014 when Marc Traylor took medication by mouth rather than by administered injection, there was a risk that he would not take the medication. This resulted in an increased risk of a further psychotic episode. This gave rise to a risk to Marc Traylor himself and to his family. Conversely, if Marc Traylor had continued to have depot injections it is unlikely that he would have relapsed. The experts also agree that the contemporaneous note of 4 June 2014 does not "represent a robust record of the risk assessment." Both experts agree that there should have been at least monthly visits to Marc Traylor with monitoring or oversight of medication compliance. Those monitoring arrangements might have included actively asking Marc Traylor about his concordance with medication, documenting any responses, and seeking collateral history from family members regarding medication monitoring.

77. Dr Ginn considers that there should have been a separate assessment of Marc Traylor's capacity at the time he stopped receiving depot injections. Both experts agree that Marc Traylor did have capacity, so the question of whether a capacity assessment should have been carried out is moot.

78. In his written evidence, Dr Ginn considered that the decision to stop depot injections and replace them with oral medication was a breach of duty. He suggested that, at the very least, the decision to stop depot medication should have been deferred to allow an appropriate risk assessment plan to be formulated.

79. Dr Iankov considered that it was not really a question of a balance of risk. That presupposes that Dr Pisaca had a free hand in the method of administering medication. He did not. Marc Traylor had capacity to consent or withhold his consent to the administration of medication. It was not therefore open to Dr Pisaca to defer a decision to move to oral medication if (as was the case) Marc Traylor was not willing to stay on depot injections. In that context what was required was the agreement between clinician and patient of a mutually agreeable plan. That is what Dr Pisaca did.

80. Dr Ginn also considered that it was a breach of duty to discharge Marc Traylor from the CTO. Dr Iankov considered that a reasonable body of psychiatrists would have discharged Marc Traylor from the CTO.

81. Dr Iankov's oral evidence broadly reflected his written reports. For his part, Dr Ginn accepted, in a number of respects, that breaches of duty that he had set out in his report could not be sustained. In particular, Dr Ginn acknowledged that Marc Traylor had capacity within the meaning of the 2005 Act, and it was not open to Dr Pisaca to administer injections without his consent.

Issue 1: Marc Traylor's claim - breach of duty of care

82. The Trust admits that there was a breach of duty in respect of the decision in December 2014 to discharge Marc Traylor from secondary healthcare, but it is common ground that this decision did not make a difference to the outcome. Marc Traylor would have continued not to take his medication even if he had not been discharged.

83. Mr Naughton helpfully withdrew many allegations of breach of duty in the light of the concessions that were made by Dr Ginn. By the end of the evidence, Marc Traylor's claim that Dr Pisaca breached the duty of care that was owed to him narrowed right down to two allegations:

(1) Dr Pisaca did not undertake a sufficient assessment of the risk that Marc Traylor would not take his medication.

(2) Hence, or otherwise, Dr Pisaca did not advise Marc Traylor that he should remain on his depot injections.

Risk assessment

84. The question of whether an adequate risk assessment was carried out is not a free-standing issue. It is linked to the second question: whether Dr Pisaca advised Marc Traylor that he should remain on his depot injections. Mr Naughton's point is that if Dr Pisaca had properly assessed the risks, then he would have appreciated that there was a real risk that Marc Traylor would not take his oral medication. In that event he would have given advice to Marc Traylor to remain on depot injections. The risk assessment therefore feeds into the duty to advise. Given that it is common ground that the duty to advise arose in any event, the question of whether Dr Pisaca adequately addressed the risks may not, in itself, take Marc Traylor's case very far. The real relevance of the risk assessment is that if Dr Pisaca had not appreciated the risks, then it might be more likely that he did not give the necessary advice. Conversely, if he had appreciated the risks then it is less likely that he omitted to give advice that helped avoid or mitigate those risks.

85. The contemporaneous notes do not make any record of any type of risk assessment. For the reasons given below (see paragraphs 90 - 91), and without in any way doubting Dr Pisaca's honesty, I do not accept that the account that he now gives can (without external support) be regarded as a reliable record of his thought process in June 2014. Nevertheless, I am satisfied on the balance of probabilities that Dr Pisaca did consider the risks, that he appreciated that Marc Traylor might not take oral medication and the consequential risks that flowed from that, and that he regarded depot injections as the preferable option. That is because:

(1) Risk assessment is integral to the practice of psychiatry. Statutory decisions under the 1983 Act require consultant psychiatrists to assess risks. One of the decisions that Dr Pisaca made, in principle, was to discharge the CTO. That in itself required consideration of questions of risk (see s17A(5)(b) of the 1983 Act).

(2) Dr Pisaca was well versed in the background both from the handover meeting from Dr Szpak and from reading the notes. That showed a long history of violence, a period of non-compliance with medication, an aversion to medical treatment and a

desire to stop medication. The risks were obvious. It is difficult to conceive that Dr Pisaca was not aware of them.

(3) The internal evidence of the contemporaneous note expressly refers to the possibility that Marc Traylor might not follow medical advice and might stop taking medication, and states that the risks have been substantially mitigated. That is primarily concerned with the advice to take oral medication and the risks of not doing so, rather than the risk of coming off depot injections. However, the risk that he would not take his oral medication only arose at the point depot injections stopped. This is the point that was reached on 4 June 2014. Dr Pisaca must have had that well in mind.

(4) There are several indications in the short note that Dr Pisaca was seeking to assess, manage and mitigate the risks. Thus, he referred to the fact that Marc Traylor was in remission, that his treatment had been reduced, that he was insightful, that he was enjoying increased support from his family, that they were more aware of his problems, that he agreed to have his next depot injection, and that mental health services could intervene early if concerns were raised. Much of the note is concerned with the question of risk, even though it is not set out in the form of a robust written risk assessment.

(5) The relapse plan, the regular visits, and the agreement of Nicole Traylor to support her husband, were all measures that were in place to control and mitigate the risks. They indicate that the risks were well appreciated.

Advice to remain on depot injections

86. It is common ground that antipsychotic medication administered by depot injection is more efficacious than orally administered medication. It also avoids the risk that a patient will stop taking his medication without the clinical team's knowledge. It requires less resource (because the level of monitoring that is needed is less if the patient is on depot injections). For all those reasons, from the clinical point of view, depot injections are preferable to oral medication. The only rational reason for substituting oral medication in place of depot injections is the patient's wish and informed decision.

87. It is therefore common ground that Dr Pisaca should have advised Marc Traylor to continue with the depot medication so that he could make an informed decision. It is common ground that if he did not give that advice then that was a breach of the duty of care owed by Dr Pisaca to Marc Traylor.

88. The contemporaneous notes do not record whether this advice was given (see paragraph 33 above). Nor does the letter to the GP (see paragraph 35 above).

89. It is likely that those who were at the consultation on 4 June 2014 were Dr Pisaca, Marc Traylor, Nicole Traylor and Carol Eccleshare. That is what is recorded in the contemporaneous note. Nicole Traylor recalls that Marc Traylor's father, Peter Traylor, was present. She is probably wrong about that, and she is probably conflating the consultation on 4 June 2014 with that on 18 June 2014. Peter Traylor only recalls going to one consultation, and he is recorded in the contemporaneous notes as being present at the consultation on 18 June 2014.

90. Dr Pisaca made a detailed witness statement and gave oral evidence. He explains, and I accept, that in late May 2014 he received a detailed handover from Dr Szpak in which they discussed Marc Traylor's case (amongst others). They agreed that as Dr Pisaca would be the permanent consultant, he was in a better position to plan the longer-term strategy for the patients he was taking over, such as Marc Traylor. The consultation for 4 June 2014 was the day before a planned depot injection. He says that he recommended that Marc Traylor should continue with his depot injection, that he explained the risks of relapse if he stopped taking his medication, that Marc Traylor listened to the advice that he was given but declined to continue on a depot injection and requested changing to oral medication.

91. Mr Naughton made it clear, in terms, that he did not challenge Dr Pisaca's honesty. He contended, however, that it is not safe to rely on his recollection of the detail of the consultation of 4 June 2014, at least not in isolation. I agree. The witness statement was made 6½ years after the consultation in question. There was nothing particularly remarkable about the consultation. Dr Pisaca will have seen very many other patients in the interim. He candidly explains that the process of producing his witness statement involved "a combined effort" with the Trust's legal team. There had been an earlier complaint investigation at which the issues were canvassed. I am satisfied that Dr Pisaca was doing his best to give an accurate and truthful account of what happened during the consultation on 4 June 2014. But I do not consider that his recollection now of what he said to Marc Traylor can, in isolation, be regarded as reliable (see, for analysis of the well-known problems with recollection in this sort of context, *Onassis v Vergottis* [1968] 2 Lloyds Rep 403 *per* Lord Pearce at 431, *Grace Shipping v Sharp & Co* [1987] 1 Lloyd's Law Rep 207 *per* Lord Goff at 215-6, *Wetton v Ahmed and others* [2011] EWCA Civ 610 *per* Arden LJ at [11]-[14], *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3560 (Comm) [2020] 1 CLC 428 *per* Leggatt J at [16]-[22] and Lord Bingham, The Business of Judging (2000) at 15-18).

92. Marc Traylor and Nicole Traylor may have better reasons to remember some of the detail of the consultation on 4 June 2014 than Dr Pisaca. Nevertheless, for similar reasons, their recollections as to what was said should be treated with some caution. In Nicole Traylor's case there are inconsistencies between her evidence as to what was said on 4 June 2014, and the contemporaneous note. She recalls (I think wrongly) that Peter Traylor was present. She recalls Peter Traylor expressing concern about Marc Traylor coming off his depot injection. If, as I have found, Peter Traylor was not present then she must be wrong about that too. She suggests that she argued against Marc Traylor being moved from depot to oral medication. The contemporaneous notes say in terms that she was arguing in favour of this. It is unlikely that this was due to a misunderstanding or a failure in communication. I am satisfied (having heard her give evidence) that Nicole Traylor is well capable of making herself understood. It is likely that during the lengthy meeting she made her views well known to Dr Pisaca. The background history shows that she was strongly supportive of Marc Traylor's preferred wishes and that she was an advocate on his behalf (for example her actions in pursuing an application to the Tribunal to discharge the order for Marc Traylor's detention under s3 of the 1983 Act). Peter Traylor says (although probably in relation to the 18 June consultation rather than that on 4 June) that Nicole Traylor was advocating in favour of Marc Traylor being allowed to come off his medication altogether.

93. Nicole Traylor was, like Dr Pisaca, an entirely honest witness. But, again like Dr Pisaca, I do not consider that her recollection of the detail of the consultation is reliable.

94. Marc Traylor suggests that he was not advised to remain on the depot medication. As with the other witnesses, I do not consider that his evidence on this issue is reliable. Moreover, he consistently lied to others on the question of whether he was taking his medication.

95. The primary source for findings as to what was said on 4 June 2014 is therefore the contemporaneous note of that meeting, together with the content of the letter of 18 June 2014, read in the context of the history as a whole and the expert evidence, with the witness accounts providing more of a secondary cross-check.

96. Although the contemporaneous notes do not record in terms that Marc Taylor was advised to continue with his depot injections, I have concluded that it is likely that this advice was given. That is because:

(1) It was a reasonably lengthy consultation. Dr Pisaca's evidence (which appears to be corroborated by the computerised timings) is that it overran the 1-hour time slot that had been allocated. The notes are therefore only a short summary of the discussion that took place.

(2) The whole focus of the consultation was the continuation of medication.

(3) Dr Pisaca's strong view (which on the expert evidence that was produced is the only tenable view) was that subject to Marc Traylor's wishes, it was preferable to administer the medication by depot injection.

(4) There was every opportunity for Dr Pisaca to give that advice in what was a lengthy consultation dealing with, effectively, a single issue, and there was no reason for him not to give the advice.

(5) Neither expert witness suggested that there is any absolute necessity for advice of this nature to be separately noted.

(6) Although the notes do not expressly record that this advice was given, they are not inconsistent with such advice being given.

(7) There are indications in the notes that are consistent with Dr Pisaca's evidence that he did give the advice. They record that Marc Traylor "agrees" to have his next depot medication, there was a "discuss[ion]" about replacing the injection with tablets. There is reference to the possibility that he might decide to come off his medication "against advice." The "advice" there mentioned relates to the prospect of ceasing medication altogether (rather than specifically as to the choice between depot and oral medication), but it is nevertheless consistent with there being a detailed discussion, including advice, as to the different options.

(8) If Dr Pisaca had not strongly advised that Marc Traylor should continue with depot medication, there is no obvious reason why Marc Traylor agreed to take the depot medication the following day (rather than immediately swapping to oral medication). This is much more likely to have been a compromise between Dr

Pisaca's preferred option, that Marc Traylor remain on depot medication, and Marc Traylor's wish to stop.

(9) Nothing in the letter of 18 June 2014 is inconsistent with Marc Traylor having been given advice to remain on depot medication. Dr Iankov opined, and I accept, that there was no reason for that letter to record the advice that had been given.

97. It follows that Marc Traylor has not succeeded in establishing either of the remaining allegations of breach of duty.

Issues 2 and 3: Marc Traylor's claim – causation and voluntary assumption of risk

98. These issues do not arise because Marc Traylor has not established a breach of duty.

99. Even if Dr Pisaca had failed to advise Marc Traylor to remain on depot medication, it was not shown that this made a difference to the outcome. Despite what he says in his evidence, it is unlikely that Marc Traylor would have accepted such advice. The events show that he was determined to come off his medication. As soon as he had the opportunity to do that, he did. And he lied about it. It is common ground that Dr Pisaca had no power to compel Marc Traylor to remain on depot medication. Marc Traylor had fixed views about the (in)efficacy of medication. No amount of advice could change those views. It is likely that he was compliant with the depot medication before June 2014 only because he was under the (mis)apprehension that the Trust had the power to compel him to take the medication, and because he thought that compliance with the Trust in the shorter term would enable him to come off the CTO quicker. The history shows that he was capable of cynical manipulation of the system in this way (see paragraph 15 above).

100. Accordingly, on the facts, Marc Traylor has not proved that any breach of duty caused the damage for which he claims.

101. If Marc Traylor had established causation in a factual sense, then I would not have acceded to the Trust's separate argument that the breach of duty was not a legal cause of Marc Traylor's relapse. The Trust is right that a more immediate cause was the free and voluntary decision of Marc Traylor not to take his medication. In other contexts that would be sufficient to break the chain of causation – see Hart and Honoré, Causation in the Law (second edition, 1985) at p136: "the free, deliberate and informed act or omission of a human being, intended to exploit the situation created by a defendant, negatives causal connection." Here, the primary purpose of what is agreed to be a duty of care (to advise Marc Traylor to remain on depot medication) was to guard against the risk that Marc Traylor would not take oral medication. The general principle identified by Hart and Honoré does not apply where the law imposes that type of duty – see *Reeves v Commissioner of Police of the Metropolis* [2000] 1 AC 360 *per* Lord Hoffmann at 367H:

> "It would make nonsense of the existence of such a duty if the law were to hold that the occurrence of the very act which ought to have been prevented negatived causal connection between the breach of duty and the loss."

102. In *Gray v Thames Trains Ltd* [2009] UKHL 33 [2009] 1 AC 1339 Lord Hoffmann said (at [28]):

> "It is not sufficient to exclude liability that the immediate cause of the damage was the deliberate act of the claimant himself. Although in general a defendant will not be liable for damage of which the immediate cause was the deliberate act of the claimant or a third party, that principle does not ordinarily apply when the claimant or third party's act was itself a consequence of the defendant's breach of duty."

103. For the same reason I do not accept the Trust's separate argument that an otherwise viable claim would be defeated because Marc Traylor had voluntarily accepted the risk created by Dr Pisaca's failure to give proper advice (and see *Reeves* at 367E-F (Lord Hoffmann) 375H (Lord Jauncey) and 381D (Lord Hope)). If the defence were available then that would effectively empty the duty of any meaningful content (see *Reeves* at 386F, quoting the judgment of Lord Bingham CJ in the Court of Appeal).

104. Mr Bishop argues that the duty identified in *Reeves* (to take reasonable care to avoid a detainee from committing suicide) arose in a different context (a duty owed by a police custody sergeant to a prisoner in a police cell). That is correct, but it misses the point. What is important is that the duty of care that exists in both contexts is a duty to prevent harm that would arise from the claimant's own deliberate act. It is because of this special and unusual feature of the duty (rather than the circumstances that give rise to it) that defences based on causation or voluntary acceptance of risk cannot succeed.

Issue 4: Marc Traylor's claim – illegality

105. As with issues 2 and 3, the defence of illegality does not arise because Marc Traylor has not established a breach of duty.

106. The jury in the criminal proceedings returned a special verdict that Marc Traylor was not guilty by reason of insanity. Mr Bishop QC helpfully indicated, at the outset of the trial, that the Trust accepts that at the time Marc Traylor took his daughter hostage, he was insane within the meaning of the *McNaughten* rules. That is (see *M'Naughten's Case* (1843) 10 Cl & F 200 8 ER 718) that he "was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong." It is not therefore necessary for Marc Traylor to rely directly on the jury verdict. It follows that no question arises as to whether reliance on the jury verdict is contrary to the rule in *Hollington v Hewthorn* [1943] 1 KB 587.

107. It is common ground that if Marc Traylor had not been insane within the meaning of the *McNaughten* rules, then his claim would be defeated by the defence of illegality. The question of whether that defence is available where the claimant was, at the relevant time, insane within the meaning of the *McNaughten* rules has not been finally determined in this jurisdiction. It was explicitly left open in *Gray* – see *per* Lord Hoffmann at [42].

108. Mr Bishop QC submits that although Marc Traylor was rightly found "not guilty by reason of insanity", he was nevertheless guilty of "a criminal act." He was only

acquitted because he did not have the requisite capacity to form the necessary intent. This is the premise on which he contends that the defence of illegality remains available. He relies on the sidenote to s2 Trial of Lunatics Act 1883 ("guilty of the act or omission charged, but insane so as not to be responsible, according to law, for his actions."). He also relies on the definition of "conviction" in s2 Bail Act 1976:

> "**2 Other definitions**
>
> (1) In this Act, unless the context otherwise requires, "conviction" includes—
>
> (a) a finding of guilt,
>
> (b) a finding that a person is not guilty by reason of insanity,
>
> (c) a finding under section 11(1) of the Powers of Criminal Courts (Sentencing) Act 2000 (remand for medical examination) that the person in question did the act or made the omission charged, and
>
> (d) a conviction of an offence for which an order is made discharging the offender absolutely or conditionally,
>
> and "convicted" shall be construed accordingly."

109. Mr Bishop QC also relies on paragraph 3 of Annex B to the Criminal Injuries Compensation Scheme 2012:

> "In exceptional cases, an act may be treated as a crime of violence where the assailant:
>
> (a) is not capable of forming the necessary mental element due to insanity; or
>
> (b) is a child below the age of criminal responsibility who in fact understood the consequences of their actions."

110. I do not accept the submission that Marc Traylor is to be treated as having committed a criminal act. The common law background and legislative history show that those who satisfy the test in the *McNaughten* rules are not regarded in law as having committed the act or having any responsibility for the act – see paragraphs 55 - 61 above. The sidenote to s2 Trial of Lunatics Act 1883 (in particular the use of the word "guilty") does not now reflect the content of the provision, which has since been amended. Even in its original form, s2 did not have the effect that the defendant was treated as being responsible for the criminal act (see paragraph 60 above). The Bail Act 1976 makes express provision (by s2(1)(b)) that a person found not guilty by reason of insanity is to be treated, for the purposes of that Act, as if he had been convicted. Rather than supporting the Trust's argument, that further shows that the special verdict is not treated, as a matter of the general law, as a conviction. Otherwise s2(1)(b) would not

have been necessary. It is not surprising that the 1976 Act, which is in part concerned with public protection and the avoidance of risk, should treat the special verdict in this way. Nor is it surprising that the criminal injuries compensation scheme should enable compensation to be recovered by victims of what would (but for the special verdict) be a crime of violence. The fact that particular provision is made for those found not guilty by reason of insanity further shows that as a matter of the general law such a person is not regarded as having committed a criminal act. Equivalent provision is made for those under the age of criminal responsibility. There are understandable policy reasons why a scheme that provides compensation to victims out of public funds should extend to those who suffer violence at the hands of someone who is insane or is under the age of criminal responsibility. That does not, however, mean that such people are to be regarded, for the purposes of the law of tort, as if they have committed a criminal offence.

111. There are many authorities which suggest that the illegality defence only applies where the claimant knew that he was acting unlawfully:

(1) In *Adamson v Jarvis* (1827) 4 Bing 66 130 ER 693 Best CJ said at 73: "… the rule that wrong-doers cannot have redress… is confined to cases where the person seeking redress must be presumed to have known that he was doing an unlawful act."

(2) In *James v British General Insurance Co Ltd* [1927] 2 KB 311 Roche J said (at 323) that the defence of illegality only applied to "a known unlawful act."

(3) In *Hardy v Motor Insurers' Bureau* [1964] 2 QB 745 Lord Denning MR expressed the illegality defence as a "broad rule of public policy that no person can claim indemnity or reparation for his own wilful and culpable crime." At 769 Diplock LJ said that the defence of illegality applied where there was "an intentional crime committed by the assured."

(4) In *Grey v Barr* [1971] 2 QB 554, Lord Denning MR said (at 558): "If his conduct is wilful and culpable, he is not entitled to recover."

(5) In *Pitts v Hunt* [1991] 2 QB 24 at 39G it was said that there is a clear distinction between "deliberate intentional acts and those which are unintentional though grossly negligent."

112. The application of the defence in a case where the *McNaughten* rules are satisfied would seemingly be contrary to this line of authority.

113. It would also be contrary to dicta in *Beresford v Royal Insurance Company Ltd* [1937] 2 KB 197 and *Clunis v Camden and Islington Health Authority* [1998] QB 978. In *Beresford* the deceased committed suicide (at a time when suicide was a criminal offence). His administratrix sought to recover under a life insurance policy. It was found that he had not been insane within the meaning of the *McNaughten* rules at the time of the suicide. At first instance, Swift J rejected the insurance company's illegality defence. The Court of Appeal allowed an appeal holding that the illegality defence applied but indicated that the position would have been different if the deceased had been insane – see *per* Lord Wright MR (giving the judgment of the Court) at 210: "If the assured had taken his life while insane, the fact would not have constituted a

defence." An appeal to the House of Lords was dismissed ([1938] AC 586), but no view was expressed on what the position would have been if the deceased had been insane at the time of committing suicide. In *Clunis* the Court of Appeal indicated that the illegality defence would not have succeeded if the plaintiff had been insane within the meaning of the *McNaughten* rules – see at 989E *per* Beldam LJ:

> "In the present case the plaintiff has been convicted of a serious criminal offence. In such a case public policy would in our judgment preclude the court from entertaining the plaintiff's claim unless it could be said that he did not know the nature and quality of his act or that what he was doing was wrong."

114. Importantly, it would also run contrary to the reasoning of a recent decision of the Supreme Court, in a similar type of case, *Henderson v Dorset Healthcare University NHS Foundation Trust* [2020] UKSC 43 [2021] AC 563. The claimant stabbed and killed her mother during a psychotic episode. She pleaded guilty to manslaughter on the grounds of diminished responsibility. The Supreme Court upheld the decision of Jay J and the Court of Appeal that the claim was defeated by the defence of illegality. In doing so, the court emphasised the desirability of maintaining consistency between the criminal and civil law – see *per* Lord Hamblen JSC at [108]: "If… it is appropriate for the civil court to move away from the *McNaghten* approach to insanity, and to develop its own approach to such issues, then [inconsistencies between the criminal and the civil courts] will be heightened." In *Henderson* the claimant had diminished responsibility but did not come within the scope of the *McNaghten* rules, so the illegality defence was available – Lord Hamblen JSC at [139] (and [142]): "The appellant knew what she was doing and that it was legally and morally wrong." The maintenance of consistency between the civil and criminal law militates in favour of the opposite outcome in the present case. That is because the concession that Marc Traylor satisfied the test in the *McNaughten* rules means that he did not know what he was doing or, if he did, he did not know that it was wrong.

115. The Trust's argument also runs counter to decisions in the United States. In *Boruschewitz v Kirts* (1990) 554 NE 2d 1112 (a decision of the Illinois Court of Appeals) it was held that a claimant's action would not be barred by public policy if the claimant "was not responsible for the underlying criminal act by reason of legal insanity." The Supreme Court of Georgia reached the same view in *O'Brien v Burscato* (2011) 289 Ga 739. In *Rimert v Mortell* (1997) NE 2d 867 (Court of Appeals of Indiana) the court said at 874-875:

> "A prohibition against imposing liability for one's own criminal acts to another through a civil action is simply not justified when a plaintiff is not responsible for the act or acts in question. Thus, if in this case [the claimant] had been found not guilty by reason of insanity, he would bear no criminal responsibility for his acts and his subsequent civil action for recovery… could not be barred by the public policy expressed above."

116. I was shown one case where the opposite conclusion was reached – the decision of the New South Wales Court of Appeal in *Hunter Area Health Service v Presland* [2005] NSWCA 33. In that case, Spigelman CJ referred to a long line of authority from this jurisdiction and concluded that the illegality defence should not succeed in cases of

insanity. So far as concerned the outcome, he was in the minority. The other two members of the constitution held that the claim in that case should fail, but neither relied on an orthodox application of the common law illegality defence (see Sheller JA at [300] and Santow JA at [315]).

117. Mr Bishop QC advanced an alternative case based on Marc Traylor's decision not to take the medication that had been prescribed (and his lies about this). Marc Traylor's conduct in this respect was not unlawful. I was not shown any authority that conduct of this nature could trigger the illegality defence. Mr Bishop QC pointed to authorities that automatism is not a defence where it is self-induced (as in the case of a diabetic who does not take food after a dose of insulin – see *R v Bailey* [1983] 1 WLR 760). That is an altogether different point.

118. Mr Bishop QC also submitted that it would be inconsistent for the law, on the one hand, to regard the actions of the police who shot Marc Traylor as lawful, but on the other hand to award compensation for injuries he sustained as a result of being shot. I am satisfied there is no inconsistency whatsoever. An award of compensation would not impugn the officers' actions; it would simply recognise (if it were the case) that those actions were the lawful consequence of a third party's tort.

119. For all these reasons, although it is not necessary to reach a final conclusion, I am not inclined to find that the illegality defence is available on the facts of this case.

Issue 5: Marc Traylor's claim – contributory fault

120. By not taking his medication, and by lying to the mental health care team, Marc Traylor did not take reasonable care for his own wellbeing. That amounts to fault within the meaning of s5 Law Reform (Contributory Negligence) Act 1945. His failure to take his medication was a cause of his relapse, and hence his injuries. It follows that the damages (that would have been recoverable if the claim had otherwise succeeded) should be reduced to such extent as is just and equitable having regard to the claimant's share in the responsibility for the damage (see s1(1) of the 1945 Act).

121. In cases of suicide or self-harm in detention, the reduction for contributory fault is generally no greater than 50% - *Corr v IBC Vehicles Ltd* [2008] UKHL 13 [2008] 1 AC 884 *per* Lord Neuberger at [62]-[69]. In those cases, it is recognised that a prisoner is particularly vulnerable by reason of incarceration, that prisoners are at a particular risk of self-harm or suicide, and that freedom of choice may, to a greater or lesser extent, be "overborne" by the fault of the defendant – see *Reeves* at 366B and *Corr* at [65].

122. Even if Dr Pisaca had failed to give advice about the merits of remaining on depot injections, I consider that Marc Traylor bore (by a substantial margin) the primary responsibility for what then happened. There is no question of his autonomy or freedom of choice being overborne by Dr Pisaca's conduct, or by imprisonment, or anything else. Over a period of around 7 months, he deliberately did not take his medication, and lied about that to Nicole Traylor and to those who came to visit him to monitor his progress. He had been advised as to the risks of not taking his medication. I consider that if the claim had otherwise succeeded it would be just and equitable to reduce the damages recoverable by three quarters.

Issue 6: Kitanna Traylor's claim – Articles 2 and 3 ECHR

123. The Trust is a public authority. By s6 Human Rights Act 1998 it is required to act compatibly with the Convention rights identified under s1 of the 1998 Act, including the right to life (article 2 ECHR) and the prohibition of inhuman and degrading treatment (article 3 ECHR). Each of those articles imposes a positive duty on the state to take positive steps to safeguard against risks of serious injury (article 3) or death (article 2). It is common ground that there is no relevant distinction between the scope of the positive duties owed under articles 2 and 3. For convenience, I address only article 2.

124. Mr Bishop QC submits that this is, in effect, a medical negligence claim, and acts of medical negligence do not generally engage article 2 ECHR. Ms Gerry's case is that if the Trust was aware of a real and immediate risk to life, then it was required to take such measures within the scope of its powers which might reasonably have been expected to avoid that risk.

125. In principle, I accept both submissions. They derive from two separate aspects of the positive obligation on the state to protect life (see *Rabone v Pennine Care NHS Trust* [2012] UKSC 2 [2012] 2 AC 72 *per* Lord Dyson at [12] and *Fernandes de Oliveira v Portugal* (2019) 69 EHRR 209 at [103]). First, the state must ensure that hospitals adopt appropriate measures for the protection of lives. So long as that is done, acts of medical negligence do not, in themselves, ordinarily amount to a breach of articles 2 or 3 ECHR – see *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 1011 at [186] (and cf at [202]-[205]). Second, there are circumstances where the state is under an obligation to provide protection against a known risk to life. In *Osman v United Kingdom* (1998) 29 EHRR 245 the court explained what is required to show a breach of this obligation:

> "…where there is an allegation that the authorities have violated their positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk."

126. This duty may also, in certain circumstances, arise so as to require an NHS Trust to protect against a risk of suicide – *Rabone* at [34]. In *Fernandes* the court found that such a duty may arise in respect of patients receiving treatment for mental health problems on a voluntary basis. In *Griffiths v Chief Constable of Suffolk Police and another* [2018] EWHC 2538 (QB) [2019] Med LR 1 Ouseley J was prepared to contemplate (at [484]) that the positive duty may extend not just to protect against suicide but also to protect against a real and immediate risk to the life of a third party posed by one of its patients. I respectfully agree. The *Osman* duty, in its original form, was designed to protect against the risk to life from the criminal acts of a third party. It has been applied (including in *Rabone*) so as to require hospitals to protect against a risk of suicide posed by patients receiving treatment for mental health problems. No reason of principle was identified why it should not, in an appropriate case, also require

hospitals to protect against a risk of violence to third parties posed by a patient. At common law, hospitals owe a duty to ensure that their staff, and visitors, are kept reasonably safe from violent patients. The 1983 Act provides compulsory powers to protect others from those suffering mental illness (see s2(2)(b), s3(2)(c), s17A(5)(b)). The treatment of the *Osman* duty in *Fernandes* did not distinguish between the duty to protect against suicide or the duty to protect against a risk of violence to a third party – it described one of the duties that was engaged (at [103]) as "a positive obligation to take preventive operational measures to protect an individual from another individual or, in particular circumstances, from himself."

127. Mr Bishop QC suggested that there was effectively a choice between what are two alternative positive operational duties under article 2 EHCR – the "systems" duty to provide hospitals that adopt appropriate measures for the protection of lives, and the *Osman* duty to protect against suicide or criminal violence. In a primarily clinical setting the former duty arises. In a primarily protective setting, the latter duty may arise.

128. I do not accept that there is this sharp distinction between the different components of article 2 ECHR, or that only one type of duty may arise in a given context, or that a choice has to be made between two competing alternative options. The language of *Fernandes* shows that two duties may coexist – see at [103]: "two distinct albeit related positive obligations under art 2… may be engaged."

129. I therefore accept Ms Gerry's submission that the *Osman* duty may, in principle, arise in the present type of context.

Issue 7: Whether the Trust knew that there was a real and immediate risk to life or physical safety

130. The test for triggering the *Osman* duty is that the Trust knew or ought to have known that there was a real and immediate risk to (Kitanna Taylor's) life (or physical safety). On the facts of this case there is no argument about the difference between "knew" and "ought to have known": it is accepted that Dr Pisaca was aware of all relevant factors, including the detailed medical history. The issues concern whether (1) the risk was real, (2) the risk was immediate, (3) the risk extended to the life (or physical safety) of Kitanna Traylor.

131. Ms Gerry does not suggest that, as of June 2014, Marc Traylor was likely, within a short space of time, to suffer a relapse. His condition had been well controlled over many months. A depot injection was administered on 5 June 2014, and the next dose of medication was not due for another month. As Mr Bishop QC pointed out, the risk that eventually materialised depended on a number of interim steps: (1) Marc Traylor not taking his medication, (2) Marc Traylor lying about not taking his medication, (3) Marc Traylor's failure to take his medication, and his lies, not being detected despite the presence of Nicole Traylor and the visits from the mental health care team, (4) Marc Traylor suffering a relapse, (5) the relapse leading to a psychotic episode of a type that gave rise to violence against Kitanna Traylor. All the pieces of this jigsaw needed to fall into place before the risk materialised. I agree with this analysis. It is against that background that the questions arise as to whether the components of the *Osman* test are satisfied.

132. Ms Gerry submits that a real risk is simply a risk that is not fanciful. I agree. I consider that the first four links in the chain that Mr Bishop QC identified were each real and foreseeable concerns (the fifth link is more appropriately considered in the context of the question of whether the risk extended to the life or safety of Kitanna Traylor):

(1) Dr Ginn conceded that Marc Traylor's previous history of not taking medication was not significant because, at that time, he had been in the throes of a psychotic episode. Without going behind that concession, I do consider that there was a clear risk that Marc Traylor would not take his medication. He had expressed a firm desire over many months to stop taking the medication. I accept the evidence of Dr Iankov and Dr Pisaca that (counter-intuitively as it might seem) the fact that he had done so provided some cause for confidence, because it showed that he was engaging with the medical professionals and was honest about his feelings. It does, however, also show that he wanted to stop taking his medication, and there was no reason to be confident that he would not, at some point, do what he had long desired. It is accepted that a duty arose to advise Marc Traylor that he should remain on depot injections. That duty arose, in part, because it was foreseeable that he might not take oral medication. The Trust's staff had repeatedly recognised the risk that Marc Traylor might not take his medication.

(2) Marc Traylor had shown his capacity to lie about taking medication (see paragraph 16 above).

(3) Marc Traylor's previous lies had not been detected until he volunteered them. Dr Iankov indicated that it was not possible to be confident that the early signs of a relapse would be detected: "If Mr Traylor was a patient with 17 admissions, a long history, the relapse signature would be very clear. Here, we are trying to develop a relapse signature based on one event. It is not possible."

(4) The agreed evidence is that without medication the risk of relapse was in the region of 80%.

133. I accept the evidence that was adduced that many patients with a profile similar to Marc Traylor recover, and that the type of catastrophe that here occurred is not inevitable. I also accept Dr Iankov's evidence that it would have been unlikely that any reasonable psychiatrist would have predicted the catastrophe that ultimately unfolded. That does not, however, mean that there was no risk. There was a risk, it was a real risk, and it was a known risk (see paragraph 23 above). It is just that the precise way in which it ultimately materialised could not be predicted.

134. Ms Gerry further submits that an immediate risk may be one that is present and continuing. Again, I accept Ms Gerry's submission which is supported by authority – see *In re Officer L* [2007] UKHL 36 [2007] 1 WLR 2135 *per* Lord Carswell at [20]. Mr Bishop QC says that where, as here, the risk is not likely to materialise for some time the *Osman* test is not satisfied. He relies on the observation of Lord Dyson JSC in *Rabone* at [39] that "[t]he idea is to focus on a risk which is present at the time of the alleged breach of duty and not a risk that will arise at some time in the future." I do not agree that this supports Mr Bishop's submission. Lord Dyson was not saying that the duty is only engaged where the risk is likely immediately to materialise. A risk may be present and continuing even though it will not materialise for some time. Take an example, explored in argument. A police officer receives clear and reliable intelligence

that a terrorist will detonate an explosive device in a crowded area in 3 months' time. The officer decides not to do anything with that intelligence. The risk is present and continuing at the time of the officer's default, even though it will not materialise until a date in the future.

135. In the circumstances of the present case, the risk was not likely to materialise for at least a period of weeks or months. But as soon as the decision was made to move Marc Traylor to oral medication rather than depot injections the risk was created, and it remained present, and it was at least possible (as the events that occurred demonstrate) that there would not be a further opportunity to avert catastrophe.

136. I acknowledge that the *Osman* test sets a high threshold which was not met on the striking facts of *Osman* itself (although the Convention is a living instrument, and it has been suggested that the result of *Osman* might be different today – see the concurring opinion of Judge Garlicki in *Van Colle v United Kingdom* (2013) 56 EHRR 839 at [OI1]-[OI6]). In *Osman* it was held that there was no "decisive" stage in the escalating campaign of harassment when it could be said that the police ought to have known of a real risk to life. By contrast, in this case, the Trust had itself identified a real risk to the life of Nicole Traylor, well before June 2014 (see paragraphs 21 and 23 above).

137. It follows that I accept that, as of June 2014, there was a real and immediate risk that Marc Traylor would suffer a relapse, and that this would then pose a risk to Nicole Traylor's life. The detailed risk assessment that was carried out did not discretely identify a risk to the life or physical safety of the children (but it did identify a risk to their psychological wellbeing). The *Osman* duty does not require that the precise victim is identified in advance (see *Sarjantson v Chief Constable of Humberside Police* [2013] EWCA Civ 1252 [2014] QB 411 *per* Lord Dyson MR at [22] - [25]). Here, Kitanna Traylor lived with Marc Traylor. There was a real risk that he would suffer a psychotic episode. The history showed that he could then resort to violence. He had weapons available to him. There was a clear risk that Kitanna Traylor might become caught up in such violence. There was, moreover, a record that he had previously threatened to kill his children (see paragraph 12 above).

138. For all these reasons I accept Ms Gerry's submission that the *Osman* duty is engaged.

Issue 8: Whether the Trust took reasonable steps to avert the risk

139. Having found that the *Osman* duty is engaged, it is necessary to assess whether the Trust "failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid [the] risk."

140. The steps that Ms Gerry says should have been taken are: (1) an adequate risk assessment, (2) (strong) advice to stay on depot injections, and (3) continuation of the CTO.

141. I have already dismissed Marc Traylor's allegations of breach of duty in respect of risk assessment and advice. For the same reasons, I reject these aspects of the case advanced on behalf of Kitanna Traylor. I am satisfied that Dr Pisaca did adequately assess the risks, even though he did not document his assessment. Ms Gerry submits that Dr Pisaca "gave too much weight to the wishes of Marc Traylor and his capacity to make decisions concerning his treatment". I do not agree. It is common ground that Marc

Traylor had capacity. It is not suggested that he should have been detained under s3 of the 1983 Act. It follows that his wishes had an overriding effect on Dr Pisaca's options. It would have been unlawful to impose treatment on him that was contrary to his wishes.

142. I am also satisfied that Dr Pisaca advised Marc Traylor (in appropriate terms) to remain on depot injections. Ms Gerry says that Dr Pisaca should have disbelieved Marc Traylor when he said that he would take his oral medication. He could not, however, force him to take the medication and measures were in place to mitigate against that risk (the role of Nicole Traylor, the relapse plan and the visits).

143. As to the suggestion that the CTO should have been continued, I do not consider that this might reasonably have been expected to avoid the risk. It would not have ensured that Marc Traylor take the medication. It would merely have facilitated a route of recall to detention under s3 of the 2013 Act if matters deteriorated. That, however, would have depended on the clinicians being able to identify a deterioration. The maintenance of the CTO would not have increased the prospect that a deterioration would have been identified. Regular visits were, in any event, taking place. Moreover, I consider it was reasonable in all the circumstances to discharge the CTO. I accept Dr Iankov's evidence on this point (even though I had some reservations as to the way it was expressed), and I do not consider that I can rely on Dr Ginn's evidence on this point (he has no experience of discharging CTOs). In particular, Dr Iankov considered that where, as here, the patient appears to be compliant and willing to take medication, it is not necessary to exercise the power of recall. An essential condition to the continuation of the CTO is not therefore present. If Dr Pisaca had known that Marc Traylor would not take the medication, then the position may have been different, but that is not this case. Ms Gerry advanced a forceful case that Dr Pisaca should have been more sceptical about Marc Traylor's protestations that he would take the medication. This, however, involves sensitive clinical judgments. There is something in the evidence of Dr Pisaca and Dr Iankov that it reasonably seemed at the time that Marc Traylor had moved on from his earlier stance, and as a result of education, the gaining of insight, and the building up of trust and confidence he was more willing to engage with the clinicians. That turned out not to be the case, but Dr Pisaca was not to know that. He was, though, alive to the possibilities and contingency measures were in place. In all the circumstances, I do not consider that the decision to stop the CTO was a breach of Kitanna Traylor's Convention rights.

144. Further, I am satisfied that the Trust did take reasonable steps to avert the risk. The risks had been explained to both Marc Traylor and to Nicole Traylor. A careful "relapse plan" had been formulated. Appropriate medication had been provided. Marc Traylor had agreed to take the medication, and Nicole Traylor had agreed to monitor his compliance. Visits were arranged to check up on Marc Traylor, and these took place at regular intervals. The one step that would have avoided the risk with any certainty would have been to maintain depot injections. That would not have been lawful without exercising compulsory powers under s3 of the 1983 Act, and it is not suggested that detention under s3 of the 1983 Act would have been lawful.

145. Complaint is made that there was no care plan in place to explain how Marc Traylor's compliance would be monitored. Although there is no separate "care plan" document, it is clear from the papers how compliance was to be monitored. There were regular visits to check up on Marc Traylor, and, in addition, Nicole Traylor was living with him. She, I find, had agreed to play a monitoring role. Complaint is made that it was

not reasonable to rely on Nicole Traylor, but I accept the evidence of Dr Iankov on this point that the primary measure was the visits, and Nicole Traylor's role was subsidiary to those visits. It was an extra measure of protection. It did not stand alone. In all the circumstances, a reasonable package of measures was in place to guard against the risks.

Issue 9: Kitanna Traylor's claim – heads of loss

146. I have found that the Trust did not act incompatibly with Kitanna Traylor's Convention rights. The question as to which heads of loss would otherwise be available does not therefore arise.

147. If there had been a breach of Kitanna Traylor's Convention rights then she would have been entitled to an award of damages for non-pecuniary losses, to reflect the distress and injury to feelings occasioned by the breach of her Convention rights. She would also, in principle, have been entitled to any consequential pecuniary losses (but that would involve establishing that they had been caused by the breach of her Convention rights).

148. A separate question arose as to whether causation must be proved to recover damages for pain, suffering and loss of amenity. Insofar as such a claim is advanced for the physical injuries sustained on 9 February 2015 and subsequent psychiatric sequelae (as opposed to the psychological damage occasioned by any breach of Convention rights itself) then I consider that it would be necessary to prove causation. This was the approach taken in *D v Commissioner of Police of the Metropolis* [2014] *per* Green J at [24]-[27]. In that case both claimants succeeded in showing a breach of their Convention rights. In both cases, the Claimants were assaulted, but in only one of the cases was the assault caused by the breach of a Convention right. It was only in that case that the court considered that compensation fell to be awarded for the assault and consequential harm.

Outcome

149. The Trust took reasonable steps to avoid the risk that Marc Traylor would suffer a relapse of his psychotic illness. Dr Pisaca sought to persuade Marc Traylor to remain on depot injections and, failing that, to remain on his oral medication. Marc Traylor and Nicole Traylor were told about the early signs and symptoms of relapse so that they could seek medical help. Regular monitoring was carried out to ensure that Marc Traylor was not relapsing and that he was taking his medication. This did not pick up that Marc Traylor had stopped taking his medication, in part because he lied to Nicole Traylor and to the mental health care team staff.

150. The Trust is not therefore liable in negligence to Marc Traylor. It is not liable to Kitanna Traylor under the Human Rights Act 1998.