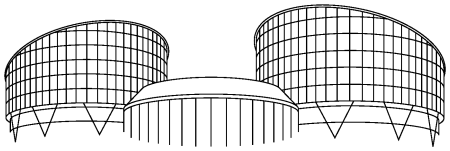

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FIRST SECTION

CASE OF M.S. v. CROATIA (No. 2)

(Application no. 75450/12)

JUDGMENT

STRASBOURG

19 February 2015

This judgment will become final in the circumstances set out in Article 44 § 2 of the Convention. It may be subject to editorial revision.

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

In the case of M.S. v. Croatia (No. 2),

The European Court of Human Rights (First Section), sitting as a Chamber composed of:

Isabelle Berro, *President*,
Mirjana Lazarova Trajkovska,
Julia Laffranque,
Paulo Pinto de Albuquerque,
Linos-Alexandre Sicilianos,
Erik Møse,
Ksenija Turković, *judges*,

and Søren Nielsen, *Section Registrar*,

Having deliberated in private on 27 January 2015,

Delivers the following judgment, which was adopted on that date:

PROCEDURE

1. The case originated in an application (no. 75450/12) against the Republic of Croatia lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Croatian national, Ms M.S. ("the applicant"), on 9 November 2012. The President of the Section acceded to the applicant's request not to have her name disclosed (Rule 47 § 4 of the Rules of Court).

2. The Croatian Government ("the Government") were represented by their Agent, Ms Š. Stažnik.

3. The applicant complained, in particular, that she had been unlawfully confined in a psychiatric hospital, and that she had been ill-treated there, in violation of Article 3 and Article 5 §§ 1 (e) and 4 of the Convention.

4. On 6 May 2013 the application was communicated to the Government. In addition, third-party comments were received jointly from the Centre for Disability Law and Policy at the National University of Ireland Galway (hereinafter: "the CDLP") and the Association for Social Affirmation of People with Psychosocial Disabilities in Croatia (hereinafter: "SHINE") (Article 36 § 2 of the Convention and Rule 44 § 3 of the Rules of Court).

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

5. The applicant was born in 1962 and lives in L.

A. Background to the case

6. For several years the applicant had been under the supervision of, and had been receiving various types of financial assistance amounting to some 600 Croatian kunas (HRK) per month from, a local social care centre.

7. In June 2008, the applicant's family doctor submitted to the social care centre a report on her medical treatment, stating as follows:

> "With regard to your question concerning Ms M.S.'s state of health and treatment and my observations on her health problems ... I confirm that she has been my patient since March 2008. She is a person with polymorphic health issues, and, in terms of the somatic aspect of her state of health, abdominal sensations related to the gynaecological area (a gynaecologist has prescribed surgery, which the patient constantly refuses) and thereby related anaemia – of course, treated by an alternative therapy.
>
> Because of a number of other health issues (frequent headaches, lumbar pain) she has been sent for specialist examinations, which attested to a sufficiency of outpatient treatment, in the form of both medication and physiotherapy.
>
> Unfortunately, the patient has her own peculiar interpretation of her health issues, on which she insists, and therefore I consider that the best help for her would be psychological/psychiatric treatment. Of course, this requires her consent, which so far could not be obtained. The continuity of the treatment is additionally hampered by the patient's change of her place of residence. Her visits to the doctor are random, and so are her wishes as to the scope and area of treatment.
>
> The particular difficulty in the medical treatment of Ms [M.]S. is related to her mental [state]."

8. On 26 June 2008 the social care centre instituted proceedings in the competent court for divesting the applicant of legal capacity, which was one of the issues giving rise to a case before the Court in *M.S. v. Croatia* (no. 36337/10, §§ 40-46, 25 April 2013).

9. Following an expert report of 19 August 2013 indicating that the applicant had been effectively engaged in psychiatric treatment, which had been progressing well, on 9 September 2013 the social care centre withdrew the request to divest her of legal capacity.

B. Circumstances of the applicant's confinement in a psychiatric hospital

10. On 29 October 2012 the applicant went to see her family doctor complaining of severe lower-back pain. Her doctor, after having examined her, called the emergency health service and sent the applicant for some further medical checks.

11. The doctor who received the applicant in the emergency service found that her general condition was good, that she was conscious and well oriented, but that she had difficulty moving. The doctor made a working diagnosis of lumbago and sent the applicant for further medical checks by a neurologist.

12. The neurologist in the emergency service examined the applicant on the same day and found that the information she was giving was incoherent and disproportionate to her pain, and that she had not been taking her medication. He made a diagnosis of back pain and anxiety disorder, and sent the applicant for a further examination by a psychiatrist.

13. The applicant was then examined by a psychiatrist in the emergency service who after interviewing her found that she was making fanciful and confusing allegations of persecution by various doctors. The psychiatrist made a diagnosis of acute psychotic disorder, systemic delusional disorder and delusional dysmorphic disorder, and prescribed hospitalisation.

14. The applicant was immediately admitted to the psychiatric clinic of the R. Clinical Hospital Centre (*Kliničcki bolničcki centar R., Klinika za psihijatriju*; hereinafter: "the hospital"), a public health-care institution. The relevant parts of the admission record, in so far as legible, indicate as follows:

> "Date of admission: 29.10.2012 Date and time of hospitalisation: 29.10.2012
>
> ...
>
> Admission diagnosis: ... anxiety disorder
>
> ...
>
> Patient's attitude towards the examination: refused examination by a psychiatrist; requested a somatic examination
>
> ...
>
> Psychological condition: conscious and well oriented, suspicious ... tense in the psychomotor sense ... distanced, cold, with ideas of ... persecution, control ...
>
> Neurological condition: syndrome of back pain
>
> ...
>
> Patient's attitude towards the hospitalisation: refuses
>
> Consent: NO
>
> ...
>
> Physical intervention: physical restraint, tying to a bed
>
> ..."

15. In the evening of the same day, another doctor examined the applicant. The relevant part of the examination record reads:

> "The patient was hospitalised after an examination by Dr [T.]L., and after having been treated in the [emergency ward] for persistant severe back pain (documentation in attachment).
>
> She was brought on a stretcher, tied down, maintaining conscience and orientation, negative, arguing, yelling, agitated, affectively dissolute, with a mind-flow disorder, substantively paranoid ideas. ...
>
> Diagnosis: Acute psychotic disorder F 23.2
>
> Delusional disorder ...

Fixation. Th. according to the list."

16. According to the applicant, following her admission to hospital she was tied to a bed with four belts tightened around her ankles and wrists, and forcefully injected with a strong drug. She was kept in that position throughout the night and felt severe pain in her back. Her left leg was restrained in such a position that the belts caused her additional pain. The room was small and had no windows. The following morning the belts were removed and she was taken to another room in the psychiatric hospital.

17. According to the Government, following the applicant's admission to hospital she was given the usual treatment for patients in a state of psychotic agitation and was then placed in an isolation room. The room had a direct connection with the adjacent staff room and was under constant video surveillance. The room measured 2.50 by 2.12 metres and the height of the ceiling was 3.15 metres. It was equipped only with one bed. It had a heating and air-conditioning system, as well as access to sanitary facilities. The belts used to restrain the applicant to the bed were specially adapted so as to avoid any injuries.

18. The Government further explained that the applicant had been tied to the bed in the isolation room from the time of her admission to hospital at 8.50 p.m. on 29 October 2012 until the next morning. She was then taken to a regular hospital room where she was again restrained until 12 noon. During that time her condition and all her needs were regularly monitored. After the initial period following the applicant's admission to hospital until her release, she was not restrained again.

19. The available medical records concerning the physical restraint used on the applicant in the hospital show that this method was used in the period between 8.50 p.m. on 29 October 2012 until around 12 noon on 30 October 2012. The relevant medical record monitoring the applicant's physical restraining, in so far as legible, reads as follows:

"29/30.10

– brought by [the emergency service] on a stretcher ...
– upon admission screaming, restive, kicking
– came [to the emergency service] because of back pain
– taken to the isolation box (hands and legs fixed), screaming, threatening, restive ...
– psychotic, paranoid [ideas]
– drunk water
– complains of lower back pain
– did not sleep well during the night, called [for assistance], drunk water (approximately one litre) ...
– manipulative
– did not sign the consent to hospitalisation, ...

30.10.2012

– morning hygiene performed in the box

– ... around 12 p.m. taken to the intensive care ward ... complains of back pain, unaware of her condition, paranoid ...”

C. Decisions on the applicant’s confinement

20. On 30 October 2012 the hospital informed the R. County Court (*Županijski sud u R.*) that the applicant had been involuntarily admitted for treatment on 29 October 2012, that she had refused further hospitalisation and that her mental condition prevented her from making a sound decision in that respect.

21. On the same day the R. County Court instituted proceedings for the applicant’s involuntary retention and appointed a legal-aid lawyer, P.R., to represent her.

22. On 31 October 2012 the judge conducting the proceedings visited the applicant in the hospital. The record of the visit in its entirety reads:

“[Number of the case file]

OFFICIAL NOTE

On 31 October 2012 the judge conducting the proceedings visited the respondent M.S. in hospital and interviewed her. She stated that because of back-pain problems on 29 October 2012 she had visited her family doctor in L., but then she had been placed in hospital by subterfuge.

She alleged that she had learned that she and several other patients would be used for ‘practising’ by some foreign doctors. When asked by the judge she replied that her parents were not alive, that she was not married and did not have children, and that she had a sister living near her in L.

During the conversation she stated that she had never been previously treated in a psychiatric hospital.

In R., 31 October 2012

[Signature]”

23. On the same day the judge provisionally extended the applicant’s involuntary retention until 6 November 2012. The judge also commissioned a psychiatric expert report concerning the applicant’s mental state and scheduled a hearing for 6 November 2012, to which he invited the applicant’s representative, P.R., and the expert.

24. At the hearing on 6 November 2012 the expert submitted a psychiatric report drawn up on 2 November 2012 whereby he found, based on the medical documentation relevant to the applicant’s admission to hospital and an interview with her, that she had manifested a psychotic disorder amounting to a serious mental illness. He also considered that the applicant’s release from the hospital could seriously endanger her health and

that it was absolutely necessary to order her involuntary retention for a further month. The hearing lasted in total ten minutes. The applicant's representative and the judge conducting the proceedings had no questions for the expert.

25. On the same day the R. County Court ordered the applicant's involuntary retention in the hospital until 28 November 2012, with the following statement of reasons:

> "On 30 October 2012 the [hospital] informed [this court] that the respondent had been involuntarily admitted to that institution. It submitted the relevant medical documentation as required under section 27 of the Protection of Individuals with Mental Disorders Act (Official Gazette nos. 11/1997, 27/1998, 128/1999 and 79/2002).
>
> When deciding on the necessity of the respondent's involuntary retention and its duration, [this court] commissioned an expert report from Dr A.Č., a neuropsychiatrist from R.; examined the medical documentation; and the judge responsible for the case visited and interviewed the respondent in [the hospital].
>
> Based on the examination of the respondent and the medical documentation, the expert found that she was demonstrating symptoms of a manifest psychotic disorder, that she had a serious mental disorder and that her release [from hospital] at this stage would seriously endanger her health.
>
> Thus the expert considered that the respondent absolutely needed treatment in a psychiatric hospital for the duration of a month ...
>
> The respondent's representative had no objections to the expert report, and this court also considers that the report is adept and objective and in compliance with other documentation from the case file.
>
> Given that the conditions for the respondent's involuntary retention in hospital have been met, within the meaning of sections 22(1) and 33(3) of the Protection of Individuals with Mental Disorders Act, it was decided as noted in the operative part of this decision."

26. The decision was served on the applicant and her legal-aid representative, the hospital and the competent social care centre.

27. On 7 November 2012 the applicant lodged an appeal against the above decision before a three-judge panel of the R. County Court, arguing that there was no reason for her confinement in a psychiatric hospital. She also stressed that at the time of lodging the appeal she was under strong medication.

28. On 9 November 2012 the applicant's sister, explaining that she was acting on behalf of the applicant because the applicant was under strong medication, lodged a further appeal before a three-judge panel of the R. County Court. She contended that the applicant had been suffering from serious back pain and because of that had visited her doctor. However, she had been forcefully taken to the psychiatric hospital. In the hospital she had been tied to a bed and had spent the entire night in agony because of the severe lower-back pain. Furthermore, she complained that nobody had ever explained to the applicant the relevant procedure and that she had realised only later that one of the persons who had visited her in the hospital was a

judge. She also stressed that the legal aid lawyer had not visited the applicant during the proceedings. This appeal was signed by the applicant and her sister.

29. The applicant addressed a handwritten complaint to the director of the hospital and the director of the R. Clinical Hospital Centre, dated 8 November 2012, which was attached to the above appeal (see paragraph 28 above). She complained that she had been tied to a bed in the hospital without any reason and in violation of her human dignity. She also stressed that nobody had taken into account her lower-back pain problems, or explained to her the relevant procedure. She further contended that her legal aid lawyer had never visited her and that her internment in the hospital had been contrary to the relevant domestic law and had even raised issues of criminal responsibility.

30. The applicant's complaint was never forwarded to the hospital's director or any other competent hospital authority.

31. On 13 November 2012 a three-judge panel of the R. County Court dismissed the appeals as ill-founded, endorsing the findings of the first-instance court. The relevant part of the decision reads:

> "It has been established in the case at issue that the respondent had lacked the capacity to make a critical assessment of her condition and illness and that she had been diagnosed with an acute psychotic disorder (F23.2) and systemic delusional disorder (F22.I.O.) Furthermore, it was established that the respondent had been tense in the psychomotor sense, affectively cold, dissociated, and that she had manifested a number of psychopathological conditions such as derealisation, depersonalisation, paranoid systemic ideas of persecution, pressure and control, that she had lacked the capacity to make a critical assessment of her condition, and that her release from hospital could seriously endanger her health. This court finds that this satisfies the requirements under section 22(1) of the Protection of Individuals with Mental Disorders Act, providing for the possibility of involuntary treatment.
>
> The above considerations, in particular the respondent's state of health, as well as her appeal arguments, suggest that she is unable to make a critical assessment of her condition, and therefore this court considers that her release at this stage could seriously endanger her health.
>
> As to the arguments concerning the breach of the respondent's rights and inadequate medical treatment, she is instructed to forward her complaints to the State Board for the Protection of Individuals with Mental Disorders within the Ministry of Health and the Hospital's Ethical Board."

32. This decision was served on the applicant and her sister, the applicant's legal aid representative, the hospital and the competent social care centre. However, from the case file it does not appear that any further action was taken.

33. On 14 November 2012 the applicant sent a letter to the hospital's director expressing her satisfaction with the hospital diet.

34. On 3 December 2012 the hospital informed the R. County Court that the applicant had been discharged from hospital on 29 November 2012.

II. RELEVANT DOMESTIC LAW

A. Constitution

35. The relevant provisions of the Constitution of the Republic of Croatia (*Ustav Republike Hrvatske*, Official Gazette nos. 56/1990, 135/1997, 8/1998, 113/2000, 124/2000, 28/2001, 41/2001, 55/2001, 76/2010 and 85/2010) read as follows:

Article 23

"No one shall be subjected to any form of ill-treatment ..."

Article 25

"All detainees and convicted persons shall be treated in a humane manner and with respect for their dignity."

Article 46

"Everyone has the right to submit objections and complaints, to give suggestions to the state and public authorities and to receive a reply in that respect."

B. Protection of Individuals with Mental Disorders Act

36. The relevant provisions of the Protection of Individuals with Mental Disorders Act (*Zakon o zaštiti osoba s duševnim smetnjama*, Official Gazette nos. 11/1997, 27/1998, 128/1999 and 79/2002) provide:

V. Involuntary admission and involuntary retention in a psychiatric institution

Section 5

"(1) The dignity of persons with mental disorders shall be protected and respected in all circumstances.

(2) Persons with mental disorders have the right to protection from any form of ill-treatment or degrading treatment.

..."

Section 6

"Psychiatrists and other health-care workers shall organise the treatment of persons with mental disorders, ensuring minimal restrictions to their rights and freedoms as well as minimising any measures causing them physical and psychological discomfort or diminishing their personal integrity and human dignity.

Section 7

"In providing treatment to persons with mental disorders, psychiatrists and other health-care workers shall give priority to consensual cooperation and to respecting the wishes and needs of the persons with mental disorders over coercive measures."

Section l0

"(1) The involuntary confinement and involuntary retention of persons with mental disorders shall be subject to judicial scrutiny in accordance with the procedure specified in this Act.

..."

Section 11

"(1) Any person with a mental disorder who is consensually or involuntarily retained in a psychiatric institution shall have the right to:

1. be informed at the time of admission, or later at his or her request, of his or her rights and duties and the manner of securing those rights,

...

6. submit complaints directly to the director of the psychiatric institution or head of department regarding the treatment methods, diagnosis, discharge from the institution and breach of his or her rights and freedoms;

7. submit requests and, without any supervision and limitations, complaints, appeals and other legal remedies before the competent judicial and state authorities;

8. consult at their own expense a doctor or a lawyer of their choice;

..."

Section 22

"(1) A seriously mentally disturbed individual who, owing to his mental disturbance, seriously and directly endangers his own life, health or safety, or the life, health and safety of others, may be placed in a psychiatric hospital without his or her consent, in accordance with the procedure for involuntary admission as provided for in this Act.

..."

Section 23

"(1) The individual referred to in section 22 shall be admitted to a psychiatric hospital ... based on a prescription of a doctor not employed in the hospital in question and who has examined the person personally and provided a relevant record thereof.

..."

Section 25

"(1) The psychiatrist who admits a person under section 23 ... of this Act shall commence his or her diagnostic and therapeutic treatment immediately and based on such treatment, [the psychiatrist] shall, within seventy-two hours, assess whether there are reasons for involuntary admission provided for under section 22 of this Act.

..."

Section 26

"(1) If the psychiatrist finds that the grounds for involuntary admission under section 22 of this Act have been met, he or she shall adopt a decision to that effect which must be reasoned and noted in the medical documentation.

(2) The psychiatrist shall inform the admitted person of that decision in an appropriate manner and explain the reasons for and objectives of the involuntary admission as well as the rights and duties of the person concerned under this Act."

Section 27

"(1) The psychiatric institution to which a person with mental disorders was involuntarily admitted under section 22 of this Act shall immediately, or within a maximum of twelve hours after the adoption of the decision on involuntary admission, directly or by means of electronic communication inform the [competent] County Court about the involuntary admission and shall forward [to that court] the records of the medical examination together with the reasons for the involuntary admission.

..."

Section 29

"(1) The proceedings for the involuntary admission of a person with a mental disorder to a psychiatric institution shall be in the competence of a single judge of the [competent] County Court.

..."

Section 30

"(1) When the County Court receives the notice on involuntary admission or otherwise learns of the involuntary admission, it shall ex officio institute the relevant proceedings and appoint a legal aid lawyer to represent the person concerned if he or she does not already have one.

(2) The judge referred to in section 29(1) of this Act shall immediately, or within a maximum of seventy-two hours after receiving the information about the involuntary admission, visit the person in the psychiatric institution and if the medical condition so allows, interview him or her.

(3) Within the time-limit under subsection (2), the judge shall extend the involuntary commitment, which cannot exceed eight days from the time of involuntary admission.

..."

Section 3l

"(1) Before deciding on the involuntary retention or discharge of a person with mental disorders, the court shall obtain an expert report of a psychiatrist from the list of permanent court experts, who is not employed in the psychiatric institution where the person concerned is interned, to ascertain whether the involuntary confinement is absolutely necessary.

...

(3) After examining the person with a mental disorder, the psychiatrist referred to in subsection (1) shall submit a written opinion to the court.

(4) Before deciding on the involuntary retention or discharge of a person with mental disorders, the court may obtain information from the social care centre and other persons who could provide relevant information."

Section 33

"(1) Based on its findings the court shall issue a decision on whether the involuntarily admitted person will remain in the psychiatric institution or be discharged.

...

(3) In its decision the court shall determine the duration of the involuntary retention which may not exceed a period of thirty days from the time of the psychiatrist's decision on the involuntary admission of the person with a mental disorder."

Section 36

"...

(2) The decision [on involuntary retention] shall be served on the retained person, his or her legal representative, a close relative with whom he or she shares the same household, another authorised representative, the competent social care centre and the psychiatric institution where the person has been retained."

Section 37

"(1) An appeal may be lodged against a decision on involuntary retention before the County Court.

(2) An appeal may be lodged by any person referred to in section 36(2) of this Act.

..."

Section 38

"(1) The appeal lodged under section 37(1) of this Act shall be decided by a three-judge panel of the County Court.

..."

VIII Use of physical force in the protection of persons with mental disorders

Section 54

"(1) Physical force or seclusion to protect persons with mental disorders may be used in the psychiatric institution only when this is the only means to prevent the person concerned endangering the life or health of others or his or her own life and health or damaging valuable property.

(2) Physical force or seclusion under subsection (1) shall be used only to the extent and in a manner absolutely necessary to eliminate any danger caused by an attack by the person with mental disorders.

(3) The use of physical force or seclusion may last only for as long as necessary to achieve the purpose referred to in subsection (1)."

Section 56

"(1) A psychiatrist shall make the decision on the use of physical force or seclusion referred to in section 54 of this Act and shall supervise its application.

..."

Section 57

"When placing a person with mental disorders in solitary confinement or using a straitjacket or other means of physical restraint against [such] a person, the continuous monitoring of his or her physical and mental condition shall be carried out by the hospital staff."

Section 58

"(1) If possible in the circumstances, the person concerned shall be cautioned before physical force is used.

(2) The reasons for using physical force, the means used and the measures taken, as well as the name of the person responsible for the decision on its use must be registered in the medical records."

IX State Board for the Protection of Individuals with Mental Disorders and psychiatric institutions

Section 60

"(1) The State Board for the Protection of Individuals with Mental Disorders shall be established within the Ministry of Health.

..."

Section 6l

"(1) The State Board for the Protection of Individuals with Mental Disorders shall be competent for:

...

c) supervising the procedure provided for in this Act and recommending to the psychiatric institution and the competent state body measures for the elimination of unlawful conduct,

d) monitoring the observance of human rights and freedoms and dignity of persons with mental disorders,

e) based on its own assessment or at the request of a third party, carrying out investigations of individual cases of involuntary admission to and involuntary retention in a psychiatric institution ...,

f) receiving complaints from persons with mental disorders, their legal representatives, family members, other representatives, third parties or a social care centre and carrying out all necessary inquires and supervision,

..."

C. Patients' Rights Act

37. The relevant part of the Patients' Rights Act (*Zakon o zaštiti prava pacijenata*, Official Gazette nos. 169/2004 and 37/2008) provides:

III Local Boards for the Protection of Patients' Rights

Section 30

"In securing and promoting patients' rights, each local authority shall establish a Board for the Protection of Patients' Rights (hereinafter: the Board)."

Scope of work of the Board

Section 33

"The Board shall perform the following tasks:

...

- monitor breaches of individual patients' rights at local level,

..."

Section 36

"The Board shall notify the complainant within fifteen days of its activities concerning the complaint."

Section 37

The Board shall have the right to access premises on which health care services are provided ... and to monitor the manner in which patients' rights are secured.

The Board shall prepare a report on the inspection under the first paragraph of this section, which shall be forwarded immediately, and at the latest within eight days, to the competent authority under the Health Care Act and the Sanitary Inspection Act, ..., the Medical Profession Act, the Dental Care Services Act, the Pharmacy Act, the Medical-biochemical Activities Act and the Nursing Act ...

The body referred to in the second paragraph of this section must inform the Board of its activities ...

When the body referred to in the second paragraph of this section, based on its activities, finds that there is a reasonable suspicion that the breach of the patients' rights under this Act amounts to a minor offence or a criminal offence, it shall immediately, and at the latest thirty days following its inspection, ... institute minor offences proceedings or lodge a criminal complaint [before the competent authority]. "

IV Board for the Protection and Promotion of Patients' Rights of the Ministry of Health

Section 38

"In securing social care that respects patients' rights, in the context of the rights and duties of the Republic of Croatia in the sphere of heath care, the Minister [of Health] shall appoint a Board for the Protection and Promotion of Patients' Rights of the Ministry of Health.

..."

Section 39

"The Board for the Protection and Promotion of Patients' Rights of the Ministry of Health shall perform the following tasks:

- supervise the manner in which patients' rights are secured under this Act,

..."

D. Heath Care Act

38. The relevant provisions of the Health Care Act (*Zakon o zdravstvenoj zaštiti*, Official Gazette nos. 150/2008, 71/2010, 139/2010, 22/2011, 84/2011, 154/2011, 12/2012, 35/2012 and 70/2012) read:

Section 23

"...

Everyone has the right to seek, directly or in writing, the protection of his or her rights concerning the quality, content and type of health-care services provided, from the director of the health institution ...

The director ... must act without delay following a complaint and notify the person concerned in writing within eight days of the measures he has taken.

If the person is not satisfied with the measures that were taken, he or she may seek protection of his or her rights before the Minister, competent Chamber or competent court."

Ethical board

Section 68

"The Ethical Board of a medical institution ensures that its activities are performed in compliance with the principles of medical ethics and deontology.

..."

Section 69

"The Ethical Board of a medical institution:

- monitors the implementation of ethical and deontological principles of health professions in the activities of the medical institution, ..."

XVII Supervision

Section 167

"Supervision of the work of medical institutions ... includes:

- internal supervision,

- expert supervision by the Chamber,

- health inspections."

Health inspectorate

Section l7l

"Inspections of the implementation and enforcement of laws, other regulations and other acts in the field of health care as well as supervision of the activities of health institutions ... shall be carried out by the Ministry [of Health] - health inspectorate.

...

In the event of professional errors by a health worker or the breach of principles of medical ethics and deontology, the health inspectorate shall transfer the case to the competent Chamber."

Section 178

"The health inspectorate in particular:

...

2. supervises the lawfulness of the work of health institutions ...

3. examines submissions of legal and natural persons concerning supervision under the defined competencies, and notifies the complainant in writing of the actions taken."

Section 179

"In the course of an inspection the inspectorate shall supervise in particular:

1. the manner in which patients are admitted, treated and discharged,

2. the application of means and methods for prevention, diagnosis, therapy, and rehabilitation,

..."

Section 180

"In course of the inspection referred to in section 179 of this Act the inspectorate shall have the following rights and obligations:

...

2. to prohibit the application of measures and activities that are contrary to the law or other regulations;

..."

Section 185

"If the inspectorate has reason to believe that the violation of the law constitutes a criminal or minor offence, it shall, together with a decision under its competence, without delay and no later than l5 days after the inspection ... lodge a request to prosecute instituting minor offences proceedings or a criminal complaint instituting criminal proceedings.

..."

E. Medical Professions Act

39. The relevant provisions of the Medical Professions Act (*Zakon o liječništvu*, Official Gazette nos. 121/2003 and 117/2008) provide:

Professional supervision of doctors

Section 30

"The Croatian Medical Chamber supervises the work of doctors ...

The performance of supervision under the first paragraph of this section is ... in particular based on:

- written and signed complaints from citizens,

- complaints received from the Minister of Health and other state authorities,

- permanent and occasional checks of the work of doctors."

Cooperation between the Croatian Medical Chamber and the Ministry of Health inspectorate

Section 31

"In performing the supervision under section 30 of this Act, the Croatian Medical Chamber shall cooperate with the health inspectorate of the Ministry of Health.

..."

Disciplinary responsibility of doctors

Section 52

"Doctors shall be held responsible for disciplinary offences before the disciplinary bodies of the Croatian Medical Chamber.

..."

F. Criminal Code

40. The relevant provisions of the Criminal Code (*Kazneni zakon*, Official Gazette nos. 110/1997, 27/1998, 50/2000, 129/2000, 51/2001, 111/2003, 190/2003, 105/2004, 84/2005, 71/2006, 110/2007, 152/2008 and 57/2011) provide:

Article 8

"(1) Criminal proceedings in respect of criminal offences shall be instituted by the State Attorney's Office in the interest of the Republic of Croatia and its citizens."

Unlawful deprivation of liberty

Article 124

"(1) Whoever unlawfully detains another person, keeps him or her detained or otherwise deprives or limits his or her freedom of movement, shall be punished by a term of imprisonment of between three months and one year.

...

(3) If the offence under paragraphs 1 and 2 of this Article was committed ... in a cruel manner ..., the perpetrator shall be punished by a term of imprisonment of between three and ten years."

Medical malpractice

Article 240

"(1) A doctor or a dentist who, in rendering medical services, fails to apply measures for the protection of patients in accordance with the requirements of the medical profession or applies an obviously inadequate remedy or method of treatment, or in general acts carelessly, thus causing the deterioration of an illness or the impairment of a person's health, shall be punished by a term of imprisonment of between three months and three years.

(2) The punishment provided under paragraph (1) of this Article shall be applied in respect of a medical professional who, in the performance of his or her activities, fails to apply measures for the protection of patients or acts contrary to the requirements of professional conduct ..., or otherwise acts carelessly, and thereby causes the deterioration of an illness or the impairment of a person's health.

..."

G. Code of Criminal Procedure

41. The relevant provisions of the Code of Criminal Procedure (*Zakon o kaznenom postupku*, Official Gazette nos. 110/1997, 27/1998, 58/1999, 112/1999, 58/2002 and 62/2003) at the material time provided:

Article 171

"(1) All state bodies and legal entities shall report any criminal offence that is subject to official prosecution about which they have been informed or about which they have otherwise learned.

..."

Article 173

"(1) Criminal complaints shall be submitted to the competent State Attorney in writing or orally.

...

(3) If a criminal complaint has been submitted before a court, the police or a State Attorney who is not competent to deal with the matter, they shall forward the criminal complaint to the competent State Attorney."

H. Civil Obligations Act

42. The relevant part of the Civil Obligations Act (*Zakon o obveznim odnosima*, Official Gazette nos. 35/2005, 41/2008 and 125/2011), reads as follows:

Section 1046

"Damage is ... infringement of the right to respect for one's personal dignity (non-pecuniary damage)."

Request to desist from a violating personal integrity

Section 1048

"Anyone may request a court or other competent authority to order the cessation of an activity which violates his or her personal integrity and the elimination of its consequences."

I. Courts' Rules

43. The relevant provision of the Courts' Rules (*Sudski poslovnik*, Official Gazette nos. 158/2009, 03/2011, 34/2011, 100/2011, 123/2011, 138/2011, 38/2012, 111/2012, 39/2013 and 48/2013) provides:

Section 163

"Irregularities and omissions found when opening letters shall be noted next to the receipt stamp ...

If the envelope contains a submission addressed to another court, body or legal entity, a relevant note shall be made next to the receipt note (such as "wrongly submitted") and the submission shall be forwarded to whom it is addressed. ..."

J. Internal rules of the R. Clinical Hospital Centre on processing individual complaints

44. The relevant part of document no. JZK- SOPK-OP- 006.00 of the R. Clinical Hospital Centre, published in 2012, and available on the internet, provides:

"PURPOSE

The purpose of this document is to provide a comprehensive procedure for receipt, processing and responding to the complaints/objections of patients and employees of the R. Clinical Hospital Centre.

RESPONSIBILITIES

The application and supervision of this [document] shall be the obligation of the Managing Board of the R. Clinical Hospital Centre. The directors of clinics and deputy directors for quality shall be tasked with the reception and handling of complaints. The deputy director for quality shall reply to complaints.

PROCEDURE

1. Submission of a complaint/objection

Complaints shall be submitted in writing on a form provided for that purpose ...

A person may also express his or her dissatisfaction orally. Submissions shall be made to the director of the clinic where the event at issue occurred.

Every person has the right to submit a complaint/objection directly to:

...

- the competent court.

2. Procedure after the receipt of a complaint/objection

...

The director of the clinic shall draft a report (Report on the complaint/objection) and submit it, together with the complaint, to the deputy director for quality. ...”

III. RELEVANT INTERNATIONAL MATERIAL

A. The United Nations

1. *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*

45. The relevant provisions of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (A/RES/46/119, 17 December 1991) read:

Principle 1

Fundamental freedoms and basic rights

“...

2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.”

Principle 9

Treatment

“1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.

...

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against

torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

...”

Principle 11

Consent to treatment

“...

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient’s medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

...”

Principle 12

Notice of rights

“1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with the present Principles and under domestic law, and the information shall include an explanation of those rights and how to exercise them.

2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient’s interests and willing to do so.

3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.”

Principle 16

Involuntary admission

“1. A person may be admitted involuntarily to a mental health facility as a patient or,) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4 above, that that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a

serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs."

Principle 18

Procedural safeguards

"1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

..."

Principle 21

Complaints

"Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law."

2. Convention on the Rights of Persons with Disabilities

46. The relevant part of the United Nations Convention on the Rights of Persons with Disabilities, A/RES/61/106, 24 January 2007 (hereinafter: the "CRDP"), ratified by Croatia on 15 August 2007, provides:

Article 13

Access to justice

"1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff."

Article 14

Liberty and security of person

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

(a) Enjoy the right to liberty and security of person;

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

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

Article 15

Freedom from torture or cruel, inhuman or degrading treatment or punishment

"1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment."

3. Practice of the United Nations Committee on the Rights of Persons with Disabilities

47. The United Nations Committee on the Rights of Persons with Disabilities ("the CRPD") in its "Concluding observations on the initial periodic report of Hungary (17-28 September 2012)", CRPD/C/HUN/1, with regard to the application of Articles 14 and 15 of the CRPD, noted:

"Liberty and security of the person (art. 14)

28. The Committee recommends that the State party review provisions in legislation that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities, and adopt measures to ensure that health care services, including all mental health care services, are based on the free and informed consent of the person concerned.

Freedom of torture or cruel, inhuman or degrading treatment or punishment (art. 15)

...

30. ... The Committee recommends that the State party implement the recommendation made by the Human Rights Committee in 2010 (CCPR/C/HUN/CO/5) to establish 'an independent medical examination body mandated to examine alleged victims of torture and guarantee respect for human dignity during the conduct of medical examinations.'"

48. In its "Concluding observations on the initial report of Austria (2-13 September 2013)", CRPD/C/AUT/1, the Committee stressed the following:

"**Liberty and security of the person (art. 14)**

29. The Committee is deeply concerned that Austrian law allows for a person to be confined against his or her will in a psychiatric institution if he or she has a psychosocial disability and is considered to be a danger to himself or herself or to

others. The Committee is of the opinion that the legislation is in conflict with article 14 of the Convention because it allows a person to be deprived of liberty on the basis of actual or perceived disability.

30. The Committee urges the State party to take all necessary legislative, administrative and judicial measures to ensure that no one is detained against their will in any kind of mental health facility. It further urges the State party to develop de-institutionalization strategies based on the human rights model of disability.

31. The Committee also urges the State party to ensure that all mental health services are provided with the free and informed consent of the person concerned. It recommends that the State allocate more financial resources to persons with intellectual and psychosocial disabilities who require a high level of support, in order to ensure that there are sufficient community-based outpatient services to support persons with disabilities.

Freedom from torture and cruel, inhuman or degrading treatment or punishment (art. 15)

32. The Committee notes with concern the continued use of net beds and other forms of non-consensual practices in the State party's psychiatric hospitals and institutions where people with intellectual, mental and psychosocial disabilities are confined.

33. The Committee recommends that the State party abolish the use of net beds, restraints and other non-consensual practices with regard to persons with intellectual, mental and psychosocial disabilities in psychiatric hospitals and institutions. It further recommends that the State party continue to provide training to medical professionals and personnel in care and other similar institutions on the prevention of torture, cruel, inhuman or degrading treatment or punishment, as provided for under the Convention."

4. Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

49. In his report on the issues of abusive practices in health-care settings, A/HRC/22/53, of 1 February 2013, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, made the following submission:

"2. Absolute ban on restraints and seclusion

63. The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is

used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.

3. Domestic legislation allowing forced interventions

64. The mandate continues to receive reports of the systematic use of forced interventions worldwide. Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment. Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged 'best interest' of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). Concern for the autonomy and dignity of persons with disabilities leads the Special Rapporteur to urge revision of domestic legislation allowing for forced interventions.

...

5. Persons with disabilities

80. Persons with disabilities are particularly affected by forced medical interventions, and continue to be exposed to non-consensual medical practices (A/63/175, para. 40). ...

V. Conclusions and recommendations

B. Recommendations

85. The Special Rapporteur calls upon all States to:

...

(c) Conduct prompt, impartial and thorough investigations into all allegations of torture and ill-treatment in health-care settings; where the evidence warrants it, prosecute and take action against perpetrators; and provide victims with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation;

...

4. Persons with psychosocial disabilities

89. The Special Rapporteur calls upon all States to:

(a) Review the anti-torture framework in relation to persons with disabilities in line with the Convention on the Rights of Persons with Disabilities as authoritative guidance regarding their rights in the context of health-care;

(b) Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation;

(c) Replace forced treatment and commitment by services in the community. Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned, with an emphasis on alternatives to the medical model of mental health, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others;

(d) Revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished."

B. Council of Europe

1. *Council of Europe Parliamentary Assembly Recommendation 1235(1994) on psychiatry and human rights*

50. The relevant part of Recommendation 1235(1994) on psychiatry and human rights of 12 April 1994 provides:

"i. Admission procedure and conditions:

a. compulsory admission must be resorted to in exceptional cases only and must comply with the following criteria:

- there is a serious danger to the patient or to other persons;

- an additional criterion could be that of the patient's treatment: if the absence of placement could lead to a deterioration or prevent the patient from receiving appropriate treatment;

b. in the event of compulsory admission, the decision regarding placement in a psychiatric institution must be taken by a judge and the placement period must be specified ...

c. there must be legal provision for an appeal to be lodged against the decision;

d. a code of patients' rights must be brought to the attention of patients on their arrival at a psychiatric institution;

..."

2. *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine*

51. The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine of 4 April 1997 (CETS 164, Oviedo Convention) in its relevant parts provides:

Article 1 – Purpose and object

Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine.

...

Chapter II – Consent

Article 5 – General rule

An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time.

Article 6 – Protection of persons not able to consent

1. Subject to Articles 17 and 20 below, an intervention may only be carried out on a person who does not have the capacity to consent, for his or her direct benefit.

...

3. Where, according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law. The individual concerned shall as far as possible take part in the authorisation procedure.

4. The representative, the authority, the person or the body mentioned in paragraphs 2 and 3 above shall be given, under the same conditions, the information referred to in Article 5.

5. The authorisation referred to in paragraphs 2 and 3 above may be withdrawn at any time in the best interests of the person concerned.

Article 7 – Protection of persons who have a mental disorder

Subject to protective conditions prescribed by law, including supervisory, control and appeal procedures, a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health.

3. Recommendation Rec(2004)10 of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorders

52. The relevant parts of Recommendation Rec(2004)10 of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorders of 22 September 2004 (hereinafter: "Rec(2004)10") read as follows:

"Chapter III – Involuntary placement in psychiatric facilities, and involuntary treatment, for mental disorder

Article 17 – Criteria for involuntary placement

1. A person may be subject to involuntary placement only if all the following conditions are met:

i. the person has a mental disorder;

ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;

iii. the placement includes a therapeutic purpose;

iv. no less restrictive means of providing appropriate care are available;

v. the opinion of the person concerned has been taken into consideration.

2. The law may provide that exceptionally a person may be subject to involuntary placement, in accordance with the provisions of this chapter, for the minimum period necessary in order to determine whether he or she has a mental disorder that represents a significant risk of serious harm to his or her health or to others if:

i. his or her behaviour is strongly suggestive of such a disorder;

ii. his or her condition appears to represent such a risk;

iii. there is no appropriate, less restrictive means of making this determination; and

iv. the opinion of the person concerned has been taken into consideration.

Article 18 – Criteria for involuntary treatment

A person may be subject to involuntary treatment only if all the following conditions are met:

i. the person has a mental disorder;

ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;

iii. no less intrusive means of providing appropriate care are available;

iv. the opinion of the person concerned has been taken into consideration.

...

Article 22 – Right to information

1. Persons subject to involuntary placement or involuntary treatment should be promptly informed, verbally and in writing, of their rights and of the remedies open to them.

2. They should be informed regularly and appropriately of the reasons for the decision and the criteria for its potential extension or termination.

3. The person's representative, if any, should also be given the information.

Chapter V – Specific situations

Article 27 – Seclusion and restraint

1. Seclusion or restraint should only be used in appropriate facilities, and in compliance with the principle of least restriction, to prevent imminent harm to the person concerned or others, and in proportion to the risks entailed.

2. Such measures should only be used under medical supervision, and should be appropriately documented.

3. In addition:

i. the person subject to seclusion or restraint should be regularly monitored;

ii. the reasons for, and duration of, such measures should be recorded in the person's medical records and in a register."

4. The Parliamentary Assembly Resolution 1642(2009) on Access to rights for people with disabilities and their full and active participation in society; reaffirmed by the Parliamentary Assembly Recommendation 1854 (2009) of 26 January 2009

53. The relevant part of the Parliamentary Assembly Resolution 1642(2009) on Access to rights for people with disabilities and their full and active participation in society reads:

"7. Firstly, the Assembly invites member states to guarantee that people with disabilities retain and exercise legal capacity on an equal basis with other members of society by:

7.1. ensuring that their right to make decisions is not limited or substituted by others, that measures concerning them are individually tailored to their needs and that they may be supported in their decision making by a support person; ..."

5. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

54. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("the CPT") visited Croatia from 19 to 27 September 2012. In Appendix III of its report CPT/Inf (2014) 9 of 18 March 2014 it reiterated the recommendations related to the use of measures of restraint in the psychiatric internment context, as provided in its report on the 2007 visit to Croatia (CPT/Inf (2008) 29). These recommendations read:

"120. In the CPT's view, every psychiatric establishment should have a comprehensive, carefully developed, policy on restraint. The involvement and support of both staff and management in elaborating the policy is essential. Such a policy should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated. Further, if resort is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers, they should be subjected to the same safeguards as mechanical restraints. In this context, guidelines on the use of restraint should include the following points:

• Regarding their appropriate use, means of restraint should only be used as a last resort to prevent the risk of harm to the individual or others and only when all other reasonable options would fail to satisfactorily contain that risk; they should never be used as a punishment or to compensate for shortages of trained staff.

• Any resort to means of restraint should always be either expressly ordered by a doctor or immediately brought to the attention of a doctor.

• Staff must be trained in the use of restraint. Such training should not only focus on instructing staff as to how to apply means of restraint but, equally importantly, should ensure that they understand the impact the use of restraint may have on a patient and that they know how to care for a restrained patient.

• The duration of the application of means of restraint should be for the shortest possible time. The prolongation of mechanical restraint should be exceptional and warrant a further review by a doctor.

• A patient subject to mechanical restraint should not be exposed to other patients.

• As regards supervision, whenever a patient is subjected to means of mechanical restraint, a trained member of staff should be continuously present in order to maintain the therapeutic alliance and to provide assistance. Such assistance may include escorting the patient to a toilet facility or helping him/her to drink/consume food.

• Every instance of the use of means of restraint - whether physical or chemical - of a patient must be recorded in a specific register established for that purpose, in addition to the individual's file. The entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by the person or staff. This will greatly facilitate both the management of such incidents and oversight into the extent of their occurrence.

• Once means of restraint have been removed, a debriefing of the patient should take place. This will provide an opportunity to explain the rationale behind the measure, thus reducing the psychological trauma of the experience as well as restoring the doctor-patient relationship. It also gives the patient an occasion to explain his/her emotions prior to the restraint, which may improve both the patient's own and the staff's understanding of his/her behaviour."

C. European Union

55. In a study carried out in 2012 entitled "Involuntary placement and involuntary treatment of persons with mental health problems" (Luxembourg, Publication Office of the European Union 2012; hereinafter: the "Report") the European Union Agency for Fundamental Rights (hereinafter: the "FRA") observed the comparative legal framework and practices of EU member States.

56. As to the statutory criteria for involuntary placement and involuntary treatment, the FRA observed that the criterion of the presence of a mental health problem was provided for in all national legislations. Although that criterion was not sufficient in itself to justify involuntary placement and involuntary treatment, the national legislations differed as regards the other criteria required, particularly those established under Rec(2004)10 (see paragraph 52 above).

57. In particular, in twelve EU member States (Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Germany, Estonia, Hungary, Lithuania, Luxembourg, Malta and the Netherlands), the existence of a significant risk of serious harm to oneself or others and a confirmed mental health problem are the two main conditions justifying involuntary placement. The need for a therapeutic purpose is not explicitly stipulated. In thirteen EU member States (Denmark, Greece, Finland, France, Ireland, Latvia, Poland, Portugal, Romania, Slovakia, Slovenia, Sweden and the United Kingdom) two criteria – the risk of harm and the need for treatment

– are listed alongside having a mental health problem. In some legal frameworks, however, the need for treatment is not explicitly referred to, although it is more or less implied. In many of those EU member States, the legislation does not specify whether both criteria must be fulfilled or whether the fulfilment of only one of them is sufficient to justify involuntary placement.

58. As to the criterion for involuntary placement and involuntary treatment provided for in the vast majority of EU member States, linked to the harm that a person could cause to himself or herself or to others, the FRA observed from some earlier studies that while a definition of risk level in some EU member States required a specified level of danger, the thresholds defined in the legislation were often vague.

59. The FRA further found that the requirement that involuntary placement and involuntary treatment should be implemented when no alternatives were available was a criterion which should be met in a majority of EU countries before involuntary placement and involuntary treatment could be permitted.

60. As to the procedural issues related to involuntary placement and involuntary treatment, the FRA noted that the vast majority of EU member States' legislation required the person's presence at the hearing that would decide on the involuntary placement, and that only in some EU member States, the person might not be heard in a formal hearing. Furthermore, the FRA considered that the requirement of "proper legal support" was directly linked to effective access to justice, and noted that the vast majority of EU member States' laws provided for free legal support either in certain circumstances or automatically.

61. Research carried out by the FRA in which a number of persons who had experienced or witnessed the use of seclusion and restraint were interviewed showed that the use of forcible restraint was perceived by those who had experienced it as "traumatic, impossible to forget and as, sometimes, causing physical injury". Some respondents felt humiliated particularly concerning their need to use the toilet, and others highlighted their disappointment that other less restrictive methods had not been tried before resorting to restraint. In particular, one respondent who had spent time as a patient in psychiatric hospitals observed that restraint had been used as a means of dealing with distress or agitation, and some of the respondents linked the misuse of restraint and seclusion to a sense that staff were hostile to, rather than supportive of, patients.

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

62. The applicant complained that she had been ill-treated during her confinement in a psychiatric hospital and that there had been no effective investigation in that respect. She relied on Article 3 of the Convention, which reads:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

A. Admissibility

1. The parties' submissions

(a) The Government

63. The Government submitted that protection from ill-treatment in the psychiatric confinement context was primarily secured through the mechanism of individual complaints before the Local Boards and the State Board for the Protection of Patients' Rights, as well as the State Board for the Protection of Individuals with Mental Disorders and the health inspectorate of the Ministry of Health. Each of those bodies was competent, and indeed obliged, to investigate allegations contained in the individual complaints. The way in which complaints were followed up thereafter depended on the specific competencies of the bodies at issue. Accordingly, the Local Boards and the State Board for the Protection of Patients' Rights were obliged to inform the health inspectorate of the Ministry of Health of any irregularity they had found and the health inspectorate was obliged to respond within a period of thirty days. If the State Board for the Protection of Individuals with Mental Disorders was the body reporting an irregularity to the health inspectorate, the latter was also obliged to reply stating the appropriate measures it had taken. In any event, all of those bodies were obliged to inform the competent criminal justice authorities in the event of a suspicion that a criminal offence had been committed, and all were obliged to inform the complainant of their actions.

64. Furthermore, the health inspectorate of the Ministry of Health could not only have investigated the relevant complaints but could also have taken certain legal measures by prohibiting further unlawful actions, lodging disciplinary and criminal complaints, instituting minor offences proceedings, ordering further training of doctors and prohibiting further medical activities. All decisions of the health inspectorate were susceptible to an administrative action before the administrative courts and, if necessary, before the Constitutional Court (*Ustavni sud Republike Hrvatske*).

65. In those circumstances, the Government considered that the Croatian system of protection of involuntarily retained individuals provided for effective legal remedies which were accessible either by lodging complaints directly before the health inspectorate or through one of the boards for the protection of patients' rights. The Government also pointed out that protection was secured through the ethical boards established within the health institutions. The Ethical Board of the R. Clinical Hospital Centre was thus obliged to examine the ethical and deontological issues of the treatment and the hospital director was obliged to examine individual complaints concerning the quality, substance and type of medical service provided. The Ethical Board was also competent to lodge disciplinary complaints before the Croatian Medical Chamber.

66. The Government considered that the applicant had failed to use any of those remedies. The only evidence she had submitted before the Court of her alleged complaints about the medical treatment had been a handwritten complaint addressed to the director of the hospital and the director of the R. Clinical Hospital Centre dated 8 November 2012. However, there was no evidence that the director of the hospital or the director of the R. Clinical Hospital Centre had ever received that document by any possible means. The only two documents which the applicant had submitted before the hospital authorities had been her appeal against the first-instance decision of the R. County Court on her involuntary retention and her comments on the hospital diet addressed to the hospital's director (see paragraphs 27 and 33 above). Had the applicant complied with the detailed and publicly available internal procedure for lodging individual complaints before the authorities of the R. Clinical Hospital Centre, for which there were special forms and mailboxes for submitting such forms, her complaint would have been examined. However, she had failed to lodge such a complaint before the director of the R. Clinical Hospital Centre or any other State authority, such as the police, the State Attorney's Office or the court conducting the proceedings concerning her internment in the psychiatric hospital.

67. Furthermore, the Government pointed out that the applicant could have lodged a civil action in the competent court for the infringement of her personal integrity, but she had not used that remedy. She could also have lodged criminal or minor offences complaints but she had failed to avail herself of that opportunity.

(b) The applicant

68. The applicant submitted that she had sent a letter to the director of the hospital and the director of the R. Clinical Hospital complaining of her ill-treatment in the hospital. It was a handwritten letter because that was the maximum she could have done at the time and in the circumstances in which she had found herself. Moreover, as she had never seen her lawyer, nobody had ever explained to her the relevant procedure. The applicant also considered that it had been for the authorities to inform the competent State

Attorney and other social and health-care services of her case, but nobody had done that at the relevant time.

2. The Court's assessment

69. The Court considers that the Government's objection should be joined to the merits, since it is closely linked to the substance of the applicant's complaint that the State had failed to conduct an effective investigation (see, for example, *Mikheyev v. Russia*, no. 77617/01, § 88, 26 January 2006).

70. The Court further notes that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3 of the Convention. Moreover, it is not inadmissible on any other grounds. It must therefore be declared admissible.

B. Merits

1. Procedural aspect of Article 3 of the Convention

(a) The parties' submissions

(i) The applicant

71. The applicant submitted, reiterating her arguments concerning the exhaustion of domestic remedies (see paragraph 68 above), that the State institutions in Croatia did not function properly, which was one of the reasons why no measures had been taken concerning her complaints of ill-treatment in the hospital. Moreover, the applicant pointed out that there was a questionnaire which every patient should have the possibility to submit on his or her release from hospital but which had never been given to her because the hospital had been afraid of what she might reveal. She stressed that the State institutions had been ignoring her complaints about her various other problems for years, and that she had lost any hope of their protecting her rights. She contended that in a situation in which she had been forcefully admitted to hospital and tied to a bed with restraining belts, and then involuntary retained for a further thirty days, the onus had been on the domestic authorities to examine her complaints properly. She had submitted the complaints in a handwritten letter because that was all she could have done in such circumstances.

(ii) The Government

72. The Government reiterated their arguments concerning the applicant's failure to use the domestic remedies available (see paragraphs 63-67 above). In the Government's view, the only reason why there had been no investigation into the circumstances of the applicant's case was because she had failed to bring her complaints before the domestic authorities, who, in those circumstances, had not been given an opportunity

to reply to the applicant's allegations. Furthermore, it was not true that the hospital had been obliged to provide the applicant with a questionnaire on her release; the onus had been on her to use such a method to complain during her stay in the hospital. The Government also pointed out that the competent social care centre had been duly informed of the applicant's situation throughout the proceedings for her internment.

(iii) The third-party intervention

73. The CDLP and SHINE stressed that it was well established in the Court's case-law that cases involving involuntary psychiatric internment called for increased vigilance in reviewing whether the Convention had been complied with. They also submitted that the requirement of a prompt and independent examination of allegations of ill-treatment in the psychiatric hospital context was implicit under the CRPD.

(b) The Court's assessment

(i) General principles

74. In the context of allegations of ill-treatment by the use of physical restraint against an applicant who was involuntary retained in a psychiatric hospital, the Court has held that Article 3 of the Convention required States to put in place effective criminal-law provisions to deter the commission of offences against personal integrity, backed up by law-enforcement machinery for the prevention, suppression and punishment of breaches of such provisions. The domestic legal system, and in particular the criminal law applicable in the circumstances of the case, must provide practical and effective protection of the rights guaranteed by Article 3. Wilful ill-treatment of persons who are within the control of agents of the State cannot be remedied exclusively through an award of compensation to the victim (see *Bureš v. the Czech Republic*, no. 37679/08, § 81, 18 October 2012).

75. Where an individual raises an arguable claim of ill-treatment under Article 3 of the Convention, the notion of an effective remedy entails, on the part of the State, a thorough and effective investigation capable of leading to the identification and punishment of those responsible (see *Selmouni v. France* [GC], no. 25803/94, § 79, ECHR 1999-V). The same applies to allegations of ill-treatment in the context of psychiatric internment where physical restraint has been used against the applicant (see *Filip v. Romania* (dec.), no. 41124/02, 8 December 2005, and *Bureš*, cited above, §§ 81 and 121).

76. Whatever the method of investigation, the authorities must act as soon as an official complaint has been lodged. Even when strictly speaking no complaint has been made, an investigation must be started if there are sufficiently clear indications that ill-treatment might have occurred (see, amongst many others, *Members of the Gldani Congregation of Jehovah's Witnesses and Others v. Georgia*, no. 71156/01, § 97, 3 May 2007; *Hajnal*

v. Serbia, no. 36937/06, §§ 96-97, 19 June 2012; *Bureš*, cited above, § 127; and *Hassan v. the United Kingdom* [GC], no. 29750/09, § 62, ECHR 2014). The authorities must take into account the particularly vulnerable situation of victims and the fact that people who have been subjected to serious ill-treatment will often be less ready or willing to make a complaint (see *Batı and Others v. Turkey*, nos. 33097/96 and 57834/00, § 133, ECHR 2004-IV). This is of particular significance for patients confined in psychiatric hospitals whose position of inferiority and powerlessness calls for increased vigilance in reviewing whether the Convention has been complied with (see, *inter alia*, *Herczegfalvy v. Austria*, 24 September 1992, § 82, Series A no. 244).

77. The Court has established that for an investigation to be considered effective it must in particular be thorough. That means that the authorities must always make a serious attempt to find out what happened and should not rely on hasty or ill-founded conclusions to close their investigation or as the basis of their decisions (see *Mikheyev*, cited above, § 108). The investigation must be capable of leading to the establishment of the facts of the case and to the identification and punishment of those responsible. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including, *inter alia*, eyewitness testimony, forensic evidence, and so on. Any deficiency in the investigation which undermines its ability to establish the cause of injuries or the identity of the persons responsible will risk falling foul of this standard (see *Denis Vasilyev v. Russia*, no. 32704/04, § 100, 17 December 2009). However, the obligation on the State is not to elucidate all the facts of the case but only those that are important for establishing the circumstances of the use of force and to determine whether official responsibility is engaged (see *Anusca v. Moldova*, no. 24034/07, § 40, 18 May 2010).

(ii) Application of these principles to the present case

78. The Court notes that the applicant's handwritten letter dated 8 November 2012 addressed to the director of the hospital and the director of the R. Clinical Hospital contained allegations of her ill-treatment during her involuntary confinement in the hospital. In particular, the applicant alleged that she had been tied with restraining belts to a bed without any reason and in violation of her human dignity; that nobody had taken into account her lower-back pain problems; that nobody had ever explained to her the relevant procedure; and that her internment in the hospital had been contrary to the relevant domestic law and had even raised issues of criminal responsibility (see paragraph 29 above).

79. The applicant's letter was attached to the appeal against the R. County Court's decision on her involuntary retention until 28 November 2012 (see paragraph 25 above). The appeal was also lodged on 9 November 2012 by the applicant's sister, who claimed that she was acting on behalf of the applicant who was at the time under strong medication, but it was signed

by both the applicant and her sister. The appeal contained several allegations of the applicant's ill-treatment in the hospital, in particular that she had been tied to a bed during the night, which had caused her severe pain related to her lower-back problems (see paragraph 28 above).

80. Those allegations were supported by medical documentation suggesting that the applicant had been diagnosed with lower-back pain problems (see paragraph 7 above), which was in fact the initial reason for her medical treatment at the relevant time (see paragraphs 10-12 above). In the Court's view, the allegations thus raised an arguable claim of ill-treatment, giving rise to a requirement of an effective official investigation (compare *Filip*, cited above, § 49).

81. However, the applicant's complaints, although sufficiently brought to the attention of the domestic authorities, notably the R. County Court, were never examined by that court or forwarded to the competent authorities for further investigation into the applicant's allegations, even though a requirement for an *ex officio* investigation into her complaints was mandated by the relevant domestic law (see paragraph 82 below) and by the relevant Convention requirements (see paragraph 75 above). See further; *Filip*, cited above, §§ 48-49 – where, in the context of a psychiatric internment, the applicant brought the allegations of ill-treatment before the domestic authorities by complaining to the first instance court and the President of the Republic; *Muradova v. Azerbaijan*, no. 22684/05, § 123, 2 April 2009 – where the Court held that the applicant brought the matter of ill-treatment to the attention of the State authorities by producing evidence in the civil proceedings; *Mađer v. Croatia*, no. 56185/07, §§ 88-89, 21 June 2011 – where the applicant complied with his duty to inform the relevant national authorities of his alleged ill-treatment by complaining before the trial court and the Constitutional Court; *Stanimirović v. Serbia*, no. 26088/06, § 41, 18 October 2011 – where the obligation for an *ex officio* investigation arose after it was established during the trial against the applicant that he had been ill-treated; and *J.L. v. Latvia*, no. 23893/06, §§ 11-13 and 73, 17 April 2012 – where the applicant sufficiently informed the domestic authorities by complaining of ill-treatment in the remedies against his conviction in the criminal proceedings.

82. In this connection the Court observes that the applicant's handwritten letter of 8 November 2012, after it was submitted to the R. County Court together with the appeal of 9 November 2012, formed part of the R. County Court's case file. Therefore the Court cannot accept the Government's argument that the applicant did not submit that letter to any of the domestic authorities (see paragraph 66 above). It was thus, even under the relevant domestic law (see paragraph 43 above; section 163 of the Court's Rules), for the R. County Court to forward the letter to the competent domestic authorities, notably the State Attorney's Office, the director of the hospital and the director of the R. Clinical Hospital to whom

the letter was addressed, in order for them to carry out further investigations into the applicant's allegations.

83. In these circumstances, the Court cannot but find that the domestic authorities were passive in the face of the applicant's credible allegations of ill-treatment, failing to discharge their procedural obligation of an official effective investigation (compare *Filip*, cited above, § 49).

84. Lastly, as regards the Government's arguments that the applicant did not lodge a civil action for damages (see paragraph 67 above), the Court has already indicated that the ill-treatment alleged by the applicant could not have been remedied exclusively through an award of compensation to the victim (see paragraph 74 above). Thus, by lodging and pursuing her complaint before the R. County Court in the circumstances identified above (see paragraphs 78- 83 above), the Court finds that the applicant was not required, under Article 35 § 1 of the Convention, to pursue that avenue (see *Bureš*, cited above, § 82).

85. Accordingly, the Court rejects the Government's preliminary objection it has joined to the merits (see paragraph 69 above) and finds that there has been a violation of the procedural aspect of Article 3 of the Convention.

2. Substantive aspect of Article 3 of the Convention

(a) The parties' submissions

(i) The applicant

86. The applicant stressed that following her involuntary admission to hospital there had been no reason to physically restrain her as she had not behaved aggressively or presented any danger to herself or others. It was not true that she had refused treatment and that measures of restraint had had to be used for that reason; nor was it true that she had been kicking or displaying any other form of aggressive behaviour. The allegations of aggressiveness had been used by the hospital in an attempt to justify the measure of her physical restraint. The fact that she had no longer been restrained after her transfer from the isolation room to a regular hospital room clearly supported her arguments, because her alleged mental condition could not possibly have improved to that extent in such a short time. She also pointed out that her refusal to cooperate with the hospital staff should be viewed in the context of the subterfuge by which she had been involuntary admitted to hospital, in that her visit to the doctor concerning her back-pain problems ended up with her being involuntarily admitted and retained. She stressed that that was why she had been agitated; it was the only reason why the hospital staff had physically restrained her and placed her in the isolation room.

87. The applicant further explained that the physical restraint measure had been used from the very beginning of her admission to hospital. Three

members of the hospital staff had pressed her head forcefully against the bed and tied her up with four belts. One of them, a doctor, had ordered his personnel to press her firmly down onto the bed and another had shouted that she should be held firmly by the legs so that she could not escape. After she had been restrained, she had asked the hospital staff several times to unleash the belts because she had serious back pain from which she had been suffering for a number of years and with which she had already been diagnosed. When they refused to do so, she had asked that at least her legs be untied, but the hospital staff had also refused to do that. That meant that she had had to endure the restraint in a painful position because of her back-pain problems, and it had lasted throughout the night. Later, she had learned that it had been the usual practice of the hospital to use measures of physical restraint against all those who had not consented to admission. Moreover, she had been constantly locked up on one hospital floor and could not move about freely.

88. The applicant pointed out that in those circumstances her internment in the hospital and the use of physical restraint against her had made her feel humiliated and debased, as there had been no reason for the use of such measures.

(ii) The Government

89. The Government submitted that the use of physical restraint measures on the applicant should be viewed in the context of her medical treatment and her admission to hospital on the day at issue. They pointed out that at first the applicant had seen her doctor for lower-back pain, but then further medical checks had suggested that her problems had been exclusively of a psychological nature and there had been nothing to indicate that she had any physical problems with her back. She had therefore been examined by a psychiatrist, who had found that she had been suffering from severe mental disorders. During the examination the applicant had made fanciful allegations, had been psychotic, agitated, upset, unpredictable and aggressive. She had refused medical treatment, and had also threatened and resisted. Thus the psychiatrist, out of fear that the applicant might harm herself or others, had ordered her immediate hospitalisation. Later on, as her behaviour had deteriorated and she had been screaming and kicking, in order to prevent her from causing any possible accidental injury to herself or any of the medical staff as a result of her unpredictable behaviour, the doctors had found that there were medical indications for the use of a measure of physical restraint. In particular, the applicant had been given antipsychotic treatment and placed in an isolation room, where she had been fastened to a bed with four belts especially designed to prevent any injury. In the isolation room, the applicant had been given food and water and the possibility to use a toilet.

90. The Government further submitted that throughout the use of the measure of physical restraint and the applicant’s placement in the isolation

room, she had been under the constant supervision of medical staff. It was true that she had complained of lower-back pain, but it had been assessed that such complaints had been merely of a psychological nature. The applicant had been restrained for fifteen hours because throughout that period the threat from her unpredictable behaviour had persisted. The use of this measure had been compatible with medical standards in psychiatry when no other measures could produce the desired result of calming an agitated individual down and thus preventing him or her from harming himself or herself or others, as in the applicant's case. Accordingly, there had been medical indications for the use of the measure of physical restraint; its application had not lasted longer than necessary and it had been proportionate to the threat of negative consequences posed by the applicant's condition.

91. The Government also pointed out that throughout the applicant's stay in the hospital her condition had been constantly monitored, she had been given the opportunity to move about and she had not made any other complaints about the conditions of her confinement. Moreover, her mental condition had later improved and was constantly improving. Thus, in the Government's view, neither the use of physical restraint nor the overall circumstances of the applicant's internment in the hospital had run contrary to the prohibition of inhuman or degrading treatment under Article 3 of the Convention.

92. Lastly, the Government stressed that they fully accepted the principles establishing special care and the necessity for securing the full enjoyment of all human rights to persons with mental disabilities. They emphasised that the Court's case-law concerning questions of involuntary admission and retention or the use of measures of physical restraint was not exclusive. Thus the use of such measures could well be justified in the circumstances of a particular case (the Government cited *Schneiter v. Switzerland* (dec.), no. 63062/00, 31 March 2005), particularly since the decision on their use was a medical judgment by medical experts. The Government also emphasised that the CPT had not recommended an absolute abolition of involuntary retention or the use of measures of physical restraint. It had only indicated what safeguards needed to be respected (see paragraph 54 above) and those had been duly complied with in the applicant's case. Moreover, in its 2012 visit to another psychiatric institution in Croatia, the CPT had not noted any misuse of measures of physical restraint or any other form of ill-treatment or abuse in the psychiatric hospital setting, which suggested that Croatia had duly complied with all relevant human rights standards in the field.

(iii) The third-party intervention

93. The CDLP and SHINE submitted that an emerging notion within the United Nations and the Council of Europe suggested that medical treatment, including health care, should only be provided with the informed consent of

the individual concerned, and that this principle should only be overridden in exceptional circumstances. It should be subjected to significant due process safeguards, including the right of the individual concerned to challenge the decision to administer treatment without his or her consent. In their view, there was also increasing recognition, particularly at the United Nations level, that the treatment of psychiatric patients against their will, in certain circumstances, could constitute torture, inhuman and degrading treatment or punishment.

(b) The Court's assessment

(i) General principles

94. The Court reiterates that Article 3 of the Convention enshrines one of the most fundamental values of a democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances or the victim's behaviour (see, for example, *Labita v. Italy* [GC], no 26772/95, § 119, ECHR 2000-IV). Where allegations are made under Article 3 of the Convention, as in the present case, the Court must apply a particularly thorough scrutiny (see, amongst others, *Wiktorko v. Poland*, no. 14612/02, § 48, 31 March 2009).

95. To fall under Article 3 of the Convention, ill-treatment must attain a minimum level of severity. The assessment of this minimum level of severity is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the gender, age and state of health of the victim. Further factors include the purpose for which the treatment was inflicted, together with the intention or motivation behind it, as well as its context, such as an atmosphere of heightened tension and emotions (see *Gäfgen v. Germany* [GC], no. 22978/05, § 88, ECHR 2010).

96. The Court has recognised the special vulnerability of mentally ill persons in its case-law and the assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has, in particular, to take into consideration this vulnerability (see *Keenan v. the United Kingdom*, no. 27229/95, § 111, ECHR 2001-III; *Rohde v. Denmark*, no. 69332/01, § 99, 21 July 2005; *Renolde v. France*, no. 5608/05, § 120, ECHR 2008 (extracts); and *Bureš*, cited above, § 85).

97. In respect of persons deprived of their liberty, recourse to physical force which has not been made strictly necessary by their own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3 of the Convention (see *Krastanov v. Bulgaria*, no. 50222/99, § 53, 30 September 2004).

98. Furthermore, the Court reiterates that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. Nevertheless, it is for the medical authorities to decide, on

the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible. The established principles of medicine are admittedly, in principle, decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist (see *Herczegfalvy*, cited above, § 82).

(ii) Application of these principles to the present case

α) Severity of the treatment

99. The Court notes at the outset that there is no dispute between the parties that the hospital was a public institution and that the acts and omissions of its medical staff were capable of engaging the responsibility of the respondent State under the Convention (see *Glass v. the United Kingdom*, no. 61827/00, § 71, ECHR 2004-II). In the context of the applicant's treatment in the hospital during her involuntary confinement on 29 and 30 October 2012, the Court considers that her physical restraint for fifteen hours – from 8.50 p.m. on 29 October 2012 to around 12 noon on 30 October 2012 – is the principal element that appears worrying (see paragraph 19 above).

100. It is particularly worrying in view of the applicant's physical health problems. In this connection, the Court notes that the applicant's medical records show that already in June 2008 her general practitioner had indicated that she had been suffering from "abdominal sensations related to the gynaecological area", which had, according to another gynaecological report, required surgery; and that she had been examined by various specialists several times for frequent headaches and lumbar pains and prescribed medication and physiotherapy (see paragraph 7 above). Similar diagnoses of back-pain problems were made during the applicant's visit to her general practitioner on 29 October 2012 and her initial admission to the emergency health service on the same day, where a general practitioner found that she was moving with difficulty and made the working diagnosis of lumbar problems (see paragraphs 10-11 above). That was also indicated by a neurologist who examined the applicant afterwards (see paragraph 12 above).

101. Furthermore, the Court notes that as soon as the applicant was involuntarily admitted to hospital she requested a physical examination, and several times during the period in which she was restrained she complained of pain in her back. However, her requests and complaints were met by the unsupportive and passive position of the hospital staff, who perceived them simply as her uncooperativeness in the treatment (see paragraphs 14 and 19 above).

102. In view of the above circumstances, the Court is particularly mindful that the applicant's physical restraint lasted for fifteen hours and that such a measure is usually perceived by those who have experienced it as traumatic, impossible to forget, capable of causing physical injury, humiliating and disappointing (see paragraph 61 above), which the applicant herself alleged (see paragraph 88 above). The Court thus considers that the applicant's physical restraint for fifteen hours must have caused her great distress and physical suffering and that Article 3 of the Convention is in principle applicable to the present case (compare *Bureš*, cited above, § 90).

β) Justification of the treatment

103. The Court has already held that the assessment of whether involuntary treatment of patients with mental disabilities in the hospital setting was justified needed to be examined against the question of medical necessity, which must convincingly be shown to exist, taking into account the current legal and medical standards on the issue (see *Herczegfalvy*, cited above § 83, and *Bureš*, cited above, § 93).

104. In respect of the use of measures of physical restraint on patients in psychiatric hospitals, the Court sees no reason to disagree in principle with the Government's submission that medical standards in psychiatry allow for a recourse to such measures when no other measures could produce the desired result of calming an agitated individual down and to prevent him or her from harming himself or herself or others (see paragraph 90 above). It notes, however, that the developments in contemporary legal standards on seclusion and other forms of coercive and non-consensual measures against patients with psychological or intellectual disabilities in hospitals and all other places of deprivation of liberty require that such measures be employed as a matter of last resort and when their application is the only means available to prevent immediate or imminent harm to the patient or others (see paragraph 36 above, section 54 of the Protection of Individuals with Mental Disorders Act; paragraph 49 above, the report of the Special Rapporteur on Torture of 1 February 2013; paragraph 52 above, Article 27 Rec(2004)10; paragraph 54 above; and *Bureš*, cited above, § 95).

105. Furthermore, the use of such measures must be commensurate with adequate safeguards from any abuse, providing sufficient procedural protection, and capable of demonstrating sufficient justification that the requirements of ultimate necessity and proportionality have been complied with and that all other reasonable options failed to satisfactorily contain the risk of harm to the patient or others. It must also be shown that the coercive measure at issue was not prolonged beyond the period which was strictly necessary for that purpose (see paragraph 36 above, sections 54-58 of the Protection of Individuals with Mental Disorders Act; paragraph 45 above, Principle 11(11) of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care; paragraph 52

above, Article 27 Rec(2004)10; paragraph 54 above; and *Bureš*, cited above, §§ 100-05).

106. In the case at issue the Court notes that neither of the applicant's medical records leading to her involuntary admission to hospital suggested that she posed any immediate or imminent harm to herself or others or that she was in any other manner aggressive. The doctor who first received her in the emergency health service noted that she was conscious and well oriented and that her general condition was good (see paragraph 11 above). It is true that the neurologist and psychiatrist who examined her in the emergency unit found that she was giving incoherent information and statements about her health issues (see paragraphs 12 and 13 above), but that in itself clearly could not justify the use of the coercive measure of physical restraint against her.

107. Furthermore, the Court notes that the medical record of the applicant's admission to hospital only reveals that she refused hospitalisation and that she demonstrated a certain mental instability in that she was suspicious, tense and distanced, with ideas of persecution (see paragraph 14 above). A more detailed medical report on her mental condition of the same day reveals that she was brought to the hospital on a stretcher, that she was restrained, and that she was behaving in an agitated manner and yelling, demonstrating mental instability, and in a generally restless condition (see paragraph 15 above).

108. At the same time, there is no evidence before the Court that any alternative means of responding to her restlessness had been attempted and that the measure of physical restraint to which the applicant was subjected at the time of her admission to hospital was used as a matter of last resort (compare *Bureš*, cited above, § 97). Instead, the circumstances suggest that the physical restraint was used against the applicant when she did not consent to her admission to hospital, in contravention of the relevant international standards (see paragraphs 104 and 105 above) and the requirements of the relevant domestic law (see paragraph 36 above, section 54 of the Protection of Individuals with Mental Disorders Act).

109. As to the Government's allegations that the measure of physical restraint was used in response to the applicant's aggressiveness, the Court notes that the alleged aggressiveness was only indicated in the record of the applicant's monitoring after the measure of physical restraint had already been used (see paragraph 19 above). However, that record does not suggest that she attempted to attack anyone; nor does it specify the existence of any danger the applicant allegedly posed to herself or others. It is true that at that time the applicant resisted the use of physical restraint but, given the circumstances in which she had been admitted to the hospital and in which she had been restrained in the first place, the Court considers that using restraints can hardly be justified by the fact that a person resists their application (see *Bureš*, cited above, § 99).

110. Thus, the Court is not satisfied that it was conclusively established that the use of restraints was to prevent the alleged attacks and that other means of trying to calm the applicant down, or less restrictive means, had been unsuccessfully tried. The Court therefore concludes that the Government have failed to show that the use of physical restraints on the applicant for fifteen hours was necessary and proportionate in the circumstances.

111. In addition, noting its findings as to the unsupportive and passive position of the hospital staff concerning the applicant's repeated complaints of pain in her back, of which the hospital was or should have been aware (see paragraphs 10-15 and 101 above), and being unable to benefit from any findings of the relevant domestic investigation into the applicant's allegations of abuse by the hospital staff (see paragraph 83 above; compare, by contrast, *D.D. v. Lithuania*, no. 13469/06, § 174, 14 February 2012), the Court is not satisfied that the applicant's condition during the use of the measure of physical restraint was effectively and adequately monitored.

112. Against the above background, the Court finds that the applicant has been subjected to inhuman and degrading treatment contrary to Article 3 of the Convention. There has accordingly been a violation of the substantive aspect of that provision.

II. ALLEGED VIOLATIONS OF ARTICLE 5 §§ 1 (e) AND 4 OF THE CONVENTION

113. The applicant complained that she had been unlawfully and unjustifiably interned in the hospital, and that the judicial decision in that regard had not been accompanied by adequate procedural safeguards. She relied on Article 5 §§ 1 (e) and 4 of the Convention.

> "1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> ...
>
> (e) the lawful detention ... of persons of unsound mind, ..."
>
> 4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

114. The Court reiterates that it is the master of the characterisation to be given in law to the facts of the case (see *Guerra and Others v. Italy*, 19 February 1998, § 44, *Reports of Judgments and Decisions* 1998-I). While Article 5 § 4 entitles detained persons to institute proceedings for a review of compliance with the procedural and substantive conditions which are essential for the "lawfulness", in Convention terms, of their deprivation of liberty (see, for example, *M.H. v. the United Kingdom*, no. 11577/06, § 74, 22 October 2013), Article 5 § 1 (e) of the Convention affords, *inter*

alia, procedural safeguards related to the judicial decisions authorising an applicant's involuntary hospitalisation (see *Winterwerp v. the Netherlands*, 24 October 1979, § 45, Series A no. 33, and *Rudenko v. Ukraine*, no. 50264/08, § 104, 17 April 2014).

115. The Court therefore considers that in the instant case the complaints raised by the applicant should be examined under Article 5 § 1 (e) of the Convention (compare *Zagidulina v. Russia*, no. 11737/06, §§ 50 and 70, 2 May 2013).

A. Admissibility

1. The parties' submissions

(a) The Government

116. The Government submitted that although the applicant and her sister had argued in their appeal against the first-instance decision of the R. County Court that the applicant's involuntary internment in the hospital had been unlawful within the meaning of Article 5 of the Convention, they had subsequently failed to bring those complaints before the Constitutional Court. The Government considered that a constitutional complaint before the Constitutional Court was a remedy to be exhausted. In that respect the Government submitted case-law of the Constitutional Court concerning complaints of deprivation of liberty in the context of criminal proceedings and asylum which had been examined in the light of Article 5 of the Convention. Furthermore, the Government pointed out that neither the applicant nor her sister had raised during the domestic proceedings the issue of the applicant's alleged inappropriate legal representation by the legal aid representative or any other shortcomings in the proceedings in respect of her internment in the hospital.

(b) The applicant

117. The applicant contended that in the circumstances in which she had found herself it had been impossible, financially and otherwise, for her to further lodge a constitutional complaint before the Constitutional Court concerning her involuntary hospitalisation. In any event, she considered that a constitutional complaint was not an effective remedy to be exhausted. Moreover, she had never seen her lawyer and nobody had ever explained to her all her rights. Thus she considered that she had done as much as she could to defend her rights at the domestic level.

2. The Court's assessment

118. The Court reiterates that under Article 35 § 1 of the Convention it may only deal with an application after all domestic remedies have been exhausted. The purpose of Article 35 is to afford the Contracting States the

opportunity of preventing or putting right the violations alleged against them before those allegations are submitted to the Court (see, for example, *Mifsud v. France* (dec.) [GC], no. 57220/00, § 15, ECHR 2002-VIII). The obligation to exhaust domestic remedies requires an applicant to make normal use of remedies which are effective, sufficient and accessible in respect of his or her Convention grievances. To be effective, a remedy must be capable of directly resolving the impugned state of affairs (see *Balogh v. Hungary*, no. 47940/99, § 30, 20 July 2004).

119. The rule of exhaustion of domestic remedies normally requires that complaints intended to be made subsequently at the international level should have been raised before the domestic courts, at least in substance and in compliance with the formal requirements and time-limits laid down in domestic law. The object of the rule on exhaustion of domestic remedies is to allow the national authorities (primarily the judicial authorities) to address an allegation that a Convention right has been violated, and where appropriate to afford redress before that allegation is submitted to the Court. In so far as there exists at national level a remedy enabling the national courts to address, at least in substance, any argument as to an alleged violation of a Convention right, it is that remedy which should be used (see *Azinas v. Cyprus* [GC], no. 56679/00, § 38, ECHR 2004-III).

120. The existence of such remedies must be sufficiently certain, not only in theory but also in practice, failing which they will lack the requisite accessibility and effectiveness (see, amongst many other authorities, *McFarlane v. Ireland* [GC], no. 31333/06, § 107, 10 September 2010). Where the Government claim non-exhaustion they must satisfy the Court that the remedy was an effective one available in theory and in practice at the relevant time, that is to say, that it was accessible, was capable of providing redress in respect of the applicant's complaints and offered reasonable prospects of success (see, amongst many other authorities, *Scoppola v. Italy (no. 2)* [GC], no. 10249/03, § 71, 17 September 2009). In particular, the Government must show that the availability of a remedy, including its scope and application, must be clearly set out and confirmed or complemented by practice or case-law (see, amongst many others, *Mikolajová v. Slovakia*, no. 4479/03, § 34, 18 January 2011, and *Luli and Others v. Albania*, nos. 64480/09, 64482/09, 12874/10, 56935/10, 3129/12 and 31355/09, § 80, 1 April 2014).

121. The Court has, however, also frequently underlined the need to apply the exhaustion rule with some degree of flexibility and without excessive formalism (see, for example, *Vučković and Others v. Serbia* [GC], no. 17153/11, § 76, 25 March 2014). In addition, according to the "generally recognised principles of international law", there may be special circumstances which absolve the applicant from the obligation to exhaust the domestic remedies at his disposal (see *Van Oosterwijck v. Belgium*, 6 November 1980, §§ 36-40, Series A no. 40; *Henaf v. France*, no. 65436/01, § 32, ECHR 2003 XI; and *Vučković and Others*, cited above,

§§ 73 and 86). It has further recognised that the rule of exhaustion is neither absolute nor capable of being applied automatically; in reviewing whether it has been observed it is essential to have regard to the particular circumstances of each individual case (see *M.S. v. Croatia*, no. 36337/10, § 63, 25 April 2013). This means, among other things, that the Court must take realistic account not only of the existence of formal remedies in the legal system of the Contracting Party concerned but also of the general legal and political context in which they operate, as well as the personal circumstances of the applicants (see *Selmouni v. France* [GC], no. 25803/94, § 77, ECHR 1999-V; and *Henaf*, cited above, § 32).

122. In the case at hand, the Court notes at the outset that although in principle the applicant could have used a constitutional complaint before the Constitutional Court, the Government have failed to provide any practice, let alone established case-law, of the Constitutional Court showing that it has dealt with issues related to the alleged unlawfulness of involuntary admission and retention of patients in psychiatric hospitals. However, it is clear from the material submitted to the Court that the Constitutional Court examines the constitutional complaints concerning the deprivation of liberty in the light of Article 5 of the Convention (see paragraph 116 above), which prevents the Court to make any final conclusion concerning the use of that remedy.

123. However, even assuming that the constitutional complaint was a remedy to be exhausted, the Court considers that in the particular circumstances of the present case, especially taking into account the applicant's vulnerable position and the situation she found herself in, the applicant may be dispensed from the obligation to exhaust that remedy (compare, for example, *Henaf*, cited above, §§ 33-39; and *Kucheruk v. Ukraine*, no. 2570/04, § 116, 6 September 2007).

124. In this connection the Court firstly observes that the applicant was diagnosed with serious mental disorder (see paragraphs 24 and 25 above). Moreover, at the relevant time the proceedings for divesting her of legal capacity were still ongoing and those proceedings, which also gave rise to a violation of Article 8 of the Convention (see *M.S.*, cited above, §§ 94-108), terminated only in September 2013 (see paragraphs 8 and 9 above). Furthermore, the Court notes that the applicant was apparently lacking the relevant financial means to secure legal representation by a privately funded lawyer (see paragraphs 6 and 117 above), and her legal aid representative, appointed by the domestic court, had never contacted her. She thus had no benefit of his legal advice and there is no evidence that the relevant legal procedure was ever explained to her, which she expressly complained about during the domestic proceedings (see paragraphs 28 and 29 above). At the same time, she was subjected to treatment contrary to Article 3 of the Convention and faced with a passive attitude of the domestic authorities concerning her complaints of ill-treatment (see paragraphs 85 and 112 above).

125. Thus, in view of the above, the Court considers that the special circumstances of the applicant's case allow it to conclude that although she did not lodge a constitutional complaint, the applicant did, by pursuing her remedies and complaining before the R. County Court, provide the national authorities with the opportunity which is in principle intended to be afforded to Contracting States by Article 35 § 1 of the Convention, namely of putting right the violations alleged against them.

126. As to the Government's argument that the applicant had not complained about her legal representation and the shortcomings in the proceedings concerning her involuntary internment, the Court observes that during the domestic proceedings the applicant raised a number of complaints before the R. County Court concerning her internment in the psychiatric hospital and expressly complained that her legal aid representative had not visited her (see paragraphs 28 and 29 above). However, her complaints were ignored by a three-judge panel of that court (see paragraph 31 above).

127. Against the above background, the Court finds that the Government's objection should be rejected.

128. The Court notes that these complaints are not manifestly ill-founded within the meaning of Article 35 § 3 (a) of the Convention. It further notes that they are not inadmissible on any other grounds. They must therefore be declared admissible.

B. Merits

1. The parties' submissions

(a) The applicant

129. The applicant stressed that she had been involuntarily admitted to hospital by subterfuge: she had initially gone to see a doctor because of persistent back pain and had then ended up in a psychiatric hospital. She stressed that during the proceedings for divesting her of legal capacity, the competent medical experts had found that her mental condition was not impaired to the extent that such a measure was needed. This had suggested that her involuntary admission to hospital had not been necessary, in particular since she had never posed any threat to herself or others. The applicant also pointed out that one of the doctors who had examined her following her admission to hospital had confirmed that she had not been aggressive. The hospital had made the allegations of her aggressiveness only to justify its unlawful actions. It was true that she had been uncooperative, but that was only because she had realised that she had been taken to a psychiatric hospital instead of for an X-ray examination, as had first been explained to her. The applicant considered that she should have been kept for only eight days in the hospital and that there had been no reason or legal ground to retain her for a month.

130. Furthermore, the applicant contended that during the proceedings for her involuntary hospitalisation, she had not met her legal aid representative or been given an opportunity to participate effectively in the proceedings. She had not been invited to the court hearing and thus had been unable to put forward all her arguments. In reality, everything had been done without her taking any part in the proceedings. It was true that she had met the judge and the psychiatric expert in the hospital but those meetings had lasted for only five minutes, which had been insufficient. They had only dealt with some legal matters, whereas she had been complaining of unlawfulness in the conduct of the hospital and her degrading treatment. At the same time, nobody had ever explained to her all her rights.

(b) The Government

131. The Government pointed out that the applicant's examination by a psychiatrist in the hospital had showed that she had been suffering from severe mental disorders impeding her normal functioning and making her behaviour unpredictable and thus potentially dangerous to herself and others. This had also been confirmed by another independent expert who had examined the applicant in the course of the proceedings before the R. County Court concerning her involuntary retention. In the Government's view, the applicant's mental disorder had been of such a degree that she had not been able to assume responsibility for her treatment and she had also represented a latent danger to others. She had been retained in the hospital for only thirty days, which had been sufficient to secure stabilisation and improvement of her mental condition. The Government therefore considered that it had been reliably shown that the applicant's mental condition had warranted her involuntary hospitalisation, which had been fully in compliance with the domestic law and all relevant medical standards.

132. The Government submitted that during the proceedings before the R. County Court concerning the applicant's involuntary hospitalisation, she had been heard by the judge conducting the proceedings and had been served with all the relevant court decisions, which she had been able to challenge before the higher courts. In addition, the R. County Court had appointed a legal aid representative who had effectively defended all the applicant's interests. It was true that he had not lodged an appeal against the first-instance decision on the applicant's involuntary retention, but that had not been of central importance as the applicant and her sister had already lodged appeals. The appeals had been examined by a three-judge panel of the R. County Court and thereby a further review of the applicant's involuntary retention had been secured. Furthermore, during the proceedings, the applicant had been sufficiently informed of all her rights and the proceedings had been conducted speedily, as required under the relevant law.

133. The Government also submitted that during the applicant's internment in the hospital, she had been provided with all the relevant information concerning her medical treatment and thus she had not been precluded from giving her informed consent to such treatment. However, due to her mental condition at the time, she had refused to give her consent to the treatment and therefore she had been involuntary retained in the hospital. The Government considered that the applicable international standards, in particular the CPT's recommendations, did not absolutely ban involuntary internment in psychiatric hospitals, although they did establish certain standards in such situations, which had been fully complied with in the applicant's case.

(c) The third-party intervention

134. The CDLP and SHINE submitted that the relevant international standards, provided for under Article 5 of the Convention, should be read together with Article 14(1)(b) of the CRPD, which required not only that the deprivation of liberty should not be arbitrary, but also that the existence of a disability should not in any case justify the deprivation of liberty. Furthermore, the importance of prompt and adequate information about the reasons for deprivation of liberty was particularly important in cases of persons with mental disabilities. Researchers and human rights institutions had described persons with disabilities, including those detained under the applicable mental health legislation, as a population with very limited rights awareness. Without adequate support to inform them of their rights, including their rights of appeal, persons with disabilities were likely to be at a disproportionate risk of being unable to seek redress for human rights violations against them.

135. In relation to access to justice, Article 13 of the CRPD required that appropriate accommodations should be made to ensure effective access to justice to all persons with disabilities on an equal basis with others and to facilitate their role as direct and indirect participants in all legal proceedings. This included legal proceedings challenging decisions on detention. The third party thus invited the Court to consider whether the Convention requirement that an individual deprived of his or her liberty be provided information "in a language which he understands" be read in conjunction with the CRPD as requiring information to be provided in an appropriate format to enable a person with a disability to understand it.

136. Furthermore, the third party pointed out that the Court had already held that Article 5 § 4 of the Convention provided for the right to seek an effective review of the lawfulness of one's detention. The States were thus obliged to secure effective access to justice, which might depend on various factors and might require effective legal representation and the possibility of appearing in person in court. The third party considered that the Court should examine whether cases concerning deprivation of liberty in relation to mental health should also comprise those elements, because such cases

involved complex areas of law and the tendering of expert evidence, as well as inevitable emotional involvement. This was particularly true given that the Court had held that passive actors in such proceedings could not satisfy the requirements of a truly adversarial procedure under Article 5 § 4 of the Convention.

137. Accordingly, it would not be sufficient merely to assign a legal representative to a person; such a representative should effectively represent that person and effectively oppose any measures which the person resisted. In the context of Article 5 of the Convention, that should mean that the representative should present the most effective case possible against involuntary confinement if the person concerned opposed it. This would also be essential if the evidence presented to justify the confinement were to be adequately examined in accordance with the adversarial nature of the proceedings. The case favouring such an extreme measure as a deprivation of liberty should be tested for its adversarial quality as effectively as possible for people with, and without, mental disabilities. However, persons with disabilities required reasonable accommodation and support when instructing their representatives in connection with proceedings in respect of deprivation of their liberty, in accordance with Article 13 of the CRPD. This almost always required that the representative meet in person those whom they were representing in order to facilitate effective communication, to support the person's understanding of their rights and to ensure that the representative understood the person's will and preferences when representing him or her. The necessity to respect the person's preferences and will was also emphasised under Article 12 of the CRPD. In some cases, merely meeting with the person would not be sufficient; representatives should be acquainted with specialist methods of securing support for those with communication impairment.

138. Lastly, the third party stressed that persons with disabilities, including those with a mental health disability, should not be seen merely as recipients of medical attention, but as holders of rights who had inherent human dignity, worthy of protection equal to that of other human beings. Such a paradigm necessarily required a change in perspective on doctrines of medical necessity and "best interest" of the person concerned, focussing on the person's right to self-determination. Accordingly, these new concepts were challenging medical procedures leading to the use of restraints, involuntary medication and involuntary placement in psychiatric hospitals and other mental health-care settings.

2. The Court's assessment

(a) General principles

139. The Court reiterates that Article 5 of the Convention is, together with Articles 2, 3 and 4, in the first rank of the fundamental rights that protect the physical security of an individual and as such its importance in a

democratic society is paramount (see, amongst others, *Storck v. Germany*, no. 61603/00, § 102, ECHR 2005-V; *McKay v. the United Kingdom* [GC], no. 543/03, § 30, ECHR 2006-X; and *Rudenko*, cited above, § 98).

140. The expressions "lawful" and "in accordance with a procedure prescribed by law" under Article 5 § 1 of the Convention essentially refer back to domestic law; they state the need for compliance with the relevant procedure under that law. The notion underlying the term in question is one of fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary (see *Winterwerp*, cited above, § 45; *Wassink v. the Netherlands*, 27 September 1990, § 24, Series A no. 185-A; *Bik v. Russia*, no. 26321/03, § 30, 22 April 2010; *Venios v. Greece*, no. 33055/08, § 48, 5 July 2011; and *Plesó v. Hungary*, no. 41242/08, § 55, 2 October 2012).

141. Although it is in the first place for the national authorities, notably the courts, to interpret and apply domestic law, a failure to comply with domestic law, under Article 5 § 1, entails a breach of the Convention. It follows that the Court can, and should, exercise a certain power of review of such compliance (see *Benham v. the United Kingdom*, 10 June 1996, § 41, *Reports* 1996-III, and *Bik*, cited above, § 31).

142. The Court has not previously formulated a global definition of what types of conduct on the part of the authorities might constitute "arbitrariness" for the purposes of Article 5 § 1. However, key principles that have been developed on a case-by-case basis demonstrate that the notion of arbitrariness in the context of Article 5 varies to a certain extent depending on the type of detention involved (see *Saadi v. the United Kingdom* [GC], no. 13229/03, § 68, ECHR 2008, and *Plesó*, cited above, § 57). One general principle established in the Court's case-law is that detention will be "arbitrary" where, despite complying with the letter of national law, there has been an element of bad faith or deception on the part of the authorities or where the domestic authorities neglected to attempt to apply the relevant legislation correctly (see *Mooren v. Germany* [GC], no. 11364/03, § 78, 9 July 2009).

143. Furthermore, the Court has constantly held that an individual cannot be considered to be of "unsound mind" and deprived of his liberty unless the following three minimum conditions are satisfied: firstly, he must reliably be shown by objective medical expertise to be of unsound mind; secondly, the mental disorder must be of a kind or degree warranting compulsory confinement; thirdly, the validity of continued confinement depends on the persistence of such a disorder (see, for example, *Winterwerp*, cited above, § 39; *Johnson v. the United Kingdom*, 24 October 1997, § 60, *Reports* 1997-VII; *X v. Finland*, no. 34806/04, § 149, ECHR 2012 (extracts); *Stanev v. Bulgaria* [GC], no. 36760/06, § 145, ECHR 2012; and *Ruiz Rivera v. Switzerland*, no. 8300/06, § 59, 18 February 2014).

144. However, the detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained. That means that it does not suffice that the deprivation of liberty is in conformity with national law; it must also be necessary in the particular circumstances (see *Witold Litwa v. Poland*, no. 26629/95, § 78, ECHR 2000 III; *Varbanov v. Bulgaria*, no. 31365/96, § 46, ECHR 2000-X; *Karamanof v. Greece*, no. 46372/09, § 42, 26 July 2011; *Stanev*, cited above, § 143; *M. v. Ukraine*, no. 2452/04, § 57, 19 April 2012; and *Rudenko*, cited above, § 103).

145. In deciding whether an individual should be detained as a "person of unsound mind", the Court gives certain deference to the national authorities. It will not substitute the decisions of States on how to apply the Convention rights to concrete factual circumstances. It is in the first place for the national authorities to evaluate the evidence adduced before them in a particular case; the Court's task is to review under the Convention the decisions of those authorities (see *Luberti v. Italy*, 23 February 1984, § 27, Series A no. 75, and *Rudenko*, cited above, § 100).

146. However, in order to defer to the judgment of domestic authorities, who are indeed better placed to assess the facts of a given case, the Court must be satisfied that they have assessed and scrutinised the pertinent issues thoroughly. This means that the domestic courts must subject deprivations of liberty to thorough scrutiny so that the detained persons enjoy effective procedural safeguards against arbitrary detention in practice (see *Ťupa v. the Czech Republic*, no. 39822/07, § 51, 26 May 2011).

147. Thus, in order to comply with Article 5 § 1 (e) of the Convention, the proceedings leading to the involuntary placement of an individual in a psychiatric facility must necessarily provide clearly effective guarantees against arbitrariness given the vulnerability of individuals suffering from mental disorders and the need to adduce very weighty reasons to justify any restriction of their rights (see, for example, *Zagidulina*, cited above, § 53, and *Rudenko*, cited above, § 104).

(b) Application of these principles to the present case

148. There is no dispute between the parties that the applicant's compulsory confinement in the hospital constituted a "deprivation of liberty" within the meaning of Article 5 § 1 (e) of the Convention, and the Court sees no reason to hold otherwise (see *Plesó*, cited above, § 54).

149. The Court notes at the outset that the events leading to the applicant's involuntary admission to hospital on 29 October 2012 unfolded after her initial visit to the family doctor concerning her back pain problems. Her doctor, after having examined her, sent her to the emergency health service for some further medical checks (see paragraph 10 above), which were carried out first by a general practitioner (see paragraph 11 above) and then by a neurologist (see paragraph 12 above). At the request of the latter,

the applicant was examined in the emergency service by a psychiatrist who prescribed treatment in the psychiatric hospital (see paragraph 13 above). Thereafter, although she had refused to give her consent to the hospitalisation, the applicant was admitted to hospital on an involuntary basis.

150. In this connection, the Court observes that following the institution of proceedings in respect of the applicant's involuntary retention in the hospital before the R. County Court, that court assigned the applicant a legal aid representative (see paragraph 21 above), whose task was to represent the applicant's interests in the proceedings, as required under section 30(1) of the Protection of Individuals with Mental Disorders Act (see paragraph 36 above).

151. However, the legal aid lawyer did not visit the applicant during the proceedings. Consequently, he did not have the benefit of hearing her arguments concerning the involuntary internment in order to understand and effectively represent her position, nor did the applicant benefit from his legal advice on the relevant legal procedure and the most appropriate course of action to follow (see paragraphs 28 and 29 above). This, as the third-party interveners pointed out (see paragraph 137 above), is particularly significant in a case in which the applicant opposed her internment and psychiatric treatment in the hospital setting, and moreover made arguable allegations of ill-treatment by the unlawful use of physical restraint.

152. Having regard to these findings, the Court reiterates that in the context of the guarantees for a review of compliance with the procedural and substantive conditions which are essential for the "lawfulness", in Convention terms, of an individual's deprivation of liberty, the relevant judicial proceedings need not always be attended by the same guarantees as those required under Article 6 § 1 for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation (see, amongst many others, *Stanev*, cited above, § 171).

153. This implies, *inter alia*, that an individual confined in a psychiatric institution because of his or her mental condition should, unless there are special circumstances, actually receive legal assistance in the proceedings relating to the continuation, suspension or termination of his confinement. The importance of what is at stake for him or her, taken together with the very nature of the affliction, compel this conclusion (see *Megyeri v. Germany*, 12 May 1992, § 23, Series A no. 237-A). Moreover, this does not mean that persons committed to care under the head of "unsound mind" should themselves take the initiative in obtaining legal representation before having recourse to a court (see *Winterwerp*, cited above, § 66).

154. Thus the Court, having constantly held that the Convention guarantees rights that are practical and effective and not theoretical and illusory (see, *inter alia*, *Stafford v. the United Kingdom* [GC], no. 46295/99,

§ 68, ECHR 2002-IV), does not consider that the mere appointment of a lawyer, without him or her actually providing legal assistance in the proceedings, could satisfy the requirements of necessary "legal assistance" for persons confined under the head of "unsound mind", under Article 5 § 1 (e) of the Convention. This is because an effective legal representation of persons with disabilities requires an enhanced duty of supervision of their legal representatives by the competent domestic courts (see paragraph 45 above, Principle 18 of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care).

155. Accordingly, as to the way in which the applicant was represented in the proceedings, the Court is of the opinion that given what was at stake for her proper legal representation, contact between the representative and the applicant was necessary or even crucial in order to ensure that the proceedings would be really adversarial and the applicant's legitimate interests protected (see *Sýkora v. the Czech Republic*, no. 23419/07, §§ 102 and 108, 22 November 2012, with further references).

156. In the present case, however, the legal aid representative never met the applicant, made no submissions on her behalf and, although he attended the hearing, acted rather as a passive observer of the proceedings. Although the domestic authorities were well aware of these omissions (see paragraphs 28 and 29 above), they failed to react by taking the appropriate measure for securing the applicant's effective legal representation. The Court therefore finds that the applicant's representative's passive attitude, in respect of which the domestic authorities failed to take the necessary action**,** deprived the applicant of effective legal assistance in the proceedings concerning her involuntary confinement in the hospital.

157. Furthermore, although the judge conducting the proceedings visited the applicant in the hospital, the documents submitted before the Court do not show that he made any appropriate accommodations to secure her effective access to justice (see paragraph 46 above, Article 13 CRDP). In particular, there is no evidence that he informed the applicant of her rights or gave any consideration to the possibility for her to participate in the hearing (see paragraph 22 above).

158. She was thus not given an opportunity to comment on the expert's findings at the court hearing which resulted in the delivery of the decision on her involuntary retention in a psychiatric hospital (compare *Rudenko*, cited above, § 114). Moreover, taking into consideration the applicant's clear and undisputed refusal to undergo any treatment and the domestic courts' awareness of this fact, which was reflected in their decisions, the need to ensure the applicant's right to be heard was ever more pressing.

159. In the absence of a convincing explanation by the domestic courts, the Court is not able to accept that there was a valid reason justifying the applicant's exclusion from the hearing, particularly since it notes that during her interview with the judge of the R. County Court, the applicant did not demonstrate that her condition was such as to prevent her from directly

engaging in a discussion of her situation (see paragraph 46 above, Article 13 CRDP; and compare *S. v. Estonia*, no. 17779/08, § 45, 4 October 2011).

160. In the light of the findings above, the Court concludes that the competent national authorities failed to meet the procedural requirement necessary for the applicant's involuntary hospitalisation, as they did not ensure that the proceedings were devoid of arbitrariness, as required under Article 5 § 1 (e) of the Convention.

161. The above procedural failures obviate the need for the Court to examine whether the national authorities met the substantive requirement for the applicant's involuntary hospitalisation by proving that her mental condition had necessitated the deprivation of her liberty (see *Zagidulina*, cited above, § 65).

162. In view of the above conclusions, the Court finds that there has been a violation of Article 5 § 1 (e) of the Convention.

III. OTHER ALLEGED VIOLATIONS OF THE CONVENTION

163. The applicant invoked Articles 13 and 14 of the Convention, Article 2 of Protocol No. 4, Article 3 of Protocol No. 7, and Article 1 of Protocol No. 12 to the Convention, without any further relevant substantiation.

164. In the light of all the material in its possession, and in so far as the matters complained of are within its competence, the Court considers that this part of the application does not disclose any appearance of a violation of the Convention. It follows that it is inadmissible under Article 35 § 3 as manifestly ill-founded, and must be rejected pursuant to Article 35 § 4 of the Convention.

IV. APPLICATION OF ARTICLE 41 OF THE CONVENTION

165. Article 41 of the Convention provides:

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

166. The applicant did not submit a claim for just satisfaction. Accordingly, the Court considers that there is no call to award her any sum on that account.

FOR THESE REASONS, THE COURT, UNANIMOUSLY,

1. *Decides* to join to the merits the Government's objection as to the exhaustion of domestic remedies concerning the complaints under Article 3 of the Convention and *rejects* it;

2. *Declares* the applicant's complaints about her internment in a psychiatric hospital, and her alleged ill-treatment in that respect, under Article 3 and Article 5 § 1 (e) of the Convention, admissible and the remainder of the application inadmissible;

3. *Holds* that there has been a violation of the procedural aspect of Article 3 of the Convention;

4. *Holds* that there has been a violation of the substantive aspect of Article 3 of the Convention;

5. *Holds* that there has been a violation of Article 5 § 1 (e) of the Convention;

6. *Holds* that there is no call to award the applicant just satisfaction.

Done in English, and notified in writing on 19 February 2015, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Søren Nielsen
Registrar

Isabelle Berro
President