THE HIGH COURT

[2012 No. 11101P]

IN THE MATTER OF ARTICLE 40.3

AND

ARTICLE 41 OF THE CONSTITUTION

AND

IN THE MATTER OF SECTION 25 OF THE MENTAL HEALTH ACT, 2001, IN THE MATTER OF X.Y. A MINOR

BETWEEN

THE HEALTH SERVICE EXECUTIVE

PLAINTIFF

AND

J.M. AND R.P.

DEFENDANTS

JUDGMENT of Mr. Justice Birmingham delivered the 16th day of January, 2013

1. These proceedings were commenced by plenary summons dated the 5th November 2012, and a notice of motion dated the same day. Also, on that day the matter was mentioned on an ex-parte basis in court at which stage a solicitor was appointed to represent X.Y. The solicitor chosen was appointed because of her involvement in another case which appeared to be potentially highly relevant and her expertise in this area. While the appointment was originally made as a *guardian ad litem*, in fact what has subsequently transpired is that the legal team that has represented X.Y. has acted not so much as *guardian ad litem*, in that the team members have not expressed any views of their own on what is in the best interest of X.Y., but rather they have acted as a *legitimus contradictor* and communicated her views to the court. While what is now before the Court is in form an interlocutory application, in certain circumstances it has the capacity to dispose of the issue.

2. The background facts by way of summary are that X.Y. is fifteen years of age and will be sixteen at the end of January. X.Y. has been diagnosed as experiencing a bipolar affective disorder. On the 15th October 2012, she was detained in the CAMHS (Child and Adolescent Mental Health Team) Inpatient Unit, Merlin Park Hospital, Galway pursuant to s. 25 of the Mental Health Act, 2001 (hereinafter "the Act of 2001"). On the 31st October, 2012, that order was extended by the District Court for a further period of three months. It is important to state that the order of the District Court providing for her detention and the subsequent order extending that detention for a further period of three months have never been challenged. It is also appropriate to note that X.Y. was not separately represented in the s.25 proceedings.

3. It is also important to appreciate by way of background that the latest admission to hospital follows on from earlier admissions to this and other mental health facilities between September and December 2011, and between March and June 2012. It is particularly noteworthy that in July 2012, X.Y. was admitted to Merlin Park Hospital from an adult psychiatric unit, following a suicide attempt. Between the date of her admission to Merlin Park on 3rd July and the 15th October, the date of the District Court order, X.Y. made several attempts to take her own life.

4. X.Y. was prescribed olanzapine, which is a mood stabilising medication. On occasions, indeed on the majority of occasions it appears, it has been found necessary to administer the medication intramuscularly with the use of physical restraint as she refuses to consent to the taking of the medication orally. Since mid-November X.Y. has been taking her prescribed medication orally. However, she has made it clear to her legal team that she does this only because she knew that the alternative was that the medication would be forcibly administered. X.Y. then began to withhold passing urine, in what was believed to be an attempt to cause herself physical harm. Following this she presented with a low grade temperature and was complaining of abdominal pain. In those circumstances the medical authorities were anxious to obtain a blood sample from X.Y. for the purpose of having it analysed. There were two reasons for this. First of all, the taking of a blood sample was appropriate and would constitute best practice, in order to identify the source of her physical complaints and symptoms. Secondly, it is regarded as important and is regarded as best practice to monitor the blood of a person who is being prescribed olanzapine. The practice of monitoring the bloods of a patient who is being treated with olanzapine is in order to guard against possible side effects. The administration of anti-psychotic medication gives rise to a risk of developing a serious physical disorder known as neuroleptic malignant syndrome. Olanzapine is known to be associated with a possible risk of developing diabetes, which risk is higher in young people and accordingly it is regarded as appropriate to carry out blood investigations for the purpose of testing glucose levels and the lipid profile, including cholesterol.

5. The plenary summons as issued had made reference to a wide range of orders that were being sought. A number of these were being sought on a provisional or precautionary basis. For example, there was reference to orders being sought permitting the Health Service Executive (hereinafter "the HSE") to commence antibiotic chemotherapy and for this to be administered intravenously, with authorisation to the HSE to use all reasonable and necessary methods to restrain and contain X.Y. in order to facilitate the intravenous administration of the antibiotic medication, if the results of blood tests were suggestive of an infection and the commencement of antibiotic chemotherapy was deemed to be in her best interests and welfare by her treating physician. Other orders referred to included granting liberty to the HSE to perform catheterisation of X.Y. in the event of a refusal to provide a urine sample. However, the application subsequently moved was put on a much more restricted basis and what is sought now is simply a single blood test. Reference has also been made to the necessity to carry out an electro-cardiogram (ECG), or alternatively an x-ray or ultrasound. That particular issue has not received major attention during the hearing and I will need clarification of what is

proposed. While what is now sought is less radical than what had been referred to initially, it is nonetheless the case that the taking of a blood sample is an invasive procedure. If resisted by the patient so that physical restraint is required, it is a very significant interference with the autonomy and bodily integrity of the patient.

6. This is perhaps the point at which to say that when the legal team was appointed to represent X.Y. it decided to consult and obtain reports from a consultant forensic child and adolescent psychiatrist, Dr. Yolande Devine from outside the jurisdiction and from Dr. Louise Sharkey, a consultant child and adolescent psychiatrist at Mater CAMHS. The report from Dr. Sharkey was based on an interview with X.Y. as well as on her medical notes, conversations held with X.Y.'s consultant psychiatrist Dr. Dermot Cohen and a history taken from both parents. The report from Dr. Devine is what is described as a desktop report and is a report based on general management principles. In the course of the interview conducted by Dr. Sharkey, X.Y. stated that she was not unwell, was fine but just wanted to die. She described various attempts at suicide. She did however say that she had no future plans to harm herself because she had sense now. Dr. Sharkey was of the opinion that X.Y. was a significant suicide risk and she recommended treatment with mood stabilising medication; olanzapine being one such medication. Dr. Sharkey referred to various alternative medications, some of which have already been tried and concluded that on balance olanzapine seemed like the most prudent choice at this point.

7. In relation to the question of capacity Dr. Sharkey made this observation

> "it is my opinion that [X.Y.]does understand the information regarding her diagnosis and treatment and she does have the ability and maturity to retain this information and to communicate her views. However, her current mental state is such that she feels worthless, she is questioning her existence, she is nihilistic and is so hopeless about her future that her judgement is impaired that she cannot make clear decisions regarding her treatment."

8. Dr. Devine in the course of her report makes the point that neuroleptic malignant syndrome sometimes presents rather insidiously so that her current physical manifestations in terms of physical symptoms might well be a manifestation of neuroleptic malignant syndrome. She points out that, it is a potentially life threatening condition but that in order to make a definitive diagnosis of neuroleptic malignant syndrome this would require specific blood tests. Dr. Devine also expresses the view that the current treatment of olanzapine is appropriate. Olanzapine, she points out is a well recognised first line of treatment for young people who experience mood disorder. She goes on to contemplate a possible increase in the dosage of olanzapine by a multiple of six or eight. In fact, I understand that there may have been an increase in the dosage since Dr. Devine reported, but not at all of the order that she was contemplating.

9. There are a number of provisions of the Act of 2001 which appear to be relevant in the current circumstances and it is convenient to set these out at this stage. Section 2 of the Act of 2001 in relevant part provides as follows:-

- "Child" means a person under the age of eighteen years other than a person who is or has been married.

- "Patient" shall be construed in accordance with s. 14.

- "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 of the Act provides as follows:-

"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 principle consideration with due regard being given to the interest 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.

Section 14 in relevant part provides as follows:-

"14-(1) Where a recommendation in relation to a person, the subject of an application is received by the Clinical Director of an approved centre, a consultant psychiatrist on the staff of the approved centre shall, as soon may be, carry out an examination of the person and shall thereupon either –

(a) if he or she is satisfied that the person is suffering from a mental disorder, make an order to be known as an involuntary admission order and referred to in this Act as an "admission order" in a form specified by the Commission for the reception, detention and treatment of the person and a person to whom an admission order relates is referred to in this Act as "a patient" or

(b) if she or he is not satisfied, refuse to make such order."

Section 25 so far as relevant provides:-

"25(1) Where it appears to a Health Board with respect to a child who resides or is found in its functional area that –

(a) the child is suffering from a mental disorder and

(b) the child requires treatment which he or she is unlikely to receive unless an order is made under this section, then, the Health Board may make an application to the District Court ("the court") for an order authorising the

detention of the child in approved centre…

25(6) Where the court is satisfied having considered the report of the consultant psychiatrist referred to in subsection (1) or the report of the consultant psychiatrist referred to in subsection (5), [where the District Court gives a direction that the Health Board arrange for the examination of a child in a situation where either the parents of the child have refused to consent to an examination or the parents of the child or those acting in *loco parentis* cannot be found] as the case may be, and any other evidence that may be adduced before it that the child is suffering from a mental disorder, the court shall make an order that the child be admitted and detained for treatment in a specified approved centre for a period not exceeding twenty one days…

(9) Where, while an order under subsection (6) is in force, an application is made to the court by the Health Board concerned for an extension of the period of detention of the child the subject of the application, the court may order that the child be detained for a further period, not exceeding three months.

(10) On or before the expiration of the period of detention referred to in subsection (9), a further order of detention for a period not exceeding six months may be made by the court on the application of the Health Board and thereafter for periods not exceeding six months.

(11) A court shall not make an order extending the period of detention of a child under this section unless –

(a) The child has been examined by a consultant psychiatrist who is not a relative of the child and a report of the results of the examination is furnished to the court by the health board concerned on the application of the board to the court under subsection (9) or (10), as the case may be, and

(b) following a consideration by the court of the report, it is satisfied that the child is still suffering from a mental disorder.

(12) Psycho-surgery shall not be performed on a child detained under this section without the approval of the court.

(13) A programme of electro-convulsive therapy shall not be administered to a child detained under this section without the approval of the court."

Section 56 provides as follows:-

"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.

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 relief 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 section 58, 59 or 60…

60(1) Where medicine has been administered to a patient for the purpose 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 period of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

61(1) Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless –

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

(b) 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…

69(1) A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself for herself or other and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient…

(4) In this section "patient" includes –

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient"

10. There are a number of comments that may be made. When an application is made to the District Court, then, if the court is satisfied that the child in respect of whom the application is made is suffering from a mental disorder, and that it is unlikely the child will receive treatment unless the order is made, the court shall make an order that the child be admitted and detained for a period not exceeding 21 days. There is provision then for the period to be extended initially for a three month period and to be extended on subsequent occasions for periods of six months. The procedure for the involuntary admission of children to an approved centre thus requires a court order initially and regular court review thereafter.

11. It is clear that X.Y. is a child within the meaning of section 2(1). The question of whether she is a patient within the meaning of s. 2(1) is less clear cut. It appears that the definition of patient is not one that is constant throughout the Act. The general position would seem to be that a child like X.Y. is not a patient having regard to the terms of ss. 2(1) and s. 14. However, for particular purposes the definition of patient is broadened to include a child. (See for example, in that regard s. 69(4) quoted above).

12. So far as the Act of 2001 is concerned the courts have taken the view that a purposive construction of the legislation is appropriate having regard to what has been described as the paternalistic intent of the legislation. (See in that regard the comments of McGuinness J. in *Gooden v. St. Otteran's Hospital* [2005] 3 I.R. 617 and the comments to like effect of Kearns J. (as he then was) in *E.H. v. Clinical Director of St. Vincent's Hospital* [2009] 3 I.R. 744).

13. Section 4(3) requires that in the making of a decision concerning the care or treatment of a person, due regard should be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy. It will be noted that this subsection is couched in very broad terms and refers to persons as distinct from patient or child. It is therefore clear that there is a statutory requirement that decisions taken in relation to X.Y. must respect her right to dignity, bodily integrity, privacy and autonomy.

14. The question arises whether the reference in the legislation to treatment encompasses the taking of blood samples for the purpose of blood monitoring. A strict or narrow construction might exclude the taking of blood samples, as the blood sample is not, certainly not directly, for the purpose of ameliorating a mental disorder. On the other hand a broader or purposive interpretation might regard the taking of a blood sample as being linked to or ancillary to the administration of the prescribed medication which undoubtedly is being administered for the purpose of ameliorating a mental disorder. As it happens the meaning to be given to the word "treatment" was the subject of a recent decision by MacMenamin J. in the case of *The Health Service Executive. v. M.X*. [2011] IEHC 326 (Unreported, High Court, MacMenamin J., 29th July, 2011). In the course of his judgment MacMenamin J. commented as follows:-

> "67. In summary, I think a broad construction of the word 'treatment' will have the following consequences: it will respect the principles that allow for a broad interpretation; it will have regard to the other provisions of the Act; it will respect and reflect the constitutional values involved and the precedents which bind this court. But it must be emphasised it should be compatible with the Constitution itself and the terms of ss. (2), (3) and (4) of the European Convention on Human Rights Act 2003. I conclude that, after these hearings, the Court in its interpretation of the Act, and in the assessment of the defendant's best interest, should allow for a medical procedure which, albeit invasive, is ancillary to, and part of the procedures necessary to remedy and ameliorate her mental illness or its consequences. Clearly 'treatment' could not include measures or procedures which are entirely unrelated to a patient's mental illness.
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> 68. Thus, applying these principles, I consider the obtaining of fbc's [full blood counts] as part of, and ancillary to the treatment and medicine regimes in this case is lawful, in the patient's best interest, and in accordance with the Act…"

15. In that case MacMenamin J. was dealing with a person who was suffering from paranoid schizophrenia and a borderline personality disorder, the condition being particularly severe. Her treating doctors in the Central Mental Hospital administered a number of drugs to counteract her psychiatric condition. It became necessary in the view of those caring for M.X. that they needed to obtain blood samples but M.X. objected to this. In that case the treatment that had been devised for the plaintiff involved prescribing anti-psychotic medication and the medication was central to the treatment plan. However, such medication could not be safely administered to the patient without blood tests being conducted at regular intervals in order to detect the possibility of an adverse reaction.

16. In that case MacMenamin J. as a first step turned to the definition of consent in section 56. In a situation where the medical and psychiatric view was that the defendant in that case lacked the capacity to consent, his attention then turned to section 57. Ultimately, he concluded that the balance fell squarely in favour of purposive interpretation and accordingly was of the view that the taking of fbc's was part of, and ancillary to the treatment regime, was lawful, was in the patient's best interests and in accordance with the Act of 2001. The facts of the M.X. case are so similar to the present case that it is a decision, which is a powerful authority and one to which I must have the closest regard.

17. The Act of 2001 draws a distinction between the position of a child and the position of an adult patient in a number of ways. Section 60 deals with the position of an adult patient and offers two methods whereby medication can be continued beyond three months. That can occur either through the consent of the patient in writing or, where the patient is unable or unwilling to give such consent with the authorisation of another consultant in addition to the consultant responsible for the care and treatment of the

patient. In contrast, s. 61 which deals with the position of a child such as X.Y., in respect of whom an order under s. 25 is in force offers only one route for the continuation of the administration of medication, namely, authorisation by another consultant in addition to the approval by the consultant psychiatrist responsible for the care and treatment of the child. The legislature has taken the position, that the written consent of a child as distinct from an adult patient cannot provide effective consent to continued medication.

18. Apart from the general position of how the legislation addresses the effect of consent from children, a further area where the legislation adopts a different approach between children and other patients is to be found in the case of psycho and electro-convulsive therapy. In the case of a child, psycho-surgery or electro-convulsive therapy cannot be performed without the approval of the court. However, in the case of a non child patient, electro-convulsive therapy and psycho-surgery can take place if the patient gives his or her consent in writing. In the case of psycho-surgery, authorisation by a Tribunal is also required. It seems to me that the approach to psycho-surgery and electro-convulsive therapy is indicative of the fact that the legislature did not feel that children were in a position to give consent to issues of such major significance.

19. I should state that the view I have formed is that X.Y. lacks the capacity to refuse consent to the taking of the blood samples. I have quoted the observations of Dr. Sharkey. The issue of capacity has also been addressed by Dr. Cohen. He sought but has been unable, in the absence of co-operation from X.Y. to carry out a formal assessment. Nonetheless, he expresses his belief that there are certain areas where she displays a good understanding of her difficulties and other areas where she does not. He believes that she has an understanding of the reason why a blood test would be necessary. X.Y. understands that she had a temperature and that a blood test could show that she had an infection. She is aware of the implications of the results of a blood test in that further treatment may be necessary. She is also aware that if she refuses the test, that it may not be possible to diagnose the presence of infection. Again Dr. Cohen is of the view that she understands the nature of the procedure as she has had blood tests done before. However, he is of the view that X.Y. does not display an understanding of the risk of failing to engage with treatment for a possible infection. X.Y. does not believe that she would become sick if she does not receive antibiotic treatment for an infection. She does not believe that she might require a transfer to a general hospital if she did not comply with treatment. She stated a belief that "only old people get sick from infections and this wouldn't happen to a younger person". In these circumstances he is of the view that she has a limited capacity to consent to the physical investigations deemed necessary by virtue of the administration of olanzapine. He indicates that he believes that her refusal to comply with treatment could be linked with her wish to die, which still persists, albeit less intensely than previously and that it is possible that she sees her refusal to consent to treatment as leading to sickness and to her eventual death. However, he believes that her simplistic view that she would not die as "this would only happen to old people" is what she really believes. He is of the view that her capacity overall is significantly influenced by her low mood.

20. The submissions on behalf of X.Y. have proceeded on the assumption that it follows that a person who has the capacity to consent to medical treatment has the capacity to refuse treatment. However, this is an assumption that may not be well-founded.

21. Ordinarily in the case of an individual consenting to treatment, the situation will be that those charged with the medical care of the person, adult patient or child, are of the view that a particular form of treatment is in the best interest of the individual. The consent of the person is to treatment regarded as appropriate and in his or her interest. The fact that there is a consensus between doctors and patient offers a degree of comfort and reassurance. In contrast when a patient is refusing treatment, it will normally be the case that the person is refusing treatment, which in the view of medical advisors would serve his or her best interest. In some cases it may even be the case that refusing treatment may put the individual's life at risk. However, while that is so, there is no doubt that an adult of full age and full capacity is entitled to consent to treatment and equally entitled to refuse treatment. Denham J. (as she then was), pointed out in the course of her judgment In *Re Ward of Court (No. 2)* [1996] 2 I.R. 79 that :-

> "The consent which is given by an adult of full capacity is a matter of choice. It is not necessarily a decision based on medical considerations. Thus, medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decision for their own reasons."

22. In this case X.Y. is neither of full age or full capacity. Indeed, not only is she not of full age, she is still under sixteen years. The significance of this being that s. 23 of the Non Fatal Offences against the Person Act 1997, provides that the consent of a minor who has obtained the age of sixteen years shall be as effective as it would be if X.Y. were of full age in relation to surgical, medical or dental treatment which would otherwise amount to a trespass in the absence of consent.

23. That the consent of a minor aged fifteen years and eleven months would not provide a statutory defence to what otherwise would be a trespass, is of course, not at all to suggest that the views of a minor of that age ought not to be treated with respect, they most certainly should be.

24. In expressing the view that X.Y. lacks capacity to refuse to provide a blood sample which is required, I am conscious that capacity can fluctuate. I am not to be taken as being of the view that there are no decisions of a medical nature which X.Y. would not have the capacity to take. Neither, am I laying down any general principle that young people aged 15 going on 16 should always be regarded as lacking capacity. The views are specific to this fifteen year old's capacity to refuse to allow a blood sample to be taken.

25. There is a further dimension that in this case the child's parents are supportive of the treatment that she is receiving and what is proposed.

26. In the course of her judgment in *Northwestern Health Board v. H.W. and C.W.* [2001] 3 I.R. 62 the P.K.U. or heel test case, Denham J. (as she then was) at p. 723 commented as follows:-

> "Every day, all over the State, parents make decisions relating to the welfare, including physical welfare of their children. Having received information and advice they make a decision. It may not be the decision advised by the doctor (or teacher, or social worker, or psychologist, or priest or other expert) but it is the decision made, usually responsibly, by parents and is abided by as being in the child's best interest. Having been given the information and advice, responsibility remains with parents to make a decision for their child."

27. In that case the court was of course dealing with a very young child indeed and there was no question of the child being in a position to make a decision or express views, which is quite different to the present situation. Nonetheless, it is the case that if the blood tests are not taken this will involve disregarding the parents' wishes. In the present situation, doctors and parents are united in their opinion that it is appropriate that a blood sample should be taken from X.Y. Refusing to permit the taking of the blood sample would set the court in opposition to doctors and parents.

28. In the course of the argument there has been extensive reference to the case of *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] A.C. 112, a case that is etched in the memory of lawyers and individuals with an interest in current affairs of a particular age. In that case the court was of the view that the relevant factor was not the age of the individual but rather the ability to understand fully what was proposed. The judgment introduced into English Law, the concept of the "Gillick competent minor" and it is an approach that has found favour in a number of common law jurisdictions. Even assuming, for this purpose only, that the concept of "Gillick competent" forms part of Irish law, it is clear that X.Y. is not in fact "Gillick competent".

29. I have already referred to the fact that there is a distinction to be drawn between capacity to consent to medical treatment that is proposed and capacity to refuse medical treatment. This is a theme that was addressed in the case of in *Re. R. (a minor) (Wardship; consent to treatment)* [1991] 4 All E.R. 177. That was a case involving a fifteen year old girl in the care of a local authority who was suffering increasingly serious episodes of mental illness characterised by violent and suicidal behaviour. She was admitted to an adolescent psychiatric unit, where the proposed programme of treatment included a compulsory administration of certain anti psychotic drugs. The local authority initially consented to the proposals but after R. in a lucid interval indicated that she would wish to refuse such treatment, it withdrew its consent and began wardship proceedings. Lord Donaldson commented as follows.

> "The failure or refusal of the "Gillick Competent" child is a very important factor in the doctor's decision whether or not to treat, but does not prevent the necessary consent being obtained from another competent source."

Later, in his judgment, the Master of the Rolls made clear that the court in the exercise of its wardship or statutory jurisdiction had power to override the decision of a "Gillick competent" child as much as those of parents or guardians.

30. In my view the taking of a blood sample is clearly ancillary to prescribing and administering medication. X.Y.'s past history leaves no room for doubt but that she is a serious suicide risk. She requires appropriate treatment or her life will be at serious risk. Section 25 of the Act of 2001 authorises the detention of children for treatment. The detention permitted is for the purpose of treatment, detention without treatment would normally be quite unacceptable. The section is structured to provide safeguards against arbitrary intervention. Therefore, the Health Board intervenes only when a child within its area appears to it to be suffering from a mental disorder and requiring treatment which he or she is unlikely to receive unless an order is made under this section. Ordinarily, an application will not be made unless the child has been examined by a consultant psychiatrist. Where that cannot happen because the parents or person acting in *loco parentis* refuses to consent or cannot be found, then the Health Board may make an application without a prior examination by a consultant psychiatrist but when that happens the court to which the application is made may direct the Health Board to arrange for the examination of the child by a consultant psychiatrist. On the hearing of the application the court can only order that the child be admitted and detained for treatment in a specified approved centre for a period not exceeding 21 days. During that initial period of 21 days if an application to the court is made by the Health Board the court may authorise detention for a further period which cannot exceed three months. If there is a further application to the court during that second period of authorised detention, the court at that stage may make a further order for a period not exceeding six months and thereafter make further orders in each case not exceeding six months. An order shall not be made unless the court is satisfied having examined a report by a consultant psychiatrist that the child is still suffering from a mental disorder. The detention authorised under s. 25 is, as I have pointed out for the purpose of treatment. Accordingly, it seems to me that the section serves to authorise medical professionals to treat a child. However, the treating doctors are not entirely at large. So, as we have seen psycho-surgery and ECG cannot take place without the prior approval of the court. Provision is also made for a child who is on long term medication in that administration of the medicine shall not be continued beyond three months unless the administration of the medicine is authorised by another consultant psychiatrist in addition to being approved by the consultant psychiatrist responsible for the care and treatment of the child. It seems to me that the terms of s.61 leave no room for doubt but that the treating doctors are entitled to administer medication to a child whose admission through an approved centre has been ordered by the court pursuant to section 25. This is what has been happening since X.Y. was admitted to Merlin Park Hospital on the 15th October 2012.

31. In this particular case there are further sources of comfort, in that the taking of the blood sample and, it may be said, her presence in Merlin Park Hospital and the treatment she is receiving there is supported by X.Y.'s parents.

32. Further comfort still, is provided by the contents of the two medical reports obtained by X.Y.'s legal team. Dr. Sharkey has stated that she would recommend treatment with a mood stabilising medication. She does so having expressed the view that X.Y. is a significant suicide risk, with that risk significantly increased in the lead up to her sixteenth birthday. Apparently X.Y. has always said that she hopes to die before her sixteenth birthday and she will turn sixteen in late January. Dr. Devine, too is of the view that her current treatment with olanzapine is appropriate. Dr. Devine is also of the view that she may well be presenting with neuroleptic malignant syndrome, a potentially life threatening condition but a diagnosis can only be made on the basis of specific blood tests.

33. The orders now sought as distinct from the range of orders that were referred to in the plenary summons are quite restricted. The taking of a blood sample is designed to protect the life and well being of X.Y.. She is a serious suicide risk and that risk is heightened over the coming weeks before her sixteenth birthday. The taking of a blood test is necessary if the prescribed mood altering drug olanzapine is to be administered in accordance with best practice. Given her current physical symptoms the taking of a blood sample is required in order that a definitive diagnosis can be made in relation to the life threatening condition that is neuroleptic malignant syndrome. It is devoutly to be hoped that the results of the blood test will exclude that condition. Seen in those terms what is proposed is clearly proportionate.

34. I should say that in the course of the written submissions filed on behalf of X.Y. it is submitted that there is no statutory provision which permits the HSE to forcibly administer medicine to X.Y. against her will. Then, in the alternative, it is submitted that if the section does permit any treatment to be imposed on the applicant except psycho-surgery and ECG then, the submission is made that the section is repugnant to the constitution (Article 40.3) and incompatible with the European Convention on Human Rights (articles 6, 8 and 13). In a situation where what is now before the court relates to the need for the taking of a blood sample rather than the question of prescribing and administering medication and where there has been no opportunity for involvement on the part of either the Attorney General or the Irish Human Rights Commission and where there has been no evidence as to how relevant sections of the legislation will be implemented in practice, I do not propose to comment specifically on that submission.

35. I would point out that s.61 of the Act of 2001, does not, of yet, have any application to X.Y. as she has not been detained for three months. In the course of his judgment in the case of *M.X. (Apum) and the Health Service Executive and The Attorney General and the Irish Human Rights Commission* [2012] IEHC 491 (Unreported, High Court, MacMenamin J., 23rd November, 2012) delivered on the 23rd November 2012, MacMenamin J. made certain observations about the necessity of reviewing the Form 17 procedure [the form that is completed by the consultant, other than the consultant responsible for the care and treatment of the patient who authorises the continuation of medication] adopted under section 60. This he indicated, could 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

regarded and due regard given to it. It may very well be that detailed consideration of s. 61 might, in the future lead to similar views being expressed. However, at present and in respect of the very limited issues before the court on what is an interlocutory application I am satisfied that X.Y.'s best interests are served by permitting the taking of the blood sample.

36. I will discuss with counsel what form the order should take and will also seek to clarify the position in relation to the ECG, x-ray/ultrasound issue, which does not seem to differ in principle in any way from the blood test issue.