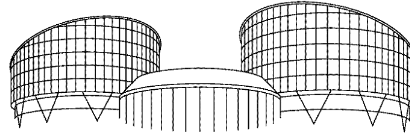


GRAND CHAMBER

# CASE OF FERNANDES DE OLIVEIRA v. PORTUGAL

*(Application no. 78103/14)*

JUDGMENT

STRASBOURG

31 January 2019

*This judgment is final but it may be subject to editorial revision.*

RLIT0002325_0001

RLIT0002325_0002

**In the case of Fernandes de Oliveira v. Portugal,**

The European Court of Human Rights, sitting as a Grand Chamber composed of:

Guido Raimondi, *President,*
Angelika Nußberger,
Linos-Alexandre Sicilianos,
Robert Spano,
Luis López Guerra,
Işıl Karakaş,
Paulo Pinto de Albuquerque,
Branko Lubarda,
Yonko Grozev,
Síofra O'Leary,
Carlo Ranzoni,
Mārtiņš Mits,
Armen Harutyunyan,
Alena Poláčková,
Pauliine Koskelo,
Jolien Schukking,
Péter Paczolay, *judges,*
and Françoise Elens-Passos, *Deputy Registrar,*

Having deliberated in private on 7 March and on 14 November 2018,

Delivers the following judgment, which was adopted on the last-mentioned date:

## PROCEDURE

1. The case originated in an application (no. 78103/14) against the Portuguese Republic lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Portuguese national, Ms Maria da Glória Fernandes de Oliveira ("the applicant"), on 4 December 2014.

2. The applicant was represented by Mr J. Pais do Amaral, Ms A. Pereira de Sousa and Ms C. Botelho, lawyers practicing in Coimbra. The Portuguese Government ("the Government") were represented by their Agent, Ms M.F. da Graça Carvalho.

3. The applicant complained under Article 2 of the Convention that her son, A.J., had been able to commit suicide as a result of the negligence of the psychiatric hospital where he had been hospitalised on a voluntary basis. Under Article 6 she also complained about the length of the civil proceedings she had instigated against the hospital.

4. The application was allocated to the Fourth Section of the Court (Rule 52 § 1 of the Rules of Court). On 28 March 2017 a Chamber of that Section, composed of the following judges: Ganna Yudkivska, President, Nona Tsotsoria, Paulo Pinto de Albuquerque, Krzysztof Wojtyczek, Egidijus Kūris, Iulia Antoanella Motoc, and Marko Bošnjak, and also of Andrea Tamietti, Deputy Section Registrar, declared the application admissible. In its judgment, delivered on the same date, the Chamber found unanimously that there had been a violation of the substantive and procedural aspects of Article 2. On 27 June 2017 the Government requested the referral of the case to the Grand Chamber in accordance with Article 43 of the Convention. On 18 September 2017 the panel of the Grand Chamber granted that request.

5. The composition of the Grand Chamber was determined according to the provisions of Article 26 §§ 4 and 5 of the Convention and Rule 24 of the Rules of Court. Luis López Guerra, whose term of office expired in the course of the proceedings, continued to deal with the case (Article 23 § 3 of the Convention and Rule 24 § 4). Péter Paczolay, substitute judge, replaced Helena Jäderblom who was unable to take part in the further consideration of the case (Rule 24 § 3).

6. The applicant and the Government both filed further written observations (Rule 59 § 1 read in conjunction with Rule 71 § 1).

7. A hearing took place in public in the Human Rights Building, Strasbourg, on 7 March 2018 (Rule 59 § 3).

There appeared before the Court:

(a) *for the Government*

Ms M. DE FÁTIMA DA GRAÇA CARVALHO, *Agent,*
Ms A. GARCIA MARQUES,
Dr A. José PIRES PRETO, *Advisers;*

(b) *for the applicant*

Ms A. PEREIRA DE SOUSA, *Counsel,*
Ms C. BOTELHO,
Dr C. FERNANDES DA SILVA, *Advisers.*

The Court heard addresses by Ms da Graça Carvalho, Ms Pereira de Sousa and Dr Pires Preto and their replies to the questions of the judges.

# THE FACTS

## I. THE CIRCUMSTANCES OF THE CASE

8. The applicant was born in 1937 and lives in Ceira (Portugal).

9. The facts of the case, as established by the domestic courts and submitted by the parties, may be summarised as follows.

### A. The background to the present case

10. The applicant's son, A.J., was born on 29 May 1964.

11. A.J. suffered from several mental illnesses, with a number of possible diagnoses being considered over the years such as schizophrenia and major depression. He also had a pathological addiction to alcohol and prescription drugs (*medicamentos)* and was sometimes violent towards his mother and sister. According to the expert medical opinion obtained after his death and during the domestic proceedings (see paragraph 33 below), A.J. may also have suffered from borderline personality disorder.

12. A.J. was hospitalised in the Sobral Cid Psychiatric Hospital (*Hospital Psiquiátrico Sobral Cid*, hereinafter "the HSC") in Coimbra on eight occasions on a voluntary basis from:

1. 5 to 8 August 1984;
2. 15 March to 3 April 1985, when he was prevented from leaving the pavilion building at least for part of his stay;
3. 15 to 28 November 1985;
4. 10 to 18 January 1993, after being accompanied to the HSC by the police who had been called to his home following a family dispute. He was released at his request, having filled out a release form;
5. 1 to 12 February 1993;
6. 1 to 3 September 1999, when he was urgently admitted to hospital on 1 September (diagnosed with chronic alcoholism), and signed his own release form on 3 September 1999 against medical advice;
7. 12 December 1999 to 14 January 2000, when he was hospitalised after a delirious episode, and referred to the HSC by the emergency department. At the beginning of his stay he was forbidden to leave the pavilion building where he was confined;
8. 2 to 27 April 2000, during which period he left the pavilion twice – on 3 and 27 April 2000 – without permission.

13. The medical files show that his degree of dependence on medical assistance (*grau de dependência*) varied during these stays between being a patient in need of partial assistance and a patient requiring intensive or full assistance. At other times the degree of dependence was not noted, as was the case for his last stay in 2000. Between some of these stays he saw a doctor at the HSC as an outpatient but on an infrequent basis.

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14. According to the Government, these stays followed emergencies or bouts of alcoholic intoxication, and only the last stay followed a suicide attempt.

15. During some of the periods he spent in hospital, A.J. was authorised to spend weekends at home with his family – three weekends during the period from 12 December 1999 to 14 January 2000, and two weekends during the period from 2 to 27 April 2000.

### B. The events prior to A.J.'s death

16. In March 2000 A.J. went to Lisbon to try to renew his driving licence for heavy vehicles. However, he was unsuccessful. On 1 April 2000 he attempted to commit suicide by taking an overdose of prescription drugs. He was taken to the emergency department of Coimbra University Hospital.

17. On 2 April 2000 A.J. was voluntarily admitted to the HSC from the emergency department (this was the last of his stays at the HSC (see paragraph 12 above). He was treated by Dr A.A., who had been his psychiatric doctor since December 1999. According to the clinical records dated 2 April 2000 and the witness statement of Dr A.A., the suicide attempt may have been the result of his failure to renew his driving licence. According to her, he had become depressed and thought his life no longer had any value, he felt marginalised and also powerless to achieve any aim in life.

18. For the first week of his stay at the HSC, he was placed under a restrictive regime, even though he was a voluntary inpatient (see paragraph 54 below). He was confined - in his pyjamas - to pavilion 8, where the Male General Psychiatric Clinic (Hospitalisation of Acute Cases) was located, and was not allowed to leave the pavilion. However, the clinical records show that on 3 April 2000 he left the pavilion after lunch and went home. He was brought back to the HSC by his brother-in-law at around 1.30 p.m. In the second and third week of that stay at the HSC, given an improvement in A.J.'s condition, the restrictive regime was lifted and he was allowed to circulate outside the pavilion and within the HSC grounds. This regime remained unchanged up until his death on 27 April 2000 (see paragraph 28 below). During that period he was allowed to spend two weekends at home.

19. During the second weekend A.J. was allowed to go home to spend Easter with the applicant and other members of his family. He left the HSC at 10 a.m. on Friday 21 April 2000 after his breakfast, and was due to return on Wednesday 26 April 2000 after breakfast. Dr A.A. was on holiday over that period (she had left on 19 April 2000) and was replaced by Dr E.R. Dr E.R. saw A.J. twice before the latter spent the Easter weekend at home.

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20. At around 10.30 p.m. on Tuesday 25 April 2000, the applicant took A.J. to the emergency department of the Coimbra University Hospital because he had drunk a large amount of alcohol. The observation record completed by the emergency department at around midnight on 25 April 2000 read as follows:

> "patient hospitalised in HSC, being seen by doctor A.A; he spent the weekend outside and must have behaved recklessly because he got drunk. History of mental weakness, depressive episodes and recurrent suicide attempts, those characteristics were not observed during the weekend. Sent back to the HSC where he is hospitalised."

He was prescribed medication in case of emergency, and it appears from his clinical records that he was given emergency medication at around 2 a.m. on 26 April 2000 at the HSC.

21. The clinical record from 8 a.m. to 4 p.m. on 26 April 2000 shows that A.J. stayed in bed and only got up to eat. He received phone calls and a visit from his sister. There is no clinical record for the shift from 4 p.m. to midnight and for the shift from midnight to 8 a.m. the next day. The domestic courts accepted that the applicant's son had been medicated for the whole day, whereas the applicant contested that fact on the basis of the lack of any clinical record.

22. The clinical record resumes at 8 a.m. on 27 April 2000. The nurse noted that between 8 a.m. and 4 p.m. A.J.'s behaviour had been calm and he had been walking around outside pavilion 8. According to the oral statement of one nurse and the clinical record, he had eaten well, including his afternoon snack at around 4.45 p.m.

23. The clinical records do not mention that A.J. was seen by the doctor on call on returning to the HSC. Dr E.R. stated in his oral evidence that he had assumed that A.J. was fine since the nurses had not requested any assessment (see paragraph 35 below).

24. At around 4 p.m. the applicant called the hospital. She was told to call back later, during the afternoon snack, as her son was not inside the building at that time. She was assured that some minutes earlier he had been standing at the door and he looked fine.

25. At around 7 p.m. it was noticed that A.J. had not appeared for dinner. The coordinating nurse was informed of his absence. The hospital staff then started searching the areas where patients were allowed to walk about freely, such as the cafeteria and the park.

26. At some time between 7 p.m. and 8 p.m. the coordinating nurse reported the disappearance to Dr M.J.P., who was on call that day (but not at the HSC at that time), and contacted the National Republican Guard.

27. At around 8 p.m. the coordinating nurse spoke on the telephone to the applicant and told her that A.J. had not appeared for dinner.

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28. It is not known at what precise time A.J. left the pavilion and the hospital grounds after he had taken his afternoon snack and thereafter followed a footpath towards the applicant's house. At 5.37 p.m., dressed in his pyjamas, A.J. jumped in front of a train running between Lousã and Coimbra.

### C. Domestic proceedings against the hospital

29. On 17 March 2003 the applicant lodged a civil action with the Coimbra Administrative Court (*Tribunal Administrativo do Círculo de Coimbra*) against the HSC under the State Liability Act (Legislative Decree no. 48051 of 21 November 1967) seeking pecuniary and non-pecuniary damages of 100,403 euros (EUR).

30. The applicant claimed that her son had been treated at the HSC for mental disorders on several occasions. He had been admitted to the hospital as a voluntary inpatient on 2 April 2000 because he had attempted to commit suicide. She alleged that he had made another attempt over the Easter weekend when he was at home with her. The fact that her son had been able to leave the hospital grounds on 27 April 2000 had led the applicant to conclude that the hospital staff had acted negligently in the performance of their duties. Because of his suicide attempts and mental condition, her son should have been under medical supervision and the hospital staff should have prevented him from leaving the hospital grounds. She maintained that her son's suicide had been caused by the poor organisation of the hospital services. The poor organisation was reflected in three aspects: a) the lack of fencing around the boundaries of the hospital, which allowed inpatients to leave the hospital easily without any supervision, b) the lack of a mechanism for checking the presence of inpatients which would allow the hospital staff to notice an absence immediately, and c) the lack of an emergency procedure capable of detecting an inpatient's absence, which would allow the hospital staff to adopt the effective measures required to ensure that the inpatient was returned safely without endangering the lives of others or his own life. The applicant relied on the specific background leading to A.J.'s hospitalisation since the beginning of April as well as details from his clinical record, notably his repeated excessive consumption of alcohol, his mental illness, and his earlier suicide attempt. She maintained that on account of all those circumstances, the monitoring measures should have been enhanced in order to prevent him from leaving.

31. On 29 October 2003 the court gave a preliminary decision (*despacho saneador*) specifying the facts considered to be established and those which remained to be established.

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32. On 5 July 2005 the court ordered that an expert report be drawn up on A.J.'s clinical condition and the supervision measures required as a result of that condition.

33. On 27 September 2006 a psychiatrist appointed by the Medical Association (*Ordem dos Médicos*) submitted his report, which was based on an analysis of photocopies from the clinical files of the HSC. The relevant parts of the report read as follows:

> "...
>
> Although alcohol dependence was the predominant diagnosis, several other diagnoses were considered. In particular, dependent personality (*personalidade dependente*); delirious outbreaks (*surto delirante*); schizophrenia; manic-depressive psychosis (*psicose maníaco-depressiva*)...
>
> A.J.'s clinical history enables us to consider him an ill person with recurring relapses into excessive alcohol consumption ... but also another kind of symptomatology...
>
> He was an individual who was "very violent and aggressive when he was drunk, and even in those moments when he had not been drinking he was a conflictual young man, easily irritable"...
>
> ...
>
> There is no detailed reference in his clinical records to his psychopathological condition on 26 April 2000 (after the alcohol intoxication episode which led him to the emergency services on 25 April 2000), 27 or 28? April 2000...
>
> ...
>
> The [plaintiff's] son suffered from disturbances which caused depressive behaviour with a significant inclination to suicide.
>
> Taking into account the clinical documents, his clinical condition may have led to another attempt to commit suicide, which turned out to be fatal.
>
> In addition, the polymorphism of the patient's psychiatric condition should be emphasised. A psychopathological condition such as the patient's has a bad prognosis and suicide is frequently preceded by an attempt (or attempts) to commit suicide. ... Indeed, it must be clarified that ... he may have been suffering from a borderline personality disorder [*perturbação de personalidade borderline*]...
>
> ...
>
> There is reference to a multiplicity of diagnoses, all of them capable of enhancing the risk of the patient's suicide (and also of suicidal behaviour).
>
> ...
>
> The clinical history and psychopathological framework [*quadro psicopatológico*], for the reasons already mentioned, would predict future suicidal behaviour; thus the occurrence of suicide is not surprising.
>
> With regard to prevention, containment and surveillance measures must without a doubt be adopted. But with a patient like this one, these measures are difficult to adopt (see for example his requests to be discharged despite the doctor's opinion, which is substantiated) and never sufficient because of the high potential for suicide.

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...

We can assume or assert the increased suicide potential of an individual when he is suffering from a psychopathological framework such as schizophrenia, major depression, chronic alcoholism; all these pathologies are mentioned in the patient's clinical records. This potential is also increased if the patient is suffering from Borderline Personality Disorder, as we mentioned; an illness which cannot be excluded with regard to this patient. The prevalence of suicide is significant among patients suffering from these pathologies. Therefore, what happened is not unusual.

The fact that the patient had been on antidepressant treatment for more than two weeks, had wandered around the hospital without ever endangering his life, and the fact that there is nothing in the medical records on suicidal thoughts, does not mean that the probability of that event (suicide) was negligible. However, it was hardly avoidable.

[Fully effective] Prevention of suicide in these patients is an impossible task.

In a patient who wanders around the hospital and whose symptomatology is not suggestive of imminent suicide, where that probability (of suicide) is higher but is not so increased at that moment (considering the background and the characteristics of the patient), prevention is much more difficult."

34. The first hearing took place on 8 October 2008. The applicant and the psychiatrist who had issued the above medical opinion gave evidence at the hearing.

35. At five hearings (namely on 8 and 9 October 2008, on 14 January 2009, and on 9 and 13 February 2009) the court heard evidence from different witnesses, including: the applicant's daughter (A.J.'s sister); nurses, doctors and medical auxiliaries who had worked for or were still working for the HSC, some of whom had started their shift at 4 p.m. on 27 April 2000; a social worker employed by the HSC since 1995, who had had contact with A.J.; and the train driver. Dr A.A., who had been A.J's psychiatric doctor at the HSC, gave evidence that his treatment consisted of taking the prescribed medication, ensuring that he received the treatment voluntarily, and establishing a relationship of trust with him in order for him to receive therapy. She confirmed that voluntary inpatients could have their freedom of movement restricted if it was thought necessary. In these circumstances inpatients would be forbidden from leaving the pavilion and would remain in their pyjamas. Dr E.R. (who had been replacing Dr A.A. at the relevant time) confirmed that on 27 April 2000 there had been no mention on the information board in pavilion 8 of any restrictive measures in respect of A.J. In other words, he had been free to leave the pavilion, although to leave the grounds of the HSC he would have needed medical permission. Dr M.J.P., who had been the emergency doctor on call on 27 April 2000, explained that had the nurses in the pavilion seen a problem with A.J.'s behaviour on that day they would have called her, which they had not done. The court also analysed several documents attached to A.J.'s clinical file from the HSC.

36. On 9 March 2009 the court conducted an on-site inspection (see paragraph 48 below).

37. On 7 January 2010 the court held a hearing at which it adopted a decision concerning the facts. The court considered, *inter alia*, that it should not explicitly define A.J.'s pathology. Regarding the episode on 25 April 2000, the court decided to view it simply as an abuse of alcohol, taking into account his underlying chronic alcoholism and the fact that the drinking had taken place in the afternoon and mainly at a café.

38. On 25 April 2011 the Coimbra Administrative Court delivered a judgment in which it ruled against the applicant. With regard to the applicant's argument that the hospital should have erected fences or other barriers around the hospital grounds, the court pointed out that the current approach in the treatment of mentally ill patients was to encourage social interaction. The existence of fencing would lead to the stigmatisation and isolation of mentally disabled inpatients. In this regard it held that the lack of security fences or walls was:

> "in line with modern theories of psychiatric science according to which the treatment of patients suffering from mental disorders must take place in an atmosphere of trust and mobility of movements, in physical conditions which promote the freedom and autonomy of movements, and which favours the interaction and the conviviality between patients and the staff in order to encourage [the patient's] reintegration; monitoring of these patients must be conducted in a discreet way".

39. As to the applicant's complaint regarding the lack of a mechanism capable of checking the presence of inpatients, the court found that the HSC had a surveillance procedure in place which consisted of verifying the inpatients' presence at meal and medication times; this was in compliance with recent psychiatric science and respected the inpatients' right to privacy and dignity. Additionally, the court found that the inpatients in respect of whom a specific restrictive regime of hospitalisation was adopted were given more attention by the nursing team and the medical assistants, who verified their presence inside the building where they were hospitalised or in the areas surrounding the building's entrance, as the case may be. With regard to the applicant's argument that no emergency procedure existed, the Coimbra Administrative Court noted that it consisted of alerting the police and the inpatient's family in the event of absence. It found this procedure to be appropriate.

40. As regards the applicant's complaint that her son had committed suicide as a result of the absence of permanent monitoring, the court held that his suicide had not been foreseeable. It was true that her son had been suffering from a mental illness which had never been properly diagnosed, either because the symptoms were complex or because he had been addicted to alcohol and prescription drugs. In this regard, the court pointed out that over the years the applicant's son had been diagnosed with schizophrenia and major depression. However, it was only after his death and as a

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consequence of an expert opinion requested from the Medical Association during the proceedings (see paragraph 33 above) that a probable diagnosis of borderline personality disorder had been made. The court established that A.J. had last been admitted as an inpatient after a suicide attempt. However, it considered that despite the possibility that inpatients diagnosed with mental diseases such as those of the applicant's son might commit suicide, during the last days before his death he had not shown any behaviour or mood which could have led the hospital staff to suspect that 27 April 2000 would be different to the preceding days.

According to the Coimbra Administrative Court, the fact that he had been admitted to the emergency department of the Coimbra University Hospital because he had consumed a large amount of alcohol had not been the result of a suicide attempt but of reckless behaviour. The Coimbra Administrative Court found that, having returned to the HSC, he had been kept under medical supervision the whole day, was medicated and accompanied by the medical staff, and that his health had improved. The court thus concluded that there were no circumstances that would have made it possible to predict the tragic outcome that had occurred. It was not possible to affirm that his suicide had been predictable, nor was there anything in the case file that could have justified the adoption of the involuntary treatment procedure in the days preceding the tragedy, since it was not foreseeable that he would commit suicide. According to the court, A.J.'s behaviour had been "absolutely unexpected and unforeseeable", given the concrete circumstances of the case.

41. On 12 May 2011 the applicant appealed to the Administrative Supreme Court, claiming that the first-instance court had wrongly assessed the evidence, that its findings of fact had been incorrect, and that it had wrongly interpreted the law.

42. On 26 September 2012 the Deputy Attorney-General attached to the Administrative Supreme Court was asked to provide an opinion on the appeal. He recommended that the first-instance judgment should be reversed. The opinion focused on the failure to put in place a surveillance framework specifically adapted to A.J.'s mental health problems and risk of suicide, as well as the alleged failure of the HSC to comply with its obligation to prevent suicide. It stated that:

> "....
>
> with regard to patients with a tendency to commit suicide only the prescription and application of enhanced monitoring (*vigilância acrescida*) could be considered adequate.
>
> In A.J.'s medical report there are references to suicide attempts; the last one occurred on 1 April 2000, some days before 26 April 2000 when he went back to HSC after being treated at [Coimbra University Hospital] due to the consumption of a large amount of alcohol; the possibility of a suicide attempt was thus a "probable risk" or,

among the possible risks, one which could be anticipated in so far as it could be expected by a prudent assessor (*avaliador prudente*).

Therefore, in our opinion, the impugned judgment has erred in considering for the purpose of assessing the level of monitoring required from the defendant, that A.J.'s suicide was an absolutely unexpected and unforeseen fact and by holding that there were no grounds to increase the monitoring in the particular case.

The [HSC] never prescribed or put in place a regime to reinforce the monitoring of A.J. – a regime which could be suited to preventing any possible exit from the hospital, ...

This enhanced surveillance, which aims at protecting the patient, is part of the therapeutic obligation of the hospital and it does not conflict with the open-door regime as a treatment method applied to patients in the circumstances in which it is considered suitable."

43. Regarding the facts which the applicant had relied on concerning several HSC inpatients who had left without permission and the resulting tragic consequences, the opinion noted that those elements should not be taken into consideration.

According to the opinion:

"the degree of surveillance that ought to be established must take into consideration "all the probable risks" and all those "which can fall within the expectations of a prudent assessor".

A.J.'s medical report, alone, already had references to suicide attempts, one of which had occurred twenty-five days earlier. Thus it was possible to predict a repetition of those.

It is therefore possible to conclude that the defendant did not establish or put in place any monitoring measure which could be considered adequate to the status of a psychiatric hospital and to A.J.'s characteristics as a patient – it could and should have done so."

44. On 29 May 2014 the Administrative Supreme Court dismissed the applicant's appeal by two votes to one, upholding the legal and factual findings of the Coimbra Administrative Court. The Administrative Supreme Court found that the facts relied on by the applicant before the lower court concerning similar cases of inpatients who had left the HSC without permission were irrelevant to the decision in the instant case. The court rejected the applicant's argument that A.J. had exhibited depressive behaviour with a "strong" tendency towards suicide, which he had attempted on different occasions. It upheld the finding of the lower court which had established only one suicide attempt on 1 April 2000.

45. The Administrative Supreme Court considered that the practice of counting of inpatients at meal and medication times was sufficient and had allowed the hospital staff to verify A.J.'s attendance during lunch and the afternoon snack on 27 April 2000. It rejected the applicant's argument that counting the inpatients when they were given their meal trays with their meals was "deeply amateurish". As to the foreseeability of the suicide, the

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Administrative Supreme Court held that the HSC had not breached any duty of care, as there had been no indication which could have led the hospital staff to suspect that the applicant's son would try to commit suicide that day, namely by leaving the hospital grounds. The Administrative Supreme Court took into account that during previous periods of hospitalisation the applicant's son had also left the hospital grounds, and that no link had been established between that behaviour and a particular risk of suicide in so far as they had only been able to establish the existence of a single suicide attempt, namely on 1 April 2000.

46. In a dissenting opinion, one of the judges stated that the hospital should have secured the grounds in some way in order to fulfil its duties of care and supervision. By not doing so, it had allowed inpatients to leave easily without being discharged, thus breaching those duties. That omission had been the cause of the "escape" and suicide of the applicant's son.

**D. Background information concerning the HSC**

47. The HSC is a psychiatric hospital located outside Coimbra on seventeen hectares of land. It is part of the Coimbra University Hospital and is State-run.

48. According to an on-site inspection made by the Coimbra Administrative Court on 9 March 2009 in the course of the proceedings against the hospital, the HSC had eighteen buildings (one for each hospital department). On the basis of information before the Court it appears that different types of patients were hospitalised in these different buildings depending on their gender and the type and extent of their illness. The grounds of the HSC were not bordered by security fences or walls of any other kind. The buildings were surrounded by green areas with trees and other vegetation, and the different buildings were accessed by means of roadways and paths, which were also surrounded by trees and other vegetation. The main entrance to the HSC had a barrier and a security guard. One of the possible exits from the hospital grounds led to a shortcut towards a railway station platform. This shortcut was accessed by taking the road behind building no. 9. The station platform was around a fifteen to twenty-minute walk from that part of the HSC's grounds.

49. In accordance with the guidelines prepared by the HSC, meals were taken in the hospital cafeteria and inpatients had to remain there until the end of the meal. There was a User's Guide intended for inpatients which set out the rules governing their hospitalisation. Inpatients were not allowed to leave the pavilion without informing the relevant nurse in advance. Inpatients were also forbidden to leave the hospital grounds without the authorisation of a specialist. If an inpatient wished to leave the hospital before authorisation had been given, a discharge form had to be signed.

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50. The following schedule was in place during A.J.'s stay in April 2000:

i. Wake-up time: between 7 a.m. and 8 a.m.;

ii. Bedtime: flexible, from 10 p.m. the inpatient must remain silent and with the lights out;

iii. Meals:

1. Breakfast: from 8.35 a.m. to 9.30 a.m.;
2. Lunch: from 12 noon to 1 p.m.;
3. Afternoon snack: 4.45 p.m.;
4. Dinner: from 7 p.m. to 8 p.m.;
5. Evening snack: 10 p.m.

51. A mechanism was in place, as recognised by the domestic courts, for checking an inpatient's presence, by counting the inpatients at each meal time (five times a day) and at medication time. In addition to this, an inpatient's presence was checked at bedtime. Inpatients under a restrictive hospitalisation regime were monitored more closely by the nursing team.

52. An emergency procedure was triggered when the absence of a patient was noticed. This procedure consisted of alerting the police, the doctor on call and the inpatient's closest relatives.

53. During hospitalisation an inpatient was accompanied by a therapeutic team made up of a doctor, a nurse, a social worker, and a medical auxiliary.

54. A distinction was made between voluntary and involuntary hospitalisation (see paragraph 58 below). Under voluntary hospitalisation, an inpatient could abandon treatment at any moment. However, according to the doctors who testified in the domestic proceedings and the Government's observations, there were two types of regime for voluntary inpatients: a restrictive regime, according to which inpatients were not allowed to leave the pavilion, and a general regime, allowing inpatients to leave the building after informing the duty nurse, although they were still not allowed to leave the grounds of the HSC without permission. Inpatients under the restrictive regime were generally dressed in pyjamas and a dressing gown, while inpatients under the general regime seem to have had a free choice as to what they wore. It appeared that inpatients were often kept on the restrictive regime at the beginning of a hospital stay, even if they were admitted on a voluntary basis. There was an isolation room for inpatients who were very agitated and aggressive and this room could also be used for voluntary inpatients.

55. The applicant submitted news articles to the Court referring to inpatients who had apparently managed to leave the HSC's grounds. The first five articles below had already been submitted to the domestic authorities (see paragraph 44 above where the Administrative Supreme Court found the information contained therein to be irrelevant to the decision in the instant case):

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(i) on 9 March 2008 the body of an inpatient who had escaped two weeks earlier was found close to the hospital grounds (in *Diário de Coimbra*);

(ii) on 29 October 2008 a man escaped from the HSC and was hit by a car after jumping in front of it (in *Diário das Beiras*);

(iii) on 31 July 2008 the body of an inpatient who had escaped from the hospital the previous month was found in a river (in *Diário de Coimbra*);

(iv) on 14 August 2008 a patient who had been involuntarily hospitalised in the HSC escaped (in *Diário de Coimbra*);

(v) in early March 2010 three different inpatients escaped from the hospital; one of them was located by the police after stealing a car and another was found dead in a nearby river (in *Bombeirospontopt*);

(vi) on 16 October 2011 an inpatient escaped from the HSC's grounds and attacked two police officers with a hoe (in *Correio da Manhã*);

(vii) on 1 March 2015 two inpatients escaped from the HSC and stole a car (in *Tvi24*).

## II. RELEVANT DOMESTIC LAW AND PRACTICE

### A. The Health Act

56. The Health Act (Law no. 48/90 of 24 August 1990) provides that health care is dispensed by State services and establishments and by other public or private, profit-making or non-profit entities under State supervision. Under Basic Principle XIV of the Act, users of the health-care system have, among other rights, the right to freely choose their doctor and health-care establishment, the right to receive or refuse the treatment offered, the right to be treated in an appropriate and humane manner, promptly and with respect, the right to be informed about their condition, of possible alternative treatments and of the likely development of their condition, and the right to complain of the manner in which they have been treated and to receive compensation for any damage suffered.

57. The Health Act is regulated by Legislative Decree no. 11/93 of 15 January 1993, which approved the National Health-Care System Regulations. Under Article 38, the State has the task of supervising health-care establishments; the Ministry of Health is responsible for setting health-care standards, without prejudice to the functions assigned to the Medical Association and the Pharmacists' Association.

### B. The Mental Health Act

58. The Mental Health Act (Law no. 36/98 of 24 July 1998) sets out the general principles of mental-health policy and regulates the voluntary and

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involuntary hospitalisation of inpatients with psychiatric disorders. The relevant provisions read as follows:

**Section 3 – General principles of mental health**

"...

a) The provision of mental-health care is carried out in the community in order to avoid the removal of patients from their usual environment and to facilitate their rehabilitation and social integration;

b) Mental-health care is provided in the least restrictive environment possible.

..."

**Section 7 - Definitions**

"...

a) Involuntary hospitalisation (*Internamento compulsivo*): hospitalisation [ordered] by judicial decision regarding a patient with a severe mental disorder;

b) Voluntary hospitalisation (*Internamento voluntário*): hospitalisation at the request of the patient with a mental disorder or at the request of the legal guardian of a minor under the age of fourteen years old.

..."

**Section 12 - Requirements**

"1 - A patient with a severe mental disorder who creates, due to that disorder, a situation of danger for legally protected interests (*bens jurídicos*) of significant value, belonging to him or herself or others, of a personal or patrimonial nature, and refuses to undergo the necessary medical treatment, may be interned in an appropriate establishment.

2 - A patient with a severe mental disorder who does not possess the necessary discernment to assess the meaning and scope of the consent may also be interned where the absence of treatment seriously damages his or her state."

**Section 13 - Locus standi**

"1 - The legal representative of a patient with a severe mental disorder, any person with legal standing to lodge prohibition (*interdição*) proceedings, the public health authorities and the State Attorney's Office (*Ministério Público*) has the legal standing to request compulsory hospitalisation.

2 - Whenever a doctor in the exercise of his or her functions diagnoses a mental disorder with the effects set forth in section 12, he or she may communicate that diagnosis to the competent public health authority for the purposes of the previous paragraph.

3 - If the diagnosis is made during voluntary hospitalisation, the clinical director of the establishment also has the legal standing to request involuntary hospitalisation."

## C. Legislative Decree no. 48051 of 21 November 1967

59. Legislative Decree no. 48051, in force at the time the proceedings were instituted by the applicant, governed the State's non-contractual civil

liability. It contained the following provisions of relevance to the instant case:

**Article 2 § 1**

"The State and other public bodies shall be liable to compensate third parties in civil proceedings for breaches of their rights or of legal provisions designed to protect the interests of such parties caused by unlawful acts committed with negligence (culpa) by their agencies or officials in the performance of their duties or as a consequence thereof."

**Article 4**

"1. The negligence (culpa) of the members of the agency or of the officials concerned shall be assessed in accordance with Article 487 of the Civil Code.

2. If there are several persons responsible, the provisions of Article 497 of the Civil Code shall apply."

**Article 6**

"For the purposes of this Decree, legal transactions which infringe statutory provisions and regulations or generally applicable general principles, and physical acts which infringe such provisions and principles or the technical rules and rules of general prudence that must be observed, shall be deemed unlawful."

60. According to domestic case-law concerning the State's non-contractual liability, the State is required to pay compensation only if an unlawful act has been committed with negligence and there is a causal link between the act and the alleged damage.

### D. Legislative Decree no. 35/99 of 5 February 1999

61. Legislative decree no. 35/99 of 5 February 1999, in force at the time of A.J.'s last stay in hospital, contains provisions on the organisation of psychiatric and mental health care. The preamble reads as follows:

"...

Thus considering, in particular, the recommendations of the United Nations and of the World Health Organization regarding the priority of promoting the provision of care at the community level in the least restrictive way and, in the specific context of psychosocial rehabilitation, the provision of care in day-care centres and in accommodation structures appropriate to the patients' specific degree of autonomy, the urgency to overhaul the mental health policy and to subsequently revise the model of services' organisation, which Legislative Decree no. 127/92 did not succeed in doing, has become even more pressing since the mid-1990s."

The relevant provisions provide as follows:

**Article 1 - Object**

"This decree lays down the guiding principles for the organisation, management and assessment of the psychiatry and mental health services, hereinafter referred to as 'mental health services".

**Article 2 – General principles**

"...

6 – The provision of mental health care shall focus on the specific needs and circumstances of the persons according to their age and it shall be promoted primarily at the community level in the least restrictive way; the hospitalisation units shall preferably be located in general hospitals."

**Article 16 – Tasks of psychiatric hospitals**

"1 – Psychiatric hospitals are responsible for:

...

c) Ensuring the necessary care of long-term evolution patients (*doentes de evolução prolongada*) hospitalised therein, and promoting the humanisation and the improvement of their living conditions, developing rehabilitation programmes adapted to their specific needs and supporting their reinsertion into the community.

..."

### E. Protocol on the use of means of "mechanical restraint" in all Portuguese hospitals, including psychiatric hospitals (Circular Normative Nr 08/DSPSM/DSPCS)

62. In 2007 the Ministry of Health introduced a protocol on the use of means of mechanical restraint in all Portuguese hospitals, including psychiatric hospitals. This was repealed and replaced by broader Guidelines in 2011 (see below).

### F. Guidelines of the Directorate General of Health on restraint no. 21/2011 dated 6 June 2011

63. Pursuant to Article 2 § 2, c) of Regulatory Decree No. 66/2007, of 29 May 2007, as amended by Regulatory Decree No. 21/2008, of 2 December 2008, the following guidelines were issued:

"1. The use of means of restraint of patients shall take place after a clinical risk assessment.

2. Patients shall be eligible for restraint measures when they:

2.1. Manifest behaviours that put them or their environment at risk of suffering damage.

2.2. Refuse compulsory treatment as provided by law.

2.3. Refuse vital, urgent treatment.

...

6. The head nurse of the service is responsible for ensuring that the following elements are registered in the patient's file:

6.1. Assessment of the patient's condition that determined the need for restraint.

6.2. Preventive measures initiated and their impact.

6.3. Description of the different restraint measures analysed with the patients or with someone who will decide in their place.

6.4. Professionals involved in the decision-making of restraint measures.

6.5. Subsequent assessments of the restraint measure. It includes the evolution of the patient's condition and the screening of injuries associated with the use of restraint measures.

6.6. Review of the care plan as a consequence of the restraint measure.

...

9. Each health care institution should define, within the scope of these Guidelines, a standard of internal performance on the use of restraint measures in accordance with the specificities of the care it provides.

...

**CRITERIA**

...

k) The following is to be considered:

i. Therapeutic restraint: a measure used to control physical activity or the behaviour of a person or a part of their body during the provision of health care, in order to improve health conditions and prevent complications. The goal of therapeutic restraint is to optimise the safety of the patients and of those around them, while maintaining, as far as possible, their comfort and dignity.

ii. Environmental restraint: use of changes that control the mobility of the patient. It could be a confined room, a closed or limited space where the patient can wander safely with clinical supervision.

iii. Physical restraint: situation in which one or more persons of the therapeutic team hold a patient, or move or block their movement to prevent exposure to a situation of risk.

iv. Mechanical restraint: use of instruments or equipment that restrict the movements of the patient.

v. Chemical or pharmacological restraint: psychoactive medication aimed at inhibiting a specific movement or behaviour.

**REASONING**

There is evidence that restraint is one of the most commonly used practices at an international level for the care of patients with behaviours involving a risk for themselves or for those around them. From the various studies carried out on this subject, the need to prevent incidents and adverse events associated with restraint measures stands out.

..."

### G. Portuguese Civil Code

64. The relevant provisions of the Code read as follows:

**Article 487**

"1. It is for the injured party to prove liability for damage through negligence (culpa), unless there is a legal presumption of it.

2. In the absence of any other legal criteria, negligence is assessed with reference to the diligence of the *bonus pater familias*, given the circumstances of the case."

### H. Case-law of the Supreme Court of Justice and the Administrative Supreme Court

65. In a judgment of 25 July 1985, the Supreme Court of Justice analysed the duty to supervise mentally ill patients who were hospitalised. It held that whenever a mentally ill inpatient was hospitalised and receiving treatment, the hospital had an obligation to comply with its medical and supervision duties. In the case at hand, the Supreme Court considered that the hospital had failed to fulfil that obligation by allowing a mentally disabled inpatient hospitalised under an open regime to leave the premises without a hospital discharge and by not making all due efforts to secure his immediate return.

66. In a judgment of 25 November 1998, the Supreme Court of Justice examined whether by failing to object to an inpatient leaving its psychiatric department, a hospital was in breach of its duty of supervision. It considered that a breach had not occurred because it had been established, *inter alia*, that (i) the psychiatry department of the hospital functioned on the basis of an "open-door" regime; (ii) there had been no express order of the health service preventing the inpatient from leaving the department; (iii) the doctors had considered it inadvisable to restrict the inpatient's freedom of movement; (iv) on the day of her suicide attempt, the inpatient had appeared to be acting normally; and (v) the inpatient's suicide attempt could not have been predicted from her behaviour.

67. In a judgment of 29 January 2009 the Administrative Supreme Court considered that the duty to supervise a mentally ill inpatient who had jumped from a window in his room had not been breached. The Administrative Supreme Court noted, *inter alia*, that the duty of supervision existed only in relation to risks which could be ascertained by a prudent assessor. In the case at issue, there had been no evidence that the inpatient might attempt to commit suicide. Thus, the level of supervision adopted had been in accordance with his condition and the foreseeable risks. The hospital had therefore not been responsible for the fact that the inpatient had jumped from the window.

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## III. INTERNATIONAL LAW AND PRACTICE

### A. United Nations

#### *1. The General Assembly of the United Nations*

68. The United Nations General Assembly Resolution A/RES/46/119 of 17 December 1991 lays down several principles for the protection of persons with mental illness and for the improvement of their mental-health care. The relevant principles are the following:

**Principle 8 – Standards of care**

> "1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
>
> 2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort."

**Principle 9 – Treatment**

> "1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.
>
> ...
>
> 3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners...
>
> 4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy."

**Principle 15 – Admission principles**

> ...
>
> 2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.
>
> 3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, [as set forth in principle 16 below], apply and he or she shall be informed of that right."

#### *2. The Convention on the Rights of Persons with Disabilities*

69. The United Nations Convention on the Rights of Persons with Disabilities (hereinafter the "CRPD") (adopted by the United Nations General Assembly on 13 December 2006, Resolution A/RES/61/106) is designed to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities and to promote respect for their inherent dignity. The CRPD updated and revised

the standards which had been established by the above-mentioned General Assembly resolution. It was ratified by Portugal on 23 September 2009. All Council of Europe member States are now parties to the CRPD except for Liechtenstein. The relevant parts of the Convention read as follows:

**Article 10 – Right to life**

"State parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others."

**Article 12 - Equal recognition before the law**

"1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

..."

**Article 14 – Liberty and security of a person**

"1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

a. Enjoy the right to liberty and security of person;

b. Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation."

**Article 25 - Health**

"States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

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(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, ...;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, *inter alia*, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

..."

### *3. The Committee on the Rights of Persons with Disabilities*

70. In April 2014, the Committee on the Rights of Persons with Disabilities (hereinafter the "CRPD Committee") adopted a General Comment on Article 12: Equal recognition before the law. The relevant parts, which deal with persons detained involuntarily, read as follows:

**Articles 14 and 25**
**Liberty, security and consent**

"36. ...

...The denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, is an ongoing problem. This practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention. ...

37. The right to enjoyment of the highest attainable standard of health (art. 25) includes the right to health care on the basis of free and informed consent. States parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment.

..."

71. In September 2015, the CRPD Committee adopted Guidelines on Article 14 of the CRPD. The relevant parts, which concern persons detained involuntarily, read as follows:

**"B. The right to liberty and security of persons with disabilities**

3. The Committee reaffirms that liberty and security of the person is one of the most precious rights to which everyone is entitled. In particular, all persons with disabilities, and especially persons with intellectual disabilities and psychosocial disabilities are entitled to liberty pursuant to article 14 of the Convention.

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4. Article 14 of the Convention is, in essence, a non-discrimination provision. It specifies the scope of the right to liberty and security of the person in relation to persons with disabilities, prohibiting all discrimination based on disability in its exercise.

...

**C. The absolute prohibition of detention on the basis of impairment**

6. There are still practices in which States parties allow for the deprivation of liberty on the grounds of actual or perceived impairment. In this regard the Committee has established that article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived impairment. However, legislation of several States parties, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others. This practice is incompatible with article 14; it is discriminatory in nature and amounts to arbitrary deprivation of liberty.

...

**D. Involuntary or non-consensual commitment in mental health institutions**

10. Involuntary commitment of persons with disabilities on health care grounds contradicts the absolute ban on deprivation of liberty on the basis of impairments (article 14(1)(b)) and the principle of free and informed consent of the person concerned for health care (article 25). The Committee has repeatedly stated that States parties should repeal provisions which allow for involuntary commitment of persons with disabilities in mental health institutions based on actual or perceived impairments. Involuntary commitment in mental health facilities carries with it the denial of the person's legal capacity to decide about care, treatment, and admission to a hospital or institution, and therefore violates article 12 in conjunction with article 14.

...

**G. Deprivation of liberty on the basis of perceived danger allegedly posed by persons with disabilities, alleged need for care or treatment, or any other reasons**

13. Throughout all the reviews of State party reports, the Committee has established that it is contrary to article 14 to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or to others. The involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty.

14. Persons with intellectual or psychosocial impairments are frequently considered dangerous to themselves and others when they do not consent to and/or resist medical or therapeutic treatment. All persons, including those with disabilities, have a duty to do no harm. Legal systems based on the rule of law have criminal and other laws in place to deal with the breach of this obligation. Persons with disabilities are frequently denied equal protection under these laws by being diverted to a separate track of law, including through mental health laws. These laws and procedures commonly have a lower standard when it comes to human rights protection, particularly the right to due process and fair trial, and are incompatible with article 13 in conjunction with article 14 of the Convention.

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15. The freedom to make one's own choices established as a principle in article 3(a) of the Convention includes the freedom to take risks and make mistakes on an equal basis with others. In its General Comment No. 1, the Committee stated that "decisions about medical and psychiatric treatment must be based on the free and informed consent of the person concerned and respect the person's autonomy, will and preferences. Deprivation of liberty on the basis of actual or perceived impairment or health conditions in mental health institutions which deprives persons with disabilities of their legal capacity also amounts to a violation of article 12 of the Convention.

..."

### 4. *Office of the High Commissioner for Human Rights*

72. In September 2014, the Office of the High Commissioner for Human Rights issued a statement concerning Article 14 of the CRPD. It stated the following:

"Liberty and security of the person is one of the most precious rights to which everyone is entitled. In particular, all persons with disabilities, and especially persons with mental disabilities or psychosocial disabilities are entitled to liberty pursuant to article 14 of the Convention.

Ever since the CRPD committee began reviewing state party reports at its fifth session in April 2011, the Committee has systematically called to the attention of states party the need to correctly enforce this Convention right. The jurisprudence of the Committee on Article 14 can be more easily comprehended by unpacking its various elements as follows:

1. The absolute prohibition of detention on the basis of disability. There are still practices in which state parties allow for the deprivation of liberty on the grounds of actual or perceived disability. In this regard the Committee has established that article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived disability. However, legislation of several states party, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived disability, provided there are other reasons for their detention, including that they are dangerous to themselves or to others. This practice is incompatible with article 14 as interpreted by the jurisprudence of the CRPD committee.

2. Mental health laws that authorize detention of persons with disabilities based on the alleged danger of persons for themselves of for others. Through all the reviews of state party reports the Committee has established that it is contrary to article 14 to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or to others. The involuntary detention of persons with disabilities based on presumptions of risk or dangerousness tied to disability labels is contrary to the right to liberty. For example, it is wrong to detain someone just because they are diagnosed with paranoid schizophrenia.

..."

### *5. The United Nations Human Rights Committee*

73. On 16 December 2014 the Human Rights Committee issued General Comment No. 35 on Article 9: Liberty and security of person, of the International Covenant on Civil and Political Rights. In Section II of the General Comment the Human Rights Committee expanded on the issue of arbitrary and unlawful detention:

> "19. States parties should revise outdated laws and practices in the field of mental health in order to avoid arbitrary detention. The Committee emphasizes the harm inherent in any deprivation of liberty and also the particular harms that may result in situations of involuntary hospitalisation. States parties should make available adequate community-based or alternative social-care services for persons with psychosocial disabilities, in order to provide less restrictive alternatives to confinement. The existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others. It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual. States parties must offer to institutionalized persons programmes of treatment and rehabilitation that serve the purposes that are asserted to justify the detention. Deprivation of liberty must be re-evaluated at appropriate intervals with regard to its continuing necessity. The individuals must be assisted in obtaining access to effective remedies for the vindication of their rights, including initial and periodic judicial review of the lawfulness of the detention, and to prevent conditions of detention incompatible with the Covenant."

### *6. United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*

74. The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health issued a report concerning the right to health for all people with disabilities on 2 April 2015. In respect of the CRPD he found as follows:

> "96. The Convention is challenging traditional practices of psychiatry, both at the scientific and clinical-practice levels. In that regard, there is a serious need to discuss issues related to human rights in psychiatry and to develop mechanisms for the effective protection of the rights of persons with mental disabilities.
>
> 97. The history of psychiatry demonstrates that the good intentions of service providers can turn into violations of the human rights of service users. The traditional arguments that restrict the human rights of persons diagnosed with psychosocial and intellectual disabilities, which are based on the medical necessity to provide those persons with necessary treatment and/or to protect his/her or public safety, are now seriously being questioned as they are not in conformity with the Convention.
>
> ...

99. A large number of persons with psychosocial disabilities are deprived of their liberty in closed institutions and are deprived of legal capacity on the grounds of their medical diagnosis. This is an illustration of the misuse of the science and practice of medicine, and it highlights the need to re-evaluate the role of the current biomedical model as dominating the mental-health scene. Alternative models, with a strong focus on human rights, experiences and relationships and which take social contexts into account, should be considered to advance current research and practice. ...”

## B. Council of Europe

### *1. The Committee of Ministers*

75. On 22 September 2004 the Committee of Ministers adopted Recommendation Rec(2004)10 concerning the protection of human rights and the dignity of persons with mental disorders. The relevant Articles read as follows:

**Article 7 – Protection of vulnerable persons with mental disorders**

“1. Member States should ensure that there are mechanisms to protect vulnerable persons with mental disorders, in particular those who do not have the capacity to consent or who may not be able to resist infringements of their human rights.

2. The law should provide measures to protect, where appropriate, the economic interests of persons with mental disorders.”

**Article 8 – Principle of least restriction**

“Persons with mental disorders should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others.”

**Article 9 – Environment and living conditions**

“1. Facilities designed for the placement of persons with mental disorders should provide each such person, taking into account his or her state of health and the need to protect the safety of others, with an environment and living conditions as close as possible to those of persons of similar age, gender and culture in the community. Vocational rehabilitation measures to promote the integration of those persons in the community should also be provided.”

76. The Explanatory Memorandum to the recommendation states that the “principle of least restriction” is fundamental. It means that if a person’s illness improves, he or she should be moved to a less restrictive environment, when appropriate to his or her health needs.

77. Article 17 of the Recommendation sets out the criteria governing involuntary placement and states that a person may only be subject to such a measure if he or she has a mental disorder and represents a significant risk to himself or others because of it, and as long as the placement includes a therapeutic purpose, no less restrictive means are available, and the opinion of the person concerned has been taken into consideration.

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### 2. *European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("CPT")*

78. The CPT visited a number of psychiatric institutions in Portugal during the course of its periodic visits in 1999, 2003, 2008, 2012 and 2016. In the visit reports which followed, the CPT reiterated a recommendation that all psychiatric hospitals should have their own written policy on the use of means of restraint and that every instance of physical restraint of a patient should be recorded in a specific register established for that purpose.

79. The CPT visited the HSC specifically in 1999 and 2012. In 1999 the CPT's delegation focused its attention on the hospital's forensic department (for inpatients who had been declared to lack responsibility and ordered to undergo compulsory treatment by a criminal court) and also visited the general psychiatry department for men. In 2012 the Committee only visited the forensic department of the HSC (pavilion 16) and did not explicitly address the case of voluntary inpatients, such as the applicant's son. In its report to the Portuguese Government on the visit to Portugal carried out from 7 to 16 February 2012 the CPT noted that the adoption of guidelines in June 2011 by the Ministry of Health was a step forward. However, they reiterated their recommendation that all forensic departments should establish a written policy on the use of means of restraint, in line with the Committee's earlier recommendations on this subject. The Committee also recommended that the necessary steps be taken to put an end to the practice of newly arrived patients at the HSC having to wear pyjamas.

# THE LAW

## I. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

80. The applicant complained that the authorities had failed to protect the right to life of her son in violation of Article 2 of the Convention. In particular, she argued that the hospital had been negligent in so far as it had not supervised him sufficiently, had not installed adequate security fencing to prevent him from leaving the grounds and had not provided for an adequate emergency procedure. Under Article 6 § 1 of the Convention she complained about the length of the civil proceedings she had brought against the hospital.

81. The Court considers that the applicant's complaints should be examined solely from the standpoint of the substantive and procedural aspects of Article 2, bearing in mind that, since it is master of the characterisation to be given in law to the facts of the case, it is not bound by the characterisation given by an applicant or a government (see *Radomilja*

*and Others v. Croatia* [GC], nos. 37685/10 and 22768/12, § 126, ECHR 2018).

82. Article 2 of the Convention, in so far as relevant to the present case, reads as follows:

> "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

## A. The substantive aspect

### *1. The Chamber judgment*

83. The Chamber held unanimously that there had been a violation of Article 2 of the Convention under its substantive limb. Having regard to A.J.'s clinical history and in particular the fact that he had attempted to commit suicide on 1 April 2000, the Chamber considered that the hospital staff had reasons to expect that he might try to commit suicide again. Another attempt to leave the hospital should therefore have been foreseen with the possibility of a fatal outcome in light of A.J.'s diagnosis.

84. While there was an emerging trend concerning persons with mental disorders to provide treatment in light of the principle of least restriction under an "open-door" regime, the Chamber considered that such "open-door" treatment could not exempt a State from its obligation to protect mentally ill inpatients from the risk they posed to themselves, in particular where there were specific indications that such patients might commit suicide. The Chamber considered that a difference should not be made as to the nature of the patient's hospitalisation. A voluntary inpatient was under the same care and supervision of the hospital and accordingly the State's obligation in his or her regard was the same as its obligation towards an involuntary inpatient. To say otherwise would be tantamount to depriving voluntary inpatients of the protection of Article 2 of the Convention.

85. The Chamber found that the two procedures in place, namely the procedure to check whether inpatients were present during meal and medication times, and the emergency procedure to search for missing inpatients on the hospital grounds and contact the family and police, had been ineffective in preventing A.J. from leaving and ultimately in preventing his suicide. In addition, the risk had been exacerbated by the open and unrestricted access to the railway platform. The hospital staff might have been expected to adopt more safeguards to ensure that A.J. did not leave the grounds. In this regard, the Chamber found that the instant case was distinguishable from *Hiller v. Austria*, no. 1967/14, 22 November 2016.

*2. The parties' submissions*

**(a) The applicant**

86. In her submissions to the Grand Chamber, the applicant reiterated that the surveillance procedures at the HSC, which consisted of counting the patients when they collected their respective meal trays through a relatively small opening in the wall, were inadequate. In addition, the emergency procedure was amateurish. The time between the meals, which was at least two hours, was enough for a patient to leave the pavilion and the hospital grounds and to commit suicide. This was what had in fact happened to A.J., whose presence had been noted at the afternoon snack at 4.45 p.m. and whose absence had only been checked at dinner time, at around 7 p.m., by which time he had already died.

87. As to the presence of doctors, patients were visited by a doctor only once a day, in the morning or in the afternoon and only when they did not have appointments or were not on emergency duty. The HSC did not have an emergency department. When a patient had a crisis, the HSC would contact the doctor on call, and he or she would decide if the patient should go to the emergency department of another hospital. In addition, according to the applicant, there was no psychologist on the HSC's therapy team, which negatively affected A.J.'s treatment. The applicant also underlined the poor diagnosis made of A.J.'s mental illness by the HSC over the years. This fact had been recognised by the domestic courts and was clearly stated in the judgment of the Administrative Court of Coimbra. Moreover, there were no updated or thorough medical records of A.J.'s clinical situation, of his evolution or of the care provided. A.J. had not received adequate psychological treatment. This could be seen from the clinical records, where on a number of occasions the care plan or evaluation was blank.

88. The applicant did not advocate a form of strict surveillance. According to her, the hospitalisation of psychiatric patients should balance therapeutic freedom on the one hand and the need for restraint on the other. A.J. had needed specific care with personal surveillance and measures of restraint. He had had a proven suicidal history and had exhibited repeated irresponsible behaviour.

89. The risk of A.J. committing suicide had been predictable or, at least, likely. The HSC had or should have known that A.J.'s life was at real and immediate risk. Treatment in an open regime could not relieve the State of its obligations to protect mental health patients from the risks they represented to themselves. Special vigilance had been required in his case.

90. The State's positive obligation under Article 2 to take preventive operational measures should be the same regardless of whether the inpatient was hospitalised on a voluntary or involuntary basis. Even where hospitalisation was voluntary, the patient was unequivocally under the State's protection. The State had an obligation to put in place a regulatory

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framework compelling both public and private hospitals to adopt appropriate measures and procedures.

91. As for the procedure in place for the HSC to request involuntary hospitalisation, a request could have been made by any doctor in the exercise of his or her functions or by the director of the health establishment.

92. Lastly, the applicant underlined that the examples provided by her from the press of patients escaping from the HSC were pertinent as they showed that the surveillance and the emergency procedures were deficient.

#### (b) The Government

93. The Government submitted that during A.J.'s last stay at the HSC from 2 April – 27 April 2000, he had been under the care of a psychiatrist and received daily medication. He had been seen by a doctor at least seven times during that period, and no references to suicidal thoughts had been noted in his clinical file. The care team, made up of doctors and nurses, had met every day to discuss each patient. Following his admission on 2 April 2000, and for approximately one week, A.J. had been confined to the pavilion, dressed in pyjamas and a dressing gown. Since an improvement in his condition had been noted, a less restrictive regime had been applied and during the second and third weeks of April 2000 he had been allowed to leave the pavilion after having informed the duty nurse. He had also been allowed to spend two weekends at home during that period.

94. The Government did not contest the fact that the HSC had had a duty to monitor and protect A.J., notably where there was likelihood of suicide, and in a way which was reasonable and proportionate. That duty also had to take into account the medical plan established for each patient and the patient's right to liberty. According to domestic law (see paragraph 58 above), involuntary hospitalisation could be ordered by a judge following a specific judicial procedure, either in the case of a serious mental disorder likely to endanger either the patient or a third person and where the patient refused to be treated on a voluntary basis, or in the case of persons who posed a danger to society and did not fall within the system of criminal punishment applied to those individuals who had committed a serious crime. The Government submitted that A.J. had not fallen into either category. The applicant had never applied for involuntary hospitalisation even though she knew that the HSC was an open hospital without fences and that when her son was hospitalised he could leave the grounds, sometimes coming home to her. Further, the Government submitted that according to the legal framework in place at the relevant time, the general principles of mental health policy provided for care in the least restrictive environment possible (see section 3 (b) of the Mental Health Act, paragraph 58 above).

95. According to the Government, the applicant was advocating the installation of walls and gates which would prevent patients leaving the hospital grounds in cases where they had suicidal tendencies. Given that suicidal tendencies were present in the majority of patients with psychiatric illnesses this approach would constitute a move towards a system of compulsory confinement. This approach was neither in conformity with current thinking in psychiatry, nor did it reflect relevant international legal norms on the matter. The best approach, according to the Government, was to accompany each patient personally with the least restrictive approach to hospitalisation, if possible providing treatment in the community; if not, within an open regime where the patient retained the right to move about freely. Indeed, even in cases of involuntary hospitalisation, it was accepted and recommended that patients be given some freedom of movement.

96. The Government submitted that it had not been proved that there existed a real and immediate risk of A.J.'s suicide on 27 April 2000, nor in the days preceding his death. According to the medical expert who had given evidence to the domestic courts, the risk of A.J.'s suicide, while present, had not been imminent, and the suicide could have been the result of an impulse. The doctor who had treated A.J. (Dr A.A.) had considered that the therapeutic relationship of confidence was adequate treatment. On 27 April 2000 A.J. had not exhibited any abnormal behaviour; he had walked around the hospital grounds and had taken all his meals, including his afternoon snack.

97. The Government highlighted the requirement set out in the Court's case-law that the positive obligation incumbent on the authorities should be interpreted in a way that did not impose an impossible or disproportionate burden on the authorities and accordingly not every claimed risk to life could entail a Convention requirement (*Osman v. the United Kingdom*, 28 October 1998, § 116, *Reports of Judgments and Decisions* 1998-VIII, and *Renolde v. France*, no. 5608/05, § 82, ECHR 2008 (extracts)). A permanent control of A.J.'s movements could have led to a violation of his other rights under the Convention (see *Hiller*, cited above, § 55). The system in place in the HSC, namely the monitoring of A.J. five times a day at meal times, in addition to the therapeutic regime, had been appropriate and proportionate.

98. The Government accepted that the positive obligation to protect patients from the danger they might represent to themselves or to third parties applied both in the case of patients who were hospitalised voluntarily and those hospitalised involuntarily. However, they submitted that in the case of patients who were hospitalised following a judicial order, and therefore involuntarily, such positive obligations assumed a special intensity and nature.

99. They submitted that the Court, in accordance with the principle of subsidiarity, should accept the findings of the national authorities, reached after a fair and adversarial national procedure, that A.J.'s suicide had not been foreseeable and that the care he had received from the HSC had been adequate.

100. Concerning whether or not A.J. had strong suicidal tendencies the domestic courts found that it had only been shown that A.J. had attempted suicide on one occasion, namely on 1 April 2000. The domestic courts also found that the internal rules for monitoring and triggering the emergency procedure were adequate and sufficient.

101. The Government confirmed that all patients (regardless of whether they were voluntarily or involuntarily hospitalised) could remain confined to their pavilion during a defined period depending on their symptoms. A patient could also be placed in an isolation room during periods of extreme agitation.

102. Lastly, the Government concluded that according to the current models for the treatment of psychiatric patients, which respected a patient's dignity and liberty, not all deaths could be avoided nor could the State be responsible for those which did occur.

### 3. *The Court's assessment*

#### (a) Preliminary remarks and the scope of the Court's assessment

103. The Court notes at the outset that the present case concerns an alleged act of medical negligence within the context of a suicide during a period of voluntary hospitalisation in a State psychiatric institution. Accordingly, two distinct albeit related positive obligations under Article 2, already developed in the jurisprudence of the Court, may be engaged. First, there exists a positive obligation on the State to put in place a regulatory framework compelling hospitals to adopt appropriate measures for the protection of patients' lives (see paragraphs 104-7 below). Second, there is a positive obligation to take preventive operational measures to protect an individual from another individual or, in particular circumstances, from himself (see paragraphs 108-15 below).

#### (b) General principles

104. The Court will set out the general principles guiding the above two obligations and subsequently assess the application of those principles in the instant case. The Court reiterates that the first sentence of Article 2, which ranks as one of the most fundamental provisions in the Convention and also enshrines one of the basic values of the democratic societies making up the Council of Europe, requires the State not only to refrain from the "intentional" taking of life, but also to take appropriate steps to safeguard

the lives of those within its jurisdiction (see *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 48, ECHR 2002-I).

*(i) The positive obligation to put in place a regulatory framework*

105. Firstly, in the particular context of health care, the Court has interpreted the substantive positive obligation of the State as requiring the latter to make regulations compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives. That positive obligation also requires an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable (see, among many other authorities, *Calvelli and Ciglio* [GC], cited above, and *Dodov v. Bulgaria*, no. 59548/00, § 80, 17 January 2008).

106. In the case of *Lopes de Sousa Fernandes v. Portugal* ([GC], no. 56080/13, § 165, ECHR 2017), the Grand Chamber recently reaffirmed and clarified the scope of the positive obligation on States pursuant to Article 2 in the context of alleged medical negligence in a hospital. Even in cases where medical negligence has been established, the Court would normally find a substantive violation of Article 2 only if the relevant regulatory framework failed to ensure proper protection of a patient's life. The Court reaffirmed that where a Contracting State had made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient could not be considered sufficient of themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life (§ 187, ibid).

107. The question whether there has been a failure by the State to comply with its above-mentioned regulatory duties calls for a concrete rather than an abstract assessment of any alleged deficiency. The Court's task is not normally to review the relevant law and practice *in abstracto*, but to determine whether the manner in which they were applied to, or affected, the applicant or the deceased gave rise to a violation of the Convention (see *Lopes de Sousa Fernandes*, cited above, § 188). Therefore, the mere fact that the regulatory framework may be deficient in some respects is not sufficient in itself to raise an issue under Article 2 of the Convention. It must be shown to have operated to the patient's detriment.

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*(ii) The positive obligation to take preventive operational measures*

108. Secondly, Article 2 may imply, in certain well-defined circumstances, a positive obligation on the authorities to take preventive operational measures to protect an individual from another individual (see *Osman*, cited above, § 115) or, in particular circumstances, from himself (see *Renolde*, cited above, and *Haas v. Switzerland*, no. 31322/07, § 54, ECHR 2011).

109. In *Osman*, the Court found that it must be established that the authorities knew or ought to have known at the time, of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (ibid., § 116).

110. In a series of cases where the risk derived not from the criminal acts of a third party, but from self-harm by a detained person, the Court found that a positive obligation arose where the authorities knew or ought to have known that the person posed a real and immediate risk of suicide. Where the Court found that the authorities knew or ought to have known of that risk it proceeded to analyse whether the authorities did all that could reasonably have been expected of them to prevent that risk from materialising (see *Hiller*, cited above, § 49, and *Keenan v. the United Kingdom*, no. 27229/95, § 93, ECHR 2001-III). Thus, the Court assesses whether, looking at all the circumstances of a given case, the risk in question has been both real and immediate.

111. The Court has already held in *Osman* that, bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising (see *Osman*, cited above, § 116).

112. At the same time, the Court reiterates that the very essence of the Convention is respect for human dignity and human freedom. In this regard, the authorities must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned and in such a way as to diminish the opportunities for self-harm, without infringing personal autonomy (see, *mutatis mutandis*, *Mitić v. Serbia*, no. 31963/08, § 47, 22 January 2013). The Court has acknowledged that excessively restrictive measures may give rise to issues under Articles 3, 5 and 8 of the Convention (see *Hiller*, cited above, § 55).

113. As regards mentally ill persons, the Court has considered them to be particularly vulnerable (see, *Renolde*, cited above, § 84). Where the authorities decide to place and keep in detention a person suffering from a mental illness, they should demonstrate special care in guaranteeing such conditions as correspond to the person's special needs resulting from his or her disability. The same applies to persons who are placed involuntarily in psychiatric institutions (see *Hiller,* cited above, § 48, with further references).

114. The Court has also been confronted with complaints on behalf of relatives of voluntary psychiatric patients. In *Reynolds v. the United Kingdom* (no. 2694/08, 13 March 2012), the applicant's son had been admitted as a voluntary inpatient, and subsequently killed himself by jumping out of a sixth-floor window due to psychotic symptoms. In finding a violation of Article 13 in conjunction with Article 2, the Court concluded that the applicant had not had civil proceedings available to her to establish any liability and compensation as regards her own suffering and her son's death (see § 67 of that judgment) and found that there was an arguable claim of a breach under Article 2 in the circumstances of a death following voluntary hospitalisation in a psychiatric institution. The Court in *Reynolds* did not explicitly find that the positive obligation to take preventive operational measures extended to voluntary psychiatric inpatients. However, it clearly did not exclude such a finding either. The Court is now called upon to decide that question in the present case.

115. Concerning suicide risks in particular, the Court has previously had regard to a variety of factors where a person is detained by the authorities (mostly in police custody or detention), in order to establish whether the authorities knew or ought to have known that the life of a particular individual was subject to a real and immediate risk, triggering the duty to take appropriate preventive measures. These factors commonly include:

i) a history of mental health problems (see *Volk v. Slovenia*, no. 62120/09, § 86, 13 December 2012; *Mitić*, cited above; and *Younger v. the United Kingdom* (dec.), no. 57420/00, ECHR 2003-I;

ii) the gravity of the mental condition (see *De Donder and De Clippel v. Belgium* no. 8595/06, § 75, 6 December 2011, and *Keenan*, cited above);

iii) previous attempts to commit suicide or self-harm (see *Renolde*, cited above, § 86; *Ketreb v. France*, no. 38447/09, § 78, 19 July 2012; and *Çoşelav v. Turkey*, no. 1413/07, § 57, 9 October 2012, and compare *Hiller,* cited above, § 52);

iv) suicidal thoughts or threats (see, for example, *Reynolds*, cited above, § 10);

v) signs of physical or mental distress (see *De Donder and De Clippel*, cited above, and compare *Younger*, cited above).

#### (c) Application of those principles to the instant case

*(i) The positive obligation to put in place a regulatory framework*

116. The Court firstly reiterates that its review of the domestic regulatory framework is not an abstract one, but rather one that assesses the manner in which it affected the applicant in the specific case (see paragraph 107 above).

117. As regards the applicant's complaint as to the lack of security fences and walls around the HSC, the Court, like the domestic courts, sees no reason to call into question the approach adopted by the HSC in this respect, which was in line with the Mental Health Act in place at the time (see paragraph 58 above). The latter indicated that mental-health care should be provided in the least restrictive environment possible. These general principles mirrored the therapeutic desire to create an open regime where the patient retained the right to move about freely. This approach is in line with the international standards which have been developed in recent years on treating psychiatric patients (see the International Law section above and see also *Hiller*, cited above, § 54). The Court further notes that the domestic legislation, the Mental Health Act of 24 July 1998 (see paragraph 58 above) provides for the possibility of involuntary hospitalisation where this may be justified by the specific needs of the patient. Irrespective of whether involuntary hospitalisation was required in order to avoid a real and immediate risk to A.J.'s life, the regulatory framework clearly provided the HSC with the necessary means of treatment to address A.J.'s possible medical and psychiatric needs.

118. While written guidelines in respect of restraint measures applicable to psychiatric patients were introduced only in 2011 (see paragraph 63 above), the Court does not see this as a deficiency which would in itself render the regulatory framework ineffective for the purpose of providing the necessary means for the protection of A.J.'s life.

119. In this respect, the Court draws a distinction between the quality of law requirements under Articles 3, 5 and 8 of the Convention where the negative aspect of the respective right is at stake and the duty to have a regulatory framework in place under Article 2 to protect a person from harm inflicted by third parties or by themselves. Quality of law under Article 5 § 1 implies that where a national law authorises deprivation of liberty it must be sufficiently accessible, precise and foreseeable in its application, in order to avoid all risk of arbitrariness (see *J.N. v. the United Kingdom*, no. 37289/12, § 77, 19 May 2016 and the references therein). The purpose of the regulatory framework requirement under Article 2 being different, namely providing the necessary tools for the protection of a patient's life, the lack of a written policy on the use of restraint measures is not determinative of its efficiency and does not in itself warrant a finding that Article 2 was breached. Moreover, it cannot be forgotten that A.J. was

admitted as a voluntary inpatient and the applicant's complaint does not relate to the particular period during which her son was under a restrictive regime. In consequence, the Court considers that there is no need to examine this issue further (see *Radomilja and Others*, cited above, § 126).

120. The Court is also unable to find any issue with the surveillance procedure in place for voluntary inpatients, which could justify a conclusion that alleged deficiencies resulted in A.J's death. The procedure consisted of establishing a clear daytime schedule to be followed by each individual patient and verifying a patient's presence at all meal and medication times, as well as general monitoring of patients by the staff on duty (see paragraphs 50-51 above). A more restrictive surveillance procedure was also available, applied at the beginning of a patient's stay and at other times when considered necessary by the treating doctor (see paragraph 54 above). When the more restrictive procedure was in place patients were not allowed to leave the pavilion and their movement was more strictly monitored by the nurses. Finally, in emergency situations, the HSC could have recourse to other forms of restraint, including the use of an isolation room. The existing surveillance procedure and the available restraint measures thus provided the HSC with the tools necessary for the treatment of A.J.

121. The Court also accepts the domestic court's finding that the surveillance procedure in place was intended to respect A.J.'s privacy and was in line with the principle of treating patients under the least restrictive regime possible. The Court itself has held that excessively restrictive measures with respect to psychiatric patients might give rise to issues under Articles 3, 5 and 8 of the Convention (see paragraph 112 above and *Hiller* cited above, § 55*)* and a more intrusive surveillance regime of A.J. could well have been challenged as being incompatible with those rights, particularly given his status as a voluntary inpatient.

122. As to the emergency procedure, it consisted of alerting the doctor on call, the police and the patient's family (see paragraph 52 above). At some time between 7 p.m. and 8 p.m. the coordinating nurse reported the disappearance to the attending doctor, Dr. M.J.P., who was on call that day (but not at the HSC at that time) and contacted the National Republican Guard and the applicant. The Court accepts the domestic court's finding that the emergency procedure in place was adequate and in any case finds no causal link between any alleged deficiencies in the emergency procedures and A.J.'s death. Accordingly, it finds that it was not deficient such as to raise an issue under Article 2.

123. Finally, the Court notes that the applicant had recourse to a judicial system which was able to determine who was accountable for A.J.'s death. The applicant lodged a civil action with the Coimbra Administrative Court and appealed a decision against her to the Administrative Supreme Court (see paragraphs 29-46 above). While issues were raised regarding the length of those civil proceedings, which are considered by the Court under the

procedural limb of Article 2 (see paragraphs 134-140 below), nothing in the case before the Court suggests a systemic deficiency in the functioning of the judicial system which denied the applicant an effective review of her civil claim.

*(ii) The positive obligation to take preventive operational measures*

124. There is no doubt that as a person with severe mental health problems A.J. was in a vulnerable position. The Court considers that a psychiatric patient is particularly vulnerable even when treated on a voluntary basis. Due to the patient's mental disorder, his or her capacity to take a rational decision to end his or her life may to some degree be impaired. Further, any hospitalisation of a psychiatric patient, whether involuntary or voluntary, inevitably involves a certain level of restraint as a result of the patient's medical condition and the ensuing treatment by medical professionals. In the process of treatment, recourse to further kinds of restraint is often an option. Such restraint may take different forms, including limitation of personal liberty and privacy rights. Taking all of these factors into account, and given the nature and development of the case-law referred to in paragraphs 108-115 above, the Court considers that the authorities do have a general operational duty with respect to a voluntary psychiatric patient to take reasonable measures to protect him or her from a real and immediate risk of suicide. The specific measures required will depend on the particular circumstances of the case, and those specific circumstances will often differ depending on whether the patient is voluntarily or involuntarily hospitalised. Therefore, this duty, namely to take reasonable measures to prevent a person from self-harm, exists with respect to both categories of patient. However, the Court considers that in the case of patients who are hospitalised following a judicial order, and therefore involuntarily, the Court, in its own assessment, may apply a stricter standard of scrutiny.

125. Accordingly, the Court must examine whether the authorities knew or ought to have known that A.J. posed a real and immediate risk of suicide and, if so, whether they did all that could reasonably have been expected of them to prevent that risk by putting into place the restrictive measures available (see *Keenan,* cited above, § 93). The Court will bear in mind the operational choices which must be made in terms of priorities and resources in providing public healthcare and certain other public services in the same way as it bears in mind the difficulties involved in policing modern societies (see paragraph 111 above).

126. As outlined in paragraph 115 above, the Court has established a list of relevant criteria concerning the assessment of suicide risks. It will look at these factors in the specific circumstances of the present case in order to establish whether the authorities knew or ought to have known that the life of the applicant's son was subject to both a real and an immediate risk, triggering the duty to take appropriate preventive measures.

127. Turning firstly to A.J.'s history of mental health problems, it is common ground that he had been hospitalised at the HSC, on a voluntary basis, on eight occasions between 1984 and 2000 (see paragraph 12 above). These stays generally followed crises or alcoholic intoxication, while only the last stay followed an attempted suicide. The domestic courts established that A.J. had suffered from several mental illnesses caused by a pathological addiction to alcohol and prescription drugs. It was also accepted that he sometimes suffered from depression. Following his death, the court-appointed psychiatrist (see paragraph 33 above) considered it possible that A.J had also suffered from a borderline personality disorder. Secondly, as to the gravity of A.J's mental health problems, it is clear, that A.J. had suffered from serious mental health problems over a long period (see *Renolde,* cited above, § 109).

128. As to suicidal thoughts or threats, the Court has no reason to reject the domestic court's finding that during the last days of his life, A.J. had not demonstrated any behaviour or mood which could have led the hospital staff to suspect that on 27 April 2000 his behaviour would be any different from the preceding days (see paragraph 40 above). Five hearings were held during which the domestic court heard numerous witnesses and subjected the collected evidence to a comprehensive review. The Court accepts therefore that A.J. had not displayed signs of suicidal thoughts throughout his stay at the HSC from 2 April 2000 onwards (see *Hiller,* cited above, § 52). The applicant argued in the domestic proceedings that A.J. had attempted to commit suicide again on 25 April 2000 by an excessive consumption of alcohol. This assertion was rejected by the domestic courts, which found that his behaviour leading to his being taken to the emergency department of the Coimbra University Hospital on 26 April 2000 had been "reckless" but not suicidal (see paragraph 40 above). The domestic courts reached this conclusion on the basis of comprehensive, relevant and persuasive analysis of the evidence which it had considered carefully. The Court accepts the domestic court's finding in respect of this episode, taking into account the fact that A.J. was a chronic alcoholic and that the drinking had occurred in the afternoon and mainly at a café. It accepts therefore the finding that A.J. attempted to commit suicide once - on 1 April 2000 - over three weeks before his death.

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129. Lastly, turning to signs of physical or mental distress, the clinical records for 27 April 2000 note that A.J. was calm, had been walking around the building in which he was hospitalised, had eaten well during lunch and had been present for his afternoon snack (see paragraph 22 above). Again, the Court accepts the findings of the domestic courts that there were no worrying signs in A.J.'s behaviour in the days immediately preceding his suicide (see paragraph 40 above).

130. The Court finds that the HSC were aware of A.J.'s long history of mental health problems and knew that, at times, he posed a risk to his own life. However, the Court also observes that while A.J. was vulnerable, he was in an environment which he had come to know well, interacting with staff whom he knew and who knew him. When the HSC considered that the risk he might pose to himself had diminished he was given the freedom to move around the HSC buildings and grounds and to return home for weekends to spend time with his family. There is no evidence to suggest that the family objected to A.J.'s weekends at home. When the risk was considered high, he was confined to the pavilion, in his pyjamas, and subject to a more restrictive regime. This had been the case after he was admitted to the HSC on 2 April 2000, when he spent the first week of his stay under the more restrictive regime (see paragraph 18 above) and on previous occasions in the past when he was hospitalised. However, the restrictive regime was always lifted when it was considered that A.J.'s symptoms were improving. This was in line with the HSC's general philosophy of giving patients a considerable degree of freedom of movement in order to increase their responsibility and optimise their return to their family environment and society itself. The Court has no reason to question the assessment of his treating psychiatric doctor, Dr. A.A., accepted by the domestic courts, that A.J.'s treatment, which consisted of taking his prescribed medication, receiving the treatment voluntarily, and establishing a relationship of trust (see paragraph 35 above) was appropriate and proportionate in the circumstances.

131. The Court concludes, in line with the assessment of the psychiatrist appointed by the Medical Association (see paragraph 33 above) that while a risk of suicide could not be excluded in inpatients such as A.J., whose psychopathological conditions were based on a multiplicity of diagnoses, the immediacy of that risk may vary. In the present case, the HSC sought to adapt to the risk posed by A.J.'s changing mental state by increasing or decreasing the monitoring regime in place. This was a decision which was taken by the team responsible for him (see paragraph 35 above). The Court refers to the factors enumerated in paragraphs 127-129 above. In addition, it takes into account the fact that according to the expert evidence, complete prevention of suicide in patients such as A.J. was an impossible task (see paragraph 33 above) and that the Coimbra Administrative Court found that A.J.'s suicide was not foreseeable (see paragraph 40 above). Moreover, the

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Court approaches the question of risk with a view to assessing whether it is both real and immediate and notes that the positive obligation incumbent on the State must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. In the light of these elements, the Court concludes that it has not been established that the authorities knew or ought to have known that there was an immediate risk to A.J.'s life in the days preceding 27 April 2000.

132. Accordingly, the Court does not need to assess the second part of the *Osman/Keenan* test, namely whether the authorities had taken measures which could reasonably have been expected of them.

##### (d) Concluding remarks

133. As regards the positive obligation to put in place a regulatory framework, the Court concludes that the manner in which the regulatory framework was implemented did not give rise to a violation of Article 2 in the circumstances of the present case. Concerning the obligation to take preventive operational measures, the Court concludes that it has not been established that the authorities knew or ought to have known at the time of the existence of a risk which was both real and immediate to A.J.'s life. In conclusion, the Court finds that there has been no violation of the substantive aspect of Article 2 of the Convention in the circumstances of this case.

### B. The procedural aspect

#### *1. The Chamber judgment*

134. The Chamber held that there had been a violation of the procedural limb of Article 2 of the Convention. The Government acknowledged that the domestic proceedings had been lengthy but failed to provide any plausible reason justifying the length. The Chamber referred to several long periods of inactivity. In particular, according to the Chamber, it took two years for the Coimbra Administrative Court to request an expert opinion on A.J.'s clinical condition; the first hearing took place on 8 October 2008, two years after the submission of the expert report to the file; and it took almost three years after that for the court to deliver its judgment.

#### *2. The parties' submissions*

##### (a) The applicant

135. The applicant contended that the delay in the proceedings represented a clear violation of Article 2. The applicant brought her civil claim against the HSC on 17 March 2003. Between 12 December 2003 and 11 January 2005, the case was at a standstill awaiting a court decision on the

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applicant's request to change certain parts of the preliminary decision (see paragraphs 31 and 32 above). Between 13 October 2005 and 16 June 2006 the case was delayed in order to obtain expert evidence (see paragraphs 32 and 33 above). The expert appointed had to wait over eight months for the court to send him the necessary elements for the establishment of his report. On 9 November 2007 the court set the hearing down for 8 October 2008. The procedural delay meant that the witnesses were questioned five years after the applicant brought the claim, and eight years after the facts took place. The applicant referred to further delays, namely, the time which elapsed between the proceedings being transferred to the Supreme Administrative Court on 11 October 2011 and the report of the Deputy Attorney General on 26 September 2012, as well as the delivery of the judgment by the Supreme Administrative Court on 29 May 2014.

**(b) The Government**

136. The Government accepted that the length of the proceedings was excessive. However, it considered that this was indicative of a violation of Article 6 § 1 of the Convention and not of Article 2.

*3. The Court's assessment*

**(a) General principles**

137. The procedural obligation under Article 2 in the context of health care requires, *inter alia*, that the proceedings be completed within a reasonable time (see *Lopes de Sousa Fernandes*, cited above, § 218). Knowledge of the facts and of possible errors committed in the course of medical care are essential to enable the institutions concerned and medical staff to remedy the potential deficiencies and prevent similar errors. The prompt examination of such cases is therefore important for the safety of users of all health services (see *Šilih v. Slovenia* [GC], no. 71463/01, § 196, 9 April 2009). Particularly in those cases concerning proceedings instituted to elucidate the circumstances of an individual's death in a hospital setting, length of proceedings is a strong indication that the proceedings were defective to the point of constituting a violation of the respondent State's positive obligations under the Convention, unless the State has provided highly convincing and plausible reasons to justify the length (see, for example, *Lopes de Sousa Fernandes,* cited above, § 219 and *Bilbija and Blažević v. Croatia*, no. 62870/13, § 107, 12 January 2016).

**(b) Application of those principles to the instant case**

138. The domestic proceedings lasted eleven years, two months and fifteen days for two levels of jurisdiction. The Court notes that the Government have conceded that the proceedings were excessively long and that a reasonable timeframe was not respected, even taking into account the alleged complexity of the proceedings and the rescheduling requested.

139. The Government have not provided any convincing and plausible reasons justifying the length of the domestic proceedings. In the present case witnesses were heard between eight and nine years after A.J.'s death and between six and seven years after the applicant had initiated the proceedings (see paragraph 35 above). The passage of time was capable of influencing the extent to which the witnesses could remember crucial facts relevant to the moments prior to A.J.'s death. Moreover, as the Court has recognised, promptness was important so that if deficiencies or errors were established they could be remedied for the future (see *Lopes de Sousa Fernandes*, cited above, § 218).

140. The Court concludes that there has been a violation of the procedural limb of Article 2 of the Convention.

## II. APPLICATION OF ARTICLE 41 OF THE CONVENTION

141. Article 41 of the Convention provides:

> "If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

### A. Damage

142. In the proceedings before the Chamber, the applicant claimed 703.80 euros (EUR) in respect of pecuniary damage, representing the expenses incurred for the funeral service. She also claimed EUR 40,000 corresponding to the loss of income sustained in respect of a monthly payment of EUR 200 that her son used to pay her. She further claimed EUR 40,000 in respect of non-pecuniary damage (EUR 30,000 in respect of the substantive violation of Article 2 and EUR 10,000 in respect of the procedural violation of Article 2).

143. The Chamber awarded the applicant in full the amount claimed in respect of the funeral service. However, as to the alleged loss of financial support, the Chamber did not discern any causal link between the violation found and the pecuniary damage alleged. As to the claim for non-pecuniary damage, the Chamber found it reasonable to award the applicant EUR 25,000 in respect of the anguish and distress suffered as a result of the

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circumstances of her son's death and her inability to obtain a domestic decision in a reasonable time.

144. Before the Grand Chamber, the applicant repeated the requests made before the Chamber in respect of pecuniary and non-pecuniary damage.

145. As regards pecuniary damage, the Court observes that the State was not found liable for the death of her son. Accordingly, as no causal link has been found between the actions of the HSC and A.J's death, no award is made in for her claim in respect of pecuniary damage.

146. Concerning non-pecuniary damage, it considers that the applicant must have experienced distress and frustration on account of the protracted nature of the domestic proceedings which she had brought to establish the cause of her son's death. The Court awards her EUR 10,000 under this head.

### B. Costs and expenses

147. Before the Chamber, as before the Grand Chamber, the applicant claimed EUR 409 for the costs and expenses incurred before the domestic courts, representing the legal fees she had paid. She submitted the relevant invoice in support of her claim. The Chamber awarded in full the sum claimed under this head, plus any tax that may be chargeable to the applicant.

148. According to the Court's case-law, an applicant is entitled to the reimbursement of costs and expenses only in so far as it has been shown that these have been actually and necessarily incurred and are reasonable as to quantum (see *Sargsyan v. Azerbaijan* (just satisfaction) [GC], no. 40167/06, § 61, 12 December 2017). In the present case, regard being had to the documents in its possession and the above criteria, the Court awards in full the sum claimed under this head, plus any tax that may be chargeable to the applicant. The applicant, who was granted legal aid for the proceedings before the Grand Chamber, submitted no claim for costs and expenses in relation to the proceedings before this Court.

### C. Default interest

149. The Court considers it appropriate that the default interest rate should be based on the marginal lending rate of the European Central Bank, to which should be added three percentage points.

FOR THESE REASONS, THE COURT

1. *Holds*, by 15 votes to 2, that there has been no violation of the substantive limb of Article 2 of the Convention;

2. *Holds*, unanimously, that there has been a violation of the procedural limb of Article 2 of the Convention;

3. *Holds*, unanimously,
   (a) that the respondent State is to pay the applicant, within three months, the following amounts:
      (i) EUR 10,000 (ten thousand euros), plus any tax that may be chargeable, in respect of non-pecuniary damage;
      (ii) EUR 409 (four hundred and nine euros), plus any tax that may be chargeable to the applicant, in respect of costs and expenses;
   (b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amounts at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;

4. *Dismisses,* by fifteen votes to two, the remainder of the applicant's claim for just satisfaction.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 31 January 2019.

Françoise Elens-Passos
Deputy Registrar

Guido Raimondi
President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the separate opinion of Judge Pinto de Albuquerque joined by Judge Harutyunyan is annexed to this judgment.

G.R.
F.E.P.

# PARTLY CONCURRING, PARTLY DISSENTING OPINION OF JUDGE PINTO DE ALBUQUERQUE JOINED BY JUDGE HARUTYUNYAN

1. I voted for a violation of both the substantive and the procedural limbs of Article 2 of the European Convention on Human Rights ("the Convention"). Whilst I can generally follow the majority's findings on the latter issue, I cannot share their views on the former issue, for factual and legal reasons. Regarding the facts, I will demonstrate that the majority's opinion is built on the assumption of facts that simply did not occur and, even worse, of a legal framework with a "general philosophy"[1] on the protection of the right to life of psychiatric inpatients that was patently inexistent. To put it simply, the majority's opinion was written for a country other than Portugal at the time of the events. The present judgment is the result of a creative exercise of judicial adjudication for an imagined country.

2. Regarding the law, I will show that the majority's opinion pursues the *Lopes de Sousa Fernandes*[2] ideologically charged minimalist approach to the State's positive obligations in the sphere of health care to its limits, this time regarding the particularly vulnerable category of psychiatric inpatients under State control. The effect is that of downgrading the level of Convention protection to an inadmissible level of State inertia.

## The obligation to put in place a regulatory framework

3. The State's positive obligation in the sphere of health care requires it to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives.[3] According to *Lopes de Sousa Fernandes v. Portugal*,[4] the State's obligation under Article 2 of the Convention in the context of health care includes a duty to create a regulatory framework to protect the patient. The majority follow this line of case-law.[5] Even assuming the existence of such a Convention obligation in the narrow terms that it was formulated in the judgment,[6] I find that the respondent State did not comply with it, for the following reasons.

4. Article XVII of Law no. 2006 of 11 April 1945 regulated the State obligation to protect the life of mentally ill patients in voluntary internment in public hospitals, providing for an open and a closed regime. This

1. See paragraph 130 of the judgment.
2. See *Lopes de Sousa Fernandes v. Portugal* (GC), no. 56080/13, ECHR 2017.
3. See *Calvelli and Ciglio v. Italy* (GC), no. 32967/96, § 49, ECHR 2002-I.
4. See *Lopes de Sousa Fernandes*, cited above.
5. See paragraphs 106 and 107 of the judgment.
6. Ibid.

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regulation was maintained by Article XXII of Law no. 2118 of 3 April 1963 and, after the revolution of 1974, Decree no. 127/92 of 3 July 1992 still referred to those regimes. The current Law – no. 36/98 of 24 July 1998 – repealed them, but they have remained in practice, without any legal basis.

5. With regard to the regulatory framework in Portugal and in particular the Hospital Sobral Cid ("the HSC") at the time of the facts, it is useful to cite the following passages from the report of the Committee for the Prevention of Torture ("the CPT"):

> "108. ... Patients could also be temporarily secluded (i.e. confined alone in a room). Seclusion, which never lasted for long periods, took place in the patient's own room or, if he shared a dormitory, in one of the individual bedrooms.
>
> 109. ... the CPT considers that *every instance of the physical restraint of a patient* should be recorded in a specific register established for this purpose. The entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff." (my italics)[7]

6. In 2003 and 2008 the CPT insisted, in general terms, on the need for a "detailed" and "written" policy on the isolation of psychiatric patients, for "all psychiatric hospitals", including "private psychiatric hospitals":

> "119. L'isolement des patients psychiatriques doit faire l'objet d'une politique détaillée ... Le CPT recommande aux autorités portugaises d'élaborer une telle politique."[8] ...
>
> "130. The CPT recommends that the Portuguese authorities take the necessary steps to ensure that *all psychiatric hospitals* have their own written policy on the use of means of restraint or implement the above-mentioned Protocol. This recommendation applies equally to private psychiatric hospitals." (my italics)[9]

7. Only in 2007 did the Ministry of Health introduce a protocol on the use of means of "mechanical restraint" in all Portuguese hospitals, including psychiatric hospitals (Circular No. 08/DSPSM/DSPCS), which was repealed and replaced in 2011 by new, broader guidelines of the Directorate General of Health no. 21/2011, of 6 June 2011, on the use of means of restraint of patients, which cover "seclusion and mechanical and chemical restraint" (*Orientação da Direção-Geral da Saúde no. 21/2011, de 6/06/2011 Prevenção de comportamentos dos doentes que põem causa a sua segurança ou da sua envolvente - Contenção de Doentes*).

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7. Portugal: Visit 1999, CPT/Inf (2001) 12 | Section: 38/47 | Date: 20/12/1999, C. Sobral Cid Psychiatric Hospital / 5. Means of restraint. This visit included the "general psychiatric department for men", where A.J. was placed several times (see paragraphs 17 and 79 of the judgment).

8. Portugal: Visit 2003, CPT/Inf (2007) 13 | Section: 37/47 | Date: 30/07/2004, C. *Structures psychiatriques pénitentiaires* / 6. *Moyens de contention et recours à l'isolement*.

9. Portugal: Visit 2008, CPT/Inf (2009) 13 | Section: 36/44 | Date: 24/07/2008, C. Psychiatric institutions / 4. Means of restraint.

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The guidelines refer to five types of restraint: therapeutic (control of the patient's physical activity or behaviour or of part of his or her body), environmental (control of the patient's freedom of movement, for instance in a restricted space, like an isolation room (*sala de confinamento*) where the patient can move around safely under clinical supervision), physical (seizing, removing or blocking a patient in order to avoid a situation of risk), mechanical (use of instruments that restrict movement) and chemical (medication that inhibits the patient's movements). According to point 9 of the guidelines, each hospital should prepare internal guidelines implementing the national guidelines in accordance with the specific health care provided by each hospital. The reasons for the guidelines were expressed as follows:

> "There is evidence that restraint is one of the most commonly used practices at an international level for the care of patients with behaviours involving a risk for themselves or for those around them. From the various studies carried out on this subject, the need to prevent incidents and adverse events associated with restraint measures stands out. Simultaneously, the benefits for the promotion of safety that may result from training in a professional context and recourse to these measures are documented."

8. In a 2012 visit to Portugal, the CPT reacted to the new framework as follows:

> "107. In its reports on the 2003 and 2008 visits, the CPT recommended that a policy for the use of means of restraint be adopted. The adoption of guidelines in June 2011 by the Ministry of Health on the use of means of restraint[10] is a step forward. They cover seclusion, mechanical and chemical restraint, and replace an earlier protocol of 2007 on mechanical restraint.[11] However, it is regrettable that the guidelines do not explicitly address many important aspects, such as: the types of cases in which means of restraint may be used; the requirement that any application of means of restraint must always be either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his approval; the duration of restraint and the need for frequent review, appropriate human contact and increased supervision by staff; the establishment of a specific register for the use of means of restraint (in addition to recording the measure in the patient's file or nurses journal). The 2011 guidelines were yet to be implemented in the forensic psychiatric hospitals visited and they did not in any event apply to the Psychiatric Hospital of Santa Cruz do Bispo Prison, which was under the authority of the Ministry of Justice. The CPT recommends that the Portuguese authorities take the necessary steps to ensure that all forensic psychiatric hospitals - including those under the Ministry of

10. *Orientação da Direção-Geral da Saúde número* 021/2011, *data* 06/06/2011 "*Prevenção de comportamentos dos doentes que põem causa a sua segurança ou da sua envolvente - Contenção de Doentes*".

11. May 2007 Ministry of Health protocol on the use of means of mechanical restraint (Circular No. 08/DSPSM/DSPCS), see footnote 59 of CPT/Inf (2009) 13.

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Justice - establish a written policy on the use of means of restraint, in line with the Committee's earlier recommendations on this subject."[12]

9. As a matter of fact, the guidelines adopted in June 2011 by the Ministry of Health on the use of means of restraint were not applied systematically in the country[13]. Worse still, even in the case of persons in voluntary internment, inpatients were not heard about the application of such regimes[14]. Medical staff did as they pleased when they pleased.

On the use of means of restraint and the use of pyjamas, the CPT could not be clearer, insisting notably on the need for a centralised register for "all forms" of use of restraint "in every psychiatric establishment":

> "111 ... The CPT reiterates its recommendation that *every resort to restraint*, including chemical restraint, must always be expressly ordered by a doctor or immediately brought to the attention of a doctor. The prescription of "SOS medication" can never justify such medication being used as a chemical restraint.
>
> 112. Another restriction of freedom of movement applied to patients in both forensic departments was a surveillance measure, known as the "pyjama" regime. Patients under that regime had to remain dressed in pyjamas during the entire day and were not allowed access to the courtyard. The "pyjama" regime was applied at Lisbon Central and Sobral Sid Hospitals during the first two weeks following the patient's admission to the institution. It could also be applied at Sobral Sid Hospital to patients who had shown aggressive behaviour or violated certain house rules (i.e. smoking indoors) for periods of one or more days; in these cases, the decision of the application of the special surveillance regime was taken on an ad hoc basis by the staff on duty and was not surrounded by clear procedures and safeguards.
>
> In the CPT's view, the systematic use of pyjamas as a means of surveillance of newly arrived patients is highly questionable. Other supervision methods for newly arrived patients should be applied without restricting their freedom of movement. The Committee recommends that the necessary steps be taken *to put an end to the practice of newly arrived patients* at Lisbon Central and *Sobral Sid Hospitals having to wear pyjamas*.
>
> 113. As regards registers, it is noteworthy that a centralised electronic register of the use of mechanical restraint had been introduced at Lisbon Central Psychiatric Hospital. However, it only included statistical information on the frequency of restraint measures in the different wards and no specific details on, for example, the duration or type of measure applied. At Sobral Sid Hospital, there was no specific register for recording cases of resort to means of restraint. In both hospitals visited, references to the use of mechanical restraint were made in the nurses' journal and occasionally in the patient's file; however, these references were often cursory and there was no mention of the time of beginning and ending the measure.

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12. Portugal: Visit 2012, CPT/Inf (2013) 4 | Section: 38/45 | Date: 25/07/2012, C. Psychiatric institutions for forensic patients / 6. Seclusion and means of restraint / a. policy on the use of means of restraint.
13. CPT report on the 2012 visit to the HSC, paragraph 107.
14. CPT report on the 2012 visit to the HSC, paragraph 123.

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> The CPT has raised this matter on several occasions[15]; it is regrettable that the 2011 guidelines by the Ministry of Health on the use of means of restraint (see paragraph 107 above) do not provide for a centralised register for *all forms of use of restraint - including seclusion, mechanical and chemical restraint - in every psychiatric establishment*. The CPT calls upon the Portuguese authorities to take the necessary steps to ensure that *every instance of restraint of a patient* is recorded in a specific register in every psychiatric establishment. The entry in this register should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to such a measure, the type of measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.[16]
>
> 123. ... The CPT must recall once again its position that the admission of a person to a psychiatric establishment on an involuntary basis, whether the person concerned be a civil or a "forensic" patient, should not be construed as authorising treatment without his/her consent. Every competent patient, *whether voluntary* or involuntary, should be fully informed about the treatment which it is intended to prescribe and be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances. The Committee calls upon the Portuguese authorities to take the necessary steps to review the relevant legislation in the light of these remarks."[17] (my italics)

10. It is highly significant that the CPT set standards that should be used in "every" psychiatric establishment with "every competent patient, whether voluntary or involuntary", such as "Every competent patient, whether voluntary or involuntary, should be fully informed about the treatment which it is intended to prescribe and be given the opportunity to refuse treatment or any other medical intervention" or calling upon the Portuguese authorities to ensure that "every instance of restraint of a patient is recorded in a specific register in every psychiatric establishment" or stating that "every resort to restraint, including chemical restraint, must always be expressly ordered by a doctor or immediately brought to the attention of a doctor". Likewise, it reproaches shortcomings in the psychiatric internment of both voluntary and involuntary patients, such as the decision to apply a special surveillance regime "on an ad hoc basis by the staff on duty" and "not surrounded by clear procedures and safeguards", the systematic use of pyjamas as a means of surveillance of newly arrived patients and the lack of a centralised register for all forms of use of restraint – including seclusion, mechanical and chemical restraint – in every psychiatric establishment.

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15. Similar observations on this matter have been made after the CPT's visits in 1999, 2000 and 2008 to Portugal, see CPT/Inf (2009)13, paragraph 129.

16. Portugal: Visit 2012, CPT/Inf (2013) 4 | Section: 39/45 | Date: 25/07/2012, C. Psychiatric institutions for forensic patients / 6. Seclusion and means of restraint / b. forensic departments of Sobral Cid and Lisbon Central Psychiatric Hospitals.

17. Portugal: Visit 2012, CPT/Inf (2013) 4 | Section: 39/45 | Date: 25/07/2012, C. Psychiatric institutions for forensic patients / 7. Safeguards / b) safeguards during placement.

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11. Hence, it is certainly not correct to limit the scope of the CPT's standards to patients in compulsory treatment ordered by a criminal court[18]. All of the above-mentioned information was ignored by the majority in their assessment of the substantive aspect of the present case, as was the fact that the first national mental health programme (2007-2016) was approved by the Council of Ministers resolution 48/2008 of 24 January 2008. In a 55-page document, there are nine references to suicide and a very vague provision for the future creation of suicide prevention programmes. It provides for three psychiatric hospitals for the entire country: Magalhães de Lemos (Porto), Sobral Cid (Coimbra) and Júlio de Matos (Lisbon) and 39 psychiatric departments in general hospitals. Decree no. 1490/2017 provided for an evaluation of the implementation of the plan with a view to establishing its follow-up until 2020. That evaluation assessed the situation as follows:

> "Assessment of the national plan on mental health 2007-2016 (*Avaliação do Plano Nacional de Saúde Mental 2007-2016*): "absence of efficient coordination of elements of the mental health care system, with persistent asymmetries in the concentration of human resources in the central hospitals; ... reduced autonomy of local and regional decision making centres; ... weak implementation of the network of continued and integrated mental health care; inexistence of incentives to put in place community interventions."[19]

12. The first national programme for the prevention of suicide (2013-2017) follows the *WHO Public Health Action for the Prevention of Suicide* (2012)[20]. For the first time, a national strategy to counter suicide was designed with specific recommendations for groups and individuals at risk, including people with mental disabilities, monitoring instructions and implementation evaluation directives.

13. In other words, in 2000 Portugal was in the pre-historic stages of suicide prevention of psychiatric inpatients. There was no legislation or regulation on what types of regimes could be applied, under what circumstances, by whom and until when. The regulatory protocol on measures to protect patients applicable in all psychiatric facilities dates from 2011 and has not been regulated at the level of each hospital, as was supposed to happen. That protocol is manifestly insufficient with regard to the international standards set by the CPT. Thus, there was and still is no clear legal framework regarding the State obligation to protect the life of mentally ill patients in voluntary internment in public hospitals like the HSC. To put it simply, in 2000 the HSC was in a legal black hole.

14. Having ignored the facts on the ground, the majority excuse the respondent State with two arguments: they claim that the approach adopted by the HSC regarding the lack of fences and walls was in line with the

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18. See paragraphs 78 and 79 of the judgment.
19. See http://www.sns.gov.pt
20. See www.dgs.pt

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Mental Health Act in place at the time, which allegedly mirrored international standards. This is simply not correct. As demonstrated above, the international standards set by the competent body, the CPT, were not duly complied with until 2011, and even then only partly. Thus, it is only possible to affirm that "the regulatory framework clearly provided the HSC with the necessary means of treatment to address A.J.'s possible medical and psychiatric needs"[21] if one seriously misreads the CPT's reiterated message to Portugal. Furthermore, the argument that the Mental Health Act provided for the possibility of involuntary hospitalisation and therefore for A.J.'s possible medical and psychiatric needs misses the point made by the applicant. The applicant never argued that her son should have been locked up. Rather, she claimed that her son did not need a form of strict surveillance, but a specific personal care regime accompanied by measures of restraint that would provide a sufficient guarantee of his medical as well as his safety needs.[22]

15. On the crucial issue of the inexistent guidelines on the use of restraint measures applicable to voluntary psychiatric patients in 2000, which was discreetly downplayed by the Government until the specific question came to the fore at the Grand Chamber hearing, the response of the majority is astonishing: they do not see it as a "deficiency" that would lead to a violation of Article 2, because this shortcoming is, in their view, only relevant for the purposes of the assessment of the quality of the law under Article 5 of the Convention. According to this view, the lack of a written policy on the use of restraint measures could lead to a violation of Article 5, but did not warrant a conclusion of a violation of Article 2, even when the lack of precise and foreseeable regulation of the use of restraint measures puts at risk the life of psychiatric inpatients under State supervision. This argument leads to the illogical conclusion that the more important (Article 2) right merits less protection than the less important (Article 5) one.

16. But the most amazing part of the judgment is yet to come. In paragraph 120 the so-called "existing surveillance procedure" is in fact a creation *ab ovo* of the majority. There were no rules regulating such a "surveillance procedure"; indeed no such "surveillance procedure" existed, let alone a "more restrictive procedure" or a procedure for "emergency situations", simply because every decision taken by the medical and nurse staff was on an *ad hoc* basis, as the CPT confirmed on the ground as recently as 2012.[23] Paragraph 120 of the judgment is, as much as its source in the facts part (paragraph 54), an inventive description of a virtual reality. Similarly, it is overstretched to claim, as the majority do in paragraph 49 of the judgment, that the user's guide "set out the rules governing their

21. See paragraph 117 of the judgment.
22. See paragraph 88 of the judgment.
23. See above, paragraph 112 of the 2012 CPT report.

hospitalisation". In reality, the document only contains "useful information for you to feel good in this Hospital" (*informações úteis para que se sinta bem neste Hospital*), namely a collection of practical information for users, with no normative character.[24] The majority are of course entitled to their own opinion on the facts, but they are not entitled to their "own facts".

17. It is true that, in the file, the medical staff and the Government referred to an "open regime" and a "closed regime", but nowhere in the law or administrative regulations was the State obligation to apply one of these regimes set out. The best evidence of this chaotic state of affairs is the contradictory way the Government themselves refer to the "closed regime" (*regime fechado*). Initially, they argued that the closed regime could have been applied to A.J., but had not been applied because it was not "adequate"[25]. Later on, the Government argued that the closed regime could only be applied to patients in involuntary internment[26], but they also admitted that A.J., who was a voluntary inpatient, had been "confined to the respective pavilion, dressed with pyjamas and robe" (*confinado ao respetivo pavilhao, permanecendo vestido com pajama e roupao*) in April 2000 and that only in the second and third weeks of April had he been allowed to leave the pavilion[27].

18. The *a priori* intention of the majority is clear, and was set in stone in paragraph 122 of the judgment: acting as a first-instance court, the majority find that there is no causal link between "any alleged deficiencies in the emergency procedures and A.J.'s death", even before approaching the question of the *in concreto* assessment of the existence of a "real and immediate"[28] risk to the life of the applicant's son and the need for adequate preventive operational measures to be taken. The judgment could have ended there. But the majority imposed on the applicant the pain of having to go through the second part of the substantive aspect of "The Law" part of the judgment (paragraphs 124-32) where she has to read that her son's first frustrated suicide attempt and his severe alcoholic intoxication crisis on the eve of the second – and successful – suicide attempt were not serious enough to deserve the full attention of the Portuguese State and therefore the majority could wash their hands of this case.

24. I cite from the document itself, which is included in page 35 of the Government's observations before the Grand Chamber.
25. See paragraph 104 of the Government's observations before the Chamber.
26. See paragraph 130 of the Government's observations before the Grand Chamber.
27. See paragraphs 21 and 85 of the Government's observations before the Grand Chamber.
28. See paragraph 131 of the judgment.

**The obligation to take preventive operational measures**

19. The majority propose to follow the *Osman* test[29] for the assessment of the positive obligation to take preventive operational measures. According to the *Osman* criteria, the extreme vulnerability of the victim must be taken into consideration.[30] The test was first applied in a suicide case in *Keenan v. the United Kingdom*.[31] In a later case the Court found a violation of Article 13 in conjunction with Article 2 in a case of lack of civil proceedings to establish liability and compensation when there was an arguable claim of a breach of that Article owing to the suicide of a voluntary inpatient in a psychiatric institution.[32] The present case is the first one where the Court has established the State's positive obligation under Article 2 to take operational measures in respect of voluntary psychiatric inpatients at risk of committing suicide.

20. The majority not only affirm that positive obligation, but qualify it in the case of involuntary hospitalisation, in the sense that the Court "may apply a stricter standard of scrutiny" of the duty to take reasonable measures to prevent a person from committing suicide.[33] Conversely, this of course means that the Court will take a hands-off approach regarding the scrutiny of voluntary psychiatric inpatients at risk. I fail to see the reason for this differentiation of treatment and the majority do not even make the effort to provide one. This justification should have been provided by the Grand Chamber, if only because it contradicts the unanimous Chamber decision. The Chamber had proffered the opposite view, namely that voluntary and non-voluntary inpatients should be treated equally, because:

> "regardless of whether the hospitalisation was of a voluntary or an involuntary nature, and in so far as a voluntary in-patient is under the care and supervision of the hospital, the State's obligations should be the same. To say otherwise would be tantamount to depriving voluntary in-patients of the protection of Article 2 of the Convention".[34]

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29. See *Osman v. the United Kingdom*, 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII). I have been pleading for a reform of the *Osman* test (*Valiulienė v. Lithuania*, no. 33234/07, 26 March 2013, and *Lopes de Sousa Fernandes*, cited above, § 63). In the present case, for the sake of simplification, I will not enter into this discussion.
30. See *Van Colle v. the United Kingdom*, no. 7678/09, § 91, 13 November 2012.
31. See *Keenan v. the United Kingdom*, no. 27229/95, ECHR 2001-III.
32. See *Reynolds v. the United Kingdom*, no. 2694/08, 13 March 2012.
33. See paragraph 124 of the judgment.
34. See *Fernandes de Oliveira v. Portugal*, no. 78103/14, §73, 28 March 2017. The degree of respect for such a decision is shown also in the fact that it is not even mentioned when the majority discuss the issue in paragraph 124 of the present judgment.

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21. The argument that there is an emerging trend to treat persons with mental disorders under an "open door" regime is not decisive[35]. First, it only shows one side of the coin, because there is also a counter-trend to increase State obligations with regard to suicide prevention, which is totally neglected by the majority, as I will demonstrate below[36]. The core of the problem today lies precisely in the inter-relationship between these two different trends of international health law and practice, which the majority do not even seek to consider.

Moreover, as put by Judge Iulia Antoanella Motoc, dissenting in *Hiller*, "the duty to protect the right to life should not be sacrificed in an attempt to comply with the above-mentioned recent trend in healthcare"[37]. The right to life prevails over the right to liberty, especially when the psychopathological condition of the individual limits his or her capacity for self-determination. It is nothing but pure hypocrisy to argue that the State should leave vulnerable suicidal inpatients in State-run psychiatric hospitals free to put an end to their lives merely in order to respect their right to freedom. At the end of the day, what really drives the majority is not the concern for more or less freedom of psychiatric inpatients interned in public hospitals, but the strict financial interest in safeguarding the hospital

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35. See the academic literature on the new mental health paradigm, Davidson, "An international comparison of legal frameworks for supported and substitute decision-making in mental health services" (2016) 44 *International Journal of Law and Psychiatry*, 30-40; Richardson, "Mental Disabilities and the Law: From Substitute to Supported Decision Making?"(2012) *Current Legal Problems*, 1-22; Richardson "Mental Capacity at the Margin: The Interface between Two Acts" (2010) 18 *Medical Law Review* 56-77; Donnelly, *Healthcare Decision-Making and the Law.* Cambridge: Cambridge University Press, 2010; McSherry and Weller (eds), *Rethinking Rights-Based Mental Health Laws*, Oxford: Hart Publishing, 2010; Nuffield Council on Bioethics, *Dementia: Ethical Issues*, London: Nuffield Council on Bioethics, 2009; Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge*, Cambridge: Cambridge University Press, 2008; Fistein, et al, "A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions" (2000) 32 *International Journal of Law and Psychiatry*, 147-55; and Mackenzie and Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self*, New York: Oxford University Press, 2000.

36. The standards to which I refer were set out in the *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm*, Geneva: World Health Organization, 2016; *Preventing suicide: a global imperative*. Geneva: World Health Organization, 2014; *Mental Health Action Plan 2013−2020*. Geneva: World Health Organization, 2013; *Preventing suicide, a resource for general physicians*, World Health Organization, 2000 (with precise indications on management of patients); *Preventing suicide, a resource for primary health care workers*, World Health Organization, 2000 (with precise indications on how to manage suicidal patients); *Primary prevention of mental, neurological and psychosocial disorders. Chapter 4: Suicide*, World Health Organization, 1998; and *Prevention of suicide: guidelines for the formulation and implementation of national strategies*, New York (NY): United Nations, 1996.

37. See the dissenting opinion of Judge Iulia Antoanella Motoc in *Hiller v. Austria*, no. 1967/14, 22 November 2016.

authorities from legal challenges to "excessively restrictive measures"[38], while "bearing in mind the operational choices which must be made in terms of priorities and resources in providing public healthcare and certain other public services".[39] Ultimately, this reflects a hidden social-welfare disengagement policy, which aims at the maximum commodification of health-care services and above all at the protection of health professionals in an untouchable legal bubble, shirking State responsibility for health-system and hospital-related death or serious injury under the Convention and consequently limiting the Court's jurisdiction in this area. In other words, the present judgment signs up to the exact same ideological agenda as *Lopes de Sousa Fernandes*.[40]

22. As acknowledged by the majority themselves, A.J. was an especially vulnerable person.[41] Several factors indicating his extreme vulnerability evidently aggravated the imminence and foreseeability of the suicide, such as, first and foremost, the fact that A.J. had attempted suicide recently. On 1 September 1999 there was already a note in his "medical file"[42] indicating "probability of attempt to his physical and psychological integrity due to deprivation of alcohol". As the Deputy Attorney-General before the Supreme Court wrote in his opinion, "A.J.'s medical report, alone, already had references to suicide attempts, one of which had occurred twenty-five days earlier. Thus it was possible to predict a repetition of those."[43]

On 1 April 2000 he attempted to commit suicide.[44] This is the note recorded in his medical file on that day after the attempted suicide: he "feels that life has no value, feels marginalized and powerless to realise a life project, hence prefers to die, which he attempted to concretise".[45] He clearly "preferred to die", because he felt "marginalized and powerless"

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38. See paragraph 121 of the judgment.
39. See paragraph 125 of the judgment.
40. See my separate opinion in *Lopes de Sousa Fernandes*, cited above, §§ 64, 73 and 74.
41. See paragraph 124 of the judgment; see also *Renolde v. France*, no. 5608/05, § 84, ECHR 2008 (extracts), considering mentally ill persons as particularly vulnerable.
42. It is clearly overstretched to call the bunch of incomplete, confused, unorganised, sometimes almost unreadable copies that the Government put at the disposal of the Court as a "medical file", but I will use this expression for ease of reference. The chaotic state of this "file" reflects well the quality of health care provided to A.J.
43. See paragraph 43 of the judgment.
44. According to the WHO, "It is estimated that, for each suicide, there are likely to have been more than 20 suicide attempts. Having engaged in one or more acts of attempted suicide or self-harm is the single most important predictor of death by suicide. …The extent to which cases become known is often compared to an iceberg, where only the tip is visible (suicide, suicide attempts and self-harm presenting to hospitals, and suicide attempts and self-harm presenting to primary care services) while the majority of suicide attempts remain "hidden" under the surface and remain unknown to health services" (*Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm*, Geneva: World Health Organization, 2016, page 6).
45. See note in the medical file of 1 April 2000.

(*marginalisado e sem poder*). As a matter of fact, A.J. had expressed several times a sense of profound hopelessness, especially after losing the possibility of getting a job as a heavy vehicle driver, which led to the attempted suicide.[46]

In *Renolde v. France* the gap between the two suicide attempts – the failed and the successful one – was of eighteen days[47]. In the case of A.J. that gap was of twenty-six days, with an episode of serious self-harm in between, two days before the suicide. In view of the rationale in *Renolde* that the risk was real and that a positive obligation to take preventive operational measures should be imposed regardless of the fact that his "condition and the immediacy of the risk of a fresh suicide attempt varied"[48], I ask myself why this was not the case for A.J.'s risk.

23. Secondly, A.J. was a schizophrenic and suffered from "major depression".[49] This was established by the domestic courts. The first time that such a diagnosis of schizophrenia was formulated was as early as 6 September 1999, well before the first suicide attempt.[50]

In *De Donder and De Clippel v. Belgium*, [51] the Court considered paranoid schizophrenia as involving a high and foreseeable risk of suicide.

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46. According to the WHO, the "individual key risk factors" are the following: "Previous suicide attempt, mental disorders, harmful use of alcohol, job or financial loss, hopelessness, chronic pain, family history of suicide, genetic and biological factors … Hopelessness, as a cognitive aspect of psychological functioning, has often been used as an indicator of suicidal risk when coupled with mental disorders or prior suicide attempts (113. The three major aspects of hopelessness relate to a person`s feelings about the future, loss of motivation and expectations. Hopelessness can often be understood by the presence of thoughts such as "things will never get better" and "I do not see things improving", and in most cases is accompanied by depression (114)." (*Preventing suicide: a global imperative*,World Health Organization, Geneva, 2014, pages 31 and 40).

47. See *Renolde*, cited above, § 86.

48. See *Renolde*, cited above, § 89: " … that risk was real and that Joselito Renolde required careful monitoring in case of any sudden deterioration." See also *Keenan*, cited above, § 96: "The immediacy of the risk varied, however. Mark Keenan's behaviour showed periods of apparent normalcy or at least of ability to cope with the stresses facing him. It cannot be concluded that he was at immediate risk throughout the period of detention. However, the variations in his condition required that he be monitored carefully in case of sudden deterioration."

49. Not only "depression", as downplayed in paragraph 127 of the judgment, but "major depression" See the expert report in the domestic administrative court proceedings cited in paragraph 33 of the judgment.

50. See the expert report in the domestic administrative court proceedings cited in paragraph 33 of the judgment. According to the WHO, "People with mental disorders experience disproportionately higher rates of disability and mortality. For example, persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended [such as cancers, cardio vascular diseases, diabetes and HIV infection] and suicide." (*Mental Health Action Plan 2013−2020*. Geneva: World Health Organization, 2013, paragraph 11.)

51. See *De Donder and De Clippel v. Belgium*, no. 8595/06, 6 December 2011.

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In that case, the Court found a violation of Article 2 even without a previous attempt to commit suicide, because it considered that "*Certes l'immediateté d'un tel risque était difficile à percevoir, mais ce critére ... ne saurait entrer peremptoirement en jeu en matiere de suicide*".[52] Again, I fail to understand the reason why immediacy of the risk was not the decisive criterion in the Belgian case, but was strictly observed in the present Portuguese case[53], in which the patient accumulated both high-risk factors of the *Renolde* and *De Donder* cases.

The above would suffice to raise the legitimate question whether the Court discriminates between first and second-class patients, since there is no justification for this difference of treatment between A.J. and the Belgian and French patients. The question is evidently not rhetorical, and is even more pressing in view of the following arguments that show that a wrong was done to A.J. that was never righted.

24. Thirdly, the domestic courts concluded that the suicide was not foreseeable because A.J. had never been properly diagnosed. In other words, the lack of timely and adequate diagnosis by the State serves as an excuse for the State not to foresee the risk of suicide. This is a typical Catch-22 situation, where the State uses its own faulty omission to excuse itself for the resulting harm. The startling justification given by his psychiatrist (Dr A.A.) was that he was not A.J.'s doctor long enough to make a more precise diagnosis of A.J.'s mental condition[54], in spite of the fact that he became his psychiatrist in December 1999, four months before the suicide.

The most disheartening thing is that the State did perform such a diagnosis, but only after A.J. was dead.[55] A.J. was diagnosed with a borderline personality disorder only after he committed suicide![56] This was, in the words of the court-appointed medical expert, "an individual prone to conflict and easily irritable ... aggressive towards his family (mother and sister), losing his temper for no reason and without being under the influence of alcohol ... This aggressiveness is sometimes turned against himself – his clinical file refers to recurring suicide attempts ...".[57]

25. Fourthly, A.J. had a long history of drug and alcohol abuse. He committed suicide on 27 April 2000. On 25 April 2000, two days before his

52. Ibid., § 76.
53. The majority do not even clarify the time frame being examined in relation to the risk assessment: is it the "last days of his life" (see paragraph 128), the "preceding days" (ibid.), or the "the days immediately preceding his suicide" (see paragraph 129)? What is the exact time frame relevant for this purpose?
54. See testimony of Dr A.A. annexed to the file.
55. See paragraph 33 of the judgment.
56. See paragraphs 11 and 40 of the judgment.
57. See the report of the court-appointed medical expert of 27 September 2006 annexed to the file.

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suicide, he had a typical "deliberate self-harm episode" of alcohol abuse.[58] Subsequently, no medical doctor assessed the consequences of that incident in terms of the need for increased monitoring of A.J. He was left to linger in his despair, abandoned to his "aggressiveness", which was "sometimes turned against himself" to use the words of the court-appointed expert.

26. Fifthly, A.J. was a young man and, according to the WHO, "Suicide is the second most common cause of death among young people worldwide. ... Moreover, young people and the elderly are among the most susceptible age groups to suicidal ideation and self-harm."[59]

27. Last, but certainly not least, A.J. was a patient already classified with a risk assessment of "GD 3" (*Grau de Dependência 3*), meaning "dependency degree three", by the HSC itself[60]. Dependency degree three "corresponds to the patient who needs intensive or total assistance in acute

58. According to the WHO, "On the basis of the definition, the inclusion criteria are as follows (i.e. the following are considered to be cases of intentional self-harm or suicide attempt): All methods of intentional self-harm (as per ICD-10 coding, Table 3.1) (e.g. alcohol overdose, illicit drug overdose, ingestion of pesticides, laceration, attempted drowning, attempted hanging, gunshot wound) where it is clear that the self-harm was intentionally inflicted." (*Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm*, Geneva: World Health Organization, 2016, page 33); and see also *Mental Health Gap Action Programme, Scaling up care for mental, neurological, and substance use disorders*, Geneva: World Health Organization, 2008, page 29: "Suicide is the third leading cause of death worldwide in people aged between 15 and 34 years, and it is the 13th leading cause of death for all ages combined. About 875 000 people die from suicide every year. High rates of suicide are associated with mental disorders such as depression and schizophrenia and with alcohol and drug dependence." See also the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), Safer Care for Patients with Personality Disorder*, Manchester: University of Manchester, 2018: "The majority of patients who took their own life had a history of self-harm (146. 95%). The last episode of self-harm occurred within a week of death in 20 cases (16%), and 81 (70%) within 3 months. Repeated incidents of self-harm were common in the year before suicide (77. 66%). In most cases the triggers were known to services (106, 98%). These were: Alcohol intoxication, … . During the last episode of care a risk assessment for suicide, self-harm and/or violence was undertaken in 121 (88%), a risk formulation undertaken in 91 (71%) and risk management plan developed in 85 (69% cases)."

59. *Mental Health Action Plan 2013−2020* Geneva: World Health Organization, 2013, paragraphs 11 and 75. See also *Preventing suicide: a global imperative*, Geneva: World Health Organization, 2014, page 11: "Young people are among those most affected; suicide is now the second leading cause of death for those between the ages of 15 and 29 years globally." According to the International Association for Suicide Prevention (IASP) *Guidelines for Suicide Prevention,* "There are also certain groups of persons who are particularly at risk for suicidal behaviour. These include those with a past history of attempted suicide, alcohol and other substance dependent persons, young males …. There have been many studies indicating that those who attempt suicide are far more likely to commit suicide in the future than other groups. … It has long been recognised that alcohol and other substance dependence is associated with an increased risk of suicide."

60. See paragraph 13 of the judgment.

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phase and/or in situation of urgency".[61] Dependency degree 1 "corresponds to the self-sufficient patient". Dependency degree 2 "corresponds to the patient who needs partial assistance". The medical file from 25 April 2000 to the time of the suicide does not mention the dependency degree of the patient. This means that no risk assessment was made by the HSC for at least two days before his suicide[62].

**Measures put in place to prevent suicide of voluntary psychiatric inpatients**

28. In view of the above, A.J. was at a foreseeable and imminent risk of suicide and the HSC and the other hospital authorities knew about that risk. But even if that were not the case, there are nevertheless certain basic precautions which it is expected will be taken. The majority do not go into this question, but the case-law does impose such a burden on the State in order to minimise any potential risk of self-harm and suicide attempts, even when it is not established that they knew or ought to have known about any such risk.[63]

Although the majority do not find it necessary to pursue this line of reasoning,[64] I feel that I have the ethical obligation to do so, for the sake of both the consistency of the case-law and the exhaustiveness of the legal analysis of the case. The question to be answered now is whether the operational measures put in place were sufficient, and the response is unhesitatingly no, absolutely not, for the following seven reasons.

29. First, there was, and still is, no adequate regulatory framework regarding the State obligation of protecting the life of mentally ill patients in voluntary treatment in public hospitals in Portugal. There are no legal limits imposed on doctors regarding whether or not a psychiatric patient should be placed in an open or closed regime or in an isolation room. The added value of this case should have been precisely to induce the Government to close this gap and provide doctors with a lawful basis for their activity.

30. Second, there were, and still are, no adequate administrative means of enhanced surveillance of inpatients with a suicide risk. The modalities of this surveillance are to be decided according to the margin of appreciation

61. See, for example, the medical file notes of 11 January 1993 and 2 February 1993. Although aware of this fact (see paragraph 13 of the judgment), the majority do not care to take into account this information when assessing A.J.'s "long history of mental health problems" (see paragraph 130 of the judgment).
62. The majority admit that no risk assessment notes were taken for "his last stay in 2000"(see paragraph 13 of the judgment).
63. See *Eremiasova and Pechova v. the Czech Republic*, no. 23944/04, § 110, 16 February 2012, reiterated in *Keller v. Russia*, no. 26824/04, § 88, 17 October 2013.
64. Paragraph 132 of the judgment avoids the second limb of the *Osman* test, but in reality, in the previous paragraphs, the majority already accepted the measures taken by the national authorities (see for example, paragraph 130 of the judgment).

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of the State, but in doing so the State should take into consideration, among other matters, the international standards of the World Health Organization (WHO). According to WHO standards, enhanced vigilance is required for patients with a suicide risk, which can be performed for example by means of video surveillance or voluntary tagging of the person or any other IT means.[65] IT surveillance helps to detect and deter poor care and monitor care standards. It creates a welcoming environment where people can be confident they will receive decent care. IT surveillance can be applied only to the common parts of the facilities and, if necessary, to bedrooms and service users' private premises. The latter approach requires consent from the service user. Hospitals use visible as well as covert surveillance equipment. Proper health patient monitoring allows for a snappy reaction to a crisis which will decide a patient's odds of survival.[66] Hence, WHO standards do not require the building of walls and certainly not a prison-like regime for people in A.J.'s circumstances.[67]

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65. See *Practice Manual for establishing and maintaining surveillance systems for suicide attempts and self-harm*, Geneva: World Health Organization, 2016, page 6: "Improved surveillance and monitoring of suicide attempts and self-harm is a core element of the public health model of suicide prevention. … However, the intention to die can be more difficult to ascertain (and therefore to record) since in certain cases even the individual involved may not be certain about his or her intentions. This is why a hospital-focused surveillance system will inevitably represent cases of intentional self-harm with varying levels of suicidal intent and varying underlying motives, and not only suicide attempts characterized by high levels of suicidal intent." According to the *Mental Health GAP Intervention Guide Version 2.0 for mental, neurological and substance use disorders in non-specialized health settings*, World Health Organization, 2016, page 136: For all cases of Medically Serious Act of Self-Harm or Imminent Risk of Self-Harm/Suicide: "Place the person in a secure and supportive environment at a health facility. DO NOT leave the person alone."

66. In its Revised CPT Standards of March 2017, the CPT accepts the use of video surveillance as a means of restraint in psychiatric establishments for adults, but it further notes that "Clearly, video surveillance cannot replace continuous staff presence." (CPT/Inf (2017)6). The Care Quality Commission is the independent health regulator in England: it regulates health care services in England and has produced guidance for health care providers and for the public on the use of surveillance in settings such as care homes and hospitals. See *Using surveillance. Information for providers of health and social care on using surveillance to monitor services*, December 2014 (updated with new regulations in June 2015): "In some circumstances, surveillance systems could be used for purposes that fall within the definition of 'deprivation of liberty' – for example, the use of CCTV or RFID tracking devices to monitor the location of an individual for the purpose of preventing them from leaving the premises. If the identified purpose or use of surveillance has the potential to act as a restriction on, or deprivation of liberty, special care must be taken to consult with individuals and to consider the relevant guidance. This is in addition to the usual considerations that must be made on the use of surveillance."

67. On suicide prevention and restraint measures, including seclusion and video surveillance of patients, see Dasic et al, "Improving patient safety in hospitals through usage of cloud supported video surveillance" (2017) 5 (2) *Macedonian Journal of Medical Sciences* 101: "Patient safety is a growing issue which can be improved with the usage of high-end centralized surveillance systems allowing the staff to focus more on treating

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31. In the particular case of Hospital Sobral Cid, internees enter and leave without any control. The same happens with outsiders, who can cross the perimeter of the hospital and even enter the pavilions whenever they please. In 2000 there was one guard alone for the entire building, posted at the entrance for cars. There was no permanent psychologist and no permanent emergency service in place. When an emergency situation occurred, the medical doctor on call was contacted and would decide on the telephone whether the patient should be transported to the central hospital of

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health issues rather than keeping a watchful eye on potential incidents."; Stolovy et al, "Video surveillance in mental health facilities: is it ethical?" (2015) 17 *Israel Medical Association Journal* 274-276: "Staff and patients perceive the surveillance positively, and there have been no complaints regarding the use of cameras since their installation. Moreover, the surveillance did not evoke paranoid symptoms, quite the contrary, patients perceive the surveillance as a safeguard …"; Carroll et al., "Hospital management of self-harm patients and risk of repetition: systematic review and meta-analysis" 2014 *Journal of Affective Disorders* 476-83; Richardson, "Mental capacity in the shadow of suicide: What can the law do?" (2013) 9 *International Journal of Law in Context* 87-105; Frank, "Videoüberwachung in der Psychiatrie - Pro, kontra, Video surveillance in psychiatric hospitals-pro & contra" (2013) 40 *Psychiatrisches Praxis* 117-119: "many arguments speak against a prohibition (of IT surveillance in psychiatric hospitals) and few arguments speak against the possibility of using this possibility"; Salzmann et al, "Panoptic power and mental health nursing-space and surveillance in relation to staff, patients, and neutral spaces" (2012) 33(8) *Issues Mental Health Nursing* 500-4: "the majority of spaces in mental health nursing serve as a field of visibility within which the patient is constantly watched."; Mullender, "Involuntary Medical Treatment, Incapacity and Respect" (2011) 127 *Law Quarterly Review* 167–71; David et al., "Mentally Disordered or Lacking Capacity? Lessons for Management of Serious Deliberate Self Harm" (2010) *British Medical Journal* 341: c4489; Desai, "The new stars of CCTV: what is the purpose of monitoring patients in communal areas of psychiatric hospital wards, bedrooms and seclusion rooms?" (2009) 6 *Diversity and Equality in Health Care* 45-53: "The use of CCTV cameras not only enabled better detection of risk factors in managing patients on a ward, but also provided video footage for training purposes. For example, Chambers and Gillard (2005) found that maintaining recorded images of incidents allowed an opportunity for after-the-event evaluation that could be used for training purposes, especially in recognising the antecedents to violent episodes and in preventing suicide. Staff believed that the recorded images provided a more accurate and therefore objective account of incidents"; Appelbaum, "Commentary: the use of restraint and seclusion in correctional mental health" (2007) 35 (4) *Journal of the American Academy of Psychiatry Law* 431-5; Kennedy, *Electronic surveillance in hospitals: A review*, Edith Cowan University, Perth, 2006: "The benefits of electronic surveillance to patient health are manifold, but it is vital that the privacy implications for individuals are not overlooked by the motivation to achieve security for the whole community"; Smith et al, "Pennsylvania State Hospital system's seclusion and restraint reduction program" (2005) 56 (9) *Psychiatric Service* 1115-22; Paris, 2004 (18) "Is hospitalization useful for suicidal patients with borderline personality disorder?" (2004) 18 (3) *Journal of Personality Disorders*, 240-47; and see also the National Institute for Care and Excellence Guidelines and literature on use of restraint on people with mental health problems in health and social care settings, available on https://www.nice.org.uk/

Coimbra. Over the years several serious, and even fatal, incidents have been caused by inpatients who managed to leave the HSC premises.[68]

32. A.J. was placed in pavilion 8, which had an isolation room. Pavilion 8 accommodated people in both voluntary and involuntary internment.[69] A.J. was placed in an open regime on 25 April 2000 after the incident of drinking abuse, as evidenced by the note that he "walked around the pavilion".[70]

33. Third, no doctor assessed the seriousness of the incident of alcohol abuse on 25 April, in spite of the fact that A.J. was in a state of "unbalance, some reactivity to the internment, lack of functional coordination and restlessness".[71] The justification given for this omission by Doctor E.R. was that he "assumed that A.J. was fine since the nurses did not request an assessment of the patient after the incident of 25/26 April".[72] Amazingly, the doctor on call did not care to see a suicidal patient who had just had a serious drinking episode because he was not requested to do so by the nurses, as if the nurses were supposed to assume the responsibility that belonged to him.

34. No doctor assessed the need for a restrictive regime from 25 April to the time of the suicide, although A.J. had already been placed in the "closed regime" several times and even in the isolation room (for example, on 12 December 1999 he was "placed in the isolation room", because he was "restless, with difficulty to calm down"; on 15 December 1999 he was ordered "not to the leave the pavilion"; on 16 December 1999 he was ordered "not to leave the service"; on 22 December 1999 he was still complaining that he wanted to leave the pavilion).[73] Only on 13 April was he seen by his doctor and "had a change of the therapy", but there is no mention of what the new therapy was.[74]

35. Fourth, on the date of his suicide and the day before, there was a gap of sixteen hours without any supervision, since the medical file contains no notes from 4 p.m. on 26 April to 8 a.m. on 27 April. Moreover, the final notes in A.J.'s medical file, referring to him as being "calm and cooperative in the beginning of the shift" (27 April, 2-7 p.m. shift) were added by the same person at 8 p.m. when it was already known that he had committed suicide![75]

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68. See paragraph 55 of the judgment. It is quite revealing that this information was not even considered by the majority when assessing the obligation to take preventive operational measures.
69. See the inspection report produced by the first-instance court.
70. See the record on 27 April in his medical file, 8 a.m-4 p.m. shift.
71. See the record on 26 April in his medical file, midnight-8 a.m. shift.
72. See testimony of Dr E.R. annexed to the file, and paragraph 23 of the judgment.
73. See the records in his medical file on these days.
74. See the record in the medical file on this day.
75. In fact, the same person also noted that there was a suspicion that he had committed suicide and the family had come to pick up A.J.'s belongings.

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36. Worse still, there was a gap of more than twenty-four hours in any medication before A.J.'s suicide, since the last medication taken by him was during the shift of 12-8 a.m. on 26 April (more precisely at 12.39 a.m., when he was seen at the General Hospital of Coimbra and at 2 a.m., when he was admitted to the HSC). This means that no medication was administered between 2 a.m. on 26 April and the time of his suicide on 27 April at 5.37 p.m. The *post-mortem* toxicological exams carried out on A.J.'s body showed that he had not been under medication at that time. The expert report itself noted the following: "there is no detailed reference, in the medical file, to the psychopathological state that the patient presented on 26 April 2000" and "we cannot answer in a more detailed way as we were not given access to documentation describing the circumstances of the suicide".[76] It is also important to note that the attempted suicide on 1 April 2000 was committed with excessive consumption of pills and alcohol. The drinking abuse incident on 25 April followed the same pattern of alcohol abuse, but this time without pills. In spite of all this, A.J. was left alone and abandoned to his own serious mental illness. In this context, it is relevant to point out that, in *Renolde v. France*, the failure to ensure that Mr Renolde was taking his daily medication was one of the factors supporting a finding of a violation of Article 2. Why was the same criterion not applied to the Portuguese patient?

37. Fifth, the Government referred to a "medical plan established for each patient".[77] There is no evidence whatsoever in the Court's file of such a "medical plan". The majority do not go so far as to side with the Government on this point too. Nor do they share the respondent Government's view that the applicant should have asked for the involuntary internment of her son if she were so convinced that he was in danger. To put the blame on the applicant is an inadmissible argument that adds infamy to injury.

38. Sixth, comparing this situation at the HSC with other psychiatric facilities, it is important to note that other similar facilities in Portugal have installed either fencing or IT surveillance systems.[78] It is also possible to find psychiatric facilities with proper individual medical plans.[79]

39. Seventh, and finally, the Government's argument that the Chamber judgment has presented them with the legal dilemma of having contradictory international obligations deriving from Article 2 of the ECHR (to put fences around hospitals or restrict the freedom of the patients) and Article 14 of the UN Convention on the Rights of People with Disabilities

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76. See the expert report dated 27 September 2006 ordered by the first-instance court (see paragraph 33 of the judgment), and the interview with A.J.'s sister given to the newspaper *O Publico*, 29 March 2017.
77. See paragraph 94 of the judgment.
78. See the references in the above-mentioned CPT reports on Portugal.
79. Ibid.

("the CRPD") (neither to put up fences nor restrict the freedom of movement of patients), and especially its interpretation by the Committee on the Rights of Persons with Disabilities ("the CRPD Committee"), is thus wrong.

40. The legal international scenario is confusing, to say the least, signaling tough ongoing discussions on the matter.[80] The Human Rights

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80. On the UN Disabilities Convention and its interpretation by the CRPD Committee, see Loza and Omar, "The rights of persons with mental disabilities: is the UN Convention the answer? An Arab perspective" (2017) 14 (3) *The British Journal of Psychiatry International*, 53-55: "The General comment on Article 12 interprets important human rights provisions from a narrow perspective, distances medical knowledge and alienates families in many cultures"; Freeman et al, "Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities" 2015 *Lancet Psychiatry*, 844-50: "In the event that a life could be saved from suicide, we submit that the Committee's assertion that involuntary treatment should never be allowed is wrong. … When there is a conflict between different rights, the right to life should trump other rights." "What if the person is hearing voices that tell him or her to hurt themselves or another person? … we cannot accept that doing away completely with involuntary admission and treatment will promote the rights of persons with mental illness"; Szumkler et al, "Mental health law and the UN Convention on the rights of persons with disabilities" (2014) 37 *International Journal of Law and Psychiatry* 245-52: "very few would support the idea that the state never, even as a last resort, has a duty to protect those who are clearly unable to make crucial treatment decisions for themselves"; Bartlett, "The United Nations on the Rights of Persons with Disabilities and Mental Health law" (2012) 75 (5) *The Modern Law Review* 752-78; Fennell and Khaliq, "Conflicting or Complementary Obligations? The UN Disability Rights Convention and the European Convention on Human Rights and English law" (2011) *European Human Rights Law Review* 662-74; Weller, "The Convention on the Rights of Persons with Disabilities and the Social Model of Health: New Perspectives" (2011) *Journal of Mental Health Law* 74-83; Lush, "Article 12 of the United Nations Convention on the Rights of Persons with Disability" (2011) *Elder Law Journal* 61–68; Minkowitz, "Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities", in McSherry and Weller (eds), *Rethinking Rights-Based Mental Health Laws*, Oxford: Hart Publishing, 2010, 151-78; Bach and Kerzner (2010) *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity*, Canada: Law Commission of Ontario; Hale, *Mental Health Law*, London: Sweet and Maxwell, 2010; Lewis, "The Expressive, Educational and Proactive Roles of Human Rights: An Analysis of the United Nations Convention on the Rights of Persons with Disabilities", in McSherry and Weller (eds), *Rethinking Rights-Based Mental Health Laws*,. Oxford: Hart Publishing, 2010, pp. 97-128; Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and the Future of Mental Health Law" (2009) 18 *Psychiatry*, 496-98; Bartlett et al, *Mental Disability and the European Convention on Human Rights*, Leiden: Martinus Nijhof, 2007; Lawson, "The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?", (2007) 34 (2) *Syracuse Journal of International Law* 563-619; Hale, "The Human Rights Act and Mental Health Law: Has it Helped?" (2007) *Journal of Mental Health Law* 7-18; Dhanda, "Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?" (2006) 34 *Syracuse Journal of International Law and Commerce* 429-62; and Richardson, "The European Convention and Mental Health Law in England and Wales: Moving Beyond Process" (2005) 28 *International Journal of Law and Psychiatry*, 127-39.

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Committee does not share the views of the CRPD Committee, since it acknowledges that involuntary hospitalisation may be justified[81]. Similarly, the Subcommittee on the Prevention of Torture[82] expressed the opinion that deprivation of liberty can be justified on grounds of risk of self-harm or harm to others. Despite being urged by the Centre for Human Rights of Users and Survivors of Psychiatry,[83] the CEDAW did not address the issue of forced psychiatric interventions and involuntary hospitalisation.[84]

41. The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 1991, provide for the circumstances in which persons can be admitted involuntarily to a mental health facility. Yet the High Commissioner for Human Rights considered that these Principles were in direct conflict with article 14 (1) (b) of the CRPD and supported an absolute ban on deprivation of liberty on grounds of disability.[85] He affirmed that:

> "article 14, paragraph 1 (b), of the Convention unambiguously states that 'the existence of a disability shall in no case justify a deprivation of liberty'. Proposals made during the drafting of the Convention to limit the prohibition of detention to cases 'solely' determined by disability were rejected. As a result, unlawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person's disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by article 14'."[86]

42. The UN Special Rapporteur on the right of everyone to enjoy the highest standard of physical and mental health criticised the 2005 *WHO Resource Book on Mental Health*, *Human Rights and Legislation*, because it allowed for certain exceptions of "normalized coercion", but expressed his opinion with caution on an absolute ban on all forms of non-consensual measures in his reports to the UN Human Rights Council, acknowledging that "their radical reduction and eventual elimination is a challenging process that will take time".[87]

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81. General comment No. 35 on Article 9 of the ICCPR, CCPR/C/GC/35, 16 December 2014.
82. Approach regarding the rights of persons institutionalized and treated medically without informed consent, CAT/OP/27/2, 26 January 2016.
83. Comments on the draft update of CEDAW General Recommendation no. 19: Forced psychiatric interventions as violence against women with disabilities, 26 September 2016.
84. CEDAW General Recommendation no. 35 on gender-based violence against women, updating General Recommendation no. 19, CEDAW/C/GC/35, 26 July 2017.
85. High Commissioner for Human Rights, "Forgotten Europeans, forgotten rights, the human rights of persons placed in institutions", 2011, 12-13; OHCHR Statement on article 14 of the CRPD, September 2014.
86. Annual report of the High Commissioner for Human Rights to the General Assembly, A/HRC/10/49, 26 January 2009, paragraphs 48-9.
87. A/HRC/29/33, 2 April 2015, and A/HRC/35/21, 28 March 2017.

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43. Within the Council of Europe, the Committee of Ministers Recommendation Rec (2004)10 concerning the protection of human rights and the dignity of persons with mental disorders permits their involuntary placement based on the Court's case-law on Article 5(1)(e) of the Convention.[88] Yet the PACE Recommendation: The case against a Council of Europe legal instrument on involuntary measures in psychiatry[89] aligned itself with the CRPD. The Reply of the Committee of Ministers[90], instead, chose to maintain its position of 2004.

44. One thing is certain: the practice of Portuguese psychiatric hospitals of placing voluntary psychiatric inpatients in a "restrictive regime" in a confined pavilion or even in an isolation room did not in 2000, and still does not today, have a specific lawful basis setting out which types of regimes could be applied, under what circumstances, by whom and until when and subjecting them to a proportionality and necessity test. Furthermore, according to the CRPD Committee, the current Law no. 36/98, of 24 July 1998 is incompatible with the CRPD, since it permits the involuntary placement of people with mental problems who have committed no crime and does so outside any criminal procedure.[91]

45. The problem of the compatibility, or lack thereof, between national law and the above-mentioned UN Convention as interpreted by the CRPD, namely the absolute prohibition on involuntary detention based on impairment[92], goes well beyond the limits of this case. The majority do not discuss this legal question, having assumed purely and simply that the approach of national law "is in line with the international standards ...".[93]

46. To conclude on this point, the dilemma referred to by the Government is also a false argument because there were, and still are, means of monitoring psychiatric inpatients at risk other than putting fencing round the HSC. The Government assess the measures that could be used in an either/or, binary fashion: either total absence of monitoring or fencing round the HSC. In addition to disregarding the existence of less intrusive alternatives, this approach fails to strike a proper balance between the competing interests: respect for the freedom of the psychiatric inpatient with a suicide risk and the State obligation to protect his or her life.

88. See paragraph 75 of the judgment.
89. PACE Recommendation 2091 (2016), 22 April 2016, which the majority do not consider.
90. Commitee of Ministers Reply to Recommendation (2091 (2016)), adopted on 9 November 2016.
91. See CRPD Concluding observations on the initial report of Portugal, 30 May 2016, paragraph 33 (b): the Committee requests that the State party "removes … the deprivation of liberty on the grounds of impairment provided for in its legislation on mental health".
92. A/HRC/34/32, paragraphs 29-33.
93. See paragraph 117 of the judgment.

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**The quality of the domestic proceedings**

47. The quality of the domestic proceedings was not up to the standards of this Court, for various reasons. First, none of the domestic courts referred to the Convention, which was totally ignored. Neither the first-instance court nor the Supreme Administrative Court ever considered the Convention or the Court's case-law. None of the domestic courts undertook a proportionality or necessity test regarding the scope of the State obligation to protect psychiatric patients.

48. In her appeal before the Supreme Administrative Court, the applicant did refer to the use of IT surveillance techniques.[94] There was no reply to the appellant's argument regarding the possible use of IT surveillance techniques. Yet both the dissenting judge of the Supreme Administrative Court and the Deputy Attorney-General argued that the HSC had not put in place a regime to reinforce A.J.'s monitoring[95] or any other sufficient measures to prevent or diminish the risk of suicide.[96]

49. Second, the domestic court considered it established that A.J. had left the building at 5 p.m. in spite of the fact that there were contradictory testimonies as to whether A.J. had already been absent at lunch time on 27 April. Witness S.P. said that he had not been present at lunch time while Witness A.D. said that he had been present. Finally, the first witness changed her testimony in a very reluctant way ("although I am convinced that A.J. was not present, I am not sure of that").[97] The first-instance court accepted that change in testimony without further checking its credibility.

50. Third, the domestic court did not accept in its preliminary decision on the facts that there had been other suicide attempts, in spite of the fact that there were two witnesses (the mother and sister of the deceased) who referred to other suicide attempts.[98] The domestic court gave no explanation for the fact that there was a written note in the medical file referring to "multiple" suicide attempts; it did not question the person who wrote that

94. See page 8 of the Supreme Administrative Court judgment.
95. See page 4 of the opinion of the Deputy Attorney-General.
96. The Government themselves referred to the use of IT surveillance techniques in their observations before the Chamber and the Grand Chamber (see paragraph 125 of the Government's observations before the Chamber and point 17 of their conclusions, and paragraph 94 of the Government's observations before the Grand Chamber). The appellant also raised in her appeal to the Supreme Administrative Court the issue of lack of special restraint or vigilance after the drinking abuse incident and asked that this fact should be added to the proven facts. The Supreme Administrative Court considered that "there [were] no reasons to add it to the factual basis", for a very formalistic reason, namely that it had not been properly raised (see judgment of Supreme Administrative Court, point 2.2 (iii), page 18).
97. See page 7 of the first decision on the facts, of 7 January 2010.
98. See page 5 of the first decision on the facts, of 7 January 2010.

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note in the medical file in order to find out why and on what basis she had done so.

51. Fourth, the applicant raised the issue of the completeness of the medical file before the domestic court, but the latter did not consider this question relevant because it had not been raised as a formal complaint of forgery of the file.[99] The domestic court had the power to check the completeness of the medical file and did not use that power, for a formalistic reason. In fact, the domestic court did not even analyse the medical file, since it entirely ignored the risk assessment notes in it.

52. Fifth, the first-instance court invoked modern psychiatric standards. But it did so only for the benefit of the State, and to the detriment of the applicant. This was a very uneven and unbalanced description of the state of the art in terms of modern psychiatric standards. The domestic court simply ignored the standards set by the World Health Organization for governments and practitioners in terms of suicide prevention especially in hospitals and medical facilities. This Court should not have made the same mistake, but it did. The Court cannot on the one hand take into consideration the WHO standards with regard to the deinstitutionalisation of people with mental disabilities and on the other hand ignore the same WHO standards on State responsibility for prevention of suicide especially in psychiatric facilities.

53. The first-instance court chose a radical, minimalist, hands-off approach to the State obligation to protect the life of patients in public psychiatric facilities and did not follow the balanced approach of the World Health Organization. As a matter of fact, the first-instance court followed the radical opinion expressed in the expert report of 27 September 2006 and presented before the first-instance court.[100] This expert report even praised the possibility of suicide! It closed with a eulogy of suicide, portraying it as an act of "freedom and liberation". After stating that "prevention of suicide in these patients is an impossible task", the expert added the following words:

> "For many suicidal individuals, that moment (of suicide) is a unique moment of freedom and liberation. How can one prevent it in absolute terms? In fact, who wants to give up on that potential? There are many people who are lucid and happy today and who would not want to give up on that possibility (of suicide)."[101]

While also concluding that prevention of suicide in patients such as A.J. was an "impossible task"[102], the Grand Chamber copy-pasted the same expert report that made a eulogy of suicide. The same report that had noted that "we cannot answer in a more detailed way as we were not given access to documentation describing the circumstances of the suicide". I regret that

99. See page 10 of the first decision on the facts, of 7 January 2010.
100. See paragraph 33 of the judgment.
101. The expert report is cited in paragraph 33 of the judgment, but the majority of the Grand Chamber do not deem it necessary to include these sentences in that paragraph.
102. See paragraph 131 of the judgment.

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once again the conscience of Europe has sided with this culture of death, even suggesting that the right "to take a rational decision to end his or her life" comes within the scope of Article 2.[103]

54. The Supreme Administrative Court did not remedy the shortcomings of the first-instance court. In fact, it did not even discuss modern psychiatric standards. The part of the judgment that deals with the "analysis of the grounds of appeal" is rather brief – only three pages – and just rubberstamped the first-instance judgment, with long citations from that judgment without any added value.[104] There is not a single word on the proportionality or the necessity test in it, as required by domestic constitutional law, in the light of Articles 18 and 24 of the Constitution, and by Convention law, in the light of Article 2, paragraph 2, of the Convention.

55. To put it differently, the quality of the domestic procedure leaves much to be desired. The procedural violation of Article 2 goes well beyond the majority's very limited criticism.[105]

## Conclusion

56. To sum up, this case is again a disappointing statement of this Court on the State obligations to provide health care to a category of vulnerable people, such as psychiatric inpatients. On the basis of a wrongful assessment of the legal and factual background to the case and a misreading of the Court's own case-law, the majority treat the case of poor A.J. differently from those of *Renolde* and *De Donder*, leaving a strong impression of double standards. Worse still, the majority's one-sided approach to international health law and practice is patent, since they consider the trend that favours the liberty of freedom of psychiatric inpatients, but forget to ponder the counter-voices to that trend which warrant an increased State commitment to suicide prevention, especially regarding people under State supervision, and even more regarding institutionalised psychiatric patients.

In the current political context in Europe, this judgment may not surprise anyone. My hope is that it will be reversed one day when the political mood changes. My concern is that meanwhile many psychiatric inpatients with a suicidal risk will die an avoidable death, like A.J. did.

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103. See paragraph 124 of the judgment. The apotheosis of this culture is *Gross v. Switzerland*, no. 67810/10, § 60, 14 May 2013, which followed *Haas v. Switzerland*, no. 31322/07, § 51, ECHR 2011. As the *Gross* judgment did not become final and the Grand Chamber declared, on 30 September 2014, the application an abuse of the right of application, the Chamber findings became invalid.

104. See bottom of page 22 to page 24 of the judgment as translated in the file.

105. See paragraph 139 of the judgment.

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