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. 61827/00
by David and Carol GLASS
against the United Kingdom

The European Court of Human Rights (Fourth Section), sitting on 18 March 2003 as a Chamber composed of

Mr M. PELLONPÄÄ, *President*,
Sir Nicolas BRATZA,
Mrs E. PALM,
Mr M. FISCHBACH,
Mr J. CASADEVALL,
Mr S. PAVLOVSCHI,
Mr J. BORREGO BORREGO, *judges*,
and Mr M. O'BOYLE , *Section Registrar*,

Having regard to the above application introduced on 5 June 2000 and registered on 16 October 2000,

Having regard to the parties' further written submissions,

Having deliberated, decides as follows:

THE FACTS

The applicants David (the first applicant) and Carol (the second applicant) Glass are United Kingdom nationals. The first applicant, born in 1986, is a severely mentally and physically disabled child who requires twenty-four hour attention. The second applicant is his mother. They live in Portsmouth, England. The applicants are represented before the Court by Leigh, Day and Co., a firm of solicitors based in London, England. The

respondent Government are represented by their Agent, Mr D. Walton, of the Foreign and Commonwealth Office, London.

A. The circumstances of the case

The facts of the case, as submitted by the parties, may be summarised as follows.

The first applicant had been particularly unwell since July 1998 when he was admitted to St Mary's Hospital, one of two hospitals belonging to the Portsmouth Hospitals National Health Service (NHS) Trust (hereinafter "the Trust"). He was operated on in order to alleviate an upper respiratory tract obstruction. The first applicant suffered post-operative complications, including infections, and had to be put on a ventilator since he had become critically ill.

During the period of the first applicant's treatment, discussions took place at the hospital between the second applicant and intensive care staff and paediatricians. Among the opinions expressed was that despite the best care, the first applicant was dying and that further intensive care would be inappropriate. The second applicant and other family members were not happy with this advice, although a note drawn up on 30 July 1998 by Dr Smith mentioned that the family had appeared to accept the situation "without distress or significant surprise." However, on 31 July 1998 following an "unconstructive and confrontational" meeting with family members, the hospital offered to arrange for an outside opinion on David's condition and his suitability for further active intensive care therapy. This offer was made twice and on both occasions was refused. The Trust consulted its solicitors and advised the applicants to consult their solicitors.

However, the first applicant's condition improved and on 31 July 1998 he was able to be returned from intensive care to the paediatric ward. The applicants draw attention to the fact that the first applicant's notes on being discharged from intensive care made reference to "Demanding family". They also observe that a note of Dr Wozniak drawn up on 3 August 1998 stated:

> "I think [the first applicant] would not survive this illness despite our efforts, but our efforts continue and we will continue his antibiotics, physio' and attempt to find feeds that he will tolerate... . we may need to consider measures to relieve distress e.g. Hyoscine for the secretions, Morphine and the risk of those measures and mum felt that this was not appropriate at present."

The first applicant was eventually able to return home on 2 September 1998. However, he had to be re-admitted to the hospital on several occasions thereafter on account of respiratory tract infections.

On one such occasion the doctors, on 8 September 1998, discussed with the second applicant the use of morphine to alleviate distress. The second applicant expressed her opposition to the use of morphine or other drugs to

relieve distress. She told the doctors that in the event that the first applicant's heart stopped she would expect resuscitation including intubation. Dr Walker considered that this would not be in the first applicant's best interests, and stated that if death were inevitable all that was on offer was "Morphine and TLC [tender loving care]". Dr Walker's case notes recorded that:

> "These replies [of the second applicant] are contrary to decisions particularly previously made and I do not believe that further intensive care is in [the first applicant's] best interest. This needs to be resolved before it becomes necessary and I have therefore said that we need a second opinion - if necessary appointed by the courts to ensure an impartial decision by which we would all comply."

That same day the applicants' General Practitioner informed the hospital that he had been contacted by the applicants' solicitor about the family's concern that the first applicant would be "helped on his way" with morphine.

Dr Walker reported as follows on a discussion which she had with the second applicant on 8 September 1998:

> "If [the first applicant] deteriorates rapidly he should receive bag and mask positive pressure respiration, but no cardiac massage and no intravenous or other drugs to resuscitate him."

As to the use of morphine, Dr Walker stressed at the meeting that the doctors would never prescribe it or other sedatives without first discussing this with the second applicant. Dr Walker stated in her notes:

> "I have told [the second applicant] that we can give morphine to alleviate distress even vs. their wishes (and we can - I am assured by the Official Solicitor that no judge has ever overturned a doctor's decision to withdraw treatment/alleviate symptons) but we wouldn't without telling them."

According to the Government, the agreement as regards non-resuscitation was confirmed with the second applicant on 9 September 1998 by Dr Hallet. Dr Hallet's contemporaneous notes on the matter state:

> "The position appears to me to be precarious. He may recover with the antibiotics but the inability to cough secretions makes it possible that he will deteriorate and die. I have discussed the latter scenario. Mother says that she would like bag and mask but understands that it would not be appropriate to go on to full intubation and ITU treatment. This is as discussed with Dr Walker."

Dr Hallet and the second applicant also discussed on that occasion the use of morphine in therapeutic doses. The applicants point out that Dr Hallet recognised that: "In the event of total disagreement we should be obliged to go to the Courts to provide support for decision. Mother says she does not understand this."

Dr Hallet's notes record the following:

> "Mother said that she would not contemplate euthanasia and I said that we would not either. The question of morphine came up and she agrees with the use of Morphine in therapeutic doses to overcome pain if necessary.
>
> (...) in view of today's and yesterday's discussions with mother which appear to have achieved a common ground, involvement of the court may not be necessary."

The first applicant's condition deteriorated. He was admitted to St Mary's Hospital on 15 October 1998, and then again on 18 October 1998 following respiratory failure.

The first applicant was treated over the course of 19 October 1998. His condition was reviewed on separate occasions by two doctors, both of whom expressed serious concern about his prospects of surviving. Dr Walker observed that the first applicant looked "ghastly" and "exhausted".

At 1.30 p.m. on 20 October 1998 the medical opinion was that the first applicant "was going into the terminal phase of respiratory failure."

At 5.45 p.m. on 20 October 1998 Dr Hallett noted that the first applicant "is dying from his lung disease".

The doctors treating the first applicant advised that diamorphine should be administered to him, believing that he had entered a terminal phase and required pain relief. The second applicant and other members of the family did not agree with the doctors' view that her son was dying and were very concerned that the administration of diamorphine (previously morphine had been mentioned) would compromise his chances of recovery. The second applicant voiced her concerns at a meeting with Drs Walker and Hallett and the Chief Executive of the Trust. A woman police officer was also present. The hospital persisted in its wish to give the first applicant diamorphine, although the second applicant was given an assurance that he would only be given "the smallest possible dose." According to the applicants, the Chief Executive of the Trust had an influential role at the meeting and made it clear to the second applicant that diamorphine would be given to the first applicant. They refer in this connection to a letter written by the Chief Executive to the applicants' MP on 23 November 1998 in which he stated that he had instructed the doctors to administer diamorphine to the first applicant at the minimum dosage over a twenty-four hour period. The Government assert that the Chief Executive had no role to play whatsoever in the exercise of clinical judgment in the first applicant's case.

The notes of Drs Walker, Ashton and Hallett all stressed that the administration of morphine was not intended to kill the first applicant but to relieve his distress. Dr Hallett observed in his notes that the doctors who had met with the second applicant had stressed that the "use of Morphine is NOT euthanasia - it is to relieve [the first applicant's] distress...".

The second applicant subsequently expressed the wish to take the first applicant home if the doctors were correct in their view that he was dying. A police officer in attendance advised her that if she attempted to remove him, she would be arrested. The hospital also indicated that unless the family members present allowed the doctors to commence diamorphine the police would remove them also. The first applicant tried without success to contact her solicitor, including at the latter's home.

A diamorphine infusion was commenced at 7 p.m. on 20 October 1998. The applicants maintain that the dose administered, namely 1mg per hour, was in reality an adult dose and excessive for a child of the first applicant's age. The Government deny this and point to the first applicant's weight and to the fact that previous treatment with opiates had rendered the first applicant more tolerant to them.

A dispute broke out in the hospital involving the family members (but not the second applicant) and the doctors. The family members believed that the first applicant was being covertly euthanased and attempted to prevent the doctors from entering the first applicant's room. The hospital authorities called the security staff and threatened to exclude the family from the hospital by force.

A "Do Not Resuscitate" order was put in the first applicant's medical notes without consulting the second applicant.

The dosage was reduced by half at 10 a.m. on 21 October 1998 in response to the family's continuing objections. The Government draw attention to the views of the doctors that the dose administered to the first applicant had improved his condition. Dr Walker found that it was:

> "... a real relief and pleasant to see [the first applicant] peaceful and settled ... and his overall condition including agitation and distress had markedly improved."

The following day the second applicant found that her son's condition had deteriorated alarmingly and was worried that this was due to the effect which the diamorphine was having on him. The family became extremely agitated and demanded that diamorphine be stopped. Dr Walker stated that this was only possible if the family agreed not to resuscitate or stimulate the first applicant. The Government contend that the objective of Dr Walker was to prevent the family from disturbing the first applicant by creating undue noise and touching him since at that time the first applicant was peaceful, breathing deeply and was not in distress.

The family tried to revive the first applicant and a fight broke out between certain members of the family and Drs Walker and Ashton.

The second applicant successfully resuscitated her son while the fight was going on. At some stage the police were summoned to the hospital in response to the assaults on Drs Walker and Ashton. Several police officers were injured and the mother of another patient on the ward was pushed against a wall. All but one of the children on the ward had to be evacuated.

The injuries sustained by Drs Walker and Ashton were such that they were unable to perform their normal duties for a time.

The first applicant's condition improved and he could respond to stimuli from his relatives. He was able to be discharged home on 21 October 1998.

The second applicant states that the Trust made no arrangements for any alternative care on discharge for the first applicant. They mention that the Trust did not arrange for the first applicant to be given an antidote for diamorphine and that the second applicant had to acquire equipment for measuring the first applicant's oxygen saturation. In this connection, the Government draw attention to a Report of Dr Hallett, which states:

> "It was felt that further care within the hospital setting was impossible and that he would be better managed at home, provided that we could obtain oxygen for the home. Arrangements were made to obtain oxygen and I discussed with his general practitioner to take on the responsibility of caring for his major chest problems at home. I then telephoned the Clinical Director at Southampton General Hospital to enquire whether they would accept if he had to be readmitted in view of the severe disturbances to the hospital staff. I discussed going home with his mother who agreed to this and we then made telephone calls to community nurses and made arrangements for home oxygen. Following this transport was arranged to take the patient home."

On 23 June 2000 some of the family members involved in the fracas with the doctors were later convicted of assault and ordered to be excluded from the hospital. On 28 July 2000 their sentences were reduced on appeal. On 26 October 1999 the Trust dropped its civil action for trespass against the second applicant for want of a legal basis.

On 5 November 1998 the Medical Director of the Trust notified the second applicant in a letter that the paediatric staff at the hospital was anxious about a repetition of the problems which arose when her son was last admitted to the hospital and was no longer confident of being able to give him the treatment he deserved. The letter continued:

> "Unfortunately [Portsmouth Hospital] believe that all we could offer [the first applicant] would be to make his remaining life as comfortable as possible and take no active steps to prolong life. This obviously means withholding or giving treatment with which you may not agree. As there seems no easy way to resolve these differences it would be sensible, if [the first applicant] required further inpatient care, for this to be provided at another hospital."

The second applicant was informed that Southampton General Hospital, about twenty-five miles from her home, was willing to admit and treat her son should he suffer a further attack.

The family's general practitioner subsequently contacted Southampton General Hospital with a view to discussing arrangements for the first applicant's admission in the event of a future emergency.

The second applicant applied for judicial review of the decisions made by the Trust with regard to the medical treatment of her son. The matter came before Mr Justice Scott Baker.

On 21 April 1998 Mr Justice Scott Baker ruled that the Trust's decision was not susceptible to review because the situation had passed and would not arise again with the hospitals managed by it nor, hopefully, at any other hospital. He added:

> "If there is serious disagreement, the best interests procedure can be involved at short notice and the court will resolve it on the basis of the facts as they are then. They will almost inevitably be different from the facts as they were in October 1998. ... In any event it is unclear precisely what the facts were in October 1998 on the evidence that is before this court. ... Furthermore, if there is a crisis in the future, I am confident that if the matter is brought before the court the Official Solicitor will again provide assistance."

In Mr Justice Scott Baker's view, judicial review was too blunt an instrument for the sensitive and on-going problems of the type raised by the case. In particular, he considered that it would be very difficult to frame any declaration in meaningful terms in a hypothetical situation so as not to restrict unnecessarily proper treatment by the doctors in an on-going and developing matter. He stressed in conclusion:

> "Nothing, I would finally say, should be read into this judgment to infer that it is my view that the [Portsmouth Hospital] in this case acted either lawfully or unlawfully."

The second applicant applied for permission to appeal to the Court of Appeal. The application was refused on 21 July 1999. Giving judgment, Lord Woolf MR was of the view that the considerations which might arise in relation to the first applicant and other children who suffered from similar disabilities were almost infinite and for the courts to try and produce clarity would be a task fraught with danger. Lord Woolf MR stated:

> "There are questions of judgment involved. There can be no doubt that the best course is for a parent of a child to agree on the course which the doctors are proposing to take, having fully consulted the parent and for the parent to fully understand what is involved. That is the course which should always be adopted in a case of this nature. If that is not possible and there is a conflict, and if the conflict is of a grave nature, the matter must then be brought before the court so the court can decide what is in the best interests of the child concerned. Faced with a particular problem, the courts will answer that problem.(...)
>
> (...) This difficulty in this area is that there are conflicting principles involved. The principles of law are clearly established, but how you apply those principles to particular facts is often very difficult to anticipate. It is only when the court is faced with that task that it gives an answer which reflects the view of the court as to what is in the best interests of the child. In doing so it takes into account the natural concerns and the responsibilities of the parent. It also takes into account the views of the doctors, and considers what is the most desirable answer taking the best advice it can obtain from, among others, the Official Solicitor. That is the way, in my judgment, that the courts must react in this very sensitive and difficult area."

Lord Woolf MR disagreed with Mr Justice Scott Baker's view that the applicants had used the wrong legal procedure. In his opinion, "particularly in cases regarding children, the last thing the court should be concerned about is whether the right procedure has been used in the particular case."

The second applicant complained to the General Medical Council about the conduct of the doctors involved in her son's care, in particular that they had assaulted him by administering to him heroin against her wishes and without court authorisation.

On 7 January 2000 the General Medical Council concluded that its investigation revealed that the doctors involved had not been guilty of serious professional misconduct or seriously deficient performance and that the treatment complained of had been justified in the light of the emergency situation which confronted the doctors at the material time. According to the General Medical Council, the test for bringing disciplinary proceedings against the doctors was not satisfied on the evidence. It had asked itself in this connection whether the doctors put themselves in a reasonable position from which to arrive at the decision they did and whether the decision reached was so "outrageous" that no reasonably competent doctor could have reached it.

The second applicant also complained to the Hampshire police about the conduct of the doctors who had treated her son. An investigation was opened. The doctors were interviewed and a report sent to the Crown Prosecution Service.

On 8 May 2000 the second applicant's solicitors informed her that the Crown Prosecution Service had decided not to bring charges against the doctors involved for lack of evidence. In a letter dated 16 June 2000 to her solicitors, the Crown Prosecution Service explained the reasons which led to this finding as well as the various materials relied on in reaching its conclusion on the advisability of bringing charges against the doctors in relation to the offences of attempted murder and conspiracy to murder and offences under the Offences against the Person Act 1861.

B. Relevant domestic law and practice

Paragraph 24 of the General Medical Council's guidance "Seeking patients' consent: the ethical considerations" provides:

> "Where a child under 16 years old is not competent to give or withhold the informed consent, a person with parental responsibility may authorise investigations or treatment which are in the child's best interests. This person may also refuse any intervention where they consider that refusal to be in the child's best interest, but you are not bound by such a refusal and may seek a ruling from the court. In an emergency, where you consider that it is in the child's best interest to proceed, you may treat the child, provided it is limited to that treatment which is reasonably required in an emergency."

In *Re J (A Minor) (Wardship: Medical Treatment*) [1990] 3 All E R, Lord Donaldson MR stated*:*

> "The doctors owe the child a duty to care for it in accordance with good medical practice recognised as appropriate by a competent body of professional opinion (...). This duty is however subject to the qualification that, if time permits, they must obtain the consent of the parents before undertaking serious invasive treatment.
>
> The parents owe the child a duty to give or withhold consent in the best interests of the child and without regard to their own interests.
>
> The court when exercising the parens patriae jurisdiction takes over the rights and duties of the parents, although this is not to say that the parents will be excluded from the decision-making process. Nevertheless in the end the responsibility for the decision whether to give or to withhold consent is that of the court alone.
>
> (...).
>
> No-one can dictate the treatment to be given to the child - neither court, parents nor doctors. There are checks and balances. The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment which they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B or both, but cannot insist on treatment C. The inevitable and desirable result is that choice of treatment is in some measure a joint decision of the doctors and the court or parents.
>
> (...)."

In *A National Health Service Trust v. D* ([2000] FCR 577), it was held:

> "The court's clear respect for the sanctity of human life must impose a strong obligation in favour of taking all steps capable of preserving life, save in exceptional circumstances."

In that case, the court accepted the views of doctors treating a child that resuscitation of the child in the event of respiratory or cardiac arrest would be inappropriate.

According to the Government, English law recognises that it may be in the best interests of a child or of an adult to be treated with medication which relieves his symptoms but has the side-effect of hastening death.

According to Part 3B of the guidance drawn up by the British Medical Association on "Withholding and Withdrawing Medical Treatment: Guidance for decision making":

> "... where there is reasonable uncertainty about the benefit of life-prolonging treatment, there should be a presumption in favour of initiating it, although there are circumstances in which active intervention (other than basic care) would not be appropriate since best interests is not synonymous with prolongation of life ... If the child's condition is incompatible with survival or where there is broad consensus that the condition is so severe that treatment would not provide a benefit in terms of being able to restore or maintain the patient's health, intervention may be unjustified.

> Similarly, where treatments would involve suffering or distress to the child, these and other burdens must be weighed against the anticipated benefit, even if life cannot be prolonged without treatment."

Paragraph 15.1 of the 2001 British Medical Association Guidance on "Withholding and Withdrawing Life-prolonging Medical Treatment" states:

> "Those with parental responsibility for a baby or young child are legally and morally entitled to give or withhold consent to treatment. Their decisions will usually be determinative unless they conflict seriously with the interpretation of those providing care about the child's best interests."

Paragraph 15.2 states:

> "The law has confirmed that best interests and the balance of benefits and burdens are essential components of decision making and that the views of parents are a part of this. However, parents cannot necessarily insist on enforcing decisions based solely on their own preferences where these conflict with good medical evidence."

At the time of the facts giving rise to the instant application, guidance had been published by the Royal College of Paediatrics and Child Health indicating the procedures that should normally be followed in the event that a parent dissents from the opinion of the health care team that treatment should be withheld from a child. The guidance states that a second opinion should normally be offered and the parent should be allowed time to consult advisers of their choice. Paragraph 3.4.3 states:

> "In most cases, with proper explanation and adequate time, parents can accept medical advice, but if the parents do not consent to withdrawal or withhold consent, a second opinion should be obtained and then the courts should be consulted. The Official Solicitor's Office can be telephoned for advice which will help clarify the need for court involvement"

Guidance published by the Department of Health in 2001, entitled "Consent: working with children" deals explicitly with the situation where clinicians believe that treatment which the parents want is not appropriate. It states:

> "One example would be where a child is very seriously ill, and clinicians believe that the suffering involved in further treatment would outweigh the possible benefits. Parents cannot require you to provide a particular treatment if you do not believe that it is clinically appropriate, but again the courts can be asked to rule if agreement cannot be reached. While a court would not require you to provide treatment against your clinical judgment, it could require you to transfer responsibility for the child's care to another clinician who does believe that the proposed treatment is appropriate."

In the case of *In re A (Conjoined Twins: Surgical Separation)*, Ward LJ stated:

> "Since the parents are empowered at law, it seems to be that their decision must be respected and in my judgment the hospital would be no more entitled to disregard their refusal than they are to disregard an adult person's refusal. I derive this from In re (A Minor) (Wardship: Consent to Treatment) [1992] Fam 11, 22, where Lord Donaldson of Lymington MR said:

> 'It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorised to give that consent. If he does so, he will be liable in damages for trespass to the person and may be guilty of a criminal assault'"

Under English law, there may be circumstances in which it is not practicable to seek a declaration from the courts, for example in an emergency situation where speedy decisions have to be taken concerning appropriate treatment. In *Re C (A Minor* [1998] Lloyd's Rep Med 1), Sir Stephen Brown affirmed that the decision of a doctor whether to treat a child:

> "is dependent upon an exercise of his own professional judgment, subject only to the threshold requirement that save in exceptional cases usually of an emergency he has the consent of someone who has authority to give that consent".

This is reflected in Paragraph 14 of the Reference Guide to Consent for Examination or Treatment, which states:

> "In an emergency it is justifiable to treat a child who lacks capacity without the consent of a person with parental authority, if it is impossible to obtain consent in time and if the treatment is vital to the survival or health of the child."

In *Re T (Adult: Refusal of Treatment*) ([1994] 1 W L R Fam. 95), Lord Donaldson stated:

> "If in a potentially life threatening situation or one in which irreparable damage to the patient's health is to be anticipated , doctors or health authorities are faced with a refusal by an adult patient to accept essential treatment and they have real doubts as to the validity of that refusal, they should in the public interest, not to mention that of the patient, at once seek a declaration from the courts as to whether the proposed treatment would or would not be lawful. This step should not be left to the patient's family, who will probably not know of the facility and may be inhibited by questions of expense. Such cases will be rare, but when they do arise ... the courts can and will provide immediate assistance."

The Department of Health's Aide-Memoire on Consent provides:

> "4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.
>
> Can children consent for themselves?
>
> 5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, some-one with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. (...)
>
> What information should be provided?

7. Parents need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid."

Non-resuscitation

Guidelines published in March 1993 by the British Medical Association and the Royal College of Nursing in conjunction with the Resuscitation Council provide in Paragraph 1:

It is appropriate to consider a do-not-resuscitate order (DNR) in the following circumstances:

a. Where the patient's condition indicates that effective Cardiopulmonary Resuscitation (CPR) is unlikely to be successful.

b. Where CPR is not in accord with the recorded, sustained wishes of the patient who is mentally competent.

c. Where successful CPR is likely to be followed by a length and quality of life which would not be acceptable to the patient."

Paragraph 3 states:

"The overall responsibility for a DNR decision rests with the consultant in charge of the patient's care. This should be made after appropriate consultation and consideration of all aspects of the patient's condition. The perspectives of other members of the medical and nursing team, the patient and with due regard to patient confidentiality, the patient's relatives or close friends, may all be valuable in forming the consultant's decision."

Paragraph 10 provides:

"Discussions of the advisability or otherwise of CPR will be highly sensitive and complex and should be undertaken by senior and experienced members of the medical team supported by senior nursing colleagues. A DNR order applies solely to CPR. It should be made clear that all other treatment and care which are appropriate for the patient are not precluded and should not be influenced by a DNR order."

Current Departmental Guidance is set out in "Resuscitation Policy (HSC Circular 2000/028). It states:

"Resuscitation decisions are amongst the most sensitive decisions that clinicians, patients and parents may have to make. Patients (and where appropriate their relatives and carers) have as much right to be involved in those decisions as they do other decisions about their care and treatment. As with all decision-making, doctors have a duty to act in accordance with an appropriate and responsible body of professional opinion."

COMPLAINTS

The applicants complain under Article 2 of the Convention that the Trust and its employees put the first applicant's life at risk of premature termination. They draw attention to the facts that the doctors treating the first applicant administered diamorphine to him, including in adult dose, without the second applicant's consent and placed a "Do Not Resuscitate" order in his medical notes without the second applicant's consent or knowledge. They criticise, *inter alia*, the inadequacy of the authorities' response to the Trust's and doctors' actions as well as the aftercare arrangements made for the first applicant.

The applicants also complain under Article 6 that the doctors overrode the wishes of the second applicant with respect to the treatment of the first applicant without court authorisation. However, the domestic courts refused afterwards to adjudicate both on the lawfulness of the doctors' actions in the circumstances and on the question of whether the Trust's refusal to treat the first applicant in future would be lawful.

The applicants further complain under Article 8 that the doctors' decision to proceed as they did and the Trust's subsequent refusal to treat the first applicant in the future interfered with the latter's right to respect for his physical and moral integrity and both applicants' right to respect for their family life. In the applicants' submission, the decision of the Crown Prosecution Service not to prosecute the doctors and the General Medical Council's decision not to hold an inquiry into the doctors' conduct deprived them of effective protection of their Article 8 rights.

With reference to Article 13, the applicants complain that they had no effective remedy under domestic law with respect to the above-mentioned breaches of their Convention rights.

Finally, the applicants complain under Article 14 that depriving disabled persons like the first applicant of the effective protection of their rights under Articles 6, 8 and 13 can only be justified in very exceptional circumstances, which did not apply in their case. They maintain in this connection that, had the first applicant not been disabled, he would not have been deprived of his rights.

THE LAW

1. The applicants maintain that the facts of the case disclose a breach of Article 2 of the Convention, which provides as relevant:

> "1. Everyone's right to life shall be protected by law. (...)"

The applicants further rely on Article 8 of the Convention in support of many of their allegations.

The Government assert in the first place that Article 2 is not applicable to the circumstances relied on by the applicants. They point out that the first applicant did not die and there was no intention on the part of the hospital to deprive him of his life or to hasten his death. The decisions to give him diamorphine and not to resuscitate him if he were to suffer respiratory arrest reflected the unanimous clinical judgment of the medical staff. Furthermore, the facts of the case cannot be said to fall within the scope of the respondent State's positive obligation under Article 2 to take appropriate steps to safeguard life, given that the measures taken by the medical staff were intended to serve the first applicant's best interests at a critical moment.

In the Government's alternative submission, if the Court were to find that a positive obligation arose in the circumstances it had to be concluded that the requirements of any such obligation were fulfilled on the facts, including with respect to the nature of the clinical decisions taken and the arrangements made for the future care of the first applicant on discharge.

The applicants assert that Article 2 is engaged on the facts. The first applicant's right to life was at issue and the necessary procedural safeguards to protect life were not observed. The applicants underline their concern that the domestic courts did not examine the merits of their complaints even though Lord Woolf MR stressed that the courts must be involved in cases where there is a serious conflict between doctors and a child's legal proxy. Furthermore, neither the General Medical Council nor the Crown Prosecution Service wished to pursue the applicants' complaints.

The Court notes that, happily, the first applicant survived and was able to be discharged home. It further notes that it has not been argued by the applicants that the doctors at Portsmouth Hospital deliberately intended to kill the first applicant. Indeed, any argument to that effect would be entirely at odds with, firstly, the doctors' clear and repeated assurances to the second applicant that it was not their intention to hasten her son's death and, secondly, the doctors' obvious relief that he survived the crisis coupled with their concern to ensure his well-being in the post-crisis phase. It would further observe that the applicants' criticism of the dosage of diamorphine administered to the first applicant cannot support a view that it was the doctors' primary aim intentionally to hasten death; nor can such a view be supported by the doctors' decision to place a "Do Not Resuscitate" notice in the first applicant's file. As to the latter point, it notes that the notice was only directed against the application of vigorous cardiac massage and intensive respiratory support, and did not exclude the use of other techniques, such as the provision of oxygen, to keep the first applicant alive. Furthermore, it is to be observed that the "Do Not Resuscitate" order was not implemented. It would also add that the applicants' allegations concerning the circumstances in which the first applicant was discharged

from hospital do not disclose any appearance of a breach of the authorities' duty to protect the first applicant's right to life. The facts do not at all suggest that the Trust was not concerned with the first applicant's welfare on discharge, less so that he was callously abandoned into the second applicant's care. As to the decision not to readmit the first applicant to St Mary's Hospital, it notes that the Trust was anxious to make alternative arrangements for the future care of the first applicant before implementing its decision. For the Court, the decision not to re-admit the first applicant must be considered reasonable in the light of the breakdown in trust on both sides.

In the Court's opinion, the applicants' complaints under Article 2 amount in effect to a criticism of the doctors' clinical judgment in the situation which arose, a situation which, in the applicants' view, could not be considered an emergency. However, it is not its function under Article 2 to gainsay the doctors' assessment of the first applicant's condition at the time, nor their decision to forego suction treatment in favour of the administration of diamorphine nor their view on the appropriate dose of diamorphine to be administered. These assessments and decisions were made against the background of the first applicant's state of health at the time, his recent case history and their perception that he was distressed and in pain and that steps needed to be taken to alleviate his respiratory difficulties.

It cannot be excluded that the acts and omissions of the authorities in the field of health care may in certain circumstances engage their responsibility under the positive limb of Article 2. However, the Court recalls that where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as error of professional judgment (even if established) on the part of a health professional in the treatment of a particular patient are not of themselves sufficient to call that State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life (see *Powell v. the United Kingdom* [decision], no. 45305/99, 4.5.2000). Having regard to the detailed rules and standards laid down in the domestic law and practice of the respondent State in the area under consideration, it cannot be maintained that the relevant regulatory framework discloses any shortcomings which can lay the basis of an arguable claim of a breach of the domestic authorities' obligation to protect the first applicant's right to life.

It is also to be observed that the events at St Mary's Hospital were the subject of a thorough review, first by the General Medical Council and subsequently by the police. The doctors whose actions have been criticised by the applicants were interviewed in the course of both investigations and the applicant's complaints were carefully considered and treated with concern. The Court accepts that the applicants are critical of the outcome of these investigations. However, from the standpoint of exposing to public

scrutiny both the course of events in the hospital and the decisions taken by the doctors, it cannot find fault with the manner in which the authorities conducted these investigations (see, *mutatis mutandis*, *Eriksson v. Italy,*[decision], no. 37900/97, 26.10.1999).

It cannot be overlooked that the applicants are critical of the doctors' decisions to override the second applicant's opposition to their choice of treatment and to place a "Do Not Resuscitate" notice without the second applicant's knowledge in the first applicant's file and, in particular, of the Trust's failure to have the matters resolved by the domestic courts. However, these are issues which fall to be addressed under Article 8 of the Convention in the context of the parties' submissions on the requirement of parental consent in domestic law and its application to the facts at issue. The Court would confine itself to noting that the standards developed within the medical profession and the relevant case-law of the domestic courts on issues such as consent to treatment or the use of "Do Not Resuscitate" notices confirm that any criticism levelled by the applicants against the respondent State's failure to protect life is unfounded.

Having regard to the above considerations, the Court concludes that the applicants' complaints under Article 2 and, as relevant, Article 8 are manifestly ill-founded within the meaning of Article 35 § 3 of the Convention and must be rejected under Article 35 § 4.

2. The applicants further complain that the facts of the case give rise to a breach of Article 8 of the Convention, which provides:

> "1. Everyone has the right to respect for his private and family life, (...).
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

The Government deny that either the decision to override the wishes of the second applicant by administering diamorphine to her son or to place a "Do Not Resuscitate" notice in the latter's medical notes unbeknown to the second applicant give rise to an interference with Article 8. The Government emphasise the nature of the emergency which confronted the hospital staff and assert that the actions taken were fully in line with Article 8 requirements. They contend in this connection that in exceptional circumstances, such as those at issue, the obligation to seek the consent of a parent before treating a child cannot be considered an absolute requirement. In any event, the hospital reasonably took the view that it had earlier reached agreement with the second applicant on the course of action to be followed in the event of a future emergency.

Developing this argument, the Government assert that the applicants have not shown that the decisions were taken in the knowledge that they contravened the wishes of the second applicant. Significantly, the second applicant chose to admit the first applicant to St Mary's Hospital on 20 October 1998 in full knowledge of the tenor of the discussions which she had had with the doctors there in the preceding months. Had there been an irreconcilable difference of opinion between the second applicant and the doctors during the period between 9 September to 20 October 1998, it would have been open to the second applicant to seek another hospital or to bring an application before the High Court. Moreover, it was not practical for the Trust to seek the intervention of the courts with respect to the second applicant's opposition to the administration of diamorphine to her son, given that the latter's condition was clearly perceived to be critical on 20 October 1998. The doctors' duty to act in the first applicant's best interests required them to react swiftly to his serious situation. For the Government, had urgent application been made to a court on 20 October 1998, whether by the Trust or by the second applicant, that court could have offered no remedy that could have benefited her in the circumstances of the case. In particular, the High Court would not have ordered the doctors to provide treatment that they did not consider clinically appropriate and would not have regarded the second applicant's views as determinative if they conflicted seriously with the doctors' views of the first applicant's best interests.

The Government moreover contest the applicants' assertion that "Do Not Resuscitate" notices are used as a means of rationing the provision of healthcare to vulnerable groups of patients. On the contrary, the policy of the authorities is to ensure that hospitals have in place appropriate resuscitation practices which respect the rights of patients.

The applicants maintain that the first applicant's right to physical and moral integrity and to personal development were at issue. Article 8 is therefore applicable. The decisions to administer diamorphine to the first applicant against the second applicant's wishes, to place a "Do Not Resuscitate" notice in his notes and to decline to admit him in future were all capable of interfering with that right. In their submission, the failure to involve the domestic courts in the decision to intervene without the second applicant's consent resulted in a situation in which there was an interference with the first applicant's right which was not in accordance with the law. As to the consent issue, the applicants stress that any agreement which may at one stage have been given to the doctors by the second applicant should not be considered irrevocable. They stress that consent to a particular course of treatment should be capable of being withdrawn in the light of changed circumstances. In her case, it would have been wrong of her to have issued a blanket permission to medical professionals without any regard to what might happen to the first applicant subsequently. In brief, she was denied

the right to change her mind. The applicants rely on the Department of Health's Aide-Memoire on Consent in this connection. They contend that in circumstances where there is a fundamental disagreement between a severely disabled child's legal proxy and doctors, it is inappropriate and unreasonable to leave the task of balancing fundamental rights to the doctors. They have no training in such a task, which is pre-eminently a judicial function.

In the alternative, the applicants argue that the measures taken had to be seen as unnecessarily brusque and disproportionate in the circumstances.

The Court considers, in the light of the parties' submissions, that the complaint raises serious issues of fact and law under the Convention, the determination of which requires an examination of the merits. The Court concludes therefore that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3 of the Convention. No other ground for declaring it inadmissible has been established.

3. The applicants also maintain that their right under Article 6 of the Convention was breached on account of the failure of the domestic courts to adjudicate on both the question of the lawfulness of the doctors' actions in the circumstances and on the question of whether refusal to treat the first applicant in future would be lawful. Article 6 provides:

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

For the Government, no procedural barriers lay in the way of the applicants' use of the High Court to obtain a declaration. They submit that the procedure for a declaration was unusable in the applicants' case on account of the special facts at issue, in particular the second applicant's last-minute withdrawal of her initial consent to the treatment being pursued with respect to her son. As to the judicial review proceedings initiated by the applicants, the Government point to the manner in which they were resolved by the High Court judge and by the Court of Appeal.

The Court considers that there are two limbs to the Article 6 issue. It notes in the first place that the applicants maintain that the Trust should have sought a High Court ruling before pressing ahead with the administration of diamorphine to the first applicant without the second applicant's consent. The applicants have not asserted that there were any legal barriers which restricted their access to the High Court. They criticise the Trust for not having invoked the jurisdiction of the High Court. The Government on the other hand aver that, in the circumstances, it would have been impossible for the Trust to have the doctors' proposed course of action approved by the High Court. For the Court, even assuming that a right of access to court issue arises in this context, the matter under consideration is more appropriately dealt with under Article 8.

Secondly, the Court accepts the concern of the second applicant that the domestic courts in the judicial review proceedings did not pronounce on the unlawfulness of the Trust's decision to administer diamorphine to her son against her wishes or to refuse to treat him in the future. However, it considers that the domestic courts' unwillingness to be drawn on this question is understandable in the circumstances, having regard to the nature of the proceedings and to the factual dispute between the second applicant and the Trust over the first applicant's precise condition at the time and the correct manner of treating him. Although Article 6 guarantees an applicant a right to have a ruling on matters involving his civil rights which he submits to a domestic court, it must be accepted that domestic courts must have some degree of flexibility in framing their response to the issues put to them, provided of course that they do not abdicate the essence of their adjudicative function. In the instant case, it is to be observed that the domestic courts provided the second applicant with a clear statement of her right to seek the intervention of the High Court if, in the future, she were to find herself in conflict with the treatment proposed by doctors treating her son. The approach taken cannot be considered a denial of the applicants' right of access to a court; nor can the domestic courts' failure to pronounce on the Trust's refusal to treat the first applicant in the future be so considered. It is to be noted in this connection that satisfactory alternative hospital arrangements were secured for the first applicant with the help of the Trust.

Having regard to these considerations, the Court concludes that the applicants' Article 6 complaints are manifestly ill-founded within the meaning of Article 35 § 3 of the Convention and must be rejected under Article 35 § 4.

4. The applicants complain that they had no effective remedy enabling them to seek redress for the violation of their above-mentioned Convention rights. They rely on 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."

The Government state that there was no arguable breach of any of the Convention rights relied on by the applicants. Without prejudice to this submission, they further aver that the requirement of an effective remedy was satisfied, having regard to the range of civil, criminal, administrative and professional remedies available to the applicants in relation to the taking and endangering of human life.

The Court observes that it has found the applicants' complaints under Articles 2 and 6 of the Convention to be manifestly ill-founded. According to its established 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 the *Boyle and Rice v. the United Kingdom* judgment of 27 April 1988, Series A no. 131, § 52). Article 13 is therefore inapplicable. As to the complaint under Article 8, it is not disputed that the applicants had a legal right to invoke the jurisdiction of the High Court for a ruling on the first applicant's treatment. In their submission, it was for the Trust to seek court authorisation to override the second applicant's objection to the treatment proposed by the doctors. The Court has adjourned its examination of this issue. However, this does not affect the conclusion that the applicants had an effective remedy in domestic law for the alleged breach of their Article 8 rights.

It follows that this part of the application is manifestly ill-founded within the meaning of Article 35 § 3 of the Convention and must be rejected pursuant to Article 35 § 4.

5. The applicants rely on Article 14 of the Convention to support their contention that the first applicant was deprived of the protection to which he was entitled under Articles 6 and 8 and 13 of the Convention solely on account of his severe disability. Article 14 states:

> "The enjoyment of the rights and freedoms set forth in the Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

The Government state that there is no evidence to suggest that the first applicant was discriminated against on grounds of his disabilities. The measures taken were intended to relieve his acute distress, even if there was a possibility that they might hasten his death. The Government stress that it was always the hope of the hospital staff that he would survive.

The Court finds that there is no evidence whatsoever on which to base an arguable complaint that the first applicant was the victim of discrimination on account of the fact that he was severely handicapped. The first applicant's disability was undoubtedly a relevant factor in assessing clinically his chances of survival and determining the treatment which was considered the most appropriate in the circumstances. However, it cannot be maintained that the doctors allowed themselves to be influenced by considerations based on his quality of life compared with that of able-bodied patients. There is no indication either that such considerations played a part either in the Trust's decision not to seek the advance approval of the High Court for the treatment administered to the first applicant or in the domestic courts' reluctance to address specifically the issues put to it by the applicants in the judicial review proceedings.

The Court concludes accordingly that the applicants' complaints under this head are manifestly ill-founded within the meaning of Article 35 § 3 of the Convention and must be rejected under Article 35 § 4.

For these reasons, the Court unanimously

Declares admissible, without prejudging the merits, the applicants' complaints that the decisions of the Trust and its doctors with respect to the treatment of the first applicant interfered with the latter's right to respect for personal integrity;

Declares inadmissible the remainder of the application.

Michael O'BOYLE
Registrar

Matti PELLONPÄÄ
President