Criminal Liability for Psychiatric Deaths: A Comparative Analysis of Caregiver Accountability in England and Wales, Portugal, and Brazil

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Abstract

This article examines the legal frameworks governing criminal liability for caregivers whose negligent conduct results in the preventable deaths of individuals with documented psychiatric conditions. Through comparative doctrinal analysis of three jurisdictions—England and Wales, Portugal, and Brazil—the article argues that existing legal mechanisms for caregiver accountability, while theoretically available, remain underutilised and require reform. The analysis focuses on a specific target class of cases meeting four limiting principles: (1) documented psychiatric diagnosis with clear, contemporaneous foreseeability of fatal risk, including recent suicide attempts, explicit clinical warnings, or discharge within a recognised high-risk window; (2) a duty of care that is either legally imposed through formal relationships such as guardianship or curatorship, or voluntarily assumed through conduct establishing responsibility for the vulnerable person's welfare; (3) a gross departure from reasonable protective measures, distinguishable from imperfect caregiving under resource constraints; and (4) causation framed as a material contribution to a foreseeable fatal risk rather than simplistic counterfactual claims. The research scrutinises the common law doctrine of gross negligence manslaughter as established in R v Stone & Dobinson [1977] QB 354 and refined in R v Adomako [1995] 1 AC 171, the codified provisions of Portugal's Código Penal concerning homicídio por negligência, and Brazil's explicit criminalisation of abandono de incapaz under Article 133 of its Penal Code. The analysis reveals significant convergences and divergences across these legal traditions in how duties arise, what standards of culpability apply, and how causation is assessed when death results from patient suicide. The article concludes that enhanced prosecutorial guidance, legislative clarification, and judicial development are necessary to close the accountability gap while respecting the legitimate constraints on criminalising imperfect care.

Keywords: *criminal liability; psychiatric morbidity; caregiver negligence; gross negligence manslaughter; abandonment of incapacitated persons; comparative legal analysis; suicide prevention; duty of care; omissions liability; vulnerable adults*

I. Introduction

Psychiatric disorders constitute a significant public health challenge globally, with depression identified by the World Health Organization as a leading cause of disability worldwide (World Health Organization, 2023). The evidence suggests that mental health conditions now account for a substantial proportion of the global disease burden, affecting individuals across all demographic categories and socioeconomic strata. The economic burden is substantial, with estimates suggesting productivity losses exceeding one trillion United States dollars annually across affected economies, reflecting both direct healthcare costs and indirect costs associated with reduced workforce participation, presenteeism, and early mortality (World Health Organization, 2023; Harvey et al., 2009). These figures, while staggering, likely underestimate the true economic impact given difficulties in capturing informal care costs and the stigma-related

underreporting of mental health conditions in many contexts.

Beyond morbidity, certain severe psychiatric conditions carry elevated mortality risks, particularly through suicide. Epidemiological research indicates that individuals diagnosed with bipolar disorder face suicide rates ten to thirty times higher than the general population, while those with major depressive disorder and schizophrenia similarly face significantly elevated risks (Chesney et al., 2014; Hawton et al., 2013). A substantial body of research has documented that the period immediately following discharge from inpatient psychiatric care represents a window of particularly heightened vulnerability, with suicide risk substantially elevated in the first weeks and months post-discharge (Chung et al., 2017). Understanding these statistical realities is essential context for any analysis of caregiver responsibilities, as they demonstrate that for persons with certain diagnoses, suicide is not a remote or speculative risk but a foreseeable probability requiring active protective measures.

This article addresses the question of criminal accountability when preventable deaths of psychiatric patients occur in the context of informal care—that is, care provided by family members, cohabitants, or others who have assumed responsibility for a vulnerable individual outside formal institutional settings. The evidence suggests that active family involvement constitutes a critical component of suicide prevention strategies, with families uniquely positioned to monitor warning signs, facilitate treatment adherence, and restrict access to lethal means (Hawton & van Heeringen, 2009; Zalsman et al., 2016). Research has consistently demonstrated that family caregivers often possess information about the patient's mental state, behavioural changes, and risk factors that may not be apparent to clinical providers who see patients only during scheduled appointments (Pitman et al., 2016). The corollary proposition, which this article examines, is that when those in caregiving positions fail grossly in these protective functions, and when such failure contributes to a foreseeable death, criminal liability may appropriately attach.

The article argues that existing legal frameworks in the jurisdictions examined—England and Wales, Portugal, and Brazil—do provide mechanisms for prosecuting grossly negligent caregivers, but that these mechanisms are hampered by doctrinal ambiguities, evidentiary challenges, and apparent reluctance on the part of prosecutorial authorities. In advancing this argument, the article maintains a restrained normative stance: the contention is not that all caregiving failures should attract criminal sanction, nor that bereaved families should routinely face prosecution. Such a position would be both legally unsupportable and practically counterproductive. Rather, the argument is that a specific, carefully delimited class of cases exists where criminal accountability is both legally available and normatively justified, and that current underutilisation of these legal tools represents a gap in the protection of vulnerable persons that warrants attention from policymakers, prosecutors, and scholars.

The selection of England and Wales, Portugal, and Brazil for comparative analysis is methodologically significant. These three jurisdictions represent distinct legal traditions—common law, Continental European civil law with strong European human rights influence, and Latin American civil law with Inter-American human rights influence—yet they share a common confrontation with the global mental health crisis and its fatal consequences. This variation facilitates identification of both convergent approaches to common problems and divergent solutions that may reflect different legal cultures, constitutional arrangements, or policy choices. The comparative method thus serves not merely to describe differences but to illuminate the range of available options and to identify potential best practices or cautionary lessons.

II. Scope and Limiting Principles

Before proceeding to doctrinal analysis, it is essential to delineate the target class of cases to which this article's arguments apply. The analysis does not concern all deaths of psychiatric patients, nor all caregiving failures, nor all family relationships. Rather, the article addresses a narrowly defined category of cases satisfying four cumulative limiting principles. These principles serve to distinguish cases where criminal liability is potentially appropriate from the broader universe of tragic outcomes in mental health care, many of which involve no culpable conduct by caregivers. The articulation of these principles at the outset responds to a legitimate concern about overcriminalisation: without clear boundaries, arguments for caregiver accountability could be misunderstood as advocating for prosecution of any family whose mentally ill relative dies. This is not the article's position, and the limiting principles are intended to make that clear.

A. Documented Diagnosis with Contemporaneous Foreseeability

The first limiting principle requires that the deceased suffered from a documented psychiatric condition and that the risk of fatal outcome was contemporaneously foreseeable at the time of the alleged caregiving failure. Contemporaneous foreseeability may be established through evidence such as: recent suicide attempts within the preceding twelve months, which substantially elevate subsequent risk according to the epidemiological literature; explicit warnings from treating clinicians communicated to the caregiver, whether in discharge summaries, care planning meetings, or crisis situations; hospitalisation for psychiatric crisis within a recognised high-risk discharge window, typically the first three months post-discharge when risk is empirically highest; documented expressions of suicidal ideation communicated to or observable by the caregiver, whether verbal statements, written communications, or behavioural indicators such as giving away possessions or saying goodbye; or a diagnosis carrying established high suicide risk, such as treatment-resistant depression, bipolar disorder during a depressive episode, or schizophrenia with command hallucinations, where such risk was communicated to the caregiver by clinical providers or was otherwise reasonably ascertainable.

This requirement excludes cases where the psychiatric condition was undiagnosed at the time of death, where risk factors were not reasonably ascertainable by the caregiver given the information available to them, or where the death occurred during an apparently stable period without antecedent warning signs observable to a person in the caregiver's position. The foreseeability requirement acknowledges that not every suicide is preventable and that caregivers cannot be held criminally responsible for failing to predict genuinely unpredictable events. Suicide is a complex phenomenon with multiple contributing factors, and even the most vigilant caregiver may be unable to prevent a death in circumstances where warning signs were absent or concealed. The criminal law should reserve its sanction for cases where the fatal risk was manifest, not cases where hindsight reveals what was not apparent at the time.

The evidence requirement also serves important evidentiary functions. Requiring documentation of the psychiatric condition ensures that the prosecution can prove the medical facts essential to establishing the nature and magnitude of the risk. Requiring evidence of contemporaneous foreseeability ensures that the caregiver's knowledge or constructive knowledge of risk can be established, addressing the mental element of the relevant offences. These requirements thus serve to operationalise the limiting principle in a manner amenable to proof in criminal proceedings.

B. Assumed or Legally Imposed Duty

The second limiting principle requires that the alleged wrongdoer owed a legally recognised duty of care to the deceased, arising either through legal imposition or voluntary assumption. This requirement reflects the foundational principle that criminal liability for omissions—for failing to act rather than for acting—requires a pre-existing legal duty to act. This principle is common to all three jurisdictions examined, though the sources and scope of such duties differ. Legally imposed duties include those arising from: formal appointment as guardian, curator, or deputy under mental capacity legislation, which creates a legally constituted relationship of responsibility; parental responsibility for minor children, which in all three jurisdictions encompasses duties of care and protection extending to provision of medical care and protection from reasonably foreseeable harms; or spousal duties as recognised in the relevant jurisdiction, though the scope of inter-spousal duties varies across legal systems.

Voluntarily assumed duties arise where, following the common law analysis in R v Stone & Dobinson [1977] QB 354, the defendant's conduct established an undertaking to care for a person unable to care for themselves. Typical indicia of assumption include: taking the vulnerable person into one's home; providing for their daily needs over a sustained period; holding oneself out to others (including medical providers) as the responsible caregiver; making medical decisions on the person's behalf; or otherwise acting in a manner demonstrating acceptance of responsibility for the person's welfare. The common law analysis is fact-specific, examining whether the defendant's conduct in totality evinces an undertaking of responsibility. Once such an undertaking is established, the defendant cannot thereafter abandon it with impunity; having assumed the duty, they bear criminal responsibility if they grossly breach it.

This requirement excludes cases involving mere kinship in the abstract. The existence of a familial relationship, without more, does not automatically generate a legal duty of care sufficient to ground criminal liability for omissions in most jurisdictions. An adult sibling who lives separately, has no established caregiving relationship, and has not assumed responsibility for their mentally ill sibling does not owe a criminal law duty to that sibling merely by virtue of consanguinity. This limitation is important because it ensures that the criminal law does not impose unlimited obligations based solely on biological relationship. The duty must be either legally constituted through recognised mechanisms such as guardianship orders or factually established through conduct demonstrating assumption of responsibility.

The requirement also reflects respect for individual autonomy and the limits of state power. Adults, including adults with psychiatric conditions, generally have the right to make their own decisions about their care and their relationships. The criminal law should not impose duties on persons who have not undertaken them voluntarily or been formally designated as responsible. The alternative—holding all family members criminally responsible for outcomes affecting their relatives—would represent an excessive intrusion into private life and would impose obligations that many persons would be unable to fulfil.

C. Gross Departure from Reasonable Steps

The third limiting principle requires that the defendant's conduct represented a gross departure from the reasonable steps that a person in their position could have taken to protect the vulnerable individual from the foreseeable risk. This standard distinguishes between, on one hand, imperfect caregiving under resource constraints—where caregivers do their best within difficult circumstances but fall short of optimal care—and, on the other hand, grossly negligent conduct that

betrays a fundamental failure to fulfil the assumed or imposed duty. The distinction is essential because caregiving for individuals with severe psychiatric conditions is inherently challenging, often overwhelming, and frequently undertaken without adequate institutional support or professional guidance. The criminal law must not become an instrument for punishing well-meaning caregivers who struggle and fail, but should reserve its sanction for conduct that represents a qualitative departure from any reasonable standard of care.

Evidence of gross departure may include: complete failure to seek medical assistance when deterioration was apparent, where the caregiver had opportunity and capacity to summon help but chose not to do so; active obstruction of treatment through withholding prescribed medication, refusing to permit professional intervention, or removing the patient from care against medical advice; deliberate disregard of explicit clinical instructions regarding supervision, means restriction, or crisis response, where such instructions were clearly communicated and understood; failure to act upon clear warning signs over a sustained period despite having capacity and resources to do so, demonstrating indifference rather than mere inadvertence; or conduct demonstrating indifference to the patient's welfare, such as prolonged absence from a person known to require supervision, exploitation of the patient's vulnerability, or subjecting the patient to conditions incompatible with their basic welfare.

This standard acknowledges that caregiving for individuals with severe psychiatric conditions is demanding and that caregivers often lack training, face burnout, and operate under resource constraints. Mental illness in a family member imposes substantial burdens on caregivers, including emotional, financial, and practical demands that may exceed their capacity. Many caregivers are themselves elderly, unwell, or otherwise vulnerable. The criminal law does not demand perfection; it demands that those who undertake responsibility for vulnerable persons not fail so grossly as to constitute a culpable cause of death. The distinction between imperfect care and gross failure is normative and must be assessed in light of all circumstances, including the caregiver's own capacities and the support available to them.

D. Causation as Contribution to Foreseeable Risk

The fourth limiting principle concerns causation, which represents perhaps the most doctrinally challenging element of these cases. The article does not argue that caregivers should be held criminally responsible on simplistic 'but for' reasoning—that is, the claim that 'but for' the caregiver's failure, the death would not have occurred. Such counterfactual claims are often speculative and fail to account for the complex aetiology of suicide, which involves interactions among biological, psychological, social, and situational factors that resist simple causal attribution. It is rarely possible to say with confidence that any particular intervention would have prevented a suicide, and the criminal law should not rest conviction on speculation.

Rather, the causation requirement should be understood as requiring that the defendant's grossly negligent conduct materially contributed to the conditions under which the foreseeable fatal risk materialised. This framing draws on both common law and civil law conceptions of legal causation, which in all three jurisdictions require more than mere factual connection. The question is whether the breach of duty was, in the legal sense, a substantial and operative cause of death—or, in civil law terminology, whether there exists adequate causal nexus (nexo de causalidade adequada) between the breach and the fatal outcome. This framing acknowledges that suicide involves agency on the part of the deceased and that multiple factors contribute to any individual death, while recognising that caregiver conduct may nonetheless be

sufficiently connected to the outcome to warrant attribution of criminal responsibility.

The causation requirement also interacts with the foreseeability requirement. Where the caregiver's duty was precisely to protect against the foreseeable risk of suicide, and where the caregiver grossly breached that duty, the suicide may be characterised not as an intervening event breaking the chain of causation but as the materialisation of the very risk the duty was designed to prevent. This analysis is developed further in the jurisdictional sections below, with attention to how different legal systems address the doctrine of intervening cause (novus actus interveniens) in the specific context of suicide following caregiver failure.

E. Scope of Patient Population

This analysis addresses criminal liability in relation to three overlapping but distinct patient populations, each of which presents distinct legal considerations: (1) adults with fluctuating capacity, who may have legal capacity during stable periods but lose capacity during acute psychiatric episodes; (2) formally incapacitated persons, who have been subject to guardianship, curatorship, or deputyship orders on grounds including psychiatric disability; and (3) minors with psychiatric conditions, where parental and guardian duties apply with particular stringency.

For adults with fluctuating capacity, the legal analysis is complicated by periods during which the patient may have exercised autonomous decision-making. A patient who, during a period of capacity, refused particular treatments or declined supervision cannot be said to have been abandoned if the caregiver respected those autonomous decisions. However, when the patient loses capacity during an acute episode, the caregiver's duties may crystallise differently, requiring intervention that would not have been appropriate during capacious periods. The Mental Capacity Act 2005 (England and Wales) and equivalent provisions in other jurisdictions provide frameworks for determining when capacity is present and what interventions are appropriate when it is absent.

For formally incapacitated persons, the existence of a court-ordered guardianship or equivalent arrangement typically establishes the source of duty with clarity. The guardian or curator has legally constituted authority and responsibility, and their failures in that role may ground criminal liability more straightforwardly than in cases of informal care. For minors, parental responsibility provides the duty source, and the standard of care expected of parents in protecting children from foreseeable harms is well-established in criminal jurisprudence across all three jurisdictions.

Where relevant, the jurisdictional analysis below notes how the source of duty and the applicable legal framework differ across these patient categories. The core principles of gross negligence, foreseeability, and causation apply across categories with appropriate modifications reflecting the distinct legal status and protection needs of each population.

III. Methodology

This study employs a doctrinal comparative legal analysis methodology, examining criminal law frameworks governing caregiver liability for psychiatric patient deaths across three jurisdictions selected to represent distinct legal traditions: England and Wales (common law), Portugal (Continental European civil law with European human rights influence), and Brazil (Latin American civil law with Inter-American human rights influence). The selection follows the principle of maximum variation sampling within the constraints of legal system classification, facilitating identification of both convergent approaches to common problems and divergent solutions reflecting different legal cultures and traditions (Zweigert & Kötz, 1998; Örücü, 2004). This methodological approach is established in comparative

law scholarship and serves to illuminate both the range of possible legal responses to analogous social problems and the contingent character of any particular jurisdiction's choices.

Primary sources include: statutory instruments, specifically the Mental Capacity Act 2005 and Mental Health Act 1983 for England and Wales, the Código Penal and Lei de Saúde Mental 2023 for Portugal, and the Código Penal Brasileiro for Brazil; judicial decisions from appellate courts in each jurisdiction; and supranational jurisprudence from the European Court of Human Rights (Fernandes de Oliveira v. Portugal) and the Inter-American Court of Human Rights (Damião Ximenes Lopes v. Brazil). Secondary sources include peer-reviewed legal scholarship, treatises, and authoritative commentaries in English, Portuguese, and available translations. Official governmental guidance documents, including prosecutorial guidelines and codes of practice, provide additional context on how formal law is applied in practice.

A note on source quality is appropriate. The original draft of this article relied in places on tertiary sources such as legal encyclopaedias and commercial summaries. Following peer review feedback, such sources have been replaced with primary authorities or, where tertiary sources are retained for non-load-bearing contextual points, they are accompanied by authoritative citations. Where substantive legal propositions are advanced—concerning the elements of offences, the scope of duties, or the application of causation doctrine—these are supported by primary statutory text or judicial decisions.

For each jurisdiction, the analysis addresses six standardised elements: (1) source of duty, examining how the legal system establishes when a person owes a duty to act to prevent harm to another; (2) offence(s) and elements, identifying the criminal provisions applicable to fatal omissions and their constituent requirements; (3) mental element and culpability threshold, examining what state of mind must be proven and what standard of negligence triggers criminal liability; (4) causation approach, with particular attention to how each system addresses the doctrine of intervening cause when death results from suicide; (5) evidentiary and prosecutorial barriers, identifying practical obstacles to successful prosecution; and (6) typical sentencing range and aggravating factors, providing context on the consequences of conviction. This standardised framework facilitates systematic comparison and identification of genuine convergences and divergences rather than superficial similarities or differences.

Limitations of this study include: the inherent difficulty of comparing legal systems with different vocabularies, conceptual frameworks, and doctrinal structures; the scarcity of reported decisions specifically involving criminal liability of informal caregivers for psychiatric patient suicide, as opposed to the more commonly litigated context of institutional defendants; the impossibility of accessing unpublished prosecutorial decisions declining to bring charges, which may represent a substantial proportion of relevant cases; reliance on English-language secondary literature for aspects of Portuguese and Brazilian law where primary source access was limited; and the absence of empirical data on the actual frequency and outcomes of prosecutions in this area. These limitations should be borne in mind when evaluating the conclusions drawn.

IV. Historical Context and Deinstitutionalisation

Before examining contemporary doctrine, it is useful to situate the legal treatment of mentally ill persons within historical context, as contemporary legal frameworks have evolved in response to historical circumstances and reflect particular policy choices made in earlier eras. The terminology employed in

historical sources—including terms such as 'lunatic,' 'idiot,' and 'insane'—reflects the understanding and attitudes of earlier periods and is reproduced here only where necessary for historical accuracy. These terms are not endorsed and do not reflect contemporary clinical or legal usage, which appropriately treats psychiatric conditions as medical matters rather than occasions for stigmatising language.

Historically, care of persons with psychiatric conditions was largely a private matter, governed by informal norms of familial duty and religious charity rather than public law. The state's interest was limited primarily to the protection of public order—intervening when mentally ill persons posed a danger to others—and to the protection of property, where wealthy lunatics' estates required management to prevent dissipation or exploitation. In England, the Lunacy Act 1845 represented an early attempt to regulate care of those deemed incapable of managing their own affairs, establishing a framework of inspection and certification for private asylums and creating the Lunacy Commission as a supervisory body. However, its focus was on institutional confinement and property protection rather than on the duties owed by family caregivers in the domestic sphere (Bartlett, 1999). Continental European systems developed parallel frameworks during the same period, with mental incapacity providing grounds for guardianship (tutela, curatela) under civil codes derived from the Napoleonic tradition (Zenati-Castaing & Revet, 2012).

The deinstitutionalisation movement, commencing in earnest during the 1960s and 1970s across Western nations, fundamentally transformed the locus and nature of psychiatric care. This movement was motivated by genuine humanitarian concerns about conditions in large psychiatric hospitals—which had been documented in exposés revealing overcrowding, neglect, and abuse—and by growing recognition of patients' rights to liberty, dignity, and community integration. The development of psychotropic medications capable of managing symptoms outside hospital settings provided a technological foundation for community care. Policy initiatives across multiple jurisdictions, including the Community Mental Health Centers Act in the United States, similar reforms in the United Kingdom, and related developments in Continental Europe and Latin America, resulted in the closure or downsizing of psychiatric hospitals and the transfer of care to community-based settings (Scull, 2015; Fakhoury & Priebe, 2007).

In practice, 'community-based care' frequently meant the homes of family members, who assumed caregiving responsibilities for which they were often ill-equipped, untrained, and inadequately supported. The promise of robust community mental health services to replace institutional care was, in many jurisdictions, never fully realised, leaving families to cope as best they could with conditions that had previously been managed by professional staff in dedicated facilities. The consequences have been extensively documented: increased family burden, caregiver burnout, deterioration of patients without adequate supervision, and, in tragic cases, preventable deaths. The contemporary question of criminal accountability for informal caregivers arises in this post-deinstitutionalisation context, where the locus of care has shifted but legal frameworks developed for institutional settings have not been systematically adapted to address the duties and responsibilities of family caregivers (Burns & Priebe, 2018).

This historical context is important for understanding both the need for and the limits of caregiver accountability. On one hand, deinstitutionalisation has placed persons who would previously have received institutional care in the hands of informal caregivers, making the question of what those caregivers owe a matter of pressing practical importance. On the other hand, caregivers often operate

in contexts of systemic failure, where the community services that were supposed to support community care are inadequate or absent. This context informs the limiting principle that criminal liability should attach only to gross failures, not to imperfect care reflecting systemic constraints. The caregiver who struggles valiantly but unsuccessfully is not the target of these legal provisions; the caregiver who abandons their charge entirely or who actively obstructs treatment represents a different category of wrongdoing.

V. Results: Jurisdictional Analysis

A. England and Wales

1. Source of Duty

In England and Wales, criminal liability for fatal omissions requires, as a threshold matter, that the defendant owed a legally recognised duty to act. Unlike some civil law systems, English law does not impose general duties to rescue strangers; the passer-by who witnesses a drowning but fails to assist commits no criminal offence, however morally objectionable their indifference. The duty relevant to caregiver liability typically arises through one of several recognised categories, of which voluntary assumption of responsibility is most pertinent to informal psychiatric care.

The leading authority on voluntary assumption remains R v Stone & Dobinson [1977] QB 354 (CA). In that case, the defendants took into their home a relative, Fanny Stone, who suffered from anorexia nervosa and was unable to care for herself. Fanny's condition deteriorated dramatically over a period of months until she died in appalling circumstances of emaciation and neglect. The Court of Appeal held that the defendants' attempts to care for her, however inadequate and ineffectual, demonstrated that they had undertaken a duty of care. Lane LJ stated that where a person 'undertakes the care of one who is physically unable to care for himself, the duty once undertaken continues until the death of the patient.' Having assumed responsibility for a helpless person by taking her into their home and making some efforts to provide for her, the defendants could not thereafter abandon that responsibility with impunity.

The Stone & Dobinson principle has been applied and refined in subsequent cases, though none directly concerning psychiatric patient suicide has reached the appellate courts in a manner that provides authoritative guidance on that specific context. The case establishes that the duty arises from the defendant's own conduct—the taking in of a helpless person and the provision of care—rather than from any pre-existing legal relationship. It is a factual inquiry whether the defendant's conduct evinces an assumption of responsibility sufficient to found a duty. Relevant factors include: the nature and duration of the living arrangement; the defendant's involvement in decision-making about the vulnerable person's care; the extent to which the defendant has held themselves out to others as responsible; and whether the defendant's assumption of responsibility has discouraged others from providing assistance.

Alternative bases for duty include: special relationships recognised at common law, particularly the parent-child relationship where parental responsibility subsists, which imposes duties of care and protection; contractual undertaking, where caregiving is the subject of a paid arrangement; creation of a dangerous situation, where the defendant's prior conduct created or contributed to the risk from which the victim died; and statutory duty, which may arise in connection with the Mental Capacity Act 2005 where the caregiver acts as a donee of a lasting power of attorney or as a court-appointed deputy. For family caregivers of adult psychiatric patients who are not subject to formal mental capacity arrangements, the

voluntary assumption analysis derived from Stone & Dobinson is typically most relevant.

2. Offence and Elements

The primary offence applicable to caregiver negligence resulting in death is gross negligence manslaughter, a common law offence preserving the ancient category of manslaughter while defining its contours through judicial development. The elements were authoritatively stated by the House of Lords in R v Adomako [1995] 1 AC 171, a case concerning an anaesthetist who failed to notice that an oxygen tube had become disconnected during surgery, resulting in the patient's death. Lord Mackay of Clashfern LC, giving the leading speech, identified the following requirements: first, the defendant owed a duty of care to the deceased; second, the defendant breached that duty; third, the breach caused or significantly contributed to the death; fourth, the breach gave rise to a serious and obvious risk of death; and fifth, the breach was so gross that a criminal conviction would be justified.

The fourth element—serious and obvious risk of death—has received further elaboration in subsequent cases. In R v Rose [2017] EWCA Crim 1168, the Court of Appeal held that the risk must be 'serious' in the sense that it is not remote or fanciful, and 'obvious' in the sense that it would be apparent to a reasonable person in the defendant's position with the defendant's knowledge. This is an objective test: the question is not whether the defendant actually foresaw the risk, but whether a reasonable person in their position would have done so. For caregivers of psychiatric patients with documented high suicide risk, the argument that such risk was 'obvious' is strengthened by evidence that the caregiver received explicit warnings from clinical providers or had direct knowledge of previous suicide attempts.

It should be noted that 'gross negligence' in this context is not merely a high degree of civil negligence. As Lord Mackay stated in Adomako, the question is 'whether, having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission.' This is ultimately a jury question, requiring normative evaluation of whether the threshold between civil and criminal liability has been crossed. The jury must consider all the circumstances, which may include the defendant's own characteristics and capacities, though the fundamental question remains whether the conduct fell so far below the required standard as to warrant criminal sanction.

3. Mental Element and Culpability Threshold

Gross negligence manslaughter does not require intention or subjective recklessness in the sense of advertence to risk. The defendant need not have consciously appreciated the risk of death; indeed, unconscious disregard for an obvious risk may itself be the foundation of culpability. The mental element is satisfied by objective gross negligence—conduct falling far below the standard of a reasonable person in the defendant's position. This objective approach has been criticised by some commentators as insufficiently attentive to individual culpability, but it remains established law following Adomako and subsequent appellate decisions.

The test is objective in the sense that the jury asks what a reasonable person in the defendant's position would have done, not what this particular defendant actually contemplated. However, the objective test takes account of circumstances known to the defendant and of circumstances that the defendant ought to have been aware of. Thus, a caregiver who was told by clinicians that the patient was at high suicide risk and who was given instructions for crisis response cannot claim ignorance of risk even if they subjectively failed to appreciate its significance.

The 'grossness' of the negligence imports a normative evaluation that distinguishes criminal from civil liability. In R v Sellu [2016] EWCA Crim 1716, the Court of Appeal described the required conduct as 'truly exceptionally bad.' This formulation serves to exclude from criminal liability conduct that, while negligent, represents the kind of errors to which reasonable persons are susceptible. The law recognises that even conscientious caregivers may make mistakes, and not every mistake—even a fatal one—warrants criminal punishment. What is required is a fundamental failure demonstrating such serious disregard for the patient's life and welfare as to demand criminal intervention rather than civil remedy alone.

4. Causation Approach

English law requires proof of both factual causation and legal causation. Factual causation is typically assessed through the 'but for' test: would the death have occurred but for the defendant's breach? Legal causation requires that the breach was an 'operative and significant cause' of death—not necessarily the sole cause, or even the main cause, but more than de minimis and still operating at the time of death. In cases with multiple contributing factors, it is sufficient that the defendant's breach made a 'significant' contribution to the death.

In cases where death results from patient suicide, the defence may contend that the deceased's deliberate act constitutes a novus actus interveniens—a new intervening act that breaks the chain of causation and absolves the defendant of responsibility. This doctrine recognises that voluntary, informed, and deliberate conduct by a third party (or, in this context, by the victim themselves) may be sufficiently significant to supersede the defendant's original wrong. If successful, the novus actus argument would mean that while the defendant may have breached their duty, they did not legally cause the death because the victim's own act was the proximate cause.

However, the novus actus doctrine is not a universal template producing automatic acquittal whenever a victim's act intervenes. The authorities suggest that a novus actus will not break the chain of causation where the intervening act was foreseeable and where the defendant's duty was precisely to guard against such an act. In R v Dear [1996] Crim LR 595, the Court of Appeal held that a victim's interference with wounds (reopening them) did not break the chain of causation where the defendant's assault was still an operating cause of death. The victim's conduct was not, in the circumstances, so extraordinary as to eclipse the defendant's responsibility.

By analogy, where a caregiver's duty is to protect a psychiatric patient from the foreseeable risk of self-harm, the patient's suicidal act may be characterised not as breaking the chain of causation but as the materialisation of the very risk the duty was designed to prevent. This argument has force where: the psychiatric diagnosis carried documented suicide risk; the caregiver was aware of that risk through clinical communications or direct observation; the caregiver's duty encompassed protective measures against self-harm; and the caregiver grossly failed in those protective measures. In such circumstances, the suicide is not an unforeseeable, extraordinary event superseding the defendant's breach but the predictable consequence of that breach.

This analysis is fact-sensitive and should not be stated as a universal rule applicable to all suicide cases. Whether suicide breaks the chain of causation will depend on the specific circumstances, including: the degree to which the risk was foreseeable given what the defendant knew or ought to have known; whether the defendant's duty, properly understood, encompassed prevention of self-harm; the temporal and factual proximity between the breach and the death; and

whether other intervening factors contributed to the death in a manner that diminishes the significance of the defendant's breach. The article argues that in cases meeting the limiting principles stated above—documented high-risk condition, explicit warnings, duty to protect—the suicide should be treated as within the scope of the risk that the duty was designed to prevent, and causation should be established. But this argument requires careful application to facts, not mechanical application of doctrine.

5. Evidentiary and Prosecutorial Barriers

Despite the theoretical availability of gross negligence manslaughter charges against negligent caregivers, prosecutions in this context appear rare. The precise incidence is difficult to ascertain because prosecutorial statistics do not disaggregate cases by victim category or caregiving context, and many decisions not to prosecute are not publicly recorded or explained. However, the anecdotal evidence and the scarcity of reported appellate decisions suggest that this is an underutilised legal tool.

Several factors may explain this underutilisation. First, deaths by suicide in domestic settings may receive less investigative scrutiny than deaths in institutional care. Coroners frequently record verdicts of suicide without detailed examination of the circumstances of care, and the threshold for referring a matter to prosecuting authorities may not be reached where the immediate cause of death (self-inflicted injury) is apparent. Second, the Code for Crown Prosecutors requires consideration of whether prosecution is in the public interest, and prosecutors may exercise discretion against charging bereaved family members where the death itself is perceived as sufficient punishment, where the defendant's own grief and remorse are evident, or where prosecution would serve no obvious rehabilitative or deterrent purpose.

Third, the high evidentiary threshold—proving gross negligence beyond reasonable doubt—may deter prosecution in cases where evidence is equivocal or where the defendant's conduct, while inadequate, is not unambiguously 'exceptionally bad.' Proving what did not happen (the protective measures not taken) is inherently more difficult than proving what did happen, and the passage of time between caregiving failures and death may obscure the evidentiary picture. Fourth, there may be practical difficulties in obtaining evidence from clinical providers, who may be reluctant to participate in criminal proceedings against family members and who may have confidentiality concerns even after the patient's death.

The Crown Prosecution Service guidance on gross negligence manslaughter provides general guidance on charging decisions but does not specifically address the context of informal psychiatric care. Development of prosecutorial guidance specific to this context—addressing the unique evidentiary considerations, the appropriate framing of causation, and the public interest factors relevant to family defendant cases—could promote more consistent decision-making and signal that such cases warrant serious consideration alongside more commonly prosecuted forms of manslaughter.

6. Sentencing

Gross negligence manslaughter carries a maximum sentence of life imprisonment, reflecting the gravity of causing death through criminal negligence. In practice, sentences vary widely depending on culpability, harm, and mitigating and aggravating factors. The Sentencing Council guideline for manslaughter (effective 1 November 2018) provides structured guidance for judges, identifying culpability factors including: the extent of the departure from the expected standard of care; the duration and persistence of the negligent conduct; and the defendant's level of awareness or indifference to risk.

For caregivers, mitigating factors may include: the burden of care and the absence of adequate support; the defendant's own vulnerability, mental health difficulties, or limited capacity; the emotional and psychological impact of the loss on the defendant; and evidence of genuine but misguided attempts to provide care. Aggravating factors may include: abuse of a position of trust; previous warnings about the patient's condition that were ignored; financial or other improper motivation for the neglect; and prolonged duration of the neglect. In practice, sentences for gross negligence manslaughter range from suspended sentences in cases of low culpability to substantial terms of imprisonment where culpability is high, with typical sentences for mid-range cases falling between two and six years' custody.

B. Portugal

1. Source of Duty

Portuguese criminal law addresses omissions liability under Article 10 of the Código Penal, which provides that a result may be attributed to a defendant who was under a legal duty to act to prevent it and who failed to do so. The duty (dever jurídico) may arise from several sources: express legal provision (lei), including statutory requirements and judicially enforceable obligations; contract (contrato), where the defendant has undertaken by agreement to protect the victim; and creation of a dangerous situation (ingerência), where the defendant's prior conduct created or contributed to the risk. For family caregivers, relevant sources include: parental authority (poder parental) over minor children; guardianship (tutela) over incapacitated adults formally declared so by court order; and the more general principle that one who assumes de facto responsibility for a vulnerable person may thereby create a legal duty to continue that care.

The Portuguese Civil Code (Código Civil) establishes obligations of maintenance and support (alimentos) among family members, including between parents and children, between spouses, and, in certain circumstances, among other relatives. However, the mere existence of a civil law maintenance obligation does not automatically translate into criminal liability for omissions. The criminal law duty under Article 10 requires that the defendant's position created a special relationship of protection vis-à-vis the victim, such that the failure to act is legally equivalent to causing the harm directly. This 'equivalence doctrine' (doutrina da equivalência) focuses on whether the defendant occupied a position of guarantor (garante) in relation to the victim's safety.

For informal caregivers of psychiatric patients, the source of duty may be established through: formal guardianship where the patient has been declared legally incapacitated and the defendant appointed as guardian or interim guardian; parental authority where the patient is a minor; or factual assumption of responsibility where the defendant's conduct demonstrates that they have undertaken to provide care, for example by taking the patient into their home, managing their medication, or representing themselves to clinical providers as the responsible caregiver. The latter category—factual assumption—is analogous to the common law voluntary assumption doctrine, though it is grounded in the Continental civil law framework of the guarantor position rather than in case-law precedent.

2. Offence and Elements

The primary offence applicable to fatal caregiver negligence in Portugal is homicídio por negligência (negligent homicide) under Article 137 of the Código Penal. Article 137(1) provides that whoever kills another person through negligence (negligência) is punished with imprisonment up to three years or a fine. Article 137(2) provides an enhanced penalty—imprisonment up to five years—where the negligence is gross (negligência grosseira). The elements of the

offence require proof that: (1) the defendant violated an objective duty of care (dever objectivo de cuidado) established by law, professional standards, or the particular relationship between the parties; (2) the fatal outcome was a foreseeable consequence of this violation; and (3) a causal connection (nexo de causalidade) exists between the defendant's negligent conduct or omission and the victim's death.

For omissions cases, the duty of care is established through the guarantor analysis under Article 10. Where the defendant occupied a position of guarantor vis-à-vis the victim—whether through formal legal relationship, contract, or factual assumption—and where that position encompassed protection against the type of harm that occurred, a breach of the protective duty constitutes a violation of the objective duty of care. The omission is then analysed as though it were an act causing the result, following the equivalence doctrine.

3. Mental Element and Culpability Threshold

Portuguese criminal law distinguishes between two forms of negligence. Conscious negligence (negligência consciente) exists where the defendant actually foresees the possibility of the harmful result but believes (wrongly) that it will not occur. Unconscious negligence (negligência inconsciente) exists where the defendant fails entirely to advert to the risk of the harmful result, in circumstances where a reasonable person exercising due care would have done so. Both forms may found liability under Article 137, but the form of negligence is relevant to culpability assessment and to determining whether the gross negligence aggravation applies.

Gross negligence (negligência grosseira) requires more than an ordinary failure to meet the standard of care. It requires a serious and unjustified violation of the duty of care, demonstrating marked indifference to the legally protected interest—in this case, the victim's life. Portuguese doctrine emphasises that the evaluation of grossness considers both objective factors (the magnitude of the risk created, the availability and cost of precautionary measures, the social utility of the defendant's conduct) and subjective factors (the defendant's personal capacity to appreciate and respond to the risk, the reasons for their failure). The gross negligence category thus imports a normative evaluation analogous to the English requirement that conduct be 'truly exceptionally bad.'

4. Causation Approach

Portuguese criminal law requires proof of adequate causal connection (nexo de causalidade adequada) between the defendant's conduct or omission and the victim's death. The adequacy theory (teoria da causalidade adequada), dominant in Portuguese criminal and civil law, asks whether the defendant's conduct, according to general experience and the ordinary course of events, was apt to produce the type of result that occurred. This is an objective, ex ante assessment: would an observer with the defendant's knowledge have considered the result a probable consequence of the conduct? If so, causal connection is established; if the result was extraordinary or unforeseeable, adequacy is lacking.

Where death results from suicide, the analysis considers whether the caregiver's failure was adequate to produce the result in the sense that suicide was a foreseeable consequence of the breach of duty. Relevant factors include: the foreseeability of suicide given the patient's condition and history; whether the defendant's duty, properly understood, encompassed prevention of self-harm; and whether the suicide represented a materialisation of the risk that the duty was designed to prevent or an extraordinary event breaking the causal connection. The adequacy test is flexible and fact-dependent, and its application to suicide cases requires careful attention to the specific circumstances.

Portuguese appellate courts have not, to this author's knowledge, directly addressed causation in informal caregiver liability for psychiatric patient suicide in reported decisions. This gap in case law means that the application of the adequacy doctrine to such cases remains somewhat uncertain. However, the conceptual framework is consistent with the argument that where a caregiver knew of suicide risk, owed a duty to prevent it, and grossly breached that duty, the suicide may be treated as an adequate consequence of the breach. This conclusion is tentative and acknowledges the need for judicial development through appropriate test cases.

5. Human Rights Context: Fernandes de Oliveira v. Portugal

The European Court of Human Rights' judgment in Fernandes de Oliveira v. Portugal (Application No. 78103/14, Grand Chamber, 31 January 2019) is essential context for understanding the contemporary framework of psychiatric patient protection in Portugal. The case concerned the suicide of A.J., a man who was voluntarily hospitalised in a public psychiatric facility following a diagnosis of depression and previous suicide attempts. Despite his documented history and the known risks associated with his condition, he was permitted to leave the hospital grounds without supervision. He threw himself under a train and died. His mother brought proceedings against Portugal, arguing that the hospital's negligent failure to supervise her son and to implement adequate safety measures violated the right to life guaranteed by Article 2 of the European Convention on Human Rights.

The Grand Chamber found a violation of Article 2 in its procedural aspect, holding that Portugal lacked an adequate regulatory framework to ensure that hospitals adopted appropriate measures to protect vulnerable psychiatric patients from the foreseeable risk of suicide. The Court noted deficiencies in supervision protocols, risk assessment procedures, and physical security measures. The judgment criticised Portugal's regulatory and institutional arrangements in stark terms, observing that the domestic framework appeared to reflect an early and inadequate stage of development in suicide prevention for psychiatric inpatients.

It is essential to distinguish the nature of this judgment when considering its implications for individual caregiver liability. Fernandes de Oliveira concerns the state's positive obligations under the Convention—specifically, the duty of public authorities to take reasonable measures to protect individuals within their jurisdiction from foreseeable risks to their lives. This is conceptually distinct from the individual criminal liability of private persons under domestic law. The Court was addressing systemic failures of regulation, institutional protocols, and public hospital practice, not the conduct of individual family members or informal caregivers. The finding of violation concerned Portugal as a state party to the Convention, not any individual defendant.

Nevertheless, the judgment is relevant by analogy for purposes of this article's analysis. The reasoning in Fernandes de Oliveira establishes several propositions with potential domestic law implications: first, that psychiatric patients at known suicide risk are owed positive protective duties by those responsible for their care; second, that the foreseeability of suicide, given the patient's condition and history, is relevant to the scope of that duty; third, that failures to take reasonable protective measures may violate fundamental rights; and fourth, that domestic legal systems must provide adequate frameworks for accountability when such failures occur.

If the state owes positive obligations to protect psychiatric patients from foreseeable suicide risk, and if these obligations ground institutional accountability for systemic failures, then, by analogical extension, individuals who have assumed specific responsibility

for a vulnerable person's care may owe analogous protective duties under domestic criminal law. The Strasbourg jurisprudence establishes a normative baseline—that those responsible for persons at known suicide risk must take reasonable protective measures—which informs the content of the duty of care under Article 137 of the Código Penal. This argument by analogy should be stated with appropriate qualification: the ECHR addresses state obligations, not individual criminal liability, and there is no directly applicable Portuguese case law holding family caregivers criminally liable for psychiatric patient suicide. The proposition that such liability could arise under Article 137 is plausible on doctrinal grounds and is consistent with the values expressed in Fernandes de Oliveira, but it represents an extension that has not been tested in reported domestic decisions.

6. Evidentiary and Prosecutorial Barriers

Similar barriers to prosecution exist in Portugal as in England and Wales. Difficulties in proving causation where death results from suicide present a significant obstacle, as the adequacy test requires persuading the court that suicide was a foreseeable and non-extraordinary consequence of the caregiver's breach. Reluctance to prosecute bereaved family members, who may themselves be grieving and traumatised, affects prosecutorial discretion. The high threshold of gross negligence for enhanced liability under Article 137(2) may lead prosecutors to conclude that cases fall into the ordinary negligence category, where sentences are modest and prosecution may seem disproportionate. Additionally, the emphasis in Portuguese mental health law on patient autonomy and least restrictive care, reinforced by the new Mental Health Act (Lei de Saúde Mental) 2023, may complicate prosecutions where patients exercised apparent autonomy in refusing care or in leaving supervised settings.

7. Sentencing

Article 137 provides imprisonment up to three years or a fine for basic negligent homicide, and imprisonment up to five years for gross negligence cases. Portuguese sentencing practice considers the degree of negligence demonstrated, the relationship between defendant and victim, the duration of the negligent conduct, and mitigating circumstances including the defendant's own vulnerability and the burden of care they shouldered. The relatively modest maximum penalties compared to England and Wales reflect the civil law tradition's tendency toward more calibrated and predictable sentencing ranges, though the practical consequences of conviction remain significant: criminal record, potential imprisonment, and the formal stigma of homicide conviction.

C. Brazil

1. Source of Duty

Brazilian criminal law provides multiple bases for establishing caregiver duty, making it arguably the most explicit of the three jurisdictions in addressing this category of wrongdoing. Article 13(2) of the Código Penal establishes general principles for omissions liability: a result is attributable to one who has a legal duty to care for, protect, or supervise the victim (dever de cuidado, proteção ou vigilância), or who by prior conduct (ingerência) created the risk that materialised in the harmful result. Additionally, Article 133—creating the specific offence of abandono de incapaz (abandonment of an incapacitated person)—explicitly addresses persons who have care, guardianship, vigilance, or authority (guarda, vigilância ou autoridade) over a person unable to protect themselves.

The sources of duty under Article 13(2) include: express legal provision, such as parental responsibility (poder familiar) or formally constituted guardianship (tutela) or curatorship (curatela); contract, where the defendant has undertaken by agreement to provide care; and creation of dangerous situation (ingerência), where

the defendant's prior conduct created or augmented the risk. For Article 133 purposes, the concepts of guarda (care/custody), vigilância (vigilance/supervision), and autoridade (authority) are interpreted broadly. Guarda encompasses both formal legal custody and de facto custodial arrangements. Vigilância includes responsibility for monitoring and supervising a dependent person. Autoridade includes relationships of power and control, such as those between employers and domestic employees or between carers and those in their charge.

Critically, Brazilian doctrine interprets 'incapaz' (incapacitated person) broadly for purposes of Article 133. The term is not limited to persons who have been formally declared legally incapacitated through curatorship proceedings under civil law. Rather, it extends to any person who, for any reason—whether permanent or temporary—is unable to protect themselves from the risks arising from abandonment (Greco, 2017). This explicitly includes: persons suffering from severe mental illness during acute episodes; persons in states of altered consciousness, whether from psychiatric crisis, substance intoxication, or medical emergency; elderly persons with cognitive impairment; and any other person whose condition renders them unable to summon help, seek shelter, obtain food or medical care, or otherwise protect themselves if abandoned. This expansive interpretation ensures that Article 133 captures the full range of vulnerable persons who may be subject to caregiver abandonment, including psychiatric patients during periods of diminished functioning.

2. Offence and Elements

Brazil possesses arguably the most explicit and targeted statutory provision for prosecuting caregiver abandonment: Article 133 of the Código Penal, which creates a specific offence of endangerment. The elements require proof that: (1) the defendant abandoned a person—that is, deserted them, failed to provide necessary care, or otherwise withdrew the protection that their position required them to provide; (2) the victim was under the defendant's care, guardianship, vigilance, or authority; and (3) the victim was unable to defend themselves from the risks arising from the abandonment. The offence is complete upon the act of abandonment creating the dangerous situation; it does not require proof that harm actually resulted, though harm and death trigger aggravated forms with enhanced penalties.

The concept of 'abandonment' (abandono) has been interpreted broadly in Brazilian jurisprudence. It includes: physical desertion, where the caregiver leaves the vulnerable person alone without ensuring alternative care; failure to provide essential needs, including food, hydration, shelter, medication, and medical attention; and withdrawal of supervision where supervision was necessary for the person's safety. The abandonment need not be permanent; temporary abandonment creating a state of danger suffices. The focus is on whether the caregiver's conduct created or perpetuated a situation in which the vulnerable person was exposed to foreseeable risks from which they could not protect themselves.

The penalty structure of Article 133 reflects the gravity of the offence and the importance attached to protecting vulnerable persons. The basic offence of abandonment carries a penalty of detention (detenção) of six months to three years. If the abandonment results in serious bodily harm (lesão corporal de natureza grave) to the victim, the penalty is increased to reclusão of one to five years—a qualitative shift from detention to the more serious category of reclusão indicating enhanced gravity. Most significantly, if the abandonment results in the death (morte) of the victim, the penalty is reclusão of four to twelve years, placing this offence among serious crimes against the person. Furthermore, the penalty is increased by an additional

one-third (aumento de um terço) if the perpetrator is an ascendant (parent, grandparent), descendant (child, grandchild), spouse, sibling, guardian, or curator of the victim. This family enhancement, yielding an effective maximum of sixteen years for abandonment resulting in death by a family member, sends an unambiguous message: betrayal of familial trust and abuse of a position of responsibility compound the wrongfulness of the abandonment.

Additionally, general negligent homicide (homicídio culposo) under Article 121(3) provides an alternative charging option where abandonment cannot be specifically proven. This offence applies where death is caused through negligence (negligência), imprudence (imprudência), or professional incompetence (imperícia), carrying a penalty of detention of one to three years. A caregiver who does not physically abandon a patient but whose grossly negligent care—failure to administer medication, failure to seek medical attention, failure to supervise during a known high-risk period—leads to death could be charged under this provision. The combination of Articles 133 and 121(3) provides Brazilian prosecutors with a flexible toolkit to address different factual scenarios of fatal caregiver failure.

3. Mental Element and Culpability Threshold

Article 133 is a crime of endangerment (crime de perigo) that employs a preterdoloso (beyond intention) structure for its aggravated forms. The mental element for the basic offence is dolo (intent)—the defendant must intentionally abandon the vulnerable person, meaning they must act voluntarily with awareness that they are withdrawing care from someone unable to protect themselves. This is distinct from negligence: mere careless oversight does not suffice; there must be a deliberate act of abandonment or withdrawal of care.

For the aggravated forms (serious harm resulting, death resulting), the structure is preterdolosa: the defendant intends the basic conduct (abandonment) while the aggravated result (harm or death) is caused by culpa (negligence). The defendant need not intend or even foresee the death; they need only have intentionally committed the abandonment, with death being a negligent consequence of the endangerment thus created. This structure means that the prosecution need not prove that the defendant intended or foresaw the victim's death, only that they intentionally abandoned the vulnerable person and that death resulted from the state of danger thereby created. The causation element links the death to the abandonment: it must be established that the death resulted from the conditions of vulnerability created by the defendant's conduct.

For homicídio culposo under Article 121(3), the mental element is purely culpa—negligence, imprudence, or professional incompetence. There is no requirement of intentional conduct; rather, the defendant's failure to observe the duty of care that could reasonably be expected of a person in their position, and the causal connection between that failure and the death, are sufficient. The culpability threshold is objective: would a reasonable person in the defendant's position have acted differently, and did the failure to do so cause the death? This is analogous to the objective negligence standard in England and Wales, though without the additional requirement that the negligence be 'gross' for criminal liability to attach. However, Brazilian prosecutorial and judicial practice exercises discretion in determining which negligent deaths warrant criminal prosecution, and de facto gross negligence considerations may influence charging decisions.

4. Causation Approach

Brazilian criminal law applies the theory of adequate causation (causalidade adequada), consistent with the civil law tradition shared with Portugal. The analysis asks whether, according to general experience

and the ordinary course of events, the defendant's conduct was apt to produce the type of result that occurred. For abandonment offences under Article 133, the causal inquiry is simplified by the structure of the offence: once abandonment and subsequent death are established, the causal connection between them is presumed unless the death was entirely unconnected to the state of vulnerability created by the abandonment. If the defendant abandoned a vulnerable person, and the person died while in the state of abandonment, causation is typically established unless the defence can show that the death would have occurred regardless of the abandonment or resulted from an entirely independent cause.

For homicídio culposo under Article 121(3), standard causation analysis applies, requiring proof of both factual ('but for') causation and normative (adequacy) causation. The defendant's negligent conduct must be both a factual antecedent of the death and an adequate cause in the sense that death was a foreseeable type of consequence. Where death results from suicide, the analysis considers whether suicide was an adequate consequence of the caregiver's negligence—that is, whether, given the patient's condition and the nature of the caregiver's failure, suicide was a foreseeable materialisation of the risk created by the negligence.

Brazilian doctrine has not definitively addressed whether suicide breaks the chain of causation in caregiver liability cases. However, the logic of Article 133 suggests that where a person is abandoned in a state where they cannot protect themselves from the risks of abandonment, and where suicide is a foreseeable consequence of that state—as it may be for persons with documented severe psychiatric illness and suicide history—the death falls within the scope of the offence. The abandonment creates the conditions of danger; the suicide is a materialisation of that danger; the causal chain is complete. This analysis is consistent with the provision's protective purpose: Article 133 exists to prevent vulnerable persons from being exposed to foreseeable harm through caregiver desertion, and suicide by a mentally ill patient is paradigmatically the type of foreseeable harm the provision is designed to prevent.

5. Human Rights Context: Damião Ximenes Lopes v. Brazil

The Inter-American Court of Human Rights' judgment in Damião Ximenes Lopes v. Brazil (Series C No. 149, 4 July 2006) constitutes a landmark in Latin American human rights jurisprudence and an important element of the normative context for psychiatric patient protection in Brazil. The case concerned the death of Damião Ximenes Lopes, a young man suffering from a mental health crisis who was admitted by his family to a private psychiatric hospital (Casa de Repouso Guararapes) in the state of Ceará. Rather than receiving therapeutic care, he was subjected to brutal mistreatment: physical restraint, blows, and neglect. Just three days after admission, he died, his body bearing unmistakable marks of the abuse he had suffered. The domestic criminal proceedings were plagued by delays and ultimately failed to produce timely accountability for those responsible.

His sister, Irene Ximenes Lopes Miranda, brought the case to the Inter-American Commission on Human Rights, which referred it to the Court. In 2006, the Inter-American Court issued its judgment, finding Brazil responsible for violations of the rights to life (Article 4), to humane treatment (Article 5), and to judicial guarantees and judicial protection (Articles 8 and 25) under the American Convention on Human Rights. The Court ordered Brazil to compensate the family, to investigate and sanction those responsible, and to implement measures to prevent recurrence, including mandatory human rights training for health professionals involved in psychiatric care. This

represented Brazil's first-ever condemnation by the Inter-American Court for human rights violations—a watershed moment in the country's human rights history.

As with Fernandes de Oliveira in the European context, it is essential to distinguish the nature of the Ximenes Lopes judgment when considering its implications. The case addressed state responsibility for failures in a private healthcare institution operating under state supervision. The findings concerned the state's positive obligations under the American Convention to protect persons in vulnerable situations, to regulate and supervise private institutions providing care to such persons, and to ensure effective judicial remedies when violations occur. The Court was not addressing the individual criminal liability of family caregivers; it was addressing systemic failures at the intersection of state regulation, institutional practice, and judicial enforcement (Montgomery, 2025).

Nevertheless, the judgment establishes principles with broader implications. First, it articulates the heightened vulnerability of psychiatric patients and the corresponding heightened duty of protection owed to them by those responsible for their care. Second, it condemns the impunity that characterised domestic proceedings, reinforcing the imperative of effective criminal accountability for deaths of vulnerable persons. Third, it establishes standards of care—humane treatment, adequate supervision, protection from abuse—that, while addressed to state-supervised institutions, inform the content of caregiving duties more broadly. Fourth, by holding Brazil internationally responsible for failures in a private clinic, the judgment recognises that state obligations extend to the supervision and regulation of private actors, suggesting that domestic legal systems must ensure accountability throughout the care ecosystem.

The Ximenes Lopes judgment can be understood as establishing a normative baseline: if the state is internationally responsible for ensuring that psychiatric patients receive humane and protective care, then domestic law must provide mechanisms for accountability when care fails catastrophically. For informal caregivers who assume responsibility for vulnerable psychiatric patients, the logic extends by analogy: those who undertake care bear obligations enforceable through domestic criminal law. The judgment does not directly establish individual criminal liability for family caregivers—that remains a matter for domestic law—but it establishes the values and expectations that domestic law must vindicate. This analogical argument should be stated with appropriate qualification: Ximenes Lopes concerned institutional care and state responsibility, and there is a gap in directly applicable case law for informal family care. The proposition that Article 133 applies to family caregivers of psychiatric patients who abandon necessary care is doctrinally sound but represents an application of the provision that extends beyond its typical deployment in cases of physical desertion.

6. Evidentiary and Prosecutorial Barriers

Despite Brazil's explicit statutory provisions, underutilisation appears to characterise this area of law, as in the other jurisdictions examined. Barriers include: the traditional boundary between public and private spheres, which has historically insulated family conduct from state intervention; difficulties in proving the mental state of a deceased psychiatric patient, which may be relevant to establishing foreseeability and causation; practical challenges in investigating deaths that occur in domestic settings without witnesses or documentation; and regional variation in prosecutorial practice across Brazil's federal system, which may result in inconsistent treatment of similar cases depending on the state or locality where the death occurred.

Additionally, the requirement under Article 133 of proving intentional abandonment (dolo) for the basic offence may present difficulties where the caregiver's conduct was careless or inadequate but not clearly deliberate. The preterdoloso structure addresses this in part—intentional abandonment plus negligent death—but prosecution still requires proving the volitional element of abandonment. Where a caregiver remained physically present but failed to provide adequate care, the characterisation as 'abandonment' may be contested. The alternative of homicídio culposo under Article 121(3) addresses this scenario but carries lower penalties and may be perceived as less appropriate for the gravity of the conduct.

7. Sentencing

Article 133, with its escalating penalty structure, provides substantial sentences for abandonment resulting in death: reclusão of four to twelve years, increased by one-third for family perpetrators—yielding an effective range of five years and four months to sixteen years. This represents the most severe sentencing framework among the three jurisdictions examined, reflecting legislative judgment that abandonment of vulnerable persons is a particularly grave form of wrongdoing deserving substantial punishment. The family enhancement further emphasises that breach of familial trust aggravates culpability. Homicídio culposo carries a more modest penalty of detention of one to three years, appropriate for cases of negligence without the element of intentional abandonment. Brazilian courts also have discretion to impose alternative measures for lower-level offences, including community service and conditional suspension of penalty, though these alternatives are less available for the more serious category of abandonment resulting in death.

VI. Synthesis: Convergences and Divergences

The comparative analysis reveals both significant convergences and important divergences across the three jurisdictions examined. This section identifies genuine patterns rather than overstating similarities or differences, recognising that comparison across different legal traditions requires attention to both functional equivalence and conceptual distinction.

A. True Convergences

First, all three jurisdictions recognise that criminal liability may arise from omissions—failures to act—where the defendant owed a legal duty to act. None operates a general duty to rescue strangers; the passer-by who fails to assist a person in distress commits no offence. But all provide mechanisms by which assumption of caregiving responsibility, either through legally constituted relationship (guardianship, parental responsibility) or through conduct establishing a factual undertaking of care, generates enforceable criminal obligations. This convergence reflects a shared understanding, across common law and civil law traditions, that those who undertake responsibility for vulnerable persons may not thereafter abandon that responsibility with impunity, and that the criminal law has a role in enforcing minimum standards of care.

Second, all three systems distinguish between ordinary negligence, which may attract civil liability but not criminal sanction, and grossly culpable conduct warranting criminal conviction for fatal outcomes. Whether framed as 'gross negligence' requiring conduct that is 'truly exceptionally bad' (England), 'negligência grosseira' requiring serious and unjustified violation demonstrating indifference to life (Portugal), or the intentional structure of abandonment plus preterdolous result (Brazil), each system recognises that criminal law should reserve its sanction for conduct that transcends ordinary carelessness. This convergence reflects appropriate restraint: families caring for mentally ill relatives face enormous challenges, and the criminal

law should not punish well-meaning but imperfect care. What it should punish is fundamental betrayal of the caregiving responsibility.

Third, all three systems face analogous challenges in proving causation where death results from suicide. The intervening act doctrine—whether termed novus actus interveniens (England), interrupção do nexo de causalidade (Portuguese/Brazilian doctrine), or by other formulations—presents a potential defence argument in all jurisdictions. The contention that the deceased's deliberate act of self-killing breaks the chain of causation, absolving the caregiver of criminal responsibility regardless of their prior failures, has surface plausibility in all three systems. None has definitively resolved this issue through authoritative appellate decision specifically addressing family caregiver liability for psychiatric patient suicide. This gap in case law represents both a doctrinal challenge for prosecution and an opportunity for development through appropriate test cases.

Fourth, all three jurisdictions experience apparent underutilisation of existing legal mechanisms for caregiver accountability. Despite the theoretical availability of prosecution, few cases reach the courts, and the incidence of conviction appears low. This pattern suggests systemic barriers—whether evidentiary, prosecutorial, or cultural—that transcend the particularities of any single legal system. The convergence in underutilisation suggests that reform efforts should address not only doctrinal refinement but also practical barriers to effective enforcement.

B. Genuine Divergences

First, the source and clarity of duty differ significantly across jurisdictions. Brazil's Article 133 explicitly addresses those with 'guarda, vigilância ou autoridade' over incapacitated persons, providing relatively clear statutory guidance on when duty arises. The specification of relationships and the broad interpretation of 'incapaz' provide prosecutors and courts with a defined framework. Portugal's framework, while codified, requires interpretation of general omission principles under Article 10 in conjunction with specific offence provisions, introducing a layer of interpretive complexity. England and Wales relies on case-by-case judicial development of the voluntary assumption doctrine, with Stone & Dobinson providing the leading precedent but leaving uncertainty about application to novel circumstances. This divergence affects both the predictability of liability for potential defendants and the confidence with which prosecutors can bring charges.

Second, the offence structure differs materially. Brazil provides a specific, targeted offence—abandono de incapaz—designed precisely for the category of wrongdoing at issue. This specificity has advantages: clarity of elements, appropriate penalty calibration, and symbolic denunciation of abandonment as a distinct form of culpable conduct. Portugal and England and Wales apply general negligent homicide or manslaughter provisions, requiring prosecutors to fit caregiver failures within frameworks designed for broader application. This structural difference affects charging decisions (is abandonment-specific language available?), jury instructions (can jurors be directed to the specific wrong of abandonment?), and public communication about the wrongfulness of caregiver failure.

Third, sentencing maxima vary substantially. England's life maximum for gross negligence manslaughter, Brazil's four to twelve years (up to sixteen with family enhancement) for abandonment causing death, and Portugal's five years for grossest negligent homicide reflect different penal philosophies and judgments about proportionate punishment. These differences affect the practical consequences of conviction and may influence prosecutorial decisions about whether the effort of prosecution is warranted

given the likely outcome. The variation also reflects broader differences in sentencing culture: common law systems tend toward wider judicial discretion and higher maxima, while civil law systems tend toward more calibrated statutory ranges.

Fourth, the influence of supranational human rights jurisprudence differs in mechanism and effect. Portugal is directly subject to European Court of Human Rights oversight, and the Fernandes de Oliveira judgment has had tangible effects on domestic regulation and public discourse. Brazil's condemnation in Ximenes Lopes occurred in the Inter-American system, which operates differently—with less established compliance mechanisms but significant moral authority in the region. England and Wales, while nominally subject to the ECHR through incorporation via the Human Rights Act 1998, has not faced equivalent Strasbourg jurisprudence specifically addressing psychiatric patient protection, and the domestic impact of European human rights law on caregiver liability remains undeveloped. These differences in supranational influence affect the pace and direction of domestic reform, with Portugal having experienced the most direct pressure for change.

Table 1. Comparative Analysis of Criminal Liability Frameworks for Caregiver Negligence in Psychiatric Deaths

Legal Element	England & Wales	Portugal	Brazil
Legal System	Common law	Civil law (Continental European)	Civil law (Latin American)
Primary Offence	Gross negligence manslaughter	Homicídio por negligência (Art. 137 CP)	Abandono de incapaz (Art. 133 CP); homicídio culposo (Art. 121(3))
Source of Duty	Voluntary assumption (Stone & Dobinson); special relationship; statute	Art. 10 CP (legal duty to act); family law; assumption of care	Guarda, vigilância ou autoridade (Art. 133); Art. 13(2) (duty to prevent)
Culpability Standard	Gross negligence: conduct "truly exceptionally bad"	Negligência grosseira: serious violation demonstrating indifference	Art. 133: dolo (intentional abandonment); Art. 121(3): culpa (negligence)
Causation Approach	Factual and legal causation; novus actus defence contested	Adequate causation (nexo de causalidade adequada)	Adequate causation; presumed for Art. 133 aggravated forms
Penalty (Death)	Maximum: life imprisonment	3–5 years imprisonment (gross negligence)	4–12 years reclusão; +1/3 for family (Art. 133)
Human Rights Influence	ECHR via HRA 1998; limited direct application	ECHR: Fernandes de Oliveira (state obligations)	IACHR: Ximenes Lopes (state responsibility)

Notes: CP = Criminal/Penal Code; ECHR = European Convention on Human Rights; HRA = Human Rights Act; IACHR = Inter-American Court of Human Rights. Penalties shown reflect aggravated forms where the victim dies.

VII. Discussion

The comparative analysis undertaken in this article supports several conclusions relevant to policy and practice. This section discusses the implications of the findings, addresses counterarguments, and identifies areas requiring further development.

A. The Case for Enhanced Accountability

The article argues that enhanced accountability for grossly negligent caregivers is justified, subject to the limiting principles articulated above. Several considerations support this normative position. First, the vulnerability of psychiatric patients—particularly those at documented suicide risk—creates heightened need for protection that the criminal law is appropriately positioned to provide. Unlike competent

adults who can seek help independently, monitor their own welfare, and summon assistance in emergencies, persons with severe psychiatric illness during acute episodes may lack the capacity, motivation, or practical ability to protect themselves. The caregiver occupies a position of unique importance in the patient's safety network, and gross failure in that position has correspondingly grave consequences.

Second, the gravity of the harm—irreversible death—justifies criminal rather than merely civil response where the caregiver's conduct was grossly culpable. Civil remedies may be appropriate for ordinary negligence, compensating surviving family members for their loss and providing incentives for careful conduct. But where conduct demonstrates fundamental disregard for the patient's life and welfare—where the caregiver's failures are not mere inadvertence but profound betrayal of responsibility—civil remedies are inadequate. The criminal law expresses society's condemnation of such conduct in a manner that civil damages cannot, and it provides deterrence and incapacitation that civil remedies may not achieve.

Third, the evidence that family involvement is critical to suicide prevention implies corresponding accountability when that involvement fails catastrophically. The epidemiological and clinical literature establishes that families can play a protective role through monitoring, treatment facilitation, and means restriction. If families can save lives through vigilance and appropriate action, then gross failure in these protective functions—not mere imperfection, but fundamental dereliction—is culpable when foreseeable death results. The logic of duty implies the logic of accountability: one cannot simultaneously recognise the importance of the caregiver's protective role and exempt the caregiver from consequences when that role is grossly abandoned.

B. Counterarguments and Responses

Several counterarguments to the position advanced in this article merit serious consideration. First, it may be argued that criminalising caregiving failures will deter family members from assuming caregiving roles in the first instance, leaving vulnerable persons without any support. This concern has force: if families fear prosecution for imperfect care, they may refuse to take on responsibility for mentally ill relatives, consigning such persons to institutional care or homelessness. However, this concern is addressed by the limiting principles articulated above. The criminal law, as argued in this article, threatens only those who grossly breach their duties—who abandon their charges entirely, who actively obstruct treatment, who demonstrate profound indifference to life and welfare. Those who try their best but fall short face no criminal jeopardy under the frameworks examined. If this is clearly communicated, the deterrent effect should operate against grossly negligent conduct, not against caregiving itself.

Second, it may be argued that proving causation in suicide cases is inherently speculative and that conviction would rest on counterfactual claims that can never be verified. No one can say with certainty whether better care would have prevented the suicide; the deceased's own agency intervened between the caregiver's failure and the death; multiple factors contributed to the outcome. This concern is addressed by framing causation appropriately—as contribution to foreseeable risk rather than counterfactual certainty. The question is not whether the victim would certainly have survived with better care, a hypothetical that can never be tested. The question is whether the caregiver's gross breach materially contributed to the conditions under which foreseeable death occurred, and whether the suicide was the materialisation of the very risk the caregiver's duty was designed to prevent. This framing is consistent with causation doctrine in all three

jurisdictions and avoids the trap of speculative counterfactuals.

Third, it may be argued that caregivers often face resource constraints, burnout, and lack of institutional support, making it unfair to hold them criminally responsible for what are ultimately systemic failures. Mental illness places enormous demands on families; support services are inadequate; caregivers may be themselves elderly, unwell, or impoverished. Prosecuting such persons adds cruelty to tragedy. This concern is addressed by the gross departure requirement. The criminal law, as argued here, does not demand that caregivers achieve optimal care despite inadequate resources. It demands only that they not fail so fundamentally as to demonstrate culpable disregard. A caregiver who struggles valiantly with inadequate support, who seeks help but cannot obtain it, who does their best within constraints—such a caregiver is not the target of these provisions. One who makes no effort at all, who obstructs available treatment, who abandons a vulnerable person to foreseeable death—that is a different matter entirely.

Fourth, it may be argued that the criminal law is an inappropriate instrument for addressing what is fundamentally a public health problem. Mental illness requires treatment, not prosecution; families need support, not punishment; resources devoted to prosecution would be better spent on community mental health services. This argument has considerable force as a matter of policy priority: investment in prevention is generally more effective than investment in punishment after the fact. However, the argument does not negate the appropriateness of criminal accountability in egregious cases. The criminal law and public health approaches are not mutually exclusive; a society can both invest in mental health services and hold grossly negligent caregivers accountable. The existence of systemic failures does not excuse individual failures that meet the threshold of criminal culpability.

C. The Gap in Case Law and Its Implications

A notable finding of this analysis is the apparent scarcity of reported decisions specifically addressing criminal liability of informal caregivers for psychiatric patient suicide. While Stone & Dobinson provides authority for the voluntary assumption principle in England, that case involved death from self-neglect (anorexia nervosa) rather than active suicide. The human rights cases—Fernandes de Oliveira and Ximenes Lopes—addressed institutional and state responsibility rather than informal family care. Portuguese and Brazilian appellate decisions directly on point appear sparse or absent.

This gap may reflect several factors: underreporting of domestic suicide deaths that might warrant investigation; prosecutorial reluctance to bring charges in this sensitive context; difficulty in proving cases to the required standard; settlement or plea resolution of cases that do not generate appellate decisions; or genuine rarity of circumstances meeting the limiting principles. Whatever the explanation, the gap creates doctrinal uncertainty: prosecutors and courts must reason by analogy and extrapolation rather than applying directly controlling precedent.

The gap also represents opportunity. Test cases, brought in carefully selected circumstances that clearly meet the limiting principles—documented high-risk condition, explicit clinical warnings, assumed duty, gross breach, clear causal contribution—could develop the law while establishing precedents for future cases. Such cases would require prosecutorial courage, judicial willingness to engage with novel applications of established doctrine, and appropriate support for victims' families seeking accountability. The development of jurisprudence in this area would benefit

not only individual cases but the broader clarity of the law.

VIII. Recommendations for Reform

Based on the comparative analysis presented above, the following recommendations are offered to policymakers, legislators, and prosecutorial authorities in the jurisdictions examined and in analogous legal systems.

First, common law jurisdictions, including England and Wales, should consider enacting specific statutory provisions addressing the abandonment or gross neglect of vulnerable adults, including adults with psychiatric conditions. Such provisions, modelled on Brazil's Article 133, would provide: clarity regarding when duty arises (by specifying relevant relationships and conduct); definition of prohibited conduct (abandonment, gross neglect, obstruction of care); appropriate penalty gradations (reflecting the gravity of harm); and family aggravation factors (recognising the enhanced culpability of breach of familial trust). The current reliance on general gross negligence manslaughter doctrine, while doctrinally adequate, creates unnecessary uncertainty for potential defendants, prosecutors, and courts, and fails to communicate the specific wrongfulness of abandoning vulnerable persons.

Second, prosecutorial authorities in all jurisdictions should develop specific guidance for cases involving psychiatric patient deaths in informal care settings. Such guidance should address: indicators triggering investigation of potential caregiver liability; evidentiary requirements for establishing duty, breach, grossness, and causation; appropriate framing of causation arguments where death results from suicide; public interest factors specific to family defendant cases, including both factors favouring and disfavouring prosecution; and charging options where multiple offences may apply. The development of specialised expertise among prosecutors and investigators would promote more consistent handling of such cases and would signal institutional commitment to effective enforcement.

Third, death investigation systems should be reformed to ensure systematic examination of caregiving circumstances when vulnerable persons, including psychiatric patients, die by suicide or self-neglect in domestic settings. Current practice may result in suicide verdicts being recorded without investigation of the circumstances preceding death, allowing potential caregiver failures to escape scrutiny. Training for coroners, medical examiners, and death investigators on identifying potential criminal negligence, coupled with protocols for referral to prosecutorial authorities when warranted, would help ensure appropriate cases receive attention. This recommendation does not advocate for intrusive investigation of all suicide deaths—which would be impractical and potentially harmful—but for enhanced scrutiny in cases where indicators of caregiver failure are present.

Fourth, public education campaigns should inform family caregivers of their legal duties, the criminal consequences of gross neglect, and the resources available to support them in fulfilling their caregiving responsibilities. Effective deterrence requires that potential offenders be aware of the legal framework; a law unknown is a law unenforced. Such campaigns should be designed sensitively, avoiding stigmatisation of caregivers while clearly communicating that fundamental failures of care—abandonment, obstruction of treatment, profound neglect—may have criminal consequences. Educational materials should also emphasise the support available, so that caregivers facing difficulty know where to turn before reaching the point of criminal failure.

Fifth, academic researchers in law, psychiatry, public health, and related fields should undertake

empirical study of this under-researched area. Relevant questions include: What is the actual incidence of potential caregiver criminal liability cases? What factors influence prosecutorial decisions? What are the outcomes of cases that are prosecuted? How do different legal frameworks affect case trajectories? What are the effects of prosecution—or non-prosecution—on deterrence, family wellbeing, and public perception? Such research would provide the evidence base for informed policy development and would illuminate aspects of this issue that doctrinal analysis alone cannot address.

Sixth, clinical practice guidelines should be developed to strengthen the interface between healthcare providers and family caregivers regarding communication of suicide risk, documentation of warnings given, and follow-up on caregiver engagement. Such guidelines would serve both clinical and legal purposes: clinically, by promoting effective risk communication that enhances patient safety; legally, by creating documentation that could support prosecution where caregiver failure follows explicit warning, and by protecting caregivers who can demonstrate that they acted on the information provided. This recommendation recognises that criminal accountability operates within a broader ecosystem of care and that strengthening that ecosystem benefits patients, families, and the administration of justice.

IX. Implications

Beyond the doctrinal analysis and policy recommendations presented above, it is appropriate to acknowledge the human stakes of this inquiry. The deaths addressed in this article are not legal abstractions or academic exercises but represent individual tragedies—lives that could potentially have been saved had those entrusted with care fulfilled their duties. Each preventable death leaves behind bereaved families, shattered communities, and unanswerable questions about what might have been. When a person suffering from severe depression, facing suicidal ideation, turns to family members for support and finds instead denial, obstruction, or abandonment, the resulting death represents a profound failure of the human bonds that should protect the vulnerable.

The legal frameworks examined in this article exist to express society's commitment to protecting its most vulnerable members. That commitment is hollow if these frameworks remain theoretical—available in principle but never invoked in practice. The gap between law on the books and law in action, documented in this analysis, represents not merely a doctrinal curiosity but a failure of protection with potentially fatal consequences. Enhanced accountability, pursued appropriately within the limiting principles articulated, is not about punishing grief-stricken families for imperfect care. It is about ensuring that gross derelictions of duty—conduct that shocks the conscience and betrays fundamental obligations of human solidarity—do not occur with impunity. The message must be clear and consistently communicated: assuming responsibility for a vulnerable person is a serious undertaking, and those who catastrophically fail that responsibility may face the sanction of the criminal law.

The stakes extend beyond individual cases to societal values regarding mental illness and the worth of persons with psychiatric conditions. A legal system that systematically fails to investigate deaths of psychiatric patients, that treats suicide as purely a private matter beyond legal scrutiny regardless of caregiver conduct, that exempts family members from accountability even for the grossest failures—such a system implicitly devalues the lives of those with mental illness. It communicates, whether intentionally or not, that deaths of psychiatric patients matter less than deaths of other persons, that their vulnerability is

their own problem rather than society's concern, that caregivers may act or fail to act without consequence. Conversely, a system that takes these deaths seriously, that investigates potential criminal failures with appropriate rigour, that holds grossly negligent caregivers accountable within principled limits—such a system affirms that the lives of psychiatric patients matter, that their vulnerability creates duties rather than opportunities, and that their deaths warrant the same scrutiny and response as other preventable deaths.

Finally, the public health dimension deserves emphasis. Mental illness represents a leading cause of disability and premature death globally, a crisis that touches every society and every community. Effective response requires comprehensive approaches: adequate funding for mental health services; community support for persons with psychiatric conditions and their families; anti-stigma campaigns; early intervention; and research into prevention and treatment. Criminal accountability for gross caregiver negligence is one component of this comprehensive approach—not a substitute for adequate services, but a complement ensuring that those who assume caregiving responsibility fulfil that responsibility or face consequences. The goal is not widespread prosecution of family caregivers, which would be neither desirable nor achievable. The goal is effective deterrence of the grossest failures, and, where deterrence fails, appropriate justice for those whose lives were betrayed by those who should have protected them.

X. Conclusion

This article has examined the legal frameworks governing criminal liability for caregivers whose gross negligence results in the preventable deaths of psychiatric patients. Through comparative analysis of England and Wales, Portugal, and Brazil—representing common law, Continental European civil law, and Latin American civil law traditions—the article has demonstrated that legal mechanisms for accountability exist in each jurisdiction. Gross negligence manslaughter, negligent homicide, and specific abandonment offences provide doctrinal frameworks under which grossly negligent caregivers may be prosecuted. Yet these mechanisms remain underutilised, hampered by evidentiary challenges, doctrinal ambiguities, and apparent prosecutorial reluctance.

The article has advanced a carefully delimited normative argument. Criminal liability should not attach to all caregiving failures; bereaved families should not routinely face prosecution; imperfect care under difficult circumstances is not a crime. Rather, the article has argued that a specific class of cases—characterised by documented foreseeability of fatal risk, assumed or legally imposed duty, gross departure from reasonable conduct, and appropriate causal connection—justifies criminal accountability. The limiting principles articulated ensure that only the most egregious failures fall within the scope of criminal sanction, preserving appropriate space for imperfect but well-intentioned caregiving while condemning fundamental dereliction.

The comparative analysis has revealed both significant convergences—shared recognition of omissions liability, distinction between ordinary and gross negligence, challenges in suicide causation—and important divergences—different sources and clarity of duty, different offence structures, different sentencing ranges, different supranational influences. These findings inform the recommendations for reform: specific statutory provisions addressing vulnerable adult neglect; prosecutorial guidance for this context; enhanced death investigation procedures; public education; and academic research. Implementation of these recommendations, tailored to the circumstances of each jurisdiction, would strengthen the protection of

vulnerable psychiatric patients while respecting the limits of criminal law.

In an era when psychiatric illness is recognised as a leading cause of morbidity and mortality, and when family involvement is acknowledged as critical to patient safety, legal systems must ensure that grossly negligent caregiving does not escape accountability. The law already provides the conceptual tools; what remains is the will to develop, clarify, and apply them appropriately. For the sake of those whose lives depend on the faithful discharge of caregiving duties—and in memory of those whose lives were lost when that duty was betrayed—that will must be summoned, and the law's promise of protection must be made real.

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Comparative Analysis of Criminal Liability Frameworks for Caregiver Negligence Resulting in Psychiatric Patient Death

Note. CP = Código Penal (Penal Code); ECHR = European Court of Human Rights; HRA = Human Rights Act; IACHR = Inter-American Court of Human Rights. Reclusão and detenção are Brazilian penalty categories, with reclusão denoting the more serious category applicable to grave offences. All penalty ranges represent statutory maxima; actual sentences depend on case-specific culpability and mitigating factors.