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

ENG - 2014/1

Application Form

About this application form

This application form is a formal legal document and may affect your rights and obligations. Please follow the instructions given in the Notes for filling in the application form. Make sure you fill in all the fields applicable to your situation and provide all relevant documents.

Warning: If your application is incomplete, it will not be accepted (*see Rule 47 of the Rules of Court*). Please note in particular that Rule 47 § 2 (a) provides that:
"All of the information referred to in paragraph 1 (d) to (f) [*statement of facts, alleged violations and information about compliance with the admissibility criteria*] that is set out in the relevant part of the application form should be sufficient to enable the Court to determine the nature and scope of the application without recourse to any other document."

Barcode label
If you have already received a sheet of barcode labels from the European Court of Human Rights, please place one barcode label in the box below.

Reference number
If you already have a reference number from the Court in relation to these complaints, please indicate it in the box below.

A. The applicant (Individual)

This section refers to applicants who are individual persons only. If the applicant is an organisation, please go to Section B.

1. Surname
Mortier

2. First name(s)
Tom

3. Date of birth
08/02/76 e.g. 27/09/2012
D D M M Y Y Y Y

4. Nationality
Belgian

5. Address
c/o Alliance Defending Freedom
Landesgerichtsstraße 18/10
1010, Wien
Austria

6. Telephone (including international dialling code)
+43 1 904 95 55

7. Email (if any)
tom.mortier@gmail.com

8. Sex
- (•) male
- ( ) female

B. The applicant (Organisation)

This section should only be filled in where the applicant is a company, NGO, association or other legal entity.

9. Name

10. Identification number (if any)

11. Date of registration or incorporation (if any)
e.g. 27/09/2012
D D M M Y Y Y Y

12. Activity

13. Registered address

14. Telephone (including international dialling code)

15. Email

Reset form

C. Representative(s) of the applicant

If the applicant is not represented, go to Section D.

Non-lawyer/Organisation official

Please fill in this part of the form if you are representing an applicant but *are not a lawyer*.

In the box below, explain in what capacity you are representing the applicant or state your relationship or official function where you are representing an organisation.

16. Capacity / relationship / function

17. Surname

18. First name(s)

19. Nationality

20. Address

21. Telephone (including international dialling code)

22. Fax

23. Email

Lawyer

Please fill in this part of the form if you are representing the applicant *as a lawyer*.

24. Surname: Kiska

25. First name(s): Roger

26. Nationality: Slovak

27. Address:
Alliance Defending Freedom
Landesgerichtsstraße 18/10
1010, Wien
Austria

28. Telephone (including international dialling code): +43 1 904 95 55

29. Fax: +43 1 904 95 54

30. Email: rkiska@alliancedefendingfreedom.org

Authority

The applicant must authorise any representative to act on his or her behalf by signing the authorisation below (see the Notes for filling in the application form).

I hereby authorise the person indicated to represent me in the proceedings before the European Court of Human Rights, concerning my application lodged under Article 34 of the Convention.

31. Signature of applicant

32. Date: 18/08/14 e.g. 27/09/2012

D D M M Y Y Y Y

D. State(s) against which the application is directed

33. Tick the name(s) of the State(s) against which the application is directed

- [ ] ALB - Albania
- [ ] AND - Andorra
- [ ] ARM - Armenia
- [ ] AUT - Austria
- [ ] AZE - Azerbaijan
- [x] BEL - Belgium
- [ ] BGR - Bulgaria
- [ ] BIH - Bosnia and Herzegovina
- [ ] CHE - Switzerland
- [ ] CYP - Cyprus
- [ ] CZE - Czech Republic
- [ ] DEU - Germany
- [ ] DNK - Denmark
- [ ] ESP - Spain
- [ ] EST - Estonia
- [ ] FIN - Finland
- [ ] FRA - France
- [ ] GBR - United Kingdom
- [ ] GEO - Georgia
- [ ] GRC - Greece
- [ ] HRV - Croatia
- [ ] HUN - Hungary
- [ ] IRL - Ireland
- [ ] ISL - Iceland
- [ ] ITA - Italy
- [ ] LIE - Liechtenstein
- [ ] LTU - Lithuania
- [ ] LUX - Luxembourg
- [ ] LVA - Latvia
- [ ] MCO - Monaco
- [ ] MDA - Republic of Moldova
- [ ] MKD - "The former Yugoslav Republic of Macedonia"
- [ ] MLT - Malta
- [ ] MNE - Montenegro
- [ ] NLD - Netherlands
- [ ] NOR - Norway
- [ ] POL - Poland
- [ ] PRT - Portugal
- [ ] ROU - Romania
- [ ] RUS - Russian Federation
- [ ] SMR - San Marino
- [ ] SRB - Serbia
- [ ] SVK - Slovak Republic
- [ ] SVN - Slovenia
- [ ] SWE - Sweden
- [ ] TUR - Turkey
- [ ] UKR - Ukraine

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Subject matter of the application

All the information concerning the facts, complaints and compliance with the requirements of exhaustion of domestic remedies and the six-month time-limit laid down in Article 35 § 1 of the Convention must be set out in this part of the application form (sections E., F. and G.) (Rule 47 § 2 (a)). The applicant may supplement this information by appending further details to the application form. Such additional explanations must not exceed 20 pages (Rule 47 § 2 (b)); this page limit does not include copies of accompanying documents and decisions.

E. Statement of the facts

34.

Mrs. Godelieva de Troyer was the mother of the Applicant. She committed 'suicide' with the assistance of a physician on 19 April 2012 by lethal injection at the Hospital of the Free University of Brussels. Her son, the Applicant, learned of this from the hospital, without prior notice, the following day.

The Applicant's mother had suffered with chronic depression for more than twenty years, something exacerbated by the break down of a relationship with her long-term partner.

Following these events, the Applicant engaged a third party, Dr Georges Casteur to meet with the physicians involved, inspect her medical notes and provide a report (Appendix 4). Dr E. Buntinx had been Mrs. Godelieva De Troyer's psychiatrist for more than twenty years. That report disclosed the chronology that follows.

On 29 September 2011, Mrs. Godelieva De Troyer saw Dr Distelmans for the first time who referred her to the psychiatrist Dr Verbeeck.

At an appointment with Dr Verbeeck on 17 November 2011, it is confirmed that Mrs. Godelieva De Troyer is suffering with depression with 'ups and downs' but that the request for euthanasia is immature.

Mrs. Godelieva De Troyer meets with another psychiatrist, Dr Thienpont on 17 January 2012. At this time, she reported that she has lost confidence in her regular psychiatrist, Dr Buntinx, as he sees her condition as treatable.

She sees Dr Thienpont subsequently on 14 February 2012 when she writes that Mrs. Godelieva can be helped to die.

On 17 February 2012, Mrs. Godelieva De Troyer meets with another psychiatrist, Dr Van Daele who writes that she can still be helped, having been referred by Dr Buntinx on 23 December 2011.

On 29 February 2012, Mrs. Godelieva De Troyer makes a 'donation' to the association LEIF, which Dr Distelmans leads, in the amount of 2,500EUR (appendix 2).

On 19 April 2012, Dr Distelmans euthanizes Mrs. Godelieva De Troyer. The Applicant is informed the following day.

Dr Georges de Casteur was unable to identify who the third of the three physicians required under the law was. He also observed that the file was missing a copy of the registration document (required to be submitted under Chapter IV of the Belgian Act on Euthanasia of May 28th,2002 to the Federal Control and Evaluation Commission).

A request was made to the Federal Control and Evaluation Commission for the registration document which was denied in a letter received on 1 April 2014 (appendix 9). The co-chair of that Commission is Dr Distelmans, the physician who performed the assisted suicide and whose association benefited from the 2,500EUR 'donation.'

A complaint was also filed with the Medical Association on 16 February 2014. The association does not provide information on the progress of any complaint.

Finally, a criminal complaint was made to the prosecutor on 4 April 2014. On 5 June 2014 it was confirmed that the case had only just been allocated for investigation due to "an unfortunate administrative error" (appendix 10). See paras. 81-89 of "Violations and Arguments" document for the likely outcome of this investigation as to why it is not an effective remedy.

Statement of the facts (continued)

35.

Statement of the facts (continued)

36.

F. Statement of alleged violation(s) of the Convention and/or Protocols and relevant arguments

37. Article invoked	Explanation
See separate "Violations and Arguments" document.	See separate "Violations and Arguments" document.

G. For each complaint, please confirm that you have used the available effective remedies in the country concerned, including appeals, and also indicate the date when the final decision at domestic level was delivered and received, to show that you have complied with the six-month time-limit.

38. Complaint	Information about remedies used and the date of the final decision

39. Is or was there an appeal or remedy available to you which you have not used? ○ Yes ◉ No

40. If you answered Yes above, please state which appeal or remedy you have not used and explain why not.

H. Information concerning other international proceedings (if any)

41. Have you raised any of these complaints in another procedure of international investigation or settlement? ○ Yes ◉ No

42. If you answered Yes above, please give a concise summary of the procedure (complaints submitted, name of the international body and date and nature of any decisions given).

43. Do you (the applicant) currently have, or have you previously had, any other applications before the Court? ○ Yes ◉ No

44. If you answered Yes above, please write the relevant application number(s) in the box below.

I. List of accompanying documents

You should enclose full and legible *copies* of all documents.

No documents will be returned to you. It is thus in your interests to submit copies, not originals.

You MUST:

- **arrange the documents in order by date and by procedure;**
- **number the pages consecutively;**
- **NOT staple, bind or tape the documents.**

45. In the box below, please list the documents in chronological order with a concise description.

1. E-mail dated 31 January 2012 from Mrs. De Troyer to her children.
2. Evidence of transfer dated 29 February 2012 by Mrs. De Troyer to LEIF of €2,500.
3. Mrs. De Troyer's farewell letter.
4. Report of Dr Georges Casteur dated 3 August 2013.
5. Summary of interventions dated 6 August 2013 by health insurance.
6. Registered letter to the Federal Control and Evaluation Commission dated 23 October 2013.
7. Complaint dated 16 February 2014 to Medical Association Provincial Council of Brabant from Applicant.
8. Registered letter to the Federal Control and Evaluation Commission dated 4 March 2014.
9. Reply to registered letter from the Federal Control and Evaluation Commission dated 19 March 2014.
10. Email from prosecutor's office dated 5 June 2014
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Any other comments

Do you have any other comments about your application?

46. Comments

Declaration and signature

I hereby declare that, to the best of my knowledge and belief, the information I have given in the present application form is correct.

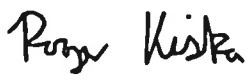
47. Date

18/8/14 e.g. 27/09/2012

D D M M Y Y Y Y

The applicant(s) or the applicant's representative(s) must sign in the box below.

48. Signature(s) ○ Applicant(s) ◉ Representative(s) - tick as appropriate



Confirmation of correspondent

If there is more than one applicant or more than one representative, please give the name and address of the one person with whom the Court will correspond.

49. Name and address of ○ Applicant ◉ Representative - tick as appropriate

Roger Kiska
Alliance Defending Freedom
Landesgerichtsstraße 18/10
1010, Wien
Austria

The completed application form should be signed and sent by post to:

The Registrar
European Court of Human Rights
Council of Europe
67075 STRASBOURG CEDEX
FRANCE

STATEMENT OF ALLEGED VIOLATIONS OF THE CONVENTION AND OF RELEVANT ARGUMENTS

Introduction

1. It is submitted that by making euthanasia available to Mrs. Godelieva De Troyer, the High Contracting Party has violated the Applicant's rights under Article 8, and his mother's rights under Article 2.

2. It is further submitted that the High Contracting Party has also violated the Applicant's rights under Article 13 given the conflict of interest created by the composition of the Federal Control and Evaluation Commission.

Article 2

Standing

1. Article 2 has been described as "the supreme right"[1] and the "fountain from which all human rights spring."[2] Where a State breaches Article 2, in contrast to a case involving other Convention rights, who remains to be able to uphold the purposes of the Convention? If only the immediate victim can ever have standing to assert such a claim, the result would be an uneasy situation whereby a State which merely *attempts* to breach Art. 2, but does not 'succeed', could be challenged; but where the state does 'succeed', no one would remain who could.

2. Indeed this much is acknowledged by this Court which, in the case of *Biç v. Turkey*[3]:

> "...individuals, who are the next-of-kin of persons who have died in circumstances giving rise to issues under Art. 2 of the Convention, may apply as applicants in their own right; this is a particular situation governed by the nature of the violation alleged and considerations of the effective implementation of one of the most fundamental provisions in the Convention system."[4]

3. It is submitted that this is a case where the Applicant has been directly affected by the impugned measure, or more specifically, the *lack* of adequate safeguards, and that as the Applicant is the immediate victim's next of kin, if there has been a violation of his mother's Art. 2 rights as argued below, then he has standing to pursue this claim.

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[1] Human Rights Committee, General Comment No. 6, HRI/GEN/1/Rev.9 (Vol I) (1982) at para 1.
[2] Report of the UN Special Rapporteur on Summary and Arbitrary Executions, E/CN.4/1983/16 (1983) at para 22.
[3] *Biç v Turkey*, (2007) 44 E.H.R.R. 38.
[4] *Ibid.* § 22.

How Article 2 has been breached

4. Article 2 provides that:

> "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."[5]

5. Although not binding on this Court, the institutions of the Council of Europe have shown consistent opposition to the legalization of assisted suicide and euthanasia. In Resolution 1859 (2012), the Parliamentary Assembly stated unequivocally that:

> "[e]uthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited."[6]

6. Not only is there an absence of any references to euthanasia in any international human rights treaty, but UN treaty monitoring bodies have questioned the practice in the small minority of countries which have legalized the practice. For example, the most recent Concluding observations of the Human Rights Committee on the Netherlands states:

> "The Committee remains concerned at the extent of euthanasia and assisted suicides in the State party ... The Committee reiterates its previous recommendations in this regard and urges that this legislation be reviewed in light of the Covenant's recognition of the right to life."[7]

7. Furthermore, the clear jurisprudence of this Court is that there is no right to euthanasia under Art. 2 of the Convention, nor does that Article impose any positive obligations on states in regard to these issues. In fact, the only positive duty on a State is the positive duty to protect life under Article 2.[8]

8. In the seminal case of *Pretty v. United Kingdom*[9], the Court was asked to consider whether the United Kingdom's refusal to grant the applicant's husband immunity from prosecution for assisting in her suicide violated Articles 2, 3 or 9 of the Convention.[10] In relation to Article 2, this Court found that there had been no violation in six short paragraphs and re-iterated that:

> "the first sentence of Art. 2 § 1 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction."[11]

9. Later in the judgment, the Court, in considering the applicant's argument that to deny a '"right to die" would place countries that have legislated to permit euthanasia in breach of the Convention, this Court indicated that each case must be decided on its merits but then continued, saying that:

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[5] Emphasis added.
[6] Parliamentary Assembly of the Council of Europe, Resolution 1859 (2012) at para 5.
[7] Human Rights Committee, Concluding Observations: Netherlands, CCPR/C/NLD/CO/4 (2009) at para 7.
[8] *Pretty v. United Kingdom*, (2002) 35 E.H.R.R. 1 § 38.
[9] *Ibid.*
[10] Claims were also brought under Article 9 and 14 though these were similarly summarily dismissed.
[11] *ibid.*

"the extent to which a State permits, or seeks to regulate, the possibility for the infliction of harm on individuals at liberty, by their own or another's hand, may raise conflicting considerations of personal freedom and the public interest that can only be resolved on examination of the concrete circumstances of the case."[12]

10. The Belgium law is an attempt to balance the intentional inflection of harm on an individual at liberty by another's hand with the conflicting public interest in preserving life and protecting the vulnerable. Where the 'harm' inflicted is the most grave possible, it follows that the public interest will be elevated and the circumstances in which this extraordinary derogation from Art. 2 will be tolerated be narrowly prescribed and clearly defined in law.

The Law in Belgium

11. The Law on Euthanasia of May 28, 2002[13] defines euthanasia as "intentionally terminating life by someone other than the person concerned, at the latter's request".[14] The physician who euthanizes a patient commits no criminal offence when he ensures that:

    a. "The patient has attained the age of majority and is legally competent and conscious at the moment of making the request."
    b. "The request is voluntary, well-considered, and repeated, and is not the result of any external pressure."
    c. "The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident."[15]

12. Before carrying out the act, the physician must also:

    a. Explain to the patient his or her medical condition and life expectancy, and discuss options other than euthanasia, such as palliative care. Both patient and doctor must conclude that no alternatives to euthanasia are available and that the patient's request is completely voluntary.
    b. Be certain of the patient's physical or mental suffering and of the durable nature of the request for euthanasia. To this end, the physician must have several conversations with the patient, spread over a reasonable period of time.
    c. Consult another doctor, not connected to the patient of the attending physician and competent to give an opinion about the disease in question, who must review the patient's record and examine the patient. This independent physician must likewise conclude that the patient's suffering, physical or mental, is constant and unbearable and cannot be alleviated.
    d. Discuss the request of the patient with any nursing team that has regular contact with the patient.
    e. Discuss the request with any relatives chosen by the patient.
    f. Be certain that the patient has had the opportunity to discuss his or her request with any person he or she chooses.

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[12] *Pretty v. United Kingdom*, *supra* note 8 § 41.
[13] Belgique, Parlement Fédéral, Loi relative à l'euthanasie F. 2002-2141 [C 2002/09590] (28 May 2002).
[14] *Ibid.*, s. 2.
[15] Unofficial translation available at: "The Belgian Act on Euthanasia of May, 28th 2002" 9:2–3 *Ethical Perspectives* 182; See also: Guenter Lewy, Assisted Death in Europe and America: Four Regimes and Their Lessons (Oxford University Press, 2010) at 74–75.

13. If the physician believes that the patient is not expected to die in the near future, they must also:

    a. Consult a second physician who is a specialist in the disorder in question. This doctor, after examining the patient, must likewise be convinced that the conditions enumerated above have been satisfied.
    b. Must allow at least one month between the patient's request and the act of euthanasia.

14. In this case, the Applicant's mother was able to dispense with the services of her treating physician of more than twenty years and visit no fewer than four new doctors over the course of a seven-month period.[16] At the end of September 2011, the request for euthanasia was considered "immature", but on 14 February 2012, a different psychiatrist concluded that she could be helped to die. Mrs. De Troyer was examined by five physicians, including four psychiatrists. Two of the four psychiatrists did not regard her as incurable and believed that she could be helped. A third psychiatrist stated that the euthanasia request was not mature.

15. Under Article 9 § 4 of the Act of 22 August 2002 concerning the rights of the patient, the applicant asked Dr. Georges Casteur to access the medical records of his mother. Dr. Georges Casteur writes in his report the following:

> "17-1-12: LT: Patient has lost confidence in her psychiatrist, Dr. Buntinx. He does not see her as incurable.
> [...]
> New psychiatrist Wim Vandaele thinks she can still be helped.
> [...]
> Report Bea Verbeeck of 18-9-11: depression with ups and downs; euthanasia request is not mature."[17]

16. The Belgian law, in the case of a non-terminal patient, requires the attending physician to consult with two specialists. Those consulted must be independent both from the patient and from the treating physician. That much is made clear by the National Council of the Medical Association in its opinion of 22 March 2003 on palliative care, euthanasia and other medical decisions concerning the end of life:

> "The lack of any relationship between the parties is the best guarantee of obtaining an independent opinion of the doctors consulted ... So it is appropriate that there were no previous contact between the patient and the doctors consulted while the absence of contractual, material and moral ties between the doctors involved is the best guarantee for the intended independence."[18]

17. The 'treating physician' Dr Wim Distelmans, newly engaged as he was, referred the applicant's mother to the psychiatrist Dr Thienpont. However, both physicians are part of the association

[16] See appendix 4 and 5.
[17] See appendix 4.
[18] Available in French online: <http://ordomedic.be/fr/avis/conseil/avis-relatif-aux-soins-palliatifs-a-l%27euthanasie-et-a-d%27autres-decisions-medicales-concernant-la-fin-de-vie>.

LEIF which is led by Dr Distelmans.[19] Furthermore, Dr Distelmans is an oncology care specialist and certainly not a specialist in mental health.

18. Further compromising any supposed 'independence' is the fact this same association received a payment of €2,500 from Mrs. De Troyer, before her death, on 29 February 2012 marked for the attention of Dr Distelmans as president of the association.[20] This discloses a blatant conflict of interest where those making the fatal decision were inappropriately involved with each other and financially with the Applicant's mother.

19. Whether or not as a result of the fact that Dr Distelmans was not a psychiatrist, insufficient care appears to have been taken by him in not considering the effects of *Paroxetine* and *Cymbalta* on the Applicant's mother. Her records show[21] that she was receiving both. Studies have linked these drugs to an increased risk of suicide[22] and yet there is nothing within the medical notes to suggest regard was had to the possibility of investigating the effect of these medicines on Mrs. De Troyer.

20. It is submitted that where a patient is able to dispense with the services of their treating physician, and thereafter visit a series of new physicians over a relatively short space of time in order to identify the required number of physicians willing to agree to euthanasia, the balance has shifted unacceptably in favour of personal autonomy at the expense of the important public interest and a State's obligation under Article 2.

21. The inadequacy of the 'protections' offered by the domestic law are further amplified by the rising number of euthanasia 'deaths' and concomitant abuse of the system. The risk has been recognized by this Court: in *Haas v. Switzerland,*[23] the Court stated that "when a country adopts a liberal approach, appropriate measure to implement such liberal legislation and measures to prevent abuse are required",[24] going on to say that "the risk of abuse inherent in a system which facilitates assisted suicide cannot be underestimated."[25]

22. Indeed, a number of studies support the premise that such unregulated euthanasia is prevalent in Belgium.[26] Against a backdrop of a year-on-year increase in the number of people being euthanized[27], a study conducted even before the recent further liberalization of euthanasia in Belgium to include minors concluded that in one region of Belgium, 66 out of 208 euthanasia 'deaths' occurred in the absence of an explicit request or consent.[28] The reasons for the lack of consent included the fact that the patient was unconscious or had dementia, because the physician felt that euthanasia was "in the patient's best interest" or because discussing it with the patient would have been harmful.[29] A separate study demonstrated the reporting rate in

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[19] See: <http://www.leif.be/nl/infoencontact/wiezijnwij.html>.
[20] See appendix 2.
[21] See appendix 5.
[22] I. Aursnes et al, "Even more suicide attempts in clinical trials with paroxetine randomised against placebo" (2006) 6:55 *BMC Psychiatry*; B. A. Salem and E. G. Karam, "Duloxetine and suicide attempts: a possible relation" (2008) 4:18 *Clinical Practice and Epidiology in Mental Health.*
[23] *Haas v. Switzerland*, (2011) 53 E.H.R.R. 33.
[24] *Ibid.* at § 57.
[25] *Ibid.* at § 58.
[26] J. Pereira, "Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls" (2011) 18:2 *Current Oncology* e38.
[27] Tinne Smets et al, "Legal Euthanasia in Belgium: Characteristics of All Reported Euthanasia Cases" (2010) 48:2 *Medical care* 187 at 1.
[28] Kenneth Chambaere et al, "Physician-Assisted Deaths under the Euthanasia Law in Belgium: A Population-Based Survey" (2010) 182:9 *CMAJ* 895 at 896.
[29] *Ibid.*

Flanders[30] to be just 52.8% with euthanasia accounting for 1.9% of all deaths in Flanders. This led the authors to conclude:

> "As such legalisation alone does not seem sufficient to reach the goal of transparency ("total" or a 100% transparency seems to be a rather utopian ideal)..."[31]

23. The manifestation of the risks identified by this Court can clearly be seen when other countries that have legalized euthanasia are analysed in more detail. The Netherlands is considered below as the Council of Europe country with the longest history, and therefore most data, in respect of euthanasia. This is followed by consideration of the law in Switzerland, which attracts 'suicide tourism'[32] from around the region and finally the US State of Oregon. Whilst not within the Council of Europe, Oregon has been promoted as a positive 'model' for well-regulated euthanasia[33] and imposes more stringent requirements, including that a patient be terminally ill, than do the four Council of Europe[34] countries that have legalized euthanasia.

The Netherlands

24. The Netherlands removed the threat of criminal prosecution in 1984 and explicitly legalized assisted suicide and euthanasia in 2002. At a first glance, one might expect the law in the Netherlands to be more robust than in Belgium supported, as it is, by two decades of preceding case law. It quickly becomes apparent, however, that such history offers no guarantees and must place Belgian, with its novel statute unsupported by case law, [35] in even greater danger.

25. The law in the Netherlands requires an explicit request from the patient with the purpose of ending "hopeless and unbearable suffering."[36] Since 2006, a year on year increase in the number of euthanasia 'deaths' has been observed, rising to 4,188 cases in 2012. Specifically, between 2006 and 2012, the number of such deaths increased by 118%[37] and euthanasia now accounts for 2.8% of all deaths in the country.[38]

26. Furthermore, even those figures do not reveal the whole picture with a study in 2005 showing that the illegal certification of assisted suicides as natural deaths is a very real problem with 19.8% of cases going unreported.[39] Reasons given in this survey of 1,933 deaths included that the physician had not "perceived their act as the ending of life" and that the physician "had

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[30] The Dutch speaking, northern part of Belgium.
[31] Tinne Smets et al, "Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross Sectional Analysis of Reported and Unreported Cases" (2010) 341 *BMJ* at 7, online <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950259/>.
[32] Alison Langley, "'Suicide Tourists' Go to the Swiss for Help in Dying", *New York Times*, New York, 4 February 2003, online <http://www.nytimes.com/2003/02/04/world/suicide-tourists-go-to-the-swiss-for-help-in-dying.html>.
[33] Nicholas D Kristof, "Choosing Death", *New York Times*, New York, 14 July 2004, online <http://www.nytimes.com/2004/07/14/opinion/choosing-death.html?action=click&module=Search&region=searchResults&mabReward=relbias%3Ar&url=http%3A%2F%2Fquery.nytimes.com%2Fsearch%2Fsitesearch%2F%23%2Fchoosing%2Bdeath%2F>.
[34] The only Council of Europe country not considered is Luxembourg where the law has only changed relatively recently (2009) and so the data available is more sparse.
[35] Maurice Adams and Herman Nys, "Comparative Reflections on the Belgian Euthanasia Act 2002" (2003) 11 *Medical Law Review* 353 at 354.
[36] *Ibid.*, at 371–372.
[37] Reporting the official statistics of 1,923 cases in 2006 compared with 4,188 cases in 2012, a percentage increase of 117.8%: Associated Press, "Euthanasia Cases in the Netherlands Rise by 13% in a Year", *The Guardian*, London, 24 September 2013, online <http://www.theguardian.com/world/2013/sep/24/euthanasia-cases-up-13-per-cent-in-netherlands>.
[38] Bregje D Onwuteaka-Philipsen et al, "Trends in End-of-Life Practices before and after the Enactment of the Euthanasia Law in the Netherlands from 1990 to 2010: A Repeated Cross-Sectional Survey" (2012) 380:9845 *The Lancet* 908 at fig 1.
[39] Agnes Van der Heide et al, "End-of-Life Practices in the Netherlands under the Euthanasia Act" (2007) 356:19 *New England Journal of Medicine* 1957.

doubts about whether the criteria for careful practice had been met (9.7%)" or that the physician "regarded the ending of life as a private agreement between physician and patient (6.6%)".[40] A more recent study in 2012 suggests that the number of cases going unreported has now risen to 23% of all euthanasia deaths.[41]

27. In addition to the increasing incidence of euthanasia and significant underreporting, there is evidence that *voluntary* euthanasia soon made way for *non-voluntary* euthanasia. In 1990, at least 1,000 patients were given lethal injections without their express consent, a figure amounting to almost 1% of all deaths caused that year in the Netherlands.[42] Despite government threats that all instances of euthanasia without the express consent of the patient would be prosecuted as murder, a remarkable 0.4% of the deaths in the Netherlands as recently as 2005 were attributed to non-voluntary euthanasia.[43] In addition, the ostensibly 'voluntary' nature of the process is completely undermined in the face of statistics from the government-commissioned 1990 study revealing that the physician had initiated the discussion in at least 21% of "euthanasia, physician-assisted suicide and the ending of life without an explicit request" deaths.[44]

28. Finally, in the face of flagrant abuse, the courts have demonstrated an increasingly liberal approach to the law.[45] The law has been interpreted by the courts to permit the giving of lethal injections to disabled babies,[46] and it is estimated that between 15 and 20 newborns are killed in this way per year.[47] In another case, a Dutch court of three judges has gone so far as to declare that a healthy 50 year-old woman's emotional distress arising out of the loss of her two children qualified her for assisted suicide and acquitted her psychiatrist.[48] More recently, in 2013, a woman who was struggling to cope, having become blind, was granted her request for euthanasia after being deemed by doctors to be suffering unbearably.[49] Thus, as has been pointed out: "Dutch doctors have gone from euthanizing the terminally ill to the chronically ill, to people with serious disabilities, to the emotionally and mentally ill."[50]

29. The fact that the protection, ostensibly offered by the law, is rendered illusory in practice by both medically and judicially liberal approaches has drawn criticism from the UN Human Rights Committee in its Concluding Observations on the Netherlands most recently in 2009[51], echoing what had been written in 2001[52], perhaps with uncanny foresight:

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[40] *Ibid.*, at 1961.
[41] Onwuteaka-Philipsen et al, "Trends in End-of-Life Practices before and after the Enactment of the Euthanasia Law in the Netherlands from 1990 to 2010", *supra* note 31 at 6.
[42] John Keown, Considering Physician-Assisted Suicide (2006) at 5–9.
[43] Van der Heide et al, "End-of-Life Practices in the Netherlands under the Euthanasia Act", supra note 32 at fig 1.
[44] The authors of the study respond to suggestions that their data reveals that physicians have initiated the conversation in 50% of cases by stating that the figure is actually 21%: Paul J. van der Maas and Gerrit van der Wal, "Euthanasia and Physician-Assisted Suicide in the Netherlands" (1997) 336:19 *New England Journal of Medicine* 1385 at 1386.
[45] See: Tinne Smets et al, "The Medical Practice of Euthanasia in Belgium and The Netherlands: Legal Notification, Control and Evaluation Procedures" (2009) 90:2–3 *Health Policy* 181 at 181–187.
[46] H Jochemsen, "Dutch Court Decisions on Nonvoluntary Euthanasia Critically Reviewed" (1998) 13:4 *Issues Law Med* 447.
[47] Eduard Verhagen and Pieter J J Sauer, "The Groningen Protocol--Euthanasia in Severely Ill Newborns" (2005) 352:10 *N. Engl. J. Med.* 959 at 960.
[48] Herbert Hendin, "Seduced by Death: Doctors, Patients, and the Dutch Cure" (1994) 10 *Issues L. & Med.* 123.
[49] Simon Caldwell, "Doctors Administered Lethal Injection to Blind Dutch Woman... after Loss of Sight Passed 'Unbearable Suffering' Test under Country's Euthanasia Laws", *The Daily Mail*, London, 7 October 2013, online <http://www.dailymail.co.uk/news/article-2448611/Blind-Dutch-woman-euthanised-loss-sight.html>.
[50] Wesley J. Smith, "Euthanasia Spreads in Europe", *National Review*, 26 October 2011, online <http://www.nationalreview.com/articles/281303/euthanasia-spreads-europe-wesley-j-smith>.
[51] Human Rights Committee, Concluding Observations: Netherlands, CCPR/C/NLD/CO/4 (2009).
[52] Human Rights Committee, Concluding Observations: Netherlands, CCPR/CO/72/NET (2001).

> "where a State party seeks to relax legal protection with respect to an act deliberately intended to put an end to human life, the Committee believes that the Covenant obliges it to apply the most rigorous scrutiny to determine whether the State party's obligations to ensure the right to life are being complied with...The Committee is concerned lest such a system may fail to detect and prevent situations where undue pressure could lead to these criteria being circumvented. The Committee is also concerned that, with the passage of time, such a practice may lead to routinization and insensitivity to the strict application of the requirements in a way not anticipated. The Committee learnt with unease that under the present legal system more than 2,000 cases of euthanasia and assisted suicide (or a combination of both) were reported to the review committee in the year 2000 and that the review committee came to a negative assessment only in three cases. The large numbers involved raise doubts whether the present system is only being used in extreme cases in which all the substantive conditions are scrupulously maintained... The Committee is gravely concerned at reports that new-born handicapped infants have had their lives ended by medical personnel."[53]

Switzerland

30. Under Art. 115 of the Penal Code of Switzerland (1942), assisted suicide is not punishable unless a selfish motive is proven. Switzerland first released assisted suicide statistics in 2009, showing a 700% increase from 43 cases in 1998 to 297 in 2009.[54] Even those numbers are subject to an important caveat; namely that they only include Swiss residents, thus excluding the estimated 550-600 people annually who travel to 'clinics' in Switzerland for this purpose from other countries. One such clinic, Dignitas, has released statistics which show that it has assisted over 1,000 suicides since 1998.[55]

Oregon

31. Oregon was the first US state to legalize physician-assisted suicide with the Oregon Death with Dignity Act which came into force in October 1997. Ten years later, it has been said that:

> "[the] reality is that the Act allows a 'terminally ill' patient who is psychiatrically disordered (though not so as to cause 'impaired judgment') to 'shop around' for any two doctors willing to certify that the Act's requirements have been met, even though neither doctor has seen the patient before or has any expertise in palliative care or psychiatry. It then allows the patient to make an oral and a written request for lethal medication...which [could, in law be] witnessed by the patient's heir and the heir's best friend, and two weeks later to obtain lethal medication which is kept and taken months afterwards when the patient is suffering physically...and mentally due to psychiatric disorder which *is* causing impaired judgment."[56]

32. Professor Alexander Capron, former Director of the Department of Ethics, Trade, Human Rights and Health Law at the World Health Organization, has observed that the safeguards in Oregon

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[53] Ibid., at para 5–6.
[54] Swiss Federal Statistics Office (FSO), Cause of Death Statistics 209: Assisted Suicide and Suicide in Switzerland (2012).
[55] Simon Rogers, "Assisted Suicide Statistics: The Numbers Dignitas Helps to Die, by Country", The Guardian, London, 25 February 2010, online <http://www.theguardian.com/news/datablog/2010/feb/25/assisted-suicide-dignitas-statistics#data>.
[56] Keown, Considering Physician-Assisted Suicide, supra note 35 at 11.

are "largely illusory".[57] Indeed, placing the facts of the instant case somewhat into context is the observation in a study of 2,649 physicians in Oregon which revealed that 35% of patients requesting a lethal prescription had already made a similar request to at least one other doctor in the past.[58]

33. In the same way as has been seen in other jurisdictions that have legalized euthanasia, a significant increase has been observed since legalization, with 16 cases of assisted suicide in 1998 increasing more than fivefold by 2012 to 85. That figure represents only those who have taken the lethal prescription provided by their doctor. In fact, official figures show that lethal drugs have been prescribed for 1,173 people since 1998.[59] Even those figures may be misleading with the passive reporting process being subject to criticism:

> "The Oregon law is significantly flawed. Oregon doctors who assist in a suicide are not required to report how they made their diagnosis or prognosis, nor required to be knowledgeable about palliative care, and not obliged to consult a physician who is and who may know how to relieve their patient's suffering."[60]

34. Furthermore, it has been observed that a number of those seeking assisted suicide change their minds after substantive palliative interventions.[61] Unfortunately, such care has not been made available to everyone with two residents without health insurance being told that the Oregon Health Plan was unable to cover their chemotherapy, but would pay for their assisted suicide,[62] leading some to argue that the 'right to die' leads to the 'duty to die'. That said, one significant difference between the law in Oregon and the law at issue in Belgium is that the former requires the patient be terminally ill, verified by two physicians, with less than six months to live which, to some extent, may explain the more limited 'expansion' seen.

The State's duty, given the risk

35. In *Mastromatteo v. Italy,*[63] the Grand Chamber was asked to consider the policy of the reintegration of prisoners in Italy after the Applicant had argued that his son's death resulted from it. The first question was whether a policy of social reintegration could of itself render a state party responsible. The Court's answer was, by implication, positive. The Grand Chamber then went on to consider whether a lack of precautions in implementing decisions on prison leave could constitute infringements of Article 2. Here, also, the answer is clearly affirmative. Indeed, the Court found that domestic authorities were required to:

> "do all that could reasonably be expected of them to avoid a real and immediate risk to life of which they had or ought to have had knowledge."[64]

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[57] A M Capron, "Legalizing Physician-Aided Death" (1996) 5:1 *Cambridge Quarterly of Healthcare Ethics* 10 at 14.
[58] Linda Ganzini et al, "Physicians' Experiences with the Oregon Death with Dignity Act" (2000) 342:8 *New England Journal of Medicine* 557 at 562.
[59] Oregon Public Health Division, Oregon's Death with Dignity Act -- 2013 at 1, online <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>.
[60] Foley Katheleen and Hendin Herbert, "Letter to the Editor" (2000) 30:1 *Hastings Center Report*, Letters 4; See generally: Keown, Considering Physician-Assisted Suicide, supra note 35 at 11–16.
[61] Ganzini et al, "Physicians' Experiences with the Oregon Death with Dignity Act", *supra* note 51 at 562.
[62] Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care", *Fox News*, 28 July 2008, online <http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care/>.
[63] *Mastromatteo v. Italy* [GC], App no 37703/97 (E.Ct.H.R., 24 October 2002).
[64] *Ibid.* § 74.

36. Ultimately, the duty of diligence was found not to have been infringed as there was nothing to suggest that the prisoner in question, once outside prison, would commit the crime, and in particular, take the life of the applicant's son. Conversely, in this case, the State, by virtue of the laws it has enacted, has placed its most vulnerable citizens at risk of express or implicit pressure to take their own lives without sufficient safeguards in place. The case of *Vo v. France*[65] confirms that this positive duty extends to the public heath sphere requiring "states to make regulations compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patient's lives."[66]

37. This consistent pattern of an increasing number of cases, a relaxation in fact, if not law, of the permissible grounds for euthanasia and an extension to include non-terminal patients is found in every country in the minority that has legalized euthanasia. In that knowledge, it is submitted that the positive obligation under Art. 2 is engaged, particularly in the case of those citizens who are most vulnerable in society including the terminally ill and those suffering from mental illness.

38. The Applicant's mother was not suffering from a terminal illness, and was euthanized for "untreatable depression" with the consent of three doctors having had no material prior involvement with her care and in the face of at least some disagreement as to the prognosis.

39. After his mother's death, the Applicant found her farewell letter which stated how much she had missed her children and grandchildren in addition to referring to the breakup with her partner. She indicated feelings of helplessness, sadness and frustration at having not built a bond with her children. In the circumstances, it is therefore understandable that the possibility of contacting her children was discussed with her a number of times. Given that the Applicant's mother refused her permission for her children to be contacted, the physicians had a duty to refuse consent for euthanasia.

40. Because the suffering of the Applicant's mother was partly caused by her loneliness and the lost contact with her children and grandchildren, it seems at least that one contact with the children is essential in order to establish that she was in a medically *hopeless* situation having constant and unbearable suffering that *could not be* healed. By her own refusal to address part of the reason for her condition, she placed herself outside of the provisions of the Belgian law which requires "constant and unbearable physical or mental suffering that cannot be alleviated."

41. Accordingly, it is submitted that a State is obliged to legislate in such a way as to afford its citizens protection from undue pressure, from making life ending decision when unfit to do so or upon the assent of physicians engaged only because of their agreement with the patient. It is respectfully submitted that the protections required by the positive obligation under Art. 2 go beyond the illusory protections offered by the Belgian law and that the State party is accordingly in breach of the Convention.

[65] *Vo v. France*, (2005) 40 E.H.R.R. 12.
[66] *Ibid.* § 89.

Article 8

Standing

42. Article 34 of the European Convention on Human Rights provides that:

> "The Court may receive applications from any person, nongovernmental organization or group of individuals claiming to be the victim of a violation by one of the High Contracting Parties of the rights set forth in the Convention or the Protocols thereto..."

43. For this right to be effective and real, in a non interim measures case, the Court must recognize the victim status under Art. 34 of a person other than the immediate victim. Understandably, this category of 'victim' has been drawn narrowly in the jurisprudence of the Court. However, in addition to the submission that the Applicant can properly bring a claim in respect of an infringement of his mother's Art. 2 rights, it is further submitted that such a violation could found a separate action in respect of the Applicant's own Art. 8 rights.

44. In *Koch v Germany*[67], the Court concluded that a husband who had been directly affected by his wife's suffering following a State's refusal to facilitate her assisted suicide had standing to bring a claim in respect of an interference with his own rights under Art. 8 of the Convention.

45. The Court referred to its previously developed criteria for allowing a relative or heir to bring an action *on behalf of* the deceased and reasoned that these would also be of "relevance" when assessing the question as to whether a relative can claim a violation of his own rights under Art. 8. The questions to be answered are:

    a. The existence of close family ties;
    b. Whether the applicant had a sufficient personal or legal interest in the outcome of the proceedings; and
    c. Whether the applicant had previously expressed an interest in the case.[68]

46. In that case, this Court also attached significance to the fact that "the instant case concerns fundamental questions evolving around a patient's wish to self-determinedly end his or her life which are of general interest transcending the person and the interest both of the applicant and of his late wife."[69]

47. Similarly, in this case, the issue before the Court is one of general interest, this Court having recognised the importance of such issues in a number of recent similar, though not identical, cases involving the end of life. Furthermore, the applicant in this case is a direct blood relative of the deceased and has been substantially emotionally affected by the State's alleged failure. Finally, it is submitted that question (c), above, has no real application in a case of this like given that the cause of action only arose upon the Applicant's mother's death as opposed to the claim in *Koch v. Germany* which subsisted for some time during the Applicant's life as a direct result of the State's violation.

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[67] *Koch v. Germany*, (2013) 56 E.H.R.R. 6.
[68] *Ibid.* at § 44.
[69] *Ibid.* at § 46.

48. The Court is therefore, respectfully, invited to conclude that the Applicant has standing to bring a claim based on his own Art. 8 rights.

How Article 8 has been breached

49. Article 8 provides that

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

50. The notion of "respect for" in Article 8 has been found to imply a duty on a State to take positive measures as early as the *Marckx v. Belgium*[70] judgment. If there has been a violation of the Applicant's mother's Art. 2 right, but the Court concludes that he lacks standing, it is respectfully submitted that such a violation could interfere with the Applicant's own rights under Art. 8.

51. Article 8 can give rise to positive obligations on the State to ensure effective respect for the rights it protects. It is clear that the concept of private life "includes a person's physical and psychological integrity."[71] It is plain to see that in the case of de-facto unregulated euthanasia that States party expose relatives of the vulnerable to injury upon their own psychological integrity.

52. Assuming such unregulated practice, according to the well established case-law of the Court, such an interference with Article 8 § 1 will not be justifiable under Article 8 § 2 unless it is: (i) "in accordance with the law", (ii) in pursuit of a legitimate aim, and (iii) "necessary in a democratic society."[72]

53. Whilst it could be argued that the legitimate aim served was honoring personal autonomy, this Court has made it clear that this is not a trump card when it comes to questions of policy. In *Laskey, Jaggard and Brown v. United Kingdom*[73] this Court found interference by a public authority in the consensual activities of a sado-masochistic group was not a violation of Art. 8, but was necessary in a democratic society for the protection of health.

54. In line with the decision above, in the case of *Pretty v. United Kingdom*[74], this Court held that States are:

> "entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals. The more serious the harm involved the more heavily will weigh in the balance considerations of

[70] *Marckx v. Belgium*, (1979-80) 2 E.H.R.R. 330.
[71] *Tomašić v. Croatia*, App no 46598/06 (15 January 2009) §§ 48-49.
[72] *Dudgeon v. United Kingdom*, (1981) 3 E.H.R.R. 40 at § 98.
[73] *Laskey, Jaggard and Brown v. United Kingdom*, (1997) 24 E.H.R.R. 39.
[74] *Pretty v. United Kingdom*, *supra* note 8.

public health and safety against the countervailing principle of personal autonomy."[75]

55. And Hence, because laws preventing, in that case, assisted suicide, are intended to safeguard life by protecting the weak and vulnerable, especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life, the Court did not consider that a blanket ban on assisted suicide was disproportionate to the aim of safeguarding life. For the same reasons, it is submitted that if a State has decriminalised euthanasia to such an extent that it permits 'euthanasia on-demand', then this will breach Art. 8 in respect of affected family members. Any median position must be carefully evaluated on the facts of each particular case. Furthermore when evaluating the law and practice of a State, in that case, the Court held that a standard of "strict scrutiny" has been applied when exceptions have been involved to this fundamental right.[76]

56. The case of *Pretty v. United Kingdom* was proceeded by *Haas v. Switzerland*[77] in which the Court noted that the notion of a "private life" within the meaning of Article 8 § 1 is a "broad concept which cannot be defined exhaustively."[78] The Court went further than it had in *Pretty v. United Kingdom* to consider that:

> "the right of an individual to decide how and when to end his life, *provided that said individual is in a position to make up his own mind* in that respect and to take appropriate action, is one aspect of the right to respect for private life."[79]

57. Therefore, where a State permits someone to end their life, without the appropriate guarantees that a person is "in a position to make up his own mind", in violation of it's positive obligations under Art 2, it is submitted that this could violate the Art. 8 rights of an immediate family member.

58. In *Haas v. Switzerland*, it was not for this Court to overrule the restrictions put in place by national authorities,[80] given the abuses inherence in such systems and taking into account the margin of appreciation. Indeed, this Court considered that the restriction placed on the Applicant's Art. 8 rights was prescribed by law and pursued a legitimate aim, namely "to protect people from taking hasty decision and to prevent abuse, in particular, to prevent a patient incapable of making up his own mind from obtaining a fatal dose of sodium pentobarbital".[81] Conversely, it must be that, when a system is revealed that allows such extreme abuse as in the High Contracting Party, in the face of its positive duty towards the Applicant's mother under Art. 2, and the Applicant himself under Art. 8, a violation be found.

59. Whilst the Chamber Judgment in *Gross v. Switzerland*[82] has now been referred to the Grand Chamber which is yet to issue its decision, it provides at least an example of a Chamber

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[75] *Ibid.*, at 74.
[76] *Pretty v. United Kingdom*, *supra* note 8 § 37.
[77] *Haas v. Switzerland*, *supra* note 16.
[78] *Ibid.* at § 50.
[79] *Ibid.* at § 51. Emphasis added.
[80] With even the outright ban in place in the UK, considered in *Pretty v. United Kingdom*, even falling within the range of reasonable restrictions.
[81] *Haas v. Switzerland*, supra note 16 at § 56.
[82] *Gross v. Switzerland*, (2014) 58 E.H.R.R. 7.

carrying out an examination of a State's laws in this regard, ultimately concluding that the law produced an uncertain result[83] and violated the Applicant's Art. 8 rights.

Article 13

60. The Federal Control and Evaluation Commission was created by the Belgian Act on Euthanasia of 28 May 2002[84] to provide oversight and ensure compliance with the legislation. Under the act, any physician "who has performed euthanasia is required to fill in a registration form...and to deliver this document to the Commission within four working days."[85]

61. The form has two parts. The first part contains the full name and details of the physicians involved as well as the patient. This part is sealed before it is delivered to the commission. The second part contains the patient's sex, date and place of birth as well as the "nature of the serious and incurable condition...", "the nature of the constant and unbearable suffering", "the reasons why this suffering could not be alleviated", "the capacity of the physician(s) consulted" and "the recommendations and the information from these consultation" amongst other things.

62. The Commission is composed of sixteen members, eight of whom are doctors of medicine, of which at least four must be professors at a university in Belgium. Four must be professors of law or practising lawyers in Belgium and four are drawn from groups that work with terminally ill patients. The Commission is chaired by a Dutch-speaking and a French speaking member, elected by the commission members of the respective linguistic group.

63. The Commission is empowered to establish "its own internal regulations" though the general procedures are established by the act: the commission studies only the second part of the submitted registration form and must "[determine] whether the euthanasia was performed in accordance with the conditions..."[86] In the case of "doubt", a majority can vote to revoke anonymity and discover the identity of the patient and physician. In the absence of such a vote, the commission would be unaware of the identity of either.

64. The commission must then "hand down a verdict within two months" and if, with a two-thirds majority, the commissions considers that the conditions have *not* been complied with then it is obliged to turn "the case over to the public prosecutor..."

65. The only provision of the legislation dealing with potential conflicts of interest does not require a conflicted member to identify or excuse themselves stating merely:

> "If, after anonymity has been revoked, facts or circumstances come to light which would compromise the independence or impartiality of one of the commission members, this member will have an opportunity to explain or to be challenged during the discussion of this matter in the commission."[87]

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[83] *Ibid.* § 66.
[84] *Supra*, note 13, s. 6.
[85] *Supra*, note 13, s. 5.
[86] *Supra*, note 13, s. 8.
[87] *Ibid.*

66. Dr Wim Distelmans, the physician who euthanized the Applicant's mother, has been co-chair of the commission since its creation. Under his leadership, the commission has reviewed more than 8,000 cases and not one has been referred to prosecutors.[88]

67. Dr Wim Distelmans is a leading campaigner for euthanasia in Belgium and has been variously described in the media as "a long-time crusader for euthanasia"[89] and as "having gained notoriety after [being] shown on TV ending the life of...a transsexual who asked to die after doctors botched his sex change therapy."[90]

68. It is submitted that it is completely improper for the same man who carried out a euthanasia to chair the board that is established to investigate its compliance with the law. The conflict is compounded in this case as a request was made on 23 October 2013 by registered mail to the committee for a copy of the completed registration form.[91] The committee did not respond to this letter.

69. A further request was made, setting out in detail the reasons for the request, on 4 March 2014 by registered mail.[92] A response was received on 1 April 2014 which refused to disclose the form.[93]

70. The co-chairman of the committee which ruled the euthanasia lawful, initially failed to engage with the Applicant's lawyer and ultimately refused to provide access to relevant documentation is the doctor who carried out the act in question and whose organization was the beneficiary of the €2,500 payment from the Applicant's mother.

71. Article 13 of the Convention requires that, in the context of alleged violations of Article 2, a

> "thorough and effective investigation capable of leading to the identification and punishment of those responsible, including effective access for the complainant to the investigation procedure."[94]

72. To be effective, the investigation must be independent of those involved in the events, both in terms of hierarchy and institution as well as independent in practical terms.[95] Furthermore, the victim should be able to participate effectively in the investigation.[96]

73. Convention case law recognises that the effectiveness of the investigation is crucial for the possibility of other domestic remedies:

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[88] G. Hamilton, "'Suicide with the approval of society': Belgian activist warns of slippery slope as euthanasia becomes 'normal'", *National Post*, 24 November 2013, online <http://news.nationalpost.com/2013/11/24/suicide-with-the-approval-of-society-belgian-activist-warns-of-slippery-slope-as-euthanasia-becomes-normal/>.
[89] G. Hamilton, "Death by doctor: Controversial physician has made his name delivering euthanasia when no one else will", *National Post*, 22 November 2013, online <http://news.nationalpost.com/2013/11/22/death-by-doctor-controversial-physician-has-made-his-name-delivering-euthanasia-when-no-one-else-will/>.
[90] J. Petre, "Outrage as 'Dr Death' offers euthanasia tours of 'inspiring' Auschwitz: Claims the visit will 'clarify confusion' about dying", *The Daily Mail*, 12 July 2014, online <http://www.dailymail.co.uk/news/article-2690157/Outrage-Dr-Death-offers-euthanasia-tours-inspiring-Auschwitz-Claims-visit-clarify-confusion-dying.html>.
[91] *See* appendix 6.
[92] *See* appendix 8.
[93] *See* appendix 9.
[94] *Z and Others v. United Kingdom*, (2001), App. No. 29392/95 § 109.
[95] *Anca Mocanu and Others v. Romania*, (2012), App. Nos. 10865/09, 45886/07 and 32431/08 § 221.
[96] *El-Masri v. "the former Yugoslav Republic of Macedonia"*, (2012), App. No. 39630/09 § 185.

> "As regards the possibility of a civil action for damages...it is undisputed that such action was theoretically possible....However...the State's obligations under Article 2 of the Convention will be satisfied if the remedies provided by law actually work in practice...It follows that the effectiveness of the investigation...was decisive as to whether such an action is likely to succeed. However, the Court has found that the ...investigations in this case where incomplete and inadequate...Under these conditions, a civil action was doomed..."[97]

74. The facts of this case, as set out above, and the requirements for an investigation in accordance with this Court's case law are at diametric opposites. In those circumstances, it is submitted that the Applicant's rights under Article 13 have been violated. The Court is additionally invited to take this breach into account when considering the effectiveness of domestic remedies in light of the difficulties the Applicant has encountered in gaining sight of the crucial document in this case, even after instructing a lawyer.

Limitation

75. The second part of Article 35(1) of the ECHR states that: "The Court may only deal with the matter ... within a period of six months from the date on which the final decision was taken."

76. The starting point of the six month period where there are no domestic remedies or domestic remedies turn out to be ineffective should be calculated with some flexibility. The Court has considered the six-month period to run from the date the act complained of, or on the date on which the applicant was directly affected by or became aware of such an act where no remedy is available.[98]

77. The Court has held that the rules of admissibility should be applied with:

> "some degree of flexibility and without excessive formalism...Account also has to be taken of their object and purpose and of those of the Convention in general, which, insofar as it constitutes a treaty for the collective enforcement of human rights and fundamental freedoms, must be interpreted and applied so as to make its safeguards practical and effective."[99]

78. In particular, the six month limit has been held to be inapplicable in cases where there is a continuing state of affairs, such as Convention-infringing legislation which continuously affects the exercise of a guaranteed right or freedom. Such was the case in *Dudgeon v. United Kingdom.*[100]

79. It is submitted that this is just such a case where legislation which on its face, or alternatively, in its application infringes the Convention, is continuing in force and continues to result in similar cases. In January 2014, a formal complaint was filed against Dr Wim Distelman's by the daughter of a patient whose depressed mother died by euthanasia without first receiving

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[97] *Eugenia Lazar v. Romania*, (2010), App. No. 32146/05, §§ 90-91 (author's own translation).
[98] *Varnava v. Turkey*, (2010) 50 E.H.R.R. 21 § 109-113.
[99] *Sanles Sanles v. Spain*, App no 48335/99 (26 October 2000).
[100] *Dudgeon v. United Kingdom*, (1981) 3 E.H.R.R. 40.

treatment for depression.[101] Both that case and the present case have resulted in a permanent and ongoing situation whereby a child is deprived of family life and one of their parents. Furthermore, the ineffectiveness of pursuing a complaint with the federal commission (who will not disclose the document which is central to this case), the Medical Board[102] (who will not disclose the status of any complaints) or with the prosecutor (who has opened a file only after an "unfortunate administrative error") has only become apparent as at 1 April 2014[103], when a letter refusing disclosure of the euthanasia registration was received.

Exhaustion of domestic remedies

80. Article 35 § 1 of the ECHR provides that:

> "The Court may only deal with the matter after all domestic remedies have been exhausted, according to the generally recognized rules of international law..."

81. Only 'available' and 'effective' remedies need be exhausted. Extraordinary remedies do not need to be exhausted. The purpose of Art. 35 is to afford contracting states the opportunity of putting right violations alleged against them before allegations are submitted to the Convention institutions. It is incumbent on a state claiming non-exhaustion to satisfy the court that the remedy identified is an effective one, available in theory and in practice, capable of providing redress and offering reasonable prospects of success.[104]

82. The Court has held that in order for a remedy to be considered available, it must be sufficiently certain, not just in theory but in practice as well.[105] The failure of having a certain remedy also will mean that there is a lack of requisite effectiveness. In the instant matter, several factors exist which show that remedies lack both certainty and effectiveness. First, even despite open and notorious breaches of the law, particularly under the reporting criteria[106], no case has ever been successfully brought by Belgian prosecutors before a Belgian Court. Physicians who perform unregulated assisted suicide and euthanasia do so with impunity. As widely publicized by Belgian media, doctors acting as experts before the Belgian Senate hearings on expanding assisted suicide to include children were shockingly candid about ignoring the procedures and safeguards when ending the lives of their patients. Despite testifying publically and on the record, no criminal case was brought against the doctors who literally confessed to their own guilt under the Belgian Act on Euthanasia.

83. Furthermore, those physicians who do complete the procedural requirements of the law under Chapter V by submitting the required form to the Federal Control and Evaluation Commission

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[101] A. Schadenberg, "Doctor Kills Depressed Woman in Euthanasia Without Any Mental Health Treatment", *Life Site News*, 5 January 2014, online <http://www.lifenews.com/2014/05/01/doctor-kills-depressed-woman-in-euthanasia-without-any-mental-health-treatment/>.

[102] *See* Appendix 7.

[103] *See* Appendix 9 (letter dated 19 March 2014) and Appendix 10.

[104] *Tomašić v. Croatia*, *supra* note 64 §§ 35-36.

[105] *Van Droogenbroeck Case*, Judgment of 24 June 1982, Publ. E.C.H.R., Series A, Vol. 50, p. 30; Case of De Jong, Baljet and van der Brink, Judgment of 22 May 1984, Publ. E.C.H.R. Series A, vol. 77, p. 19; Cullia Case, Judgment of 22 February 1989, Publ. E.C.H.R. Series A, vol. 167, p. 16; Case of *Vernillo v. France*, Judgment of 20 February 1991, Publ. E.C.H.R., Series A, vol. 198, p. 12.

[106] "So what happened after the publication of the article? A leading public figure confessed to a crime – possibly many crimes – before witnesses who included the 'judge' in charge of administering the law for this particular crime. Surely there must have been outrage at the arrogance of a doctor who regards himself as above the law. Surely the head of the commission must have initiated an investigation. But nothing happened. Nothing at all" – *See,* M. Cook, "Belgium and the majesty of the law", *Mercatornet*, 5 January 2014, online <http://www.mercatornet.com/careful/view/13344>.

have unfettered discretion in shaping the facts, diagnosis and outcome of how the assisted suicide was undertaken including fabricating the entire form by falsifying facts. This leaves vulnerable patients with treatable depression like Mrs. De Troyer at the mercy of overzealous physicians. Stories like that of Mrs. De Troyer are becoming commonplace in Belgium precisely because physicians have no fear of non-existent prosecution under the law.

84. According to well tried principles of ECHR case-law with respect to the exhaustion of local remedies and the requirement that they be effective; remedies which in the circumstances of the case appear to be ineffective need not be exhausted.[107] It has also been deemed by the European Human Rights Commission that the local remedies rule does not require resort to appeals that have no objective prospect of success[108]; and furthermore it has been held that a remedy which has no prospect of success does not constitute an effective remedy.[109] As has been evidenced since the 2002 Act on Euthanasia has been enacted, remedies have neither been available or effective.

Availability

85. A remedy is considered available if it has a certain degree of immediacy[110] and certainty; the availability of an application to a constitutional court, for example, may not be sufficiently certain if that court has a discretion to refuse such application.[111]

86. In *Tomašić v. Croatia*, the Court stated that:

> "in reviewing whether the rule has been observed, it is essential to have regard to the particular circumstances of the individual case. This means, amongst other things, that the Court must take realistic account not only of the existence of formal remedies in the legal system of the Contracting Party concerned but also of the general legal and political context in which they operate as well as the personal circumstances of the applicants."

87. As policing of the Act requires action by the prosecutor to bring a criminal complaint before a competent court, those family members directly affected by the loss of a loved one through unregulated assisted suicide as in the instant matter, cannot themselves bring a criminal action no matter how egregious the victimization involved is. And despite widespread media reporting of instances of abuse and physicians openly testifying of their own guilt under the provisions of the Act, a single prosecution has yet to take place in Belgium. Furthermore, the urgency of this matter requires action by the Court as years continue to elapse without proper policing of the Act and the number of victims who would not have otherwise wilfully submitted to being euthanized had procedures been duly followed continues to grow exponentially.

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[107] See e.g. Application No. 299/57, Yearbook 2, pp. 192-193 (inter-State); Application No. 434/58, Yearbook 2, p. 374; Application No. 788/60, Yearbook 4, p. 168 (inter-State; Application No. 712/60, Yearbook 4, p. 400; Application No. 5006/71, Collection 39, p. 93.

[108] See: e.g.: Communications Nos. 210/1986 and 225/1987, HRC1989 report, p. 228; Communication No. 220/1987, HRC 1990 Report, Vol. II, p. 122; Communication No. 222/1987, HRC 1990 Report, Vol. II, p. 130; Communication No. 306/1988, HRC 1990 Report, Vol. II, p. 182; Communication No. 356/1989, HRC 1993 Report, Vol. II, p. 87.

[109] See e.g.: Application No. 12097/86, D.R. 53, pp. 216-217; Application No. 12810/87, D.R. 59, p. 177; Application No. 14507/89, D.R. 65, p. 300; Application No. 13134/87, D.R. 67, p. 224; Application No. 16130/90, 12 H.R.L.J. (1991), p. 402; Communication No. 220/1987, H.R.C. 1990 Report, Vol. II, p. 122; Communication No. 222/1987, H.R.C. 1990 Report, Vol. II, p. 130; Communication No. 306/1988, H.R.C. 1990 Report, Vol. II, p. 182.

[110] *Ciulla v. Italy*, (1991) 13 E.H.R.R. 346 § 30-32.

[111] *Horvat v. Croatia*, App no 51585/99 (E.Ct.H.R., 26 July 2001) § 41-45.

Effectiveness

88. An Applicant is dispensed from the obligation to exhaust domestic remedies which offer no real prospect of success. In the case of *Costello-Roberts v. United Kingdom*[112], the Commission upheld the Applicant's submission that there would have been no point pursuing a private criminal prosecution or civil proceedings as they held no prospect of success at that time. As more than 30 percent of Belgian cases of assisted suicide are without express consent[113] and with cases like those arising in the instant application becoming commonplace[114], family members only have recourse to filing a complaint with the public prosecutor. A two-step filter then exists whereby the Prosecutor has unfettered discretion whether to bring the case before a court and then in turn the court also has a discretion whether to accept the case or not. To date, despite the overwhelming evidence of abuse of the Act and a disregard for procedural safeguards which amounts to gross negligence, not a single instance of successful prosecution under the Belgian criminal system has occurred. It is clear that no effectiveness exists in either protecting potential victims and their family members from abuse of the law or punishing doctors who break the law by performing unlawful assisted suicides.

[112] *Costello-Roberts v United Kingdom*, (1995) 19 E.H.R.R. 112 § 58-59.
[113] *Supra* fn. 27.
[114] See for *e.g.*: http://archives.lesoir.be/-ma-mere-ne-repondait-pas-aux-criteres-pour-etre-euthan_t-20110115-01783D.html; http://www.bbc.com/news/magazine-25651758.

ATTACHMENTS

1: E-mail dated 31 January 2012 from Mrs. De Troyer to her children.
2: Evidence of transfer dated 29 February 2012 by Mrs. De Troyer to LEIF of €2,500.
3: Mrs. De Troyer's farewell letter.
4: Report of Dr Georges Casteur dated 3 August 2013.
5: Summary of interventions dated 6 August 2013 by health insurance.
6: Registered letter to the Federal Control and Evaluation Commission dated 23 October 2013.
7: Complaint dated 16 February 2014 to Medical Association Provincial Council of Brabant from Dr Tom Mortier.
8: Registered letter to the Federal Control and Evaluation Commission dated 4 March 2014.
9: Reply to registered letter from the Federal Control and Evaluation Commission dated 19 March 2014.
10: Email from prosecutor's office dated 5 June 2014.