Neutral Citation: [2013] IEHC 490

THE HIGH COURT

[2013 No. 4413 P]

BETWEEN

X.Y., A MINOR SUING BY HER GUARDIAN AD LITEM, RAYMOND McEVOY

PLAINTIFF

AND

THE HEALTH SERVICE EXECUTIVE

DEFENDANT

AND

THE ATTORNEY GENERAL AND THE IRISH HUMAN RIGHTS COMMISSION

NOTICE PARTIES

Judgment of Mr. Justice Birmingham delivered on 7th day of November, 2013.

1. In this case the plaintiff seeks a declaration that s. 25(6) of the Mental Health Act 2001 is repugnant to the Constitution or, alternatively, a declaration pursuant to s. 5 of the European Convention on Human Rights Act 2003 that s. 25(6) is incompatible with the European Convention on Human Rights. Also sought is a declaration that the forcible administration of treatment to the plaintiff and her physical restraint by the defendant since her admission to hospital is unlawful.

2. The issues that arise for consideration now are a sequel to an earlier judgment delivered by me on the 16th January, 2013, in *Re X.Y.* [2013] 1 I.L.R.M. 305. There, I set out the facts in some detail and this judgment should be read in conjunction with that judgment, but to recap, the plaintiff is now sixteen and a half years of age. She has been diagnosed with bipolar affective disorder. The plaintiff was hospitalised on a number of occasions and on the 3rd July, 2012, she was transferred from an adult psychiatric unit to Merlin Park Child and Adolescent Mental Health Service Inpatient Unit following a suicide attempt. Of note is that on the 15th October, 2012, the Health Service Executive (HSE) made an application for an order pursuant to s. 25 of the Mental Health Act providing for her detention. The plaintiff minor was not present in Court for the hearing nor was she legally represented. However, her parents were present and consented to the order sought. A letter from the plaintiff setting out her views was submitted to the Court and considered by Judge Mary Fahy of the District Court.

3. In October 2012 the plaintiff was prescribed Olanzapine. On occasions she refused to take the prescribed medication and on these occasions the medication was administered by injection, which involves physical restraint.

4. On the 5th November, 2012, the defendant, for reasons set out in greater detail in the earlier judgment, was anxious to obtain a blood sample from the plaintiff. However, she refused to provide one. In these circumstances, the defendant applied *ex parte* for an order permitting the taking of blood samples forcibly. The taking of blood samples is regarded as necessary to guard against the development of very serious side effects which can be associated with anti-psychotic medication. I adjourned the application so that the plaintiff could be separately represented, appointing a solicitor to act as guardian *ad litem* for her. The solicitor in question is highly experienced in this area of law. She was, as I have indicated, originally appointed as guardian *ad litem*, but in fact in the course of the present proceedings has performed the role of *legitimus contradictor* and communicated the views of the plaintiff to the Court, but did not express her own views in the course of the proceedings as to what was in the plaintiff's best interests. A number of medical reports were commissioned by the solicitor guardian which were submitted to the Court. These independent reports did not take issue with the appropriateness of the plaintiff's treatment regime. The matter came on for hearing on the 6th December, 2012 and I delivered judgment on the 16th January, 2013, authorising the HSE to obtain a blood sample.

5. The order of the District Court was extended on the 31st October, 2012 for a three month period. The matter was back before the District Court on the 28th January, 2013, when the order was extended for a period of approximately three weeks. On this occasion a guardian *ad litem*, Mr. Raymond McEvoy, was appointed and the Court sought a report from Dr. Delia McGuinness, Consultant Child and Adolescent Psychiatrist. On the 20th February, 2013, the order was extended once more and it was further extended on the 23rd April, 2013 for a period of approximately three months to the 9th July, 2013. On that occasion a video link was put in place so that the plaintiff could speak directly to the judge of the District Court dealing with the matter, Judge Mary Fahy.

6. The plaintiff remains in Merlin Park Hospital on foot of an order of the District Court.

7. Insofar as the treatment she has been receiving is concerned, when she was first admitted to CAMHS Merlin Park Hospital Galway, the medication that she had been on, Aripiprazole (a mood stabiliser) was continued but, subsequently, this was discontinued after a period at the suggestion of the plaintiff. On admission to hospital the plaintiff was commenced on the Dialectical Behaviour Therapy Programme, which is a programme for people with severe suicidal ideation and a history of self harm. In August 2012, the plaintiff was commenced on a trial of Quetiapine (antipsychotic medication) and on the 31st August, 2012, she was commenced on a liquid form of Quetiapine. In October 2012, the plaintiff began to refuse medication. In that context it is of some significance that she spoke to hospital staff about her belief that taking the medication would reduce her capacity to formulate and execute the plans that she had for her suicide. The plaintiff's treating consultant, Dr. Dermot Cohen, sought an expert pharmacological opinion from Professor David Taylor, who is Professor of Psychopharmacology at King's College London and Maudsley Hosptial. Dr. Taylor recommended Olanzapine. The plaintiff refused to take her medication, and it was deemed necessary on these occasions to physically restrain the plaintiff so that the medication could be administered safely.

8. Sadly, the plaintiff remains at high risk of suicide. There is, I believe, a broad consensus that it would be highly dangerous for her to be discharged from hospital at this stage and doing so would put her life at serious risk.

9. The plenary summons and statement of claim seek declarations that s. 25(6) is repugnant to the Constitution and incompatible

with the European Convention on Human Rights, and a similar approach was taken in the written submissions filed on behalf of the plaintiff. However, a very different note was taken by counsel for the plaintiff in his oral submissions. On this occasion counsel indicated that it was possible to, as he put it, square the circle and achieve what was sought by less radical means than declarations of repugnancy or incompatibility, referring in that regard to the approach of Hogan J. in *B.G. v. District Judge Murphy* [2011] 3 I.R. 748.

10. The case to which counsel referred and which it is suggested could serve as a model for how this case could be dealt with was an interesting one. Hogan J. was dealing with a situation where the applicant had been charged with the indictable offence of sexual assault. The Director of Public Prosecution was prepared to see the case dealt with in the District Court on a plea of guilty. However, there were doubts about the applicant's mental capacity and so the District Court judge dealing with the case could not be satisfied that the applicant understood the nature of the offence with which he was charged, which was a necessary requirement in order for a plea of guilty to be entered and accepted. In these circumstances the applicant was sent forward to the Circuit Court so that the issue of fitness to plead could be determined. The difficulty for the applicant was that even if the Circuit Court found him fit to plead, he was no longer in a position to have the case dealt with summarily, as this option was closed to him once the case was sent forward from the District Court to the Circuit Court, and, accordingly, he was now at risk of having a far more severe penalty imposed on him than he would have faced had the case been dealt with in the District Court.

11. Hogan J. was of the view that Article 40(1) of the Constitution had been violated in that the Oireachtas had failed to have proper regard to the rights of those whose mental capacity was uncertain as it failed to provide a mechanism whereby persons charged with indictable offences, whose fitness to plead was later established in the Circuit Court, could obtain the benefit of a guilty plea in the District Court in the same way as was available to those whose mental capacity was not in doubt. Hogan J. was of the opinion that the classic response, the striking down of the relevant statutory provision, was not the only possible remedy. In those circumstances, Hogan J. made an order declaring that if the applicant was found fit to be tried and subsequently pleaded guilty, that his constitutional right to be held equal before the law would be breached if the sentencing Circuit Court Judge imposed a sentence in excess of the statutory District Court maximum. By analogy to the approach taken by Hogan J., counsel was of the view that the requirements of the present case could be met by declarations dealing with the necessity for the District Court to appoint a guardian *ad litem* and for the guardian to obtain and put before the Court independent expert medical reports and that when particular forms of treatment were regarded as appropriate or necessary, that this would be communicated to the Court and its approval sought.

The argument that the section is unconstitutional and/or incompatible with the Convention
12. Even though, in circumstances which I have already outlined, arguments to this effect have not really been pressed, I will address this aspect first.

13. The argument made is that the statute contemplates the detention of minors under the Mental Heath Act without providing any, or certainly any adequate safeguards for a minor who is objecting to detention and thereafter for the forcible administration of medication. Indeed, it is said that this is graphically illustrated by what has happened in the case of X.Y. It is said that there are, with the exception of specific statutory provisions in relation to psychosurgery and electro-convulsive therapy, no procedural safeguards in relation to treatment and that this is in conflict with fundamental constitutional principles and is also clearly incompatible with the European Convention on Human Rights.

14. On behalf of the plaintiff it is argued that she, and other minors in a similar position, enjoy lesser protection than would be available to adults and it is said that this is an unjustified, arbitrary and, indeed, invidious form of discrimination. In that regard, counsel points in particular to the fact that children do not have their detention reviewed by the Mental Health Tribunals, that the District Court can and does act on the report of a single psychiatrist who may be the treating psychiatrist and that there is no statutory obligation to notify the Mental Health Commission of the making of the order under s. 25.

15. In my view, the suggestion that s. 25 is so lacking in procedural safeguards and that it treats children in a less favourable way than adults are treated is without foundation. On the contrary, s. 25, when read on a stand-alone basis, but more particularly when read in conjunction with the provisions of the Child Care Act 1991, as it ought to be, provides significant safeguards. Section 25(1) requires the making of an application to the District Court before the initial order providing for detention is made. Manifestly, the District Court is an independent forum, each of the judges of that Court having made a solemn declaration to uphold the law and the Constitution. Section 25(2) provides that ordinarily the child must be examined by and be the subject of a report from a consultant psychiatrist, who must not be a relative of the child. Where that is not possible, an alternative procedure is provided. In relation to s. 25(6), the order made by the Court provides that a child be admitted and detained for treatment (my emphasis) in a specified approved centre for a period not exceeding twenty one days.

16. Section 25(7) provides that an application may, if the Court is satisfied that the urgency of the matter so requires, be made *ex parte*. It will be noted that it is only if the Court is satisfied that the urgency of the matters so requires that the application can be made *ex parte*. In other circumstances the application has to be made on notice. In this context, the provisions of s. 4 of the Mental Health Act 2001 are very much in point. That section 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 principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.
>
> (2) Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this subsection.
>
> (3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy."

The section deals with care and treatment of persons and does not make any distinction between adults and children. Accordingly, in making decisions concerning the care or treatment of children, the best interests of the child should be the principal consideration and the child is, insofar as is reasonably practical, to be notified of what is proposed and is entitled to make representations and those representations are to be given due consideration before any decision is made.

17. Section 25(8) provides that between the making of an application for an order under the section and its determination, the Court can of its own motion or an application of any person (my emphasis) give such direction as it sees fit in relation to the care and

custody of a child. The phrase "any person" is clearly broad enough to include parents and family members of a minor, persons acting in the role of guardian *ad litem* and performing similar roles and, indeed, the minor herself. Section 25(9) provides for the possibility of further orders providing for detention not exceeding three months and s. 25(10) for a further detention for a period of six months. It should be noted that these further detention periods are maximum periods, rather than minimum or stipulated periods and can be made only on foot of further applications and reviews by the independent forum that is the District Court. Further detention can only be ordered if a report from a consultant psychiatrist is presented to the Court and the Court is satisfied that the child is still suffering from a mental disorder. Sub-sections (12) and (13) provide that psychosurgery or electro-convulsive therapy (ECT) cannot, in the case of a minor, take place without the approval of the Court. Insofar as the plaintiff has contrasted the position of a child and an adult under the Mental Health Act, the provisions in relation to psychosurgery and ECT are protective of the child, taking a paternalistic approach to the child as, unlike in the case of an adult, the consent of a minor is not sufficient and the approval of the Court itself is required. In contrast in the case of ECT, this can occur if an adult patient gives consent, while in the case of psychosurgery, the consent of a Tribunal is sufficient. A similar differentiation is to be found in the case of long-term medication. Long-term medication can be prescribed to an adult patient, either on the basis of written consent from the patient, or if that is not forthcoming, on the basis of an authorisation from a consultant psychiatrist other than the treating one, but in the case of a child, the child's consent is insufficient and only a second psychiatrist can authorise long-term medication. Again, this is indicative of an approach to minors on the part of the legislature which is paternalistic and protective. X.Y. is currently prescribed medication in accordance with the provisions of s. 61 of the Mental Health Act 2001. Specifically it is the case that Dr. Delia McGuinness, Consultant Child and Adolescent Psychiatrist, authorised continuing medication. She had been asked by the District Court to provide a second opinion in relation to the treatment of the plaintiff.

18. The plaintiff is dismissive of the significance of the provisions of the Child Care Act incorporated by s. 25, subs. (14), saying that the provisions of the Child Care Act 1991 that are incorporated add little, if anything, to the provisions of the Mental Health Act. It is said that s. 24 of the Child Care Act, with its requirement that the welfare of the child be the primary consideration, adds nothing to what had already been provided by s. 4 of the Mental Health Act. Section 25 of the Act of 1991 is merely a power to join the child as a party and this is not something that is likely to happen all that often in the mental health area. Section 26 of the Act of 1991 merely permits a guardian *ad litem* to be appointed but does not mandate or require this to happen. Again, section 27, it is said, merely permits the Courts to procure a report but does not mandate or require this. The plaintiff says that this permissive approach is to be contrasted unfavourably with the requirement to obtain a report in the case of an adult.

19. In my view, the plaintiff is unduly dismissive of the significance of the Child Care Act provisions. It is true that the Child Care Act, the provisions of which were incorporated in the Mental Health Act 2001, does not in terms mandate the joining of the minor as a party or the appointment of a guardian *ad litem*, but it must be recalled that the District Court is mandated and is required to regard the welfare of the child as the first and paramount consideration and is mandated in so far as practicable , to give due consideration, having regard to his or her age and understanding, to the wishes of the child.

20. I will be addressing issues relating to the European Convention on Human Rights more specifically presently. However, at this stage I would simply refer to the fact that on behalf of the plaintiff it has been acknowledged, and rightly so in my view, that the Constitution provides for at least arguably greater procedural safeguards for the individual than those required by the European Convention on Human Rights. That is not to ignore the fact that constitutional interpretation is informed and influenced by the European Convention on Human Rights, an international agreement to which the State has acceded. In that regard, I refer to the judgment of *M.X. (APUM) v. HSE and Ors.* [2013] 1 I.L.R.M. 322, in which MacMenamin J. observed as follows (at para. 72):

> "As in the Irish and ECtHR authorities identified, I believe the broader range of constitutional 'personal capacity rights' identified earlier, now fall to be informed by the United Nations Convention on the Rights of Persons with Disabilities, as well as the principles enunciated in the judgments of the European Court of Human Rights."

The views expressed by MacMenamin J. are of considerable interest, particularly given that they were expressed in the context of consideration of provisions contained in the Mental Health Act. But it must be said that they are not at all novel, indeed they mirror closely observations made by Costello P. in *R.T. v. Director of Central Mental Hospital* [1995] 2 I.R. 65.

21. In my view, judges in the District Court to whom applications are made will be very aware of the importance attached both domestically and internationally to hearing the voice of the child. The European Convention on Human Rights Act 2003 requires that judicial notice be taken of decisions of the European Court of Human Rights. Accordingly, one can be confident that courts will have regard to and be influenced by ECtHR jurisprudence when considering matters such as whether to join the child as a party, whether to appoint a *guardian ad litem* or whether to seek an independent report.

22. In the present case, when the matter was before the District Court on the 15th and 31st October, 2012, letters written by the plaintiff were handed to the judge and the judge, it seems, specifically referred to the views of the plaintiff and to the fact that she was expressing the view that she did not wish to be in a mental health facility. The plaintiff's parents were present, and supported the making of the order.

23. It does seem to me that the arguments on behalf of the plaintiff do not take into account the central role of parents when it comes to the taking of decisions in relation to their child and their central role in determining if it is in the best interests of a child. It will ordinarily be the case that decisions in relation to a child's medical treatment will be taken on behalf of a child by his or her parents. That is so whether the child has or has not mental health issues.

24. In the course of her judgment in *Re Ward of Court (No. 2)* [1996] 2 I.R. 79, Denham J., as she then was, commented as follows (at p. 156):

> "Medical treatment may not be given to an adult person of full capacity without his or her consent . . . if the patient is a minor then consent may be given on their behalf by parents or guardians. If the patient is incapacitated by reason other than age, then the issue of capacity to consent arises. In this instance, where the patient is a ward of court, the court makes the decision."[*Emphasis added*]

25. The written submissions in this case and both the written and oral submissions in the earlier *X.Y.* case had focused attention on the position of the so-called "Gillick" competent minor, a reference to the very well known case of *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] A.C. 112. However, in my view, this is a case where context is all. It seems to me that the considerations that apply in deciding whether a sexually active teenager should be permitted to access contraception are of an altogether different order to those that apply in deciding whether a troubled teenager should be permitted to refuse medical treatment so as to advance a determination to commit suicide. A capacity or entitlement to refuse is not necessarily to be equated with a capacity or entitlement to consent to treatment.

26. Returning to the history of the present case, on the 5th November, 2012, Ms. O'Shea was appointed by the High Court to respresent the plaintiff, and a guardian *ad litem* was appointed by the District Court on the 28th January, 2013. It is noteworthy that no information has been put before either the District Court or this Court by the guardian or anyone else to suggest that the plaintiff's detention and the treatment she is receiving is not in her best interests. As we have seen, on the 28th January, 2013, Dr. Delia McGuinness, Consultant Child and Adolescent Psychiatrist, at West Galway Child and Adolescent Mental Health Service, provided a second opinion in relation to the treatment being provided.

27. When the HSE wished to take blood samples which were necessary if the prescribed medication was to be administered safely, the HSE brought the matter before the High Court. Ms. O'Shea proceeded to instruct junior and senior counsel who advanced the plaintiff's views. Even though those views did not carry, the day an order was made, without opposition, that the guardian's costs should be met by the HSE. The matter was again brought back before the High Court on the 19th February, 2013 when the guardian sought clarification of legal issues in relation to restraint in the aftermath of the earlier decision. Again an order was made without opposition, providing for payment of the guardian's costs by the HSE. The minor has exercised her right of access to the courts in order to have her views on her treatment considered.

28. It seems to me that the history of this case shows that the safeguards in the Mental Health Act and those contained in the Child Care Act which were incorporated by s. 25(14) are not only capable of working but do in fact work in practice. That is not to say that the legislation could not be improved upon, and that the protections that are available and must be available to the minor could not with advantage be spelt out with greater specificity. However, that does not provide a basis for a constitutional challenge.

29. In relation to the argument that children are the subject of invidious discrimination, it is certainly the case that the procedures applicable to children are significantly different to those that apply to adults. However, viewed in the round, I am not at all convinced that the position of children is inferior. The provisions of the Child Care Act which I regard as being of real and substantial value have no application to adults. The role of the District Court is specific to children. It seems to me that the role played by the District Court and the option of an appeal to the Circuit Court and, indeed, the possibility of judicial review, are at least the equal of what is provided in the case of adults through the Mental Health Tribunals. This is a case where a diversity of arrangements has been provided and that that should be so is not at all surprising. Indeed, it is entirely to be expected that different arrangements would be provided for children, given that the children that we are dealing with are particularly vulnerable because of their young age and their mental health difficulties.

30. The arguments specific to the European Convention on Human Rights have relied heavily on the case of *X v. Finland*, (Application no. 34806/04, 3rd July, 2012). It may be said that the factual background to that case could scarcely be more different as it involved a paediatrician whose compulsory hospitalisation in a state mental hospital began when, in the course of her medical practice, she met with a mother and daughter, the daughter having allegedly been sexual abused by her father. The paediatrician allegedly assisted the mother to remove her daughter from care. Thereafter, X was charged with the offence of involvement in kidnapping. The path then taken was a somewhat unusual one, in that the criminal proceedings were brought to a conclusion because it was determined that the applicant's mental state was such that she lacked capacity to be held criminally responsible. However, in the course of the proceedings she was transferred to a mental hospital where she was detained, diagnosed as suffering from delusional disorder and judged to meet the criteria for involuntary confinement. When she refused to take medication that was prescribed, she was forcibly injected. Thus, the starting point for the controversy was criticism of Ms. X's response as a professional to an allegation of child sexual abuse that was presented to her. This brought her into conflict with the prosecution system, the court system, the mental health service and the medical staff at Vanha Vaasa Hospital where she was detained.

31. While the factual background to the *X v. Finland* case contains some quite unusual features, of more direct relevance is to consider the criticisms made by the ECtHR of the Finnish mental health system. The ECtHR was of the view that the initial confinement of a "forensic" patient after a psychiatric examination, and the involuntary treatment in a mental hospital by the Forensic Psychiatry Board of the National Forensic Medical Authority, whose decisions were subject to independent judicial review, were not problematic from the point of view of the rule of law. However, crucially the court was critical of the fact that when it came to continuation of such treatment that there was no adequate safeguard against arbitrariness.

32. The present situation is quite different. The initial order providing for detention for treatment was made by an independent body, indeed made by a court. It is a decision which is subject to appeal and, indeed, is subject to judicial review. The decision, if made, is time limited, it can be made for a maximum period of twenty one days. There are also clear restrictions on the circumstances in which an order can be made. It is not, of course, sufficient that a child is suffering from mental disorder. But it is also necessary that the child requires treatment for that mental disorder which he or she is unlikely to receive unless an order is made under the section. An order cannot be made if an alternative treatment programme which meets the child's needs can be delivered. The order can be made only if that is required. In effect the order can be made only if there is no alternative.

33. In contrast to the situation in Finland, the order, if it is to be extended, will be extended on foot of a further order of an independent body. A further difference from the situation that appeared to prevail in Finland is that by virtue of the provisions of s. 47 of the Child Care Act 1991, the District Court may on its own motion or on the application of any person, and obviously that includes parents, family members, guardians *ad litem*, and, indeed, minors themselves, give directions or orders to vary or discharge any direction or order made. Thus, the situation in Ireland is that the independent body that is the District Court is at the heart of the detention for treatment at all stages. In contrast, the situation in Finland appeared to be that a patient detained did not have any possibility of initiating proceedings in which the issue of whether the conditions for his or her confinement were still met could be examined.

34. The ECtHR commented that the situation under consideration was aggravated by the fact that in Finland a care order issued for the involuntary hospitalisation of a psychiatric patient was also understood to contain an automatic authorisation to treat the patient even against his or her will and a patient could not invoke any immediate remedy in that respect.

35. Again, the situation in Ireland is quite different. The order made by the District Court is one that provides for detention for treatment. There is no question of detention other than for treatment, so the question of treatment is the concern of the District Court from the outset. It is open thereafter to the Court on its own motion or on the application of any party to give directions as to the procuring of a report. As the present case has shown, this is a provision that is capable of being used for the purpose of obtaining an independent second opinion on the appropriateness of treatment. Again, the provisions of s. 47 of the Child Care Act 1991 to which I have referred provide a route by which any party, who might wish to do so, can seek to have conditions imposed in relation to treatment.

36. In summary, it is my view that the provisions of s. 25 of the Mental Health Act are capable of being implemented in a manner that is fully constitutional and Convention compliant. It is to be expected and assumed that the legislation will be operated in just that

fashion. In these circumstances the plaintiff is not entitled to an order declaring the section to be repugnant to the Constitution or to a declaration that the section is incompatible with the Convention.

37. The view that I have reached is based on my expectation that the Act will be implemented in the way that I have indicated. Indeed, a failure to do so might well render orders made susceptible to challenge. The HSE, which initiates s. 25 applications, has a particular interest in ensuring that orders made are robust and not susceptible to challenge. For that reason it would seem desirable that the HSE would adopt a practice of drawing the attention of the Court and the parties to the provisions in relation to the appointment of a guardian *ad litem*, so that the desirability of adopting this approach in a particular case or perhaps adopting some suitable alternative, such as joining the child as a party, can be considered.

38. I would simply add the observation that had I found it necessary to declare s. 25 unconstitutional, that this would not have served the plaintiff's interests. This would not have grafted on the procedural safeguards that the plaintiff seeks, rather it would simply have struck the section down.

39. If a consequence of a declaration of unconstitutionality was that the plaintiff's treatment in hospital was terminated, then this would very likely have very serious, indeed quite possibly, fatal consequences.

A case for the making of declarations

40. I have considered carefully whether this is a case where it would be appropriate to make declarations as suggested by counsel for the plaintiff and for a number of reasons I have decided that that would not be appropriate. In the first place, declarations made now would not provide any practical advantage for the plaintiff. At this stage, X.Y. is assisted by a guardian *ad litem*. The District Court has commissioned an independent report seeking a second opinion in relation to her treatment. There is every reason to believe that the regime to which X.Y. is subject serves her best interests. She will have an opportunity to canvass any concerns that she has in relation to her treatment when the matter is listed again before the District Court. Equally, the plaintiff has the opportunity to raise issues in relation to the appropriateness of her treatment in the High Court. To date, the opposition on her behalf has been confined to procedural issues and specifically to an alleged lack of adequate procedural safeguards. However, it may be that the plaintiff will seek to address the appropriateness of the treatment that she is receiving. In other words, address the merits of the issue at some stage and if so, that is an option that is open to her.

41. This is a situation where making the declarations sought would not offer the plaintiff any practical advantage. It seems to me that to attempt to formulate declarations in a vacuum would be inconsistent with the requirement for judicial restraint. The situation is the precise opposite to that which faced Hogan J. who tailored declarations designed to provide a practical remedy to the plaintiff, Mr. B.G.

42. It is also the situation that where various options are available to the Court, such as joining the minor as a party, commissioning reports, or appointing a guardian *ad litem*, it seems to me that it would not be possible to formulate declarations that would not be unduly prescriptive. Alternatively, the declarations would be in such broad terms referring to the need to follow procedures that were fair and transparent that nothing would be added to the existing law. I am also conscious that the circumstances in which applications under s. 25 are brought before the Court are likely to vary greatly. In that regard, the situation of X.Y. is atypical. Here, X.Y. has had a lengthy stay in hospital and has received treatment over a prolonged period. The initial application to the District Court goes back as far as the 15th October, 2012. However, the average duration of a hospital stay for a minor detained under the section was, it appears, seventeen and a half days. It may be that at the time of the initial application to the District Court in a particular case that there will be an expectation that any period of hospitalisation will be brief, perhaps very brief. On the other hand, there may be cases where symptoms are so severe that the expectation will be of an extended stay. These factors will obviously influence the selection of appropriate procedures. However, whether the expectation is of a short-term or extended stay, the Court will need to follow procedures that are fair and which will allow the child's voice to be heard. Again, it does not seem to me possible to prescribe procedures that would be appropriate for all of the different situations that may arise. In summary, as I am declining to make the declarations sought in relation to unconstitutionality and incompatibility, and as I do not propose to make the declarations sought, I must dismiss the plaintiff's claim.