Insanity should not be equated with illegality: Traylor v Kent and Medway NHS Social Care Partnership Trust [2022] EWHC 260 (QB)

written by Imogen Hildred | 11 February 2022

Summary: The High Court has today handed down judgment in *Marc Traylor and Kitanna Traylor v Kent and Medway NHS Social Care Partnership Trust*, a clinical negligence case full of interesting legal issues including the application of the illegality doctrine, voluntary assumption of risk, contributory negligence and Human Rights Act claims. Although the claims ultimately failed, the Claimants were successful on a number of the legal arguments, bringing some welcome clarity to the scope of the illegality defence, among other things.

The basic facts are that on 9 February 2015, in the midst of a psychotic episode, Marc Traylor took his daughter hostage. Armed police were called to the scene, and Mr Traylor was shot several times, but not before he had managed to stab his daughter. Neither were killed, but both were seriously injured. It is this tragic background that led to two claims being brought against the Trust, which was responsible for managing Mr Traylor's mental health care and treatment.

The Claims

Mr Traylor's claim

Mr Traylor suffered from paranoid schizophrenia with morbid jealousy, and had a known history of violence. He argued that the Trust had negligently failed to manage his mental illness by failing to properly assess or manage the risk of medication non-concordance in various ways (some admitted by the Trust). Crucially, Mr Traylor's medication regime was switched from depot injections to oral medication, following which he stopped taking any medication at all. Months later, he suffered a relapse, and the tragic events of 9 February 2015 occurred. His claim was for personal injuries arising from his gunshot injuries.

Crucially, and unlike similar cases in this area which will be familiar to clinical negligence practitioners and which failed (see *Henderson**[1]***, *Gray**[2]***, *Clunis**[3]***), Mr Traylor had been found **not guilty by reason of insanity** when tried for attempted murder in the criminal courts (as opposed to guilty of manslaughter by reason of diminished responsibility). The Trust raised a number of legal defences, including that Mr Traylor's claim was barred by the doctrine of illegality (*ex turpi causa*), and that there had been a voluntary assumption of risk by Mr Traylor's actions in ceasing to take oral medication.

Ms Kitanna Traylor's claim

Kitanna Traylor brought a Human Rights Act claim for breach of the "operational" (*Osman**[4]***) duty, on the grounds that the state (via the NHS Trust managing her father's care) knew or ought to have known of real and immediate risk to life and failed to take positive steps to protect her pursuant to Articles 2 and 3 of the Convention.

The claim was heard by Mr Justice Johnson over 5 days in January 2022.

The outcome

Both claims failed because the Court was not persuaded that there had been a causative breach of duty on the facts.

However, the Court went on to consider the complex legal issues engaged nevertheless and brought some helpful (obiter) clarity, under the main headlines below:

The Illegality Doctrine

The Court held that the illegality defence would not have succeeded, since Mr Traylor had been found not guilty by reason of insanity under the *M'Naughten* rules.

This was the first time this issue fell to be considered in this jurisdiction, having been expressly left open in *Gray* [107].

The Trust argued that Mr Traylor had, irrespective of the *M'Naughten* finding, nonetheless committed "a criminal act" and that he was only acquitted because he did not have the requisite capacity to form the necessary intent. The Trust drew parallels with, among other things, the Criminal Injuries Compensation Scheme, which awards victims compensation in cases where their assailant has been found not guilty by reason of insanity in criminal proceedings.

In considering these arguments, Johnson J held:

"I do not accept that 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 M'Naughten rules are not regarded in law as having committed the act or having any responsibility for the act." [110].

The key dividing line was whether a claimant knew he was acting unlawfully [111]. Unlike the Claimants in *Henderson*, *Gray*, or *Clunis*, Mr Traylor was regarded in law as not culpable for his actions. Under the Trial of Lunatics Act 1883, as amended by the Criminal Procedure (Insanity) Act 1964, a "special verdict" of not guilty by reason of insanity is given. This is treated in law as an acquittal. Furthermore, where such a verdict is received, the defendant can be given a hospital order, supervision order or absolute discharge. Johnson J concluded that such orders do **not** involve any element of punishment [61].

The Court also reviewed decisions from the US and Australia, and concluded that had the underlying claim succeeded, the illegality defence would have failed [119].

This makes sense from both a policy perspective and for consistency. There is no inconsistency in allowing a claimant who has been found not guilty for his actions under the criminal law to recover in the civil law. The overarching principle is *culpability*: If a claimant has no culpability for their actions, then they should not be automatically prevented from recovering damages in civil law.

The Court also considered the issues of voluntary assumption of risk, and contributory negligence, concluding that had the conventional claim succeeded, contributory negligence would have been appropriate given Mr Traylor's decision not to take oral anti-psychotics. The Judge considered the authorities (*Reeves*, *Corr*) and held that he would have made a reduction to any award of damages in the order of 75% [122].

Article 2/Article 3 claim

Kitanna Traylor's claim was advanced on the grounds that the state (via the NHS Trust managing her father's care and treatment) had a positive obligation to protect her from the risks of serious injury and/or risks to life.

Johnson J held that there was no reason in principle why the *Osman* duty could not operate to require hospitals to protect third parties against a risk of violence posed by their patients [126; 133]. It was therefore accepted in principle that the *Osman* duty could apply in the present sort of case.

The Court then considered whether the Trust knew (or ought to have known) that there was a real or immediate risk to life (the context being that the risk would not materialise immediately upon cessation of medication).

The judge found that there was a real risk in this case [132], with the agreed evidence being that without medication, Mr Traylor's risk of relapse was in the region of 80% [132].

The judge also accepted the submission that an "immediate risk" may be one that is present and continuing (*In re officer L [2007] UKHL 36 [2007]*). The risk satisfied the test of "*real and immediate*" threshold despite the fact that the risk would not materialise for some months (i.e. when Mr Traylor was not taking medication, the risk did not materialise immediately). The Judge gave the comparable example of a police officer who received clear and reliable intelligence that a terrorist would detonate an explosive device in a crowded area in three months' time, observing that an officer who decided not to do anything with that intelligence created a present and continuing risk at the date of that default [134].

Further, there was no requirement under *Osman* that the precise victim be identified in advance (*Sarjantson v CC Humberside Police*[5]). It was accepted that, as of June 2014, there was a real and immediate risk Mr Traylor would suffer a relapse and then pose a risk to his *wife's* life. There was a clear risk that his daughter, with whom he lived, could be become caught up in the extreme violence to which Mr Traylor was prone to when unwell [137].

Having established that the *Osman* duty was engaged, the judge then considered whether the Trust took reasonable steps to avert the risk. This required an assessment of whether the Trust failed to take measures within the scope of their powers which, judged reasonably, might have been expected to have been taken to avoid the risk [139].

For the same reasons that Mr Traylor's allegations of breach of duty were dismissed, the case advanced on behalf of Kitanna Traylor was rejected. The judge was satisfied that the Trust did take reasonable steps to avert the risk [143]. Accordingly, the HRA claim was also dismissed.

Comment

Overall, whilst the claims did not succeed, *Traylor* provides particularly welcome clarity following *Henderson* on the limits of the doctrine of illegality. The doctrine should not bar claims advanced by those who are not culpable as a matter of law for their acts at the relevant time.

Furthermore, Kitanna Traylor's claim demonstrates that the *Osman* duty can apply in cases where an NHS Trust knows of a real and immediate risk to life that a patient poses to a third party, even when that risk would not materialise for some time [134]. The precise identity of that third party does not need to be known [137].

The judgment is also helpful because of the clear and comprehensive exposition of the authorities

underpinning the doctrines of illegality, voluntary assumption of risk, contributory negligence, and the *Osman* operational duty. None of those are easy tests to apply in clinical negligence claims.

Sebastian Naughton and Rachael Gourley acted for Mr Traylor, and were instructed by Emma Wray at Hodge Jones and Allen.

[1] *Henderson v Dorset Healthcare University NHS Foundation Trust [2020] UKSC 43*

[2] Gray v Thames Trains Limited [2009] 1 AC 1339

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

[4] *Osman v United Kingdom (1998) 29 EHRR 245*

[5] *[2013] EWCA Civ 1252 QB 411*