Neutral Citation Number: [2009] IEHC 236

**THE HIGH COURT**

**2009 112 SS**

**IN THE MATTER OF AN APPLICATION FOR AN INQUIRY PURSUANT TO ARTICLE 40.4.2 OF THE CONSTITUTION OF IRELAND AND IN THE MATTER OF THE MENTAL HEALTH ACT, 2001**

**BETWEEN:**

**M.MC N**

**APPLICANT**

**AND**

**THE HEALTH SERVICE EXECUTIVE**

**RESPONDENT**

**THE HIGH COURT**

**Record Number: 2009 No.113 SS**

**IN THE MATTER OF AN APPLICATION FOR AN INQUIRY PURSUANT TO ARTICLE 40.4.2 OF THE CONSTITUTION OF IRELAND AND IN THE MATTER OF THE MENTAL HEALTH ACT, 2001**

**BETWEEN:**

**L.C.**

**APPLICANT**

**AND**

**THE HEALTH SERVICE EXECUTIVE**

**RESPONDENT**

**Judgment of Mr Justice Michael Peart delivered on the 15th day of May 2009:**

Each of the above applicants was as of the date of hearing before me in an acute psychiatric unit at the Western Regional Hospital, Dooradoyle, Limerick. Each was originally detained as an involuntary patient on foot of an Admission Order since it was considered by a consultant psychiatrist there that each was suffering from a mental disorder within the meaning of section 3 of the Mental Health Act, 2001 ("the Act"), namely severe dementia.

Subsequently, and prior to any review of that detention by a Mental Health Tribunal, each Admission Order was revoked, thereby bringing that involuntary detention to an end. This was on the basis that each was no longer suffering from a mental disorder as so defined. Thereafter, however, each applicant has remained in the said unit as voluntary patient.

The issue which arises in respect of each applicant results from the undisputed fact that neither applicant has the mental capacity to make a full and informed decision to remain in the unit on a voluntary basis. Essentially it is the consultant psychiatrist who has categorised each now as a voluntary patient when completing the Revocation Orders, there being no other basis for their remaining in the hospital once neither is considered to be suffering from a mental disorder as defined by s. 3 of the Act, and the orders are revoked.

The fact is that each applicant remains in the same locked unit and in the same conditions as they were when being detained on foot of the Admission Order. It is submitted on their behalf that they are in de facto detention even though the Admission Orders have been revoked, and yet they have ceased to enjoy the panoply of rights and safeguards which the Act provides for patients being detained involuntarily. That de facto detention is submitted to be not in accordance with law.

It is clear that the relevant medical personnel consider each applicant to be a voluntary patient, now that the Admission Orders have been revoked, there being no other basis under the Act on which the applicants can remain at the hospital. However, neither is free to leave the hospital unless they do so in the company of a family member. The hospital personnel consider however that they are free to go and are not being involuntarily detained. But there is evidence to the effect that if either applicant was to attempt to leave the hospital unaccompanied, the provisions of s. 23 of the Act would be invoked, which provides that where a person, who is in the hospital as a voluntary patient, indicates at any time that he or she wishes to leave, then, if, inter alios, a consultant psychiatrist is of the opinion that the person is suffering from a mental disorder, he/she may detain the person for a period not exceeding 24 hours.

It is submitted on behalf of the applicants that in the prevailing circumstances the de facto detention of each applicant is unlawful and that the Court should order that each be released.

**Background facts – M.McM:**
Ms. Etain Boyce, solicitor was appointed by the Mental Health Commission to represents the interests of this applicant after she had been involuntarily admitted to the respondent hospital on the 18th December 2008 at 12.45pm. A date for a

review of that detention by a Mental Health Tribunal was fixed for the 6th January 2009. That Admission Order had been made following a recommendation for voluntary admission signed by the applicant's General Practitioner on the 18th December 2008 at 9.55am. His opinion at that time was that the applicant was suffering from "advanced dementia".

The Admission Order signed at 12.45pm stated the consultant psychiatrist's opinion as follows:

> *"Has a diagnosis of dementia for several years. Over past weeks has become dangerously physically aggressive especially to husband with whom she lives".*

That opinion had been formed having examined the applicant at 2pm on the 17th December 2008, which pre-dated the application by the applicant's husband for a recommendation which had not been completed until 9.45am on the 18th December 2008, and Ms. Boyce had intended bringing this matter to the attention of the Tribunal at the review hearing, since s. 10 of the Act requires that the examination take place within 24 hours after the receipt of that application. Section 10 of the Act provides that such examination "shall be carried out within 24 hours of the receipt of the application". I do not have to decide whether in fact that means that the examination must take place within 24 hours following that receipt or within the previous 24 hours. Even if the provision is to be construed as meaning the former, that failure to comply with the provision in s. 10 is in any event a matter which the Tribunal would have had power to consider overlooking on the review in accordance with the provisions of s. 18 (1) (a) (ii) of the Act if it was satisfied that the failure did not affect the substance of the order and did not cause an injustice. However I express no view on the matter.

However on the 6th January 2009, but before the review hearing, Ms. Boyce received a letter from the Mental Health Commission stating that the involuntary admission and treatment of the applicant had ended and that the arrangements for the review hearing had *"for the time-being been discontinued".* The Revocation Order was signed by the responsible consultant psychiatrist at 3.30pm on the 5th January 2009, and it appears therefrom that at 3pm on that date the responsible consultant psychiatrist had become of the view, from his examination at that time, that the applicant *"is no longer suffering from a mental disorder as defined by the Mental Health Act, 2001"*. Being of that opinion the responsible consultant psychiatrist must choose which of three boxes to tick thereafter. He could choose to state either that the patient was being discharged pursuant to s. 28 of the Act, or that the patient *"has chosen to remain in the approved centre on a voluntary basis"* and *"is entitled to have his or her detention reviewed by a tribunal in accordance with s. 18 of the Act…."*. The responsible consultant psychiatrist chose to tick the box only indicating that the applicant *"[had] chosen to remain in the approved centre on a voluntary basis".*

The letter from the Mental Health Commission which Ms. Boyce had received went on to state in fact that the applicant was entitled to have her detention reviewed by a Tribunal if she so indicates by notice in writing. A letter in similar terms was sent to the applicant at her home address.

Following her appointment as legal representative, Ms. Boyce had met the applicant on the 5th January 2009 and had formed the opinion that the applicant lacked capacity to give her instructions for the purpose of the Tribunal hearing. She met the applicant again on the 8th January 2009 in order to ascertain if the applicant wished to have a review of her detention under s. 28 of the Act as set out in the said letters. At that time the applicant was accompanied at all times by a nurse, and Ms. Boyce was unable to get an answer to any of the basis questions she put to the applicant such as how she was and whether she knew that she was in hospital. She goes on to state that she asked the applicant if her husband had visited her to which she shook her head, and Ms. Boyce states that in fact she (Ms. Boyce) had seen her husband on the Unit that morning when he had come to see her. When Ms. Boyce attempted to explain to the applicant that her status at the hospital had changed *"the applicant simply looked perplexed at her nurse".* She states that it was clear to her that the applicant did not know who Ms. Boyce was or what her purpose there was and that she did not understand anything which she told her about her change of status. She became of the view that the applicant did not have the capacity to understand what was being said to her and that she was unable to give instructions or make decisions of her own free will and understand the consequences of those decisions, and was unable to get any instructions within the 14 day period from the 5th January 2009 as referred to in s. 28 (5) (b) of the Act.

Ms. Boyce goes on to state that while it appears on the face of the records that the applicant has been released from involuntary detention and is free to leave at any time, the applicant in substance continues to be detained and that the provisions of s. 28 of the Act (power to revoke admission order) and that the applicant lacks the capacity to make a full and informed decision to remain in the care of the respondent on a voluntary basis. It is submitted that in these circumstances the applicant is unlawfully detained on the following bases as stated in her grounding affidavit:

> *"1. The applicant, incapable of exercising her right to remain voluntarily, is being de facto detained, and yet enjoys none of the rights and safeguards afforded to patients detained under the statutory scheme set out in the Mental Health Act, 2001.*
>
> *2. The applicant has been unable due to her continued dementia, to give instructions … to exercise her entitlement to a Tribunal hearing.*
>
> *3. In any event, any Tribunal hearing would be limited to the applicant's detention from 18th December 2008 to 5th January 2009 and not into her current status remaining as a voluntary patient on an apparent basis.*
>
> *4. There is no scope within the statutory scheme for an independent review of the applicant's apparent re-grading to that of a voluntary patient.*
>
> *5. There are no procedural safeguards within the statutory scheme for the applicant, a compliant incapacitated individual suffering from dementia, whose Admission Order has been apparently revoked and in particular no review mechanism".*

Dr Reynolds, Consultant Psychiatrist who signed the Admission Order on the 18th December 2008 and the Revocation Order on the 5th January 2009 has sworn two replying affidavits in respect of this applicant. He states that he examined the applicant at 12 noon on the 18th December 2008 and was of the opinion at that time that the applicant was suffering

from a mental disorder for the purposes of s. 3 of the Act as *"she had a severe dementia and presented as being extremely agitated and aggressive"*. He formed the opinion that she should be admitted to involuntary care in circumstances where she had become dangerously physically aggressive especially to her husband with whom she was living at that time.

Dr Reynolds went to state that the applicant had a diagnosis of dementia established in 2003, and that there had been a major deterioration in her mental state and cognitive function in the six weeks prior to her admission to hospital. He states that this had necessitated an admission to a nursing home for a two week period from the end of November 2008 to the 11th December 2008, but that for financial reasons the family had taken her home again. He describes incidents of violence and threats to drown herself after her return home, following which she was seen by her General Practitioner who had found no medical reason for her presentation. He states that his opinion was that her judgment was so impaired at this time that a failure to admit her to an approved centre would have been likely to result in a serious deterioration in her condition, and, in addition, that she was a danger to herself and to others and that it was in her best interests to be detained on an involuntary basis.

Dr Reynolds then describes how he complied with the requirements of the Act, and that she was admitted to Unit 5B at the hospital and was treated by himself and his colleague, Dr Meaney. He states that upon this admission her medication was altered as described, and that this had the effect of stabilising the applicant's condition and her mood, and that the provision of 'one to one' nursing care further assisted her. She responded well to her medication and became more settled by the end of December 2008, and it appears that in the beginning of January 2009 her psychiatric conditions had settled and Dr Reynolds considered at that time that she no longer met the criteria of 'mental disorder' for the purposes of s. 3 of the Act, even though she remained "psychiatrically symptomatic" attributable to delirium but her condition was not so severe as to warrant the protection of the Act.

In these circumstances he decided to revoke the involuntary detention on the 5th January 2009 as described earlier, and he states that in advance of completing the revocation order (Form 14) as required by s. 28 of the Act he expressed his concern to a social worker colleague in the Health Service Executive about there being only two options provided for in the form (i.e. discharging the patient or indicating that the patient "has chosen to remain in the approved centre on a voluntary basis"). This concern arise because Dr Reynolds considered that the applicant was not in a position to give her consent to remaining on a voluntary basis, but that one or other of the boxes had to be ticked. He accepts that the applicant is *non compos mentis* and that she continues to require both medical and psychiatric treatment, but that she does not require to be detained involuntarily, and that it is in her best interests to remain a patient in Unit 5B aforesaid. He goes on to say, however, that the applicant is free to leave the hospital with her family at any time and that there is no restriction whatever on the right of her family to visit her. He confirms that the applicant remains in excellent care at the hospital, remains in a state of delirium and exhibits difficulties swallowing, and is being managed with every regard for her best interests.

Dr Reynolds concludes his first affidavit by stating that as the Act currently stands there is no provision for the applicant be involuntarily detained in circumstances where he is of the opinion that the severity of her symptoms with which she presented in December 2008 have changed and reduced to a level which can be managed on the ward without depriving her of her liberty. Both he and Dr Meaney are of the view that she is not a person with mental disorder for the purpose of s. 3 of the Act, and that he and his colleagues have no option but to regard her as a voluntary patient even though she remains psychiatrically symptomatic. He states also that the applicant's family are unaware that the present application was being made but that he understands *"that it is open to the applicant's family to make an application for her to be considered a Ward of Court thereby providing them with the requisite locus standi to apply for the applicant to be detained on an involuntary basis".*

Dr Meaney has sworn a short affidavit in which he confirms that he is in agreement with what Dr Reynolds has stated in his first affidavit.

In his second affidavit Dr Reynolds describes Unit B at the hospital and the care regime in place for the applicant. He states that it is an acute psychiatric ward and is a secure unit, the entrance doors into and out of the unit being secured by an electric buzzer system which is operated from reception. He states that all public access is through these doors, and that visitors to the unit use an intercom system to communicate with reception in order to gain entry to the ward. He states also that there is no restriction whatever on any member of the applicant's family or friends from visiting her while she is there. He states also that there are no dedicated security personnel for Unit 5B but that if security personnel are required the staff can contact such personnel for assistance.

In relation to the care plan in place for the applicant, Dr Reynolds states that she has suffered a number of medical problems as an in-patient and has needed treatment for a urinary tract infection which was resistant to treatment and caused delirium. She has other difficulties also as described by him and she requires ongoing treatment. She has been restless and has also difficulty sleeping. There is some concern that colonic cancer may have returned and a CT scan was being organised in that regard at the time he swore this affidavit. He states that while they are availing of the support of medical teams in her treatment she is best managed on the psychiatric ward where her nurses know her and she is able to walk around the ward in an unrestricted fashion. He concludes by stating that in view of her care plan, the applicant will be discharged from "voluntary care" when her medical problems have been addressed and she is not distressed and an appropriate placement has been identified and is available. It is envisaged that at such a stage the applicant will be placed in long stay care by her next of kin.

**Background facts – L.C :**
In respect of this applicant also, Ms. Boyce, solicitor, has sworn a grounding affidavit. She was appointed as this applicant's legal representative on the 4th December 2008, following the latter's admission on the 1st December 2008 to the same Unit 5B at the respondent hospital, and for the purpose of a review hearing before a mental Health Tribunal. This applicant was admitted as an involuntary patient under an Admission Order signed on the 2nd December 2008 following a recommendation signed by his General Practitioner. At that time, Dr Meaney, Consultant Psychiatrist, was of the opinion that the applicant was suffering from a mental disorder, namely severe dementia, for the purpose of s. 3 of the Act, having examined this applicant at 12 noon on the 2nd December 2008. An independent consultant psychiatrist later examined the applicant on the 4th December 2008 and was of the view that he presented with advanced dementia and other associated features as described in his report, and that because of the severity of his condition his judgment was so impaired that failure to admit him to an approved centre would be likely to lead to a serious deterioration in his condition or would prevent the administration of appropriate treatment that could be given only by such admission.

Paragraph 14 of that report expresses the opinion that due to a significant degree of cognitive impairment the applicant does not have the capacity to live independently, has no insight and cannot communicate in a meaningful way, and further that he dies not have the ability to retain the treatment information and *"hence he cannot give valid informed consent".*

Ms. Boyce goes on to state that she met with the applicant on the 10th December 2008 prior to the hearing of his review by a Tribunal scheduled for the 19th December 2008, and that she formed the view that the applicant did not have the mental capacity to give her any instructions for the purpose of the Tribunal hearing. The Tribunal affirmed the Admission Order. A Renewal Order was subsequently made on the 19th December 2008 in which Dr Meaney stated that she was of the opinion that the applicant was on that date suffering from severe dementia. The period of detention was for a period of three months ending on the 21st March 2009.

However, on the 6th January 2009 Ms. Boyce received a letter from the Mental Health Commission stating that the involuntary admission and treatment of the applicant had ended, and that he was entitled under s. 28 of the Act to have his detention reviewed by a Tribunal if he so indicates to the Commission within 14 days. She subsequently received a copy of the Revocation Order dated 5th January 2009 which was signed by Dr Reynolds, and as in the case of the first named applicant above it is indicated on that form that the applicant is no longer suffering from a mental disorder as defined by s. 3 of the Act, and that he *"has chosen to remain in the approved centre on a voluntary basis".*

Ms. Boyce describes how when she met with this applicant on the 10th December 2008 he was unable to communicate with her in any meaningful way. She attempted to say who she was and her purpose in visiting him, his involuntary status and the purpose of the Tribunal hearing due to take place. She sets out in some detail her attempts at conversation and how the applicant reacted or responded. In addition she attempted to obtain the applicant's consent to the release of his medical notes but she states that he unable to understand her request and she formed the view that he could not give consent. She met with him again on the 8th January 2009 in order to obtain instructions in relation to his entitlement under s. 28 of the Act to have his detention reviewed by a Tribunal following the revocation of the involuntary detention. On that occasion the applicant was brought to the consultation room by a nurse but he refused to enter the room and continued to walk around the corridor of Unit 5B. She walked alongside of him for a while trying to engage him in some conversation, but he was unable to respond to her. She believes that he did not remember her from her previous visit on the 10th December 2008, and was unable to communicate with her in any meaningful way. She saw no improvement from that date in the applicant's ability to understand her or to give her instructions, and she was unable to obtain the instructions which she was seeking in relation to a review of his detention.

For the same reasons as she gave in relation to the first named applicant, Ms. Boyce is of the view that while it appears on the face of the records that this applicant has been released from involuntary detention and is free to leave, he continues to be detained since, in her view, the provisions of s. 28 of the Act were invalidly invoked, leading to the revocation of the renewal order, and that in her view the applicant continues to suffer from a mental disability within the meaning of s. 3 of the Act and that he lacks any capacity to make a full and informed decision to remain in the care of the respondent hospital on a voluntary basis as indicated on the revocation order. She concludes by saying that she believes that his continued unlawful detention is not in the applicant's best interests since he enjoys none of the procedural safeguards which he would have if his detention was not invalidly revoked on the 5th January 2009.

Dr Meaney has sworn an affidavit in response to this application. She is one of this applicant's treating psychiatrists, and she examined the applicant on the 2nd December 2008 and that she was of the view on that date that the applicant was suffering from a mental disorder within the meaning of s. 3 of the Act in that he had a history of severe dementia and presented as being extremely agitated, and she concluded that his involuntary admission was necessary for his own protection. She describes his history of mental illness for which she had seen him in May 2008, and states that at that time he did not meet the criteria for mental disorder as defined in s. 3 of the Act, and that he could be adequately treated by local community services. However she had recommended that if he deteriorated medically he would have to be admitted to hospital, and that if he developed a mental disorder a recommendation could be made by his General Practitioner for his detention in an approved centre.

She goes on to describe the treatment which the applicant has received since his admission to Unit 5B, and states that this treatment led to a stabilising of his mental disorder, and in particular his agitation. She states that upon his admission it had been noted that he had an abnormal liver function and that this could have contributed to the onset of his agitation. Investigations revealed the presence of gallstones. It appears that on the date on which he was to receive treatment for this condition he fell out of bed and fractured a hip. He underwent a hip replacement following which he suffered from a post-operative confused state resulting in increased confusion and insomnia. In due course he was transferred back to Unit B and continues under care there.

She confirms in her affidavit that by the 19th January 2009 the applicant's psychiatric condition had settled. She was on leave on that date but she states that this was the view of Dr Reynolds, and that he no longer met the criteria of mental disorder under s. 3 of the Act The applicant had responded extremely well to the change in his medication and to his new environment, and that while he remained, and remains psychiatrically symptomatic, albeit to a much lesser degree, his condition was not so severe as to warrant the protection of the Act.

She accepts that the applicant is non compos mentis, and that he requires physical and to a lesser extent psychiatric treatment, but short of involuntary detention. She believes that it is the applicant's best interests to remain as a patient in Unit B. She confirms that he is free to leave at any time with his next of kin and that there is no restriction whatever on his visitation rights. She again refers to the fact that once a decision is made that the applicant no longer meets the criteria for mental disorder he must be discharged or remain as a voluntary patient, and that they have no option but to regard as him as a voluntary patient even though he remains psychiatrically symptomatic.

I should add that Dr Reynolds has sworn an affidavit which sets out, as in the case of the first named applicant, which describes Unit 5B and the care plan in place for this applicant. He states that as soon as this applicant's medical problems have resolved and a suitable and available placement is identified he will be discharged from voluntary care. He is of the view that the applicant's best interests are being met., but that there is also the option for the family to have the applicant made a ward of Court.

**Legal Submissions:**
The helpful legal submissions submitted to the Court on behalf of each applicant refer to the undisputed evidence that

each applicant is currently within the same unit 5B as they were prior to the revocation of the Admission Order and Renewal Order respectively, and to the fact that in each case the applicant is non compos mentis and incapable of making a decision to remain there as a voluntary patient. R. David Kennedy SC of the applicants submits that in reality each applicant is not free to leave, and has gone further and submitted that it is clear that if either applicant attempted to leave, the provisions of s. 23 of the Act would be invoked in order to prevent that from occurring. The submissions refer to the contents of The Mental Health Commission Annual Report 2007 which, according to the submissions, describes the locked nature of Unit B and its layout and security arrangements. The submissions also refer quite extensively to entries in each patient's hospital notes where, according to what is contained in the submissions, each patient has on a number of occasions in January 2009/February 2009 either indicated a wish to leave or attempted to leave. It is necessary to state, however, that what is contained in these submissions as to the contents of such Report and notes has not been the subject of any affidavit evidence on this application. I imagine that there is no issue as to the accuracy of what has been extracted from that Report and the notes, but it is important nevertheless that this Court reaches it conclusions based on evidence and not simply by reference to other factual matters which are contained in written legal submissions only.

When the revocation orders were made, the consultant psychiatrists were of the opinion that each applicant no longer met the criteria for a s. 3 mental disorder and could be managed in the ward without being involuntarily detained. It would appear that medication and treatment administered since first admission had produced a sufficient improvement to enable that professional opinion to be formed.

For the purpose of my conclusions I am prepared to accept as fact what is contained in these written submissions as to the attempts to leave which were made by each applicant and their expressions of desiring to leave. I am prepared to accept also for the purpose of my conclusions that if such an attempt was made following the revocation of the admission/renewal orders, it may well have led to the invocation by the respondent of the provisions of s. 23 of the Act. That would enable it to detain the patient(s) for a period not exceeding 24 hours or a shorter period, so that the procedures provided for in s. 24 could be activated. It clearly allows for the possibility that following the revocation of an admission order or a renewal order resulting in a voluntary detention status, a patient may thereafter suffer a relapse or a deterioration in his/her state of mental health, requiring that such a person be detained again on an involuntary basis *"if a consultant psychiatrist, registered medical practitioner or registered nurse on the staff of the approved centre is of opinion [at that time] that the person is suffering from a mental disorder…".* This avoids the need for the entire procedure under s. 10 being re-invoked after the patient may have left the approved centre.

It clearly is in the best interests of a patient not to be allowed to leave, even when there on a voluntary basis, where such a mental health professional is of the view that a mental disorder under s. 3 exists.

I am also satisfied to accept the description of Unit B as set forth by Dr Reynolds in his affidavit, including that it is a locked facility, being described by him as a secure unit.

The issue to be decided is whether the applicants, being incapable of consenting to remain as voluntary patients following the revocation of the admission and renewal order respectively, are in unlawful detention since they are present in the same locked/secure unit as previously, and it is probable that if either of them attempted to leave the unit or the hospital they would be prevented from doing so, including by the possible invocation of the provisions of s. 29 of the Act, unless they were departing in the company of a family member.

Applicants' legal submissions:

It is submitted by Mr Kennedy that where a person is incapable of incapable of making a decision to remain on a voluntary basis and is unaware of understanding that he/she has the right to leave, even on the basis that he/she is accompanied by a family member, the voluntary basis of being in the hospital is of no avail, and that it is de facto involuntary detention lacking any statutory basis.

Mr Kennedy has submitted also that the lawfulness of the revocation of the admission/renewal orders in respect of these applicants is not determined solely by whether or not either applicant continued to suffer from a 'mental disorder'. He has referred to the provisions of s. 3 of the Act, which provide as follows:

> "3. – (1) In this Act "mental disorder" means mental illness, severe dementia or significant intellectual disability where –
>
> (a) because of the illness, disability or dementia, there is serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
>
> (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and
>
> (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent."

In the case of MMcM it is submitted that paragraph (a) requires a risk-based decision, and that paragraph (b) requires a treatment-based decision, and that for the purpose of s. 28 of the Act, when considering whether or not to revoke an admission order or a renewal order, the consultant psychiatrist must not confine his/her consideration to simply whether the patient continues to suffer from a mental disorder. Rather, it is submitted, where he/she is of the opinion that the patient is no longer suffering from a mental disorder, consideration must be given to the criteria set forth in both paragraph (a) and (b) of s. 3.

Mr Kennedy has again referred to the patient notes for MMcM, which have not been exhibited. The submissions have set forth what purport to be extracts from these notes indicating that on numerous occasions in January 2009 after the admission order was revoked she was variously restless, agitated, confused, disorientated, aggressive, including by hitting windows, lashing out at staff, spitting food at staff, and otherwise assaulting staff. It is submitted therefore that it is

clear that this applicant remained at risk of harm to herself and therefore must have been somebody who came within paragraph (a) being at risk to herself and to others, and furthermore that she came within paragraph (b) because the evidence has been that she remained in one to one care by a psychiatric nurse.

In the case of LC similar reference is made to extracts from the patient notes which are not exhibited, but which are said to demonstrate similar matters in her regard, and such that she must have remained a person coming within s. 3 of the Act.

In these circumstances it is submitted that in respect of each applicant it was not appropriate to revoke the admission/renewal orders in question.

No independent medical evidence has been adduced by or on behalf of the applicants.

Michael Howard SC for the respondent has submitted that the claim being advanced that it was unlawful for the respondent to revoke the admission/renewal orders in this case is not a matter which this Court should consider on an application for release from alleged unlawful detention under Article 40.4 of the Constitution. He refers to the fact that the opinion in each case that each patient was no longer suffering from a mental disorder for the purpose of s. 3 of the Act is an expert opinion and one which the Court should not be asked to ignore, particularly where no countervailing expert evidence has been adduced.

On this aspect of the applicants' claim, I am of the view that it is not appropriate to argue the invalidity of the revocation orders in the present proceedings. If there is some case to be made that the applicants were still, on the date when the revocation orders were made, persons whose mental illness remained within the definition contained in s. 3 of the Act, that matter would more properly be the subject of an application by way of judicial review, or alternatively could be the subject of a review by a Tribunal as notified to each applicant in the letter received from the Mental health Commission. I make no concluded finding in this latter respect. It is certainly not a ground for seeking an order for the release of the applicants under Article 40.4 of the Constitution. If the admission/renewal orders were not appropriately revoked under s. 28 of the Act, it would mean that the pre-existing admission or renewal order ought to have remained in place, subject to any review thereof by a Tribunal, rather than revoked.

In the present cases, the consultant psychiatrist in question came to a professional opinion that neither patient remained within the definition of mental disorder under s. 3 of the Act, and accordingly revoked the orders under which the respondents were detained. This Court cannot second-guess that opinion, especially where no countervailing expert evidence is adduced. There is no basis for considering that the consultants failed to have proper regard to any particular paragraph of s. 3 of the Act. I have already referred to the fact that only unexhibited extracts from the patients' notes were referred to in submissions in these cases, and that is not a basis on which this Court, or in my view any other Court could proceed to determine that particular issue. But my view remains that such consideration is not appropriate in an application for release under Article 40.4 of the Constitution.

Nevertheless the fact is that the revocation of the orders in question ahead of the Tribunal's review has had the result, through the provisions of s. 28 (5) of the Act, that no review of the correctness or otherwise of the consultant's view that the applicants were not suffering from a mental illness which necessitated their detention has taken place. It is true that under s. 28 (3) of the Act a patient who is discharged by the consultant psychiatrist must be notified of the right to have his/her detention reviewed by a tribunal, provided that he/she so indicates by notice in writing addressed to the Commission within 14 days of the date of discharge. But that implies a degree of mental capacity which is lacking in the case of the present applicants. They cannot decide to have their detention so reviewed.

The consultant has categorised the applicants as voluntary patients following his revocation of the detaining order in each case, even though each lacks the capacity to remain voluntarily. They remain in the same secure or locked unit where they were when detained involuntarily, and in circumstances where it seems clear that they will not be permitted to leave the unit or the respondent hospital unless in the company of a family member. If either of them attempted to leave, it seems clear that the provisions of s. 23 of the Act might be invoked so as to prevent hat happening, even though the s. 23 provisions require the professional concerned to be of the opinion that the patient in question is "suffering from a mental disorder", the very thing which he has stated in each case that neither is suffering from, and which led him to revoke the orders.

Mr Kennedy has highlighted the imperative in s. 28 (1) of the Act not only to revoke the admission order or renewal order where the consultant psychiatrist becomes of the view that the patient no longer suffers from a mental disorder, but to also "discharge the patient". He has referred to a number of occasions upon which the Courts have emphasised the need, in cases where the liberty of the person is at stake, including those detained under this Act, to faithfully comply with and observe the statutory safeguards built into the statutory scheme for the protection of the citizen. It is submitted that these applicants should have been discharged as required upon the revocation of the orders, rather than left in a situation where they remain as before, but without any of the protections to which they would otherwise entitled if held involuntarily.

Mr Kennedy has referred to the judgment of Lord Steyn in *R v. Bournewoood Community and Mental Health NHS Trust, ex parte L (Secretary of State for Health and others intervening)* [1998] 3 ALL ER 289, where similar issues arose for consideration in the context of an application for judicial review and release by way of application for Habeas Corpus. In his judgment, Lord Steyn drew attention to what has become known as "the Bournewood Gap" where persons lacking mental capacity to consent, and therefore in the same position as the present applicants, are de facto detained, albeit on a voluntary basis, but in respect of whom none of the protections available to those who have mental capacity are available, such as a review. The detention was eventually found by a majority in the House of Lords to be lawful, not by virtue of the relevant statutory provisions but on the basis of the common law doctrine of necessity, which, it was considered, had not been ousted or displaced by the complete statutory scheme contained in s. 131 of the Mental Health Act, 1983.

It is helpful to examine that case, and to refer also to the judgment of the European Court of Human Rights in *HL v. The United Kingdom* [2004] ECHR 45508/99, to which Mr Kennedy has also referred, the applicant being the same person as L in the House of Lords decision just referred to.

L was a person with autism, and as a result was mentally disabled and incapable of consenting to medical treatment.

Having been a patient of a hospital run by an NHS Trust for over 30 years, he was discharged into the community in 1994 and had gone to live with a couple who were his paid carers. In 1997 while attending at a day centre and while his carers were not present, he became agitated, as a result of which he was sedated by a doctor who had been called, and was taken by ambulance to hospital where he was assessed by a psychiatrist as being in need of in-patient treatment. However, since he appeared compliant and was not resisting his admission to hospital, it was felt unnecessary to invoke the provisions of the Mental Health Act, 1983 which would have enabled him to be admitted as an involuntary patient. He was admitted "informally". The House of Lords found that persons being treated in hospital for mental illness fell into three categories. Firstly, there are involuntary patients; secondly, there are persons, who, having the capacity to consent to their admission, consented to their admission, and are treated as voluntary patients; and thirdly there are those persons who do not have the capacity to consent, but who nevertheless are admitted on the basis that they require treatment and do not object. This last category are those who are categorised as 'informal patients', such as L.

The statutory basis in England for the admission of this third category of so-called informal patient is s. 131 (1) of the Mental Health Act, 1983 which provides as follows:

> *"Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained."*

The safeguards built into the Act in respect of patients detained on an involuntary basis are absent in respect of patients admitted under this informal system under s. 131(10 of the Act.

At first instance, Owen J. was satisfied that L had not been 'detained', but rather had been informally admitted under the above section which in his view applied not only to persons who actually consented, but also to those who, like L, did not dissent from their admission, and that in fact L had been free to leave until such time as the medical personnel might take steps to prevent him from so doing under the relevant statutory provisions in that regard.

It had been submitted that once L had been lawfully admitted to the hospital, the treatment he received was given to him under the common law doctrine of necessity. In that regard, Owen J. appears to have taken the view that the powers under s. 131 (1) of the English Act contemplated the exercise of common law powers. He refused the reliefs sought by way of judicial review, habeas corpus and damages.

However, the Court of Appeal took a different view, namely that L was unlawfully detained, being of the view that s. 131(1) applied only to those persons who had capacity to consent. That Court was of the view that L had been 'detained', that being a matter of objective fact to be determined, and that *"a person is detained in law if those who have control over the premises in which he is, have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving".* There had been evidence in the case that if L had made an attempt to leave he would have been 'sectioned' and detained as an involuntary patient under the Act.

It was held also by the Court of Appeal that the 1983 Act created "a complete regime" which excluded the application of the common law doctrine of necessity, and therefore could not form a lawful basis for the treatment of L and his presence in the hospital.

In allowing the appeal and reversing the decision of the Court of Appeal, the House of Lords held unanimously, firstly, that s. 131 (1) of the English Act did indeed permit the admission of those who, not having capacity to consent, did not object, and that actual consent was not required; secondly, that it was the plain intention of the Act that informal patients who were admitted but lacked the capacity to consent to treatment, would be cared for and would receive such treatment as was considered to be in their best interests, and that such care and treatment could be justified under the common law doctrine of necessity, in the absence of any justification for it within the statute itself; and thirdly (Lords Nolan and Steyn dissenting), that L had not in fact been detained since, as he had made no attempt to leave and had been accommodated in an unlocked ward, it could not be said that he had actually been deprived of his liberty.

In his speech in which he dissented on the question of whether the applicant had been 'detained' (the majority being of the view that he was not), Lord Steyn at p.305 described the regime in which L was held, and concluded that he was 'detained' and stated as follows in that regard:

> *"… the psychiatrist told the carers that L would be released only when she, and other health professionals, deemed it appropriate. (5) While L was not in a locked ward, nurses closely monitored his reactions. Nurses were instructed to keep him under continuous observation and did so.*
>
> *Counsel for the Trust and the Secretary of State argued that L was in truth always free not to go to hospital and subsequently to leave the hospital. This argument stretches credulity to breaking point. The truth is that for entirely bona fide reasons, conceived in the best interests of L, any possible resistance by him was overcome by sedation, by taking him to hospital and by close supervision of him in hospital and, if L had shown any sign of wanting to leave, he would have been firmly discouraged by staff and, if necessary, physically prevented him from doing so. The suggestion that L was free to go is a fairy tale …… In my view L was detained because the health care professionals intentionally assumed control over him to such a degree as to amount to complete deprivation of his liberty."*

Mr Kennedy draws a parallel between that situation and the situation in which the applicants in the present case remain in the respondent's care, where they are in the very same secure unit as they were when they were subject to an admission/renewal order, and are not in reality free to leave even though they can be visited by family, and he draws attention also to the fact, as asserted on the basis of the medical notes referred to, that if either applicant had attempted to leave the provisions of s.23 of the Act would have been invoked in order to again detain them.

I should remark at this point on the great similarity between s.131 (1) of the English Act or 1983 and s. 29 of the Mental Health Act, 2001 in this jurisdiction, the latter providing as follows:

> *"29. – Nothing in this Act shall be construed as preventing a person from being admitted voluntarily to an approved centre for treatment without any application, recommendation or admission order rendering him or her liable to be detained under this Act, or from remaining in an approved centre after he or she has ceased to be so liable to be detained."*

Essentially, it is the same provision as that under consideration in L, albeit that in the case of L he was admitted in the first instance as a voluntary patient under this section even though lacking the capacity to consent to voluntary admission, whereas the applicants herein were initially admitted as involuntary patients, that status being altered to that of a voluntary patient following the revocation of the orders in question, and after which they remained in the approved centre after they ceased to be liable to be detained. I will return to that matter in due course.

As I have mentioned, following the decision of the House of Lords, L applied to the European Court of Human Rights, submitting that his time in the hospital as an informal patient amounted to a deprivation of his liberty within the meaning of Article 5(1) of the Convention, that his detention was not in accordance with a procedure prescribed by law, and therefore was unlawful within the meaning of Article 5(1)(e), and that the procedures available to him as an informal patient for the review of the legality of his detention did not comply with the requirements of Article 5(4) of the Convention.

The Court of Human Rights concluded firstly that, given the regime in place, the question of whether or not the ward was locked was not determinative, and that there was a deprivation of liberty in circumstances where the health care professionals exercised complete and effective control over his care and movements, and that if he had resisted admission or attempted to leave he would have been prevented from doing so, and his involuntary admission would have been considered.

Secondly, the Court concluded that the lack of any procedural rules as to the exact purpose of admission and that where there were no limits in terms of time, treatment or care, and where detention was on the basis of the common law doctrine of necessity, failed to protect against arbitrary deprivations of liberty, and constituted a violation of Article 5(1) of the Convention. The Court stated in this regard at para. 120 of its judgment:

> *"In this latter respect, the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted. The contrast between this dearth of regulation and the extensive network of safeguards applicable to psychiatric committals covered by the 1983 Act … is, in the Court's view, significant."*

Thirdly, the Court concluded that remedies available to L by way of habeas corpus application were insufficient for the purpose of Article 5(4) of the Convention as it did not allow a determination of the merits of the question as to whether the mental disorder persisted; and neither did judicial review provide an effective remedy.

Mr Kennedy submits that in this jurisdiction, the provisions of the Act similarly contain no safeguards against an arbitrary or de facto detention of a person such as these applicants who are incapable of deciding to remain as a voluntary patient, following the unilateral decision by the psychiatrist concerned to re-grade the patient from involuntary status to voluntary status by the revocation of the admission or renewal order, and yet who are, in reality, required to remain in the hospital indefinitely, and where if they attempt to leave they will be once again prevented from doing so by the invocation of the powers contained in s. 23 of the Act. The decision to revoke is not, in the case of these applicants who lack capacity, subject to any review by a review tribunal, or independent consultant psychiatrist.

I have already referred to the fact that s. 29 of the Act here is in very similar terms to s. 131(1) of the English Act. In so far as the respondent is submitting that this section entitles the respondent to keep the applicants, now being voluntary patients, in the secure unit where they were before the orders were revoked and until such time as they leave in the company of a family member, Mr Kennedy submits that s. 29 cannot justify such a position. He refers to the definition of a "voluntary patient" contained in s. 2 of the Act which defines a voluntary patient as *"a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order".* In so far as it may appear that this definition fits exactly the applicants herein, he submits additionally, given the provisions of s. 16 (2)(g) of the Act, that a person may be a voluntary patient only if he or she indicates a wish to be admitted as a voluntary patient, these applicants cannot be so classified since they lack the capacity to so decide. In that regard, firstly, s. 16 (1) of the Act provides:

> *"16. – (1) Where a consultant psychiatrist makes an admission order or a renewal order, he or she shall, not later than 24 hours thereafter –*
>
> *(a) send a copy of the order to the Commission, and*
>
> *(b) give notice in writing of the making of the order to the patient."*

Then, s. 16(2) provides that the notice referred to in s. 16(1)(b) shall include a statement in writing informing the patient of various matters as set forth therein, including as set forth at (g) that the patient *"may be admitted to the approved centre concerned as a voluntary patient if he or she indicates a wish to be so admitted".*

Mr Kennedy submits therefore that it is clear that in order to be a voluntary patient the patient must have indicated a wish to be a voluntary patient.

Mr Kennedy then refers also to s. 56 (1) of the Act which defines what is meant by consent. It provides:

*"In this Part [i.e. Part 4 – Consent to Treatment] consent, in relation to a patient, means consent obtained freely without threats or inducements, where (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment ……".* Accordingly, in his submission, the applicants cannot be properly categorised as voluntary patients, since they cannot express either a wish to remain on a voluntary basis or give consent to treatment.

Before setting out the further submissions made by Mr Kennedy, it is convenient to state that Michael Howard SC for the respondent has, in relation to what has been submitted by Mr Kennedy in relation to s. 56(1), referred to the provisions of s. 57 (1) of the Act to which no reference was made by Mr Kennedy, and which he submits is of importance. Section 57 of the Act provides (in relation to consent to treatment):

> *"57.—(1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent." (my emphasis)*

The respondent relies on this provision, and I will return to that in due course.

In relation to the issue of consent and the fact that these applicants are acknowledged by all concerned not to have capacity to give consent to remain in the approved centre as voluntary patients, Mr Kennedy submits that the applicants' constitutional rights must not be diluted or diminished by reason of their mental incapacity. In that regard he has referred to the judgment of Hamilton CJ in *Re A Ward of Court (No.2)* [1996] 2 IR 79, where at p. 126 of his judgment the learned Chief Justice stated, albeit in a context far removed from the present case:

> *"The loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution, including the right to life, the right to bodily integrity, the right to privacy, including self-determination, and the right to refuse medical care or treatment.*
>
> *The ward is entitled to have all these rights respected, defended, vindicated and protected from unjust attack and they are in no way lessened or diminished by reason of her incapacity."*

He refers also to the judgment of Laffoy J.in *Fitzpatrick & another v. FK & another* [2008] IEHC 104. That judgment of course dealt with an issue far removed from the present case, and which, as stated therein by Laffoy J. at p.2 thereof, was *"whether and, if so, in what circumstances, a court may intervene in the case of a patient who is an adult and is not compos mentis, who has refused treatment, and by order authorise the hospital and its personnel in which he or she is a patient to administer such treatment to the patient."*

The patient in question was considered by the medical personnel treating her to be in immediate need of a blood transfusion, but were informed that she would not take blood as she was a Jehovah's Witness. She was transfused following the granting of an order obtained *ex parte* from the High Court, and the issues in the case arose for determination thereafter.

During the course of her judgment, and at p. 43 thereof, Laffoy J. set out a number of principles relevant to the question of assessing a patient's capacity, two of which are referred to by Mr Kennedy. Those two principles are set forth as follows:

> *"(1) There is a presumption that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse medical treatment, but the presumption can be rebutted.*
>
> *In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment whether –*
>
> *(a) by reason of permanent cognitive impairment, or*
>
> *(b) temporary factors, for example, factors of the type referred to by Lord Donaldson in In re T,*
>
> *the test is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made."*

Mr Kennedy referred also to the judgment of Clarke J. in JH v. Russell [2007] 4 IR 242 where at p.258-259 he stated:

> *"Secondly, it is suggested that, at a number of points in the history of the detention of the applicant, orders were made which were contrived for the purposes of attempting to fit the circumstances of the applicant into what was, undoubtedly, a flawed statutory regime. In addition to the point with which I have just dealt, it is also suggested that the period of apparent voluntary detention (as referred to above) was not genuine in that the applicant was subjected to an identical regime concerning control (some of it apparently in accordance with his wishes) when he was formally detained under detention orders and when he was a voluntary patient. It is also questioned as to whether the applicant was truly a consensual patient during the relevant period …*
>
> *… While I was satisfied that what occurred was done with the best of intentions I was not satisfied that the applicant went into a period of genuine voluntary treatment at that stage. I appreciate that it would appear that part of his own motivation in signing the relevant documentation related to a desire to stay in Cavan. However, I*

*was not satisfied that the relevant period during which the applicant was, apparently, a voluntary patient, was in substance properly voluntary and I am satisfied that he was inappropriately detained for in excess of the maximum 24 hour period."*

Mr Kennedy relies on this passage for his submission that a person can remain in hospital as a voluntary patient and yet in substance be considered as 'detained', but without any of the statutory protections which he/she enjoyed when there on an involuntary basis under an admission order or renewal order.

**Respondent's legal submissions:**
Michael Howard SC for the respondent has at the outset drawn attention to the fact that each of these applicants, in addition to their mental health illness, suffered from other medical problems for which they have needed, received treatment, and to an extent require ongoing care. It will be recalled that in the case of LC he was treated for gallstones, and that thereafter he had fallen out of bed and had undergone hip replacement surgery, and that in the case of MMcM she had historical problems with hypertension, non-insulin dependent diabetes, arthritis, hypo calcaemia, adenocarcinoma of her caecum, hip replacements in 1993 and 1994, as well as chronic depression. He refers to this aspect of the background in the context of the overall duty of care owed by the respondent to the applicants, and the provisions of s. 29 of the Act, which in his submission support the lawfulness of the applicants *"remaining in an approved centre after he or she has ceased to be so liable to be detained"* as stated in that section.

Mr Howard has also stated that any reliance of a common law doctrine of necessity, which he submits is applicable, is very much a fall-back position on which the respondent would seek to rely, and that reliance is placed principally upon the statutory provisions themselves as providing a lawful basis for the applicants remaining in the hospital following the revocation of the orders and the discharge of the applicants, as notified to them.

It has been submitted that this Court cannot, on these applications for release under Article 40.4 of the Constitution, question or otherwise second guess the opinion formed by the consultant psychiatrist that these applicants had ceased to suffer from a mental disorder requiring their involuntary detention at a point before the tribunal sat to review the detentions, given the improvement observed following the treatment administered up to that point, and that the provisions of s. 28 are mandatory in this regard, namely that where that opinion is formed, the psychiatrist *"shall by order in a form specified by the Commission revoke the relevant admission order or renewal order, as the case may be, and discharge the patient"*(my emphasis). This form was duly completed, and the other statutory formalities were complied with. He draws attention to the fact, as already stated, that no other expert opinion has been expressed and no evidence in that regard has been offered on behalf of the applicants. Following revocation, the view was that each applicant required ongoing treatment, both medical and psychiatric, but not such as involuntary detention was warranted, and that it was in their best interests to remain in the hospital until such time as they could leave in the company of a family member, since they would be otherwise at risk given their ongoing problems. The respondent refers to the fact that in the affidavits sworn to ground these applications, no reference is made to the fact that these applicants required ongoing medical, as opposed to psychiatric, treatment and care.

Mr Howard has referred to the fluid nature of mental illness, whereby following an opinion being formed by a psychiatrist that a person suffers from a mental disorder within the definition in s. 3 of the Act and is made the subject of an admission order, the patient's condition may well respond to treatment administered to the point where the patient is no longer suffering from a disorder within that definition, and he submits that this is what is shown to have occurred in the present cases, and that the consultants' opinion in this regard cannot be ignored, and particularly in the absence of any expert opinion to the contrary, must be accepted. In this regard he has referred to the judgments of O'Neill J. in *MR v. Byrne* [2007] 3 IR 211, where at p. 224 he stated:

*"[37] It should be stressed that the foregoing analysis or description of these provisions [section 3] merely seeks to set out the legal framework of the operation of the statutory provisions. It cannot be over emphasised however that on a daily basis these provisions will have to be operated by clinical experts who within the broad framework set out above have to make clinical judgments and I would like to stress that it is not intended in this judgment to interfere in the proper realm of clinical judgment or to cut down or limit the proper scope of clinical judgment. All that is sought to be done is to set out, as stated above, the appropriate legal framework in which the statutory provisions operate."*

Mr Howard has referred also to what O'Neill stated in the same judgment at para. 43 thereof as follows:

*"[43] … Dr O'Neill as the consultant psychiatrist responsible for the care of the applicant had a specific function to discharge under the Act of 2001, namely on the day of the making of the renewal order he had to form a view as to whether or not the condition of the applicant was such as to give rise to a finding that the applicant was at that time suffering from "mental disorder" on either of the bases set out in s. 3 (1) of the Act of 2001. It necessarily follows in my view that his discretion in that regard could not be fettered by any decision made either by himself on a previous occasion or by a Mental Health Tribunal on a previous occasion, as to the mental health status of the applicant. This must necessarily be so because the condition of this applicant or any other applicant, perhaps in response to treatment, could change."*

Mr Howard has submitted that in the present cases, it is clear that the applicants are not unlawfully detained when the clear evidence adduced by the respondent is that, having been discharged (albeit that they are still at the hospital) each applicant is free to leave provided that they do so in the company of a family member, such a situation being in the best interests of the patient, and even accepting that neither patient is capable of making a decision to leave. It is submitted also that the fact they remain in the same unit as prior to their discharge does not of itself alter that situation, albeit that it is a secure unit as described in the affidavits filed.

Mr Howard has referred to the speech of Lord Goff of Chieveley in *R v. Bournewood Community and Mental Health NHS Trust, ex parte L,* where he refers to patients in the position of the present applicants who have been discharged but remain on a voluntary basis, though lacking capacity to decide to so remain, and seeks to draw support from same for his submissions in this case. Lord Goff stated:

*"…… The following conclusions can be drawn. The first is that, as I have already recorded, although Mr L had been discharged from hospital into the community on a trial basis, and on that basis has gone to live with Mr and Mrs Enderby as his paid carers, nevertheless he had not been finally discharged. It followed that the appellant trust remained responsible for his treatment, and that it was in discharge of that responsibility that the steps described by Dr Manjubhashini were taken.*

*The second is that when, on 22 July, Mr L became agitated and acted violently, an emergency in any event arose which called for intervention, as a matter of necessity, in his best interests and, at least in the initial stages, to avoid danger to others. Plainly it was most appropriate that the appellant trust, and Dr Manjhubashini in particular, should intervene in these circumstances; certainly Mr and Mrs Enderby, as L's carers, could not assert any superior position.*

*Third, I have no doubt that all steps in fact taken, as described by Dr Manjhubashini, were in fact taken in the best interests of Mr L and, in so far as they might otherwise have constituted an invasion of his rights, were justified on the basis of the common law doctrine of necessity …*

*In the present case all the steps in fact taken by Dr Manjhubashini were, in my opinion, lawful because justified under the common law doctrine of necessity and this conclusion is unaffected by her realisation that she might have to invoke the statutory power of detention.*

*Finally, the readmission of Mr L to hospital as an informal patient under s. 131 (1) of the 1983 Act could not, in my opinion, constitute the tort of false imprisonment. His readmission as such did not constitute a deprivation of his liberty. As Dr Manjhubashini stated in para 9 of her affidavit, he was not kept in a locked ward after he was admitted and the fact that she, like any other doctor in a situation such as this, had it in her mind that she might thereafter take steps to detain him compulsorily under the Act, did not give rise to his detention in fact at any earlier time. Furthermore his treatment while in hospital was plainly justified on the basis of the common law doctrine of necessity. It follows that none of these actions constituted any wrong against Mr L."*

In so far as Mr Kennedy has relied also upon the judgment of the European Court of Human Rights in *HL v. United Kingdom*, as already set forth, Mr Howard responds by submitting first of all that this decision is not binding upon this Court in as much as Ireland was not a party to that case, and in that regard has drawn attention to the provisions of Article 46.1 of the Convention which provides that *"The High Contracting Parties undertake to abide by the final judgment of the Court in any case to which they are parties"*. Of course, pursuant to s. 2 of the European Convention on Human Rights Act, 2003 requires this Court when interpreting and applying any statutory provision or rule of law, to do so *"in so far as is possible, subject to the rules of law relating to such interpretation and application …… in a manner compatible with the State's obligations under the Convention provisions".*

Mr Howard submits that the finding of the European Court of Human Rights in HL that the detention of L was a violation of Article 5.1 of the Convention was largely based on the absence of procedural safeguards, stating at para. 124 in that regard:

*"The Court therefore finds that this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of art 5(1) of the Convention. On this basis, the Court finds that there has been a violation of art. 5 (1) of the Convention." (my emphasis)*

In that regard, the Court had earlier stated at para. 120 of the judgment:

*"In this latter respect [the aim of avoiding arbitrariness] the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant persons is conducted. The contrast between this dearth of regulation and the extensive network of safeguards applicable to psychiatric committals covered by the 1983 Act …… is, in the Court's view, striking."*

Mr Howard submits that in the present case the statutory framework not only provides a lawful framework for the continuing presence of the applicants in the hospital until such time as they are in a position to leave in the company of a family member (i.e. s.29 of the Act), but that even when an admission order or renewal order is revoked, the patient may, if he/she chooses to do so, seek to have his detention reviewed by the Tribunal as notified to him/her following revocation (s. 28 (3) of the Act).

In submitting that the applicants are not in unlawful detention such as would be a violation of Article 5.1 of the Convention, Mr Howard has referred to the judgment of O'Neill J. in *E.H. v. The Clinical Director of St. Vincent's Hospital and others*, unreported, High Court, 6th February 2008, where he referred to the Court's obligation to interpret and apply the 2001 Act in a manner compatible with the State's obligations under the Convention. Having considered the provisions of Article 5.1 in the context of a voluntary patient who lacked mental capacity, and in respect of whom no admission or renewal order was in place, but who continued to require treatment, O'Neill J. stated:

*"I am quite satisfied that the definition of "voluntary patient" in the Act is consistent with the Constitution and, indeed, it was not suggested or submitted otherwise on behalf of the applicant. No provision of the Constitution, in my view, requires that for the purposes of construing this definition in conformity with the Constitution, that in effect the definition is to be narrowed to exclude a detention which, apart from the compliance with the express provisions of the definition of the Act, was otherwise illegal in law. It would seem to me that the definition was cast in wide terms used in order to provide for the variety of circumstances wherein a person is in an approved centre receiving care and treatment, but not subject to an admission order or a renewal order, including, in my view, the type of situation which has indeed arisen in this case, namely where a detention pursuant to an admission order or a renewal order breaks down but where the patient is suffering from a mental disorder and receiving care and treatment."*

Mr Howard submits that these remarks are equally relevant to the applicants' situation where they are persons who are outside the definition of mental disorder contained in s. 3 of the Act and who cannot give consent, and who remain in hospital, and are treated on the basis of the provisions of s. 29 of the Act.

In *EH,* O'Neill J. concluded, having given consideration to the judgment of the European Court of Human Rights in HL, that the presence of the applicant in that case in the respondent hospital could not be characterised as a deprivation of her liberty in an arbitrary fashion, and stated in that regard:

> *"In the light of the foregoing, I am satisfied that the procedural safeguards, and the fair and proper procedures fairly required for compliance with Article 5.1 were abundantly in place in the provisions of the 2001 Act, and, indeed, the applicant's detention from June 2008 to the present, in my opinion, was regulated in accordance with these."*

He concluded also that *"the definition of voluntary patient as it stands in the Act is compliant with Article 5 of the European Convention on Human Rights".*

Central to the applicants' submissions is the absence of their consent to being in the hospital as voluntary patients, given their incapacity to give any such consent. Mr Howard submits that Mr Kennedy is incorrect in submitting that such consent is a necessary ingredient before they can be classed as voluntary patients, even given the provisions of s. 16(1) and (2) as submitted by Mr Kennedy. Mr Howard refers to the definition of "voluntary patient" which is contained in s.2 of the Act which, as already set forth earlier defines him/her as *"a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order".* He submits that this is very clear and precisely covers the status of the applicants. He submits also that the fact that these applicants have remained in the hospital after the revocation of the admission order/ renewal order so that they can continue to be cared for and if necessary treated is precisely within what is provided from by s. 29 of the Act as already set out, as they are persons *"remaining in an approved centre after he/she has ceased to be so liable to be detained [under an admission order/renewal order]".*

In so far as Mr Kennedy has relied also upon the provisions of s. 56 of the Act which I have already set forth, and which defines what is meant by 'consent' in the context of treatment as opposed to admission, Mr Howard, as already stated, refers also to s. 57 of the Act to which Mr Kennedy had not made reference and where it is provided that such consent to treatment is required *"except where … the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent"* (my emphasis). Apart from that submission, he maintains that this statutory provision applies only to treatment as opposed to admission or remaining as a voluntary patient, and he returns to the definition of voluntary patient in s. 2 of the Act.

**Conclusions:**
Part of the concern on the part of the applicants' solicitor, who was appointed by the Mental Health Commission to represent these applicants after their admission orders were made, is the manner in which these orders were revoked immediately prior to the review of the orders by a Mental Health Tribunal. It has been submitted that the information to be gleaned from the medical notes shows that these applicants still remained within the definition of a mental disorder under s. 3 of the Act and met what has been described as the 'risk-based' criterion of a mental disorder. It is submitted that these notes show that the applicants were persons in respect of whom, as stated in s. 3(1) (a) of the Act, *"because of the illness, disability or dementia, there is serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons".* In essence the applicants seek to satisfy this Court on this application that the consultant psychiatrist concerned was not entitled to form the view that these applicants were patients who were no longer suffering a s. 3 mental disorder and that he was wrong therefore to revoke the orders. As I have said, this Court cannot second guess that expert medical opinion. There is in any event no countervailing expert opinion put forward. I appreciate the solicitor's concerns since the unexhibited medical notes certainly to a lay observer or non-medical observer certainly seem to describe the actions of persons in need of treatment and care. But that is not disputed by the medical staff. They are equally concerned that these applicants remain in a situation where they can be properly cared for. That is why they will not allow the applicants to leave unless they do so into the company of a family member. The view of the consultant psychiatrist is that the applicants' conditions can be managed other than in an involuntary detention context. That is why he would be content to allow the applicants leave the hospital into the care of family members, who presumably can be expected to make sure that the applicants take whatever medication is prescribed in order to manage their present condition. It must be borne in mind also that the medical personnel would be entitled to have concerns not only in relation to the mental difficulties still endured by these applicants but also their general medical difficulties already outlined earlier. But, as referred to by O'Neill J. in *MR v. Byrne* [supra] the patient's condition is a fluid matter. The patient may improve or deteriorate. The patient may or may not respond to medication administered following an involuntary admission. In the present cases, it is the fact that they did indeed improve, in the opinion of the consultant psychiatrist, following admission and to a point where neither remained within the definition of mental disorder in s. 3 of the Act, albeit that they still were suffering from mental illness of various kinds, and even though they remained incapable of making decisions for themselves or even understanding in any meaningful way why they were in hospital or under what circumstances they remained there, and that the admission/renewal order was revoked. As O'Neill J. stated, things can change, and the Act allows for that sort of situation. But it is a matter for the relevant clinicians to reach a conclusion regarding the extent of improvement and the nature and extent of remaining mental illness from time to time. That does not mean that there might not be some egregious case in the future where it is shown by appropriate expert evidence that a decision to revoke and discharge was made without any reasonable medical or clinical basis. What reliefs that could give rise to is not something to be addressed in this judgment, as it does not arise. But generally speaking, the decision that a person is or is not suffering from a s. 3 mental disorder is one to be made solely by the consultant psychiatrist responsible for the care and treatment of the patient, and this Court must accept that decision as being appropriate and correct, barring very clear evidence to the contrary.

I cannot see any basis for this Court making any finding on this application that the orders in respect of these two applicants ought not to have been revoked.

Section 28 of the Act requires that once a person is no longer suffering from a s. 3 mental disorder, he/she must be discharged. The point has been made that this has not occurred for these applicants and that they remain as before, including in the same Unit 5, a secure unit, and that the failure to discharge them in the sense of allowing them to leave

the hospital is not in accordance with the statutory scheme and that the presence in the hospital following revocation amounts to an unlawful detention.

In my view the mere fact that the unit in which the applicants are is locked and secure should not be seen in the context of forced restraint amounting to a false imprisonment or other unlawful detention. The respondent owes a duty of care to these vulnerable applicants. It is not disputed that they are suffering from both mental and general medical illness. They cannot look after themselves unaided by others. It is reasonable therefore that they should be in a part of the hospital from where they cannot leave unnoticed. Also, it would be grossly negligent for the hospital, following the required revocation of the admission/renewal order, to immediately bring these vulnerable patients to the front door of the hospital, lead them down the steps and to pavement and say to them "we no longer have any legal basis for keeping you in hospital, so off you go – home or wherever you can". How could such an appalling vista be within the contemplation of an Act such as this which has at its heart the best interests of vulnerable patients?

When considering whether keeping these patients in the same Unit 5 as before amounts of itself to an unlawful detention, one must bear in mind the overall context in which they are in that unit, and not simply the physical geography of the unit. Yes, it is a secure unit, with staff who monitor the patients and ensure that they cannot leave it. But visitors are allowed, and indeed it has been quite clearly stated that these applicants are free to leave but only where they are safe when leaving, such as in the company of a family member. The reality for these applicants is that if a responsible adult family member of one came to the hospital and indicated that he or she wished to take either applicant him or her home and look after him/her, the applicant in question would not be prevented from leaving. That presupposes of course that by that time the condition of the patient in question had not once again deteriorated to a point within the s. 3 definition. So the fact that Unit 5 is a secure unit cannot of itself mean that the applicants are detained in any technical sense. Rather it can be seen as a safe environment for the applicants to be, given their illnesses, but one which they may leave if appropriately accompanied as I have said.

One can think of other situations in which vulnerable persons are kept inside a locked door environment without that situation amounting to a 'detention'. For example, there can be some schools where children cannot exit the school because the exit doors are locked. That is something which occurs for the protection and safety of the children. It prevents a young child exiting unnoticed and being put at risk, and it prevents undesirable outsiders from gaining entry to the school thereby endangering the safety of children. The locking of doors in such circumstances is pursuant to a duty of care owed to the children. I believe that the locking of the unit where these applicants are is little different. Would it make any difference to the reality for these patients if instead of the unit itself being locked it was open but all perimeter doors were locked? The reality would be that neither applicant could leave the hospital following the revocation of the orders and their discharge, unless accompanied by a responsible family member. So it is not in my view the fact that the unit is secure that is fundamental to the question of whether these applicants are detained or not. It is a question of law firstly. Are they detained under any order allowing their detention? The answer is 'No'. Are they free to leave? The answer is 'Yes' provided they do so with a family member who can look after them. Would they be prevented from leaving if they tried to do so alone? The answer is 'Yes'. But if the answer is 'No' it seems clear that the hospital would be guilty of negligence of a high order. Such an exit may be prevented by the invocation of powers under s. 23 of the Act. But that could be done only if the requirements of that section were met. That section could not be invoked simply as a pragmatic device to prevent a person leaving who cannot do so without posing a danger either to himself or to others.

If the requirements of s. 23 of the Act are not met in the situation I am imagining in the previous paragraph, I still believe that the hospital in discharge of its duty of care to its patient would be entitled to keep the patient, who is *non compos mentis*, safe within the hospital by reasonable means, and I believe that the provisions of s. 29 of the Act, quite apart from any Common Law duty of care, give it ample powers in that regard.

In so far as s. 29 is very similar to the English equivalent in s. 131 of the English Act, and in so far as much reference has been made to the case of L ("the Bournewood Gap"), it is necessary to draw a fundamental distinction between the facts of the present case and the case of L. The point at issue in L was really whether s. 131 empowered the hospital to admit L as a voluntary patient who could not so consent, or whether by doing so he was 'detained' and unlawfully detained. That is a different situation to the present applicants. There is no dispute about the fact that they were each lawfully made the subject of an Admission Order when first admitted as involuntary patients. Their detention there under those orders, one of which was the subject of a later Renewal Order, was completely in accordance with the clear statutory provisions. The Mental Health Tribunal may have decided that these orders, or either of them, should be revoked, had they not been revoked prior to the hearing, but that is not relevant for present purposes. But, Section 29 was not the basis of their admission, as s. 131 of the English Act had been the case in respect of L. For that reason it is necessary to distinguish L on its facts. That is not to say that what is contained in the speech of Lord Goff of Chieveley and others is not of considerable interest and of some relevance, but I prefer to decide the present case on its own facts and by reference to the statutory provisions of the Act here. For the same reason, the judgment of the European Court of Human Rights in HL is of limited value, though it is of interest and this Court is required to have regard to the jurisprudence of that Court when interpreting the provisions of the Act here. I have had regard to that judgment.

It does not seem to me that there is any statutory requirement under the Act that a person must be capable of expressing, and express, a consent to being in an approved centre on a voluntary basis before that person can be categorised as being a 'voluntary patient'. The term 'voluntary patient' has a specific definition as appearing in s. 2 of the Act. As provided therein, and as referred to already a voluntary patient is defined as being "[save where the context otherwise requires] *…a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order".* There is not in my view any context in relation to these applicants which mandates that this definition is not appropriate to be applied. Having been lawfully admitted on an involuntary basis, these applicants' state of mental health improved as a result of medication and care provided, yet not to the point where they were capable of being discharged in the sense of released home. The Form 14 provided for signature by the consultant psychiatrist required him to state either that the patient "is being discharged" or that he "has chosen to remain in the approved centre on a voluntary basis". The latter box was ticked. It might be more appropriate for the alternative to discharge to be differently worded so as to indicate that the patient "remains in the approved centre as a voluntary patient". That would overcome the dilemma that the consultant psychiatrist found himself in and which he discussed at the time with a Social work colleague in the Health Service executive. But the mere fact that the Form14 was worded in the way it is cannot of itself influence the proper interpretation of the term 'voluntary patient' in s. 2 of the Act, and cannot itself import an additional element of actually giving consent and, therefore, being mentally capable of giving such a consent. Where that consent can be given and is given, clearly there is no difficulty, but where, as in these cases, that consent cannot be given, there is no reason by reference to the statutory provisions to conclude that they are outside

the statutory definition of a voluntary patient, given the very clear definition of a voluntary patient.

Mr Kennedy has referred to the requirement in s. 16 (1)(b) to give notice to the patient of the making of an admission order, and to the requirement in s.16 (2)(g) that such notice must state that the patient may be admitted as a voluntary patient "if he or she indicates a wish to be so admitted", and has referred also to the provision of s. 56 of the Act where consent in relation to treatment is defined. But s. 16 has no application to the present case. Clearly if a person is capable of giving consent to voluntary admission prior to being admitted, that is something which can be done, should the patient so wish. But it is not the case that this provision can be called in aid of a submission that at some later stage such consent must be given if a person is remaining in the approved centre as a voluntary patient following the revocation of the admission order. That occurs under different provisions. Equally, s. 56 is not relevant to the question of whether the applicants must have expressed their consent to voluntary status, since s. 56 of the Act relates solely to the 'Consent to Treatment'. In any event, as Mr Howard pointed out, s. 57 of the Act specifically removes the need for consent to treatment where the patient is incapable of giving consent to treatment.

In my view, in spite of the fact that Form 14 is worded in the way it is, it was necessary and permissible for the consultant psychiatrist to indicate that that the applicants were remaining as voluntary patients, and this was the only way of dealing with the matter. It must be borne in mind that while s. 28(1) of the Act requires that the order be revoked if the opinion is that the patient is no longer suffering from a mental disorder (as defined in s. 3 of the Act) and that the patient be discharged, the provisions of s. 28 (2) are relevant. The revocation of the order and the discharge of the patient are two distinct matters, even if one follows upon the other. Section 28 (2) requires the consultant psychiatrist, following the revocation of the admission/renewal order, to have regard, *inter alia*, to the need to ensure (a) that the patient is not inappropriately discharged. The section does not provide that before making a revocation order the psychiatrist must have regard to the need not to inappropriately discharge the patient. The appropriateness of a discharge is not a condition precedent to the revocation of the order. The order must be revoked if the patient no longer suffers from a mental disorder as defined. It seems to me to make complete sense that following the revocation order, a consultant psychiatrist must retain the capacity to ensure that a patient is not thereupon discharged from the hospital into a situation of, say, danger, to himself or others. As I have said, this follows from the ongoing duty of care owed to a particularly vulnerable person.

One could also make a distinction between a discharge from involuntary detention under the admission order/ renewal order, and an actual discharge from the approved centre. The Act does not define what is meant by "discharge". But the provisions of s. 29 of the Act support the idea that a person, whose detention under an admission order/renewal order, may remain at the approved centre after he or she has ceased to be subject to an involuntary detention order. That section does not state in any way that consent in that regard is required. It facilitates the situation in which these applicants are, by giving the approved centre the ability to continue to care and treat the patient where it would be inappropriate to release him or her onto the street, where to do so would place the patient at risk if not accompanied by a responsible family member.

It is unnecessary to reach any conclusion on the question of whether the doctrine of necessity is a sufficient basis for the keeping the applicants in the hospital following the revocation of the orders.

I should conclude by stating and making clear that there is absolutely no suggestion made on this application that any decision made by relevant personnel was other than one made bona fide and in the best interests of the applicants. Section 4 of the Act requires that *"in making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made."*

I am in no doubt that this principle was observed and fulfilled by the decision made to revoke the orders and to ensure that the applicants remained in the hospital until such time as they were in a position to leave in the company of a responsible family member. As I have already concluded, these applicants have been voluntary patients as defined in s. 2 of the Act in spite of the fact that neither could give a consent to that status, and their continuing presence at the hospital on that basis is one which is consistent and permitted in my view by the provisions of s. 29 of the Act. They are not unlawfully detained, and I refuse the applications made on their behalf.

I would like to record the fact that three days ago when this matter was listed for mention before me, I was informed by Mr Kennedy that since the hearing of these applications, the applicant LC, has sadly died.