Neutral Citation Number: [2007] IEHC 129

THE HIGH COURT

[2007 No. 408 S.S.]

IN THE MATTER OF AN INQUIRY PURSUANT TO ARTICLE 40.4.2 OF THE CONSTITUTION OF IRELAND

BETWEEN

T. O'D.

APPLICANT

AND

HARRY KENNEDY, CLINICAL DIRECTOR OF THE CENTRAL MENTAL HOSPITAL, AND THE HEALTH SERVICE EXECUTIVE

RESPONDENTS

AND

THE MENTAL HEALTH COMMISSION

NOTICE PARTY

Judgment of Mr. Justice Peter Charleton delivered the 25th day of April 2007.

1. On the 2nd April, 2007, this matter first appeared before the High Court as an application for an inquiry into the lawfulness of the detention of the applicant under Article 40.4.2 of Bunreacht na hÉireann. The matter was made returnable for 14.00 hours on the next day. On hearing the parties, it was impossible to dispose of the case then. When a listing was suggested later in the week, or early in the following week, it emerged that important personnel who needed to swear affidavits in relation to this difficult case were unavailable. The matter was therefore heard on the 17th April. The issues involved being complex matters of importance as to the proper interpretation of the powers of detention contained in the Mental Health Act, 2001, the case therefore put in for judgment for today.

2. The time taken to dispose of this application is at the limit of the stricture set out in Article 40.4.2 which requires a judge to whom a complaint is made that a person is being unlawfully detained to "forthwith inquire into the said complaint". The complexity of the facts and law bearing on the contention of unlawful detention have to be borne in mind in the disposal of this matter. It is important to take time but, in this regard, the minimum amount of time necessary to fairly dispose of such issues. *In The State (Whelan) v. Governor of Mountjoy Prison* [1983] I.L.R.M. 52 at 55 it was pointed out that although the adverb "forthwith" in Article 40.4.2 qualified the manner in which the decision to order an enquiry was to be conducted; it did not govern the time in which the inquiry itself was to be undertaken or within which judgment should be delivered. However, the urgency and importance of proceedings of this kind must be kept in mind by a court, which is entitled to conduct the hearing in a manner which it thinks is best calculated to resolve the issues of law and fact and to achieve justice between the parties.

3. The applicant claims that he is unlawfully in detention in the Central Mental Hospital pursuant to orders of detention made under The Mental Health Act, 2001. Insofar as it is argued that the Mental Health Tribunal, set up under the Mental Health Commission first established under that Act, have ruled that his detention is lawful, it is asserted in these proceedings that his ruling was beyond the powers of the Tribunal under the Act.

Facts

4. The applicant is very ill. In stating that as a fact in the present, it certainly does not mean that the applicant may not recover. The letter written by the applicant to the court, and his comments on the replying affidavit of Dr. Damien Mohan in these proceedings indicate a lively and intelligent mind. Unfortunately, the problems which the applicant currently faces are very serious. He has expressed sexual ideation concerning paedophilia; he has delusions of being persecuted; he has attempted to strangle his former girlfriend; he has jumped from a height to escape from a mental hospital; he has assaulted staff members at various psychiatric hospitals, threatening to kill them; and he has a history of serious substance abuse of alcohol, drugs and veterinary anaesthetic.

5. The applicant was first admitted to St. James's Hospital in 1997 after an attempt to strangle his girlfriend, in consequence of a belief that she was being unfaithful. There were further admissions to the same hospital in November, 1997 and June of 1998. A diagnosis of paranoid schizophrenia was made. Further admissions to that hospital occurred in September of 1999 and April of 2001. Out-patient treatment continued between admissions. As a result of an incident in April, 2001 he was transferred from St. James's Hospital to the Central Mental Hospital and remained there for the next seventeen months. Further incidents of assault occurred during that time. Under s. 185 of the Mental Treatment Act, 1945 the applicant was admitted to St. James's Hospital on the 13th June, 2003, and then, pursuant to s.208 of that Act, transferred to the Central Mental Hospital. This certification under s.184 was further endorsed on 11th December, 2003. On 13th June, 2003, the applicant had been transferred to St. Brendan's Hospital from St. James's Hospital but on the 13th May, 2004, he was transferred to the Central Mental Hospital. The Applicant was admitted to the psychiatric unit of St. James's Hospital on 7th June, 2005, under s.184 of the Mental Treatment Act, 1945 and then transferred to the Central Mental Hospital. This certification under s.184 was endorsed on 7th December, 2005, and further endorsed on 6th June, 2006, for a six month periods. During the next five months the situation of the applicant was diagnosed in the manner which is set out in the replying affidavit of Dr. Damien Mohan, consultant psychiatrist as follows:-

> "The Applicant continued to express a chronic systemised delusional system. I say that he continued to believe that people were trying to kill him and that there was a conspiracy against him. I say that he also continued to express chronic delusions that… I say that he made considerable progress in terms of rehabilitation work and attendance at various courses. I say that he also participated in accompanied parole and had completed a relapse prevention programme. He continued to engage in individual psychological work and occupational therapy".

6. The problems in relation to the legal aspect of the detention of the applicant apparently began on 11th December, 2006 when at 15.15 hours Dr. Mohan, who was the applicant's treating psychiatrist, was informed that the renewal order in respect of his detention under s.184 of the Mental Treatment Act, 1945 had not been extended, as it should have been on 7th December, 2006. On consulting the Mental Health Commission, they advised Dr. Mohan to tell the applicant that he was in hospital as a voluntary patient. When Dr. Mohan spoke to the applicant and informed him that he was a voluntary patient, the applicant accepted that he remained mentally unwell and admitted harbouring ideas of harm towards children. Issues as to a possible transfer to a hostel for psychiatric patients in the community were discussed between the applicant and Dr. Mohan. Dr. Mohan explained to him that s. 23 of the Mental Health Act, 2001 would enable him to certify the applicant so as to detain him in hospital for 24 hours. The procedure whereby another consultant psychiatrist would then review him was also explained. The applicant expressed the view that one part of him wanted to go to St. James's Hospital and another part wanted to stay in the Central Mental Hospital in order to finish his course of treatment. On 11th December, 2006, the applicant agreed to remain on in the Central Mental Hospital as a voluntary patient. On 13th December, 2006, the mental condition of the applicant had, regrettably, deteriorated and it appeared, on the evidence before me, that he did not have the requisite capacity to give a valid and informed consent to remain in the Central Mental Hospital. The applicant told Dr. Mohan that

he had his bags packed and wanted to leave. Section 23(1) was then invoked. On the next day, Dr. Mary Darby gave a second opinion as required by s. 24 (2) of The Mental Health Act and an admission order was signed on that day.

7. On 3rd January, 2007, the Mental Health Tribunal reviewed the detention of the applicant and affirmed his involuntary detention order dated 14th December, invoking s. 18 (1) (a) (2) of the Mental Health Act, 2001 to cure the procedural irregularities which had occurred. On 17th January, 2007, Dr. Mohan was informed that a renewal order which should have been completed in respect of the applicant had not been made and that therefore his detention was invalid. Dr. Mohan informed the applicant of this who indicated that he wished to leave the hospital. Section 23 (1) of the Act was again invoked and the applicant was certified for a 24 hour period. That certificate, however, was not completed in accordance with the procedure under the Act until the 24th January, 2007. This exceeded the relevant 24 hour period, within which that should be done, by six days.

8. On 5th February, 2007, the Mental Health Tribunal considered the detention of the applicant and affirmed the admission order dated the 24th January, 2007. Their reasons were as follows:-

> "That the substance of the order admitting him as an involuntary patient is valid and the procedural irregularities do not cause him an injustice in that the best interests of the patient is served by his admission as an involuntary patient. For the following reasons we affirm the order dated 24th January, 2007 having taken into account the submissions made by the legal representative Mr. Paul McKnight, the evidence of Dr. Mohan and the medical reports… and the independent report of Dr. Denis Murphy dated the 30th January, 2007, and the evidence of the patient, Mr. T. O'D."

The 2001 Act

9. The Mental Health Act, 2001 (Commencement) Order 2006, (S.I. 411 of 2006), brought ss. 6, 8 to 30 and 56 to 75 inclusive of the Act into operation on 1st November, 2006. Sections 1 to 5, which deal with definitions and other important matters, were all ready in force. The interregnum between Mental Treatment Act, 1945 and the Mental Health Act, 2001 has caused considerable difficulties in terms of implementation. Not least, it would seem that personnel trained to look after the needs of seriously mentally ill patients have not yet fully put in place systems for checking the time limits for the involuntary detention of mental patients specified by the Mental Health Act, 2001. In a prison context, where a prisoner is sentenced, the number of days he has to serve is written up in a book and posted on his door, when the actual sentence minus twenty-five percent remission has been calculated. A similar, but perhaps less obvious or intrusive, system might recommend itself in this context.

10. There are two fundamental sections to the Mental Health Act, 2001 and these are ss. 3 and 4. Section 3 defines the nature of a mental disorder. It reads:

> "3 (1) In this Act "mental disorder" means mental illness, severe dementia or significant intellectual disability where
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> (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
>
> (b)
>
> (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and
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> (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.
>
> (2) In subsection (1)
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> "mental illness" means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons.
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> "severe dementia" means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;
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> significant intellectual disability" means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person".

11. It is when a person suffers from a mental disorder that the rest of the Act may be operated. As O'Neill J. stated in *M.R. v. Byrne* (High Court, Unreported, 2nd March, 2007), this section is of critical importance as it establishes the benchmark against which all forms of mental illness must be assessed before an admission order or a renewal order can be made. These orders have the result of detaining persons against their will. I adopt his analysis from pages 15 to 18 of his judgment in that case:-

> "As is clear from this section there are two separate bases upon which "mental disorder" can be established.
>
> The first of these is as set out in s. 3(1)(a) and it is where the Mental Illness, severe dementia or significant intellectual disability is such that there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons.
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> The second basis is where the severity of the mental illness, dementia or disability is such that the judgment of the person concerned is so impaired that a failure to admit the person would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission and that the reception, detention and treatment of the person concerned in an approved centre would likely to benefit or alleviate the condition to a material extent.
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> I am quite satisfied that these two bases are not alternative to each other and indeed it would be probable in my view

that in a great many cases of severe mental illness there would be a substantial overlap between the two. Thus it would be very likely in my opinion that in a great many cases in which a person could be considered to fall within the categorisation in s. 3(1)(a) that they would also be likely to fall within s. 3(1)(b). To a mush lesser extent, it is probable that persons who are primarily to be considered as falling within s. 3(1)(b), would also be likely to have s. 3(1)(a) applied to them.

Insofar as s. 3(1)(a) is concerned the threshold for detention in an approved centre by way of either an Admission Order or as in this case a Renewal Order is set high. There must be a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons.

In the course of argument in this case it became common case that the standard of "serious likelihood" was said to be higher than the ordinary standard of proof in civil actions namely balance of probability but somewhat short of certainty.

In my view what the Act envisages here is a standard of proof of a high level of probability. This is beyond the normal standard of proof in civil actions of "more likely to be true", but it falls short of the standard of proof that is required in a criminal prosecution namely beyond a reasonable doubt and what is required is proof to a standard of a high level of likelihood as distinct from simply being more likely to be true.

The harm apprehended must in the first instance be "immediate". This presents obvious difficulties of construction, in the context of mental illness, because of the unpredictability of when the person concerned may cause harm either to themselves or others.

In my view the critical factor which must be given dominant weight in this regard is the propensity or tendency of the person concerned to do harm to themselves or others. If the clinicians dealing with a person concerned are satisfied to the standard of proof set out above that that propensity or tendency is there then in my view, having regard to the unpredictability of when the harm would be likely to occur, the likelihood of the harm occurring would have to be regarded as "immediate".

Next one must consider what constitutes "serious" harm.

The word "harm" is a very general expression and clearly its use is intended to encompass the broadest range of injury. Thus physical and mental injury are included.

The term "serious" is somewhat more difficult to fully comprehend. In this regard it may very well be that a somewhat different standard would apply depending upon whether the harm was inflicted on the person themselves or on others. Clearly the infliction of any physical injury on another could only be regarded as "serious" harm, whereas the infliction of a minor physical injury on the person themselves could be regarded as not "serious".

Thus assaults directed at others, which had the potential to inflict physical injury could be considered to fall within the ambit of the term "serious". Behaviours on the part of a person suffering from mental illness, dementia or disability, where there was a serious likelihood of these behaviours resulting in serious actual physical injury to the person concerned, should rightly be regarded as "serious" harm. Where the likely end result of these behaviours was merely trivial injury, it would not or should not, normally be regarded as constituting "serious" harm for the purposes of s. 3(1)(a),

This brings me to s. 3(1)(b).

In my view it is appropriate to take the two parts of this subsection together namely b(I)(II). Between them they establish three essential elements which must be present before "mental disorder" under this provision is established.

These are as follows:

> (1) the severity of the illness mental, disability or dementia must result in the judgment of the person concerned being impaired to the extent that failure to admit the person to an approved centre is likely to
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> (2) lead to a serious deterioration in his or her condition or prevent the administration of appropriate treatment that can be given only on such admission and
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> (3) that the reception, detention and treatment of the person in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

These elements in s. 3(1)(b)(I) and (II) are in my view clear and self explanatory. It is perhaps worth drawing attention to the fact that in 3(1)(b)(I) there are alternative provisions, namely that the failure to admit to an approved centre be likely to lead to a serious deterioration in the condition of the person or that the failure to admit into an approved centre would prevent the administration of appropriate treatment that could be given only by such admission.

It should be stressed that the foregoing analysis or description of these provisions merely seeks to set out the legal framework of the operation of the statutory provisions. It cannot be over emphasised however that on a daily basis these provisions will have to be operated by clinical experts who within the broad framework set out above have to make clinical judgments, and I would like to stress that it is not intended in this judgment to interfere in the proper realm of clinical judgment or to cut down or limit the proper scope of clinical judgment."

12. Under s. 32 of the Act, the Mental Health Commission was established in order, as it states, to promote, encourage and foster the establishment and maintenance of high standards and good practice in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres. Part II of the Act deals with the involuntary admission of persons to mental hospitals, which are here called approved centres. I will call them hospitals, as that is clearer. A recommendation may be made for an involuntary admission under s. 10 of the Act by a registered medical practitioner in the first instance. This remains in force for seven days. Under s. 13 of the Act a person may then be moved to a hospital. The Gardaí may become involved under s. 13 of the Act at the request of the clinical director of the hospital where the person recommended for admission is seriously likely to cause immediate and serious harm to himself or any other person. Under s. 12 of the Act, as a separate

procedure, a member of An Garda Síochána who has reasonable grounds for believing that a person is suffering from a mental disorder and that there is a serious likelihood of that person causing immediate and serious harm to himself or others, may take that person into custody and then make an application for a recommendation under s. 10. An admission order under s. 14 of the Act is made by a consultant psychiatrist on the staff of the relevant hospital. If s. 3 of the Act is found to apply to the patient, in other words that they suffer from a mental disorder, there can be a detention of the patient for 24 hours. Then, a full examination must take place, but within that time. Under s. 15 of the Act, where an admission order is made, it authorizes the reception, detention and treatment of the patient for twenty-one days and this then expires unless the matter is brought before a Mental Health Tribunal under s. 18 (4) of the Act. A renewal order can be made, but the Tribunal will have heard the matter by then, by medical means under s. 15 (2) of the Act for a further period not exceeding three months. This order may be extended under s. 15 (3) for a further a period of six months beginning on the expiration of the renewal order made by the psychiatrist under s. 15 (2). This may be further extended by a consultant psychiatrist for periods each of which must not exceed twelve months under s. 15(3). In order to make these orders, which are referred to in the Acts as renewal orders, the consultant psychiatrist concerned must examine the patient within a week before making the relevant order under s. 15(4).

13. When these orders are made, they are sent to the Mental Health Commission. Their job, in essence, is to monitor such detentions and ensure that the rights of the patient were upheld. As well as notifying the Commission, therefore, the consultant psychiatrist is obliged to give the patient a notice telling him that he is being detained pursuant to ss. 14 or 15; that he is entitled to legal representation; that he will be given a particular kind of treatment during a particular period; that he is entitled to communicate with an inspector from the Mental Health Commission; that his detention will be reviewed by a Tribunal under s. 18 of the Act; that he is entitled to appeal such review to the Circuit Court; and that he may be admitted as a voluntary patient if that is sought.

14. Under s. 17 of the Act, once the Mental Health Commission is notified of an admission order or a renewal order, the Commission must refer the matter to a Tribunal; assign a legal representative to the patient; direct an independent examination of the patient; and review the patient's records. All of this is done in order to fairly determine whether the patient is indeed suffering from a mental disorder. The relevant report must be given within fourteen days of the examination, interview and review, to the Mental Health Tribunal to which the matter has been referred and a copy of the report is to be provided to the legal representation of the patient.

15. These provisions are exacting and complex. They were designed, however, by the Oireachtas in order to replace the situation whereby it was potentially possible for a person to be certified and detained in a mental hospital and then forgotten. The need for periodic review and renewal, and the independent examination of these conditions is not a mere bureautic layer grafted on to the previous law for the treatment of those who are seriously ill and a danger to themselves and others: it is an essential component of the duty of society to maintain the balance between the protection of its interests and the rights of those who are apparently mentally ill.

16. Under s. 48 of the Act, the Mental Health Commission appoints Mental Health Tribunals, and these may sit in one or more divisions. When one turns to s. 49(2) which, as the side note indicates, defines the powers of such Tribunals, one is disappointed in one's expectation. This merely allows the Tribunals to hold sittings under the Acts; to make directions similar to a court in terms of the production of witnesses and documents; to compel co-operation; and to penalise untruth, which is categorised under the Act as perjury.

17. Before turning to the next two sections of the Act which I regard as crucial to the resolution of this issue, namely ss. 4 and 18, I wish to turn to the purpose of the Act as an aid to its interpretation.

Purposive Interpretation

18. In *Re Philip Clarke* [1950] I.R. 235 the Supreme Court held that s. 165 of the Mental Treatment Act, 1945 was consistent with the concept of liberty under the Constitution. Specifically, the court held that the Constitution does not require that there should be a judicial inquiry or determination before a person can be placed, against their will, in a mental hospital. The section then in question constituted an earlier form of legislation requiring the detention of certain mental patients which was less protective, in terms of its procedures, as to their interests. The Supreme Court was of the view that the detention of those who are seriously mentally ill and are a danger to themselves or others cannot be construed as an attack upon the personal rights of the citizen but, on the contrary, they held that such a provision is "designed for the protection of the citizen and for the promotion of the common good". The Mental Health Act, 2001 repealed the Mental Treatment Act, 1945 apart from Part VIII and ss. 241, 276, 283 and 284. In addition it repealed the Mental Treatment Act, 1953 and the Mental Treatment (Detention in Approved Institutions), Act, 1961 and the Mental Treatment Act, 1961, apart from ss. 39 and 41. In *Gooden v. St. Otteran's Hospital* [2005] 3 I.R. 617 this kind of purposive approach to the interpretation of the Mental Treatment Act, 1945 was reiterated by the Supreme Court. In *M.R. v. Byrne* (Unreported, High Court, 2nd March, 2007) O'Neill J. made the following comment with regard to the Mental Health Act, 2001, which I also endorse:-

> "As is plainly obvious there are provisions included in the Act of 2001 which can be regarded as radical reforms of the Mental Treatment Act, 1945. The principal reform is the establishment of the Mental Health Commission and Mental Health Tribunals, thus providing for a quasi-judicial intervention for the purposes of the independent review of detention of persons in approved centres alleged to be suffering from "mental disorders"."

Key Provisions

19. I turn now to what are the key provisions for the purposes of this application. Section 4 of the Mental Health Act 2001 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.
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> (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.
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> (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."

20. Section 18(1) of the Mental Health Act 2001 provides as follows:-

"18.—(1) Where an admission order or a renewal order has been referred to a tribunal under section 17, the tribunal shall review the detention of the patient concerned and shall either—

(a) if satisfied that the patient is suffering from a mental disorder, and

(i) that the provisions of sections 9, 10, 12, 14, 15 and 16, where applicable, have been complied with, or

(ii) if there has been a failure to comply with any such provision, that the failure does not affect the substance of the order and does not cause an injustice,

affirm the order, or

(b) if not so satisfied, revoke the order and direct that the patient be discharged from the approved centre concerned."

24 Hour Detention

21. When the applicant decided that he no longer wished to be a voluntary patient at the Central Mental Hospital and, on the further occasion, when he was incapable of so consenting, Dr. Mohan invoked s. 23(1) of the Mental Health Act 2001. This provides that where a person who is being treated in a hospital as a voluntary patient indicates that he wishes to leave then, the consultant psychiatrist, a registered medical practitioner or a registered nurse on the staff may, if they are of the opinion that the person is suffering from a mental disorder as defined by s. 3, detain the patient "for a period not exceeding 24 hours" from the time when they make that decision. Under s. 24, where a person has been detained under s. 23, the consultant psychiatrist responsible for the treatment of that person is obliged either to discharge him or arrange for him to be examined by another consultant psychiatrist. If that examination takes place, this second consultant psychiatrist may issue a certificate stating their opinion that because of the mental disorder of the patient under s. 3 of the Act, the detention should be continued. When that occurs, then the consultant psychiatrist responsible for the care of the patient will make an admission order under s. 24(3). This then becomes the same kind of detention as that applying to persons subject to an admission order under s. 14 of the Act and carrying the relevant rights as defined therein under ss. 15 to 22. Since this, in effect, is what happened to the applicant, some comments are needed with a view to clarifying these provisions and how they interact with the rest of the Act, in particular ss. 4 and 18.

22. I have no doubt that the involuntary detention of a patient who is previously a voluntary patient, under s. 23(1) of the Act is an emergency measure that is limited to a maximum period of 24 hours. Apart from the plain wording of the section, I would regard it as wrong that a nurse or doctor would be able to add to the specific period of detention in the Act that is set at 24 hours. In seeking to question as to whether this would ever be possible, I look in vain for any provision which might allow the continued detention of the person once the consultant psychiatrist responsible for their care has been informed and once he or she seeks an opinion under s. 24 from another consultant psychiatrist as to whether the patient is suffering from a mental disorder. It does not exist. In addition, it is plain from the structure of the time limits as set out in ss. 10 to 16, that the purpose of the Act, apart from being paternalistic, is not only to set down guidelines but to ensure that there are strict time limits set within which decisions must be made as to the appropriate status of the patient in question. One of these strict time limits is that set out in s. 23. I would therefore hold that within a 24 hour period of a voluntary patient being certified for detention under s. 23(1) of the Act, the consultant psychiatrist responsible for the care of that person must ensure that the patient is examined by a second consultant psychiatrist. The decision to detain a patient, based on the statutory criteria, or to release him, must then be made within that 24 hour period and no longer.

The Mental Health Tribunal

23. In seeking to construe the powers of the Mental Health Tribunal, I have read the whole of the Mental Health Act, 2001; bearing in mind that the individual section most in question here, namely s. 18, cannot be divorced from its statutory context. Little assistance is afforded by ss. 48 or 49 of the Act and, it would appear, even less by s. 19. This provides that a patient who has been made the subject of a decision of the Mental Health Tribunal to affirm his detention may appeal to the Circuit Court. The powers of the Circuit Court, on appeal, are strictly limited. Section 19(4) of the Act provides that, on an appeal to it, the Circuit Court is obliged to affirm the order unless it is shown by the patient to the satisfaction of the court "that he or she is not suffering from a mental disorder". This contrasts with the apparently wide powers set out in s. 18. There, as the wording indicates, the Mental Health Tribunal is concerned, as would the Circuit Court be on appeal, with whether the patient is suffering from a mental disorder and also, unlike the Circuit Court on appeal, whether the procedures and time limits set out in ss. 9, 10, 12, 14 and 16 have been complied with and, further, if they have not, whether there has been an injustice. The further power that is given by the Act to this quasi-judicial Tribunal is set out in s. 18(1)(a)(ii). It is to affirm an order of detention even though there has been a failure to comply with the statutory provisions, provided the Tribunal remain satisfied that the patient continues to suffer from a mental disorder and that the failure to comply with the statutory provisions "does not affect the substance of the order and does not cause an injustice".

24. It has been argued on behalf of the applicant that s. 4 of the Act has no application to a decision of the Mental Health Tribunal under s. 18(1) in affirming an order detaining a patient and that the references to the specific statutory provisions, the infringement of which may apparently be excused, concern only such minor matters as the forwarding of notices to the patient or the preparation of documentation for the Mental Health Commission. I cannot agree with these submissions.

25. Section 4 of the Mental Health Act, 2001 infuses the entire of the legislation with an interpretative purpose as well as requiring the personnel administering the Act to put the interests of the person to be treated as being paramount, with due regard to those who may be harmed by a decision not to treat that person. I note that s. 4(2) specifically requires that the patient, or proposed patient, should be heard and that his or her rights should be considered in making any decision under the Act. It may be argued that the principle of *audi alteram partem* would be implied in any event into s. 18(1) but that, it appears to me, is not of itself sufficient answer to a specific statutory provision that is designed to bring to the attention of non legal personnel who are administering a form of detention, the fundamental principles upon which their decision-making should pivot. In addition, any possibility that medical people might ignore the rights of a patient to such matters as dignity, bodily integrity, privacy and autonomy are also given prominence under s. 4(3) of the Act by requiring these to be addressed. These principles apply to all aspects of patients care in this context. I could not hold that a Mental Health Tribunal, which is set up by the Mental Health Commission, itself specifically charged with ensuring that the best interests of mental patients are upheld, would be entitled to make any decision without bearing in mind the interests of the person whose treatment is at issue and the risks of those who may be harmed in consequence. Were it to be the case that a Tribunal set up under s. 18 had ignored the rights of such a patient, then this court, on a judicial review application, would have authority to intervene. The Mental Health Tribunal under s. 18 is acting as an integral part of the scheme of protection of patients, and prospective patients, under the Mental Health Act, 2001. They are reporting to the Mental Health Commission which is charged with the maintenance of the best standards in the psychiatric care of patients. It is, pursuant to the statutory scheme, a branch of that body and, although its function is limited, in reporting to the Mental Health Commission it is assisting that body in fulfilling its statutory function. Finally, a decision under s. 18(1) cannot be construed as anything other than one which has the result

that a person must continue in care as a patient or may be discharged as someone who has been found, on a review of the evidence and documents, not to be suffering from a mental disorder. It would be wrong, and completely contrary to the scheme whereby the Mental Health Tribunal fits into the administration constructed by the Mental Health Act, 2001, to regard such a decision as being anything other than one which concerns the care or treatment of a person.

26. Section 18(1) of the Mental Health Act, 2001 specifically mentions ss. 9, 10, 12, 14, 15 and 16 and then excuses a failure to comply with such provisions provided that failure does not affect the substance of an order detaining a patient and does not cause an injustice. The Act is, on occasion, specific in its terms in referring to subsections when this is required and, at the other end of the spectrum of statutory construction, setting out broad principles as aims to be pursued by the Mental Health Commission and, as we have just seen under s. 4, by those administering the Act. I have no doubt that in referring to these sections that concern the administration of involuntary detention, s. 18(1) refers to the entirety of them and not simply to more minor matters as to typing, time or procedure. I would hold that the purpose of s. 18(1) is to enable the Mental Health Tribunal to consider afresh the detention of mental patients and to determine, notwithstanding that there may have been defects as to their detention, whether the order of admission or renewal before them should now be affirmed. In doing so, the Mental Health Tribunal looks at the substance of the order. This, in my judgment, means that they are concerned with whether the order made is technically valid, in terms of the statutory scheme set up by the Act or, if it is not, whether the substance of the order is sufficiently well justified by the condition of the patient.

27. In this regard, the Mental Health Tribunal was entitled to have regard to the fact that Mr O'D. was at all material times suffering from a serious psychiatric illness which required that he should be treated and which treatment was of assistance to him and to the community. In addition, they were obliged, in my judgment, to have regard to the fact that if the applicant had been discharged, which would have been the effect of their refusal to uphold the order, the applicant himself would have been at immediate risk from his paranoid delusional fantasies as would those with whom he might come into close contact. I would specifically hold that the purpose of s. 18(1) of the Act is to enable the Tribunal to affirm the lawfulness of a detention which has become flawed due to a failure to comply with relevant time limits.

28. That, however, is not the end of the matter. An injustice can be caused by a reckless failure to fulfil the statutory scheme, either as regards the time limits set out in the relevant sections or through ignoring the dignity of the patient or in failing to make decisions concerning his or her care which have, as the principal consideration, the best interests of that person with due regard being given to the interest of those other persons who may be at risk of serious harm if a decision to detain is not made. If, for instance, a person were to be warehoused, without any proper review, and without any genuine attempt to comply with the statutory provisions of the Mental Health Act, 2001 that would constitute an injustice, notwithstanding that the substance of the orders earlier made, but long elapsed, were valid. As to what other examples of injustice, within the meaning of s. 18(1) of the Mental Health Act, 2001 might arise, that is a matter for decision should any later cases arise. The ordinary remedy, however, where there is an issue as to the appropriateness of a time limit and compliance with the other statutory norms, is to bring the matter before the Mental Health Tribunal. The High Court in exercising its jurisdiction under Article 40.4.2 has a much more limited function in simply declaring, at any particular point in time, whether someone is or is not lawfully detained. It does not have the powers of the Mental Health Tribunal set out in s. 18(1). It can review their decisions but I do not see that this would be either appropriate or necessary if the statutory scheme is followed. I would expressly hold that if at a time when the High Court considers an application for habeas corpus, a period of unlawful detention has been cured validly by a decision of the Mental Health Tribunal under s. 18(1) of the Mental Health Act, 2001 that the remedy is no longer available.

Result

29. In the result I would dismiss this application. There have been periods of unlawful detention of the applicant in the past. These were caused not by malice but by mistake. These have now been rectified by order of the Mental Health Tribunal under s. 18 of the Mental Health Act 2001. The applicant clearly has a mental disorder. He has never been subjected to reckless or inhumane treatment as to his detention, and any further review should take place within the statutory scheme under the Act. This is what the Oireachtas intended.