This quarter we deal with the European Convention on Human Rights as it touches on the medical issues of confidentiality, mental health, and access to abortion. The confidentiality of medical records is well established under the protective umbrella of the right to privacy described by Article 8 of the Convention. Less explored is the extent to which that provision can protect the confidentiality of research disclosure which might lead to the discovery of the identity of the research participants. As the Gillham case suggests, the courts are more inclined to lean towards the right to information under Article 10 of those seeking access to the material.

As usual we cover a range of mental health cases, including an interesting ruling on mental health insofar as it relates to capacity to consent to sexual intercourse. The case involving whether a man with an IQ of 48 had the mental capacity to consent is an issue which lies at the boundary of law, medicine and ethics.

A recent ruling on detention under the Mental Health Act has substantially expanded the liability of local authorities for unlawful detention of mental health patients beyond the previous statutory limits. As the TTM case shows, a claimant will no longer have to show that a health professional who supports detention has acted in bad faith or without reasonable care to establish a claim in damages for unlawful detention under Article 5 of the ECHR.

On abortion and reproductive rights a pair of cases, one against Ireland in the Grand Chamber in Strasbourg, and a High Court challenge to UK law on the administration of early medical termination drugs, demonstrate that courts are cautious about interfering with legislative restrictions on the accessibility of termination treatment.

1. Confidentiality
2. Mental Health
3. Treatment: Abortion rights
4. Inquests

1. Confidentiality

The fact of their confidentiality does not preclude the medical records of third party patients being disclosed in legal proceedings. So too in relation to sensitive information given confidentially in the context of medical research, in the light of a recent Strasbourg case.


A Swedish professor failed in his European Court of Human Rights challenge to his conviction for disobeying a court order to hand over sensitive information in medical research, despite having promised the participants that the information would be for his use alone.

Professor Gillberg was the former director of the Department of Child and Adolescent Psychiatry in
Sweden. This Department stored theses on attention-deficit hyperactivity disorder, based on neuropsychiatric research from 1977 to 1992. One hundred and forty-one pre-school children participated in the study. Professor Gillberg alleged that it was a precondition to the research that sensitive information about the participants would be accessible only to himself and his staff.

Gillberg was convicted of misuse of office after he destroyed these records in response to an order by the Swedish Administrative court which ordered him to grant access to the material to two academics (a sociologist and a paediatrician).

Having failed in his appeals against conviction in national courts, he took his case to Strasbourg, claiming (among other things) that the conviction infringed his rights under Article 8 (right to privacy) and Article 10 (right to freedom of expression).

His argument under Article 8 was that, having regard to his promise of confidentiality to the families of the children who took part in the research, his criminal conviction infringed his right to private life as set out in Article 8, to which his professional life was a part. The court did not rule on whether there was in fact interference with Professor Gillberg’s private life, because even assuming that there was such an interference, his conviction for misuse of office was justifiable as necessary in a democratic society, and his sentence was not disproportionate.

Professor Gillberg also argued that his right to freedom of expression under Article 10 was infringed. He sought to argue that Article 10 included a 'negative right' not to be compelled to express oneself. The Court noted that he had not been convicted, however, for failing to give evidence, but for misuse of office in not complying with the judgments of the Administrative Court of Appeal. The Court doubted that his conviction amounted to an interference with his Article 10 rights, but again found it unnecessary to determine this question, as the conviction was in any case justifiable as proportionate to the legitimate aim of the prevention of disorder and crime, and the protection of others.

Of course, it would be wrong to accord too much significance to the decision in Gillberg, especially given the fact that it was not his own information that Professor Gillberg was seeking to protect. Instead, he had to construct his challenge on the rather tenuous basis that his conviction for disobeying the order of a national court impermissibly interfered with his own Convention rights, and it would have been surprising had the Court in effect validated such disobedience. Rather, the judgment suggests reluctance on the part of Strasbourg to challenge the decisions of national courts relating to the disclosure of confidential information. If a UK court orders disclosure of medical information, the odds would seem to be against getting that decision overturned in Strasbourg.

**A (A Child) v Cambridge University Hospital NHS Foundation Trust**
**[2011] EWHC 454 (QB)**

A seven-year-old child with severe disabilities caused by medical negligence during his birth should be the subject of an order under section 39 of the Children and Young Persons Act 1933 that prohibits the identification of a child in any newspaper report.

The order was granted in the course of a hearing to approve the settlement between the child and the defendant hospital. The judge held that there was a risk that the objective of such proceedings, namely to ensure that settlement money is properly looked after and wisely applied, would be defeated if the claimant was identified. Further, identification of the child would curtail his and his family’s right to respect for their private and family under Article 8 of the ECHR and there was insufficient general public interest in identifying the child to justify that curtailment.
An order under section 39 of the Children and Young Persons Act 1933 is less restrictive than a full anonymity order and therefore was held to be a more acceptable alternative.

The facts were broadly as follows. The claimant, A, had been starved of oxygen due to a negligent delay in his birth. As a result, A was physically very incapacitated but mentally entirely, or very substantially, intact. He was intelligent and able to communicate, albeit with difficulty. A’s preserved cognitive functioning meant that he might have legal capacity as an adult. A required care in every aspect of his life and the relevant proceedings were to approve a very large sum of money in settlement of his claim.

The application before the court was for an order under section 39 to prevent any newspaper report revealing the name or picture of the child in question. Whilst there are no clear criteria to be applied in respect of a s.39 application, apart from a Court of Appeal case [R v Lee [1993] 2 All ER 17] which held that nothing in the statute supported the stance that reporting restrictions should be granted except “in rare and exceptional cases”. The judge considered that the passing of the Human Rights Act 1998 developed the law further by requiring the court to have regard to freedom of expression protected by Article 10 of the ECHR, as well as to the requirements of open justice under Article 6 and respect for private life under Article 8.

The Court of Appeal’s guidance given in JIH v News Group Newspapers Ltd [2011] EWCA Civ 42 in respect of anonymity orders was held to apply equally to orders applied for under section 39. In JIH Lord Neuberger MR held that the general rule was for the names of parties to an action to be included in orders and judgments of the court and that an anonymity order or any order restraining publication is a derogation from open justice and an interference with the Article 10 rights of the public at large. Accordingly, a court should only make such an order after close scrutiny and considering whether restraint on publication is necessary and if so, whether any less restrictive alternative would suffice. The question for the court is whether there is sufficient general, public interest in publishing a party’s identity or normal reportable details to justify any resulting curtailment of the right to privacy and family life.

In considering the impact on A’s rights, the judge noted that modern technology meant that any report of the proceedings would be as readily accessible by the time A reached adulthood as it would be today. The purpose of the instant proceedings was to ensure that the settlement sums were properly looked after and wisely applied so that the claimant had access to the finances necessary to compensate him. A’s physical disabilities meant that A would be vulnerable as an adult and if the sums at A’s disposal were readily known, it would put him at risk of losing that money to “inappropriate friends, fortune hunters or even thieves” thereby defeating the object of the proceedings.

Further there was no sufficient general, public interest in publishing a report of the proceedings which identified A to justify the resulting curtailment of his right and his family’s right to respect to their private and family life. Consequently an order under section 39 was appropriate.

This judgment, like that in JXF (a child) v York Hospitals NJS Foundation Trust [2010] EWHC 2800 (QB) where an anonymity order was granted to a child, will be significant whenever a child claimant who is likely to attain capacity seeks anonymity. Both A and JXF can be viewed as authority that orders restricting publication are to be very much the exception and not the rule, and the latest judgment indicates that, in relation to child claimants, section 39 orders are to be preferred over other anonymity orders unless severe restrictions are necessary.
Margaret Bowron QC of 1 Crown Office Row represented the Claimant.

2. Mental Health


This is a fascinating case both legally and morally. A judge in the Court of Protection has ruled that a 41-year-old man with a mild learning disability did not have the mental capacity to consent to sex and should be prevented by a local council from doing so.

The case arose when a local council, following allegations that a mentally disabled man made sexual gestures towards children, sought a court order stating that “Alan” (a false name) did not have the mental capacity to consent to sexual relations. The council ultimately wanted Alan to be banned from having sexual relations with his former house-mate and sexual partner.

The central question for the court was how to assess if a person has the mental capacity to consent to sex. The question is fraught with difficulty, as a negative answer can lead to the state controlling a person’s sexual activity, as it ultimately did in this case, but also because a prospective sexual partner could be accused of rape for having had sex without consent.

Alan has an IQ of 48, and is seriously challenged in all aspects of his mental functioning.

Dr Hall, the court’s expert medical witness, described sex as “one of the most basic human functions”. Thus, warned the judge,

“the Court must tread especially carefully where an organ of the state proposes that a citizen’s ability to perform, in a non-abusive way, the sex function should be abrogated or curtailed. It involves very profound aspects of civil liberties and personal autonomy” [para 11]

But what characteristics does a person need to consent to sex? The judge drew on two analogies.

First, following Mr Justice Munby in Re E (an Alleged Patient); Sheffield City Council v E and S [2004] EWHC 2808 (Fam), he compared sexual consent to consenting to marriage. While a sexual relationship is “not a vital ingredient of marriage it is, generally speaking, implicit in the marriage agreement.” So,

“it can be seen that the test of capacity to marry must be very closely related to the test of capacity to consent to sexual relations. And it would be a very strange thing if the latter were set higher than the former, for it would be an absurd state of affairs if a person had just sufficient intelligence to consent to marriage but insufficient capacity to consent to its [generally speaking] intrinsic component of consummation.” [para 15]

So how intelligent do you need to be to consent to marriage? Not very, it turns out. The test has altered little since the 19th century, when in the 1885 case of Durham v Durham, it was stated:

“the contract of marriage is a very simple one, which does not require a high degree of intelligence to comprehend. It is an engagement between a man and woman to live together, and love one another as husband and wife, to the exclusion of all other.”

The second analogy Mr Justice Mostyn considered to be closely related is the capacity of a girl to consent to contraception (see our recent post on the issue). In Gillick v West Norfolk and Wisbech Area Health Authority [1986] 1 FLR 224, HL the House of Lords (now the Supreme Court) held that a girl under 16 could validly consent to contraception “provided that she has
sufficient understanding and intelligence to know what they involve”. As such, all a person needs is “sufficient rudimentary knowledge” to enable them to decide whether to give or withhold consent (para 22).

Ultimately, the judge concluded that the capacity to consent to sex requires an understanding and awareness of:

1. The mechanics of the act
2. That there are health risks involved, particularly the acquisition of sexually transmitted and sexually transmissible infections
3. That sex between a man and a woman may result in the woman becoming pregnant (para 43)

Alan, according to the medical expert, “had no understanding at all of heterosexual coitus” but he did understand “the mechanics of mutual masturbation and anal sex, with persons of either gender.” But as regards the latter, he did not understand the health risks involved.

Alan did not therefore have the capacity to consent and engage in sexual relations. He would have to be supervised for the time being and prevented from future sexual activity by the council.

However, it is a fundamental principle of the most recent mental health legislation that a person should not be treated as unable to make a decision unless all practicable steps to help him to do so have been taken. Therefore, the judge also ordered that the local authority provided Alan with sex education and he would be reassessed by the court after, appropriately, 9 months.

The court made clear that sex is a fundamental right. Some would say that it is too fundamental a right to ever be taken away by the state. But in this case that right had to be balanced against legitimate concerns for public safety. Even so, the judge saw fit to exhaust all possible avenues before declaring Alan permanently unfit for sexual relations. In short, people with low enough IQs cannot always validly consent to sex, but as much as possible should be done to find out if they are able to make the decision for themselves.

G v E & Ors [2010] EWHC 3385 (Fam) [21 December 2010]

In another recent mental health case Manchester City Council has been ordered to pay the full legal costs of a 20-year-old man (“E”) with severe learning disabilities who was unlawfully removed from his long-term foster carer. The council, in the court’s words, demonstrated a “blatant disregard” for mental health law.

The case has wound an interesting route through the courts, with hearings in the Court of Protection, Court of Appeal, and also a successful application by the Press Association to reveal the identity of the offending local council in the interests of transparency.

Now, Mr Justice Baker has taken the unusual step of ordering that Manchester City Council pay all of E’s family’s legal costs. The general rule in the Court of Protection is that costs should not be awarded, but as the judge ruled it can be broken in certain circumstances:

“The work carried out by the local authorities and other public bodies such as NHS Trusts in this important field cannot be underestimated... That does not mean, however, that local authorities, or any other public bodies, can be excluded from liability to pay costs in appropriate cases.” (para 38)

Simply, the local authority’s behaviour was so bad in this case that it justified breaking from the rule:

“I am entirely satisfied that the local authority’s blatant disregard of the processes of the MCA and their obligation to respect E’s rights under the ECHR amount to misconduct which justifies departing from the
general rule.” (41)

Moreover, it was no excuse that the local authority staff were ignorant of the rules under the Mental Capacity Act. Mr Justice Baker made clear that ignorance is no excuse in this or future cases:

“Given the enormous responsibilities put upon local authorities under the MCA, it was surely incumbent on the management team to ensure that their staff were fully trained and properly informed about the new provisions... As it is, the local authority’s actions in this case would have infringed E’s Article 5 and 8 rights under the old law as well as under the MCA.” (41)

Nor was the judge interested in hearing how strained public finances are:

“I deprecate the practice of relying on arguments that the impact of a costs order would reduce the local authority’s social care budget. The Legal Services Commission could equally well argue that the denial of a costs order in this case in favour of G, F and E will reduce the funds available for other cases. If a costs order is made, that will be the fault of Manchester City Council, not the Court.” (39)

E’s family have already spent a lot of time in court, and the costs bill will be substantial. The complicated background to the case is set out in paragraph 6 to 21 of the judgment. In short, E suffered from severe learning difficulties. He had been living with F, his former foster carer, for around 10 years when he was removed from her care by the Local Authority.

Mr Justice Baker ruled in March that the council had deprived E of his liberty and infringed his rights under article 5 of the European Convention on Human Rights, and had also breached his article 8 rights to family life by removing him from his long-term foster carer without enough consideration or consultation. The Court of Appeal upheld the decision.

The family may not have had their last day in court, however. Permission is being sought to appeal to the Supreme Court for the original judgment against the council. If the appeal is successful, Mr Justice Baker has agreed to reconsider his decision on costs. And the question of damages for breach of E’s rights is to be decided later this year.

For now, this decision will serve as a warning to local authorities that they will not always be protected from paying out legal costs in the Court of Protection. In the most serious cases, where rules have been ignored and the rights of highly vulnerable people breached, authorities may have to pay out legal costs however empty the public purse.

TTM (By his Litigation Friend TM) v London Borough of Hackney, East London NHS Foundation Trust; Secretary of State for Health [2011] EWCA Civ 4

We previously considered this case last year in Newsletter 25. The Court of Appeal has now recently considered the question of patient detention, and the ruling provides important guidance on the liability of mental health and medical professionals in this difficult area, as well as the ability to recover damages where a claimant is unlawfully detained.

Where there has been unlawful detention under Section 3 of the Mental Health Act 1983 the local authority, but not the detaining hospital, was liable to pay compensation.

In December 2008 TTM had been lawfully admitted under Section 3 of the Act to Homerton Hospital, run by the Respondent NHS Foundation Trust. Subsequently, TTM’s nearest relative TM exercised his power under Section 23 of the Act to give notice to require TTM’s release by 22 January 2009.

The authorities took the view that TTM would be likely to
act in a manner dangerous to other persons or to himself and so on his subsequent release from formal detention, it was agreed that TTM should remain informally in hospital.

Whilst voluntarily remaining in hospital, TTM refused to take any medication and his treating clinicians also differed on whether medication was necessary. Consequently, two independent psychiatrists assessed TTM and recommended admission under Section 3 of the Act for the safety of TTM and others.

On 30 January 2009 "the approved medical health professional" (AMHP) made a written application for admission on the basis of the psychiatrists’ opinion. Although he spoke with TM several times before making the application, the AMHP mistakenly concluded TM no longer objected. Consequently TM could no longer prevent admission.

TTM applied for a writ of habeas corpus and also claimed, inter alia, a declaration that his admission had been unlawful, damages for this detention under Articles 5(5) and 8 ECHR. Should such a claim be barred by the Mental Health Act (Section 139(1) which limits the civil liability of the responsible local authority to cases where the act was done in bad faith or without reasonable care) he sought a declaration that Sections 139(1) and 6(3) of the Mental Health Act were incompatible with Article 5 of the ECHR (the right to liberty).

He was initially successful in obtaining a writ of habeas corpus and a declaration that Section 3 admission was therefore unlawful.

By the time the case reached the Court of Appeal, the question of the lawfulness or otherwise of his detention became more complicated. The Court held that the detention had been unlawful from the start when the AMHP erred in whether the patient’s relative objected to admission. The local authority responsible for the AMHP could not rely on the Mental Health Act’s statutory protection from civil liability, which had to be read down by virtue of Section 3 of the Human Rights Act 1998 to give effect to the patient’s right to liberty under Article 5 of the ECHR.

On the other hand the Hospital Trust was saved by Section 6(3) which rendered the detention lawful since the Trust had the power under that section to detain a patient on the basis of a Section 3 application that appeared to be duly made – it was entitled to rely on the AMHP’s application without further enquiry as to the objections of the nearest relative.

The Court rejected, however, the Respondent Local Authority’s and the Health Secretary’s argument that as the Hospital Trust had detained TTM lawfully he was not unlawfully deprived of his liberty by the conduct of the AMHP. The fact that the hospital trust’s actions were lawful were not curative of the underlying unlawfulness:

"There may be false imprisonment by A although it was B who took the person into custody and B acted lawfully, provided that A directly caused B’s act and that A’s act was done without lawful justification” [35]

In other words, a lawful act by a second act does not prevent the claimant’s detention being a direct consequence of the AMHP’s unlawful act, nor cannot it cure the unlawful nature of the act. Section 6(3) simply means the claimant cannot complain of unlawful detention against the hospital managers – it cannot make an unlawful detention lawful. Consequently, TTM had been unlawfully detained contrary to Article 5 of the ECHR and was entitled to compensation.

In regard to the mechanism of achieving compensation, the Court held that the function of Section 139(1) could be read down by virtue of Section 3 of the Human Rights Act so as to permit a compensation claim.

In contrast, the Court rejected the submission that Section 6(3) should be exposed to the same interpretation. It serves a “positive purpose” and should
not be “weakened”:

“It is in the public interest that a hospital trust should act promptly on receipt of an application for admission which appears to be in proper form...” 

Consequently, TTM had been unlawfully detained as a matter of domestic law and under Article 5 and TTM was given leave to pursue compensation against the Local Authority but could not recover against the Hospital Trust.

Neil Garnham QC and Sydney Chawatama of 1 Crown Office Row appeared for East London NHS Foundation Trust in this case

Whilst the TTM decision will undoubtedly have consequences for local authorities making Section 3 applications, particularly in regards to the procedures and safeguards in place, the ruling is reassuring for hospital authorities. They will undoubtedly be relieved by the Court’s acceptance that there are good public interest reasons why a hospital should not have to look behind a prima facie legitimate Section 3 application. The flexibility to deploy medical practitioners to assess a patient afresh when the clinical circumstances, including differing clinical judgments, require it in the patient’s interest will also be welcome in this difficult area.

Secretary of State for Justice v RB [2010] UKUT 454

Staying with the law on detention under the Mental Health Act, the Upper Tribunal has recently departed from a line of court authority by deciding that where a patient has been detained under the 1983 Act, conditionally discharging that patient from hospital subject to conditions which might themselves amount to a form of detention is compatible with Article 5 of ECHR.

RB, who was aged 75, had been detained under the Mental Health Act on 30 June 1999 following a conviction for indecent assault on a boy aged under 16. He suffered from a persistent delusional disorder, which rendered him a “strongly misogynistic”, lifelong paedophile.

Following a failed application for discharge from hospital in 2007, on 24 April 2009 the Mental Health Review Tribunal decided that under sections 72 and 73 of the Act, RB could be discharged subject to conditions, including a condition that he reside at a specified care home, and that he did not leave the grounds of that care home except when supervised. If he breached any of these conditions he could be recalled to hospital. RB was keen for the discharge to occur and willing to comply with those conditions.

The Secretary of State sought to oppose the release of RB, and appealed this decision to the Upper Tribunal.

The unusual aspect of the appeal was that the Secretary of State relied in part on Art 5, which enshrines the right to liberty and freedom from arbitrary detention. He argued that according to authority, a discharge to a care home as ordered in the case of RB, having regard to the conditions imposed upon him, amounted to a continuing deprivation of liberty, and was contrary to Art 5 and ultra vires (outside of his powers).

The upshot of this argument was that the discharge order was unlawful, and RB should have remained detained in hospital. It appears that the Secretary of State was motivated by the view that if a patient is not sufficiently safe to be discharged without restrictive conditions placed upon his movement, he should not be released at all.

The line of authority relied on by the Government suggested that the Upper Tribunal was bound to apply the “PH principle”, which provided that the concept of “discharge” under section 73 of the Mental Health Act entailed a release from actual detention, so that when a
conditional discharge had such stringent conditions attached that it did not constitute a release from detention, it was unlawful.

The Upper Tribunal declined to follow this line of authority. Broadly speaking it said that pursuant to changes made by Tribunals, Courts and Enforcement Act 2007, it was exercising a jurisdiction equivalent to what the High Court had exercised in the past – it was therefore dealing with decisions of a court of coordinate jurisdiction, and was not bound to follow its decisions if it considered them to be wrong.

On the substantive issue before it, the view of the Upper Tribunal itself was that the word “discharge” did not necessarily entail a release from detention to a state of liberty. It preferred what it considered to be a more natural approach to the word; it noted that dictionary definitions showed that, depending on context, the word could mean “release from custody”, but could also mean release in the more general sense of “dismiss” or “send away”:

“Thus, in ordinary language, a patient may be “discharged” from hospital, without any connotation that he is being released from the deprivation of liberty in the legal sense. In relation to section 72, it seems more natural to read the word “discharge” as meaning simply release from the state there mentioned, that is from “detention in a hospital for treatment”.

This resulted in a much narrower PH principle: a tribunal could not conditionally discharge a person with conditions that amount to detention in a hospital for treatment. Continuing detention in some other environment, however (or presumably a shift to another hospital under conditions which did not amount to detention), would not be ultra vires or a breach of Art 5.

In reaching this decision, the Upper Tribunal appeared perturbed by the invocation of Art 5 as a means of requiring the continued hospital detention of a patient, rather than facilitating his discharge. In paragraph 52 of its judgment it said:

We agree respectfully...that it is “curious” to find the Secretary of State praying in aid Article 5 of the ECHR to deny the patient a conditional discharge. We note the similar comments of Dr. McKenna, from his “perspective as a clinician”, as to the use of the “unusual lever” of cases on human rights to restrict the liberty of a man who “has capacity and who consents (enthusiastically) to the proposed transfer”.

It is perhaps this unease which motivated its reasoning, and its clear desire to avoid following case law which, even if not binding, was to have strong persuasive value. It might be asked why, when the dictionary offers “release from custody” as one of the natural meanings of “discharge”, this was not the most natural interpretation to choose in context. After all, RB’s detention did amount to a form of custody, and as the Upper Tribunal itself noted, the powers of the Mental Health Review Tribunal to order discharge under sections 72 and 73 of the Mental Health Act 1983 were enacted as a direct result of the Strasbourg decision in X v United Kingdom [1981] 4 EHRR 188, which held in relation to Art 5(4) that compulsorily detained patients were entitled to periodic review of their detention by a court with power to direct, rather than simply to recommend, discharge. They were thus enacted to ensure that a prisoner could challenge their detention; discharge was perceived as a means of securing liberty.

On the other hand, it might be argued that if the Government is concerned that dangerous patients are being inappropriately released, the proper means of addressing that issue is a change in the criteria upon which discharge may be ordered, rather than the counter-intuitive invocation of a right to liberty. It concluded that “[t]he tribunal’s concern [when considering to discharge a patient] should be simply to decide what is necessary for the well-being and protection of the patient, and the protection of the public and to satisfy themselves that the patient is willing to
comply with the conditions and to that extent consents to them”. A tribunal should not have to preoccupy itself with fine distinctions involved in the question of whether or not the conditions it deems necessary would amount to a deprivation of liberty, undermining its own power to act in the first place.

1 Crown Office Row’s Robert Kellar appeared for the Secretary of State for Justice in this case.

3. Treatment: Abortion rights

A, B and C v. Ireland (Application no. 25579/05)

The much awaited ruling by the Grand Chamber of the Strasbourg Court has culminated not in a bang, but a whimper. The Chamber ruled that abortion must be more accessible in Ireland for women whose lives are at risk, but rejected applications that abortion must be more widely available in other circumstances. The emerging consensus is that the European court went no further than it needed to, and did little more than reasserting the status quo in Irish law.

The ruling does not represent a significant departure from the current state of Irish law – in that it does not require the state to legalise abortion more than it technically already has done – but the probable changes in the law may result in a general softening towards abortion in general, as, in theory at least, it will be much easier for women in life threatening situations to obtain an abortion. Up until now, the law has made it practically impossible to do so.

Moreover, the recognition that abortion falls under article 8 (the right to private and family life) may also lead in future to more wide-ranging judgments, along the lines of the 1973 United States Supreme Court decision in Roe v Wade.

Abortion is technically allowed in Ireland, but only if a woman’s life is at risk. The three women in this case argued that in practice, doctors could face imprisonment if it was found the woman’s life was not at risk, and as such abortions are almost impossible to obtain. It is estimated that over 4,000 Irish women per year have abortions abroad.

The applicants were three women who live in Ireland. All three applicants travelled to the UK to have an abortion after becoming pregnant unintentionally.

The women had different reasons for not wanting to continue with their pregnancies. The first applicant, a former alcoholic whose four children had been placed in foster care, decided to have an abortion to avoid jeopardising her chances of reuniting her family. The second applicant was not prepared to become a single parent. The third applicant, in remission from cancer and unaware that she was pregnant, underwent a series of check ups contraindicated during pregnancy.

All three women claimed that the impossibility for them to have an abortion in Ireland made the procedure unnecessarily expensive, complicated and traumatic. In particular, that restriction stigmatised and humiliated them and risked damaging their health and, in the third applicant’s case, even her life.

They relied on Articles 2 (right to life) and 3 (prohibition of inhuman and or degrading treatment) of the European Convention on Human Rights.

They all also complained under Article 8 (right to respect for family and private life), that the national law on abortion was not sufficiently clear and precise, since the Constitutional term “unborn” was vague and the criminal prohibition on abortion was open to different interpretations.

Only the third applicant was successful. The court held that the third applicant’s article 8 rights were infringed as:

against this background of substantial uncertainty, the Court considers it evident that the criminal provisions of
the 1861 Act would constitute a significant chilling factor for both women and doctors in the medical consultation process, regardless of whether or not prosecutions have in fact been pursued under that Act. Both the third applicant and any doctor ran a risk of a serious criminal conviction and imprisonment in the event that a decision taken in medical consultation, that the woman was entitled to an abortion in Ireland given the risk to her life, was later found not to accord with Article 40.3.3 of the Constitution. Doctors also risked professional disciplinary proceedings and serious sanctions.

The third applicant was awarded €15,000 in damages.

British Pregnancy Advisory Service v Secretary of State for Health [2011] EWHC 235 (Admin)

Another recent case on abortion does not expressly deal with the application of privacy rights in this area but Article 8 could have been invoked in this challenge to the law governing the administration of early medical abortion drugs. Although this case concerned very different facts to the Irish case above, the submissions turned on a very similar issue: the stress caused to women who have to undertake unnecessary and burdensome travel in often traumatic circumstances to receive the treatment.

The current accepted treatment for a medical abortion up to 9 weeks’ gestation involves the prescription and two-phase administration of drugs at intervals of 24-48 hours. The claimant organisation argued that the requirement for women to return to the hospital or clinic for a second visit created unnecessary stress and hardship and therefore that the term “treatment” in the relevant legislation should be interpreted to mean that only the prescription and issuing of the drugs should take place in a hospital, allowing women to stay at home after the first visit.

In support of this contention the claimant submitted that a primary concern of Parliament in passing the 1967 Abortion Act was to ensure that abortions were carried out safely and in proper conditions. At the time when Parliament was considering the meaning of both “termination” and “treatment”, abortion was considered an invasive form of medical/surgical intervention with potentially serious possible complications. The concerns about the safety of women undergoing abortions could, in 1967, only be met by ensuring that the abortion process was undertaken in a hospital or another medical facility, such as a nursing home.

But since the passing of the Human Fertilisation and Embryology Act 1990, which amended the Abortion Act, the availability of medical abortion had become widespread and other countries, such as France, did not require attendance at hospital at all phases of the treatment. In practical terms the claimant was contending for an interpretation which allowed the prescription of misoprostol (the first-phase drug) and mifepristone (second-phase) at the same time; they can then take the misoprostol home and self-administer there, in the comfort and support of their own home.

They submitted that the safety of the abortion was unaffected by whether the relevant medication, namely misoprostol, is taken in an approved place or at home. The mischief of the Act was therefore met by defining the treatment as the prescription of the medication rather than the administration.

The Court dismissed the claim. Section 1[3 A] of the Act made clear that the responsibility for approval of a wider range of place (including potentially the home), and for the conditions on which such approval might be given relating to the particular medicine and the manner of its administration or use, lay with the Secretary of State, and not with the medical profession. In Supperstone J’s view the claimant’s interpretation of “treatment” ran counter to the natural and ordinary meaning of the word, which is defined, in the medical context, as
management in the application of remedies; medical or surgical application or service. The words “medical... application” plainly, in my view, embrace the taking of an abortifacient drug.

The judge concluded that there was a clear purpose in the legislation which can only be fulfilled if the Secretary of State’s interpretation of the concept of treatment is adopted.

4. Inquests

R (Humberstone) [Claimant] v Legal Services Commission [Defendant] & HM Coroner for South Yorkshire [West] [Interested Party] [2010] [2010] EWCA Civ 1479 (December 21, 2010)

A recent High Court decision concerning the funding of a party at a coroner’s inquest has highlighted the importance of distinguishing between the two different types of investigative duty that arise under Article 2 ECHR.

The judge ruled in this case that the state’s obligation under this provision to proactively conduct an effective investigation into a death did not arise in all cases where a death occurred whilst the deceased was in the care of the state but only in a much narrower range of cases where it was arguable that the state had breached its substantive obligations under Article 2. The possible necessity to provide representation at an inquest only usually arose in the narrower circumstances.

H applied for a judicial review of the decision of the Legal Services Commission (“LSC”) not to recommend to the Lord Chancellor that she receive public funding for representation at the inquest into the death of her son (D). D had died, aged 10, of an asthma attack. H had been arrested on suspicion of gross negligence manslaughter, but was released without charge. Her arrest appears to have been triggered by concerns from health professionals about her historic management of her son’s asthma.

A number of other parties whose conduct may have been criticised, including medical professionals and agencies, were due to be represented at the inquest, some through public funds. The sitting coroner supported H’s application to the LSC on a number of grounds, including concerns about the serious in the allegations that she faced in respect of her son’s death, her inability to deal with the complex issues raised, and the question of equality of arms.

In his judgment, Hickinbottom J addressed two questions. First, was Article 2 engaged so that there was an obligation on the state to investigate the death? Second, was Article 2 breached because the lack of representation meant that there could not be an effective investigation into the death? He answered both questions in the affirmative and quashed the LSC’s decision.

The obligation to investigate under Article 2

Hickinbottom J interpreted Article 2 as imposing two obligations. The first, which he termed “the primary duty”, is that the state should not kill and should take appropriate and reasonable administrative and legislative steps to protect individuals from threats to their lives [44]. He characterised “the secondary duty” in the following way [45]:

“The obligation on a state under Article 2 also encompasses a duty, in some circumstances, to investigate a death. That has sometimes been phrased as a discrete procedural obligation to investigate, but .... more usually as part of the positive obligation to establish a framework of legal protection of the substantive right.”

Those limited circumstances arose where the death
occurred whilst the deceased was in the custody of the state or, in the context of allegations against hospital authorities, where the allegations were of a systemic nature. They did not include cases where the only allegations were of simple medical negligence. It was not always easy to decide whether an inquest would engage the narrower Article 2 obligation and it was not possible to say that an allegation of individual negligence would never engage it but it was necessary to ensure that allegations of individual negligence were not dressed up as systemic failures. The person best placed to decide whether the Article 2 obligation of proactive investigation was engaged was the coroner conducting the inquest but in the instant case, he had not volunteered his opinion.

On the other hand the enhanced type of inquest considered in the case of R (Middleton) v West Somerset Coroner [2004] UKHL 10 might have been appropriate in the circumstances since there was evidence that there were sufficient grounds for concern about the resources and operational systems of the relevant ambulance service to trigger the broader obligation under Article 2 to undertake an investigation.

A case did not have to be “exceptional” in order to attract representation for the families of the deceased and any such presumption by the Legal Services Commission against representation and an overlooking of the right of family members to question witnesses.

Humberstone illustrates a number of important aspects to the investigative obligations under Article 2. First, it demonstrates by default that there are obligations, in the plural. Second, it shows the importance of establishing at an early stage which of the duties is triggered. Third, the analysis presented here suggests that the differences between the two types of investigation – and hence between Middleton and Jamieson inquests – should not be over-stated, as the same requirements can arise under both (although this will not necessarily be the case).

Finally, Humberstone provides a warning about the unhelpful and imprecise terminology that has developed in this area. Hickinbottom J’s initial question of whether or not “Article 2 was engaged” is one that he is not alone in posing. In any investigation into any death Article 2 is engaged. What is relevant to the legal analysis and the practical steps that follow is whether it is the general or the enhanced obligation that is triggered. Only when that question has been answered can the legal requirements of the investigation, such as the need for representation of the next of kin, be identified.

Editor’s note: See posts by Adam Wagner and Matthew Hill on the UK Human Rights Blog for further analysis and discussion on this “enhanced” obligation to investigate following a death in a state hospital. All the other cases covered in this newsletter are also discussed on our blog, with links to other sites and primary case law.