Neutral Citation [2012] IEHC 491

THE HIGH COURT

[2011 No. 9548P]

BETWEEN

M.X. [APUM]

PLAINTIFF

AND

HEALTH SERVICE EXECUTIVE

DEFENDANT

AND

BY ORDER

THE ATTORNEY GENERAL

NOTICE PARTY

AND

IRISH HUMAN RIGHTS COMMISSION

AMICUS CURIAE

JUDGMENT of Mr. Justice John MacMenamin delivered on Friday, the 23rd day of November, 2012

1. The unfortunate factual background to the proceedings to date has already been set out in a previous judgment in this matter, namely, *HSE v X. [APUM]* [2011] IEHC 326. Since that time, new proceedings have been initiated on behalf of the plaintiff, M.X. (hereinafter referred to as "X"). On her behalf, her counsel seeks to challenge a number of aspects of the procedure which have been adopted in her care regime. It is now claimed that the medical decisions, made in the context of her incapacity by reason of treatment-resistant paranoid schizophrenia, fail to have regard to her equal rights before the law as a citizen; and that she should be entitled to have the decision that she lacks capacity to decide whether or not to receive treatment subject to an independent review, ideally by an independent tribunal or court. While not fully alluded to in the pleadings, it is claimed that she is entitled to have the medical options concerning her treatment made on an "assisted decision-making" basis, which would give proper weight to her own wishes as to that treatment. It is contended that the plaintiff is being treated under s. 57 of the Mental Health Act 2001 ("the Act"), and that this provision is repugnant to the Constitution, incompatible with the European Convention on Human Rights ("ECHR"), and also fails to have due regard for the provisions of the United Nations Convention on the Rights of Persons with Disabilities ("UNCRPD"). The Attorney General and the Irish Human Rights Commission have been joined as notice parties to the proceedings. As this judgment outlines, the law in this area is evolving, and this case must be decided on its very unusual, if not unique, facts. It is essential to bear in mind the nature of the treatment being administered against the plaintiff's will. It involves the regular administration of the drug Clozapine, together with the necessary involuntary abstraction by a syringe of blood samples from the plaintiff's veins. This is itself an invasion of the plaintiff's bodily integrity – a constitutionally protected right.

Issues to be considered

2. This judgment, first, considers how the plaintiff's assessment was carried out in the context of the Act of 2001, and in particular the precise provisions of that Statute which are applicable.

3. Second, in cases like the present, where challenges are brought to the constitutionality of legislation, and declarations as to the incompatibility of legislation with the European Convention on Human Rights are also sought, the sequencing approach which a court should follow has been set out in a number of decisions of the Supreme Court. The guiding principle regarding determinations of constitutionality was set out by Henchy J. in *The State (Woods) v. Attorney General* [1969] I.R. 385 at p. 400 where he stated "… that a court should not enter upon a question of constitutionality unless it is necessary for the determination of the case before it". Similarly, in *Murphy v. Roche* [1987] I.R. 106, Finlay C.J. stated at p. 110:-

> "… where the issues between the parties can be determined and finally disposed of by the resolution of an issue of law other than constitutional law, the Court should proceed to determine that issue first and, if it determines the case, should refrain from expressing any view on the constitutional issue that may have been raised."

Therefore, a court must initially seek to resolve an issue by a means other than through constitutional reference. Here, counsel for the plaintiff contends, in a novel argument, that the UNCRPD is directly applicable within this jurisdiction, by virtue of the fact that the European Union is a signatory to that Convention. As will be explained later, the Court is not of the view that this Convention has direct effect in this jurisdiction at this time. That is not to say however that the provisions of that Convention are entirely immaterial, however.

4. Therefore, it will then be necessary to consider the other aspects of the plaintiff's claim, namely that the impugned provisions are unconstitutional, and/or incompatible with the ECHR. In accordance with the judgment in *Carmody v. Minister for Justice* [2010] 1 I.R. 635, this judgment will first assess questions of constitutionality before turning to consider the compatibility of the legislation with the ECHR. At p. 650 of *Carmody*, Murray C.J. pointed out:-

> "… when a party makes a claim that an Act or any of its provisions is invalid for being repugnant to the Constitution and at the same time makes an application for a declaration of incompatibility of such Act or some of its provisions with the State's obligations under the Convention, the issue of constitutionality must first be decided.

If a court concludes that the statutory provisions in issue are incompatible with the Constitution and such a finding will resolve the issues between the parties as regards all the statutory provisions impugned, then that is the remedy which the Constitution envisages the party should have. Any such declaration means that the provisions in question are invalid

and do not have the force of law. The question of a declaration pursuant to s. 5 concerning such provisions cannot then arise. If, in such a case, a court decides that the statutory provisions impugned are not inconsistent with the Constitution then it is open to the court to consider the application for a declaration pursuant to s. 5 if the provisions of the section including the absence of any other legal remedy, are otherwise met."

5. As will be explained, the Court does not conclude that any of the statutory provisions impugned are inconsistent with the Constitution. The conclusion is, rather, that procedures which have been adopted in purported compliance with s. 60 of the Act of 2001 are to be applied in a constitutional manner, which process, in this specific category of cases, involves a right to independent review and assisted (rather than substituted) decision making. The incursion into the plaintiff's constitutional rights is very significant. It involves medical treatment against her will. The conclusion is that it is only in this manner can the rights of the plaintiff under the Constitution be vindicated "as far as practicable" (Article 40.3 of the Constitution). I do not think such vindication can take place unless the steps outlined here are an integral part of the process and, allow for remedies commensurate with the protection of rights. To decide whether the plaintiff is entitled on a mandatory basis to an independent tribunal or court to determine the issues as to her treatment, and in light of the connections between rights identified in the Charter of Fundamental Rights in European Union jurisprudence and the ECHR, it will then be necessary to outline some current jurisprudence of the Strasbourg Court. The judgment follows the following sequence therefore. Having outlined the statute law and the evidence, it asks first can the issues be decided and finally disposed of by an issue of law other than constitutional law (section 1) (see The *State (Woods) v. Attorney General and Murphy v. Roche*). This question is answered in the negative. Section 2 addresses the constitutional issues (see *Carmody*). Section 3 addresses whether the plaintiff is entitled to a declaration regarding an independent tribunal or court under s. 5 of the European Convention of Human Rights Act 2003, in the absence of any other legal remedy.

6. Finally, the judgment addresses the issue of the plaintiff's locus standi (section 4). While parts of this judgment may overlap with the earlier judgment relating to the same plaintiff, for completeness it is necessary to outline certain of the statutory provisions in detail.

The provisions of the Mental Health Act 2001

7. Section 2 of the Act provides:-

> "2(1) In this Act, save where the context otherwise requires— …
>
> 'treatment', in relation to a patient, includes the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder;"
>
> …
>
> Section 4 provides:-
>
> "4(1) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.
>
> (2) Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this subsection.
>
> (3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy."

Part 4 of the Act deals with the question of consent to treatment. For present purposes ss. 56-60 must be read together. They provide as follows:-

> "56. In this Part 'consent', in relation to a patient, means consent obtained freely without threats or inducements, where—
>
> (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
>
> (b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment."

Section 57 of the Act provides:

> "57(1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
>
> (2) This section shall not apply to the treatment specified in sections 58, 59 or 60."

8. It is important to point out, therefore, that s. 57 does not apply in relation to forms of treatment specified in s. 60. The latter section deals with a position where it is necessary to administer medicine for a continuous period of three months. The evidence now clearly establishes that the treatment regime adopted in the case of the plaintiff is that identified in s. 60, and, contrary to what is asserted on behalf of the plaintiff, not under s. 57 of the Act. Sections 58 and 59 of the Act are not relevant. However, s. 60 provides:-

> "60. Where medicine has been administered to a patient for the purposes of ameliorating his or her mental disorder for a

continuous period of 3 months, the administration of that medicine shall not be continued unless either—

(a) the patient gives his or her consent in writing to the continued administration of that medicine, or

(b) where the patient is unable or unwilling to give such consent—

(i) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

and the consent, or as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained."

9. During the four day hearing, a number of witnesses testified regarding the treatment regime. I would emphasise that all the evidence indicates that the greatest care has been taken by each of the practitioners involved in the plaintiff's care in a unique and very difficult situation.

The evidence on capacity

Dr. Paul O'Connell
10. Dr. Paul O'Connell is employed as Consultant Forensic Psychiatrist in the Central Mental Hospital. Earlier in the case, he set out the nature of his first involvement in the provision of care to the plaintiff. He is the primary treating psychiatrist responsible for her care. He gave a detailed account of the course of her treatment, along with her medical and forensic history dating from 2007.

11. The plaintiff's diagnosis is one of treatment resistant paranoid schizophrenia, the salient symptoms of which include auditory hallucinations, which take the form of mocking voices, which are at different times attributed to members of the staff or laughter of small children. Associated with these hallucinations, the plaintiff has reported the delusional belief that she has been controlled by the voices or, more often, by members of staff. When acutely psychotic, the plaintiff admits to urges to assault or kill members of staff. At times, she exhibits various behaviours including agitated pacing, facial expression of excitement and fixed staring at those she believes are mocking her. At such times she has made efforts to, and has assaulted, members of staff. As was pointed out earlier, prior to being placed in the Central Mental Hospital, she harboured urges to harm, or even to kill small children.

12. In the course of the hearing of these proceedings, Dr. O'Connell gave further testimony on the question of capacity. He was satisfied, as the treating consultant that the plaintiff was not capable of fully understanding the nature, purpose and likely risks of the proposed treatment. He concluded the plaintiff's understanding was made up of different components. His clinical view has remained consistently, that the plaintiff could not form a balanced judgment in relation to the treatment being afforded to her. She saw both the staff and himself as a threat to her. She was delusional, and while she would not admit to hallucinating, he was of the strong clinical conclusion that she was hallucinating. He was also of the firm clinical opinion that the plaintiff lacked capacity because of her mental disorder and therefore was, to quote him, "unable to consent to, or refuse, either the administration of anti-psychotic medication, or the ancillary and necessary blood tests associated with that treatment course".

13. The witness went on to conclude that the plaintiff's illness has the effect of impairing her reasoning, emotional regulation, and judgment. Although she is able to register and retain information with respect to her care and treatment, she remains unable to exercise her judgment in coming to a balanced decision about that treatment, insofar as she lacks insight and fails to appreciate the nature of her mental illness and the need to receive treatment. She fails to appreciate that her illness, if untreated, would represent a serious and immediate risk to herself and others, and would inevitably deteriorate, exacerbating that risk.

Professor Harry Kennedy
14. Professor Harry Kennedy, Consultant Forensic Psychiatrist and Executive Clinical Director of the National Mental Health Service at the Central Mental Hospital testified that his function was as leader of the team of psychiatrists working in the hospital. He described his responsibility for clinical governance and for the planning of modernised services. He testified that when ill, the plaintiff has homicidal preoccupations which focus particularly on children, or on the children of those who come into contact with her. He said that the plaintiff loses insight, and her capacity to give or withhold consent to treatment, is at its lowest. He, too, testified that when the plaintiff became agitated, she attacked doctors and nurses causing significant injuries. On such occasions, it was necessary that she be secluded for her own safety, and that of others. At times, this seclusion has had to be for prolonged periods which have been monitored by the Mental Health Commission Inspectorate of Mental Health Services.

15. Professor Kennedy pointed out, importantly, that capacity can fluctuate, and that many patients in the hospital experience differing levels of capacity at different times. He considered that it would be profoundly wrong to assume that all patients in the hospital lack capacity. Where a patient has capacity, they are encouraged to take their full role in the therapeutic decision making regarding their care and treatment. Professor Kennedy has a particular professional interest in this issue. He has led a research team that has published learned articles on the assessment of mental capacity to consent to treatment, and that subject forms part of his teaching responsibilities. He too, was of the strong professional opinion that the plaintiff lacked capacity to give or withhold consent to treatment. She does not understand the information about her mental health and the treatment options, lacks the ability to reason about these options, and is unable to compare such choices. She is unable to reason about the possible or potential side effects or consequences of the treatment. He testified that she is unable to appreciate the importance of information about mental health and mental illness for herself. She does not believe information because of her paranoia, her delusions, and her impaired capacity to reflect on her situation.

16. Professor Kennedy highlighted a number of the procedural safeguards in place in the Central Mental Hospital. All patients in the hospital are subjected to regular multi-disciplinary review. A treating doctor in a situation such as this does not act alone. He pointed out that there is in being, a process of obtaining second opinions from a consultant psychiatrist who is not attached to the hospital. This is not unique to this case but is rather a consistent feature of treatment in the hospital since the commencement of the Act of 2001.

17. The witness took issue with a typification of the treatment regime as being one "imposed against the plaintiff's will". He stated

that, rather, treatment is provided in the absence of her capacity to make decisions, and subject always to independent review and safeguards. Second, he testified that it was the plaintiff's illness, and not the views of her treating doctors, that deprived her of the ability to consent to, or refuse treatment. Every effort is made to engage a patient in the decision-making process. If, and when, a patient such as the plaintiff regained sufficient mental capacity, she will then be again empowered to make decisions regarding her treatment including the then regained ability to give or withhold consent. Professor Kennedy also expressed the view that the UNCRPD, to which reference was made earlier, did not contain any explicit condemnation of "paternalism", which he summarised as being an ethical principle of protecting the best interests of vulnerable persons and which, he claimed, was not in conflict with a rights based respect for disabled people as persons. This part of the testimony is particularly relevant, and I will return to it later.

18. The witness took issue with a contention that disability was seen through medical criteria as a deviation from the norm which he characterised as a polemic "straw man". He distinguished between "disability" (not an inherently medical categorisation being a qualitative term defining status in society before the law), and, on the other hand, medical measurements of impairment due to disorder which are quantitative. The former "qualitative" approach is inherently more reductive, and hence lends itself to ease of definition and legal convenience; as opposed to the latter quantitative medical approach which recognises degrees of impaired and restored mental capacity. He entirely rejected any suggestion that the plaintiff had been subjected to inhuman or degrading treatment. In fairness, it must be pointed out that any such suggestion was withdrawn by the plaintiff's legal advisers. Professor Kennedy's view was that it was the plaintiff's own lack of capacity which constituted an infringement on her rights and rendered her unable to exercise those rights. He described it as unhelpful and damaging to therapeutic relationships to imply that a "finding" by psychiatrists, rather than the absence of capacity of itself, was what was important.

Dr. Ian Bownes

19. It is important here to re-emphasise that the defendant, (the HSE), assisted in the retention of an independent psychiatrist to testify on behalf of the plaintiff. Dr. Ian Bownes is a Consultant Forensic Psychiatrist with the South Eastern Health and Social Trust in Northern Ireland. He is a Forensic Psychiatrist with the Northern Ireland Prison Service. His report was furnished to the Court and admitted in evidence. He examined the plaintiff on behalf of her solicitors, and presented a report to the court with his assessment of her condition. That assessment is largely, if not entirely corroborative of the views of Dr. O'Connell and Professor Kennedy.

Dr. Brendan Kelly's evidence – the "Form 17" procedure

20. Dr. Brendan Kelly is a Consultant Psychiatrist at the Mater Misericordiae University Hospital and Senior Lecturer in Psychiatry at University College, Dublin. He was retained by the HSE on a national panel of consultants who are in a position to carry out assessments for the purposes of s. 60 of the Act of 2001. He explained that the function of the independent psychiatrist, carrying out a s. 60 assessment, is to exercise a fully independent clinical judgment in appraising the situation. He noted that, in the past, he had had occasion to disagree with responsible consultant psychiatrists, and had no difficulty in so doing. On a number of occasions in this case, Dr. Kelly completed the Mental Health Commission forms recording his decisions pursuant to s. 60 authorising the continued administration of medicine without consent to the plaintiff. These forms are referred to as "Form 17".

21. In evidence, Dr. Kelly described the number of occasions when he carried out examinations in pursuance of the Form 17 procedure. He described the structure of such an examination as follows. First, the clinician considers whether a patient suffers from a mental disorder as understood in the 2001 Act. Second, that clinician considers the question of capacity and insight. This includes a consideration of whether the patient has any understanding of his or her illness, (including whether they accept that they are in fact ill), the proposed treatment, and the purposes of that treatment. Third, if the patient has capacity or is found to so have, the question of whether the patient is willing to undergo the treatment is next considered. Fourth, the proposed medication regime is considered, and particularly, whether it will likely benefit the patient. Finally, the clinician records his notes in writing in accordance with the structured mental state examination structure. In doing so he summarises the key issues, before forming a view on the entire examination which is then reflected on the completed Form 17, which is checked and then signed.

22. Dr. Kelly was satisfied that each time he was requested to authorise the continuance of medication to the plaintiff without her consent, he carried out an independent examination and assessment, and concluded that, first, the plaintiff was unable to consent to treatment, and second, that she would benefit from the continuation of the treatment with the medication in question. He had examined the plaintiff on at least six occasions between November 2010 and December 2011. Finally, he agreed with an analysis of the plaintiff's doctors regarding the taking of blood samples in conjunction with the administration of the anti-psychotic medication in question, and noted that, to date, and to the best of his knowledge, nobody in the State had died from Agranulocytosis resulting from the administration of Clozapine following the introduction of a mandatory blood testing requirement.

Findings on the section 60 procedure

23. I am satisfied that each of the doctors faithfully complied with the procedure laid down under Form 17, which, itself, forms part of treatment under section 60. The evidence established conclusively that the situation which existed is not one where the treatment regime was being administered under s. 57 which, among other areas, deals with treatment which is required urgently to safeguard a patient's life or to restore him or her to health. Section 57 treatment arises when the patient is "incapable" of giving consent. The evidence clearly establishes that here the medicine has been, to use the terms deployed in s. 60 of the Act, *"administered to a patient for the purposes of ameliorating … her mental disorder for a continuous period of 3 months" and where "the patient is unable or unwilling to give consent"*.

24. Some idea of the extent of the difficulty in this case can be derived from Dr. Bownes reports, where he described visiting X on a number of occasions. On those occasions her mood fluctuated. On the first occasion, she was pacing backwards and forwards, muttering to herself relentlessly for the duration of the interview. She became increasingly agitated on questioning, and her narrative became tangential, poorly structured, contradictory and internally inconsistent.

25. On a later visit, on 26th February, 2012 the plaintiff welcomed him warmly with a handshake using his correct name and recalled the previous examination. She was able to sit at peace during the session. Nevertheless, during the course of the interview, her mood became increasingly low, irritable, and perplexed, and she evinced extraordinarily hostile and homicidal attitudes towards her doctors. She felt that her doctors were poisoning her, and were administering her medication which was in some sense being kept a secret from her. She also showed suicidal ideation, and stated that she would kill herself "at the first opportunity". She stated that her family never visited her, but that her children were well looked after and there was now no need for her to stay alive. It is difficult, therefore, to exaggerate the extremely tragic nature of the plaintiff's illness.

26. Section 60 of the Act addresses the limited circumstances in which a finding of incapacity takes place. It requires that two decisions be made, the first on the appropriateness of the medicine proposed, and the second on the issue of consent by the responsible consultant. These decisions must then be approved by the independent consultant psychiatrist before the treatment can be authorised. All this was done in the plaintiff's case. The case, insofar as it relates to a challenge to the constitutionality of s. 57 of the Act is unsustainable. I am unable to conclude that the provisions of s. 57(1) are engaged at all. Moreover, I think it would be

inconsistent with the earlier judgment in these proceedings to adopt anything but a broad and purposive approach to the concept of "treatment". As such, any treatment which is ancillary to principal "treatment" administered pursuant to s. 60 of the Act must benefit from the same protections and prescriptions as that principal treatment. This does not absolve the Court from a consideration of the issues arising from the treatment regime however.

The procedural safeguards under s. 60 of the Act
27. The focus of analysis in this judgment must be confined to the terms of s. 60 on the administration of medicine and the safeguards identified in that section. This is not a case where there is a dispute in relation to the correctness of the treatment. It is clear that the responsible treating consultant psychiatrist, and the independent consultant, Dr. Kelly, at an early stage clinically assessed the plaintiff's capacity to consent to the proposed treatment as part of their respective functions. Dr Bownes agreed with this diagnosis and proposed treatment.

Matters not addressed in Form 17
28. It is important also to emphasise, however, that the contents of Form 17 are set out in what might be termed "box" form. After a description of the patient, her location, the treating psychiatrist, the medication intended, and how it will benefit the patient, the form simply sets out options for the independent consultant to identify whether the patient is unable or unwilling to give consent to the treatment. Dr. Kelly indicated that the plaintiff was unable to give such consent. The form, thereafter, identifies the name of the independent consultant psychiatrist and how the details of the treatment will benefit the patient. However, it goes no further. The form does not address the patient's views at all. This has consequences which are addressed later in the judgment. I now turn to consider whether the UNCRPD is directly effective in the State.

Section 1 – Can the issues be decided and finally disposed of by an issue of law other than constitutional law?

The United Nations Convention on the Rights of Persons with Disabilities
29. The European Union acceded to the UNCRPD through Council Decision 2010/48/EC, formally adopted on 26 November, 2009. The instrument of ratification on behalf of the EU was then deposited in December 2010. This was the first occasion that the EU became a party to an international human rights treaty, and that an intergovernmental organization had joined with a United Nations human rights treaty. Although a signatory to the UNCRPD, Ireland has not, as yet, itself ratified the Convention.

30. The Convention specifies rights and obligations with regard to persons with disabilities. Of particular relevance to the present case are Articles 12(1) and (2) which provide:

> "1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
>
> 2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."

It is right to say that the values enunciated in the Convention constitute a "paradigm-shift" in the manner in which persons with disabilities are to be treated by, and before, the law. However, the Convention, in its preamble, also acknowledges the diversity of persons with disabilities. Therefore, in considering the applicability and the interpretation of the Convention, due regard must be had to the individual circumstances of each individual. What is the legal status of the Convention within the State?

31. Article 300(7) of the Treaty for the Establishment of the European Community ("TEC") provides that international treaties, once concluded by the EU, are binding on European institutions and Member States, *provided* that they relate to areas of EU competence. The European Court of Justice ("ECJ") has adopted a "monist" approach to international agreements, whereby such agreements have legal effect without the requirement for further active implementation (see the decision in *Haegemen v. Belgium* [1974] E.C.R. 449). Under certain conditions, international agreements can, in principle, be invoked before a national court by an individual, if there is direct effect (see *Demirel v. Stadt Schwabish Gmund* [1987] ECR I-3719). In order for there to be such effect, the provisions sought to be relied on must be clear, precise and unconditional. It is argued that the terms of Article 12 come within these criteria.

32. Counsel for the plaintiff contends that the main objective of the UNCRPD is the equal treatment of, and the prohibition of discrimination against, disabled persons. It is important to the argument now made, to state that it is the plaintiff's contention that this area is also covered in *'large measure'* by Community law – for example, Directive 2000/43/EC, which governs non-discrimination on the grounds of ethnic origin; Directive 2000/78/EC, which establishes a general framework for equal treatment in employment and occupation; Directive 2002/73/EC, which governs the equal treatment of men and women in the employment sphere; and Directive 97/80/EC, which governs matters of proof in sexual discrimination cases. The plaintiff argues that as a Member State of the European Union, Irish law must give force to Article 12 as part of their obligations under the EU's legal order.

33. Two questions arise from these contentions. First, this Court must consider whether the principles set out in the UNCRPD, despite Ireland's non-ratification, have the force of law in this jurisdiction. In order to establish her case, the plaintiff would be required to establish (a) that the relevant provision of the UNCRPD falls within a community competence which had been exercised to a "large degree" or was an "integral part of Community law"; and, also, (b) that the provision sought to be enforced is sufficiently clear, concise and unconditional as to be capable of itself directly regulating the legal position of individuals. Alternatively, the Court is asked to consider whether the UNCRPD is a "guiding instrument" in respect of the interpretation of the plaintiff's constitutional rights, or her rights under the European Convention of Human Rights.

(a) Community competence
34. The UNCRPD is a mixed international agreement where the EU, its member states, and other third party states are contracting parties. As a mixed agreement, the UNCRPD does, in fact, cover fields that, in part, fall within the competence of the EU; in part within the competence of member states; and in part within the shared competence of the EU and its member states. This issue will be explained in greater detail later. However, it is not the case that, once the EU ratifies an international convention, its subject matter automatically falls within its competence, and is thus directly enforceable in its member states. Nor is such convention enforceable simply by virtue of the fact that the EU has legislated in some of the areas which the Convention addresses.

35. Member states, when participating in mixed agreements, are subject to a duty of loyal cooperation between one another and the EU, deriving from Article 4(3) of the TFEU. This duty of loyal co-operation embraces two sets of obligations. First, member states must take appropriate measures, whether general or particular, to ensure fulfilment of the obligations arising out of the TFEU, or resulting from action taken by EU institutions. Second, member states must facilitate the achievement of the EU's tasks, and abstain from any measures which could jeopardise the attainment of the objectives of the TFEU.

36. The plaintiff relies on principles enunciated in *Commission v. France* [2004] E.C.R. I-09352, in which the issue was whether France, in failing to take all appropriate measures to prevent, abate and combat heavy pollution of the lagoon area known as the Étang de Berre, had breached its obligations under Articles 4(1) and 8 of the Convention for the Protection of the Mediterranean Sea Against Pollution and its Protocol, which had been signed and approved on behalf of the European Economic Community by two Council Decisions. The European Court of Justice held that the fact that there had been no EEC legislation covering the nature of the breach committed by France did not release that state from its obligations under the Convention. The breach fell within Community law, because the Convention and Protocol was a mixed agreement in a field in "a large measure covered by Community law". Thus, in such cases, there was "a Community interest in compliance by both the Community and its Member States with commitments entered into". Therefore, a member state must implement such a mixed agreement, provided the measure to be implemented falls within the competence of the EU, either by way of being covered by Community legislation, or, where the particular issue was "covered in large measure" by Community legislation.

37. At Article 44(1), the UNCRPD requires regional integration organisations such as the EU, who accede to the Convention to declare the extent of their competence in their instruments of formal confirmation or accession. The Council Decision sets out the legal basis under the Treaties by which the EU has ratified the UNCRPD, and also lists EU instruments that demonstrate its competence. The Council Decision also provided that the extent of the EU's competence must be assessed by reference to the precise provisions of each measure, and in particular, the extent to which the provisions establish common rules. The Decision goes on to say that the scope and the exercise of EU competence are subject to continuous development, and that the EU will complete or amend its declaration, if necessary in accordance with Article 44(1) of the UNCRPD. It is thus possible to identify which areas of the UNCPRD fall under EU competence, and which do not.

38. Despite a Commission proposal to use a number of legal bases (Articles 13, 26, 47(2), 55, 71(1), 80(2), 89, 93, 95 and 285 EC in conjunction with Article 300(2), and the first subparagraph of Article 300(3) EC), in fact the Council selected only two substantive legal bases, namely Article 13 and Article 95 EC, in conjunction with the (procedural) provisions of Article 300(2) EC and Article 300(3) EC, as authorising the EU to conclude the UNCRPD. This has some legal significance, in that the ECJ has ruled that the legal basis cited gives an indication to the other contracting parties of the extent of EU competence, and the division of competence between the EU and its member states (see *Commission v. Council* [2006] E.C.R I-00001). However, although the choice of legal basis for the decision is of some significance, it is not decisive for implementation, as the ECJ has also held that it is not necessary for the same provisions to be used as the legal basis for the adoption of the measures intended to implement the agreement at Community level (see *Commission v. Parliament* [2006] E.C.R. I-00107).

39. The Court has been referred to a report compiled by the European Foundation Centre in response to a request by the European Commission in 2010 to carry out a study in relation to the implementation of the UNCRPD. The aim of the study was to analyse in detail the obligations set out there, and to gather information about the various practices relating to the implementation of the Convention by the EU and its member states. This study was designed to support the objectives of the current EU Disability Acton Plan; which, too, emphasised full participation and equal opportunities for all people with disabilities, and which was intended to contribute to the preparation of the new EU Disability Strategy, based more explicitly on the UNCRPD. The project team carrying out the study included a wide range of experts in the field of disability law and policy, including many persons who took part in the negotiations of the UNCRPD, and who made submissions to the *ad hoc* committee of the UNCRPD as to the drafting of the Convention. This report has been admitted into the case without any dispute. I am prepared, therefore, to admit it as being a useful reference work and as an aid to interpretation. The plaintiff's submissions face an immediate difficulty here.

40. In a table provided therein at p. 40, the Article in question here, Article 12 is stated to fall *solely* within the competence of Member States. It is not within EU competence, or the shared competence of the EU and Member States.

41. The report also notes that before the Council Decision issued, the High Level Group on Disability (HLGD), in its first report on UNCRPD, identified nine areas of interest for the EU, considering both the EU, and its member states, with regard to implementation. These areas included legal capacity under Article 12. The Report points out that some of the matters addressed by the HLGD were beyond the EU competence to act. Notwithstanding this, in 2008, member states confirmed that collaboration at European level would be of added value in implementing the UNCRPD, and that the EU would become the "platform" to facilitate this collaboration. However, the only clear inference from this is that, as matters stand, Article 12 lies outside the EU competence. The Report also points out that some member states expressed reservations in relation to Article 12.

42. By way of distinction, the ECJ recent addressed the direct applicability of international agreements in *Lesoochranarske Zoskupenie*, C-240/09, 8th March 2011, where the issue at stake was Article 9(3) of the Aarhus Convention dealing with access to administrative or judicial procedures. There, the ECJ specifically held that the objective of the Aarhus Convention was consistent with the objectives of the Community's environmental policy listed in Article 174 of the EC Treaty. This was found to be an area in which the Community *did* share competence with its member states, and where a comprehensive body of legislation was evolving and contributing to the achievement of the objective of the Convention, not only by its institutions, but also by public bodies within its member states.

43. As matters stand, however, the same cannot be said of the law relating to mental capacity, an area in which to date, the EU has not assumed any large or appreciable jurisdiction. Furthermore, the measures to which the plaintiff referred, do not support the assertion that, at present, the EU has legislated or exercised a large degree of competence in the matters governed by Article 12. I am not convinced that Directive 2000/43/EC, Directive 2002/73/EC, nor Directive 97/80/EC are, in the relevant particulars, comparable to the questions of legal capacity, or to the detention and treatment of persons in the category of the plaintiff. I must accept the submission made on behalf of the Attorney General that the *Commission v. France* case is distinguishable as that case concerned a shared competence between the EU and member states.

44. There being no such competence here, I must conclude, therefore, that as the law stands, the plaintiff's argument on this point cannot succeed.

(b) Direct applicability

45. The question also arises as to whether Article 12 is capable of being directly applicable. It is contended on behalf of the Attorney General that the Article constitutes a "principle not a rule" and is dependent on subsequent measures to identify a particular manner in which the principle may be respected. It is not necessary for this Court to express a view on this point. For the reasons outlined earlier, the court does not consider that the UNCRPD can, as yet, be seen as a rule in the interpretation of an application of EHCR jurisprudence or, through that avenue, to E.U. rights law. This does not, however, prevent the UNCRPD being a guiding principle in the identification of standards of care and review of persons in this category.

46. As matters stand, the realm of EU law has not yet extended to the area of mental health law, nor to the issue of legal capacity.

However, the rights of equal treatment and non-discrimination are core values in the EU legal order. As far as the present case goes, it has not been shown the right to equal treatment, as enshrined in the UNCRPD, is presently part of the EU's legal order such that Article 12 UNCRPD creates directly enforceable rights or obligations.

47. The law in this area is evolving, both in the legislative and judicial realm. It is of interest that a recent judgment, *R. (on the application of NM) v. the London Borough of Islington and Northamptonshire County Council and Others* [2012] EWHC 414, Sales J. observed at para. 102 that:-

> "In principle, a point might be reached when the [UN]CPRD has been ratified by sufficient European states, or when sufficient European states have brought their domestic law and practice into line with the standards set out in the CPRD, that the CPRD or the practice flowing from it could be taken to amount to a relevant European consensus to inform the interpretation and application of the Convention rights. Also, though the position is less clear, a point might be reached where the CPRD is taken to be a leading international instrument establishing an appropriate standard against which to judge the conduct of member states of the Council of Europe, as in relation to other international instruments…"

48. However, that judge expressed reservations as to whether the Convention has yet acquired this significance for the purposes of interpretation in light of the significant number of member states which have yet to ratify it. Sales J. observed that none of the Strasbourg authorities cited to him in that case went as far as to say that an individual could, *in substance*, rely on the provisions of UNCRPD under the guise of relying on ECHR rights. If the rights asserted here are not to be found in EU law which is directly effective in the State, can they be found elsewhere and if so, precisely which rights?

Section 2 – Decision as to the constitutionality of the impugned provisions

Constitutional requirements

49. What are the applicable constitutional and legal principles? The facts of the present case from two legal authorities where the question of consent has been very comprehensively considered. These were *Fitzpatrick & Anor. v. K.* [2009] 2 I.R. 7 and *Re Ward of Court (Withholding Medical Treatment) (No. 2)* [1996] 2 I.R. 79. By way of distinction from Fitzpatrick, we are not dealing, here, with a person, who was, at least prima facie, of full capacity although as was held, there, that the patient's capacity had been affected by the influence of others. Nor are we considering a situation such as that which arose in Re Ward of Court (No. 2), where the ward was in a condition known as P.V.S. or persistent vegetative state. But what is involved here is involuntary medication, together with the invasive taking of blood samples by a syringe on a regular basis. The plaintiff strongly objects to the procedure. The invasive nature of the treatment results in a loss of bodily integrity and dignity. (see the judgment of Denham J. in *Re Ward of Court*, cited above, at p.158 of the report)

50. In the latter case, the High Court, at first instance, had the opportunity of considering evidence from family members of the ward as to what her wishes would have been had she been in a position to speak about her tragic situation. By virtue of the ward's legal status, the court was vested with jurisdiction over all matters relating to her person and estate, and in the exercise of its jurisdiction, was subject only to the provisions of the Constitution. The High Court, and on appeal the Supreme Court, held that, in the exercise of that jurisdiction, the prime and paramount consideration must be the best interests of the ward. Both Courts found that, although the views of the committee and family of the ward were factors to be taken into consideration, they could not prevail over the court's view as to what was in the ward's best interests. The Supreme Court upheld the finding of the trial judge that the court should approach from the standpoint of a prudent, good and loving parent in deciding what course should be adopted, and held that the treatment being afforded by means of a gastrostomy tube, surgically inserted into the stomach was an intrusive interference with the ward's bodily integrity, and could not be regarded as a "means of nourishment". The care and treatment being afforded constituted medical treatment and not merely medical care. The Supreme Court held that the nature of the right to life, and its importance, imposed a strong presumption in favour of taking all steps capable of preserving it, save in exceptional circumstances. However, it concluded that, if the ward had been mentally competent, she would have had the right to forego or discontinue her treatment, and the exercise of that right would be lawful in the pursuance of her constitutional right to self determination implicit in her right to bodily integrity and privacy. However, this right did not include the right to have life terminated, or death accelerated, and was confined to the natural process of dying. The court decided that the loss by the ward of her mental capacity did not result in any diminution of her personal rights recognised by the Constitution, including the right to life, bodily integrity, privacy (including self determination), or the right to refuse medical treatment.

51. At the statutory level, s. 60 provides for a mechanism whereby the plaintiff's rights, and those of the community, can be balanced and protected. That is not to say, of course, that her rights could not also be vindicated under the inherent jurisdiction of this court, that jurisdiction having been invoked in this case. But there are constitutional dimensions to this case which cannot be ignored. In the next paragraphs, the main emphasis is on the concept of decision making. It logically follows that the observations which are made here, also apply to a right of independent review, a statutory right provided by s. 60 itself.

52. The plaintiff's complaint is that the review procedure, as outlined earlier, insufficiently vindicates her constitutional rights, and fails to give recognition to rights identified in the jurisprudence of the European Court of Human Rights. Her counsel contends that the effect of the current procedure results in what is termed "substituted decision-making" (bearing the hallmarks of a paternalistic approach to the treatment of mental health patients), rather than "*assisted* decision-making" which better vindicates the range of rights engaged. For brevity, the range of values and rights involved will be collectively referred to as "personal capacity rights". These comprise the Article 40.3 values of self-determination, bodily integrity, privacy, autonomy and dignity, all unenumerated, but identified in case-law, as well as the explicit right to equality before the law, as identified in, and qualified by, Article 40.1 of the Constitution. For the purposes of consideration here, these are all, whether characterised as values or rights, capable of vindication in the courts. The case is now made that both the treatment regime, and the protections therein, fail properly to reflect the changes and provisions under the United Nations Convention on the Rights of Persons with Disabilities which, by contrast, aims at encouraging assisted decision-making and seeks to vindicate the interests of disabled persons.

53. Prior to a consideration of those rights, it is worthwhile recollecting the observations of Costello J. in *R.T. v. Director of the Central Mental Hospital* [1995] 2 I.R. 65, where he drew attention to the concept that, in considering the safeguards necessary to protect the rights of vulnerable people, regard should be had to the standards set by the recommendations and conventions of international organisations of which this country is a member. The superior courts have resorted to international human rights instruments in order to interpret appropriate constitutional standards in a number of cases. *In The State (Healy) v. Donoghue* [1976] I.R. 325, the Supreme Court had regard to Article 6 of the European Convention of Human Rights and also to the United States Constitution. In *O'Leary v. The Attorney General* [1993] 1 I.R. 102, Costello J. referred to Article 6(2) ECHR; Article 11 of the United Nations Universal Declaration on Human Rights; Article 8 (2) of the American Convention on Human Rights; and Article 7 of the African Charter of Human Rights in holding that the presumption of innocence in a criminal trial was one which enjoyed "universal recognition". Are these principles of interpretation applicable here?

54. Article 40.1 of the Constitution provides:-

> "1.All citizens shall, as human persons, be held equal before the law.
>
> This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function…."

At Article 40.3 it is provided:-

> "1. The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.
>
> 2. The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen."

55. Hitherto, arising from the facts in each case, decisions of the Superior Courts in this area have tended to lay emphasis on a paternalistic intent of legislation concerning persons with incapacity. This approach, very much in line with long-established decided authority, was most recently reiterated by the Supreme Court in *E.H. v. Clinical Director of St. Vincent's Hospital* [2009] 3 I.R. 774.

56. By way of illustration of the approach, in *Gooden v. St. Otteran's Hospital* [2005] 3 I.R. 617, McGuinness J. pointed out, at p.633, that:-

> "In *Re Philip Clarke* [1950] I.R. 235 the former Supreme Court considered the constitutionality of s. 165 of the Act of 1945. O'Byrne J. who delivered the judgment of the court described the general aim of the Act of 1945 at pp. 247-248 thus:-
>
> 'The impugned legislation is of a paternal character clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and wellbeing of the public generally. The existence of mental infirmity is too widespread to be overlooked and was, no doubt, present to the minds of the draftsmen/draughtsmen when it was proclaimed in Article 40.1 of the Constitution that though all citizens as human persons are to be held equal before the law, the State, may, nevertheless in its enactments, have due regard to differences of capacity, physical and moral, and of social function. We do not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity to *remain at large to the possible danger of themselves and others.*'" (emphasis added)

57. In *E.H.*, Kearns J., speaking on behalf of the Supreme Court, observed that the same principle should be adopted in interpreting the provisions of the Mental Health Act 2001, again, in issues concerning personal liberty. He stated:-

> "I do not see why any different approach should be adopted in relation to the Mental Health Act 2001, nor, having regard to the Convention, do I believe that any different approach is mandated or required by Article 5 of the European Convention on Human Rights 1950."

58. However, it is noteworthy that these observations, very understandably on the facts, deal with the interpretation and application of the statutes predominantly in the context of the right to liberty and the right to fair trial. The position here is distinct. The case before this Court does not concern the right to liberty or fair trial, but rather, the plaintiff's entitlements *while* being treated in involuntary care.

59. I do not think there is anything inconsistent with the avowedly paternalistic nature of the legislation or that jurisprudence, insofar as they concern liberty, in also ensuring that the wishes and choices of a person suffering from a disability, while under such care, should be guaranteed in a manner which, "as far as practicable" (to use the phrase adopted in Article 40.3.1 of the Constitution), vindicates his or her personal capacity rights. The interpretation of the Constitution in this area of the law should be informed by, and have regard to international conventions. This principle of interpretation, of course, applies a *fortiori* in relation to the regard which, as a matter of law, must be had to decisions of the European Court of Human Rights (see ss. 2-5 of the European Convention on Human Rights Act 2003).

60. That the Constitution is a living instrument which adapts to protect rights that develop over time cannot be controverted. In *The State (Healy) v. Donoghue* [1976] I.R. 325, O'Higgins C.J. observed of the values espoused in the preamble to the Constitution that:-

> "The judges must therefore, as best they can from their training and their experience interpret these rights in accordance with their ideas of prudence, justice and charity. It is but natural that from time to time the prevailing ideas of these virtues may be conditioned by the passage of time; no interpretation of the Constitution is intended to be final for all time. It is given in the light of prevailing ideas and concepts…"

61. Should this Court then have reference to the UNCRPD if not as a rule, then at least as a guiding principle? The values in question here are in no sense contrary to any provision of the Constitution. The UN Convention affirms the contemporary existence of fundamental rights for persons with a mental disorder. Although the UN Convention itself is not part of our law, it can form a helpful reference point for the identification of "prevailing ideas and concepts", which are to be assessed in harmony with the constitutional requirements of what is "practicable" in mind. A court will, of course, (subject to the qualification pronounced in *McD. v L*. [2010] 2 I.R. 199) also "have regard" to the jurisprudence of the European Court of Human Rights to which Ireland also adheres on the basis of an international convention. As well as the UNCRPD itself, are there also relevant principles, ideas and concepts identified in Strasbourg case law? By virtue of ss. 2-5 of the European Convention on Human Rights Act 2003, this court is required to interpret laws of this State in compliance with the State's obligation under the ECHR provisions. Judicial notice is to be taken of decisions of the ECHR and the principles contained therein. This allows a court in an appropriate case to consider whether those principles may inform present day interpretation of "prevailing ideas and concepts" provided such principles accord with the Constitution.

62. *Shtukaturov v. Russia*, (Application no. 44009/05, ECHR, 27th June 2008) concerned the issue of capacity in mental health. There, the ECtHR had regard to "Principles concerning the legal protection of incapable adults", Recommendation No. R (99) 4, adopted by the Council of Europe on the 23rd February 1999. The Court referred in its judgment to Principle 3 of the Recommendation which stipulates that legislative frameworks relating to persons suffering from incapacity should *as far as possible* recognise that different degrees of capacity may exist and that incapacity may vary from time to time. Accordingly, measures of protection should not result automatically in a complete removal of legal capacity. Principle 3.2 specifically provides that measures of protection should

not automatically deprive a person of "… the right to consent or refuse consent in the health field…"

63. While it was suggested in argument in this case that the European Court of Human Rights had not specifically approved the United Nations Convention on the Rights of Persons with Disabilities, I do not think this is so. The judgment of the ECtHR in *Glor v. Switzerland* (Application No. 13444/04, ECHR, 30th April 2009), is noteworthy for pointing out that the UNCRPD signalled the existence of a European and universal consensus on the need to protect persons with disabilities from discriminatory treatment.

64. In *Kiss v. Hungary* (Application No. 38832/06, ECHR, 20th May, 2010) the ECtHR pointed out:-

> "The court further considers that the treatment as a single class of those with intellectual or mental disabilities is a questionable classification, and the curtailment of their rights must be subject to strict scrutiny. This approach is reflected in other instruments of international law …"

65. More immediately relevant is the decision of the ECtHR in *X v. Finland* (Application no. 34806/04, ECHR, 3rd July 2012). That judgment of the Court will now be analysed. The applicant complained that her involuntary confinement in a mental hospital following psychiatric examination was in breach of her right to liberty conferred by Article 5, particularly in the absence of an independent second opinion. The Court agreed with this contention. It stated at paras. 169-171:-

> "169. The Court first draws attention to the fact that, in the present case, the decisions to continue the applicant's involuntary confinement after the initial care order were made by the head physician of the Vanha Vaasa hospital after having obtained a medical observation statement by another physician of that establishment. In the Finnish system the medical evaluation is thus made by two physicians of the same mental hospital in which the patient is detained. The patients do not therefore have a possibility to benefit from a second, independent psychiatric opinion. The Court finds such a possibility to be an important safeguard against possible arbitrariness in the decision-making when the continuation of confinement to involuntary care is concerned. In this respect the Court also refers to the CPT's recommendation that the periodic review of an order to treat a patient against his or her will in a psychiatric hospital should involve a psychiatric opinion which is independent of the hospital in which the patient is detained (see paragraph 133 above). This covers all of the criteria in section 8 of the Mental Health Act.
>
> 170. Secondly, the Court notes that the periodic review of the need to continue a person's involuntary treatment in Finnish mental hospitals takes place every six months. Leaving aside the question whether a period of six months can be considered as a reasonable interval or not, the Court draws attention to the fact that, according to section 17(2) of the Mental Health Act, this renewal is initiated by the domestic authorities. A patient who is detained in a mental hospital does not appear to have any possibilities of initiating any proceedings in which the issue of whether the conditions for his or her confinement to an involuntary treatment are still met could be examined. The Court has found in its earlier case-law that a system of periodic review in which the initiative lay solely with the authorities was not sufficient on its own (see mutatis mutandis *Rakevich v. Russia*, no. 58973/00, §§ 43-44, 28 October 2003; and *Gorshkov v. Ukraine*, no. 67531/01, § 44, 8 November 2005). In the present case this situation is aggravated by the fact that in Finland a care order issued for an involuntary hospitalisation of a psychiatric patient is understood to contain also an automatic authorisation to treat the patient, even against his or her will. A patient cannot invoke any immediate remedy in that respect either.
>
> 171. The Court considers, in the light of the above considerations, that the procedure prescribed by national law did not provide in the present case adequate safeguards against arbitrariness. The domestic law was thus not in conformity with the requirements imposed by Article 5 § 1 (e) of the Convention and, accordingly, there has been a violation of the applicant's rights under that Article in respect of her initial confinement to involuntary care in a mental hospital."

66. The ECtHR further examined claims that the forced administration of medication was in breach of the applicant's rights under Article 8 of the ECHR. The Court noted that under Finnish law, an involuntary care order also included an automatic authorisation to treat such a patient, even against his or her will. It also found that the decisions of a treating doctor are not subject to appeal. In those circumstances, it concluded, at paras. 220-222:-

> "220. The Court considers that forced administration of medication represents a serious interference with a person's physical integrity and *must accordingly be based on a "law" that guarantees proper safeguards against arbitrariness*. In the present case such safeguards were missing. The decision to confine the applicant to involuntary treatment included an automatic authorisation to proceed to forced administration of medication when the applicant refused the treatment. The decision-making was solely in the hands of the treating doctors who could take even quite radical measures regardless of the applicant's will. *Moreover, their decision-making was free from any kind of immediate judicial scrutiny: the applicant did not have any remedy available whereby she could require a court to rule on the lawfulness, including proportionality, of the forced administration of medication and to have it discontinued*.
>
> 221. On these grounds the Court finds that the forced administration of medication in the present case was implemented without proper legal safeguards. The Court concludes that, even if there could be said to be a general legal basis for the measures provided for in Finnish law, the absence of sufficient safeguards against forced medication by the treating doctors deprived the applicant of the minimum degree of protection to which she was entitled under the rule of law in a democratic society (see *Herczegfalvy v. Austria*, cited above, § 91; and, mutatis mutandis, *Narinen v. Finland*, no. 45027/98, § 36, 1 June 2004).
>
> 222. The Court finds that in these circumstances it cannot be said that the interference in question was "in accordance with the law" as required by Article 8 § 2 of the Convention. There has therefore been a violation of Article 8 of the Convention." (emphasis added)

67. The emphasised part of the passages quoted leave it unclear whether access to a court is thought to be mandatory, or, as I believe, whether there must be a right of access capable of vindication other than just by State initiative. This is considered in section 3 of this judgment.

68. The Article 13 contention, that the applicant was denied an effective remedy to challenge the forced administration of medication, was not examined on the basis of the findings in relation to Article 8.

> "229. The Court reiterates that the applicant complained in essence about the lack of an effective remedy to challenge the forced administration of medication.

> 230. In view of the submissions of the applicant in the present case and of the grounds on which it has found a violation of Article 8 of the Convention, the Court considers that there is no need to examine separately the complaint under Article 13 of the Convention."

69. The issues raised are relevant to the instant case. The decision clearly establishes that adequate safeguards must be placed in legislation apparently permitting a patient's involuntary detention and involuntary treatment. It was held that these safeguards were not present in the Finnish legislation. In the instant case, the detention procedures are not being questioned. Therefore, this aspect of the case has limited application.

70. How then should these concepts and principles be applied here? Under the provisions of s. 60 itself, the right to independent review and independent determination of capacity are already, in effect, recognised statutory procedural rights; the provisions give effect to the duty of the State to vindicate the plaintiff's personal capacity rights. Professor Kennedy's evidence establishes that the proper vindication of these rights is "practicable".

71. But what is at issue here are truly *fundamental* constitutional rights in more than just name. What is at stake is truly, in the words of Kenny J. in *Ryan v. Attorney General* [1965] I.R. 294 at p. 313, the right to the "integrity of the person". Each of the rights affected under s. 60 fall within that category, should be policed and monitored by the courts, and are susceptible to judicial supervision, where necessary. Do they necessitate ancillary rights, analogous to the right to legal aid in defence of a serious criminal charge, which itself derives from the constitutional right under Article 38.1 to a criminal trial "in due course of law"?

72. As in the Irish and ECtHR authorities identified, I believe the broader range of constitutional "personal capacity rights" identified earlier, now fall to be informed by the United Nations Convention on the Rights of Persons with Disabilities, as well as the principles enunciated in the judgments of the European Court of Human Rights. The vindication of these rights to a sufficiently high level is necessary because of the serious incursion into bodily integrity and the other personal capacity rights which arises in the case of persons who are subject to orders made under s. 60 of the Act of 2001. Decisions of this type, involving the continued administration of an involuntary drug regime and the taking of blood samples require, in the words of the European Court of Human Rights, "heightened scrutiny".

73. I believe a constitutional reading of s. 60 of the Act of 2001 now requires that this range of rights must be recognised at the constitutional as well as the legal level, especially if the present application of that legal provision does not vindicate those rights "as far as practicable". The constitutional protections must act as an appropriate counterweight to the nature of the incursion into fundamental constitutional rights. Professor Kennedy's evidence establishes that every effort is made to engage a patient in the decision-making process, and that when a patient regains sufficient mental capacity, they will again be empowered to make decisions regarding their treatment, including the then regained ability to give or withhold consent. Why then should the voice of a patient not be heard, and if not by the patient, then through a representative? This was not a situation, unfortunately, where the plaintiff had family members to speak for her. Such a situation may arise in other cases. What is necessary is to achieve the maximum protection which is "practicable". If a patient lacks capacity, does it not follow that, in order to vindicate these rights, the patient should, where necessary, be assisted in expressing their view as part of the decision-making process? It cannot be said that such a process is impractical. I think the constitutional duty involved here is a positive one. I do not think even a retrospective declaration of incompatibility under the European Convention on Human Rights Act 2003 could be a sufficient protection. A sub-constitutional, and possibly retrospective, remedy is not commensurate with the nature of the rights engaged, and the extent of the possible incursion into such rights.

74. There is, of course, the irony that in this case, on its unique facts, the entire process involved in this extensive court hearing may already be seen as a vindication of each one of the rights claimed, including that of assisted decision-making. The function of counsel for the plaintiff in this case has been nothing less than to put forward, in as comprehensive a manner as is practicable, the views and choices of the plaintiff regarding her treatment regime under s. 60.

75. But the unique nature of the case gives rise to an obstacle from the plaintiff's point of view. Decision-making, even assisted decision-making, does not predetermine the outcome of the deciding process. The nature of this case necessitated that it went to court because of the unusual legal issues which arose. The plaintiff has a right of access to court under the Constitution. As discussed at other points in this judgment, I do not envisage that a court procedure will be necessary or mandatory in the vast range of other such cases involving patients subject to s. 60 of the Act. In my view, it would require a truly exceptional case to necessitate a court application. What I think is constitutionally necessary is a right of access to the courts, independent of any State agency, should the need arise. I do not think that an assisted decision-making process of this type need necessarily involve lawyers. The views of the patient might be expressed by carers, social workers or, perhaps most appropriately, by family members. Very frequently, such decisions are ones in which the courts will have little expertise. I would also observe that the evidence of Professor Kennedy indicates that, at least in part, these entitlements are already observed as a matter of course in the hospital where, as he testified, patients are asked to *participate* in decisions regarding their own treatment. This begs the question as to why this participation process cannot be performed on behalf of the incapacitated patient by another, suitably qualified, person. The case has not been made that assisted decision-making is not practicable; the contrary is so. To judge from experience in neighbouring jurisdictions, and in light of legislative proposals on mental capacity here, such a form of decision making must be seen as "practicable".

76. But, here, the plaintiff indisputably does not have capacity to make decisions. There is no controversy on the point. Therefore, having heard the parties, it fell to this court to make decisions as to her treatment, applying the best interest test identified in *Re Ward of Court (No. 2)*. This test has been applied, having examined whether the choices made are the least restrictive, and involve the minimum practical incursion into the plaintiff's rights.

77. Having made that determination, however, it should not be thought that what is involved here is the application of what is termed a "status" approach. This involves making an "across the board" assessment of a person's capacity or views capacity in "all or nothing terms". A "once and for all" status approach in cases in this narrow category does not, I think, vindicate rights as far as practicable. It would not take into account patients whose capacity fluctuates, or those who have episodic mental illness. It may also not take into account the actual capacity of otherwise incapacitated individuals to make decisions in a particular sphere. However, here, there is the real problem that the patient wished to make a decision, which would be not only detrimental to her own health, but would place her life, and the life of others, at risk.

78. In adopting the best interest test, it might be suggested that what was applied then was an "outcome approach" involving the court assessing the patient's wishes, based on an assessment of the *outcome* of the process. Failure to make what might be a "prudent" decision will not always, of itself, be an indicator of want of decision making capacity. Here, one must look at not only the decision itself, but the quality of the plaintiff's decision making capacity. Unavoidably in this instance, the nature of the decision and the dangerous nature of the plaintiff's wishes must be a factor. The court cannot disregard that it has constitutional duties toward

the plaintiff and the public.

79. As the ECtHR judgments point out, however, such decision-making in this area should seek to apply a "functional" approach" to capacity, involving both an issue-specific and time-specific assessment of the plaintiff's decision-making ability. One determination should not be permanent; the process must refer to "differences in capacity" (Article 40.3 of the Constitution). This involves analysing, not only differences in capacity *between* patients, but also variations in each patient's capacity at particular times. Only in that manner can their rights be properly vindicated in accordance with the constitutional requirement.

80. In all this, there must be both trust and commonsense. Every decision cannot be made by a court. This case is one where, sadly, on the indications so far, the plaintiff has an ongoing condition. While her capacity fluctuates, the evidence does not show that, at any point since the initiation of these proceedings, she has reached a point where she is capable of making a decision independently. It has not been suggested that any decisions have been made which were not in the plaintiff's best interests, or at a time, when she actually had capacity to make decisions as to her treatment.

Conclusion

81. In summary, I conclude that the plaintiff is entitled to both an independent review and to an assisted decision-making process in vindication of her rights. But the entire process here involved a vindication of other rights. It has been necessary for this Court to make the ultimate decision because of her incapacity. In the strict sense, therefore, the plaintiff cannot be entitled to the reliefs she claims. It has not been shown that s. 60 of the Act of 2001, constitutionally interpreted, is repugnant to the Constitution. Applying the principle of double construction what then is necessary for a constitutional interpretation and application of the section? What is required is that it should be applied in a constitutional manner, giving effect to rights to be found within the Constitution itself (see *East Donegal Co-operative Ltd v Attorney General* [1970] I.R. 319). The constitutional application of that section should have regard to international norms and conventions identified in this part of the judgment.

82. For the future, I think it will be necessary to review the Form 17 procedure, adopted under s. 60. This can be done in a manner so as to ensure that the range of "personal capacity rights" of a patient objecting to treatment under s. 60 of the Act are vindicated, not only in form but in substance. There should be independent review and the patient's decision or choice, albeit whether assisted or not, should be recorded and due regard given to it. The patient's choice, however conveyed, will not always be determinative, but must always be part of the balance. But the role of the consultant psychiatrists remains pivotal. I turn now to another aspect of the relief claimed.

83. The plaintiff, at paragraph 1 of the statement of claim has sought also a declaration that the finding in respect of capacity must be subject to independent tribunal or court review. In this case, I think that right has already been vindicated to date, and will continue to be. But then the claim goes rather deeper. Does a s. 60 treatment-decision necessitate ongoing court review on a mandatory basis?

Section 3 – Is the plaintiff entitled to a declaration of incompatibility under the ECHR Act and is there an ECHR right to an independent court or tribunal to consider future treatment?

84. It is now contended that, if the HSE should continue to administer treatment on the basis that the plaintiff lacks capacity, that defendant must convincingly show that such treatment is necessary *before an independent tribunal or court*. I would observe here that because of the highly unusual nature of this case it was proper that the matter should be dealt with by the Court. Can a genuine right to a court or tribunal hearing in *all* cases of this type be found? Do the constitutional rights, to be vindicated in each case, necessitate a mandatory ongoing court involvement in every such case? I am not persuaded that a *mandatory* engagement, even in a narrow category of cases involving difficult clinical decisions, can be seen as "practicable". In my view, it would involve a degree of legal involvement in the field of psychiatry, which would be unprecedented, and, I believe, often impractical. Even on this basis alone, it would be very difficult to give recognition to such a right. Does such a right nonetheless exist under the ECHR? Is the plaintiff, therefore, entitled to a declaration that s. 60 is incompatible with the provisions of the ECHR under s. 5 of the Act of 2003?

85. Even having regard to the decision in *X v. Finland*, I am not persuaded that such a right exists in ECHR jurisprudence. That case must be seen as still pending as at present an application for admission to a Grand Chamber hearing remains to be considered. I think the passages cited earlier lack clarity as to whether what is in question is a right to a court hearing as alleged, or, rather a right of access to a court. The rights identified in the cases which follow lay particular emphasis on review of *detention* procedures. Clearly, at a minimum, there must be a right of court access. Decisions as to involuntary medical treatment must be subject to the rule of law, and must be independently reviewed. They must be capable of being *assessed* by a court, and cannot be arbitrary. The case of *Storck v Germany* (Application 61603/00, ECHR, 16th September 2005), addresses involuntary treatment and detention but is based on very different facts. There was a real question there as to the plaintiff's incapacity, and as to the lawfulness of her detention. The ECtHR held that under Article 5 and Article 8 ECHR, there were positive obligations to ensure that an involuntary deprivation of liberty was carried out in accordance with a procedure prescribed by a rule of law. Significantly, it held that special procedural safeguards may be necessary to protect the interests of persons not fully capable of acting for themselves; that even a minor interference with the physical integrity of an individual was to be regarded as an interference with the respect for private life, if carried out against that person's will; and that the State had a positive obligation to protect the applicant against interference with her private life guaranteed by Article 8 of the Convention. By way of distinction with that case, there is no question here that the plaintiff has been wrongly diagnosed, or as to her decision-making capacity. The detention process, here, is in accordance with law. The treatment has been independently assessed by Dr. Kelly, Dr. Bownes and by this Court. It cannot be said that any part of the process is arbitrary therefore.

86. Earlier, in *Winterwerp v. The Netherlands* [1979 – 80] 2 E.H.R.R. 387, the applicant had been compulsorily detained pursuant to successive court orders, was not allowed to appear or be represented at proceedings and was not notified when such proceedings were in progress. As a consequence of his detention, the applicant also automatically lost the capacity to administer his property. There, the ECtHR unanimously held that the applicant's ability to have his detention reviewed by a court and the failure to hear him constituted a violation of Article 5(4) of the Convention. I do not think this case is on point here.

87. Three further decisions of the ECtHR were cited to this Court. All must now be seen in light of the decision in *X v. Finland*. The first, *Shtukaturov*, has already been briefly referred to. The applicant there suffered from a mental disorder but despite this was a relatively autonomous person. His mother lodged an application with the District Court of St. Petersburg seeking to deprive him of his legal capacity. An expert team assessed the applicant and concluded that he was suffering from "simple schizophrenia". A hearing then occurred, of which the applicant was neither notified nor present, where the judge declared the applicant to be legally incapable and his mother was appointed to be a legal guardian. The hearing lasted only ten minutes. At his mother's request he was then placed in a psychiatric institution where he was prohibited from having contact with the outside world. Unsurprisingly, the European Court of Human Rights in that case held that although domestic courts had a certain margin of appreciation, there had been a breach of the applicant's right to fair trial, as guaranteed under Article 6 of the Convention. This arose because, in assessing whether or not a

particular measure such as the exclusion of the applicant from a hearing was necessary, relevant factors had to be taken into account including the nature and complexity of the issue which had been before the domestic courts, what had been at stake for the applicant and whether the applicant's appearance in person represented any threat to others or to himself. It was held that the domestic court proceedings had been unfair. The court observed that the applicant had played a double role in the proceedings, that of interested party and also the main object of the court's examination. His participation was therefore necessary not only so that he could present his own case but so as to afford the judge the opportunity to form an opinion about the applicant's mental capacity. The court also held that the declaration of the domestic court with the effect that the applicant was regarded as having full incapacity for an indefinite period which could not be challenged otherwise than through the guardian constituted a breach of Article 8 of the Convention.

88. It is significant in the context of this case that the ECtHR laid emphasis on the right of a person, the subject matter of an order, to *representation* and *participation* in the proceedings concerning a very significant incursion in their right to liberty and *to private life*.

89. Similar observations were made by the court in *Stanev. v. Bulgaria* (Application no. 36760/06, ECHR, 17th January 2012), where, in national court proceedings on capacity, the applicant was denied the right to have a lawyer of his choice. This had not been authorised by his guardian. He could not perform legal transactions or take part in court proceedings without his guardian's consent; although the guardian's decisions were subject to review by an authority, there was no clarity as to whether the applicant as a partially incapacitated person could challenge the decisions of that authority by way of judicial review. As a consequence, the court held that there were breaches of Article 5(4) involving an entitlement to institute proceedings reviewing a decision and a denial of direct access to courts in violation of Article 6(1) of the Convention. Again, the facts are very different from those in the instant case.

The *Wilkinson* case
90. In the earlier judgment, I made reference to the decision in *R. (On the Application of Wilkinson) v. Broadmoor Special Hospital Authority and Others* [2002] 1 W.L.R 419. As well as pursuing remedies in domestic legislation, the plaintiff in that case, also sought to pursue his rights in the European Court of Human Rights in *Wilkinson v. United Kingdom*, (Application No. 14659/02, 28th February, 2006).

91. The applicant had been detained in a psychiatric institution under the Mental Health Act 1983 in England following conviction for rape of a minor in 1969. Though a clinical consensus existed at the relevant time that he suffered from psychopathic personality disorder, opposing views had been expressed as to whether he suffered from a recognised mental illness. In 1999, his treating doctor sought to administer antipsychotic medication without consent, on the basis that it was necessary to relieve the applicant of 'paranoid ideation'. The treatment was administered moments after an independent doctor approved it under s. 58(3) of the 1983 Act, without notice to the applicant (due to the prospect that he would respond violently). The applicant resisted the injections and had to be physically restrained. On the first occasion, he suffered an angina attack and had to be secluded. The medication was administered on one further occasion, and thereafter he engaged solicitors to contest the treatment.

92. *Wilkinson* is significant because the provisions at issue were broadly akin to those which arise in these proceedings. Section 63 of the 1983 United Kingdom Act removed the general requirement for obtaining a patient's consent for any treatment given to him for his mental disorder so long as the treatment was approved by the clinician in charge of his treatment subject to special requirements stipulated in the case of long term medication, ECT and psychosurgery, equivalent to ss. 58, 59 and 60 of the Act of 2001. However, I think that the observations of the ECtHR must now be seen in the light of the *Glor, Kiss* and *X v. Finland* judgments referred to earlier.

93. At the time of the hearing, I was not referred to any of the ECHR jurisprudence involving a right to ongoing court or tribunal engagement as to ongoing treatment decisions. However, counsel subsequently brought to my attention the case of *X v. Finland* (Application no.34806/04, 3 July, 2012), where a request to the Grand Chamber is pending. The findings of the ECtHR have been set out earlier.

94. I fully agree that the interference with a patient's rights, in cases like the present, is so serious to require adequate safeguards against arbitrariness. What is necessary is a clearly defined procedure, in accordance with law, which vindicates ECHR rights to privacy and autonomy involving proper clinical decision-making procedures. I believe such safeguards are to be found in s. 60 through the requirement for a second opinion from an independent consultant, in relation to the proposed treatment, at regular three month intervals, together with such charges as may be necessitated by this judgment. I would add that a further consequence of assisted decision-making is that it enhances the right of access to the court on behalf of a s. 60 patient. But I do not think any of the ECtHR case law goes further than the rights identified here under the Constitution. In short, I do not understand the law, whether national or under the ECHR, presently to require a mandatory court hearing in every case. I note the *X. v Finland* case remains pending before the Grand Chamber. I should re-iterate that, in the instant case, the plaintiff here was, thanks both to the HSE and to her lawyers, able to have the legality of her treatment procedure reviewed by this Court. But the plaintiff is not, in my view, entitled to a declaration of incompatibility under s. 5. The provisions of s. 60 are of course to be interpreted and applied in a manner compatible with the State's obligations under the ECHR. On my understanding of the ECHR jurisprudence, this objective is achieved by virtue of the adherence to the constitutionally compliant procedures under s. 60 of the Act, outlined earlier in this judgment.

Section 4 - Locus Standi
95. It is necessary finally to address the question of the plaintiff's *locus standi*. This case directly arose from questions which were raised in the earlier case wherein the plaintiff in these proceedings was the defendant. The questions directly related to the proper interpretation of the Act of 2001. The plaintiff was directly concerned with how Part 4 of the Act applied to her. It must be recollected also that the HSE, the plaintiff in the original proceedings, as an alternative to the statutory argument, advanced the contention that the Court would be entitled to grant the reliefs sought, pursuant to its inherent jurisdiction. The issues in this case, in my view could only properly have been resolved by court proceedings.

96. Even though it cannot be said that the plaintiff has succeeded on the issues, this case comes within one of the exceptions identified by Henchy J. in *Cahill v. Sutton* [1980] I.R. 269, as being one where the legal provisions involved were directed to, or operable against a group which includes the plaintiff and where the plaintiff may be said to have a common interest, albeit in circumstances where it may be difficult to segregate the plaintiff's own position from the rights of other persons similarly affected. The law in this area is in a state of evolution and the issues here required judicial determination. In an area where the law required clarification, I therefore conclude that the plaintiff did have *locus standi*.

97. Having regard to all the circumstances, I must find that the plaintiff is not entitled to relief under the headings identified in the claim.

98. I would like to express appreciation to counsel for the parties and the notice parties whose submissions helped to chart the way through the shoals of this difficult area of jurisprudence. It is to be hoped their efforts have resulted in the arrival at a destination which best protects the interests and rights of the plaintiff and those in similar situations.