Neutral Citation [2016] IEHC 445

THE HIGH COURT

[Record No: 2015/7270 P]

IN THE MATTER OF R.

IN THE MATTER OF ARTICLE 40.3 AND ARTICLE 41 AND 42 OF THE CONSTITUTION

AND IN THE MATTER OF THE INHERENT JURISDICTION OF THE HIGH COURT

BETWEEN:

HEALTH SERVICE EXECUTIVE

PLAINTIFF

AND

R. (A PERSON OF UNSOUND MIND NOT SO FOUND REPRESENTED BY HIS SOLICITOR)

DEFENDANT

AND

A.B. AND C.D. (PARENTS)

NOTICE PARTIES

AND

[Record No. 2014/5588 P]

BETWEEN:

CHILD AND FAMILY AGENCY

PLAINTIFF

AND

R. (A MINOR REPRESENTED BY GUARDIAN AD LITEM) AND A.B. AND C.D. (PARENTS)

DEFENDANTS

JUDGMENT of Ms. Justice Bronagh O'Hanlon delivered on the 22nd day of July, 2016

1. R., the subject matter of these proceedings, born on 12th September, 1997, is no longer subject to orders of the Court and a place is currently available to him in a Nua Healthcare facility known as the Fairways Unit in Edenderry, Co. Offaly.

2. He was subject to orders detaining him in St. Andrew's Psychiatric Hospital, Northampton, England under the inherent jurisdiction of the High Court between June, 2014 and 31st May, 2016, at which point he was assisted in transferring voluntarily to the Nua Healthcare facility in Ireland.

3. Birmingham J. of the High Court made the original order dated 26th June, 2014 (in proceedings under High Court number 2014/5588 P) for his removal from this jurisdiction and his placement in the care, custody and control of the Director of St. Andrew's Hospital, Northampton for the purpose of the provision of welfare and therapeutic services. The Director of St. Andrew's was permitted by that order to detain R. temporarily pending further order of the High Court. The Child and Family Agency were also ordered to have an independent child and adolescent psychiatrist review, on an appropriate periodic clinical basis, the assessment and treatment provided to R. The Child and Family Agency were further ordered to report to the High Court on the care, protection and welfare circumstances of R. Mr. Harry Law was also appointed as guardian *ad litem* on behalf of R. in those proceedings. By order dated 25th June, 2015, the Health Service Executive was joined as a notice party to the original Child and Family Agency proceedings.

4. The order of this Court in the Child and Family Agency proceedings dated 23rd July, 2015 records that reports were provided by Dr. Joanne Vernon, Dr. Robert Daly and Dr. Garrett McDermott and this Court declared that R. did not have capacity to make material decisions in terms of his medical treatment and therapy and that it was in his best interests to remain in St. Andrew's. The Health Service Executive was also given liberty to issue proceedings in respect of R.

5. R. reached his majority on 12th September, 2015, prior to which the current proceedings (High Court number 2015/7270 P) came before the High Court in order to plan for his best interests given that his majority was imminent.

6. White J. of the High Court made an order dated 9th September, 2015 which declared that R. was placed in St. Andrew's as a minor for therapeutic and educational purposes by order of the High Court pursuant to the inherent jurisdiction and Article 56 of Council Regulation (EC) No. 2201/2003. That order further declared that R. is an Irish citizen and would remain habitually resident in Ireland during the period of his treatment at St. Andrew's. This Court declared that upon reaching his age of majority he would lack capacity to consent to the provision of necessary and appropriate medical, nursing, psychiatric treatment and welfare and therapeutic services or to make his own decisions regarding his accommodation. It was ordered that the Health Service Executive, its servants or agents, be permitted to continue to place R. at St. Andrew's Hospital, Haygate Unit, for the purpose of receiving treatment there together

with any welfare and therapeutic services subject to intensive welfare review for a period of six months or such lesser or greater periods as the High Court decided.

7. The HSE was further ordered to make an application forthwith to the Court of Protection in England, including for urgent interim provision, pursuant to the provisions of Mental Capacity Act 2005, seeking an order for the enforcement and recognition of the Orders of this Honourable Court pursuant to Part 4 of Schedule 3 of said Act with permission to disclose the papers from these proceedings before the Court of Protection in the jurisdiction of England and Wales. The HSE was also ordered to notify the Official Solicitor in London of the said proceedings. The above outlined order has been extended by this Court on a number of occasions.

8. Under Article 56 of the Council Regulation (EC) No. 2201/2003 of 27th November, 2003 Concerning Jurisdiction and the Recognition of Judgments in Matrimonial Matters and the Matters of Parental Responsibility a child may be placed in another Member State. Article 56 states as follows:-

> 1. "Where a court having jurisdiction under Articles 8 to 15 contemplates the placement of a child in institutional care or with a foster family and where such placement is to take place in another Member State, it shall first consult the central authority or other authority having jurisdiction in the latter State where public authority intervention in that Member State is required for domestic cases of child placement.
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> 2. The judgment on placement referred to in paragraph 1 may be made in the requesting State only if the competent authority of the requested State has consented to the placement.
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> 3. The procedures for consultation or consent referred to in paragraphs 1 and 2 shall be governed by the national law of the requested State."

9. Since R. became an adult, EC Regulation 2201/2003 was no longer applicable. Therefore, the procedure is that, on foot of orders from the Irish High Court, the plaintiff, its servants or agents, then make an application to the Court of Protection in England pursuant to the provisions at Part 4 of Schedule 3 of the English Mental Capacity Act 2005 seeking an order for the enforcement and recognition of the Irish High Court orders. This procedure was accepted by Baker J. of the English Court of Protection in the case of *Health Service Executive of Ireland v. P.A. & ors* [2015] EWCOP 38. Baker J recognised and enforced orders of the Irish High Court almost identical to those in this case although it was clarified that certain procedural safeguards must continue to be in place and that a regular review of the treatment and circumstances of the detained individual must be held in order to prevent the orders from being "manifestly contrary to public policy". This has been done by intensive welfare review on a monthly basis and the English Court of Protection has enforced the Irish High Court orders, finding that Ireland was compliant with the European Convention on Human Rights and noting that the regular intensive welfare reviews ensured said compliance.

10. R. is a young man with extremely complex needs and a diagnosis of Autism Spectrum Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder and a Development Co-Ordination Disorder. R. also has a general mild intellectual disability. R. was living in the Fairburn Ward in St. Andrew's which is a medium secure unit for adult males with hearing impairments. R. does not have a hearing impairment. The reason that he was moved to this ward was for his safety following a number of violent incidents.

11. This Court made an order dated 30th May, 2016 noting R.'s willingness to reside at the Nua Healthcare Facility at the Fairways, Edenderry, Co. Offaly. This Court ordered that R. be transferred from St. Andrew's to Ireland on 31st May, 2016 and that, as of midnight on 31st May, 2016, the interlocutory detention orders made herein on 26th June, 2014 were discharged.

Evidence on the Issue of Capacity

Evidence of Dr. Daly

12. Dr. Robert Daly, Consultant Psychiatrist and Clinical Director of the Ashlin Centre gave evidence to the Court on 26th January, 2016. He provided the Court with reports dated 19th July, 2015, 14th October, 2015, 4th February, 2016, 26th May, 2016 and 20th June, 2016. Dr. Daly adopted these reports as part of his evidence. Dr. Daly has met with R. on a number of occasions. He gave evidence that R. was doing relatively well as of 26th January, 2016, that he had obtained a Level 4 security clearance and that he had engaged with his psychologist in St. Andrew's. Dr. Daly stated that R. has a diagnosis of "mild mental retardation", ADHD and autistic spectrum disorder.

13. Dr. Daly gave evidence on 26th January, 2016 that R. had been benefitting from the treatment he received in St. Andrews. The treatment had been appropriate, however, Dr. Daly was of the view, as of 26th January, 2016, that the restrictions on his liberty may not be appropriate. Dr. Daly was of the view that R. does have the capacity to consent to medical treatment. Dr. Daly has been consistent in this view since his report of October 2015 and again stated that he believes that R. has the capacity to consent to treatment on 30th June, 2016 in evidence before this Court.

14. Dr. Daly accepted that Dr. Andrew Iles, who had clinical responsibility for R. in St. Andrew's, believes that R. lacks capacity. Dr. Daly indicated that the difference in opinion may come down to the fact that Dr. Iles is working in the UK mental health system and that, while the criteria for capacity are broadly similar internationally, perspective may influence their medical opinion. Dr. Daly noted that Dr. Iles cited the reason for his finding on capacity to be based on his opinion that R. cannot grasp subtle nuance. Dr. Daly did not place the same emphasis on this element of the test for capacity.

15. Dr. Daly also noted the difference of opinion held by Dr. Anthony Kearns, the independent psychiatrist who conducted an assessment on behalf of R. himself and who has extensive experience. Dr. Daly understood Dr. Kearns' position to be that R. currently lacks capacity to make informed decisions and his capacity is compromised by his emotional fluctuations. Dr. Daly gave evidence that, at the time of his original report in July, 2015, R.'s fluctuations happened on a daily basis and he had not been engaging in treatment. The circumstances have now changed and R. has become more regularised and stabilised in his emotions. Dr. Daly noted that capacity is usually focused on a once off medical decision and a snap shot in time is used. In this case, however, there has been a continuing assessment of R.'s capacity to consent to treatment over periods of months. Dr. Daly identified a marked improvement in R. since the previous assessment in July, 2015. Dr. Daly accepted that if R. was assessed in a time of extreme anger he may lack capacity but these are rare moments and R. has capacity the majority of the time.

16. On 26th January, 2016, Dr. Daly confirmed his belief that R. should be returned to Ireland. He further confirmed that proper services are required but that a firm plan had not been put in place at that time on 26th January, 2016. Dr. Daly was willing to take clinical responsibility for R.'s transition plan, were that to occur, and he also noted that there would be a residual area of responsibility within the Child and Family Agency Aftercare Department. Dr. Daly indicated a belief that they could not form a transition plan while they did not know whether or not R. would be permitted to be transitioned to Ireland. Dr. Daly accepted under cross examination that

he had not seen R. for a number of months at the point of giving evidence on 26th January, 2016.

17. Dr. Daly accepted that capacity should be defined at a point in time. However, Dr. Daly stated that he does not believe that R.'s capacity has deteriorated and he has continued in his belief that R. has capacity. Under cross examination, Dr. Daly indicated an awareness of the uncommenced legislation in the area of capacity in Ireland and the case law on the subject. It was put to him that there is a "three part test" for capacity as found in the Irish case law which includes the comprehension and retention of information, the ability to make a voluntary choice based on that information, and the ability to weigh or balance the information when making that decision. Dr. Daly was of the view that R. met all of these criteria and therefore had the requisite capacity.

18. Dr. Daly gave evidence that he was of the view that it would not be justifiable to find R. lacking in capacity simply because he does not understand the subtle nuances of his treatment plan. Dr. Daly gave evidence that R.'s ADHD is under control and that the Autistic Spectrum Disorder is not interfering with R.'s decision making capacity. Dr. Daly gave evidence that, in addition to R.'s primary diagnosis he also has a history of substance misuse and a conduct disorder. Dr. Daly further stated that R. may have precursors to an anti social disorder but this would not be a suitable diagnosis to make at his current developmental stage.

19. Dr. Daly accepted that he had given previous evidence to the Court that there was no suitable place in Ireland for R. to stay at an earlier point in these proceedings. However, things have now changed as R. is now an adult. Dr. Daly stated that they were working on a plan regarding a suitable placement in Ireland. Dr. Daly gave evidence that placements were being considered with the Nua Healthcare organisation.

20. Dr. Daly differs from the other experts on the issue of "subtle nuance" as he believes an understanding of the subtle nuances in treatment is not necessary for a person to have capacity. It was put to Dr. Daly that Dr. Iles feels that it would be unethical to try and treat R. without the ability to detain him. Dr. Daly's view is that R. can be cared for in Ireland in a Nua Healthcare facility and that R. does not need to be detained in order to treat him. Dr. Daly accepted that a low secure unit within St. Andrew's might have been a positive and suitable stepping stone for R. while the transition to Ireland is being worked out however, this was not possible. Dr. Daly further reiterated his view that R. is an adult with capacity and so it is up to R. to choose whether he wants to engage in treatment.

21. Dr. Daly's view was that he was against any detention of R. and he indicated that the limited liberty that R. gained in relation to moving around the grounds of St. Andrew's had improved him. Dr. Daly also indicated in evidence on 26th January, 2016 that it may be beneficial if R. could stay voluntarily in St. Andrew's for a period of some months in order to consolidate his treatment. However, this Court notes that St. Andrew's cannot keep a person in their facility without a mandatory court order.

22. Dr. Daly agreed to conduct an updated assessment of R. and gave further evidence to the Court on 8th February 2016. Dr. Daly went to St. Andrew's on 4th February, 2016 with his team to visit R. and prepare an updated report for the Court. Dr. Daly gave evidence that R. had been placed on the Fairburn Ward for his own safety following incidents of assault on the Pritchard Ward. Dr. Daly noted that R. appeared to be making good progress. Dr. Daly was of the understanding that R. had kept up his therapeutic activities in the Pritchard Ward while residing on the Fairburn Ward. The staff in St. Andrew's were happy with R. and they were working on building on his understanding and regulating his emotions. The Fairburn Ward is specifically for adult men with hearing impairments and R. does not have any hearing impairment. It was Dr. Daly's understanding that the doctors in St. Andrew's had canvassed a potential referral to the Nasby Ward which is a low secure unit. The referral had been made and they were waiting at that time for an assessment by the team from the Nasby Ward.

23. It is Dr. Daly's view that R. continues to have capacity around consenting to his treatment as stated on 26th January, 2016 and again stated to this Court on 30th June, 2016. This is similar or the same as Dr. Daly's previous opinion as to him having capacity that was formed in October, 2015. Dr. Daly gave evidence that R. may have even more capacity than previously. Dr. Daly gave evidence that R. was more fluent as to engaging with future interventions. It is Dr. Daly's view that they facilitated a critical period of maturation in St. Andrew's which included stabilisation, medication and various therapies although the facility has now served its purpose and it was now time for R. to move on.

24. Dr. Daly gave evidence that R. is aware of all his prescribed medication and the reasons that they are being prescribed. R. also recognised that he has spells of depression and that he has an attention deficit disorder. Dr. Daly further stated that R. is willing to take the medication and has been doing so on a continuous basis. It is the view of Dr. Daly that R. is able to express his views and preferences. He has stated that he would prefer to be back in Ireland although he recognised the desirability to continue treatments and the need for an environment which would be supportive. R. had an awareness that he should not return to his family home. R. understands that his return is a complex process. Dr. Daly gave evidence that he discussed possible alternatives with R. who is aware that if he were to return without a support system there would be dangers and risks. R. also understands that he would not be obliged to stay in the potential Nua Healthcare placement in Ireland and that he would not be detained there.

25. Dr. Daly gave evidence that he has had dealings with the type of care situation that R. would be returning to with Nua Healthcare and he has had experience of them having a positive effect and being able to facilitate individuals to engage with treatment. Dr. Daly also spoke with R. about the desirability that there would not be a rapid change from full detention to full freedom and the need for a transition plan and R. appeared to Dr. Daly to be agreeable. Dr. Daly indicated that R. would benefit from further residential placement such as that of a Nua Healthcare facility in order to consolidate his improvement. Dr. Daly is of the view that the least restrictive setting possible would be preferable. Dr. Daly also stated that the assessment officer from Nua Healthcare was travelling to see R. and that this was the beginning of the process of planning for a possible return of R. to Ireland. Dr. Daly responded, under cross examination, that he believed that it may take a number of months for Nua Healthcare to have a suitable placement available for R.

26. Dr. Daly gave evidence that he does not believe that R. has to stay in St. Andrew's to get the appropriate treatment. He further explained that the alternative would be a placement with Nua Healthcare in Ireland although there was no placement immediately available as of February, 2016. Dr. Daly indicated that R. definitely wishes to leave St. Andrew's and return to Ireland.

27. Dr. Daly said that one cannot predict human behaviour but that he agreed with the statements made by others that R. has improved and his resolve at the moment would be to not engage with confrontation and that he would walk away. It was also put to Dr. Daly that it was stated in the guardian *ad litem* report that if R. was having a confrontation with staff he'd "leave the gaff". Dr. Daly noted that this shows an ability to disengage from conflict which is a positive improvement for R. However, it was also put to Dr. Daly that the guardian *ad litem* has also indicated that R. has limited insight into his condition and his treatment. Dr. Daly believes that R. actually has quite good or, at least reasonable, insight. He indicated that R.'s acknowledgement of risk factors of being in Dublin displays reasonable insight.

28. This Court requested that Dr. Daly conduct a further assessment of R.'s capacity to consent to treatment in the context of his

residency in the Nua Healthcare Facility. Dr. Daly supplied the Court with an updated report dated 20th June, 2016 and gave evidence based upon it on 30th June, 2016. He stated that he continues to be of the view that R. has the capacity to consent to treatment. Dr. Daly emphasised that R. also has the capacity to make decisions which the clinicians may consider to be incorrect decisions. He noted that the move to Fairways had been somewhat difficult and there had been a number of incidents since his return although there have also been positive signs including going to psychotherapy sessions. He also noted that it was reasonable to expect a difficult settling in period as it was an extreme change in circumstances for R. It was put to Dr. Daly that R.'s treating psychiatrist may be best placed to assess his capacity but Dr. Daly disagreed. Dr. Daly accepted under cross examination that this was a report to update the Court as to capacity and it was not a full welfare or treatment review.

Evidence of Dr. McDermott

29. Dr. Garrett McDermott, Senior Clinical Psychologist and Neuro-Psychologist, gave evidence on 8th February, 2016 that he travelled to St. Andrew's also as part of Dr. Daly's team on 4th February, 2016 and was a cosignatory to Dr. Daly's report. Dr. McDermott conducted an assessment of R.'s intellectual functioning and ranked R. on the Wechsler Adult Intelligence Scale and on the Adaptive Behaviour Assessment Scale. Dr. McDermott stated that this was his fourth time meeting R. in St. Andrew's. He conducted an assessment of R.'s levels of intellectual functioning and completed a number of tests. This was to identify where R. was on the Adult Intelligence Scale as previously R. was assessed in relation to the children's test only. Dr. McDermott did state that they would not typically expect there to be a big difference between results in the children and adult tests. Dr. McDermott gave evidence that R.'s treating team filled a questionnaire in advance of his arrival and then he conducted various tests with R. Dr. McDermott indicated that R. willingly completed the ten subtests and that took just under an hour to complete. Dr. McDermott gave evidence that R. had a tendency to disengage when he felt the testing was difficult although he generally engaged well.

30. Dr. McDermott gave evidence that R.'s overall score led to a finding that he has a borderline intellectual disability (IQ of 70 – 80). This is also indicated in Dr. McDermott's report dated 5th February, 2016 where he found R.'s overall IQ to be between 68 and 77. R. had previously scored significantly below that. Dr. McDermott was asked why there was an improvement and he responded that it could come down to the fact that there has been a period of stability and that R. was now better able to show his true ability than he was previously. Dr. McDermott gave evidence that R. is in the borderline area of intellectual disability and he indicated that there are shades of grey within that and that R. is at the lower end of the borderline range. They also completed an evaluation of R.'s functional skills for daily living. R. displayed impairment in all nine categories. Dr. McDermott gave evidence that this may be down to the fact that R. has been institutionalised and his educational development was disrupted prior to his detention in St. Andrew's also. Dr. McDermott indicated that there is space for improvement because of therapies R. may get going into the future. R. could gain the skills in another setting outside of the detention setting provided that R. himself was motivated to do so.

31. Dr. McDermott indicated that services would be available in Ireland to bring about these improvements in R.'s functional skills. Dr. McDermott indicated that there were services outlined in the aftercare report and they would be available to R. in Nua Healthcare. Dr. McDermott noted when asked about the strengths that R. has that he has good communication skills and a good use of humour. Dr. McDermott identified that R. would need parallel psychological support that may be a slow process over a number of years to support R. in his emotional regulation. Dr. McDermott agreed that R. would benefit from vocational activities. Dr. McDermott stated that Nua Healthcare would be a good move for R. and that he needs a structured supportive environment but that he does not need to be detained. Dr. McDermott agreed that there needs to be a clear step down process and plan in place. Dr. McDermott also accepted that R.'s parents are very important to him and that services for parents should be available to help them but that he could not identify any specific courses to assist them while giving evidence at that time.

32. Dr. McDermott was asked under cross examination whether the stabilisation period in St. Andrew's could have brought about the improvement in R.'s IQ since he was previously tested as a child. Dr. McDermott responded that the setting may have facilitated him in performing better.

33. He was further asked if the removal of R. to a non secure setting would be damaging to him. The doctor responded that R. could take it in his stride if he had input and choice in his step down placement. However, Dr. McDermott indicated that some form of supported accommodation would be useful to R. in the future as, if it were the case that he could walk away from his placement in Ireland too easily, he may gravitate towards negative peers. Dr. McDermott indicated that the therapies being put in place would assist R. It was noted that people have the right to disengage from these types of services in Ireland. Dr. McDermott noted that it is important to engage with R. so that he will stay in the Nua Healthcare facility. Dr. McDermott accepted that the option would be there for R. to leave and that it was hard to predict what exactly might happen.

34. Dr. McDermott indicated to the Court that R. does have a faculty to learn albeit slowly and he is capable of retaining information. It was further accepted by Dr. McDermott that when R. is very upset he may find it difficult to make a rational decision although he is calm most of the time now. Dr. McDermott made it clear that R. will need support going into the future and that it should be a phased step down transition to Ireland. Dr. McDermott further noted that it was important to engage R. in the process and make it clear to him what is going to happen. Dr. McDermott stated that R. is currently in a medium secure unit in St. Andrew's which is not appropriate for him. Dr. McDermott accepted that a plan be available lest there be a serious regression, seemed like a prudent idea.

35. Dr. McDermott confirmed that R. was within an identified a range (68 – 77) rather than given a specific figure for IQ and also, that contextual factors were taken into account. It was accepted that there was a possibility that R. could come out at another time with a below borderline intellectual disability depending on the various factors at play when he might be tested. However, Dr. McDermott indicated that, on the balance of the evidence, in his assessment, R. is in the borderline intellectual disability range. Dr. McDermott indicated that he was not certain whether R. would fall within the category of persons who would receive disability benefit as an assessment would have to be carried out by the HSE disability services in this regard.

36. Dr. McDermott detailed that it was just one area that was dragging down R.'s score which was the "Perceptual Reasoning" subtest. Dr. McDermott gave evidence that R. had been rated by people who had worked with him and the forms were filled in by people from the Pritchard Ward. It was noted that there was a gap between the outcome of the objective testing of intellectual ability and the subjective testing of the actual tendencies and functioning. Dr. McDermott stated that with appropriate inputs R. could improve his functioning but he needs to be in a community to gain those skills and he cannot gain those skills in an institutionalised detention setting.

Evidence of Dr. Kearns

37. Dr. Anthony Kearns, Consultant Forensic Psychiatrist based at the Central Mental Hospital and a specialist in the area of disability with full registration in both the UK and Ireland also gave evidence on 26th January 2016. Dr. Kearns interviewed R. on the 16th of January 2016 and provided a report to the Court dated 19th January 2016. Dr. Kearns agreed with the diagnosis of R. as outlined by Dr. Daly. It was indicated that R. engaged in disruptive behaviour and altercations although his behaviour did appear to have settled down to some extent. Dr. Kearns accepted that R. did have a level of understanding of his medications and their purposes. Dr. Kearns

indicated that capacity cannot be determined in a general way but must be seen in relation to specific decisions. Dr. Kearns indicated that, because R.'s distressed behaviour is diminishing in frequency, R. could gain capacity in the following few months. Dr. Kearns also indicated that a return to Ireland would be beneficial to R. as it would be culturally more familiar to him.

38. In his report, Dr. Kearns indicated that he considered the headings outlined in the Assisted Decision Making (Capacity) Act 2015 although it has not yet been commenced as a guide for assessing R.'s capacity which read as follows:-

> S. 3(2) A person lacks the capacity to make a decision if he or she is unable—
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information long enough to make a voluntary choice,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his or her decision (whether by talking, writing, using sign language, assistive technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party.

39. Dr. Kearns further outlined in his report that R. was able to recount the reasons for his being in hospital and some of the treatments available to him, including the use of medication and psychological interventions, however, his understanding of these is only partial. R.'s ability to understand and retain relevant information with which to inform his decision to accept treatment is also very frequently compromised by his continuing emotional volatility. Therefore, Dr. Kearns did not believe that R. could be considered to understand fully the need for his treatment and on that basis, he did not consider that R. has capacity at present to consent in an informed manner to his treatment. However, Dr. Kearns further stated in his report that he believes that R. may eventually be helped to acquire the capacity to understand and consent to this treatment and while R.'s progress has been slow Dr. Kearns is of the view that there are indications that it has been in a positive direction.

40. In his addendum report also dated 19th January 2016, Dr. Kearns applied the test for capacity outlined by Laffoy J. in *Fitzpatrick v F.K.* [2009] I.R. 7. Dr. Kearns identified that R. is deprived of capacity by reason of a combination of permanent cognitive impairment and intermittent agitated anxious or distressed emotions which further impair his cognition. Dr. Kearns is of the view that R.'s mental state fluctuates to an extent which leads to his being overall lacking in capacity to make informed decisions as to his treatment in hospital. It is the view of Dr. Kearns that may gain said capacity with therapeutic work.

Evidence of the Guardian ad litem

41. Mr. Harry Law, guardian *ad litem* gave evidence on 8th February, 2016 that he had met with R. that week. He indicated that he wanted to update the Court as to the social aspect of R.'s life rather than leaving the Court with a narrow medical view. Mr. Law gave evidence that R. seemed positive in the Fairburn Ward despite the obvious difficulties of being on a ward specifically for people with hearing impairments. Mr. Law stated that he was satisfied that R. felt safe on this ward and he had a positive relationship with one of the peers who moved there with him from Pritchard Ward.

42. Mr. Law has been involved in R.'s case since June, 2014 and has visited him on a monthly basis. Mr. Law has continued to give the Court feedback on R. himself and how he was and his views throughout the lengthy proceedings. Mr. Law believes he could continue to make a helpful input into R.'s treatment plan and his after care plan if R. is to be transitioned back to Ireland.

43. Mr. Law gave evidence of having been at the CPA (Care Programme Approach) meeting on 6th January, 2016 where it was indicated that R. attended and mostly engaged well at the meeting. The issue of psychology was raised at that meeting and R. felt overwhelmed and put his head on the table saying "I don't know, I don't know". Mr. Law gave evidence that there is a need for appropriate language when communicating with R. and language used ought to be simple. Mr. Law indicated that St. Andrew's has enabled R. to mature and that a stabilisation over time has been seen by the doctors. Mr. Law stated that he did not think that R. had improved significantly and that he still has to keep contact to the most basic level. Mr. Law noted that R.'s abilities should be taken into account. It was accepted that many people can live in the community with R.'s level of cognitive function. Mr. Law was concerned were R. to give evidence to the Court and about R.'s perception of what has been going on in the court proceedings.

44. Mr. Law noted the significant number of incidents involving R. in St. Andrew's and that he has had significant negative peer interactions. Mr. Law believes that there may be a case of "running ahead of ourselves" in these proceedings by discussing a step down to a possible Nua Healthcare facility. Mr. Law identified that R. needs ongoing treatment so that he recognises the triggers for his anger and is able to prevent the violent outbursts. Mr. Law stated that he put examples of conflict with his peers to R. and that R. said he would walk away. Mr. Law accepted that R. has a tendency towards fight or flight and that the easiest thing for him to do is to just get away from a conflict situation. Mr. Law believes that R. is yet to develop alternative coping mechanisms.

45. Mr. Law was of the view that R. should continue some treatment in St. Andrew's and in the mean time that the State should set up a bespoke arrangement for R. within Ireland. It was noted that if the Court rules that R. has capacity then he is not detainable. Mr. Law believes that parallel planning should continue but that R. should remain in St. Andrew's. Mr. Law noted that R. should be moving to the Nasby Ward and that would be of huge benefit as it is a low secure unit. It is the view of Mr. Law that this would test R. and his ability to remain in the facility under a slightly less strict regime. Mr. Law emphasised that the detail of the aftercare plan will be important and he also note that R. needs to know that there is a plan going forward.

46. The assistance of Mr. Law as guardian *ad litem* throughout these proceedings was emphasised by counsel for the Child and Family Agency. This was of particular importance because of R.'s unusual presentation and the particular experience of Mr. Law and his highly effective and good rapport with R. This is why Mr. Law was asked to remain on as guardian *ad litem* beyond R.'s eighteenth birthday.

Evidence of Dr. Iles

47. Dr. Andrew Iles, Responsible Clinician and Consultant Forensic Psychiatrist working in the Pritchard Ward of St. Andrew's Psychiatric Hospital, Northampton, England gave evidence by video link. At that point, Dr. Iles' most up to date report was dated 28th January, 2016. Dr. Iles had been working with R. for some time. R. originally went into the Haygate Ward in June, 2014 when he was 16 years old and he was not under Dr. Iles' care at that point. However, R. was transferred to Pritchard Ward, an adult medium secure unit in October, 2015 after he turned eighteen. He had been the clinical responsibility of Dr. Iles since that date.

48. Dr. Iles gave evidence that there had been issues as to R.'s safety in recent months while on the Pritchard Ward. R. was

assaulted twice in the preceeding month. Dr. Iles stated that R. was then moved to the Fairburn Ward as a "sleep over" patient although he remained the clinical responsibility of Dr. Iles. Dr. Iles gave evidence that R. was being provided therapies by the Pritchard Ward staff on the Fairburn Ward. The Fairburn Ward is a specialist service for deaf men. Dr. Iles indicated that R. was getting on better on the Fairburn Ward than he was on the Pritchard Ward.

49. Dr. Iles continued to maintain his view that R. does not have the necessary capacity to consent to his treatment. It was accepted by Dr. Iles that it is difficult to measure a capacity to consent while R. was living in such a restrictive environment. Dr. Iles believed that R. did not understand the subtle nuances of his treatment programme and the role of his medication. Dr. Iles was of the view that R. had little insight into his mental disorder. The complexity of the treatment presented a problem. Dr. Iles noted that capacity is an outdated concept in English law. Dr. Iles accepted that there may be some elements of R.'s treatment that he could make an informed choice about but that R. was not able to consent to his regime in its entirety. Dr. Iles accepted that there was a difference of opinion between the medical professionals and that Dr. Daly was of the view that R. did have capacity and Dr. Iles agreed that St. Andrew's would support any step down process if the Irish High Court directed same.

50. It was accepted by Dr. Iles that the Fairburn Ward option had been seen as a very short term placement for R.'s safety. Dr. Iles was firm in his belief that it would not be safe for R. to return to the Pritchard Ward. Dr. Iles gave evidence that the clinicians in St. Andrew's were considering a move to the Nasby Ward, which is a low secure unit for young adults. Dr. Iles noted that another clinician who has clinical responsibility for the patients in the Nasby Ward, Dr. Berber would need to make an assessment of R. and decide whether the Nasby Ward was a suitable placement for him. Dr. Iles indicated that a move to a low secure unit would be a good part of a step down process towards R. returning to live in Ireland. Dr. Iles noted that R. needed to learn certain skills for living in the community.

51. It was emphasised that Dr. Iles is in a different position to that of Dr. Daly and Dr. McDermott as he had more regular access with R. as the psychiatrist with clinical responsibility for R. Dr. Iles noted that he knows R. very well and has a therapeutic relationship with him. Dr. Iles stated that he was informed that there is no legal definition of capacity in Ireland and accepted that his interpretation would be coloured by the English Mental Capacity Act 2005 although he stated that he used the ordinary dictionary definition of capacity. Dr. Iles stated that he did not make an assessment of R.'s capacity to litigate although he accepted that there would be a difference in comparison with his capacity to consent to treatment.

52. Dr. Iles identified that it is not possible to separate out the treatment element and the coercion/detention element in the St. Andrew's context. Dr. Iles noted that R.'s ongoing medication would require ongoing psychiatric supervision.

53. Dr. Iles noted that there are three relevant diagnoses; mild mental retardation, hyperkinetic conduct disorder and childhood autism. Dr. Iles accepted that the diagnosis of childhood autism would not negate capacity in isolation. Counsel for R. put to Dr. Iles that Dr. Kearns has a particular expertise in mental disability and explained that he went to interview R. in St. Andrew's. Dr. Iles stated that he had not seen Dr. Kearns's report and is not aware of the general conclusions and he was not even aware of his visit. Dr. Iles also indicated that he had not seen Dr. Vernon's (responsible clinician in the Haygate Ward) report and was unaware that she believed a further assessment of cognitive function was recommended or required. Counsel for R. put it to Dr. Iles that Dr. Vernon had also recommended a speech and language assessment and an education assessment. Dr. Iles noted that this assessment may have taken place but that he did not have the correct documents with him when giving evidence to be able to say what the results of any such assessments were.

54. Counsel for R. put it to Dr. Iles that Dr. McDermott recently completed an IQ test. All that Dr. Iles knew in relation to this test was R.'s own indication to him that it had gone well; he had not seen Dr. McDermott's report. Dr. Iles gave evidence that the English medical practitioners do not think in terms of borderline intellectual disability any more. Counsel for R. explained that Dr. McDermott's report found that R.'s functioning was extremely low and it was noted that there was a divergence between the objective assessment and the subjective assessment. Counsel for R. suggested that R. is someone who would be able to improve his functioning if he was assisted with occupational therapy and vocational support and education.

55. Counsel for R. also put it to Dr. Iles that R. did particularly well on the working memory subtest and he further noted that R. was able to tell Dr. Kearns all the medications that he is on and the purposes for each of them. Counsel for R. suggested that this is indicative of R. being able to understand and retain information about his treatment regime and therefore have an element of capacity. Dr. Iles takes a different view and stated that he believes that R. does not understand the nuance of his medications. Dr. Iles further indicated that there are other aspects on which R. failed to reach the level for capacity, in his view, in terms of not understanding side effects and alternatives and the advantages and disadvantages of various different treatments. Dr. Iles indicated that, as a British psychiatrist, he may require a higher standard to reach the capacity standard. Counsel for R. put it to Dr. Iles that there is a limit to the extent that any lay person can possibly remember all those details about treatments and medications. Dr. Iles stated that a basic level of understanding of the side effects would be expected. Dr. Iles agreed that emotional volatility is a particular problem for R. although he noted that the mild mental retardation makes it more difficult for R. to manage his emotions.

56. Dr. Iles accepted that R.'s experience on the Pritchard Ward had been very difficult and that he has been subject to a number of assaults by members of his peer group. Dr. Iles indicated that R. was quite good at walking away from conflict situations. Dr. Iles recommended that R. should receive Dialectic Behavioural Therapy (DBT) to encourage emotional regulation. Dr. Iles gave evidence that it has been difficult to motivate R. to get involved with the therapies being offered to him by Pritchard Ward staff on the Fairburn Ward. Dr. Iles accepted that R. is in St. Andrew's not just because of an assessment of lack of capacity but also provided that he is getting necessary treatments.

57. Dr. Iles stated that he doubted whether R. would ever have the capacity to consent to treatment. He accepted that it is not possible for anyone to consent to this level of containment and detention. Counsel for R. put it to Dr. Iles that it is logically impossible for anybody to consent to treatment in a medium secure setting. The entire regime works on the premise of a lack of consent. Dr. Iles noted that R. is in detention, not just because he is a risk to himself but also because of issues of security for others.

58. Dr. Iles gave further evidence on 7th April 2016 based on his updated report dated 10th March 2016. Dr. Iles indicated that R. had been assessed and accepted as being suitable for the Nasby Ward since the last occasion that Dr. Iles gave evidence. However, Dr. Iles gave evidence that there were no available places on the Nasby Ward at that point in time. Dr. Iles indicated that R. was in limbo and that he was not engaging in any therapeutic work because of this situation. Dr. Iles explained that the delay in relation to a place in the Nasby Ward is to do with patients on the Nasby Ward being delayed in their own step down placements out of St. Andrew's Hospital and that this has created a back log. Dr. Iles estimated that there would not be a bed on the Nasby Ward for R. before the beginning of May 2016.

59. Dr. Iles emphasised that R. is not going backwards where he is. Dr. Iles also stated that it is positive that R. stays away from the

people on the Pritchard Ward that previously assaulted him. Dr. Iles was questioned as to what therapeutic inputs R. was receiving on the Fairburn Ward. Dr. Iles stated that R. was doing group sessions on Fairburn and was being provided with one to one sessions from the staff coming from the Pritchard Ward when they were available.

60. Dr. Iles also stated that R. had very limited access to the grounds as they do not have sufficient staff members to support such access. It was noted, however, that while his parents visited, R. went away from the St. Andrew's Campus with them on supervised community leave. Dr. Iles gave evidence that they have moved away from the rigid level system but he indicated that R. was then at the least restrictive type of security level available to him while he remains treated as a medium secure patient in St. Andrew's. Dr. Iles gave evidence that the next steps would be to have more escorted ground leave and then move to unescorted leave and after that R. would be at a point where he could be discharged.

61. Dr. Iles stated that R.'s psychological programme requires commitment from him. Dr. Iles stated that R. has made improvements throughout his time in St. Andrew's. He noted that R. does have a significant problem with emotional regulation but stated that he has become more amenable to staff persuasion over time and he loses his temper less frequently. Dr. Iles is of the view that R. still lacks capacity to consent to treatment and has a therapeutic need to be detained in a hospital. Dr. Iles did accept that R. was not suitably placed on Fairburn Ward.

62. Counsel for the guardian *ad litem* summarised that R. was, at that point, on the least restrictive regime that he could be on while still remaining in a medium secure unit. Dr. Iles accepted this and noted that R. would be more suitably placed in a low secure unit where he could work towards unescorted ground access and then towards unescorted community leave though Dr. Iles was unsure about when R. could build up to being at that point. Dr. Iles gave a rough estimate that R. would have to stay on the Nasby Ward for between 6 and 12 months before he would be allowed go on unsupervised community leave. This would be dependent on R.'s progress and engagement. It was confirmed that the Nasby Ward is still a place of detention although there is a less strict regime to the one in which R. was residing. Dr. Iles stated as of 7th April, 2016 that after the 12 months on the Nasby Ward R. might be able to transition to a Nua Healthcare facility at that point and that St. Andrew's would support this transition although R. would first have to go on more limited unescorted community leave before he could fly to Ireland.

63. Counsel for the parents put it to Dr. Iles that R. should have been receiving a more regular time table of activities in his circumstances on the Fairburn Ward as it is the view of the parents that he was doing nothing at all and was very isolated on the Fairburn Ward and that he was spending his days sleeping and eating. Dr. Iles indicated that Pritchard Ward staff had been going over to the Fairburn Ward but only when they were available. Dr. Iles stated in evidence that R. needed to undertake self directed activity.

64. Dr. Iles gave evidence that R. didn't engage well when he moved to the Pritchard Ward from the adolescent unit. There were also issues around the dynamic with the other patients. Dr. Iles admitted that there were no structured psychological supports available to R. at that time on the Fairburn Ward. R. had been able to attend group sessions of occupational therapy and living skills with his peers on the Fairburn Ward although it was admitted that he could not communicate with his peers as they are deaf. Dr. Iles stated that R. was not willing to engage in his treatment programme. It was put to Dr. Iles that there had been a significant lack of therapeutic input for R. from March 2015 to date. Dr. Iles did not agree with this assessment. Dr. Iles is firm in his belief that R. should remain in a secure setting.

Evidence of Ms. Sheridan

65. Ms. Michelle Sheridan, After Care Social Worker gave evidence on behalf of the Child and Family Agency in relation to the After Care Plan for R. on 7th April, 2016. Ms. Sheridan became directly involved with R.'s case in May 2015 as he was approaching his majority. She gave evidence that she provides an advocacy role and assists in representing his wishes and views for future care. She has been in regular contact with R. and stated to the Court that she gets on well with R. It was noted that R. struggled in St. Andrew's when he was approaching his majority and had a high level of anxiety although Ms. Sheridan stated that that is a normal enough reaction. Ms. Sheridan indicated her understanding was that R.'s own view was that he wanted to return to Ireland.

66. Ms. Sheridan gave evidence that she brought R.'s case to the aftercare steering committee which involved a range of personnel including adult disability services and the idea was that there would be inter agency cooperation. It was the view that R.'s clinical care would have to transfer to the adult side of the HSE services. Ms. Sheridan also met with the guardian *ad litem*, Mr. Harry Law, who she recognised as having played an important role. The view at that time in May, 2015 was that there was no suitable placement available in Ireland. Ms. Sheridan indicated that various sites have been looked at and ruled out. The final option that was considered was Nua Healthcare.

67. Ms. Sheridan gave evidence that she was continuing to do parallel planning in order to be ready if the Court decides that R. has capacity and should return to Ireland. Ms. Sheridan recognised that the family is concerned that R. would engage in behaviours and could find himself in the criminal justice system. Ms. Sheridan also noted that the family would prefer a placement outside Dublin where there have been previous negative influences but that they would also like to see R. very regularly. Ms. Sheridan stated that R. needs a placement with 24 hour staff. Ms. Sheridan further recognised the concern of R.'s parents about his chances of refusing to engage when given the option in an unsecure setting like that which is being proposed in the Nua Healthcare facility. Ms. Sheridan stated to the Court that Aftercare services are more than willing to continue to working with R. in parallel.

68. Ms. Sheridan accepted that the Aftercare services were unaware in April, 2016 of the date or circumstances of any release from St. Andrew's and that that somewhat limited their ability to put a transition plan in place. It was accepted that parallel planning is wise but there is only so much that can be achieved as they did not know exactly what may be required to meet R.'s needs.

69. Ms. Sheridan indicated that the decision to go with Nua Healthcare was based upon what was suitable and available within Ireland. Ms. Sheridan gave evidence that Nua Healthcare have a number of different sites and that they would be the ones making the decision as to which site would be most suitable for R. Ms. Sheridan further noted her understanding that Nua Healthcare would have imported psychological input and that should be available on a continuous basis to R. while in their care. Ms. Sheridan accepted that there was a concern that R. would not avail of the services if they were not available to him on site although she stated that many of these decisions would be a matter for Nua Healthcare to decide. Ms. Sheridan accepted that all this planning would depend on whether the Court decided that R. had capacity or not.

70. The guardian *ad litem* wanted to bring their attention to a facility called Three Steps but Ms. Sheridan indicated that was rejected because it is a more mainstream facility while Nua Healthcare deal with specific mental disabilities and that is why they were identified as a better choice.

71. Ms. Sheridan agreed that planning had been quite tentative up to this point as they were waiting on the Nua Healthcare

assessment of R. Nua Healthcare have a spectrum of services and they can provide long term care for R. if he engages. The guardian *ad litem* has already asked to be included in the meeting and planning for R.'s future and Ms. Sheridan indicated that the after care team were happy to work with anyone who is interested in R.'s onward care including the guardian *ad litem*.

72. Ms. Sheridan praised the parents for their full and positive involvement in R.'s care. It was noted that the aftercare plan would be part of continued support and this would be very different from what was happening in St. Andrew's. Ms. Sheridan noted that Aftercare is more of a process than an end point and it is a more of a social work role than a therapeutic role. She indicated that a transition to the low secure unit in St. Andrew's might have been beneficial.

73. Ms. Sheridan recognises the worries of the parents that R. would go home to them and that they would not be able to cope with the various difficulties. Ms. Sheridan gave evidence that this was a work in progress and did not have specific details as they were waiting the assessment of Nua Healthcare to make that decision of where exactly he could go. The after care team were also awaiting the decision of the Court in relation to R.'s capacity. Ms. Sheridan accepted that the parents should be part of the next step of planning. Counsel for the parents also sought support services for the parents themselves and Ms. Sheridan indicated that this was something that the after care team were looking into.

74. Mr. Sheridan stated that the aftercare plan was originally made in May 2015 and has been updated regularly since then. Aftercare was first raised at a CPA meeting when R. was approaching his eighteenth birthday and the after care team have attended some of the CPA meetings since then. Ms. Sheridan indicated that she did not go to the CPA meeting of 6th January, 2016 as she did not want to undermine R.'s treatment. It was the view of the after care team that attending said meeting may have given R. mixed messages about when or if he would be returning to Ireland and that meeting was more for the purposes of introducing the adult services in St. Andrew's to the parents.

75. Ms. Sheridan indicated that they continued to parallel plan in the background. Ms. Sheridan noted her understanding that since this Court visited R. in November 2015 he has improved significantly, had renewed hope and has tried to engage with therapy much more. Ms. Sheridan did not accept that they have effectively taken the view that until the capacity issue was resolved the planning has stalled. She stated that they continued to parallel plan throughout.

76. Under cross examination, Ms. Sheridan gave details about the onward care options that were investigated for R. She stated that a placement called Redwood which was part of the Talbot group was rejected as HIQA had advised that it should no longer be used for individuals such as R. A placement in Raheeny was also rejected as it houses a very vulnerable group and could not provide the supports that R. needs. Ms. Sheridan stated that that left the after care team with the Nua Healthcare option. Ms. Sheridan gave evidence that she was not aware of any other services and she had consulted with the experts within the HSE and the disability managers. Ms. Sheridan accepted that she had not taken any input from outside the HSE or the Child and Family Agency. She also accepted that they did not consult with the guardian *ad litem* at that point.

77. Ms. Sheridan indicated that she has dealt with many complex cases but nothing specifically like this particular case. Ms. Sheridan gave evidence that the aftercare service has not dealt with this issue of taking someone back from St. Andrew's with such complex needs but that the HSE has done this and that this is why they are working so closely with the HSE on this case. It is the aftercare team's opinion that Nua Healthcare is the only option left in Ireland and that no other providers are suitable. Ms. Sheridan also noted that Nua Healthcare have experience working with St. Andrew's for other cases to facilitate similar transition plans. Ms. Sheridan stated that they can only work with the services available to them.

78. Counsel for R. asked whether R. was any closer to having an onward placement as of 7th April, 2016 than he was when aftercare originally became involved in May 2015. Ms. Sheridan gave evidence that R. was very excited in June 2015 and was under the impression himself that he would get to return to Ireland once he turned 18. However, this did not happen and then his behaviour deteriorated and his security levels increased in St. Andrew's and he had to move to an adult ward and he needed time to settle and adjust. Ms. Sheridan explained that they had been in contact with various private providers to seek an onward placement for R. and that they were much closer to a transition plan for him.

79. Ms. Sheridan noted that she actually met R. before he was ever in St. Andrew's and then met him again in St. Andrew's and she noted that there was a great improvement. Ms. Sheridan did accept that there was a period of deterioration because of the uncertainty over the summer of 2015 but now R. has stabilised.

Summary of submissions and the legal position

80. It is now the position of the plaintiff, the HSE, that R. has capacity based on the evidence of the expert witnesses, Dr. Daly and Dr. McDermott. Counsel for the HSE noted on a number of occasions including 30th June, 2016 that the evidence points to R. having capacity to consent to treatment. On that basis and in conjunction with the Child and Family Agency after care team, the HSE proposed that R. be transferred to a Nua Healthcare Facility in Ireland, Fairways. They requested that the Court discharge the orders detaining R. in St. Andrew's. A detailed updated aftercare plan was provided to the Court and was approved by this Court on 22nd April, 2016. It was clearly stated by both state bodies that the aftercare plan is voluntary and dependent on R.'s willingness to engage.

81. Counsel for the HSE also noted that R. had not been in the appropriate ward in St. Andrew's for some time. He had been residing on the Fairburn Ward which is specifically for adults with hearing impairments. It was further accepted by the HSE that R. had been receiving intermittent therapeutic inputs from the staff going to him from the Pritchard Ward. Although R. was approved for a placement on the low secure Naseby Ward which would have been more appropriate for him, that placement had not become available because of a backlog within the St. Andrew's system which is outside the control of the HSE. Counsel for the HSE submitted on 22nd April, 2016 that, apart from the capacity issue, R.'s best interests were not being served by his detention on the Fairburn Ward. Counsel for the HSE confirmed as of 30th May, 2016 that the transition back to the Nua Healthcare Facility could not happen while the detention orders remained in place and they were applying to have those orders discharged entirely. It was further noted that Nua Healthcare is not an approved centre of detention and cannot detain a person, especially a person who has capacity which is the HSE position. Counsel for the HSE made it clear on 30th May, 2016 that R. would be received into the care of the Nua Healthcare Facility on a voluntary basis only. The clinical view within the HSE supported the move to Nua Healthcare although the risks were acknowledged.

82. The position of R. was that he wanted to return to Ireland. It was submitted on 9th February, 2016 by counsel on behalf of R. that his capacity is fluctuating and that it may need to be reassessed by Dr. Kearns in the context of R. living in the Nua Healthcare Facility in Ireland. Counsel for R. highlighted on many occasions throughout these proceedings that R. could not be detained in St. Andrew's if he was not receiving the appropriate treatment and services and, therefore, not receiving a therapeutic benefit from his detention. Counsel for R. further stated on 7th April, 2016 that there is an issue that R. was in an inappropriate ward in the UK with

no possibility of swiftly being placed in the correct ward and also that the HSE maintained that there was no appropriate facility within this jurisdiction to meet R.'s needs. On 30th May, 2016, counsel for R. raised the issue that the Nua Healthcare Facility is a form of detention as there are locks on the door and that R. does not have a key.

83. Written legal submissions on the issue of capacity were filed on behalf of R.'s parents dated 27th May, 2016. Counsel for the parents outlined that R. is now an adult, he does not suffer from a mental illness falling within the scope of the Mental Health Act 2001 and thus there is no statutory jurisdiction to detain him for the purpose of obtaining treatment. R. does suffer from a multi axis diagnosis such that he might be broadly classified as a vulnerable adult.

84. It was submitted that the inherent jurisdiction of this Court to detain a vulnerable adult who lacks capacity for therapeutic care derives from Article 34.3.1° of the Constitution read in conjunction with Article 40.3. Counsel for the parents cited the case of *HSE v J.O'B* [2011] 1 I.R. 794 where Birmingham J. exercised this inherent jurisdiction as follows at para. 25:-

> "… where a adult lacks capacity and where there is a legislative lacuna so that the adult's best interests cannot be served without intervention by the Court, I am satisfied that the Court has jurisdiction, by analogy with cases like D.G. and the several High Court decisions from different judges of the High Court there referred to, to intervene."

85. It was submitted on behalf of the parents that, for this court to exercise its inherent jurisdiction in this case, it must be satisfied that R. lacks capacity in matters concerning his treatment and care. Counsel for the parents outlined the case of *Fitzpatrick v. F.K.* [2009] 2 I.R. 7 where Laffoy J. set down the following principles applicable to the determination of the question of capacity at para. 84:-

> "(1) There is a presumption that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse medical treatment, but that presumption can be rebutted.
>
> (2) In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment whether-
>
> (a) by reason of permanent cognitive impairment, or
>
> (b) temporary factors, for example, factors of the type referred to by Lord Donaldson in *In re R (Adult: refusal of medical treatment)* [1993] Fam. 95
>
> the test is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made.
>
> (3) The three stage approach to the patient's decision making process adopted in *In re C (Adult: refusal of medical treatment)* [1994] 1 WLR 290 is a helpful tool in applying that test. The patient's cognitive ability will have been impaired to the extent that he or she is incapable of making the decision to refuse the proffered treatment if the patient-
>
> (a) has not comprehended and retained the treatment information and, in particular, has not assimilated the information as to the consequences likely to ensue from not accepting the treatment,
>
> (b) has not believed the treatment information and, in particular, if it is the case that not accepting the treatment is likely to result in the patient's death, has not believed that outcome is likely, and
>
> (c) has not weighed the treatment information, in particular, the alternative choices and the likely outcomes, in the balance in arriving at the decision.
>
> (4) The treatment information by reference to which the patient's capacity is to be assessed is the information which the clinician is under a duty to impart information as to what is the appropriate treatment, that is to say, what treatment is medically indicated, at the time of the decision and the risk and consequences likely to flow from the choices available to the patient in making the decision.
>
> (5) In assessing capacity it is necessary to distinguish between misunderstanding or misperception of the treatment information in the decision making process (which may sometimes be referred to colloquially as irrationality), on the one hand, and an irrational decision or a decision made for irrational reasons, on the other. The former may be evidence of a lack of capacity. the later is irrelevant to the assessment.
>
> (6) In assessing capacity, whether at the bedside in a high dependency unit or in court, the assessment must have regard to the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of proffered treatment. In the private law context this means that, in applying the civil law standard of proof, the weight to be attached to the evidence should have regard to the gravity of the decision, whether that is characterised as the necessity for "clear and convincing proof" or an enjoinder that the court "should not draw its conclusions lightly."

86. Counsel for the parents also drew the Court's attention to the English Court of Appeal case of *Masterman-Lister v. Brutton & Co*. [2003] 3 All ER 162 wherein at para. 26 Kennedy L.J. stated that:-

> "… the mental abilities required include the ability to recognise a problem, obtain and receive, understand and retain relevant information, including advice; the ability to weigh the information (including that derived from advice) in the balance in reaching a decision, and the ability to communicate that decision."

87. It was submitted on behalf of the parents that the common law test is mirrored to an extent in s. 56 of the Mental Health Act 2001 which defines consent for the purposes of that Act as follows:-

"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."

Counsel for the parents did, however, emphasise that the Mental Health Act 2001 does not establish a test for capacity.

88. It was submitted on behalf of the parents that this Court may be guided by the criteria for capacity as laid out in the Assisted Decision-Making (Capacity) Act 2015 although it has yet to be commenced. Section 3 of the 2015 Capacity Act states that a person's capacity should be construed functionally and then sets out the criteria for capacity as follows:-

"3. (1) Subject to *subsections (2)* to *(6)*, for the purposes of this Act, a person's capacity shall be assessed on the basis of his or her ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time.

(2) A person lacks the capacity to make a decision if he or she is unable—

(a) to understand the information relevant to the decision,

(b) to retain that information long enough to make a voluntary choice,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his or her decision (whether by talking, writing, using sign language, assistive technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party.

(3) A person is not to be regarded as unable to understand the information relevant to a decision if he or she is able to understand an explanation of it given to him or her in a way that is appropriate to his or her circumstances (whether using clear language, visual aids or any other means).

(4) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him or her from being regarded as having the capacity to make the decision.

(5) The fact that a person lacks capacity in respect of a decision on a particular matter at a particular time does not prevent him or her from being regarded as having capacity to make decisions on the same matter at another time.

(6) The fact that a person lacks capacity in respect of a decision on a particular matter does not prevent him or her from being regarded as having capacity to make decisions on other matters.

(7) For the purposes of this section, information relevant to a decision shall be construed as including information about the reasonably foreseeable consequences of—

(a) each of the available choices at the time the decision is made, or

(b) failing to make the decision."

89. It is the view of the parents, as presented by their counsel to the Court that it is in R.'s best interests to be transferred to the Nua Healthcare facility in Ireland. They wished to record the fact that they believe that St. Andrew's was of great assistance to R. and that he has improved greatly while he was detained there but that any further benefit to him in remaining there is very limited. Counsel for the parents stated as of 7th April, 2016 that it was not possible for him to improve any more in the Fairburn Ward with the limited therapeutic input and that the justification for his detention there no longer existed. On 30th May, 2016, counsel for the parents stated again that in order for the Court to detain R. it has to be satisfied that he lacks capacity. It is accepted by all parties that capacity is time sensitive, however, the parents support the view of the HSE and the expert witnesses before this Court in saying that he currently has capacity. This was repeated to the Court by counsel on behalf of the parents again on 30th June, 2016.

90. Written submissions were also filed on behalf of the guardian *ad litem* dated 4th May, 2016. Counsel for the guardian *ad litem* outlined the circumstances of the case and that the issue under consideration of the Court is whether R. has capacity although the question of capacity impacts on whether the proposed placement possesses the requisite integrity of purpose and suitability of therapeutic provision. The guardian *ad litem* is concerned by the speed of the proposed transition and the fact that there is no fall back position if R.'s placement with Nua Healthcare breaks down. Counsel for the guardian *ad litem* also highlighted that a move to a non-secure unit in the absence of any determination that R. has capacity to consent to such a move renders the legal position quite unclear.

91. It was submitted on behalf of the guardian *ad litem* that, while invoking the inherent jurisdiction of the High Court to protect minors is well established, it is not quite so commonplace in the protection of vulnerable adults. Counsel for the guardian *ad litem* submitted that, based upon the case of *HSE v. J.O'B.* [2011] 1 I.R. 794 the inherent jurisdiction of the High Court in relation to adults would seem to arise where the adult lacks capacity and where there is a legislative lacuna so that the adult's best interests cannot be served without intervention by the Court.

92. Counsel for the guardian *ad litem* submitted that the professional medical view in relation to R. is that, while he might move towards having capacity in the future, he currently does not have capacity. A particular emphasis was placed by counsel for the guardian *ad litem* on the fact that Dr. Iles has been working with R. on a continuous basis for a number of months and he is of the view that R. does not have capacity. It was, therefore, submitted that R. should be detained under the inherent jurisdiction of the High Court while he lacks capacity.

93. Counsel for the guardian *ad litem* applied the test for capacity as laid out by Laffoy J. in the case of *Fitzpatrick v. F.K.* [2009] 2 I.R. 7 as posing the following question:

> "Has JM's cognitive ability been impaired to the extent that he does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting pr rejecting it in the context of the choices available at the time the decision is made."

It was submitted on behalf of the guardian *ad litem* that the evidence of Dr. Iles suggests that, in accordance with the above criteria, J is currently lacking capacity.

94. Counsel for the guardian *ad litem* referred the Court to the UK Mental Capacity Act 2005 where a person is found to lack capacity when there is an inability to make decisions at s. 3 of that Act as follows:-

> "(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable –
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means).
>
> (2) A person is not to be regarded as unable to understand the information releveant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).
>
> (3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him being regarded as able to make the decision.
>
> (4) The information relevant to a decision includes information about the reasonably foreseeable consequences of –
>
> (a) deciding one way or another, or
>
> (b) failing to make the decision."

It was submitted on behalf of the guardian ad litem that Dr. Iles appeared to refer to these criteria when coming to the conclusion that R. lacks capacity and that this is very similar to the terminology in the, as yet, not commenced Assisted Decision-Making (Capacity) Act 2015.

95. Counsel for the guardian *ad litem* submitted that, if the Court finds that R. lacks capacity then the Court can make orders as required to ensure that he receives the appropriate treatment, however, if R. is found to have capacity then the High Court has no further role in making orders in relation to R. On 30th May, 2016, counsel for the guardian *ad litem* further raised the point that the Court must decide on the issue of whether R. had capacity for the period from the date of his 18th birthday to the date of his discharge because if he had capacity during that time then his detention was illegal. Counsel for the guardian further noted the issue that there is an element of locking at the Nua Healthcare Facility and that this may be a deprivation of liberty and he questioned what the legal basis for this deprivation could be. The guardian *ad litem* was also concerned as to the speed of the transition and his counsel stated on 30th June, 2016 that this concern had been somewhat borne out by the various incidents that occurred after his transfer to the Nua Healthcare Facility.

Updated position 21st July, 2016

96. An opportunity was given on 21st July, 2016 to hear evidence from Dr. Séan O'Domhnaill, Consultant General Adult Psychiatrist working with Nua Healthcare. However, due to R.'s absence from the Nua facility, the doctor was unable to conduct an assessment or write a report and it was accepted that there would be no benefit in hearing evidence from him on that occasion. Similarly, this Court gave an opportunity for Dr. Kearns to conduct a supplementary assessment upon R.'s transition to Ireland. This also proved impossible because of R.'s absence.

97. Counsel for the HSE applied on 21st July, 2016 to take this matter out of the Court's list on the basis that R. returned to Ireland on a voluntary basis and he is now not engaging with the services that have been offered to him. He has been completely absent from the Nua Healthcare facility for one week. Counsel for the HSE was careful to state that it was within R.'s rights to refuse to engage. He further stated that the HSE have made every effort but that there was nothing further that they could do at this point.

98. Counsel for R. himself sought all records and reviews of the transition plan. He clarified that nothing should be stated in relation to fault at this point. However, there were questions to be answered around the implementation of the transition plan. Counsel for R. summarised the position that R. had been detained in St. Andrew's Hospital in Northampton for a prolonged period of time including a period of time after he attained his majority on the basis that he lacked capacity. Counsel for R. then stated that, upon the evidence of the various professionals, it became clear that R. had not been getting sufficient treatment in St. Andrew's and that he was being detained without a therapeutic benefit. A transition plan was drawn up as a matter of urgency and R. was brought back to this jurisdiction on a voluntary basis to live in the Nua Healthcare facility. Counsel for R. wanted to see the reviews of the transition plan in order to see what steps had been taken, where things had perhaps not gone to plan and what had been done in response to this.

99. Counsel for the parents stated that they have been present in Court throughout this process and that they have been fully engaged throughout. He stated that they are now quite upset and that they feel that they are in an even worse position than they were in before R. went to St. Andrew's. They believe that he is currently living in a type of homeless accommodation with another young person. They have seen him on several occasions during the period that he has been absent from the Nua Healthcare facility however, he was argumentative and aggressive and as he is now an adult there is nothing they can do to prevent him from leaving their home when he visits. They have tried to encourage R. to return to the Nua Healthcare facility but he tends to tell them what they want to hear and then not do what he says he will do. Counsel for the parents highlighted the need for After Care Services to be put in place.

100. Counsel for the guardian *ad litem* noted the objections which the guardian had raised at various points throughout the transition that there was no back up or alternative plan to the Nua Healthcare plan. Counsel for the guardian highlighted the need for the Nua placement to stay open to R. for a period of time and that efforts need to be redoubled in order to encourage R. to return to Nua and engage with the supports and services that are on offer. The guardian is of the view that it would be premature to take the case out of this Court's list at this point. Counsel for the guardian noted that the Court has a very limited role and cannot make any orders if R. is found to have capacity.

Conclusions

101. The High Court ordered the transfer of R. as a minor to St. Andrew's Hospital, Northampton, England for the purpose of his care and treatment in a secure facility. The reason that the Child and Family Agency required his detention to occur in England was that there was no suitable facility in this jurisdiction to appropriately treat his complex needs. This triggered the mechanism under Article 56 of Regulation 2201/2003 whereby the Irish High Court orders are recognised and enforced in the English Court of Protection. This matter was kept for regular review before the Irish High Court.

102. In May, 2015 the Child and Family Agency and this Court began to explore the options for R. upon attaining his majority on 12th September, 2015. The aim of the Court was to ensure that R.'s best interests were catered to. The possibility of him returning to Ireland was looked into. R. was very much of the position that he wanted to return to Ireland.

103. When R. turned 18 years old he had to be moved from the adolescent Haygate Ward to the adult Pritchard Ward. Several problems arose in the Pritchard Ward. It is accepted that he both caused assaults and was the victim of assaults. This Court notes that it is the reality of the situation in a facility such as St. Andrew's that there could be mix of patients that would not get on well together and this may cause problems. However, this Court became highly concerned as to his safety and R. was moved to the Fairburn Ward. It became clear that R. was receiving little therapeutic benefit while living in the Fairburn Ward. The evidence from Dr. Iles, his treating psychiatrist in St. Andrew's, was that he received therapy sessions when staff from the Pritchard Ward were available to go to him on the Fairburn Ward. Although R. was accepted as being suitable for the low secure Nasby Ward a place was not available for him. A further problem also arose about R.'s own motivation as he had been focused on returning home to Ireland. Because of these issues it became clear to the Court that R. was not receiving the appropriate level of therapeutic benefit and his detention was no longer justifiable. It appears to have been accepted by all involved that there was a considerable stagnation in R.'s improvement.

104. Although the Court noted that the guardian *ad litem* raised concerns about a speedy transition from a medium secure ward in St. Andrew's to a non secure facility in Ireland, the Court was not willing to leave R. where he was. Therefore, when a place became available in a Nua Healthcare facility, this Court decided to allow for his voluntary transition there and discharged the detention orders as of 31st May, 2016 on the basis that the therapeutic rationale for his detention had become highly questionable.

105. The issue of R.'s capacity to consent to treatment was left until after his transition as the Court was keen to have him reassessed again upon his return to Ireland although Dr. Daly had been consistent in his view since October, 2015 that R. had the necessary capacity. Dr. Daly conducted a further assessment of R.'s capacity to consent to treatment after his transition to the Nua Healthcare facility, and he produced a final report dated 20th June, 2016 and gave evidence on 30th June, 2016 to the effect that R. continues at this stage to have capacity.

106. This Court gave an opportunity both to Dr. Kearns and to Dr. O'Domhnaill to conduct their own capacity assessments after R.'s transition to Ireland. However, it became clear that this was impossible as R. refused to attend for assessment and this was within his rights as a voluntary resident in the Nua Healthcare facility. R. was absent from Nua Healthcare for significant periods of time and it appears that he is currently living in alternative accommodation. Evidence of an after care plan has been heard and this Court is of the view that supports will be offered if requested by him.

107. At this point, this Court has an obligation to make a final decision as to capacity. It is the position of Dr. Daly and Dr. McDermott who have jointly conducted several capacity assessments that R. has had the capacity to consent to treatment since October, 2015 and that his level of capacity has improved since then. They considered the test for capacity as set out in the above cited case of *Fitzpatrick v. F.K.* [2009] 2 I.R. 7. Dr. Iles disagreed and was of the view that R. lacked capacity. While this Court accepts that Dr. Iles is a highly qualified medical professional and had regular contact with R., this Court accepts the evidence of Dr. Daly that the difference in opinion in relation to capacity could be as a result of the different approaches in the two jurisdictions. Dr. Kearns' view as of January, 2016 when he gave evidence to the Court was that R.'s capacity was fluctuating and that he could gain capacity with treatment.

108. This Court agrees with Dr. Daly's approach in relation to the issue of "subtle nuance" that to require a person to have an understanding of the subtle nuances in their treatment in order for them to have capacity to consent would set an impossibly high threshold for capacity. This Court further agrees with Dr. Daly's evidence that a person who has capacity may make decisions about their treatment that may not objectively be good decisions. Personal autonomy is a core value and the courts cannot limit the liberty of those who have capacity to make decisions about their own lives so long as they act within the law.

109. On this basis, and in consideration of the test for capacity as set out in the case law cited above, this Court finds that R. has capacity.

110. This case cannot be left to continue indefinitely before the High Court, especially in circumstances where R. is refusing to engage with Nua Healthcare and/or the professionals involved. Nor is R. engaging either with his own legal team or with the Court. One final review of the position may be necessary to update the Court as to whether or not the Nua Healthcare place has been taken up by R.

111. This Court will hear submissions as to the form of the order if any is required.