Neutral Citation: [2015] IEHC 259

THE HIGH COURT

[2015 No. 2139 P]

BETWEEN

GOVERNOR OF X PRISON

PLAINTIFF

AND

P McD

DEFENDANT

JUDGMENT of Ms. Justice Baker delivered on the 31st day of March, 2015

1. At the outset of these proceedings before me I made an order pursuant to s. 27 of the Civil Law (Miscellaneous Provisions) Act, 2008 prohibiting the publication or broadcast of any matter relating to the proceedings which would, or would be likely to, identify the applicant.

2. Fasting, or going without food, for the purposes of extracting justice or redressing a wrong has had a long history in Ireland and indeed it could be said to be a particularly Irish form of protest. It is found in early Irish law where it was called *troscud*, the particular protest being focused on the fact that to show that a person had refused you hospitality was to hold that person up to ridicule and disdain in society.

3. Mr. McD is conducting a hunger strike at X Prison not for any political or historic cause, and his complaint is purely personal, and relates to the conditions of his detention. This case concerns the question of whether his choice to so express his protest is one made with the full knowledge of the consequence, and whether his expressed wishes are to be respected, even should he fall into coma.

4. An application was brought by the Governor of X Prison for declaratory relief in respect of the defendant, a 45-year old man who is currently serving a 12-year sentence at the prison. Since or about the 8th February, 2015, the defendant has been on a hunger strike at the prison as part of his protest against the conditions of his detention, full details of which I will outline below but which have resulted in his being voluntarily isolated from almost all human contact since 2012. The application first came before me on Wednesday 25th March, 2015, and at that stage the affidavit evidence was that the applicant was of sound mind and capable of coming to a decision to refuse food, which he continued to do. Certain questions were raised by me in the course of the hearing and I will detail the consequence of that enquiry below. The matter was adjourned to Friday 27th March, 2015, at which point it seemed that the defendant's physical state had deteriorated, and at that adjourned hearing counsel for the defendant indicated that they were concerned as to his capacity to understand and consent to the enormity of the decision which he had made and which he was continuing to implement. The defendant's counsel in particular raised the question of whether the court's inherent jurisdiction might require me to consider broader questions of law and fact, and that the defendant might in law be a vulnerable person, or in the alternative, a person in respect of whose right to life I ought to consider the option of requiring, or permitting, the prison Governor to commence a programme of artificial feeding. The matter first came on for hearing as an interlocutory motion but I directed a hearing of oral evidence and on Monday 30th March, 2015 I heard oral evidence from the defendant himself and his personal comfort was facilitated by hearing that evidence at a place that would cause him the least distress.

Background facts

5. The defendant is a member of the Travelling community, whose family background and history has been characterised by extreme physical and sexual abuse; and he spent his childhood after the age of 10 or thereabouts in care in the UK. His family travelled between the UK and the USA, and he had no real connection with any Travelling community in Ireland.

6. He has a long history of alcohol and drug use, and he started taking so-called soft drugs when he was not yet a teenager. He was in a car accident as a child, as a result of which he lost his spleen, which is said to make him susceptible to infection. He had been diagnosed as suffering from a psychological condition, a borderline personality disorder, and he has a history of self-harm, which has continued into his prison life.

7. He has spent 30 years of his life in prison, and the prison sentence imposed on him on the 7th December, 2011, was the first sentence imposed upon him in Ireland, and this is the first time he has spent any time in an Irish prison. His anticipated release date is December 2017, having regard to a period of time that he spent in remand in Cloverhill Prison in respect of the conviction for burglary, assault and a threat to kill an elderly person.

The defendant's conditions in X Prison

8. The defendant at his own wish has chosen not to mix or associate with other prisoners in X, as he fears that he is at risk from harm from other prisoners, primarily from groups of the Irish Travelling community, and he notes a particular feud between two Travelling families in the prison which he believes has posed a direct risk to his own personal safety. He said that since he arrived in X he has been subjected to name calling, verbal abuse, and also complains of discriminatory and anti-Traveller abuse from other prisoners and from prison staff. His main complaint and fear, however, has arisen from his concern that he is at risk from other Travellers in the prison.

9. He opted to serve his sentence under Rule 63 directions, which involves him living in a segregated cell, and effectively means that he is locked up for 23 hours every day. This 23-hour lock up has continued since he first arrived in X Prison in December, 2011. In the last eight months or thereabouts he has declined to take his one hour of allocated outdoor exercise, and his complaint with regard to the exercise options available to him is one of the two complaints which has lead to his hunger strike.

10. The defendant receives no family visits as all his extended family live in the UK, and he says on affidavit that he does not make or receive phone calls or letters to or from any family members. He does not mix with any prisoners, and he has no friends or companions

or any personal or social support in the prison, apart from one nurse with whom he has established a rapport and whose support he has found helpful, and some prison officers, one of whom accompanied him to the hearing.

11. Two of his siblings and his mother all died in the last year and he says on affidavit that the fact that he could not go to their funerals was "very difficult to cope with". He expresses the result of his limited, social interaction as follows: "At times, my restricted regime is very difficult to cope with and I turn to self harm out of frustration."

The hunger strike
12. On the 8th February, 2015, the defendant commenced a hunger strike. He said that at first he simply refused food, but that on the 20th February, 2015, he informed prison staff that he was on hunger strike and this fact was officially recorded. He has taken fluids, initially tea and coffee as well as water, but he has now restricted himself to water as his failing physical state is not tolerating the stimulant effect of either tea or coffee.

13. His hunger strike is expressed by him as his protest against prison conditions. He had previously threatened a hunger strike in February 2011 when he was still in detention in Cloverhill Prison, and he conducted a so-called "dirty protest" in that prison in February 2011. This hunger strike is the first serious and lengthy protest in which Mr. McD has engaged and the inevitable consequence of this protest is that his death is fast becoming imminent.

14. Mr. McD himself made a formal complaint to the prison Governor on the standard compliant form, one on the 9th February, 2015, and the other on the 10th February, 2015. The first refers to a conversation he had with the Governor who asked him to commit his complaint to writing in the formal designated way. The second of these complaints contained written details Mr. McD's concerns.

15. His solicitor then communicated his complaint in a letter of the 13th March, 2015. His complaints as so articulated, and confirmed in his own affidavit and oral evidence before me, are as follows:

16. First, he objects to revised arrangements which were put in place some seven or eight months ago to allow him to take one hour of recreation per day. He previously took his exercise in the period between 1pm and 2pm when other prisoners were locked in their cells. He says that he found the time when he was able exercise quietly on his own "a particularly enjoyable time for me to exercise as prisoners could not assault or abuse me in any way". He says that if he took his exercise at any other time he was subjected to verbal abuse, and more especially and troubling to him, he was assaulted by other prisoners throwing things down on him from places such as the school and the gym, and he in particular noted a suspicion that liquid that was being thrown at him was urine. He said he found these experiences "extremely intimidating and stressful and they caused me to self harm". The exercise time and place was changed some eight months ago as the prison was unable to facilitate his exercise between 1pm and 2pm "due to staffing levels". He was offered recreation in another part of the prison, in a so-called "protection yard" but this is a totally covered area into which sunlight does not penetrate. The option to exercise in the CPU yard was also offered, but was unacceptable to Mr. McD as he believed it was used by prisoners who were violent. The evidence from the Governor is that it is not possible with current staffing levels to facilitate his exercise during the period when prisoners are locked up, and Mr. McD, has as a result for some eight months, been confined to his cell for 24 hours a day.

17. His other complaint relates to the way in which his food is delivered to him. Until some eight or nine months ago "kitchen officers" used to serve food in the unit of the prison where he is currently detained.

18. It seems that due to either financial restraints or a form of industrial action the kitchen officers no longer serve food in that part of the prison, and the food is served by other prisoners. Mr. McD expresses a fear of having his food served by persons who have been abusive to him, and he is in particular fearful that they wish to spit or put traces of their blood in his food with a view to contaminating him with HIV, Hepatitis C or some other infectious disease. He describes this as "a very real and pressing concern for him", and notes in particular the fact that his ability to fight infection has been impaired by the removal of his spleen when he was a child.

19. He says that once the new food delivery regime was put in place he refused all food except Wheatabix, and that was the only food he was eating until he commenced his hunger strike on the 8th February, 2015. He says that the plaintiff did not come up with "any meaningful proposal regarding the service of food to me", and in particular says that the willingness on the part of the prison to seal his food in sealed containers would not allay his fears as those containers would be easily identifiable. He also feels that having regard to the various surface wounds and bandages on his person as a result of his frequent self-harming activities that it is not hygienic for him to serve his own food from a food trolley.

20. Mr. McD was taken to the A&E department in the Mater Hospital on the 12th March, 2015, having developed an infection that required the administration of intravenous antibiotics. After 20 hours in A&E, when he was handcuffed to a chair in the unit, he asked to be returned to his cell which was duly done. In the time when he was waiting in A&E he met Dr. Mohan briefly, and Dr Mohan's evidence was before me both on affidavit and by way of oral evidence on Monday 30th March, 2015. His solicitor indicates that Mr. McD then wished to return to hospital but wanted to be admitted quickly.

21. The Governor of the prison responded within two days of the date of the letter from Mr. McD's solicitor setting out his position and explaining that Mr. McD could not be provided with his daily exercise at the times he sought due to "resource constraints and the demand on a finite number of kitchen staff".

22. Mr. McD remains on hunger strike, and he now takes small daily amounts of water, and while initially his physical state was quite robust and he lost a relatively small amount of weight in the first few weeks of his hunger strike, his health has deteriorated quite rapidly in the last few days.

The proceedings
23. A plenary summons was issued on the 16th February, 2013, and a motion grounded on affidavit on the 18th March, 2015, returnable before me on the 25th March, 2015. At that stage the evidence which was available was the grounding affidavit of Brian Murphy, the Governor of the prison, the affidavit of Enda Kelly, the nurse manager which exhibited a short report from Dr. Damian Mohan, consultant forensic psychiatrist at the Central Mental Hospital, and an affidavit of Grainne O'Mahony. The matter was heard on affidavit on that day, and counsel offered and I accepted that they would furnish written legal submissions and address me more fully on the law on Friday, the 27th March, 2015 and the case was adjourned for that purpose. On the return date an affidavit of Suzanne O'Kennedy, solicitor from the Chief State Solicitor's Office was available and that exhibited a longer medical report of Dr. Mohan, to which he had annexed a number of other reports. There was also available at the first hearing before me the affidavit of Mr. McD himself to which he exhibited a long report of Professor Brendan Kelly, associate clinical professor of psychiatry and consultant psychiatrist at the Mater Misericordiae University Hospital, Dublin. By the return date Professor Kelly had updated his

report and had dealt with some of the questions that I had raised in the course of the first hearing. Aine Flynn, Mr. McD's solicitor also swore an affidavit in which she reported a meeting with Mr. McD the previous evening, Thursday the 26th March, at the medical unit in X Prison and where she described him as appearing "considerably weaker and more despondent than when I last saw him", only two days previously, although she took the view that he was "still lucid". He also appeared at that stage to have decided that he would not attend at hospital even if he was assured of being admitted quickly, and I was told during the course of the hearing on Friday that a bed had been made available for Mr. McD, which he had refused to take. He said directly to Ms. Flynn, "What's the point in prolonging my life? It's not good." He refused to give permission to the prison staff to contact his sister, his next-of-kin, or any other members of his family and he felt there was nothing more to talk about with the Governor and he did not intend to see him again. He also said to Ms. Flynn, "I am done with it all."

24. Mr. McD's position on medical intervention seems to have hardened considerably between Wednesday 25th March and Thursday 26th March and he refused even with the intervention of Ms. Moore, the nurse in whom he had confidence and who had been good to him, to have any tests done or to attend at hospital. He self-described himself as more entrenched in his position. He also made the following comment to her, "I am ready to stop drinking water. I am ready to throw in the towel and go into a coma because no one cares."

25. Ms. Flynn urged Mr. McD to reconsider his hunger strike and expressed in her affidavit a concern that his physical condition had deteriorated and that his mental state was such that he "had now given up all hope for the future". She also makes the following comment which is echoed in the reports of the doctors who have evidence on affidavit and before me, "I believe he is engaged in a protest in which he is prepared to die but that he does not want to end his life".

The form of the proceedings
26. Counsel for the defendant argued that the matter could not be dealt with on affidavit and that the matter required oral evidence and the opportunity to cross-examine. Some argument was also had at the initial stage of the interlocutory application before me as to whether the High Court had any jurisdiction to make a declaration with regard to the validity of the stated choice of Mr. McD to refuse food, and whether the issues raised by the plaintiff in the proceedings are proper matters for judicial consideration. Accordingly, the first question I must decide is whether this is a matter that is properly brought by interlocutory application, and the second is whether the matter is one within the jurisdiction of the High Court.

Plenary hearing
27. The relief sought in the notice of motion echoes that in the six paragraph plenary summons. The plaintiff as the Governor of X Prison claims for the following:-

> 1) A declaration pursuant to the inherent jurisdiction of the court as to the defendant's capacity to make a decision to refuse all forms of medical assistance should the necessity of such assistance arise.
>
> 2) A declaration pursuant to the inherent jurisdiction of the court that the defendant's decision dated the 20th February, 2015 [the date on which his decision to refuse food was notified to the prison] to refuse such medical assistance is valid and should remain operative in the event that the defendant becomes incapable of making a decision or whether to accept such treatment.
>
> 3) A declaration pursuant to the inherent jurisdiction of the court that the plaintiff's decision not to feed the defendant contrary to his wishes, i.e. to force-feed him is lawful.
>
> 4) A declaration pursuant to the inherent jurisdiction of the court that the plaintiff is entitled to give effect to the defendant's wishes not to be fed and not to receive medical assistance.
>
> 5) In the alternative, directions pursuant to the inherent jurisdiction of the court as to the appropriate course of action for the plaintiff to take in the event that emergency care for the defendant is required.

28. The plaintiff seeks declarations that the hunger strike action now being taken by the defendant was one voluntarily undertaken by him and in circumstances where he had full capacity to understand the nature, quality and consequence of his actions. It is clear that the inevitable consequence of his action is that he will fall into unconsciousness and at that time be incapable of reversing his decision, and that he will lose his life. The plaintiff and the other healthcare professionals who now care for the defendant, and who may come to care for him in the future, seek declarations to assist them in how they approach Mr. McD's present circumstances and the circumstances that will inevitably flow from his actions. The assistance of the court is also sought with a view to clarifying whether the prison has an obligation to engage in some type of force-feeding to prevent the death of Mr. McD.

29. The defendant has raised certain questions as to the jurisdiction of the court and says that the test of capacity is ultimately one for the court, and not the medical experts.

30. I accept as a matter of first principle that the plaintiff is entitled to seek guidance from the court and in particular that the court would adjudicate as to the capacity of Mr. McD to make the decision that he now makes to refuse food, and to consider what, if any, assistance or treatment should be given to Mr. McD should he fall into unconsciousness or become weaker or if his cognitive abilities come to falter. I will deal more fully with the question of jurisdiction below.

31. However, it seems to me that the first relief sought is the only form of relief which I might properly give on an interlocutory basis, and that it is possible for me having read the affidavit evidence and having heard the submissions of counsel, to come to a finding on the present capacity of Mr. McD to refuse both food and any form of ancillary feeding or medical intervention. The difficulty with that approach is that Mr. McD's physical state is deteriorating rapidly and this came into stark relief in the two days between the first hearing on Wednesday 25th March, 2015, and the resumed hearing on the 27th March, and to that extent it seems to me that the order that might usefully be made ought to guide not just the now current circumstances but also those that are likely to prevail in the future, possibly in the near future, that I need to engage fully with the facts. For that purpose oral evidence is necessary. I say that for a number of reasons.

32. First, it seems to me, and I will return more fully to the question below, that the test of capacity is a legal test, and that while there is no dispute between the psychiatrists who have furnished extensive and helpful reports to me, that the test is one that must apply by reason of my analysis of those facts, and ideally by the consideration of the defendant's own evidence, which was available on affidavit and in two short letters that he has written directly to me and which were made available to counsel on both sides.

33. Second, the test of whether a person has capacity to make a decision must of course depend on the nature of the decision, and

the gravity and complexity of the consequence of such a decision. Birmingham J. in *X.Y., A Minor v. H.S.E.* [2013] 1 I.L.R.M. 305 made a distinction, which I adopt, between a decision to consent to recommended treatment and the decision to refuse such treatment. The latter type of decision involves a high degree of understanding and a clearly stated wish, and for the court to assess the quality of the decision it is required that oral evidence be heard and tested as necessary.

34. Third, the case law would suggest oral evidence would normally be required. For example, in *re a Ward of Court (withholding medical treatment)(No. 2)* [1996] 2 I.R. 79 Lynch J., in the High Court, heard oral evidence from the family of the ward, and the doctors and nursing staff who treated her and had observed her condition and lack of responses or any responsive engagement with any of them or with the world around her. Those proceedings initially came on by way of a notice of motion brought by the mother and committee of the ward. Lynch J. directed the exchange of points of claim and defence and heard oral evidence on four consecutive days from medical and nursing practitioners, the family of the ward and from moral theologians.

35. Similar directions were given by Kearns P. before the Divisional Court of the High Court in the case of *P.P. v. HSE* [2014] IEHC 622 which gave its judgment on the 26th December, 2014, in the case of a pregnant woman who had suffered a catastrophic brain event and who was in medical terms dead. That application was for directions as to the treatment, if any, that should be afforded to a young woman having regard to the fact that she was pregnant and in the context of the constitutional imperative in Article 40.3.3.

36. Abbott J. gave an *ex parte* order on oral evidence in the case of *Fitzpatrick v. F.K.* [2009] 2 I.R. 7, where the first defendant had given birth to a baby and shortly afterwards suffered a massive haemorrhage. The application came before the court in the context of the refusal of the mother, who was a Jehovah's Witness, to accept a blood transfusion. Abbott J. authorised the hospital to infuse the mother. That matter ultimately came to be heard over 37 days in the High Court by Laffoy J. who heard extensive oral evidence, although by the time that case came on for hearing the mother and her child, then aged almost 18 months, were thriving. Laffoy J. considered that on an objective appraisal of the basis on which Abbott J. had made an order *ex parte* the only reasonable inference was that he was not basing his decision on any concern as to the capacity of the mother to make a valid refusal. On the contrary, he was overriding her decision in the interests of the rights of her newly born infant to a family life. I consider it to be implicit in Laffoy J.'s analysis that she regarded the question of capacity to be one that would have required, save in the most extraordinary and urgent of circumstances, that the court engage upon a full hearing of plenary proceedings.

37. I concluded accordingly that the appropriate means by which this matter ought to be determined was on plenary hearing, and I accepted for that purpose that the questions set out in the written legal submissions furnished by counsel formed the basis of the statement of claim or a statement of issues, and of defence. It is fair to say, and the legal representatives of each side are to be commended, that there was no unnecessarily adversarial approach taken in this case, and the legal advisors co-operated in achieving a consensus as to the issues before the Court.

38. I will first outline the Prison Rules 2007 and then turn to consider the second preliminary issue, that of jurisdiction. It will be clear that the Prison Rules themselves mandate that the wishes of a prisoner on hunger strike be respected, but I consider that the Rules do not direct the result of the enquiry before me, and the Governor is justified in seeking the assistance of the Court on the question of the applicability of the Rules to the issues in hand.

The Prison Rules 2007

39. Rule 75(8) requires the Governor of a Prison to "efficient and appropriate delivery of healthcare services" within a prison. Rule 100(1)(g) of the Rules provides that a healthcare professional may:-

> *"only administer treatment to a prisoner or conduct any tests on a prisoner with the consent of that prisoner except in the case of treatment or a test required by or under these Rules, any statute, or by order of a court."*

40. The Irish Prison Service has developed a protocol on food refusal and this prohibits the force-feeding of prisoners of full capacity who refuse nourishment. The World Medical Association in October 1975 adopted guidelines known as "The Tokyo Guidelines" during its 29th General Assembly and these guidelines provide some assistance to understand the medical context and clause 6 provides as follows:-

> *"Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner."*

Jurisdiction of the High Court: vulnerable adult?

41. Counsel for the defendant made the point that Mr. McD was arguably a vulnerable adult and I was referred to the judgment of Munby J. in *Re S.A. (Vulnerable Adult with Capacity: Marriage)* [2005] E.W.H.C. 2942 (Fam.) where he analysed the extent of the inherent jurisdiction of the court to protect vulnerable adults and make orders protective of their interests. In particular I note the three interconnected categories of vulnerable of persons that Munby J. identified which he briefly identified as follows:-

> *"…the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of a capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent"*

42. The third category identified by Munby J. is class of catch-all which identifies a broad rang of circumstances, including where a person's understanding and reasoning power might be affected by:-

> *"deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others."*

43. To an extent the powers of self-determination of Mr. McD are already constrained by his incarceration, and by the deprivation of liberty which has lawfully resulted from his conviction and sentence. His powers of self-determination are of course further constrained, perhaps to a greater extent than is apparent in the case of other inmates of X, by the fact that his isolation and lack of interpersonal support, albeit freely chosen, arise from his complaints about how his isolation is to be managed.

44. I consider that the High Court has an inherent jurisdiction to protect and vindicate Mr. McD's constitutional and common law

rights, those under international law and arising under the European Convention on Human Rights and the Human Rights Act of 1998, and that inherent jurisdiction of course arises under Article 34.3.1 of the Constitution, but also by reason of the imperative on the High Court to protect the rights of all citizens, whether those citizens be to a greater or lesser extent vulnerable either as a result of passing circumstances, arising from their inherent characteristics or from conditions imposed upon them. I am of the view that Mr. McD is to some extent a vulnerable adult, and that in that context the Court is entitled to engage in an enquiry as to whether he has freely given consent to refuse food and other medical treatment, and whether his consent is intended by him to operate in the conditions that will arise from the inevitable and natural consequence of his refusal of food when he falls into unconsciousness, suffers renal failure and moves towards his death.

45. I accept that counsel for the defendant has said that all adults are presumed to have capacity, but even adults with capacity may invoke the jurisdiction of the court in the protection of their constitutional and other rights, and equally it seems to me that the Prison Governor who has ultimate responsibility for the care and well-being of Mr. McD is entitled to invoke the jurisdiction of the court for that purpose, and to clarify his obligations in the furtherance of his responsibility.

46. I turn now to consider the law on capacity to consent to medical treatment or to refuse treatment.

The legal test of capacity
47. Following the decision of the Supreme Court in *re a Ward of Court (withholding medical treatment) (No. 2)* it is clear that the law in Ireland is that a competent adult is free to decline medical treatment. This is a necessary corollary of the right of an adult person with full capacity to accept medical treatment, and Denham J. in that case pointed to the fact that giving medical treatment without consent may be a trespass against the person in the civil law, a battery in criminal law, or a breach of that person's constitutional rights. Denham J. said there could be exceptions to this right in an individual case where there was a medical emergency, or where the person had a contagious disease which might affect those with whom he or she might come in contact with. The right can, in other words, in some instances be tempered by the rights of others.

48. The right to life is of course the pre-eminent personal right respected by Article 40.3 of the Constitution and one which is legal terms is absolute and in respect of which the State and its organs have an obligation to act positively to protect. Denham J. at p. 160 of the judgment in *re a Ward of Court (withholding medical treatment) (No. 2)* stated as follows:-

> *"The State's respect for the life of the individual encompasses the right of the individual to, for example, refuse a blood transfusion for religious reasons. In the recognition of the individual's autonomy, life is respected."*

49. This suggests that the autonomy to choose medical treatment is one which derives from the right to life, and the State's duty to protect that right to life also includes a duty to respect decisions autonomously. The import of this will be considered more fully below.

50. Laffoy J. considered and followed various English decisions in *Fitzpatrick v. F.K.*, including In *re T (Adult: refusal of medical treatment)* [1993] Fam. 95 where Lord Donaldson M.R. stated at p.102:-

> *"An adult patient who, like Miss T., suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered".*

51. As Laffoy J. said the first principles as so enunciated by Lord Donaldson mirror those contained in the dicta of the Supreme Court in *re a Ward of Court (withholding medical treatment) (No. 2).* She accepted that there is a presumption in favour of capacity and pointed to the fact that in testing capacity in any individual case, "*the evidence should be clear and convincing having regard to the matter for decision*", per Hamilton C.J in *re a Ward of Court (withholding medical treatment) (No. 2),* p. 127.

52. However, it is clear, and it seems to me that it must be clear as a matter of law, that while an adult person might be presumed to have capacity, and while that presumption is rebuttable, such that the person who does have capacity may be deprived of capacity by many factors including temporary factors, that certain circumstances may give rise to cases of reduced capacity and in particular I consider the following statement taken from a list of eight propositions contained in the judgment of Lord Donaldson to be particularly apposite in this case at p.116:-

> *"In all cases doctors will need to consider the true scope and basis of the refusal. Was it intended to apply in the circumstances which have arisen? Was it based upon assumptions which in the event have not been realised? A refusal is only effective within its true scope and is vitiated if it is based upon false assumptions."*

53. The question of capacity to decide of course is inter-linked with the question of the information available to the decision-maker. I adopt the comments of Laffoy J. in *Fitzpatrick v. F.K.* as follows at para. 60:-

> *"What the law, as set out in In re C. (Adult: refusal of medical treatment) [1994] 1 W.L.R. 290, requires is that the patient be given the relevant information about his or her condition, the proposed treatment, any alternative treatment available and the likely outcome of adopting such options as are open to the patient…. If the patient is not given the relevant information or, alternatively, fails to assimilate it and believe it, the first two elements of the…test are not fulfilled. If the patient does assimilate and believe the information but nonetheless rejects the treatment on the basis of a religious conviction, for example, adherence to a scriptural proscription on accepting the treatment, he or she has passed the…test as to capacity notwithstanding that the doctor and non-believers may consider the basis of his or her refusal to be wholly irrational. Article 44, which protects the patient's religious belief, requires that, as does the recognition at common law of his right to self determination."*

54. Laffoy J. also quoted at para. 62 with approval the guidance by Dame Butler-Sloss P. in In *re B. (Consent to Treatment: Capacity)* [2002] E.W.H.C. 429 (Fam):-

> *"If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision."*

55. It is important in that context also to recognise that certain decisions may be competently given even though the stated reason for the decision is, on any reading, irrational. Charles J. in *XNHS Trust v T (Adult Patient: Refusal of Medical Treatment)* [2004] EWHC 1279 (Fam.) at p.437. considered the meaning of irrationality in that context as follows:-

> *"Irrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it… Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence but they may be symptoms or evidence of incompetence. The graver the consequences of the decision, the commensurately greater the level of competence is required to take the decision".*

56. I consider the six principles explained by Laffoy J. in *Fitzpatrick v. F.K.* at para. 84 as those applicable to the determination of capacity to be a correct statement of the law in Ireland and I set them out in full as they are central to my deliberations:-

> *"On the basis of the foregoing analysis of the authorities from other jurisdictions and having regard to the constitutional framework within which the capacity question must be determined in this jurisdiction, it seems to me that the relevant principles applicable to the determination of the capacity question are 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 that presumption can be rebutted.*
>
> *(2) 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. (Adult: refusal of medical treatment) [1993] Fam. 95,*
>
> *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.*
>
> *(3) The three stage approach to the patient's decision making process adopted in In re C. (Adult: refusal of medical treatment) [1994] 1 W.L.R. 290 is a helpful tool in applying that test. The patient's cognitive ability will have been impaired to the extent that he or she is incapable of making the decision to refuse the proffered treatment if the patient-*
>
> > *(a) has not comprehended and retained the treatment information and, in particular, has not assimilated the information as to the consequences likely to ensue from not accepting the treatment,*
> >
> > *(b) has not believed the treatment information and, in particular, if it is the case that not accepting the treatment is likely to result in the patient's death, has not believed that outcome is likely, and*
> >
> > *(c) has not weighed the treatment information, in particular, the alternative choices and the likely outcomes, in the balance in arriving at the decision.*
>
> *(4) The treatment information by reference to which the patient's capacity is to be assessed is the information which the clinician is under a duty to impart - information as to what is the appropriate treatment, that is to say, what treatment is medically indicated, at the time of the decision and the risks and consequences likely to flow from the choices available to the patient in making the decision.*
>
> *(5) In assessing capacity it is necessary to distinguish between misunderstanding or misperception of the treatment information in the decision making process (which may sometimes be referred to colloquially as irrationality), on the one hand, and an irrational decision or a decision made for irrational reasons, on the other. The former may be evidence of lack of capacity. The latter is irrelevant to the assessment.*
>
> *(6) In assessing capacity, whether at the bedside in a high dependency unit or in court, the assessment must have regard to the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of the proffered treatment. In the private law context this means that, in applying the civil law standard of proof, the weight to be attached to the evidence should have regard to the gravity of the decision, whether that is characterised as the necessity for 'clear and convincing proof' or an enjoinder that the court 'should not draw its conclusions lightly'."*

Conclusion on the test for capacity

57. I adopt the detailed and considered analysis of Laffoy J. in *Fitzpatrick v. F.K* and her statement of the applicable law with regard to the test of capacity. The most important principles which may be drawn from her analysis is that the question of capacity is a question of fact, and one which the law must assess in the context of the gravity of the decision. If a person understands fully the consequences of a decision, both in positive terms, in that the person understands the likely consequence of the decision communicated, and in negative terms in that the person understands the consequences of not making a decision in those terms, and where the consequence is of a high degree of seriousness or gravity, which undoubtedly the decision now communicated by Mr. McD has, the court must be satisfied that the evidence before it is "cogent, clear and convincing" and as Laffoy J. stated the court should not "*draw its conclusions lightly*". This has the consequence, it seems to me, that the court must assess the evidence in the light of the seriousness of the decision, taking into account, not just that Mr. McD's decision is to refuse food, but also in assessing whether he has understood fully the options available to him, the consequence of his decision to refuse food, and of the options available to

him which might have a different outcome.

The evidence
58. A number of medical reports were made available to me on the first day of the hearing on Wednesday 25th March and further reports on Friday 27th March. I summarise now the contents of these reports.

59. Mr. McD was assessed by Dr. Mohan, a forensic psychiatrist employed by the plaintiff on the 12th March, 2015. Dr. Mohan gave a very short report that date in which he stated the following:-

> "I am satisfied that he has the requisite capacity to understand the consequence of his food refusal. He understands that he is at high risk of going into renal-failure and ultimately death, as a result of his actions. Mr. McD when asked about his motivation for refusing food cited two reasons: Firstly, he had an issue with access to the exercise yard. Secondly he objects to other prisoners serving him food.
>
> I advised Mr. McD that prolonged refusal of food will result in him becoming disorientated. His judgment will be come impaired. I further advised him that we have a duty to protect his life and that this may involve force feeding. In response Mr. McD was resolute in his determination to continue his food refusal and he did not give us consent for any medical intervention."

60. I pause here to note that Dr. Mohan confirmed that Mr. McD did not suffer from a mental disorder as defined by the Mental Health Act 2001, or the Criminal Law Insanity Act 2006, and there is no doubt that this is legally correct, and while Mr. McD does suffer from a personality disorder, the nature and effects of which I will consider below, the legislation is clear in excluding from the definition of a person with a mental illness any person who has a personality disorder. I merely note this in passing and the fact that Mr. McD does not suffer from any condition which would characterise him as being mentally ill under the legislation does not mean that he has capacity to consent to the decisions, the subject matter of these proceedings.

61. I also pause to note that Mr. McD in his affidavit sworn on the 24th March, 2015, suggests that Dr. Mohan spoke to him for about 30 seconds, and as Dr. Mohan saw Mr. McD while he was in the A&E department of the Mater Hospital on that day, and it would seem probable in those circumstances that Dr. Mohan did not have an opportunity to engage in any great detail with Mr. McD's history or then current psychological state. Dr. Mohan however prepared a later psychiatric report of the 23rd March, 2015, which considered Mr. McD's personal and medical history and he annexed a long and detailed psychiatric report prepared by Dr. Darren Flynn, a registrar in forensic psychiatrist at the Central Mental Hospital, Dundrum and a visiting psychiatrist at Cloverhill Prison dated the 8th February, 2011, and a report of the 10th August, 2012, from Professor Harry Kennedy, consultant forensic psychiatrist at the Central Mental Hospital. It is fair to point out that Dr. Mohan did not have the opportunity to assess the current mental state of Mr. McD and that Mr. McD did not engage with him. I make no criticism of Dr. Mohan and I find the appendices annexed to his report, and his oral evidence, very informative, but Dr. Mohan's evidence of itself is not sufficient to enable me to engage in the degree of scrutiny required to fully assess Mr. McD's mental state.

62. Dr. Mohan diagnosed Mr. McD as suffering from "anti-social personality traits", and that he demonstrates "a very low tolerance for frustration and a low tolerance for discharge of aggression, including violence". He confirms that Mr. McD's refusal to take food is "unrelated to any mental disorder or impairment" and repeats his assertion that Mr. McD has the "requisite capacity to understand the implications of his food refusal", and that he understands the inevitable consequence of his actions. Dr. Mohan takes the view that Mr. McD's behaviours are "consistent with malingering, and are designed about a primary gain" namely to "negotiate the terms of his sentence".

63. The reports from Dr. Flynn which were prepared more than four years ago, did recommend that Mr. McD engage with psychological counselling services, but confirmed Mr. McD was not suffering from a mental disorder. It is to be noted that his report was prepared for the purposes of assessing whether Mr. McD was fit to be tried on the charges with which he was ultimately convicted and sentenced.

64. Professor Kennedy's report of August, 2012 confirms that he did not illicit "any abnormality of the possession of thought" and that Mr. McD did not suffer from any "ideas of reference, persecutory ideation or delusions", and confirmed that he was egocentric, but did not suffer from any mental illness or mental disorder. He recommended a cognitive approach to psychological treatment.

65. The most useful evidence was the evidence of Mr. McD's own choice of physician, Professor Brendan Kelly. Professor Kelly had a consultation with Mr. McD in prison on the 18th March, 2015 and his assessment was made specifically in the context of the hunger strike in which Mr. McD has been engaged. Professor Kelly described him as "clear in his thinking" and who found no evidence of formal thought disorder, "He is clear that he wishes to be alive and will abandon his hunger strike if his complaints are addressed to his satisfaction"

66. Professor Kelly found Mr. McD's cognition to be "grossly intact", and that he was normal in orientation, time, place and person, that his long and short term memory appeared intact and his concentration was good. With regard to Mr. McD's insight into his condition Professor Kelly stated the following: "Mr. McD has good insight into his position, and understands the potentially fatal consequences of his hunger strike."

67. Professor Kelly answered four questions and concluded as follows:-

(a) That Mr. McD was not suffering from a mental illness

(b) That he did have legal capacity to make decisions regarding his own welfare and that the decision to refuse food was being taken on the basis of full legal capacity. He noted that Mr. McD did not wish to die, and that he understood the alternative courses of action, could weigh up the advantages and disadvantages of those alternative causes of action, could reach a decision and could communicate this decision clearly. Professor Kelly stated the following: -

> "In summary, Mr. McD can understand the relevant information, retain it, use and weight it up to make his decision, and communicate his decision. Therefore Mr. McD currently has mental capacity to make decisions regarding his hunger strike and either continuing or ending it. He is clear that he will eat if he can reach agreement with the prison authorities in relation to the two issues he highlights, relating to exercise yard and distribution of food at meal times."

(c) That the conditions under which Mr. McD had been voluntarily detained had an effect on his mental state, and that the fact that he had not been having an hour of daily exercise had "adversely affected him". Professor Kelly pointed to the fact, noted in

considerable detail by Cregan J. in his judgment in *McDonnell v. Governor of Wheatfield Prison* [2015] IEHC 112 that solitary confinement is associated with substantive adverse affects. I pause here to note that Cregan J. had noted that such effects could include "*anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis and self-harm*".

(d) That Mr. McD would benefit from treatment. Professor Kelly confirmed that Mr. McD did not have a mental illness or mental disorder but that his psychological wellbeing would be improved if he resumed eating, accepted medical care and an agreement could be reached between Mr. McD and the prison authorities about his exercise time so that he was no longer in his cell for 24 hours a day.

68. Professor Kelly stressed the urgency of the matter and the view that he could be persuaded to return to hospital. In the events it transpired that Mr. McD refused to attend hospital even when a bed was found for him after the first hearing before me. Professor Kelly stressed the obvious point that while Mr. McD had mental capacity when he examined him, that the hunger strike would likely adversely affect that capacity in the near future.

69. In the course of the first hearing before me I raised a number of questions particularly in regard to certain matters that had emerged from Mr. McD's own affidavit evidence, namely the fact that he had been in isolation and had had no interpersonal contact for almost four years, that he was suffering from grief reaction as a result of the recent death of three close family members, that he had no interpersonal support or connection with any family member who might have offered him comfort or support. I also expressed some disquiet as to a clear diagnosis of borderline personality disorder in the reports that were before me on the first day of hearing, and whether this psychological condition, while it was not one within the definition of mental illness legally or medically, might impair his cognition. Professor Kelly prepared a supplemental report on the 26th March, 2015, and answered each of these questions. His answers are important and I now review these.

The first issue: the effect of solitary confinement on Mr. McD
70. Professor Kelly pointed to the fact that, overall, solitary confinement is associated with adverse psychological consequences and said the following:-

> "It is inevitable that the very low number of variables in Mr. McD's day to day life in 23 hour solitary confinement is relevant to the high level of salience he accords to specific matters, such as his exercise and meal time arrangements. More specially, as Mr. McD is fully aware of the fatal consequences of his hunger strike, he has de facto, accorded the issue of his exercise and meal time arrangements a single "life-or-death" level of salience, which it is highly unlikely he would have accorded them if there were more variables potentially subject to change in his day to day life."

71. Mr. McD in common parlance had become somewhat obsessed with the two matters in respect of which he was conducting his protest, and he had lost a degree of perspective. Professor Kelly took the view that the high level of salience which Mr. McD afforded to the two areas of which he complained did not mean that he lacked mental capacity. Professor Kelly accepted that Mr. McD's response was appropriate:-

> "This is an entirely human response to the situation in which he finds himself which is a highly constricted one in which specific matters assume high levels of salience which they would not otherwise assume in different situations or circumstances."

72. Notwithstanding this degree of focus Professor Kelly was of the view that Mr. McD remained capable of making the decisions he had made.

The second issue: The effect of personality disorder on his decision-making
73. Mr. McD suffers from a borderline personality disorder, a type of personality disorder characterised by maladaptive behaviour, instability in interpersonal relationships, and poor self image. Persons with this type of specific personality disorder are impulsive and often self-harm. Professor Kelly, while noting that personality disorder was not a mental illness, made the following comment:-

> "Notwithstanding this fact, it is noteworthy that an individual's personality undoubtedly has an influence and decision making, and that personality disorder is typically characterised by enduring maladaptive passions of behaviour, cognition and inner experience.
>
> In this light, it appears unlikely that Mr. McD's personality disorder is entirely unrelated to his decisions but any matter including his decision to go on hunger strike – a decision which might well be regarded as maladaptive and thus consistent with the core feature of personality disorder. It is also not unreasonable to imagine that Mr. McD's personality disorder may be linked to a lack of flexibility in his decisional style and may thus affect his pattern of decision making in relation to this and other matters."

74. Professor Kelly took the view however that this did not mean that Mr. McD's mental capacity was impaired. He says rather that Mr. McD's personality type means that his decisions are often firmly, and perhaps even stubbornly, held, that he is inflexible in his decisional style, and that this inflexibility may result in him making decisions which might to an outsider seem "maladaptive", but which are consistent with his own personality type.

The third issue: The effects of bereavement
75. Professor Kelly makes the not unexpected point that decision-making can be affected by emotions, including powerful emotions such as grief. He took the view however that Mr. McD did not suffer from an abnormal grief reaction and did not believe that Mr. McD's capacity was impaired by the strong emotions he was experiencing.

The fourth issue: The effect of likely physical deterioration on decision-making
76. Mr. McD's hunger strike is undoubtedly affecting his physical state. He has lost relatively little weight, only some five kilos, in the first seven weeks of his hunger strike and he continued to take liquids. Professor Kelly points to the fact, again not unexpected, that along with deterioration in his physical capacity, Mr. McD's mental capacity will deteriorate in parallel. His depleted physical state will result in a lack of capacity. Professor Kelly is of the view that this incapacity has not yet occurred.

77. I note that in this report again Professor Kelly made a number of recommendations and stressed the urgency of the situation, and noted in passing that there was one member of the nursing staff in X whom he trusted. He took the view that as a matter of urgency the possibility of a certain amount of care, perhaps through the trusted medium of the nurse in whom he had confidence and who had been good to him, might alleviate the problem.

Oral evidence
78. On Monday 30th March, 2015, I heard evidence from Mr. McD, who struck me as intelligent, expressive and sensitive to the position in which he found himself, respectful of the prison staff, albeit he believed that only some members of the prison staff were helpful to him, and respectful of the court. He said he was not biased against all staff in the prison and that he respected that it was, as he put it, "a two way street" between the prison staff and the prisoners.

79. He gave evidence of his complaints which he had already expressed in his affidavit, but one matter which became clear in the course of his oral evidence was his intense interest in personal hygiene, and how this was important to him in his daily life, arising principally because of the fact that he had suffered the loss of his spleen as a young boy, and because his family ethos had taught him that personal hygiene was important. He said that his fear of infection was on his mind at all times, and that he spent a large part of every day cleaning and keeping clean his cell. He said he was in fear of other prisoners, and that he felt as an outsider. He said he was frightened and that they regarded him as a "rat" because it was perceived that he had informed on them to the prison staff, particularly in the context of drug taking in prison.

80. Dr. Mohan and Professor Kelly also expressed a view, which fortified my impressions of Mr. McD, that he was intelligent, articulate and expressive, and that this was particularly remarkable in the context of his having had very little education as a boy.

81. Mr. McD said that he understood that the role of the court in this case is not to change or direct any change in his prison conditions.

82. He confirmed the choice that he had made to be on hunger strike, and to continue on hunger strike, and that he did not wish any medical or nutritional intervention. He said that he understood the consequences of his actions, and that they would inevitably lead to death, and he said that his choice was made in that context. He said he believed in God, and that he understood that this was the "the only life he had" but that he still chose to be on the path he was on, even if it meant the end of that life. He said he read widely and was interested in birds, trees and flowers, and that this interest had served him well in the almost 30 years he had spent in various prisons, and that he got solace in reading.

83. I heard oral evidence from Dr. Mohan who said he was "absolutely satisfied" that Mr. McD had no disorder of mind, and that any traits of borderline personality disorder from which he suffered "do not impair his capacity to make a judgment". He confirmed that he understood the consequences of his action and that this would inevitably lead to a shutdown of his physical system until death. He said that Mr. McD was acting rationally, that he was clear, and that he had thought out his choice, considered the alternatives and had made the choice directed towards a goal. He confirmed that he was not suicidal, and that Mr. McD did not wish to die. He accepted that it was somewhat contradictory that, on the one hand Mr. McD did not wish to die, but that on the other hand he had embarked on a path which would inevitably lead to his death, but he considered that this reinforced his view that Mr. McD understood the gravity of the choices made.

84. He took note of the contents of the complaint form submitted by Mr. McD to the Prison Governor and he believed that they were clear and reasoned, and while there did seem to be a disproportionate weight given to certain factors, that there was some logic in the complaints and that the responses were considered. He did not believe that he had any pathological obsession with cleanliness, and he pointed to the fact Mr. McD had engaged in a "dirty protest" and had removed the sutures from wounds from time to time which was not consistent with an obsessive compulsion towards cleanliness. He did say that Mr. McD's personal hygiene did suggest a degree of obsessiveness, but not one such as to preclude him from him taking a rational view of his current choices.

85. Dr. Mohan expressed a view that some of the concerns expressed by Mr. McD may indeed be legitimate, and as he put starkly "prison can be a dangerous place". He said that Mr. McD may well be at risk from other prisoners and to seek 24-hour lock-up and not to eat food served by other prisoners was a reflection of his wish for self-preservation. His disengagement from prison life arose from what was in his view a legitimate choice, and that his fears may be well-founded. He did say that it was possible but not probable that Mr. McD's food was being contaminated, but that his fear of other prisoners was real and not irrational. Put simply he said that his choice of isolation was legitimate, and his concerns for his own safety are well-founded.

86. Dr. Mohan expressed the view that the matters arising were matters not of psychological or psychiatric concern but of "prison management".

87. I also heard evidence from Professor Kelly who expressed an opinion that Mr. McD has full decision-making capacity, that he is aware of and understands the issues, the consequences of his actions, that he is in a position to weigh those consequences and to consider the alternatives and to reach a decision. His evidence was that a personality disorder can undermine a decision-making capacity and that this tends to be a lifelong condition. He pointed to the fact that there is a debate among psychiatrists as to whether a personality is a disorder as such, or an aspect of personality. In his view Mr. McD's personality was not affecting his capacity.

88. Professor Kelly helpfully described the decision-making process as complex, and not binary. Most of us rely on others to make decisions and sometimes decisions are made on facts that are not quite understood. He said that in truth the capacity to make decisions may fall in different parts of the spectrum, or "that there are shades of grey". He took the view that the Assisted Decision-Making Bill now before the Oireachtas attempts to reflect the reality of the tiered process.

89. He had a long interview with Mr. McD before he gave oral evidence, and that consultation was had in the relative comfort of a room in the Four Courts. His opinion was that Mr. McD had full capacity to decide in the matter at hand. He did say the variables in his life have been reduced by his isolation, and that has the effect that his decision-making landscape is also reduced. This does not in his view affect the capacity of Mr. McD to make decisions.

90. On Mr. McD's broad capacity, his view is that Mr. McD has a capacity to articulate those things he has lost by virtue of being in prison, and is likely to lose if he falls into unconsciousness and heads towards his death. He confirms Mr. McD does not wish to be dead.

91. He said he had discussed with Mr. McD the manner of his death and that it is unlikely to be peaceful or pain free. He said that while persons do not easily think of the manner of their death, circumstances have forced Mr. McD to consider and reflect on these, and that in his view he has understood them.

Conclusion on the evidence
92. Having heard the evidence and considered in particular the clearly expressed and articulate evidence of Mr. McD, I am of the view that he has the capacity to make the decision he has made to refuse food, and that the decision was made by him in the full

understanding of its consequences and of the alternatives, and that his decision-making capacity is not vitiated by any frailty arising from his current living conditions or from his personality traits.

93. I consider that Mr. McD has fully and freely chosen his path of hunger strike, and that his decision has been fully informed. I turn now to consider whether the Sate has an obligation to take steps to protect Mr. McD's life notwithstanding his stated and freely given choice.

The constitutional imperative and the question of respect for human rights

94. The sentence of imprisonment lawfully imposed upon Mr. McD has of course deprived him of his right to personal liberty, but it is not suggested, and cannot be suggested as a matter of law, that he has thereby lost all of his constitutional rights including the right of personal autonomy, and the right of bodily integrity. The law was very clearly and forcibly stated by Fennelly J. in *Creighton v. Ireland & Ors.* [2010] IESC 50:-

> *"Nonetheless, the prisoner may continue to exercise rights 'which do not depend on the continuance of his personal liberty…' I would say that among these rights is the right to personal autonomy and bodily integrity. Thus, it is common case that the state owes a duty to take reasonable care of the safety of prisoners detained in its prisons for the service of sentences lawfully imposed on them by the courts. This does not amount, however, to a guarantee that a prisoner will not be injured…"*

95. Edwards J. expressed the view, in *Devoy v. Governor of Portlaoise Prison & Ors.* [2009] IEHC 288, that a prisoner might have "*residual constitutional rights*", including the right to be "*treated humanely and with human dignity*."

96. A person has under the Constitution certain fundamental rights including the right to life, the right to personal autonomy, the right to bodily integrity, and the right to self-determination, the right to live one's life as one wishes provided those wishes do not impact upon or harm others, and provided no conflict arises between that individual right and the interests of society.

97. The court has an obligation to protect the sanctity of life but as is stated in the unanimous Supreme Court judgment given by Denham C.J. in *Fleming v. Ireland* [2013] IESC 19, the obligation of the court to protect life is not an absolute obligation and may in certain circumstances have to give way to a freely expressed decision of an adult competent to make a choice to renounce that right. Denham C.J. said:-

> *"It does not, however, necessarily follow that the State has an obligation to use all of the means at its disposal to seek to prevent a person in a position such as that of the appellant from bringing her own life to an end."*

98. The Divisional High Court in the case of *P.P. v. HSE* considered the question of "how far the Court should go in terms of trying to vindicate" the right to life. The Court quoted with approval the dicta of Denham J. in *re a Ward of Court (withholding medical treatment) (No. 2)* that while the State had an interest in preserving life, this interest is not absolute:-

> *"In respecting a person's death we are also respecting their life — giving to it sanctity. That concept of sanctity is an inclusive view which recognises that in our society persons, whether members of religion or not, all under the Constitution are protected by respect for human life. A view that life must be preserved at all costs does not sanctify life."*

The jurisprudence of the European Court of Human Rights

99. In *Nevmerzhitsky v. Ukraine* (2006) 43 EHRR 32 the Court noted that the Convention did not solve the conflict between an individual's right to physical integrity, which might involve a right to refuse food, and the State's positive obligation under Article 2 of the Convention to protect life. In *X. v. Germany* (1984) 7 EHRR 152 the Commission noted that under German law this conflict had been solved in that it was possible under German law to force-feed a detained prisoner, if this person, due to hunger strike, would be subject to injuries of a permanent character and that force-feeding in German law was sometimes obligatory if an obvious danger for the individual's life existed.

100. The Court in *Nevmerzhitsky v. Ukraine* stated the following:-

> *"The Court reiterates that a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. The same can be said about force-feeding that is aimed at saving the life of a particular detainee who consciously refuses to take food. The Convention organs must nevertheless satisfy themselves that the medical necessity has been convincingly shown to exist… Furthermore, the Court must ascertain that the procedural guarantees for the decision to force-feed are complied with."*

101. The applicant in *Nevmerzhitsky v. Ukraine* had gone on hunger strike on a number of occasions to protect his conditions in prison in Ukraine. The method by which he was force-fed was particularly objectionable in that it involved an amount of inhumane and forceful restraint. The state of Ukraine had also not established that the medical necessity for the force-feeding regime had been shown, and the Court held that there had been a violation of Article 3.

102. The position in European human rights law seems to be that there is no obligation under Article 3 to provide medical assistance to a person in detention against that person's will but that the giving of such assistance by force if necessary will not be in principle a breach of Article 3.

103. In the dilemma was expressed as follows:-

> *"The Court notes that in previous case-law the Commission held that the 'forced-feeding of a person does involve degrading elements which in certain circumstances may be regarded as prohibited by Article 3 of the Convention'. When, however, as in the present case, a detained person maintains a hunger strike this may inevitably lead to a conflict between an individual's right to physical integrity and the High Contracting Party's positive obligation under Article 2 of the Convention – a conflict which is not solved by the Convention itself'."*

104. The European Court of Human Rights has held that it is not in breach of the Convention to force-feed a prisoner, but that does not suggest that a breach is found if prison authorities ignore his stated wish not to be fed. One statement is expressed in the negative, that force-feeding is of itself a not violation of Convention rights, and the other in the positive, that the prison may fully respect Mr. McD's wish even if these wishes mean that he will die. I do not believe that it is possible to legally extrapolate from the

decisions of the European Court of Human Rights that force-feeding of itself is not a violation of the Convention rights of a prisoner, that not forcibly administering food or medicine is also a breach of those rights.

The case of Fleming v. Ireland

105. The Supreme Court in *Fleming v. Ireland* considered the very difficult question of whether the plaintiff was entitled to an order declaring that she was entitled to the benefit of assistance to end her life where she had found herself in a physical state of severe pain and disability as a result of advanced multiple sclerosis. The medical evidence was that there was no underlying mental illness or condition that affected her decision-making capacity. She expressed her unwillingness to live a life with what she perceived as little or no dignity, and in pain and isolation and unable to communicate. The Supreme Court held that there was not implied under the Constitution a positive right to commit suicide or to arrange for the termination of one's life at the time of one's choosing. The Court came to this conclusion having taken a view:-

> *"The concept of autonomy which extends not just to an entitlement, but to a positive right to terminate life and to have assistance in so doing, would necessarily imply a very extensive area of decision in relation to activity which is put, at least prima facie, beyond regulation by the State. When it is considered that recognition of such a right implies correlative duties on the State and others to defend and vindicate that right (and which must necessarily restrict those parties' freedom of action), it is apparent that the right contended for by the appellant would sweep very far indeed. It cannot properly be said that such an extensive right or rights is fundamental to the personal standing of the individual in question in the context of the social order envisaged by the Constitution. The right to life which the State is obliged to vindicate, is a right which implies that a citizen is living as a vital human component in the social, political and moral order posited by the Constitution…. In particular the protection of the right to life cannot necessarily or logically entail a right, which the State must also respect and vindicate, to terminate that life or have it terminated."*

106. The decision of the Supreme Court in *Fleming v. Ireland* must be seen in the context of the already established jurisprudence that an adult person with full cognitive capacity is entitled to refuse medical treatment, even if that refusal is likely to inevitably lead to that person's death. Thus it seems to me that while it could not be said that a person has a right to commit suicide, it can be said that he has a right to freely elect to refuse food, provided his choice is full, free and informed and he does not require assistance to achieve that end, and it is rather the case that he has refused such assistance. The distinction is between a positive right to directly end one's life, and to make choices which have the indirect effect that death follows. The latter right is constitutionally recognised as flowing from the autonomy of the self.

107. The question for me is whether the court ought to weigh the right of Mr. McD to self-determination against the obligation of the State to protect what is the most fundamental right of all, namely the right to life, and whether the High Court should interfere in the progress of Mr. McD's protest and order the Prison Service to administer to him such medicine and food therapy as is necessary to preserve that right.

108. I am mindful of, and adopt, the dicta of Denham J. in *Re a Ward of Court (withholding medical treatment) (No. 2)* that the right to life includes, and imports and carries with it, a right to die with dignity. That right was also considered as central to its deliberations by the Divisional Court in *P.P. v HSE*. I am satisfied that as a matter of law Mr. McD can elect to fully and freely continue his hunger strike, and that the plaintiff is fully respecting his rights by not administering food or medical treatment to him.

The English case law

109. Some assistance can be found from the English jurisprudence. Thorpe J. considered the question of the rights of a prisoner refusing food in *Secretary of State for the Home Department v. Robb [*1995] Fam.127. The adult prisoner in that case had begun to refuse all nutrition, and medical experts agreed that he was of sound mind and fully understood the consequence of his decision to refuse food and understood that death would result from his choice. The Home Secretary sought a declaration that the prison officers, and the medical staff at the prison, might lawfully observe and abide by his refusal to receive nutrition and the declaration was granted by Thorpe J. It has to be noted however that that decision was given without any opposition from Mr. Robb himself, and although he had initially expressed a wish to contest the making of any declaratory relief with regard to his future care, Mr. Robb had wavered in his determination to continue his hunger strike, and after he spent a long period in consultation with a medical expert of his choosing he decided to resume nutrition. The judgment of Thorpe J. is useful however for the principles it enunciates. He made the declaration that Mr. Robb was entitled to refuse nutrition and hydration, that the right was not diminished when he was a detained prisoner, that although the right was not absolute, no countervailing interest set the balance in favour of ignoring his wishes; and that accordingly there was no duty on the plaintiff or on the prison staff to provide him with nutrition against his will.

110. Thorpe J. delivered his judgment at the request of counsel and in view of the absence of any modern authority and notwithstanding that the issue had become a moot having regard to Mr. Robb's choice to resume nutrition. I find the following statement helpful:-

> *"The first principle is that every person's body is inviolate and proof against any form of physical molestation…. Secondly, the principle of self-determination requires that respect must be given to the wishes of the patient. So that if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged the doctors responsible for his care must give effect to his wishes even though they do not consider it to be in his best interest to do so….*
>
> *The next proposition …is that a patient who is entitled to consent to treatment which might or would have the effect of prolonging his life and who refuses so to consent, and by reason of the refusal subsequently dies, does not commit suicide. A doctor who, in accordance with his duty, complied with the patient's wishes in such circumstances does not aid or abet a suicide."*

111. Thorpe J. referred to the old case of *Leigh v. Gladstone* [1909] 26 T.L.R. 139 in which Lord Alverstone C.J. directed the jury that it was the duty of prison officials to preserve the health of prisoners in their custody, and that that duty extended to force-feeding. Thorpe J. held that that authority was *"of no surviving application and can be consigned to the archives of legal history".* The plaintiff in that case was a suffragette who had been force-fed in prison, and the decision was made at a time when suicide was a criminal act, and where the political climate was a public conflict between the suffragette movement and the government of the day.

112. Thorpe J. went on to say as follows:-

> *"It seems to me that within this jurisdiction there is perhaps a stronger emphasis on the right of the individual's self-determination when balance comes to be struck between that right and any countervailing interests of the state. So this decision is not a borderline one; this is a plain case for declaratory relief. The right of the defendant to determine his*

future is plain. That right is not diminished by his status as a detained prisoner."

113. The decision of Thorpe J. was considered in the judgment of Mostyn J. in *Nottinghamshire Healthcare NHS Trust v. R.C.* [2014] EWCOP 1317, a decision of the Court of Protection, in regard to the respondent, the adult child of parents who were practicing Jehovah's Witnesses. R.C was not brought up as a Jehovah's Witness and was taken into care at the age of four. He embraced that religion after he reached his majority. He had a troubled childhood and had a long history of repeated self-harming and was diagnosed as suffering from an anti-social and emotionally unstable personality disorder. Mostyn J. held that R.C. had full capacity to refuse the administration of blood products and he followed the decision in *Secretary of State for the Home Department v. Robb*, and made the point that with the advent of the Human Rights Act 1996 "*the argument for declaratory relief in such a case becomes appreciably stronger*".

114. I adopt the principles stated in *Secretary of State for the Home Department v. Robb* and in *Nottinghamshire Healthcare NHS Trust v. R.C.* and note in particular the statement of Mostyn J. that in the context of the UK Human Rights Act, and *ipso facto* in the context of the Irish Constitution, the argument for declaratory relief in respect of a choice of self-determination made by a competent adult is formidable.

Conclusion on Constitutional and human rights question

115. I conclude that the right of self-determination may prevail over the duty of the State to preserve the right to life. The duty of the State imposed upon it by the Constitution reflects the social order and the fact that the citizen is part of a community, and that the social contract requires that the State protect that citizen from an attack on his or her life and person. While the duty on the State may be stated in the affirmative and is not merely a reactive obligation, or an obligation to react or defend a right that is actively under attack, that duty, if it is to fully protect the citizen, must in an appropriate case give way to the express free choices of the individual. To consider otherwise would be in my view to give the State power to overbear the right of the individual not envisaged by the Constitution, and would fail to recognise the right of autonomy and individual self-determination that it promotes.

116. Thus, there is in my view no reason arising from considerations of the Constitution or human rights law that mandates the Court or the plaintiff to ignore Mr. McD's express wishes, and that the constitutional imperative goes the other way, and requires that the plaintiff abide by his wishes.

Advance care direction

117. Mr. McD wrote two letters specially addressed to the Court. The first of these is dated the 19th March, 2015, and addressed for the attention of the High Court Judge. The first comment I wish to make about these letters is that Mr. McD expressed himself forcibly with regard to his prison conditions, and his attempts to resolve the two specific issues which gave him such concern. He stressed as he put that he did not "play school games in prison" and that he was not trying to "manipulate or blackmail the prison service". He said he deserved his punishment in prison and that he did not complain about that. He was emphatic that he did not wish for or deserve sympathy, but that his complaints were rightful and just. He said that "money was more important that my wellbeing". Nothing in this letter amounts to an advanced care directive or any statement of Mr. McD that he does not wish to be treated should he fall into unconsciousness or become incapable of making a decision.

118. The second letter from Mr. McD was dated the 26th March, 2015, and two pages of this letter outlined again his complaints and his specific fear and intolerance of the abuse that he stated he suffered from gangs in the prison. He made the following statement: "If I die because of inhuman treatment at this stage I don't care now."

Later in his letter he says:-

> "I am sick and not able to explain anymore. I am refusing all medical help. I totally won't be going to hospital now as truthfully I don't care now and with so much inhumanity to man and grieving my sister's death most recently and my mum and brother last year I don't care about myself now. I have decided to just lay down and die. I know it won't be long now anyway. I am 6 weeks and half now with no food or sugar."

119. I find Mr. McD's letters moving and carefully expressed. His complaints do not seem to me to be irrational, and there is nothing in the medical reports before me that would suggest that he is delusional in believing that the activities of some of the prison inmates might result in him being infected by AIDS or Hepatitis C. Even were there to be no such risk, the lack of sunlight and fresh air, and the absence of a tolerable way to deliver food to him are matters which go to the very heart of his dignity as a human being. It is clear that his despair at improving his conditions is profound. Neither letter to my mind could be said to be an advanced care direction, or a statement from Mr. McD that he does not wish to have medical or food treatment should he become more unwell.

120. He does however make a statement in his affidavit of the 24th March, 2015, which can be considered to be a direction and a stated wish with regard to his future treatment. I quote these paragraphs in full:-

> "22. I understand about my hunger strike is likely to lead to organ failure and death. Nevertheless I wish to continue with my hunger strike as I will not consent to any form of sustenance until my two concerns regarding exercise and meals are properly met.
>
> 23. I feel that my health is declining as a result of my hunger strike. I suffer from headaches, dizziness and pain in my kidneys as well as having blood in my urine. I will be open to addressing the problems with my kidneys. I will be willing to accept antibiotics intravenously if necessary. However I do not want any form of food administered to me in hospital.
>
> 25. I do not at present, take issue with this Honourable Court making an order declaring that I currently have legal capacity to refuse medical assistance and food."

121. He made a similar and forceful statement in his oral evidence, and clearly and fully stated a wish not to be afforded any medical or nutritional assistance should he fall into coma.

122. Laffoy J. in *Fitzpatrick v. F.K.* considered the judgment of the Court of Appeal of Ontario in *Malette v. Shulman* [1990] 67 D.L.R. (4th) 321 (Ont. C.A.) where Robins J.A. rejected the argument that nothing short of a conscious contemporaneous decision to refuse medical treatment would suffice to permit a hospital not to administer emergency treatment. The patient in that case had provided an advance care direction giving instructions that transfusion was not to be effected and Robins J.A. rejected the argument that the hospital could not safely respect the instructions given in the advanced directive. He said as follows:-

> *"The patient manifestly made the decision on the basis of her religious convictions. It is not for the doctor to second*

guess the reasonableness of the decision or to pass judgment on the religious principles which motivated it. The fact that he had no opportunity to offer medical advice cannot nullify instructions plainly intended to govern in circumstances where such advice is not possible. Unless the doctor had reason to believe that the instructions in the Jehovah's Witness card were not valid instructions in the sense that they did not truly represent the patient's wishes, in my opinion he was obliged to honour them. He had no authorisation under the emergency doctrine to override the patient's wishes. In my opinion, she was entitled to reject in advance of an emergency a medical procedure inimical to her religious values."

123. In that case, the Court of Appeal of Ontario held that the advance care direction had set out unequivocally and in an unqualified manner instructions applicable to the emergency circumstances which had arisen, and Laffoy J. accepted that by analogy to the approach adopted by that Court of Appeal that the instructions of a patient not to transfuse given verbally even in an emergency should be followed "*unless there is evidence to cast doubt on the capacity for the patient to give instructions at the time*".

124. Laffoy J. in *Fitzpatrick v. F.K.* stated, albeit *obiter*, a general view that an expression of future intention with regard to care may lawfully be respected, and that a decision could be made in advance to decline medical treatment provided of course that the court was satisfied that the person was competent at the time. She quoted the decisions of the Court of Ontario in *Malette v. Shulman and the English Court of Appeal in Re T (Adult Refusal of Medical Treatment)* [1993] Fam 95.

125. Thorpe J. considered this question also in *Nottinghamshire Healthcare NHS Trust v. R.C.* Section 26 of the English Mental Capacity Act 2005 provides that the court may make a declaration as to whether an advance decision was valid and applicable to a treatment. Thorpe J. was satisfied that the advanced decision had complied with the statutory requirement and considered that as he was of the view that *R.C.* was competent to make a decision to refuse a blood transfusion in the circumstances which he was then considering, that were such capacity to disappear that the advance decision would be operative and that to "*impose a blood transfusion would be a denial of the most basic freedom.*"

Conclusion on advance care direction
126. I consider that as a matter of law, and finding the above statements persuasive, that a person may make a freely stated wish in regard to their future care and that this ought to be, and can in an appropriate case be, respected by those with care of that person.

Decision on the choice made by Mr. McD
127. I accept that I have jurisdiction to determine the validity of the decisions made by Mr. McD and also that the legal imperative is to engage a high degree of scrutiny having regard to the fact that the inevitable consequence of his chosen path is the end of his life. Mr. McD has stated that he does not wish to die. The medical evidence is that he is not suicidal. The choice he has made and expressed will inevitably lead to his death, but it could still be said that his stated wish is not a positive wish to die, that his wish is a conditional one that if he cannot achieve an improvement in his conditions then he accepts the inevitable result of his protest against these conditions.

128. The scrutiny that must be engaged is a fulsome one as to the level of insight, understanding and of the direct and inevitable, albeit not expressly chosen, result of the path which Mr. McD has taken. Death may not be his intended choice, but death is the indirect result of that choice. If the choice is freely made and fully informed it is one that must be respected.

129. I am satisfied that Mr. McD has freely made a choice to continue his hunger strike and to refuse treatment should he become incapacitated as a result and fall into coma.

130. I am also satisfied that the State may properly respect the personal autonomy and right of self-determination of Mr. McD by giving effect to his stated wish and direction not to be treated. I consider he has fully and freely expressed a decision that treatment not be afforded to him

131. I accordingly make declarations as follows:

(a) A declaration that the defendant's decision to refuse medical and nutritional assistance is valid.

(b) A declaration that the defendant's wish and direction should remain operative in the event that the defendant becomes incapable of making a decision whether to accept such treatment.

(c) A declaration that the plaintiff is entitled to give effect to the defendant's wishes not to be fed and not to receive medical assistance.

The events on the third day of hearing
132. On the third day of hearing counsel for Mr. McD indicated that he had fresh instructions and now wished in separate proceedings to seek declaratory or other relief in regard to Mr. McD's prison conditions. It was agreed by Mr. McD in that context that he would take up the offer of a bed in the Mater Hospital and that he would take intravenous medication and liquid nutrition, but no solids, pending the case management and prosecution of those intended proceedings. Mr. McD had help from Professor Kelly in coming to this decision, and he has agreed to go to hospital immediately, and his solicitor has agreed to keep him informed of the progress of the case and of my decision in this case which I reserved until today.

133. This development is welcome and shows indeed the extent of Mr. McD's insight into his condition. In that context counsel for the State indicated a preference that I would deliver this judgment, and counsel for Mr. McD expressed equally that wish. This judgment must be seen as given in the light of the evidence available to me and the questions I was asked, and circumstances may evolve that might change the ultimate outcome.