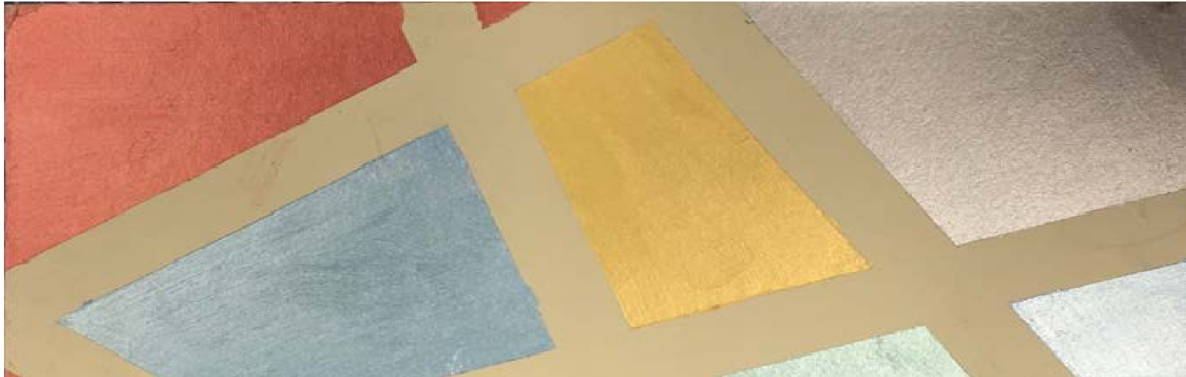
39 Essex CHAMBERS



Welcome to the July 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: sexual capacity complexities, wishes and feelings in the balance, and finding the P in a PDOC case;

(2) In the Property and Affairs Report: deputy bond provider problems and a job opportunity in the Official Solicitor's office;

(3) In the Practice and Procedure Report: how far can the Court of Protection go to ensure its orders are complied with, and risk taking, best interests and health and welfare deputies;

(4) In the Mental Health Matters Report: Tier 4 beds (again) and the Mental Health Tribunal and the Parole Board;

(5) In the Wider Context Report: local authority consent to confinement, the Irish courts continue to grapple with the consequences of the framework, and Strasbourg pronounces on assisted dying;

(6) In the Scotland Report: exasperation at the pace of the Scottish Government's Mental Health and Capacity Reform Programme.

There is one plug this month, for a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

Alex trusts that readers will not mind a slight blowing of the trumpet at his having been awarded Outstanding Legal Achievement at the 2024 Modern Law Private Client Awards for his work sharing knowledge about the Mental Capacity Act 2005 (and hence, in significant part, thanks to his fellow editors on this Report), and being appointed Professor of Practice at King's College London from August 2024 (a position which reflects the opportunities given by Chambers to him to moonlight so often away from the day job – for which he is very grateful!).

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

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Local authorities, care orders and consent to confinement

Re J: Local Authority consent to Deprivation of Liberty [2024] EWHC 1690 (Fam) (High Court (Family Division) (Lieven J))

Article 5 ECHR – deprivation of liberty – children and young persons

Summary

Lieven J's campaign against the decision of the Supreme Court in *Cheshire West* continues. In *Re J: Local Authority consent to Deprivation of Liberty* [2024] EWHC 1690 (Fam), she has held that a local authority can in the exercise of its 'corporate' parental responsibility, consent to the confinement of a child under 16 subject to a care order, so as to take the child's circumstances out of the scope of Article 5 ECHR. At paragraph 19, she identified that:

> *The rationale for the court considering DoLs applications in circumstances such as this may be, as suggested in Cheshire West and subsequent cases, to ensure that safeguards are in place and there is court oversight of the process. Article 5 requires that any deprivation of liberty must be "in accordance with a procedure prescribed by law". The Supreme Court in Re T (A Child)* [2021] UKSC 35 *held that the use of the High Court's inherent jurisdiction fell within the "in accordance with law" requirement. However, the need for a legal process if there is a deprivation of liberty cannot itself be relevant to the substantive content of the right. If the LA can provide valid consent in J's case, then there is no requirement for a DoLs order, whatever the possible benefits of "safeguards" of a court process, in this case the High Court DoLs List.*

The local authority argued (albeit somewhat faintly) that it could not give such consent, basing itself on the clear statement to that effect by Keehan J in *Re D (A Child) (Deprivation of Liberty)* [2015] EWHC 3125:

> *29. Where a child is in the care of a local authority and subject to an interim care, or a care, order, may the local authority in the exercise of its statutory parental responsibility (see s.33(3)(a) of the Children Act 1989) consent to what would otherwise amount to a deprivation of liberty? The answer, in my judgment, is an emphatic "no". In taking a child into care and instituting care proceedings, the local authority is acting as an organ of the state. To permit a local authority in such circumstances to consent to the deprivation of liberty of a child would (1) breach Article 5 of the*

> *Convention, which provides "no one should be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law", (2) would not afford the "proper safeguards which will secure the legal justifications for the constraints under which they are made out", and (3) would not meet the need for a periodic independent check on whether the arrangements made for them are in their best interests (per Lady Hale in Cheshire West at paragraphs 56 and 57)."*

Lieven J considered that Keehan J's analysis:

> *23.* […] *conflates two separate issues relevant to Article 5. For present purposes I accept that the first and third limbs of Storck are met, because the LA, or in fact its agent the care provider, does not allow him to leave the premises unaccompanied. Therefore the restrictions on J are imposed by the State. However, that does not mean that the LA, acting as the corporate parent under s.33 CA, cannot consent to that deprivation.*

Lieven J considered s.33(b) CA 1989, and the observations of the Court of Appeal in *Re H (Child)* [2020] EWCA Civ 664 (a case about vaccination) that "*some decisions are of such magnitude that it would be wrong for a local authority to use its power under s.33(3)(b) to override the wishes or views of a parent*." She considered that:

> *31. Although that case concerned a very different issue to the present, namely the giving of vaccinations, there is no obvious reason why the core test should not be the same. Namely, is the decision that the LA is being asked to make under s.33(3)(b) CA "of such magnitude" that it cannot be made by the LA, but rather must be made by the Court.*
>
> *32. There is no doubt, as Lady Hale said, and is clear from Guzzardi, that the removal of an individual's liberty is a significant infringement of their human rights and an important decision. However, in this, as in every other aspect of human rights law, context is all and it is necessary to consider the facts of the individual case.*
>
> *33. The approach that the LA can never exercise its powers of parental responsibility under s.33(3)(b) to grant valid consent for a deprivation of liberty rests on the proposition that a deprivation of liberty is necessarily a decision of such magnitude as to require the role of the court. Although logically that conclusion might flow from what Lady Hale said in Cheshire West and Re D, neither of those decisions concerned the scope of parental responsibility in respect of children under the age of 16, let alone the scope of s.33(3)(b) in decisions concerning children of that age and deprivation of liberty.*
>
> *34. Further, if one applies the test to the facts of J's case, it is in my view clear that the decision to deprive him of his liberty is an inevitable one, which no reasonable court or parent would depart from. One way of testing this proposition is to consider what would happen if the LA, or those authorised to look after J i.e. the Children's Home, did not put in place the restrictions sought. They would very obviously be in breach of their duty of care to J, given his known vulnerabilities and the manifest risks to his safety if he was allowed to leave the home unsupervised. In reality it is the obligation of any responsible carer of J to place restrictions upon him in order to keep him safe. Therefore, far from the restrictions amounting to a serious infringement of his rights that no LA could lawfully consent to, they are restrictions essential to ensuring his*

> *best interests, and indeed required by the State's positive obligations under Article 2 ECHR to protect his life. In those circumstances in my view they fall within the LA's statutory powers in s.33 CA.*
>
> *35. Therefore the decision to "deprive him of his liberty" is not in my view a decision of such magnitude as to fall outside the LA's powers, but rather an exercise of their statutory duties to him. In my view the LA have the power to consent to the restrictions and therefore to the deprivation of his liberty, and no DoLs order is needed.*

Comment

At the time of writing, it is not known whether there will be an appeal. As with Lieven J's other recent case in this context, it would be very unfortunate if there were not, because it is difficult to square her decision with the approach taken by the appellate courts to deprivation of liberty. It also is at direct odds not just with the decision of Keehan J in *Re D*, but also the decision of Sir James Munby in *Re A-F* [2018] EWHC 138 (Fam), in which the then-President of the Family Division held:

> *12 (i)* [w]*here a child is subject to a care order (whether interim or final) neither the local authority nor a parent can exercise their parental responsibility in such a way as to provide a valid consent for the purposes of Storck component (b): see In re AB (A Child) (Deprivation of Liberty: Consent) [2015] EWHC 3125 (Fam), [2016] 1 WLR 1160* [i.e. *Re D*], *paras 26-29, 36, considered in Re D (A Child) [2017] EWCA Civ 1695, paras 48, 109-112.*

That decision, unfortunately, does not appear to have been cited to her by the parties.

Looked at on its own terms, there is, further, a somewhat troubling sense of 'boot-strapping' in the approach taken.

As the decision of the Supreme Court in *Re D* makes clear, the ability of 'true' parents to give consent to the confinement of their child (below the age of 16) arises in consequence of the interaction between Article 5 and Article 8 ECHR in circumstances where "the responsibility of parents to bring up their children as they see fit, within limits, is an essential part of respect for family life in a western democracy" (see *Re D* at paragraph 3).

It is difficult to say that a local authority, as corporate parent – and as an agent of the state – could itself enjoy Article 8 rights, or require respect to be owed to it as regards how it chose to bring up 'its' children. Indeed, it is precisely because the child's 'true' parents are either unable or unwilling to look after their child that the law empowers the state to intervene in the child's life by way of a care order.

It is therefore unsurprising that Lieven J in her judgment does not rely upon Article 8 ECHR as part of her argument.

However, if Article 8 falls away, so does any argument for relaxing the strict requirements of Article 5 ECHR.

On what basis, therefore, can a local authority be said to be acting within its powers to consent to the confinement of a child under 16 so as to take their circumstances out of the scope of Article 5 ECHR? That basis, Lieven J explains, is because it has the statutory power to do so. But, with respect, that argument is circular, because it would mean that the state had at the same time empowered itself to confine a child and to consent on behalf of that child to that confinement so as to take its circumstances outside the scope of Article 5 ECHR. The entire

point of Article 5 is that it is supposed to constrain the exercise of state power to prevent it being deployed in an arbitrary fashion even if the person wielding it considers that they are doing so in a beneficent fashion. As the Strasbourg court noted in HL v United Kingdom:

> *121. […] While the Court does not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of procedural safeguards is to protect individuals against any "misjudgments and professional lapses" (Lord Steyn, paragraph 49 above)*

On the logic adopted by Lieven J, further, the Court of Protection could empower a deputy to consent to confinement on behalf of an adult lacking capacity, and, by enabling the deputy to give that consent, remove the person's circumstances from the scope of Article 5 ECHR. That logic has clearly not won favour with the European Court of Human Rights. As Lady Hale noted in *Re D*:

> *42. […] But, as also pointed out in Cheshire West, it is striking that the European Court of Human Rights has consistently held that limb (b)* [i.e. that the confined person is not consenting] *can be satisfied despite the consent of a person with the legal right to make decisions on behalf of the person concerned: see Stanev v Bulgaria 55 EHRR 22, DD v Lithuania [2012] MHLR 209, Kedzior v Poland [2013] MHLR 115, Mihailovs v Latvia, unreported, [2013] ECHR 65, and now Stankov v Bulgaria [2015] 42 ECtHR 276. In Stanev, the court did observe, in passing, that "there are situations where the wishes of a person with impaired mental facilities may be validly replaced by those of another person acting in the context of a protective measure and that it is sometimes difficult to ascertain the true wishes or preferences of the person concerned" (para 130). However, as Keehan J observed in the Court of Protection (para 118) that is very far from adopting a general principle of substituted consent. The consent of a legal guardian may have been sufficient to make the confinement lawful in the domestic law of the country concerned, but that did not prevent its being a deprivation of liberty, or guarantee that it fulfilled the Convention requirement of legality. In the cases where limb (b) has been held to be satisfied, it is because the evidence showed that the person concerned was willing to stay where he or she was and was capable of expressing that view. Parental consent, therefore, cannot substitute for the subjective element in limb (b) of Storck.*

Re D, as Lieven J pointed out, concerned a child over 16. But the logic of the passage immediately above (and the cases from Strasbourg referred to) is not age dependent. Rather, and with respect, it might be thought fatally to undercut the basic premise on which Lieven J's argument in J's case is based.

The logic of Lieven J's decision also leads to a result which might be thought to be odd, even for those who might be attracted to it. Care orders do not stop at age 16 (even if restrictions start to bite about applying for them as the child moves towards 18). Even if Lieven J could distinguish Re D as it applied to J when he was under 16, her approach logically suggests that the local authority's consent must be able to continue throughout the life of the care order. When he turns 16, the local authority would then be armed with greater powers to exercise parental responsibility than his true parents would have been, given Re D is binding authority for inability of parents to consent to confinement of those over 16. It is worth repeating that this restriction on parents exists even with Article 8 in the parental corner, a right

that the local authority cannot itself pray in aid. No explanation for this anomaly is given in the judgment, nor, in truth, is it apparent as to what explanation could be given. In this regard, it is noteworthy that in the course of examining the concept of deprivation of liberty carefully and confirming that a local authority could as corporate parent control the mobile phone use of a 16 year old subject to a care order, it did not appear to have crossed the mind of MacDonald J that the local authority could also consent to the confinement of the child in *Manchester City Council v P (Refusal of Restrictions on Mobile Phone)* [2023] EWHC 133 (Fam).

The logic of the paragraph above further raises the somewhat disturbing prospect of a local authority caring for an older teenager, highly resistant to the restrictions on them, opting them out of the protections of Article 5, on the basis that the local authority considers (with no external scrutiny) that it is acting in the child's interests.

The argument can be tested another way. Article 5 ECHR requires a procedure prescribed by law. It also provides that there is a limited and exhaustive set of circumstances under which someone can be deprived of their liberty. It might – just – be said that a local authority could consent to the confinement of a child subject to a care order if in so doing it is following a procedure prescribed by law.[1] However, there is no suggestion that the local authority in J's case was in giving consent to confinement in purported exercise of powers under s.33 Children Act 1989 doing so by reference to the criteria under either Article 5(1)(d) (detention for the purpose of the educational supervision of a child) or Article 5(1)(e) (detention on the basis of 'unsound mind'). So it would be difficult to argue – and in fairness, Lieven J does not seek to suggest – that the local authority in exercising its apparent 'consent' power was directing itself in such a way as to comply with Article 5 ECHR. Rather, and to reiterate, Lieven J concluded that it was acting in such a way as to take itself outside the scope of Article 5 altogether. Which many people might find challenging as a conclusion.

Finally, and as *Cheshire West* and *Re D* make clear, the fact that a local authority may be directly or indirectly confining the child in furtherance of positive duties towards the child (for instance to save their life) goes to the question of whether the deprivation of liberty is justified, rather than to whether there is a deprivation of liberty in the first place.

Taken together, therefore, we would suggest that this case needs to be read with a very large health warning – but, again, that the situation of children under 16 needs to be examined urgently by the appellate courts so as to resolve the increasingly complicated position that is unfolding.

IRELAND

HSE v. P.T. [2024] IEHC 397

This judgment, available here, is a particularly interesting judgment concerning the evolution of safeguards in respect of detention orders under the inherent jurisdiction of the High Court. The matter concerned when the court might accept that the respondent's views are not required to be ascertained. P.T. was admitted to wardship in 2017 and is in his thirties. The court was asked by the HSE to extend existing detention and treatment orders concerning P.T. In determining that application, the court considered the issues

[1] Albeit it would be better, perhaps, to describe it as authorising the confinement, rather than consenting to it.

of capacity, vindication of the respondent's rights, and whether or not his views should be ascertained. The court described it as "a very unusual scenario". The proposal not to ascertain the respondent's views on the application was supported by his multidisciplinary team ("MDT"). His MDT felt that he would not have the capacity in respect of the relevant information, regardless of how it was communicated to him, and that it would be distressing for him.

The court accepted that it was appropriate in the circumstances to proceed without the participation of the respondent as his challenges prevent him from participating in a meaningful way, and he would only be caused avoidable distress by insistence on participation.

This is really interesting when one compares it with the requirement to not only serve a Relevant Person with a Capacity Application but to explain to them the nature and consequences of the application. This judgment perhaps opens a window of possibility that if there was sufficient evidence in a given case, it may be appropriate not to serve the Relevant Person. However, this is also contrasted with the adage adopted by the High Court in KK (No. 2) "nothing about them without them".

Emma Slattery BL

IN THE MATTER OF M.D., A WARD OF COURT [2024] IEHC 394

This is a very short but striking judgment, which illustrates well a further operational difficulty arising with Part 10 of the ADMCA. M.D. is a young man who resides in a specialist facility in England & Wales, as such care is not currently available in Ireland. He was admitted to wardship in 2017 and his detention in the UK has been periodically reviewed by the wardship court. In accordance with Part 10 of the ADMCA, all wards who are detained at the time of commencement of the ADMCA are required to have their detention reviewed under section 107 or 108 of the Act, and either have that detention continued under that section or be discharged from detention. Evidence from both an Independent Consultant Psychiatrist ("ICP") and Responsible Consultant Psychiatrist ("RCP") is required.

In this case, no ICP report had been made available to the court to allow the court to complete the Part 10 review. Mr. Justice Heslin found that "as a matter of law it is not open to this court to dispense with the requirement for an ICP report". Given that there was no ICP report available to the court, Mr. Justice Heslin found that it was impossible to carry out the Part 10 review and noted that the position in this case was "materially different" to the position in M.C. Consequently, the court found that an application could be made pursuant to the court's inherent jurisdiction.

It is not clear from the judgment what type of Orders are required under the inherent jurisdiction that can't be made under the court's existing wardship jurisdiction, assuming the ward has not yet been discharged from wardship. It is similarly not clear whether wards such as this will ever have the benefit of their statutory entitlement to a Part 10 review if an ICP report cannot be made available to the court.

Emma Slattery BL

Decision Support Service Annual Report

The 2023 Annual Report from the Decision Support Service (DSS) highlights its activities since the commencement of the Assisted Decision-Making (Capacity) Act 2015 on April 26, 2023. During its first operational period, the DSS received various submissions for decision-making support arrangements, including 15 decision-making assistance agreements (of which nine were acknowledged), and 29

applications for co-decision-making agreements, with 10 registered. Additionally, there were 185 court-issued decision-making representation orders, of which 83 were registered, alongside 407 applications for enduring powers of attorney, with 385 registered. By year's end, the DSS portal maintained active applications across several categories: 96 for DMAA, 61 for CDMA, and 1,671 for EPA, collecting total fees of €21,477. Also noted were notifications involving ten registered co-decision-making agreements and one accepted notification of an enduring power of attorney.

The report further reflects on the operations across its divisions, including the establishment of a panel comprising 92 decision-making representatives, 44 general visitors, and 34 special visitors, with 30 nomination requests received from the panel, largely from court orders related to wardship discharges. The DSS handled 25 complaints in 2023, with various outcomes including ongoing investigations, discontinuations, and some resolved amicably. Additionally, no requests were made for visits by special or general visitors in 2023, demonstrating a year focused on foundational activities and public engagement.

Emma Slattery BL

Research Corner

[A message on behalf of this brilliant [2] project: *Use of the Mental Capacity Act 2005 with people experiencing multiple exclusion homelessness in England*.]

Are you a health, social care or homelessness practitioner in England who works with people experiencing homelessness and disadvantage such as mental illness or substance use? Your views are important, whether you work occasionally, or wholly, with this population, and whether or not you conduct capacity assessments.

This survey will only take 10 mins of your time: https://app.onlinesurveys.jisc.ac.uk/s/kings/mental-capacity-homelessness-national-practitioner-survey-202-1

To receive the research findings and/or enter the £100 voucher draw just add your email at the end.

Thanks for helping improve understanding and support for this population.

The human condition and physician assisted dying – the latest view from the European Court of Human Rights

Karsai v Hungary [2024] ECHR 516 (European Court of Human Rights (First Section)

Other proceedings – civil

In *Karsai v Hungary*, the European Court of Human Rights has made clear that, whatever the current political head of steam behind moves towards legalising assisted dying / assisted suicide, there is only limited judicial appetite to frame it as a matter of rights.

Mr Karsai, a leading human rights lawyer in Hungary, has motor neurone disease (or ALS as it is known elsewhere). He unsuccessfully challenged the ban in Hungary on obtaining what was described in the judgment as some form of physician assisted dying (it is not entirely clear from the judgment whether he wished to receive assistance, but take the final step himself, or to be administered the lethal medication himself. He brought his challenge to Strasbourg, and,

[2] Alex is biased; he is involved in it.

unsurprisingly, sought to raise every argument that he could to challenge the Hungarian ban by reference to the ECHR. In a submission which may well be thought to chime with what is often read in the media:

> *96. The applicant pointed out that over twenty years had passed since the judgment in Pretty (cited above). Referring to the judgments in Haas and Mortier(both cited above), the applicant argued that the case-law of the Court had evolved, as had the legislation in many member States, which increasingly recognised the right to make end-of-life decisions. Referring to recent judgments in Italy, Germany, Austria and Canada, and to the legislation in the countries where assisting suicide had been decriminalised through a legislative process, the applicant argued that there was an emerging consensus in the Euro-Atlantic legal space on the disproportionate nature of the absolute ban on all forms of assisted suicide with respect to terminally ill patients who were fully mentally competent but unable to terminate their life without help. In his submission, the European consensus was reflected also in the attitude and acceptance of PAD by the general population and the medical profession. The applicant referred to the results of several opinion polls on the extent of public acceptance of PAD in Hungary.*

Interestingly (and unusually), the court heard from two experts; a palliative care expert and a bioethics expert, as well as considering submissions from the Italian government, as well as bodies arguing both in favour and against assisted dying. The court also undertook a review of comparative law across the Council of Europe and further afield, including reviewing cases decided domestically in England & Wales, Germany, Italy and Canada.

The Government of Hungary sought to argue that Mr Karsai's case was inadmissible, on the basis that there was no right to self-determined death under the ECHR, and the Article 8 did not apply, as the question of the prosecution of third parties who might wish to assist him did not touch upon his own interests. The Court had little truck with this argument, finding that his:

> *87.* […] *complaint falls to be examined as concerning an aspect of the applicant's right to respect for his private life within the meaning of Article 8. As regards the question whether this Article goes so far as to require the respondent State to allow or provide the applicant a certain form of PAD, this is a matter which can be resolved only through an examination on the merits, with due regard to the conflicting considerations and the State's margin of appreciation.*

When it came to the merits of the case, the ECtHR first asked itself whether the case involved the State's negative and / or positive obligations. Negative obligations are (in essence) rights not to have things done to you by the State (for instance, a right not to be tortured). Positive rights are (in essence) things that you can demand from the State. It noted that anyone who provided Mr Karsai with assistance to die in Hungary, or to a Hungarian national abroad, could be punished under Hungarian criminal law. On the fact of it, therefore, this appeared to be a situation where his right to respect for private life under Article 8 ECHR was being interfered with – i.e. this was a case purely about negative rights. Importantly, however, the court continued:

> *136. This being stated, the Court notes that the applicant himself argued that the State should be under a positive obligation to secure the conditions for the effective exercise of the right to a self-determined and dignified death, and that the decriminalisation of certain*

forms of assisted suicide would require strict regulation and appropriate safeguards (see paragraph 94 above). In the case of PAD, this would also necessarily involve a positive provision of access to medical intervention, such as access to life-ending drugs (see paragraph 48 above, and also Haas, cited above, § 53). The applicant's complaint therefore goes beyond mere non-interference, engaging negative and positive obligations, which are intertwined. In this respect, the Court would reiterate that the boundaries between the State's positive and negative obligations under Article 8 do not always lend themselves to precise definition. However, the applicable principles are similar. In both contexts regard must be had to the fair balance that has to be struck between the competing interests.

The court then turned to see whether the ban in Hungary was compatible with Article 8, requiring it to examine:

> *138.* [..] *whether a fair balance has been struck between the applicant's interest in being able to end his life by means of PAD, and the legitimate aims pursued by the legislation in question, regard being had also to the positive obligations entailed by decriminalisation of PAD (see paragraphs 135 and 136 above) and the State's margin of appreciation in this domain.*

The ECtHR:

> *143.* [could] *not but note that a certain trend is currently emerging towards decriminalisation of medically assisted suicide, especially with regard to patients who are suffering from incurable conditions (see paragraph 63 above). Nevertheless, and even if access to PAD has recently been or is being deliberated in the parliaments of certain other member States (see paragraph 60 above), the majority of member States continue to prohibit and prosecute assistance in suicide, including PAD (see paragraph 61 above). Moreover, the Court notes that the relevant international instruments and reports (see paragraphs 35-41 above), including the Council of Europe's Oviedo Convention, provide no basis for concluding that the member States are thereby advised, let alone required, to provide access to PAD (contrast, mutatis mutandis, Fedotova and Others, cited above, §§ 175-77).*
>
> *144. In view of the foregoing and noting that this subject continues to be one that raises extremely sensitive moral and ethical questions, and one on which opinions in democratic countries often profoundly differ (compare A, B and C v. Ireland [GC], no. 25579/05, § 233, ECHR 2010), the States must be granted a considerable margin of appreciation (see Haas, cited above, § 55). From the perspective of Article 8 this margin extends both to their decision to intervene in this area and, once they have intervened, to the detailed rules laid down in order to achieve a balance between the competing interests (see Pejřilová v. the Czech Republic, no. 14889/19, § 43, 8 December 2022, and Evans v. the United Kingdom [GC], no. 6339/05, § 82, ECHR 2007-I). Having said that, the Court would reiterate the long-established principle that even when the margin of appreciation is considerable it is not unlimited and is ultimately subject to the Court's scrutiny (see Handyside v. the United Kingdom, 7 December 1976, § 49, Series A no. 24; A, B and C v. Ireland, cited above, § 238, and Verein Klimaseniorinnen Schweiz and Others v. Switzerland [GC], no. 53600/20, §§ 450 and 541, 9 April 2024).*

> *145. Having regard to the arguments raised by the Government and some of the third parties (see paragraphs 99-100, and 114-116 above), the Court finds it appropriate to point out that it has already found that Article 2 does not prevent the national authorities from allowing or providing PAD, subject to the condition that the latter is accompanied by appropriate and sufficient safeguards to prevent abuse and thus secure respect for the right to life (see paragraphs 126 and 127 above). It is in the first place for the national authorities to assess whether PAD could be provided within their jurisdiction in compliance with this requirement.*

The Hungarian government placed considerable reliance on the argument that relatxation of the relevant legislation could "*expose vulnerable people to overt and covert pressure to end their lives, affect their sense of self-worth, undermine trust in the medical profession, and create the effect of a 'slippery slope'*" (paragraph 149). In response, the ECtHR noted that:

> *150.* […] *any system of PAD - even one limited to terminally ill patients with refractory symptoms (see paragraph 94 above) - would require the development of a robust regulatory framework, capable of being effectively and safely applied in practice, and willingness to cooperate on the part of the medical profession. It notes in this connection that the safeguards which are already in place with respect to RWI in Hungary and some other contracting States might admittedly be of some relevance (see paragraphs 21, 77, 79, 94, above; compare also the criteria for compatibility with Article 2 of PAD and withdrawal of life-sustaining interventions, summarised in paragraphs 127 and 130 above). However, it cannot be overlooked that the provision of PAD in respect of patients who are not dependent on life support may give rise to further challenges and a risk of abuse (compare Pretty, cited above, § 74).*
>
> *151. In this connection, the Court notes that both of the experts heard by the Court referred to the challenges in ensuring that a patient's decision to use PAD is genuine, free from any external influence and is not underpinned by concerns which should be effectively addressed by other means (see paragraphs 49 and 54 above). Furthermore, the process of communication with the patient must be capable of accommodating the real possibility that the patient will change his or her view on PAD as the disease progresses. Ensuring the ongoing validity of the request can be particularly difficult in the case of medical conditions, such as ALS, where patients might ultimately lose the ability to communicate (ibid., and paragraph 12 above). In any case, the Court understands from the expert evidence that effective communication with the patient requires special skills, time and significant commitment on the part of medical and other professionals, as does the provision of adequate palliative care, which both experts considered to be a necessary precondition for considering recourse to PAD (see paragraphs 49 and 54 above). The Court notes in this connection that the assessment and allocation of such resources is, in principle, a matter which falls within the margin of appreciation of the domestic authorities.*

An important plank of Mr Karzai's case was that he would be condemned to "*existential suffering*" in the period of time before a combination of the withdrawal of life-sustaining treatment at his request (in the court's jargon, "RWI," for "refusal… or withdrawal of life-sustaining or life-saving interventions). As the court noted, he appeared to "*rely heavily on this alleged lack of any*

alternative means of addressing his suffering" (paragraph 154).

The court identified that "*according to the expert evidence heard by the Court, the available options in palliative care, guided by the European Association of Palliative Care's Revised Recommendations, including the use of palliative sedation, are generally able to provide relief to patients in the applicant's situation and allow them to die peacefully*" (paragraph 154).

Mr Karzai did not dispute this, but instead:

> *155.* […] *argued that he would refuse such a course of action, since, by being medically sedated, he would lose what is left of his autonomy (see paragraph 91 above; see also the concerns expressed by the German Federal Administrative Court, paragraph 71 above). The Court notes that this is a legitimate personal choice, and one of an undoubtedly crucial nature (see paragraph 46 above). However, it considers that a personal preference to forego otherwise appropriate and available procedures cannot in itself require the authorities to provide alternative solutions, let alone to legalise PAD. To hold otherwise would effectively mean that Article 8 could be interpreted as encompassing PAD as a right that is enforceable under the Convention, regardless of the available alternatives.*

The court noted that the existential suffering to which Mr Karzai referred was not uncommon in patients with ALS / MND, but not exclusive to them, and also that "*existential suffering may be refractory to medical treatment* […] *and that the use of sedation to alleviate it might be contested or unwarranted in certain situations.*" It continued:

> *158. The gravity of the applicant's suffering can in no way be underestimated. However, in the Court's opinion, it is part of the human condition that medical science will probably never be fully capable of eliminating all aspects of the suffering of individuals who are terminally ill. Moreover, although it amounts to genuine and severe anguish, existential suffering relates essentially to a personal experience, which may be susceptible to change and does not lend itself to a straightforward objective assessment (see, for instance, paragraph 43 above). It is not for the Court to determine the acceptable level of risk involved in PAD in such circumstances; it is enough to note that the difficulties in objectively appraising refractoriness and other relevant elements of existential suffering may further exacerbate the risks addressed above (see paragraphs 149-151). For this reason, the Court is unable to accept this argument as one which militates for an obligation under Article 8 of the Convention to legalise PAD. However, this heightened state of vulnerability warrants a fundamentally humane approach by the authorities to the management of these situations, an approach which must necessarily include palliative care that is guided by compassion and high medical standards. The applicant did not allege that such care would be unavailable to him (see paragraph 154 above), and the domestic authorities cannot therefore be regarded as falling foul of any positive obligation that might arise from Article 8 of the Convention in this regard.*

The ECtHR dismissed relatively briefly Mr Karzai's claim that the criminal prohibition in the Hungarian law (including the application to assisting him to having recourse to it abroad) was disproportionate, placing particular weight on the considerable margin of appreciation granted to member States of the Council of Europe. It reiterated that "*the applicant's complaint that he was prevented from having recourse to PAD in Hungary because of the*

criminal-law prohibition on its use cannot be examined separately from the question of the positive provision of PAD, which it has already addressed. That is because, as explained previously […]*, the introduction of an exception to the impugned prohibition would inevitably require positive measures and regulation of PAD by the State*" (paragraph 159).

In conclusion, on the "pure" Article 8 ECHR claim:

> *166. The Court emphasises that the issue it has been asked to determine in the present case is not whether a different policy - such as one providing for PAD - might have been acceptable, but whether in striking the particular balance that they did between the competing interests, the Hungarian authorities remained within their considerable margin of appreciation (compare, for instance, Hristozov and Others, cited above, § 125). Against the above background, the Court does not find that the Hungarian authorities overstepped that margin. It thus follows that there has been no violation of Article 8 of the Convention.*
>
> *167. That being said, the Court would reiterate that the Convention has to be interpreted and applied in the light of present-day conditions. The need for appropriate legal measures should therefore be kept under review, having regard to the developments in European societies and in the international standards on medical ethics in this sensitive domain (compare S.H. and Others v. Austria, cited above, § 118, and Y v. France, no. 76888/17, § 91, 31 January 2023).*

The ECtHR then turned to the question of whether Mr Karzai was discriminated against because Hungarian law did not provide him with an option to hasten his death, although it did provide such an option to terminally ill patients who were dependent on life-sustaining treatment. It dismissed this complaint briskly:

> *174. The Court takes note of the Government's argument that RWI and PAD are inherently different acts in terms of their causation and intent (see paragraph 172 above), and that the applicant cannot be compared to those persons whose lives depend on life-sustaining treatment (see paragraph 171 above). However, the Court is not required to determine these contested points as, in any event, the alleged difference in treatment has objective and reasonable justification. As a further preliminary point, it should be noted that the applicant also argued that terminal illness as the condition to have recourse to RWI was not defined in law (see paragraph 170 above). The Court notes that the Healthcare Act refers to a serious illness leading to death within a short period of time (see paragraph 21 above). While the Healthcare Act does not specify that period in further detail, the Court does not find this of particular importance, especially since the applicant's main argument is based on the fact that he is expected to need continuous life-sustaining treatment, if at all, only at the very end stage of his disease.*
>
> *175. The Court notes that the right to refuse or request discontinuation of unwanted medical treatment is inherently connected to the right to free and informed consent to medical intervention, which is widely recognised and endorsed by the medical profession, and is also laid down in the Oviedo Convention (see paragraphs 35, 36, 41 and 56 above; see also Mayboroda v. Ukraine, no. 14709/07, § 52, 13 April 2023, and Reyes Jimenez v. Spain, no. 57020/18, §§ 29 and 30, 8 March 2022). This point has also been consistently reiterated by the Court with regard to situations where the refusal to*

> *accept a particular treatment might lead to a fatal outcome (see Pretty, cited above, § 63; V.C. v. Slovakia, no. 18968/07, § 105, ECHR 2011 (extracts); and Jehovah's Witnesses of Moscow v. Russia, no. 302/02, § 135, 10 June 2010). It must be acknowledged that the refusal or withdrawal of treatment in end-of-life situations is the subject of particular consideration or regulation because of the need to safeguard, inter alia, the right to life (see paragraphs 37, 38, 130, and 171 above); however, such refusal or withdrawal is intrinsically linked to the right to free and informed consent, rather than to a right to be assisted in dying.*
>
> *176. The Court further notes that it has found it justified for Hungary to maintain an absolute ban on assisted suicide, on account, among other aspects, of the risks of abuse involved in the provision of PAD, which may extend beyond those involved in RWI (see paragraph 150 above); the potential broader social implications of PAD (see paragraph 149 above); the policy choices involved in its provision (see paragraphs 151, 157 and 161 above); and the considerable margin of appreciation afforded to the States in this respect (see paragraph 144 above). Similar cogent reasons exist under Article 14 for justifying the allegedly different treatment of those terminally ill patients who are dependent on life-sustaining treatment and those patients who are not, and who in consequence cannot hasten their death by refusing such treatment. The Court would note in this connection that, in contrast to the situation with regard to PAD, the majority of the member States allow RWI (see paragraph 59 above). Furthermore, as mentioned above, the right to refuse or withdraw consent to interventions in the health field is recognised also in the Oviedo Convention, which, in contrast, does not safeguard any interests with regard to PAD (see paragraphs 35 and 36 above). The Court therefore considers that the alleged difference in treatment of the aforementioned two groups of terminally ill patients is objectively and reasonably justified.*
>
> *177. It follows that there has been no violation of Article 14 taken in conjunction with Article 8 of the Convention.*

The arguments under Articles 3 and 9 ECHR were not considered to raise any separate issues.

Judge Wojtzczek would not have held that the application was admissible. Judge Felici wrote a strong dissent suggesting that the court could have developed its case-law to allow for PAD, even if this needed to include a positive obligation on the state under Article 8 ECHR. Judge Felici also strongly regretted the fact that the case had not been remitted to the Grand Chamber "*which would have allowed a more up-to-date approach to the principles regarding end-of-life care and PAD, which, given the extreme importance of the subject, was certainly the task and responsibility of the Grand Chamber*."

Comment

In line with our normal approach to this issue, we will not comment on the merits of whether what we will call here PAD (after the judgment) should be made legal. It is, however, a decision which makes interesting reading given the prominence of the issue in politics in the United Kingdom (and its surrounding islands) at the moment. It is, indeed, a decision which we suggest makes necessary reading for those wanting to grapple with the underpinning rights issues in a way which goes beyond soundbites (and, for those wanting to go behind headlines, this explainer

from Alex may also be useful). The court's decision is, in particular, helpful in making clear how legalising PAD is not simply a matter of the State getting out of the way of willing doctors wishing to prescribe medication to wanting patients. Rather, as the court makes clear, it inevitably involves positive actions on the part of the State, including providing "access to medical intervention, such as access to life-ending drugs." That is, in itself, not an argument for or against legalisation. It is, however, an argument for clarity about what it entails.

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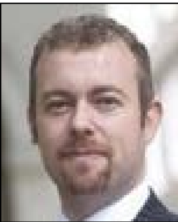

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Adrian will be speaking at the following open events:

1. The World Congress on Adult Support and Care in Buenos Aires (August 27-30, 2024, details here)
2. The European Law Institute Annual Conference in Dublin (10 October, details here).

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If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

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