CONSEIL DE L'EUROPE

COUNCIL OF EUROPE

COUR EUROPÉENNE DES DROITS DE L'HOMME
EUROPEAN COURT OF HUMAN RIGHTS

FOURTH SECTION

DECISION

AS TO THE ADMISSIBILITY OF

Application no. 3346/02
by Barbara FRANCIS
against the United Kingdom

The European Court of Human Rights (Fourth Section), sitting on 8 April 2003 as a Chamber composed of

Mr M. PELLONPÄÄ, *President*,
Sir Nicolas BRATZA,
Mrs V. STRÁŽNICKÁ,
Mr R. MARUSTE,
Mr S. PAVLOVSCHI,
Mr L. GARLICKI,
Mr J. BORREGO BORREGO, *judges*,
and Mr M. O'BOYLE, *Section Registrar*,

Having regard to the above application lodged on 12 December 2001,

Having deliberated, decides as follows:

THE FACTS

The applicant, Mrs Barbara Francis, is a United Kingdom national, who was born in 1948 and lives in Southend-on-Sea.

A. The circumstances of the case

The facts of the case, as submitted by the applicant and as may be deduced from the documents, may be summarised as follows.

The applicant's son, Jason, born in 1971, had a history of alcohol abuse. Between 1994 and 1998, he was seen at the Southend Hospital Accident and Emergency Department, on some 27 occasions, for *inter alia* overdoses, fits, attempted suicide and injuries to his hand (apparently self-inflicted). He had spent periods in Rochford and Runwell Hospitals and was being treated by Dr Killala, a consultant psychiatrist based at the drug and dependency unit at the former hospital.

The applicant states that her son had attempted suicide on eight previous occasions. It appears that Jason's doctor, Dr Killala, had maintained that his problems were alcohol-related rather than psychiatric and that any psychotic attacks were due to the alcohol or its withdrawal. He treated Jason on that basis, despite the applicant's conviction that Jason had psychological problems. He had also discharged Jason from hospital on several occasions contrary to the applicant's views as he did not consider that Jason was "sectionable" (i.e. liable to be compulsorily detained under the Mental Health Act 1983) and took the view that Jason had access to all the treatment that he needed to tackle his alcohol problem if he so wished.

On the morning of 18 August 1998, the applicant found Jason in a state of illness and distress and sent for an ambulance which took him to Southend Hospital. The admitting doctor noted that he was well-known to the hospital for psychiatric problems and that Jason had taken an overdose of tempazipam tablets together with some wine and was expressing suicidal intentions. Jason referred to voices telling him to kill himself. He was assessed as a high suicide risk with a suicide intent scale of 20 out of 27. The casualty doctor referred him to the duty psychiatrist to see whether he should be detained under the Mental Health Act 1983. The duty psychiatrist was unable to make an adequate assessment as Jason was too drowsy from the drugs. He stated that without a psychiatric assessment it was not possible to detain a patient under the Mental Health Act. He advised that Jason should stay in hospital overnight and that he should be reviewed in the morning. A medical doctor reviewed him again before 18.00 hours and noted tremors and the fact that Jason was withdrawing from alcohol. He recommended that observation continue and that the duty psychiatrist see him in the morning. Drugs were prescribed for withdrawal symptoms. The applicant and Jason's father were present at this time. However, Jason

refused to stay and insisted on discharging himself against the advice of the applicant and the medical staff present. He left the hospital at some time after 19.00 and his father took him back to his flat.

Later, that evening, around 20.00 hours, Jason's body was found underneath the flat where he lived. He had suffered extensive injuries and later died in hospital. The police investigation concluded that there were no suspicious circumstances and that Jason had taken his own life by climbing out of the window of his flat and jumping.

The applicant had already been dissatisfied with Jason's treatment by the health establishment, including Dr Killala who had failed in her view to take Jason's problems seriously over a period of years. She made official complaints to the health authority and to the General Medical Council (GMC). She also had suspicions as to whether the death was in fact suicide.

On 17 November 1998, an inquest was opened into the death. As a result of queries raised by the applicant as to the circumstances of the death, the Coroner adjourned the inquest and requested that the police investigate the points raised, in particular whether Jason had been unlawfully killed by others rather than having committed suicide. The police submitted a report on 28 January 1999, concurring with the findings of the original investigation and rejecting assertions that Jason's death could have been caused at the hands of others.

By early 1999, Dr Killala had been suspended from practice. It appeared that there were a number of patients complaining about his conduct and the GMC began an investigation. During 1999, various reports were issued by the health authority, including a report by an independent consultant, concerning the applicant's complaints about the care given to her son. An internal report into the death found that there had been no basis on which the hospital could have kept Jason from discharging himself on 18 August as he was an adult and he was not showing signs at the time of mental disorder justifying compulsory committal. Further reports on the drugs prescribed to the applicant's son during his treatment by Dr Killala rejected the applicant's suspicions that J. had been prescribed harmful medicines.

During 2000, there was correspondence between the Coroner and the applicant's solicitors concerning whether there should be a jury inquest. It was also becoming apparent that Dr Killala was showing signs of mental ill-health and the inquest continued to be adjourned, on occasion at the request of the applicant who was at the same time pursuing other avenues of inquiry and possible redress.

A report dated 27 October 2000 was issued by the Health Service Ombudsman concerning the applicant's complaints about her son's treatment by the health authority (Southend Hospital NHS Trust), in particular that staff had allowed Jason to discharge himself from hospital when he was at risk of self-harm. The Ombudsman found, on the basis of expert assessors' views, that there had been no basis to detain the applicant

formally at the hospital as under the Mental Health Act it was only possible to detain a person dependent on alcohol or drugs if the patient was suffering from a mental disorder. As it had not been possible to assess Jason due to his drowsiness, no assessment could be made prior to his departure from the hospital. While the Trust had stated that it would have been preferable for the duty psychiatrist to have been contacted before Jason discharged himself, the assessors had not considered that this had been necessary. Any attempt to restrain him would have probably resulted in violence. The assessors considered that Jason's history did not disclose that he suffered from any condition other than severe alcohol dependency, and it was common for heavily alcohol-dependent patients to experience hallucinations. They doubted that, even if the duty psychiatrist had been called and been able to assess Jason, there would have been any grounds to detain him under the Mental Health Act. The report concluded that the health authority had not failed in their duty of care to Jason.

The inquest held, with a jury, on 23-25 May 2001 returned an open verdict. The Coroner had directed that there was no evidence to found a verdict of unlawful killing and left four verdicts to the jury (suicide, that he took his life while the balance of his mind was disturbed, accidental death or an open verdict). The applicant was represented during the inquest.

The applicant was advised by her lawyers that an application for judicial review of the inquest proceedings would not stand any chance of success.

The applicant applied without success to the Home Secretary for a public enquiry to be held.

By early 2001, Dr Killala's representatives were claiming that his mental ill-health should prevent further investigation of the charges raised in the GMC enquiry concerning his conduct as a doctor. The applicant had provided the GMC investigation with information about alleged shortcomings in the treatment of her son by Dr Killala. She grew dissatisfied with the solicitors and counsel, who were acting for the GMC and who she considered should be representing her interests in the proceedings, on the grounds, *inter alia*, that they did not appear to be resisting moves to transfer the case out of the Professional Conduct Committee and that many of the charges drawn up by her concerning her son had been dropped by the GMC expert for lack of evidence. Of eight charges, six were dropped, leaving two charges concerning the applicant's son - the failure to answer the applicant's complaints about her son's treatment made in April 1998 before his death and a prescription of 8 weeks' supply of the drug Nozinan on 7 August 1998.

After preliminary hearings before the GMC, the matter was transferred, despite the applicant's opposition, from the Professional Conduct Committee, which would have heard evidence in public proceedings, to the Health Committee on the basis of medical reports about Dr Killala's mental health. After a hearing by the Health Committee held *in camera* in

November 2001, the Committee decided on 26 January 2002 to suspend Dr Killala for 12 months, to be reviewed in a year. On the basis *inter alia* of four medical reports, it found that Dr Killala's fitness to practise was impaired by an emotionally unstable personality disorder and that his current mental condition prevented him from giving instructions to his legal advisers and from following the proceedings. If his mental state was found to recover, the matters would be referred back to the Professional Conduct Committee for the serious charges to be considered.

COMPLAINTS

The applicant complains under Article 2 that the doctors, in particular Dr Killala, were responsible for her son's death, under Article 6 that she was denied a public hearing or investigation and under Article 13 that she has no remedy.

THE LAW

1. The applicant complains that the doctors who treated her son were responsible for his death, invoking Article 2 of the Convention which provides in its first paragraph:

> "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. ..."

The Court recalls that the applicant made numerous complaints about her son's death to the authorities. The police carried out several investigations as did the various experts on behalf of the health authorities. In the report of 27 October 2000, the Health Ombudsman reviewed, in particular, the applicant's complaints that her son had been allowed to discharge himself from hospital prior to his death. The Ombudsman found that there had been no grounds on which her son could have been detained against his will and that the hospital had provided the proper care for him in the circumstances.

As regards the applicant's allegations that her son's treatment by Dr Killala during the years preceding his death was negligent and failed to address his mental health problems, there is no material before the Court capable of establishing any sufficient causal link between the alleged shortcomings and the tragic events of 18 August 1998. It notes that it would have been open to the applicant to institute negligence proceedings against either the relevant health authority or Dr Killala for any harm caused to her son by lack of proper medical treatment. However, it is not apparent that the applicant has taken any steps in that regard.

Consequently, there is insufficient evidence to substantiate the applicant's claims that any public official was responsible for the death of her son.

As regards the procedural obligation under Article 2 to conduct an effective investigation into suspicious deaths, which the applicant has not expressly raised, the Court notes that the facts surrounding the applicant's son's death were investigated by the police several times in response to her allegations, by the health authorities and Health Service Ombudsman and at an inquest at which evidence was heard publicly before a jury. While the inquest took place only in 2001, after a lapse of 21 months, it appears that the adjournments resulted from further police investigations into the death at the applicant's request, complications arising from the concurrent health authority and General Medical Council (GMC) investigations and the mental ill-health of Dr Killala. The applicant does not appear to have objected to any of the inquest adjournments or taken any steps to expedite the inquest. In the circumstances, the delay was not unreasonable and did not undermine the effectiveness of the inquest.

The applicant contends that the inquest was a "sham". In particular, complaint is made that information was withheld from the inquest jury, that Dr Killala was not called as a witness because of his alleged ill-health, that the solicitor and counsel who represented her in the proceedings were not independent as they were funded by the GMC, that she was not permitted in her evidence at the inquest to refer to the responsibility of Dr Killala or to suggest foul play and that the inquest jury was only given the option of bringing in one of four verdicts. The Court has carefully examined each of these complaints but does not find that, considered individually or collectively, they cast doubt on the independence or effectiveness of the inquest proceedings.

This part of the application is therefore manifestly ill-founded and must be rejected pursuant to Article 35 §§ 3 and 4 of the Convention.

2. The applicant invokes Article 6 § 1 of the Convention, complaining that she was denied a public investigation into her son's death.

Article 6 § 1 provides:

> "In the determination of his civil rights and obligations ..., everyone is entitled to a fair and public... hearing ... by [a] ... tribunal..."

The applicant's principal complaint here appears to be the lack of a public hearing into her complaints about Dr Killala's medical negligence, which were not dealt with in the inquest. The charges of professional misconduct were to have been heard in public before the Professional Conduct Committee but due to four medical reports on Dr Killala's mental state he was suspended as unfit in a hearing held *in camera*. These proceedings did not in any event deal with any civil right or obligation of

the applicant's – she participated in the GMC enquiry as a complainant in a disciplinary matter. She would have been able to sue Dr Killala and the health authority for any medical negligence in civil proceedings though any such proceedings might potentially have run into similar difficulties as the GMC enquiry due to the mental ill-health of Dr Killala. This would not however be a matter for which the Government could be held responsible.

Accordingly, the Court finds no appearance of lack of access to a public hearing contrary to Article 6 of the Convention. This complaint must therefore be rejected as manifestly ill-founded pursuant to Article 35 §§ 3 and 4 of the Convention.

3. The applicant finally invokes Article 13 of the Convention which provides:

> "Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

According to the Court's case-law, Article 13 applies only where an individual has an "arguable claim" to be the victim of a violation of a Convention right (see *Boyle and Rice v. the United Kingdom,* judgment of 27 April 1988, Series A no. 131, § 52).

The Court has above found that the applicant's complaints are manifestly ill-founded. For similar reasons, the applicant does not have an "arguable claim" and Article 13 is therefore inapplicable to her case. It follows that this part of the application is also manifestly ill-founded within the meaning of Article 35 § 3 of the Convention and must be rejected pursuant to Article 35 § 4.

For these reasons, the Court unanimously

Declares the application inadmissible.

Michael O'BOYLE
Registrar

Matti PELLONPÄÄ
President