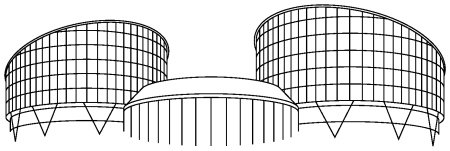

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FOURTH SECTION

CASE OF HILLER v. AUSTRIA

(Application no. 1967/14)

JUDGMENT

STRASBOURG

22 November 2016

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

In the case of Hiller v. Austria,

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

András Sajó, *President,*
Vincent A. De Gaetano,
Nona Tsotsoria,
Krzysztof Wojtyczek,
Egidijus Kūris,
Iulia Motoc,
Gabriele Kucsko-Stadlmayer, *judges,*
and Marialena Tsirli, *Section Registrar,*

Having deliberated in private on 11 October 2016,

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

PROCEDURE

1. The case originated in an application (no. 1967/14) against the Republic of Austria lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by an Austrian national, Ms Rozalia Hiller ("the applicant"), on 3 January 2014.

2. The applicant was represented by Mr T. Angkawidjaja, a lawyer practising in Vienna. The Austrian Government ("the Government") were represented by their Agent, Mr H. Tichy, Head of the International Law Department at the Federal Ministry for Europe, Integration and Foreign Affairs.

3. The applicant complained in substance under Article 2 of the Convention that her son had been able to commit suicide as a result of the psychiatric hospital's negligence.

4. On 12 May 2015 the application was communicated to the Government.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

5. The applicant was born in 1953 and lives in Vienna.

6. M.K., the applicant's son born in 1981, was taken to the Otto Wagner Hospital on 19 March 2010 suffering from an acute episode of paranoid schizophrenia. The Otto Wagner Hospital is a public institution of the City

of Vienna specialising in neurology, orthopaedics, psychiatry and pulmonology. It is situated on a vast area outside the city center in the west of the green-belt of Vienna, consisting of some 26 hospital buildings with annexes, a church, a museum, a theatre and a large park.

7. In a decision of 7 April 2010, the Fünfhaus District Court (*Bezirksgericht*) ordered M.K.'s involuntary placement in the psychiatric unit of that hospital pursuant to section 8 of the Hospitalisation Act (*Unterbringungsgesetz*).

8. On 12 May 2010 M.K. failed to return from an authorised walk in the hospital grounds. He had escaped from the premises and died after jumping in front of a subway train.

9. Subsequently, in August 2010 the applicant brought a civil action in the Vienna Regional Civil Court (*Landesgericht für Zivilrechtssachen*) under the Official Liability Act (*Amtshaftungsgesetz*) against the City of Vienna (*Stadt Wien*) as the authority responsible for the hospital, seeking compensation of 20,000 euros (EUR) plus interest in respect of non-pecuniary damage.

10. She stated that in 2006 and 2007 her son had already undergone inpatient treatment for paranoid schizophrenia at the Otto Wagner Hospital and the Vienna General Hospital (*Allgemeines Krankenhaus Wien*). Hospitalisation had been ordered on 19 March 2010 because M.K. had posed a danger both to himself and others. He had attacked a chewing gum dispenser with a sledgehammer and appeared to be utterly confused when the police arrived on the scene. The expert Dr P., who was called to assess M.K.'s mental state, diagnosed him with paranoid schizophrenia. Because of M.K.'s delusional behaviour, there was a risk that he would harm himself or others. The expert concluded that M.K.'s mental state required him to be placed in a closed psychiatric institution.

11. However, on 25 and 29 March 2010 M.K. managed to escape from the closed ward of the Otto Wagner Hospital and was found and brought back only after a search conducted by the police and the hospital staff. On 12 May 2010 he escaped from the open ward to which he had been transferred in the meantime, and committed suicide by jumping in front of a subway train.

12. The applicant claimed that she had suffered a massive shock as a result of her son's death. Before his involuntary placement in the hospital, M.K. had lived with her in the same household and they had had a very close relationship. The applicant claimed that as a result of his death she had suffered from depression and insomnia and had been seeing a psychotherapist since June 2010. Nonetheless, her mental state had not improved since.

13. The fact that her son had been able to escape from the hospital premises led the applicant to conclude that the hospital staff had acted negligently in the performance of their duties. Because M.K.'s behaviour

had been unpredictable, he should have been under strict supervision. In the circumstances, and especially because he had managed to escape twice before, restriction of his freedom of movement within a closed ward was proportionate, necessary and adequate. Furthermore, such restriction should have included a degree of supervision by the hospital staff. The contract for M.K.'s treatment had included duties of protection and care. There had been signs of suicidal thoughts on the patient's part, and the hospital staff should therefore have prevented him from leaving the ward. However, the necessary diligence had not been exercised. For these reasons, the applicant claimed that the City of Vienna had been at fault and was therefore responsible for the non-pecuniary damage she sustained.

14. The City of Vienna asked the Vienna Regional Civil Court to dismiss the applicant's claim. It argued that M.K.'s involuntary placement in the psychiatric institution on 19 March 2010 had been necessary as he had not been aware of his mental illness and had refused to be treated. At the time, he had been utterly confused and it had not been possible to reason with him. Because of the threat he posed to himself and others, he had repeatedly had his freedom of movement restricted whilst in hospital and had had to be medicated parenterally. On 25 March 2010 he had left the acute station without permission and went to his parents' place. When the police and the ambulance brought him back to the hospital, he had had to be sedated intravenously because of the highly psychotic state he was in. On 29 March 2010, only four days later, he escaped again from the acute station, but was apprehended by the hospital's security staff on the premises of the hospital. However, from 2 April 2010, M.K.'s attitude changed and he became willing to take oral medication. From that day on, his freedom of movement was no longer restricted. He had appeared well-adjusted and friendly. In view of the progress in his treatment, and as he appeared more reasonable and able to abide by agreements, he had been transferred from the acute station to the subacute ward on 20 April 2010. However, he had then succumbed to so-called "dynamic exhaustion" (*dynamische Entleerung*), which manifested itself in a noticeable loss of drive and the desire for a quiet environment. The hospital staff had therefore tried to animate M.K. through occupational therapy and recreational walks in the hospital grounds, which − on the basis of a well-documented medical order − he had been allowed to take on his own as of 21 April 2010. This medical order had taken into account the fact that M.K. had twice before escaped from his ward. Thereafter, however, M.K. had continued to receive treatment for over three weeks and there had been a considerable improvement in his condition. Moreover, he had been made aware that he was not allowed to leave the hospital premises and had to notify the staff before going out for a walk and again upon his return. He had also been permitted to leave the building to smoke a cigarette. The hospital had maintained detailed documentary records of his medical treatment and

progress. There had been no indication of suicidal thoughts. However, on 12 May 2010 at 5.15pm the doctor on duty was informed by the hospital staff that the applicant's son had not returned from an authorised walk in the hospital grounds and had apparently taken his personal clothing with him. A search operation had immediately been initiated on the premises and at the same time the police had been asked to search for him. At approximately 9pm the police informed the hospital that M.K. had been killed in a subway train accident at around 4 pm.

15. The City of Vienna submitted that under the provisions of the Hospitalisation Act and in keeping with current practice in the treatment of mentally ill patients, "open" psychiatry was the norm and restriction of a patient's freedom of movement was permissible only in cases of absolute necessity and within the bounds of proportionality. In the present case, by 12 May 2010 restriction of the physical movement of the applicant's son (known as "fixation"), and/or the spatial restriction of his movement to the confines of a psychiatric bed, or his permanent supervision, were no longer medically indicated, nor would such measures have been reasonable or adequate. On the contrary, the lack of any indication of suicidal thoughts on the part of M.K. would have rendered any further restriction of his freedom of movement unlawful under the Hospitalisation Act.

16. During the oral hearing of 3 September 2012 the applicant reduced her claim to 15,000 EUR plus 4% interest per annum.

17. On 30 November 2012 the Vienna Regional Civil Court granted the claim. It found that even shortly before his death on 12 May 2010, it could be assumed that M.K. still posed a threat to himself and others, in particular because he still suffered from the delusional idea that he was a different person and did not recognise his parents as his own. Self-harming behaviour could occur outside the hospital environment, due to overstimulation, even in patients who had shown progress after a psychosis. It was no longer possible to determine whether the applicant's son had jumped in front of the subway train in order to deliberately commit suicide, or whether he followed a spontaneous impulse or a delusional thought to that end. In any event the hospital should have made sure that he was not able to leave the hospital grounds, even if therapeutic walks were medically indicated and permissible in the circumstances.

18. From a legal perspective, the Regional Civil Court affirmed that, as the authority responsible for the Otto Wagner Hospital, the City of Vienna could be held accountable for any culpable action or omission by its organs or officials, pursuant to section 1 of the Official Liability Act. At the material time, the applicant's son had been lawfully hospitalised by a decision of the Fünfhaus District Court of 7 April 2010, which remained valid until 21 May 2010. Sections 3 and 33 of the Hospitalisation Act in force at the time provided that, in cases where hospitalisation had been ordered, it was also necessary to guard against threats potentially posed by

the patient. Accordingly, the hospital was obliged to ensure restriction of the patient's freedom of movement in order to protect against potential damage. In the instant case, M.K. was allowed to take walks on the hospital premises because such walks were medically indicated. However, no measures were taken to ensure that he respected the restrictions on his freedom of movement. There was no effective supervision of his walks or their duration. By disregarding its duty of supervision, the hospital had implemented the Hospitalisation Act incorrectly. It was immaterial that the applicant's son had not shown any signs of suicidal tendencies because the hospitalisation was originally effected because of the danger he posed to himself and to others. Therefore, even if he did not pose a threat to himself anymore, the requirement for hospitalisation was still valid because of the threat he posed to others. In the instant case, the lack of supervision of M.K. resulted in the applicant having to suffer the shock of the death of her son. The court concluded that the civil claim was justified and granted the applicant EUR 15,000 plus interest by way of compensation in respect of non-pecuniary damage.

19. The City of Vienna appealed, claiming that the court had wrongly assessed the evidence, that its finding of facts was incorrect, and that it had wrongly interpreted the law.

20. On 26 March 2013 the Vienna Court of Appeal (*Oberlandesgericht*) granted the defendant's appeal and dismissed the applicant's claim. In its view, there had been no causal link between the wholly unexpected suicide of the applicant's son and the alleged dereliction of the hospital's duty of supervision under the Hospitalisation Act. Although it was stated in the hospital admission report that there was a danger of M.K.'s putting himself and others at risk due to his disoriented state, it was also explicitly mentioned that he had no suicidal thoughts. According to the expert opinion by Dr P of 25 May 2012, the continuation of M.K.'s hospitalisation on 12 May 2010 was indicated only because of the threat he posed to others, in particular to his mother, but no longer to himself. This was the reason why his freedom of movement at that point had been restricted to the hospital premises rather than just the closed ward. The court found that in the light of the improvement in his symptoms, it was not unusual that he had been allowed to take walks for therapeutic purposes, even if it might have been advisable to allow these walks only when accompanied by hospital staff.

21. The Court of Appeal further affirmed that there had been no indication of self-harm during M.K.'s entire stay at the hospital. He had not voiced suicidal thoughts or undertaken any actions of a suicidal nature. It could not be established whether his jumping in front of the subway train was a suicide which he had planned even before he left the hospital premises, or whether it had been a spontaneous act of self-harm resulting from his psychosis. Naturally, M.K. would not have been able to commit suicide if he had been prevented from leaving the hospital grounds. Even

with patients whose psychotic symptoms had improved, the phenomenon of overstimulation could occur if they left the therapeutic environment, whereas such a situation was much less likely to occur within the confines of a hospital. Section 3 § 1 of the Hospitalisation Act referred, as its purpose, only to the protection of the life and limb of the mental patient himself and third parties. The behaviour of M.K. had not been foreseeable because there had no longer been any indication of possible self-harm at the material time and his action was therefore not attributable to the hospital. The fact that the risk of self-harm could never be entirely excluded in the case of psychotic patients did not change this assessment.

22. The applicant appealed, arguing that at the time when M.K. had committed suicide, the initial decision by the Fünfhaus District Court on his hospitalisation had still been valid and was based on the assessment that he posed a danger to himself and others because of his paranoid schizophrenia. No new expert opinion had been obtained, and the hospital had not informed the guardianship court (*Pflegschaftsgericht*) that the threat of self-harm had ceased to exist. Consequently, the medical indication would still have been a restriction of M.K.'s freedom of movement. By failing to restrict his movement, the hospital had acted contrary to the court decision ordering his hospitalisation.

23. On 18 July 2013 the Supreme Court dismissed the applicant's appeal, upholding the legal and factual findings of the Court of Appeal. It added that a lawful implementation of the Hospitalisation Act was possible both inside and outside a closed ward. M.K.'s hospitalisation had therefore not been unlawful, even though he had been placed in the open ward from 20 April 2010. Contrary to the applicant's line of argumentation, the Otto Wagner Hospital had not had a duty to implement the Fünfhaus District Court's decision on M.K.'s hospitalisation in a manner which compelled it to restrict his movement. This followed from section 32 of the Hospitalisation Act – according to which a hospitalisation order could be lifted at any time by the head of the institution – and section 33, which stated that restriction of movement was permissible in limited cases only. The District Court's decision had not defined the extent or duration of any specific restriction of movement. Section 33 of the Hospitalisation Act provided that a restriction of freedom of movement might only be used as an exceptional measure and "last resort". Also, Articles 3 and 5 of the Convention restricted the permissibility of isolating mentally ill patients. Even within a closed ward, mentally ill patients had to have the widest possible amount of freedom of movement. Only the more restrictive measures under section 33 of the Hospitalisation Act were subject to judicial review.

24. The Supreme Court also stated that from a therapeutic perspective M.K. had been allowed to take unaccompanied walks because of the improvement in his condition. Moreover, from the time he had been

authorised to take these walks, he had always returned without problems. This measure, which had been ordered by the psychiatrist treating him, had therefore been proportionate and necessary pursuant to section 33 of the Hospitalisation Act. In conclusion, the hospital had not acted culpably, for which reason the applicant's claim under the Official Liability Act was not justified.

II. RELEVANT DOMESTIC AND INTERNATIONAL LAW AND PRACTICE

A. Domestic Law

1. The Hospitalisation Act (as in force at the relevant time)

25. Section 1 of the Hospitalisation Act stipulated that the personality rights of mentally ill persons who were hospitalised must be specially protected, and that their dignity must be respected and preserved under all circumstances.

26. According to its section 2, its provisions applied to all hospitals and psychiatric departments where patients were treated in a closed ward or were otherwise subject to restrictions on their freedom of movement. The confinement of an individual's movement to the premises of a hospital, even if that person was free to move around within those premises, amounted to a "hospitalisation" within the meaning of the law.

27. According to section 3, a person could only be hospitalised if they suffered from a mental illness and posed a significant threat to themselves or others because of their illness and could not adequately be treated in any other manner. This provision laid down the principle of the subsidiarity of hospitalisation. Preference had to be given to other forms of treatment not involving deprivation of liberty, such as semi-inpatient treatment, outpatient treatment, or residential nursing facilities. According to the explanatory reports to the Hospitalisation Act, restrictions of movement were subject to the principle of the least necessary interference and were to be applied as *ultima ratio* only.

28. Section 8 provided that a person may only be hospitalised against their will or without their consent after examination by a public service doctor (*Amtsarzt*), who was to confirm that the requirements for hospitalisation were fulfilled.

29. The competent District Court decided on the admissibility of the hospitalisation (sections 12 and 18) after having examined the prerequisites under Article 3. If the court declared it admissible, it set a time-limit for the hospitalisation, which initially had not to exceed three months (section 26 § 2). Even prior to the expiry of the fixed period, the head of the department where the person concerned was placed had to examine and

document the continued existence of the prerequisites for hospitalisation and to immediately terminate it if the reasons for its implementation ceased to exist (section 32).

30. Under section 33, restriction of the patient's freedom of movement was permitted only if the nature, extent and duration of the restriction were strictly necessary for the purposes of section 3 of the Hospitalisation Act and for the medical treatment or care in question, and if it was proportionate to the aims pursued. In general, the restriction could only extend over several rooms or specific areas. Any further restriction, for instance to a single room, was permissible only if individually ordered by a doctor and had to be documented. The patient's guardian had to be immediately informed and had the right to request that a court decide on the admissibility of such a measure. The patient's freedom of movement had to be restored as soon as the circumstances so permitted.

2. The Official Liability Act

31. According to section 1 of the Official Liability Act, the Federation (*Bund*), the regions (*Länder*), the districts (*Bezirke*), the municipalities (*Gemeinden*) and other legal entities defined under public law (*Körperschaften öffentlichen Rechts*) are liable pursuant to civil law for pecuniary damage or damage to a person which has been culpably and unlawfully caused by one of their organs or officials in the fulfilment of their duties under the law. Involuntary placements under the Hospitalisation Act are acts under public administration (*Hoheitsverwaltung*) and are therefore are subject to claims under the Official Liability Act.

B. International law and practice

1. Council of Europe

32. On 22 September 2004 the Committee of Ministers adopted Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder, in particular those who are subject to involuntary placement or treatment. Article 8 lays down the "principle of least restriction":

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

The explanatory memorandum to the recommendation states that the "principle of least restriction" is fundamental. It implies that if a person's illness improves, they should be moved to a less restrictive environment, when appropriate to his or her health needs.

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

2. United Nations

(a) General Assembly Resolution A/RES/46/119

34. This resolution of 17 December 1991 laid down several principles for the protection of persons with mental illness and for the improvement of their mental health care. The relevant principles are the following:

> **Principle 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 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.
>
> 2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
>
> ...
>
> 4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy. ...

(b) The Convention on the Rights of Persons with Disabilities ("the CRPD")

35. The CRPD, adopted by the United Nations General Assembly on 13 December 2006 (Resolution A/RES/61/106), was designed to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities and to promote respect for their inherent dignity. It was ratified by Austria on 26 September 2008. It reads as follows in its relevant parts:

> **Article 10 - Right to life**
>
> States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

Article 14 - Liberty and security of the person

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

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

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

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

(c) Subsequent developments

36. In September 2014, the United Nations Office of the High Commissioner for Human Rights issued the following statement concerning Article 14 of the CRPD:

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

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

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

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

3. ..."

37. The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, has set as "one of his priorities to look into the role of the health sector and health professionals in the implementation of ambitious goals raised by the CRPD". On 2 April 2015 he issued a report concerning the right to health for all people with disabilities and scrutinised the practice of deprivation of liberty in closed psychiatric institutions:

> "96. The Convention is challenging traditional practices of psychiatry, both at the scientific and clinical-practice levels. In that regard, there is a serious need to discuss issues related to human rights in psychiatry and to develop mechanisms for the effective protection of the rights of persons with mental disabilities.
>
> 97. The history of psychiatry demonstrates that the good intentions of service providers can turn into violations of the human rights of service users. The traditional arguments that restrict the human rights of persons diagnosed with psychosocial and intellectual disabilities, which are based on the medical necessity to provide those persons with necessary treatment and/or to protect his/her or public safety, are now seriously being questioned as they are not in conformity with the Convention. ...
>
> 99. A large number of persons with psychosocial disabilities are deprived of their liberty in closed institutions and are deprived of legal capacity on the grounds of their medical diagnosis. This is an illustration of the misuse of the science and practice of medicine, and it highlights the need to re-evaluate the role of the current biomedical model as dominating the mental-health scene. Alternative models, with a strong focus on human rights, experiences and relationships and which take social contexts into account, should be considered to advance current research and practice. ..."

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

38. The applicant complained that the authorities had failed to assure the protection of her son's life in violation of his rights under Article 2 of the Convention, which reads in its first paragraph:

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

A. Admissibility

39. The Court notes that the application is not manifestly ill-founded within the meaning of Article 35 § 3 (a) of the Convention. It further notes that it is not inadmissible on any other grounds. It must therefore be declared admissible.

B. Merits

1. The parties' submissions

(a) The applicant

40. The applicant reiterated that the Fünfhaus District Court had ordered her son's hospitalisation and that this order had remained valid until 21 May 2010. The fatal incident had therefore occurred during the court order's period of validity. M.K. had managed to escape from the hospital on several occasions before then. It was important to note in this connection that his hospitalisation had been ordered because of the threat he had posed to himself and to others. If such a threat had no longer existed on the day of his suicide, the hospital would have had to request the lifting of the hospitalisation order, which it had not done. It could therefore be assumed that on the day of his death M.K. had still posed a threat to himself and others.

41. The applicant submitted that the object and purpose of the Hospitalisation Act was to assure the protection of the life and limb of the hospitalised person and of third parties. In the instant case, however, this protection had not been assured. There would have been no point in the hospitalisation of M.K. had he been able to leave the hospital at will, without any control. Hospitalisation in such circumstances would be absurd. The applicant concluded that the Republic of Austria, through its organs and officials, had failed to assure the protection of the life of her mentally ill son.

(b) The Government

42. The Government submitted that, as a general principle, mentally ill individuals should be treated and cared for in the same way as other categories of patient, namely in outpatient or "open" inpatient wards, without restriction of their personal rights. This was expressed through the provisions of the Hospitalisation Act and its explanatory reports and was in accordance with the development of psychiatric care reform movements that have been ongoing in Europe since the 1980s. The coercive approach to psychiatric treatment had been reduced, and it was intended to treat patients on a socio-psychiatric basis and, as far as possible, in a natural atmosphere. Unlike in "closed" wards, where the measures restricting the patients' freedom of movement were laid down in general and externally recognisable organisational structures, the characteristic features of an "open" type of hospitalisation were individual restrictions on a patient's freedom of movement, which were effected in ways other than that of confinement to permanently closed areas. That this "open" approach would in practice inevitably result in more escapes was accepted, since the advantages of open hospitalisation outweighed the disadvantages of

"closed" hospitalisation. According to the literature on the subject, the frequency of escape from open psychiatric wards or institutions was in any event overestimated.

43. The Government also submitted that diagnostics and therapy at the Otto Wagner Hospital were based on state-of-the-art developments in psychiatric science and research. The aim of the psychiatric treatment was the reintegration of mentally ill patients into everyday life so that they were able to come to terms with their illness and its consequences, to gradually assume responsibility for their own life with the help of the staff, and to live their lives independently. Therapeutic walks outside the hospital premises in order to prepare for the patient's release after several weeks of inpatient treatment were subject to a particularly careful decision-making process and would only be permitted if they posed no acute danger to the patient or to others. The decision as to whether and when such preparations for an actual release could start was up to the doctor treating the patient in question. In determining this question, the doctor also took into account the assessment of the nursing staff, the psychologists and the therapists involved in the treatment and care process of the patient concerned. Moreover, it was subject to a regular re-assessment.

44. The Government argued that it was evident from the relevant case-law and literature at the material time that unaccompanied walks by hospitalised persons were admissible, even if the Hospitalisation Act was silent on the issue. It could not be deduced from the fact that "hospitalisation" was defined as a restriction of freedom of movement that this restriction had to remain at the same intensity throughout its entire duration. It was rather the case that any restriction was admissible only in so far as it was strictly necessary and proportionate. This included, if appropriate, allowing the patient to temporarily leave the hospital premises. It followed from section 33 § 1 of the Hospitalisation Act that a patient's freedom of movement had to be restored as soon as the circumstance necessitating its restriction ceased to exist. Granting a person a wider freedom of movement by allowing unaccompanied walks on the hospital premises or even outside did not mean that the hospitalisation was thereby lifted or interrupted.

45. The Government maintained that the Austrian courts had conducted detailed and thorough investigations and had come to the conclusion that the hospital neither was nor could have been aware of a real and imminent risk of suicide on the part of M.K. At no time during his hospitalisation between 19 March and 12 May 2010 had there been any indication of the existence of such a risk, as was documented in detail by the hospital and corroborated by the statements under oath of the three treating doctors before the Vienna Regional Civil Court on 16 May 2011. As in *Keenan v. the United Kingdom*, no. 27229/95, § 99, ECHR 2001-III, there was no such indication on the day of his death either. In contrast to *Renolde v. France* (no. 5608/05,

§ 83, ECHR 2008 (extracts)), there was no reason to anticipate any sudden deterioration in his condition, for example because of a recent change in medication. On the contrary, M.K. was being prepared for his release, as his hospitalisation was to end on 21 May 2010. In the light of the progress he had made, it had not been considered necessary to request the competent District Court to prolong the measure.

46. The Government concluded from the above that in the instant case there had been no violation of its positive obligations under Article 2 of the Convention.

2. The Court's assessment

(a) General principles

47. The Court reiterates that the first sentence of Article 2, which ranks as one of the most fundamental provisions in the Convention and also enshrines one of the basic values of the democratic societies making up the Council of Europe, enjoins the State not only to refrain from the "intentional" taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction (see *L.C.B. v. the United Kingdom*, 9 June 1998, § 36, *Reports of Judgments and Decisions* 1998-III).

48. Those principles apply in the public-health sphere too. States are required to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives and to set up an effective independent judicial system so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable (see *Dodov v. Bulgaria*, no. 59548/00, § 80, 17 January 2008, and *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 49, ECHR 2002-I). Where the authorities decide to place and keep in detention a person with disabilities, they should demonstrate special care in guaranteeing such conditions as correspond to the special needs resulting from his or her disability (see *Jasinskis v. Latvia*, no. 45744/08, § 59, 21 December 2010, with further references). The same applies to persons who are placed involuntarily in psychiatric institutions. In the case of mentally ill patients, consideration must be given to their particular vulnerability (see, *mutatis mutandis*, *Keenan*, cited above, § 111; *Rivière v. France*, no. 33834/03, § 63, 11 July 2006; and *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], no. 47848/08, § 131, ECHR 2014).

49. The Court further reiterates that Article 2 may imply in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual from another individual or, in particular circumstances, from himself (see *Renolde*, cited above, § 81, and *Haas v. Switzerland*, no. 31322/07, § 54, ECHR 2011). However, in the particular circumstances of the danger of self-harm, the

Court has held that for a positive obligation to arise, it must be established that the authorities knew or ought to have known at the relevant time that the person concerned was under a real and immediate risk to his life and that they had not taken measures which could reasonably have been expected of them (*Keenan*, cited above, § 93). Such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities (compare *Tanribilir* v. Turkey, no. 21422/93, §§ 70-71, 16 November 2000, and *Keenan*, cited above, § 90).

(b) Application of those principles to the instant case

50. The Court notes at the outset that it was undisputed between the parties that M.K.'s hospitalisation had been lawful, and that at the time of his death the respective court order was still in force. The parties' views differ, however, when it comes to the question of the foreseeability of M.K.'s suicide and a possible duty on the part of the hospital to prevent him from taking his own life by further restricting his freedom of movement.

51. The Court reiterates that after his hospitalisation on 19 March 2010, the applicant's son had managed to escape twice from the closed ward, namely on 25 and 29 March 2010. The third escape, which resulted in his suicide, took place on 12 May 2010, thus about one and a half months later, when he had already been transferred to an open ward. According to the comprehensive findings of the national courts – which were based on witness statements and an expert opinion – both M.K.'s willingness to comply with hospital orders and his condition had significantly improved after 2 April 2010. From that time on, the national authorities considered that it would no longer have been proportionate to keep him in the closed ward, even though his last escape had only taken place a few days earlier. M.K. had successively been given more personal freedom, in particular because of the need to animate him to counteract the dynamic exhaustion which afflicted him, and in order to facilitate his re-integration into society. The domestic authorities had not found any counter-indication as he had at no point in his entire stay expressed any suicidal thoughts or demonstrated such behaviour. According to the expert opinion of Dr P (see paragraph 20 above), at the time of his fatal escape, hospitalisation was indicated only because of the threat he still posed to others, but not to himself any more.

52. The Court considers the assessment of the facts by the domestic authorities comprehensive, relevant and persuasive, and also in line with its case-law on the issue. In *Renolde v. France*, cited above, the Court found a violation of Article 2 because the authorities had known from a previous suicide attempt that the applicant's brother was suffering from an acute psychotic disorder capable of resulting in self-harm. In the instant case, it appears from the hospital records that there had been no signs of suicidal thoughts or attempts throughout M.K.'s entire stay at the institution. In these circumstances, it would not have been lawful under the

Hospitalisation Act for the hospital to keep him in the closed ward any longer (see paragraphs 27 and 30 above). During the weeks preceding M.K.'s death, that is to say from the beginning of April 2010 until 12 May 2010, he had been calm, inconspicuous and had taken his medicine voluntarily. When he was given the freedom to take walks by himself from 21 April 2010 – more than three weeks after his previous escape – he had always returned from his walks as agreed. He notified the hospital staff that he was taking a walk before leaving and informed them again upon his return and – as instructed – never left the hospital grounds.

53. In *Keenan*, cited above, the Court found no violation of Article 2 because there was no reason for the authorities to be alerted on the day of the inmate's death that he was in a disturbed state of mind, rendering a suicide attempt likely, even though he had previously voiced such thoughts. In the instant case, from the documents at hand and from the fact that the hospital kept a detailed record of his treatment, the Court is convinced that the hospital staff could not at any point have had any reason to expect that M.K. would commit suicide, either on the day of his commitment to the hospital or on any of the other days during which he remained within their sphere of responsibility. The Court finds the above elements sufficient to allow it to conclude, just like the domestic courts, that M.K.'s escape and subsequent suicide had not been foreseeable for the hospital and was not therefore attributable to it.

54. From the above findings it also follows that the hospital did not act negligently in allowing M.K. to take walks on his own once his mental state had improved after 2 April 2010. As evident from the international law sources pertaining to the issue (see paragraphs 32-37 above) and as the Government has comprehensively argued, today's paradigm in mental health care is to give persons with mental disabilities the greatest possible personal freedom in order to facilitate their re-integration into society. The Court considers that from a Convention point of view, it is not only permissible to grant hospitalised persons the maximum freedom of movement but also desirable in order to preserve as much as possible their dignity and their right to self-determination. It also follows from the case-law on Article 5 of the Convention that a deprivation of liberty must be lifted immediately if the circumstances necessitating it cease to exist or change (see, for example, *Winterwerp v. the Netherlands*, 24 October 1979, § 39, Series A no. 33; *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) or must be scaled down to the extent which is absolutely necessary under the given circumstances (see, *mutatis mutandis*, *Witold Litwa v. Poland*, no. 26629/95, §§ 78 and 79, ECHR 2000-III; *Johnson*, cited above, § 63; *Luberti v. Italy*, no. 9019/80, § 27 Series A no. 75). In the instant case, M.K.

continued to be deprived of his liberty within the meaning of the Court's case-law even after he was transferred to the open ward, in so far as he was required to give notice of his walks and return to the hospital afterwards, amongst other things. However, the hospital had scaled down the extent of the deprivation of his liberty without delay when his medication started to work and he was compliant with the hospital rules. In the circumstances of the present case, the Court agrees with the Government that the advantages of an open hospitalisation of M.K. clearly outweighed the disadvantages of the closed option.

55. In light of the above considerations the Court cannot find that the Austrian courts and authorities had disregarded their positive obligations flowing from Article 2 of the Convention. In this respect the Court would agree with the Austrian Supreme Court which found that if the hospital would have restricted M.K.'s liberty more than it did issues under Articles 3, 5 and 8 of the Convention might have arisen (see also *Storck v. Germany*, no. 61603/00, ECHR 2005–V; *Shtukaturov v. Russia*, no. 44009/05, ECHR 2008; and *Stanev*, cited above).

56. Looking at the procedural aspect of Article 2, the Court lastly notes that the domestic courts have thoroughly examined the case and have argued extensively why M.K.'s death could not be attributed to the authorities. There have been no apparent shortcomings in the investigation.

57. The foregoing considerations are sufficient to enable the Court to conclude that there has been no violation of Article 2 of the Convention under either its substantive aspect or under its procedural limb.

FOR THESE REASONS, THE COURT,

1. *Declares*, unanimously, the application admissible;

2. *Holds*, by six votes to one, that there has been no violation of Article 2 of the Convention.

Done in English, and notified in writing on 22 November 2016, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Marialena Tsirli Registrar	András Sajó President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following separate opinions are annexed to this judgment:

(a) concurring opinion of Judge Sajó;

(b) dissenting opinion of Judge Motoc.

A. S.
M. T.

CONCURRING OPINION OF JUDGE SAJÓ

1. In the present case the applicant's son, who was under a court order of involuntary placement, committed suicide after escaping from the open ward to which he had been transferred in the meantime. The applicant pleaded a violation of Article 2. Given the very stringent test that is applicable in similar circumstances (see *Keenan v. the United Kingdom*, no. 27229/95, § 90, ECHR 2001-III)[1] I had to conclude that there was no real and immediate risk of which the authorities ought to have known, given the uncontested medical opinions. Therefore, I had to vote together with my colleagues finding no violation.

2. There are, however, some disturbing elements in this case. The applicant was under a court order of placement, and that order had been changed by the hospital personnel for medical reasons to facilitate his reintegration. It is true that the State is obliged to take immediate steps to facilitate release from detention and that under the Austrian Hospitalisation Act freedom of movement has to be restored as soon as the circumstances so permit. However, this cannot be done in breach of an unconditional court order, but must involve prompt judicial action; moreover, the person had already escaped twice in breach of the court order. Moreover, the Austrian Hospitalisation Act was silent on the issue of unaccompanied walks. Where a contrary judicial order has been issued, the silence of the law cannot be interpreted as authorisation.

3. The medical personnel took a professional decision to facilitate the integration of the applicant's son. For the Court this seems to fit into an emerging trend in international law concerning persons with mental disorders, and in particular as a matter to be considered in the light of the "principle of least restriction" (see paragraph 32). Now the UN Office of the High Commissioner for Human Rights has issued a statement concerning Article 14 of Convention on the Rights of Persons with Disabilities (CRPD) ("the existence of a disability shall in no case justify a deprivation of liberty") as meaning, in view of the CRPD Committee's position, that "it is contrary to Article 14 to allow for the detention of persons with disabilities based on the perceived danger to themselves or to others." (see paragraph 36). This approach resulted in the tragic loss of the applicant's life, and it is now endorsed by the Court. I beg to differ: precaution is not paternalism. There was a judicial finding that such placement is necessary and there is no finding that this was not necessary for the above-mentioned purposes.

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1. "For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk."

4. It must be added that the applicant complained exclusively under Article 2. Since the Court is master of the characterisation to be given in law to the facts of the case, it does not consider itself bound by the characterisation given by the applicant or the Government (see *Scoppola v. Italy (no. 2)* [GC], no. 10249/03, § 54, 17 September 2009). Without prejudging the matter, I think that given the factual allegations of the application the case should have been reclassified and recommunicated under Articles 3 and 8.

DISSENTING OPINION OF JUDGE MOTOC

"With a truly tragic delusion," Carl Jung noted, "these theologians fail to see that it is not a matter of proving the existence of the light, but of blind people who do not know that their eyes could see. It is high time we realized that it is pointless to praise the light and preach it if nobody can see it. It is much more needful to teach people the art of seeing." - Carl Jung

This case is extremely important given the increasing number of deaths in custody and the rise in the number of persons with mental health problems. I respectfully disagree with the majority that the case presents no violation of Article 2 of the Convention.

The majority sees no reason to question the finding of the Austrian domestic courts to the effect that M.K.'s escape and subsequent death had been neither foreseeable nor attributable to the hospital authority as a matter of negligence. On the facts, the majority agrees with the Court of Appeal and the Supreme Court that the hospital did not fail to comply with its positive obligations arising from Article 2 of the Convention and considers that restrictions on M.K.'s freedom of movement would have adversely affected his recovery process as well as raised questions related to the infringement of other articles of the Convention (see paragraphs 55-56 of the judgment).

It is important to reiterate that the Court will respect the principle of subsidiarity; thus, it is not the Court's task to substitute its own assessment of the facts for that of the domestic courts and, as a general rule, it is for those courts to assess the evidence before them. It follows that any assessment of the relevant facts and evidence that has previously been made in the domestic context must be taken into account. Thus, the Government's submissions, which state that open psychiatry is the norm in the treatment of mentally ill patients and that restriction of the patient's movement was no longer indicated or medically adequate in M.K.'s circumstances, will not be contested. These findings are the result of medical expert analysis and have already been appropriately reviewed in procedure and substance by the Austrian national courts.

In the same way, it is difficult to contest the medical findings that M.K. had displayed no indication of an intention to take his own life, and thus, according to the jurisprudence on the matter, that his suicide was not foreseeable. The majority's assessment considered whether there was a "real and immediate risk" that M.K. would try to commit suicide, which they rightly answered in the negative based on the present facts. The well-established definition of "real and immediate" implies that the risk must be "substantial or significant" "not a remote or fanciful one" and "real and ever-present" (see cases such as *Osman v. the United Kingdom*, 28 October 1998, § 108, *Reports of Judgments and Decisions* 1998-VIII, and *Opuz v. Turkey*, no. 33401/02, ECHR 2009). Considering that the risk

of suicide was neither explicit nor recurring, or an overall and present worry in respect of the patient, the majority's conclusion that there has been no violation of Article 2, as in the case of *Keenan v. the United Kingdom*, no. 27229/95, ECHR 2001-III, was natural.

I do not disagree with the majority in this finding. Rather, I argue that the main question which my colleagues, in line with the national courts, have addressed is not the correct one. In the circumstances of the forced hospitalisation of a mentally-ill person, Article 2 implies a positive obligation on the hospital authorities to take preventive operational measures to protect an individual from others or from him- or herself. The general duty of these authorities in cases concerning their obligation to protect the life of the person in their custody is to take all necessary and reasonable steps in the circumstances (see *Keenan*, cited above, § 91). The majority upholds the Austrian Government's argument that the hospital authorities had indeed done all that was reasonable and necessary, since they did not and could not have known that M.K. was at risk of committing suicide at the relevant time. But this question is a truncated version of that posed in Keenan. The broader question, which is relevant in these circumstances, relates to the duty of the hospital authorities to know whether, at the time of the unsupervised walks, M.K. posed a real and immediate risk to his own life in general (and not merely at risk of deliberately committing suicide). I argue that his medical condition clearly indicated that he was at such a risk, and that in such circumstances giving him wide freedom of movement was not what could reasonably have been expected of the medical authority.

The majority seems to focus too much on the foreseeability of suicide and disregards the foreseeability of an act of self-harm caused by a delusional thought. In both medical testimony and the Government's arguments it is stated that M.K. still posed a threat to himself on account of his delusional status. It is stated repeatedly in the applicant's claim and acknowledged in the Government's counter-claim that self-harming behaviour is likely to occur outside the hospital environment due to overstimulation, especially in patients with M.K.'s condition. Thus, I cannot agree with the finding of the Court of Appeal, endorsed by both the Supreme Court and the majority of my colleagues, that "there is no causal link between the wholly unexpected suicide of the applicant's son and the alleged dereliction of the hospital's duty of supervision" (see paragraph 20 of the majority judgment). If the national courts were really to have taken the symptoms of paranoid schizophrenia into consideration, they would naturally have contemplated whether a delusional patient might put himself in harm's way as a result of a psychotic episode, without any intention of actually taking his own life. Once this is established, the State authorities are under an operational obligation to take reasonable measures and to act with due diligence.

It is clear that keeping M.K. in a locked ward would have been detrimental to the process of his recovery, but in view of the foreseeable danger to his safety, the hospital authorities were required to strike a balance between taking all necessary precautions in the circumstances and respecting his freedom of movement. The majority argued that the hospital was reasonable in allowing the patient to go on unsupervised walks and to report back at his convenience, in view of his seemingly improved state which gave no indication of suicidal thoughts. If the envisaged consequences of M.K.'s freedom are not suicide-related but escape-related, then I would argue that the total lack of supervision represents a complete forfeiture of any obligational duty to implement reasonable measures. Although the patient showed signs of improvement, he had already tried to escape on two previous occasions. This cannot be completely disregarded when weighing the benefits of open treatment against its downfalls. As unfamiliar environments are likely to trigger delusional fits in patients with M.K.'s diagnosis, his escape should have been a real issue for the hospital authorities and should have implied at least some minimal procedural obligations. The medical authorities failed to carry out such a balancing exercise, and by giving the patient such wide exposure to new surrounding they placed him in a dangerous environment which eased the triggering of his delusions and paranoid state (see *Reynolds v. the United Kingdom*, no. 2694/08, 13 March 2012).

I also disagree with the Austrian Government's statement that "[t]he behaviour of M.K. had not been foreseeable ... and the fact that the risk of self-harm could never be entirely excluded in the case of psychotic patients did not change this assessment" (see paragraph 21 of the judgment). Article 2 of the Convention also implies a duty to investigate in circumstances where a patient such as M.K. takes his or her own life. It is evident that it is no longer possible to determine whether the applicant's son deliberately committed suicide or followed a delusional impulse. Nevertheless, an investigation into the patient's vulnerability and the level of risk he posed to himself on account of his condition could have been conducted to determine the degree of control the hospital ought to have exercised over him in order to guarantee his safety during his walks. Thus, the fact that a psychotic patient faces a risk of self-harm is highly relevant to the circumstances at hand. It, firstly, implies a need for medical examinations into the patient's specific condition and, secondly, indicates that the hospital should be cautious, so as to ensure that it does not unduly provoke a psychotic episode which would increase the patient's chances of self-harming. M.K.'s therapeutic walks could still have assisted his recovery even had some additional supervisory measures been put in place by the authorities. Thus, a balance could have been achieved, by granting him the freedom of movement that was deemed beneficial, while still policing

against his foreseeable tendency to escape, which could have been anticipated to have destructive consequences.

In these circumstances, I have to agree with the applicant and the Regional Civil Court, to the effect that the hospital authority has breached its positive duty under Article 2 by failing to impose some procedural safeguards to ensure that the patient would not escape from the hospital premises, as it was foreseeable that any such escape could be fatal in the light of his diagnosis.

To conclude, the duty to protect the right to life should not be sacrificed in an attempt to comply with the above-mentioned recent trend in healthcare. I cannot disagree with the findings of the majority, to the effect that the advantages of an open hospitalisation regime are far greater in the treatment of persons in M.K.'s state than an entirely restricted hospital regime. Nevertheless, a balance must be struck in providing this "open" medical care, while still ensuring that the hospital authority imposes certain safeguards in order to comply with its positive obligations under Article 2. I strongly believe that no such balance has been reached in the circumstances at hand.