Neutral Citation: [2016] IEHC 593

THE HIGH COURT

[Record No: 2015/ 8041 P]

IN THE MATTER OF T.M.

AND IN THE MATTER OF ARTICLE 40.3 OF THE CONSTITUTION

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

BETWEEN:

HEALTH SERVICE EXECUTIVE

PLAINTIFF

AND

T.M.

DEFENDANT

AND

[Record No: 2012/ 3857 P]

BETWEEN:

CHILD AND FAMILY AGENCY

PLAINTIFF

AND

T.M. (REPRESENTED BY HIS GUARDIAN AD LITEM) AND C.M. (MOTHER)

DEFENDANTS

JUDGMENT of Ms. Justice Bronagh O'Hanlon delivered on the 27th day of October, 2016

1. T.M., the subject matter of these proceedings, was born 8th October, 1997 and has been subject to orders of the High Court detaining him in St. Andrew's Hospital, Northampton, England for therapeutic and educational purposes. He voluntarily returned to Nua Healthcare on 24th October, 2016 having attained the age of majority and pending a decision of this Court on capacity. T.M. was first placed as a minor in St. Andrew's on 16th November, 2012 pursuant to the inherent jurisdiction of the High Court and Article 56 of Council Regulation (EC) No. 2201/2003. T.M. is an Irish citizen and at all material times has been and remains domiciled and habitually resident in this State.

2. 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" states as follows:-

> "Placement of a child in another member State
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> 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."

3. Since T. became an adult, EC Regulation 2201/2003 has no longer been applicable. Therefore, on foot of orders from the Irish High Court, the plaintiff Health Service Executive, its servants or agents, made 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 similar to those in this case and noted that certain procedural safeguards were 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 procedure has been in place and the English Court of Protection has enforced the Irish High Court orders in this case in a similar fashion.

4. T.M. attained his majority on 8th October, 2015 and in order to detain a person under the inherent jurisdiction beyond their eighteenth birthday that person must lack the capacity to consent to medical treatment. The issue of whether T.M. has capacity is the significant issue remaining in this case.

5. This Court found, as set out in the order of 7th October, 2015, that T.M. has capacity to instruct a solicitor and to defend the proceedings herein represented by his solicitor. That order also held that T.M. lacked the capacity to make material decisions in respect of medical, nursing and psychiatric treatment and related welfare and therapeutic services or to make decisions regarding his accommodation for the purposes of receiving such treatment and services. This Court ordered that T.M. continue to be detained in St. Andrew's in order to facilitate the HSE in providing a step down placement with Nua Healthcare. An appearance was entered for T.M. on 15th October, 2015.

6. This Court ordered on 29th October, 2015 that an independent psychiatric assessment of T.M. be carried out and a report furnished to the Court.

7. The Statement of Claim lodged by the HSE dated 13th April, 2016 stated that, upon attaining his majority, T.M., by reason of an impairment of his personal faculties, will not have the capacity to protect his own interests or to make material decisions in respect of medical, nursing and psychiatric treatment and related welfare and therapeutic services or to make decisions regarding his accommodation for the purposes of receiving such treatment and services. At that point, they were seeking his continued detention in St. Andrew's although they also sought orders to facilitate T.M.'s return to Ireland and, in particular, in relation to the step down facility with Nua Healthcare in the Midlands.

8. The Defence filed on behalf of T.M. dated 25th April, 2016 stated that this Court does not have the jurisdiction or authority to detain T.M. in a foreign State, in the absence of the Oireachtas legislating in that regard. Counsel for T.M. also stated in that Defence that the HSE are not entitled to the reliefs sought as they are misconceived and/or unknown to the law and/or outside the jurisdiction of the Court and/or inconsistent with the personal rights of T.M. as enshrined in the Constitution.

9. The current position of the HSE is that T.M. has been transitioned out of St. Andrew's to Nua Healthcare in Ireland. The HSE opened this case on the basis that, while they do put forward medical evidence to suggest an impairment in the capacity of T.M., their position is that it is not of a degree to rob him of his decision making capacity. The HSE solution as of May, 2016 was that they have sought to transition T.M. back to Ireland to a Nua Healthcare facility. The plaintiffs set out that, while the patient was sent to St. Andrew's Hospital for therapeutic benefit, there had been a stagnation in the last twelve months and there had not been the necessary improvement. In all the circumstances, the plaintiffs were not prepared to stand over the level of detention for T.M. as of May, 2016. The Child and Family Agency were also represented as they provide after care services.

10. Counsel appeared on behalf of the defendant himself and indicated that he naturally wanted to come back to his own country and would engage with the step down and transitional processes. He wished to have a limited or finite period for this process. Counsel for the guardian *ad litem* outlined that the guardian was in support of the Nua Healthcare plan. She accepted that there were risks involved but that any continued detention was no longer proportionate.

11. The position of the mother of T.M. as outlined by her counsel on a number of occasions is that she has concerns that Nua Healthcare is unlikely to succeed and that it is her belief that it is unsafe to move him from St. Andrew's Hospital to Nua Healthcare. The mother's position is that he is making slow but steady progress and, therefore, continues to gain a therapeutic benefit from his detention in St. Andrew's.

Summary of the Evidence

12. Dr. Larkin Feeney, Consultant Psychiatrist and Senior Lecturer in Psychiatry with Cluain Mhuire Community Mental Health Services and the Royal College of Surgeons in Ireland, gave evidence on 10th May, 2016. Dr. Feeney provided a report dated 19th October, 2015 and an updated report dated 29th April, 2016 to the Court which he adopted into his evidence.

13. Dr. Feeney recognised that T. has made progress in the almost 4 years that he has been detained in St. Andrew's Hospital. The frequency of his violent and self-harming behaviours has lessened and he has moved through the security levels within the St. Andrew's framework with less seclusion and restraint. He acknowledged that there is stagnation at the moment. There is limited engagement in therapy and education and the question of T.'s desire to return to Ireland has impacted upon him and his progress in St. Andrew's. Dr. Feeney accepted that T. attended the majority of the therapeutic sessions available to him but identified that his engagement may not have been very good during these sessions.

14. In relation to the risks, Dr. Feeney is of the view that it is very difficult to predict what the outcome will be. Dr. Feeney asserted that he cannot be confident that a return would involve a bad outcome. The risks Dr. Feeney saw include a risk of institutionalisation and a risk of not being able to live an independent life. He stressed the considerable deprivation of liberty in a very restrictive environment that T. is currently living in. There are also the risks of violence directed towards himself and others that are associated with his personality disorder and his ADHD.

15. Dr. Feeney set out that T.M. would not meet the criteria for admission to the Central Mental Hospital. Dr. Feeney discussed the Mental Health Act 2001 and his involvement since 2006 using that legislation and that he has been giving second opinions for the Mental Health Commission since 2008. He said that to detain a person in Ireland there would usually have to be psychosis or mania or psychotic depression or, rarely, acute anxiety. Dr. Feeney stated that he could not be certain about the diagnosis of bipolar disorder because a considerable amount of time had elapsed and that it is very difficult to make such a diagnosis in children. He stated that T. does have an emerging emotionally unstable personality disorder. Dr. Feeney confirmed that he had never seen a person detained under the Mental Health Act for ADHD and that T. could not be detained under the Mental Health Act in his present condition. Dr. Feeney also emphasised that we do not detain people in Ireland under the Mental Health Act 2001 for personality disorders.

16. Regarding the facilities proposed in Nua Healthcare, were T.M. to engage, Dr. Feeney considered it to be an excellent situation with two to one staffing, psychologists, occupational therapy, the possibility of engaging with Dialectical Behaviour Therapy and other specialist inputs. Dr. Feeney described Dialectic Behavioural Therapy (DBT) as not being a "panacea for all ills", that it is lengthy and intensive and that the individual therapeutic relationship is important and that, unless a person buys into it, it cannot be imposed like a pill. He pointed out that St. Andrew's had suspended DBT as T. was not engaging and he pointed out that upon his return to Ireland, while DBT may be offered, T. suffers from a low frustration tolerance and impulsivity and he could choose not to engage. Dr. Feeney felt that they should be aiming for the long term good outcome of teaching T.M. to make good and wise decisions in the future. Dr. Feeney mentioned the setting in the rural Midlands for the proposed Nua Healthcare placement and further details would be required prior to the doctor's full approval. Dr. Feeney accepted that the contingency plan might not be what he would like it to be at that time.

17. Dr. Feeney further explained that T.'s case was extreme because he had experienced years of institutionalisation and that the transition in his case was therefore more complicated. Dr. Feeney noted that there would always be risks in any transition from secure care to a non secure care setting. Dr. Feeney described the numbers and quality of staff and the physical environment as being hugely different in the anticipated move. The doctor accepted that T. is saying that he wants to try Nua Healthcare and all that it is offering. However, the underlying suspicion might be that T. simply wants to go home to see his friends and this would be a normal aspiration. He agreed that T.M. may get worse before he gets better if he does come back and that there would be a period of disregulation upon his return to Ireland. He did feel that when he does come back it will be a high risk period because he naturally wants to be free and not necessarily in Nua Healthcare.

18. Dr. Feeney says that the situation is complicated by the fact that T. has partial capacity, although capacity is not entirely absent. He asserts in his reports that T. cannot understand all the information given to him, that he does not fully appreciate his vulnerabilities and can be overly optimistic, although he can retain information and he can communicate his preferences. Dr. Feeney felt that T. may need support in his decision making due to the potential limitations to his capacity. Counsel for T.'s mother put it to

Dr. Feeney that Dr. Ashimesh Roychowdhury of St. Andrew's says T.'s capacity is impaired most of the time. It was accepted by Dr. Feeney that different doctors have different views and it was noted that Dr. Maria Romanus has a different view again. Dr. Feeney reiterated his view that T.'s capacity is limited but not absent and that he has a borderline intellectual disability. Dr. Feeney pointed out that T. can recite his care plan in a "parrot-like" manner but he would have a limited depth of understanding.

19. The doctor noted that T.M. was safe and secure in St. Andrew's. However, Dr. Feeney felt that it was necessary now to test the risks in a less secure environment. The doctor said, on balance, the transition plan is more likely than not to be a success. He accepted that there was a very high risk of loss of emotional control and impulsive violence and a very high risk of suicide with a very severe emotionally unstable personality disorder. Dr. Feeney stated that we should be able to treat all of our citizens within the State.

20. Ms. Lorraine Ryan of Nua Healthcare was called to give evidence on 10th May, 2016 and she described the proposed Nua Healthcare setting for T. as being in the Midlands and that it would be ready for occupation in September, 2016. She outlined that T. would have a converted cottage where there would be five others on site in similar circumstances in a separate building. She stated that the gates and doors would have numerical keypads. T. would not be given the access code and if he learnt it then the Nua Healthcare staff would change it. Ms. Ryan confirmed that the doors to this facility can be opened by force and that, according to the plans, the fencing would be seven foot high and this was the highest form of protection they could offer without being an approved detention centre under the mental health legislation.

21. She noted that the facility was not yet staffed as of May, 2016. Ms. Ryan indicated that it was crucial that staff relationships would be built up and that this was a most important factor to get T. to engage. A history of extreme violence on T.'s part was put to this witness and she said that the programme would have to be agreed with the local Gardaí and local hospital and they would have to inform the consultant psychiatrist at the local general hospital of T.'s placement. She stated that there was no lack of agreement from the HSE regarding services and support to Nua Healthcare. Ms. Ryan did agree that a vital part of the plan would be a crisis intervention plan with access to community services at the local hospital and that she would prefer to have an agreement on that in advance.

22. The guardian *ad litem*, Ms. Mary Tiernan also gave evidence on 10th May, 2016. She has had extensive experience in dealing with this young man and she stated that she has produced approximately 50 reports in this case and she adopted those reports as part of her evidence. She gave her professional opinion that if T.M. were left for a further three years in St. Andrew's "we could lose him". She has visited him approximately every six weeks while he has been in St. Andrew's. She indicated that most of his difficulties are peer related and that the future success of his placement would depend a lot on the actual group he would be with. She does not believe his motivation will increase if his detention in St. Andrew's were to continue.

23. Ms. Tiernan pointed out that the two to one arrangement for supervision of T. was the single most important factor for his onward placement. She further indicated that it would be positive that he has his own space within the Nua Healthcare environment. She noted that there has been no requirement for the use of seclusion in St. Andrew's since last year because he uses a quiet room and calms himself down. Her concern was that we could be at this same point three or four years on from now were we not to attempt this transition to Ireland. She felt that she would need to visit the house where he is going to be in order to fully assess the risks associated with the Nua Healthcare facility.

24. Dr. Maria Romanus, Consultant Forensic Psychiatrist in St. John of God Hospital, Dublin was asked by T.'s legal team to conduct an independent psychiatric assessment of T.M. Her report is dated 23rd November, 2015 and she gave evidence on 11th May, 2016. She agreed with the other professionals that T.'s participation had been superficial over the past number of months and it has been difficult to engage him in any meaningful way in his therapies. When asked whether there is evidence of T. having improved during his time in St. Andrew's, Dr. Romanus stated that his behaviours are more contained now, his aggression has diminished and he has been able to engage with some of the educational services there. She was in agreement with the other psychiatrists that it is too early in T.'s development to diagnose him as having a personality disorder but that it could be considered to be an emerging personality disorder.

25. On the issue of capacity, Dr. Romanus is of the view that T. demonstrated very little understanding of his medications and treatment when she met with him. She is also of the opinion that he has no insight at all into his condition although he had been attempting to show himself in a good light when he met with her. She believes that he is fixated on the idea of returning to Ireland. Dr. Romanus also stated that T. made several contradictory statements to her when she was interviewing him. Dr. Romanus was of the view that T.M. was very unrealistic about the obstacles he may face upon a return to Ireland and how he may deal with them. She also stated that he is unable to weigh the pros and cons of different treatment options, he has minimal insight into the risks that substance abuse pose to him and he is of the view that he does not have a mental illness. Dr. Romanus believes that T. will not stay in the Nua Healthcare facility if given the choice despite him saying that he intends to engage fully with Nua Healthcare. Dr. Romanus accepted that T.'s condition does fluctuate but she stated that he does not have capacity at any point as he does not have the cognitive ability to understand.

26. She further noted that he has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) which is a mental illness that leads T. to be unable to regulate his emotions. It was put to Dr. Romanus that Dr. Feeney had stated that he had never come across a case where a person had been detained for ADHD. Dr. Romanus indicated that the study of ADHD is a developing field; more research is required but that T. should be offered every treatment available before he is removed from the secure setting. She was of the view that the anti-psychotic drug Clozapine may be beneficial in assisting T. in regulating his emotions. She stated that it would be worth investing another year in detention to trial this drug or some other drug to see if T. could improve. Dr. Romanus stated that the involuntary detention of a person under the Mental Health Act 2001 depends on the discretionary judgment of a clinician establishing whether that person meets the criteria laid out in the legislation. One of the criteria for such detention is treatability and Dr. Romanus is of the opinion that T.M.'s treatability has not been fully tested. When she was asked what would happen if he is not treatable she indicated that the clinicians could support him on an out patient basis but that he was likely to end up in the criminal justice system.

27. Dr. Romanus identified T.'s future risks as including deliberate self harm, violent behaviour, impulsivity and substance misuse. She further identified a very high risk of violent sexual behaviour although she cited an incident which occurred prior to his detention in St. Andrew's when he was approximately 14 years old as evidence of this risk. Dr. Romanus believes that these risk factors, taken together, mean that T. would be a very serious and potentially fatal risk to himself and others if he were released from a secure setting.

28. She does not believe that T. can survive without detention. She also stated that she believes that T. is detainable in Ireland in the Central Mental Hospital because he is treatable. It was put to Dr. Romanus under cross examination that there is a risk of

institutionalisation in this case. She disagreed and stated that he was not at that point yet, that he needs the structure of detention and that he can still benefit from treatment in a secure setting. She did agree that simply being in a secure setting is not sufficient, that he must also be receiving the appropriate treatment.

29. Dr. Rudolph Venter, Consultant Psychiatrist at St. Andrew's Hospital, Northampton gave evidence by video link on 11th May, 2016. Dr. Romanus's idea in relation to the use of Clozapine for the treatment of T's ADHD was put to Dr. Venter. Dr. Venter stated that Clozapine is only licensed in cases of schizophrenia, that there is sometimes an unlicensed usage of it for the treatment of bipolar disorder and that it would not be recommended for the treatment of ADHD. Dr. Venter stated that some clinicians may use Clozapine for the treatment of ADHD but that he would not do so. Dr. Venter accepted that there has been a stagnation in the improvement of T.M. over the previous few months in St. Andrew's. He further accepted the HSE view that there is little therapeutic benefit for T. in St. Andrew's. Dr. Venter identified a certain value in the containment of T.M. Dr. Venter noted that the uncertainty as to whether T. would be returning to Ireland has caused problems for T.

30. Dr. Venter stated that he would generally support the placement of people closer to home, however, it is his view that T. requires at least a low secure mental health unit. Dr. Venter stated that things can go wrong for T. very quickly. He noted that T. has not had sufficient exposure to any level of freedom. Dr. Venter noted that there have been several incidents of absconsion and that T. is very frustrated with his detention. A Security Level 4 is required in St. Andrew's before he could be allowed to leave the grounds at all and T. has fluctuated between Level 2 and Level 3. It may be noted that T. reached Security Level 4 in St. Andrew's prior to his return to Ireland. Dr. Venter refrained from commenting on the Irish legislation and whether T. is detainable under the Irish Mental Health Act 2001.

31. Dr. Venter stated that he has not done a full assessment of T.'s capacity. Dr. Venter stated that T. does not have the capacity to understand his long term treatment plan. Dr. Venter stated that T. accepts his diagnosis although he sometimes challenges it. He further stated that there has been some improvement in T.'s presentation since he first arrived in St. Andrew's and that there has been a reduction in violence. Dr. Venter is of the view that any further treatment for T. would be measured in years rather than months although he may be able to gauge T.'s progress after six months. It was put to Dr. Venter that stimulants could be tested and he agreed that a trial of such medication could potentially occur.

32. T. himself also gave evidence by video link from the St. Andrew's hospital in Northampton on 11th May, 2016. He stated that his priority is that he would like to return to Ireland. He further stated that he is willing and happy to go to the Nua Healthcare facility to continue his recovery and improvement. He recognises that the Nua Healthcare facility will be different from living at home and that he needs that routine and the support that he will receive when he struggles to manage his emotions.

33. T.'s mother also gave evidence on 11th May, 2016. She emphasised her love and affection for her son. However, she identified "another side" of T. that is dangerous and has caused many placements to break down over the years. She further stated that she has seen some improvement and progress since he was first detained in St. Andrew's and that he has committed fewer assaults although this is significantly dependent upon his mood. She stated a wish that any transition be done in a safe way. T.'s mother also stated that she does not believe that T. will remain in the Nua Healthcare facility and that she fears he will attempt to return to the family home. She fears for his own safety and for the safety of others. It is the view of the family that T. is best to remain detained in St. Andrew's.

34. Once the Nua Healthcare option was being considered it was required that Dr. Séan Ó Domhnaill, Consultant Psychiatrist for Nua Healthcare would give evidence and he did so on 13th July, 2016. He also supplied the Court with a report dated 8th July, 2016 which he adopted into his evidence. Dr. Ó Domhnaill outlined his qualifications and noted his specific interest in ADHD and his expertise in neuropsychopharmacology. At the point that Dr. Ó Domhnaill met with T. he was aware that there was an intention to return him to Ireland on 27th September, 2016. Dr. Ó Domhnaill gave evidence that T. was very enthusiastic about his move to the Nua Healthcare facility and he seemed to understand the various components of his residency there and his medication.

35. He also indicated that T. is experiencing anxiety related to his ADHD rather than depression and that if they treat his ADHD there could be significant improvements. Dr. Ó Domhnaill was of the view that the Nua Healthcare facility was appropriate for T. especially because of his own close link with Nua Healthcare and his expertise in ADHD which would assist in the treatment of T. Dr. Ó Domhnaill is happy to continue as part of the multidisciplinary team treating T. on a voluntary basis. Dr. Ó Domhnaill gave evidence in relation to the physical structure of the Nua Healthcare facility, that it would not be a detention facility and that it is based on a social care model. Dr. Ó Domhnaill noted that it was the very early stages of any transition but that he is enthusiastic about T.'s prospects. He further stated that the optimal situation would be if T. goes voluntarily to reside in the Nua Healthcare facility on 27th September, 2016 as set out in his transition plan.

36. Dr. Ó Domhnaill was asked about his view in relation to medication and he reiterated what was set out in his report that T.'s dosage of Olanzapine should be reduced or eliminated and he should continue on Atomoxetine. Dr. Ó Domhnaill stated that he believed that the Atomoxetine was already having a beneficial effect on T. and if his dosage is increased it would continue to reduce the impulsivity and anxiety which is linked to his ADHD.

37. Dr. Ó Domhnaill outlined the diagnoses for which he saw evidence of in T.'s files and from meeting with him as being Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Emotionally Unstable Personality Disorder, and Borderline/Mild Intellectual Disability. Dr. Ó Domhnaill accepted that there was a previous concern in relation to bipolar disorder although he believed that the symptoms identified were in fact a manifestation of the anxiety T. suffers in relation to his ADHD and what the doctor referred to as Alexythimia which is an inability to identify and describe his emotions which may have led to a misdiagnosis. Dr. Ó Domhnaill stated that T. does not suffer from a major mental illness as defined in the Mental Health Act 2001.

38. Under cross examination, Dr. Ó Domhnaill accepted that T.'s capacity may still be limited while his ADHD goes without complete treatment. Dr. Ó Domhnaill identified that the reason T. may be diagnosed with a mild intellectual disability is that he has been underscoring on tests due to his ADHD and that, with the appropriate medication, he could improve by up to as much as 25%. Dr. Ó Domhnaill identified that T.'s capacity to consent will increase when T. is able to access his own intellectual ability which is currently being blocked by his ADHD. Dr. Ó Domhnaill identified that T. is a risk to himself and others although this risk could be reduced by reducing the impulsivity that is associated with his ADHD. When asked about a crisis admissions plan, Dr. Ó Domhnaill indicated that Nua Healthcare work closely with the HSE and have support from them if required.

39. Dr. Ó Domhnaill gave further evidence on 29th September, 2016 after T.'s return to Ireland was delayed because of a Garda vetting issue in relation to the staff in the Nua Healthcare facility. The new date of 24th October, 2016 was established for T.'s return to Ireland. Dr. Ó Domhnaill set out that T. is doing very well and has reached Safety Level 4 in St. Andrew's. Dr. Ó Domhnaill noted that he appears to be responding well to the Atomoxetine medication. Dr. Ó Domhnaill is of the view that T. has capacity

although at times of severe stress that capacity is limited. He stated that T. can certainly give his consent to voluntarily live in the Nua Healthcare facility.

Legal Submissions on behalf of the Health Service Executive

40. The HSE filed written legal submissions dated 14th January, 2016. Counsel for the HSE first outlined the factual background of the case. Counsel for the HSE submitted that it is permissible and necessary for this Court under its inherent jurisdiction to distinguish between a person's capacity to consent to treatment and their capacity to instruct legal representatives. There is a recognition that, as a matter of law, an adult is presumed to possess capacity.

41. Counsel for the HSE addressed the issue of whether this Court can appoint a guardian *ad litem* to represent the defendant in circumstances where he is already legally represented. Counsel for the HSE also considered whether there were alternative options available to the Court to allow it to benefit from the knowledge and experience of the guardian *ad litem* who has acted previously on behalf of the defendant when he was a minor.

42. It was submitted that the appointment of a guardian for an adult is governed by Order 15 of the Rules of the Superior Courts and is not properly a matter for the inherent jurisdiction of the Court. Counsel for the HSE submitted that the inherent jurisdiction should not be invoked where there is a satisfactory and existing regime available for dealing with the issue. It was further submitted by counsel for the HSE that the defendant is an adult and is properly a legally represented party to the proceedings and there is no evidence that he lacks litigation capacity. Therefore, the HSE is of the view that this Court does not have the jurisdiction to appoint a guardian *ad litem* as a party to this case.

43. The HSE submitted that there are no obstacles to the Court directing that the defendant may continue to avail of the advice and assistance of the former guardian *ad litem* as occurred in the case of *HSE v. J.B.* [2015] IEHC 216. It is the view of counsel for the HSE that Ms. Mary Tiernan may assist the defendant in a role of independent advisor or expert witness but not as an additional representative before the Court alongside the defendant's own legal team and therefore, she should not be legally represented in this case.

44. It was submitted by counsel for the HSE that this Court has an inherent jurisdiction to vindicate and defend the personal rights guaranteed under Article 40.3 of the Constitution. Counsel for the HSE stated that this inherent jurisdiction has been invoked at Supreme Court level for the purpose of detaining a minor for treatment in *D.G. v. Eastern Health Board* [1997] 3 IR 511. This jurisdiction has been extended by the High Court in respect of adults whose safety and welfare was deemed to be at serious risk by reason of an absence of or deficiency in decision-making capacity in *HSE v. J.O'B.* [2011] IEHC 73.

45. By analogy, Birmingham J. extended this jurisdiction to vulnerable adults in the case of *HSE v. J.O'B.* [2011] IEHC 73. Consideration was given by Birmingham J. to Article 5 of the European Convention of Human Rights which provides:-

> "1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure described by law;
>
> > (e) The lawful detention of persons for the prevention of the spreading of infectious diseases of person of unsound mind, alcoholics or drug addicts or vagrants."

Birmingham J. further analysed the case law of the European Court of Human Rights in relation to the detention of individuals of "unsound mind" and found that certain minimum requirements must be met:

> (a) the individual must reliably be shown to be of unsound mind
>
> (b) the mental disorder must be of a kind or degree warranting compulsory confinement
>
> (c) the validity of continued confinement depends upon the persistence of such a disorder.

After further discussion of the cases in the English jurisdiction, in particular *Re S.A. (Vulnerable Adult with Capacity Marriage)* [2006] F.L.R. 867, Birmingham J. held:-

> "where an 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."

Therefore, Birmingham J. ordered the detention of Mr. O'B. in the Central Mental Hospital subject to the regular review of the Court.

46. Counsel for the HSE distinguished between "decision specific" and "general" legal capacity. The Law Reform Commission Report on Vulnerable Adults and the Law (2006) was cited by counsel for the HSE in stating that a decision on legal capacity in relation to one issue does not necessarily mean that the same decision will be given in relation to a different issue. It was further submitted that such a decision specific approach was adopted by Laffoy J. in respect of the capacity to consent to medical treatment in *Fitzpatrick v. F.K.* [2009] 2 IR 7.

47. Counsel for the HSE also submitted that this Court should take cognisance of the functional approach provided for in respect of defendants in criminal proceedings by s. 4(2) of the Criminal Law (Insanity) Act 2006 which provides:

> "An accused person shall be deemed unfit to be tried if he or she is unable by reason of mental disorder to understand the nature or course of the proceedings so as to –
>
> > (a) plead to the charge,
> >
> > (b) instruct a legal representative,
> >
> > (c) in the case of an indictable offence which may be tried summarily, elect for a trial by jury,
> >
> > (d) make a proper defence,
> >
> > (e) in the case of a trial by jury, challenge a juror to whom he or she might wish to object, or

(f) understand the evidence."

48. It is submitted that, as the Oireachtas has deemed the above to be the appropriate test for determining a person's capacity to stand trial in respect of criminal charges, it may reasonably be applied *mutatis mutandi* to civil proceedings, including proceedings in which a person's capacity is in question and which may involve that person's detention under the inherent jurisdiction of the Court in the interests of his or her safety and welfare.

49. Counsel for the HSE stated that T. is not detainable under the Mental Health Act 2001 as he does not have a mental illness as defined by that Act nor is he receiving any therapeutic benefit. He may have an emerging personality disorder which has been consciously omitted by the Oireachtas from being a mental illness for which a person may be involuntarily detained under the Act.

50. The HSE application at this point in the proceedings as of May, 2016 was for the Court to allow for the return of T. voluntarily to Ireland to live in the Nua Healthcare facility. The HSE proposed that this transition would occur within approximately three to six months and that a precise date could be set at a later point. There was a hope that T. would reach the Security Level 4 within St. Andrew's and be tested with some level of freedom there, this has now occurred.

51. It is the case of the HSE that the question of capacity does not have to be decided if there is no therapeutic benefit to the continuing detention. Counsel for the HSE further submitted that T. is certainly able to instruct lawyers. Counsel for the HSE stated that because there is no therapeutic benefit for his continued detention this put the HSE in a difficult position. T. cannot be detained and the HSE is not asking for him to be detained.

52. Counsel for the HSE noted on 12th May, 2016 that the Nua Healthcare facility would be ready and available for T. by the end of September 2016. Counsel for the HSE further reiterated on 13th July, 2016 that T. has been in St. Andrew's for a prolonged period of time and that there has been a level of stagnation in his improvement. It was submitted on behalf of the HSE that T. should be given the opportunity to transition to the Nua Healthcare facility despite not having what could be termed as full capacity.

Legal Submissions on behalf of the Defendant

53. Counsel for the defendant filed written legal submissions on 30th April, 2016. The defendant asserts that he has capacity and wishes to return to live in Ireland, from which he has now been absent for a period approaching four years.

54. It was submitted on behalf of T.M. that the High Court does not possess an inherent jurisdiction to order the detention of persons lacking capacity as such detention is statutorily regulated via the Mental Health Act 2001. The Mental Health Act 2001 regulates the circumstances and manner of detention, psychiatric assessment and medical treatment of persons with a mental disorder. Section 8 of the Mental Health Act 2001 deals with the involuntary admission of persons to approved mental health centres and provides as follows:-

> "(1) A person may be involuntarily admitted to an approved centre pursuant to an application under section 9 or 12 and detained there on the grounds that he or she is suffering from a mental disorder.
>
> (2) Nothing in subsection (1) shall be construed as authorising the involuntary admission of a person to an approved centre by reason of the fact that the person –
>
> (a) is suffering from a personality disorder,
>
> (b) is socially deviant, or
>
> (c) is addicted to drugs or intoxicants."

Counsel for T.M. acknowledged that the High Court does have an inherent jurisdiction to vindicate personal rights guaranteed pursuant to Article 40.3 of the Constitution. However, it was submitted that that jurisdiction may be exercised only in exceptional cases, where it is necessary to do so and ought not to be invoked where there is a satisfactory and existing regime available for regulating the issue in question.

55. It was submitted that there is no lacuna in the law in relation to the involuntary detention of vulnerable adults. The view that a lacuna does exist is challenged by counsel for the defendant. *HSE v. J.O'B.* [2011] IEHC 73 which invoked the inherent jurisdiction for the purposes of the detention of an adult lacking capacity but falling outside the remit of the Mental Health Act 2001 was analysed by counsel for the defendant in their submissions. In tracing the origin of the inherent jurisdiction in relation to minors back to the judgment of the Supreme Court in *D.G. v. Eastern Health Board* [1997] 3 IR 511, Birmingham J. concluded by analogy with cases like *D.G.* and the several High Court decisions that followed, the Court has jurisdiction to intervene "where an 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". It was submitted that the parallel drawn was misplaced.

56. Counsel for T.M. submitted that it was the lacuna within the Child Care Act 1991 in relation to secure care which allowed the High Court to use its inherent jurisdiction to detain high risk children in secure care. Section 23 of the Children Act 2001 sought to establish said detention on statutory footing, however, it is yet to be commenced. Counsel for T.M. identified the distinction between this and the situation in relation to vulnerable adults where the Oireachtas has legislated for their involuntary detention in certain circumstances. It was submitted on behalf of T.M. that the mere fact that the legislation does not detain for all mental illnesses does not justify the conclusion that there is a legislative lacuna warranting the use of the inherent jurisdiction.

57. Counsel for T.M. also submitted that the inherent jurisdiction violates the legal requirements of precision, foreseeability and freedom from arbitrariness that must apply when a person is deprived of his liberty. It was further submitted that this means that detention under the inherent jurisdiction is in violation of Article 5 of the European Convention on Human Rights. Counsel for the defendant cited *H.L. v. UK* (App. 45508/99)(5 October 2004) in which the European Court of Human Rights concluded that the vague and unregulated nature of the necessity based detention system in the UK rendered it procedurally deficient and thus non compliant with the Article 5 standards. It was submitted that this Court is somewhat powerless to regulate the circumstances of detention of the defendant as he has been in the control of the clinicians in St. Andrew's.

58. Counsel for the defendant submitted that if the Court rejects the above arguments about the inapplicability of the inherent jurisdiction then a decision must be made as to whether T.M. has the capacity to make decisions in relation to his medical treatment. In *Fitzpatrick v. F.K.* [2009] 2 I.R. 7, Laffoy J. set out the principles which this Court must consider in determining whether an

individual has capacity, in particular at para.84(3):-

> "(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."

59. It was submitted that, in applying the test laid out in *Fitzpatrick v. F.K.* [2009] 2 IR 7 by Laffoy J., the defendant has capacity. Counsel for T.M. also stated that there have been considerable developments in mental health and capacity law in the years since that judgment and an updated test for capacity would also find that the defendant retains his presumption of capacity.

60. It was further submitted that if the Court concludes that the defendant does lack capacity and that it therefore enjoys an inherent jurisdiction to detain him, it must next proceed to consider whether or not such detention would be in his best interests. For the detention to be in T.'s best interests he would have to be gaining a therapeutic benefit from said detention.

61. Counsel for T. made further oral submissions on 11th May, 2016 which set out the updated position. It was submitted that the theoretical legality issue may be set to one side because the HSE has conceded that T. is not receiving a therapeutic benefit from his detention. However, it remains their position that this Court cannot exercise its inherent jurisdiction in relation to the detention of adults who lack capacity. It was submitted that, considering that a transition plan is being put in place for T.'s release from detention, it may not be necessary to litigate this issue.

62. A supplemental letter dated 8th July, 2016 further set out the position on behalf of T. It is the view of his legal team that the High Court does not have jurisdiction to detain adults under its inherent jurisdiction, whether in this State or another State. It was stated that their intention would be to appeal any orders made that restricted T.'s liberty. However, it had been the intention of T. to cooperate with the step down process and become a voluntary patient in the Nua Healthcare facility. It was stated that T. would be in a position comparable to a voluntary patient in a psychiatric unit under the Mental Health Act 2001.

Legal Submissions of T.'s Mother

63. Counsel for T.'s mother made oral legal submissions on 11th May, 2016. It was submitted that the consensus of the medical professionals is that T. has limited capacity. In relation to the therapeutic benefit, it is the position of the mother that there has been slow but steady progress in St. Andrew's. It was further submitted that it is important to remember why there has not been progress in recent months, that it is because he has been kept in an unsuitable ward in St. Andrew's and that trials of medications which could be affective had not yet occurred. Counsel for T.'s mother also submitted that T. may be detainable under the Mental Health Act 2001 as Section 8(2) states that involuntary detention cannot be because of a personality disorder only and that he could be detained due to other mental illnesses including the ADHD.

64. Counsel for T.'s mother further raised the issue that the Nua Healthcare facility will be a locked facility and that there is a contradiction in that if the HSE accept that they cannot detain T then he cannot be kept in a locked facility. It was further noted that the Nua Healthcare facility will be surrounded by a seven foot fence and that the exterior doors will be locked with a security keypad. It is the view as presented on behalf of T.'s mother that this constitutes detention and that in the absence of a detention order T. cannot be lawfully placed in the Nua Healthcare facility.

65. The position of T.'s mother was further set out by letter dated 4th July, 2016. It was stated that the High Court has the jurisdiction to detain adults under the inherent jurisdiction in accordance with the principles enunciated in *HSE v. J.O'B.* [2011] IEHC 73 and this inherent jurisdiction includes a power of the High Court to detain adults in another jurisdiction. It is necessary to show that the adult lacks capacity in order for the High Court to detain them and it was submitted on behalf of T.'s mother that no expert opinion has been put before the Court that states that T. has full capacity. It is also necessary to show that there is a therapeutic benefit from the detention and it is the mother's view that T. is making gradual progress in St. Andrew's and that he would also benefit from further medication trials under the conditions of security in St. Andrew's in line with the recommendations of Dr. Romanus. It was submitted on behalf of T.'s mother that the Mental Health Act 2001 does not remove the inherent jurisdiction to detain adults so long as said adults fall outside the remit of the Mental Health Act 2001. It was further stated that T. has several diagnoses and therefore would not be detained only by reason of a personality disorder so that his detention would not be prohibited under s. 8 of the 2001 Act.

66. It was further submitted on behalf of T.'s mother that if he is transferred to the Nua Healthcare facility there should be orders in place so that he can be returned there by An Garda Síochána if he absconds.

Legal Submissions of the Guardian ad litem

67. Although it had been an issue of contention before the Court it is now accepted by all parties that the guardian *ad litem* would remain represented in these proceedings beyond T.'s eighteenth birthday despite the fact that he is represented by his own legal team directly.

68. The guardian *ad litem* has taken a practical approach and has supported T. voluntarily returning to the Nua Healthcare facility in Ireland although she has warned, in evidence and through counsel, of the risks related to such a transition. Counsel for the guardian *ad litem* set out on various occasions that the guardian believed T. was not receiving a therapeutic benefit from his detention in St. Andrew's and should be returned to Ireland. In relation to the issue of capacity, it is the position of the guardian *ad litem* that T. has some limitations to his capacity and needs to be supported in his decision making.

Conclusions

69. On the issue of the Mental Health Act 2001, Dr. Feeney felt that T. did not currently meet the criteria for mental disorder as defined by s. 8 and is therefore not detainable under the Act. There is disagreement between the experts in this case around the diagnosis of ADHD and T.'s detainability where Dr. Larkin Feeney stated that he has never come across a case of a person being detained under the 2001 Act on the basis of an ADHD diagnosis while Dr. Maria Romanus stated that this is a developing area and it

would be at the discretion of the responsible clinician to decide whether to detain T. The definition of mental disorder under English mental health legislation is much broader than it is in Ireland and T. could be detained due to his personality disorder in England so long as appropriate treatment is made available to him. This Court does not hold that to detain T. in England under English mental health legislation is appropriate as he remains habitually resident in Ireland and is an Irish citizen. This Court finds that T. is not detainable under the 2001 Act.

70. The development in this case came at the point when T. was no longer taking up the therapy in St. Andrew's. The therapeutic rationale for T.'s continued detention in St. Andrew's no longer exists. There is broad consensus amongst the medical professionals that T.'s improvement has stagnated significantly. It is quite clear, since the commencement of these proceedings, that the position of the plaintiff Health Executive shifted somewhat and the basis of their desire to seek the return of T. to this jurisdiction came to be focused on the fact that there occurred this stagnation in T.'s progress. Appropriate treatment has been made available to T. since he went to St. Andrew's. Due to the fact that T. was not availing of this therapy or displaying a improvement there over the last significant number of months, it is the view of this Court that it is highly unlikely and improbable that T. would engage with therapy were he further detained in England. This Court does not feel that continuing his detention would be either proportionate or justifiable.

71. A question was also raised about T.'s treatability. Dr. Feeney sees T.'s personality disorder as the most pertinent of his mental health conditions. He cited that treatment options for emotionally unstable and antisocial personality disorders are very limited and he set out that where a person is able and motivated the recommended treatment is a community based, structured psychological programme over an extended period. The difficulty is that T. was offered Dialectical Behavioural Therapy (DBT) in England but he did not make optimal use of this therapy.

72. The issue of capacity is central to this case. It is accepted by all parties that T. does have litigation capacity and that he has limited capacity to consent to treatment but there are varying views on the extent of this. In Dr. Feeney's report, he states that T. did have the basic intellectual capacity to make decisions regarding his future treatment and living arrangements. Dr. Feeney believes that he is likely to have this capacity for the majority of the time. Dr. Feeney found that T. was able to discuss potential downsides to his return to Ireland and had an awareness of the negative consequences that could result from aggressive outbursts in community. T.'s intellectual ability was found by the doctor as sufficient for him to understand the pros and cons of what is being recommended to him, to believe and retain this information, to weigh it, to make a decision and to communicate this decision. These are the core elements of the test for capacity as set down by Laffoy J. in *Fitzpatrick v. F.K.* [2009] 2 I.R. 7. Dr. Feeney found that T.'s capacity becomes more severely impaired at times when he is emotionally distressed to the point that he may not have this capacity for short periods. His capacity is limited by his emotional immaturity, his personality disorder, his below average intellectual ability, his experiences of restrictive institutional care for over past four years and his understandable impatience to be reunited with family and friends and to have freedom. The Court relies on the evidence of Dr. Feeney and Dr. Ó Domhnaill that T. has sufficient capacity.

73. The Nua Healthcare placement which has been proposed is the most suitable place for T. to go. Considering the fact that this Court finds that T. has sufficient capacity he can only reside in the Nua Healthcare facility on a voluntary basis. On balance, the doctor came to the conclusion in his oral testimony that the transition plan is more likely than not to be a success. This is somewhat more positive than the evidence contained in his reports to this Court.

74. There is no doubt that there are significant risks associated with transitioning T. out of detention to a non-secure facility. Dr. Feeney's view was that problems, such as his likelihood of consuming alcohol and drugs, which would accentuate his severe difficulties with impulse control, may lead to episodes of potentially lethal self harm and violence. Dr. Feeney was of the view that this is likely to lead him to lose accommodation and supportive relationships and is likely to bring him to the attention of the Gardaí. Dr. Feeney described the risks for T. as very serious indeed and he sees him as highly impulsive and not able to control his anger. He stated that T. is at a very high risk of suicide. He describes in a general sense, a significant percentage of those with a diagnosis of emotionally unstable personality disorder will eventually die by suicide and he sees T.'s complex difficulties leading him to conclude that his risk is significantly higher. Dr. Feeney identified that the risk of suicide would be higher in Nua Healthcare than in St. Andrew's because it is a non-secure unit. The guardian *ad litem* acknowledges that there is high risk and recommends that T.'s progress and welfare be reviewed after he moves back to Ireland.

75. It is essential to note that risk alone is not a legitimate cause for detaining a young man. There is an obligation on the HSE and the Child and Family Agency to assist T. in his transition and to provide supports for T. in order to mitigate against the risks involved. This Court notes the finding of O'Donnell J. in *D.P.P. v. Anthony McMahon* [2011] IECCA 94 where he held that there was no jurisdiction to impose an open ended preventative detention on the grounds of anticipated future risk of harm. It was also held that the Mental Health Act 2001 provides the only mechanism for the detention of someone considered a danger to the public or themselves.

76. This Court takes the view that there are statutory obligations on the State under the Child Care Act 1991 (as amended). S. 45 of that Act uses the word "may" and therefore involves the discretionary provision of after care up to the age of 21 or 23 years of age subject to the Child and Family Agency being satisfied of his need for assistance. Naturally, after care is something which would be adjusted depending on the situation of this young person leaving detention in the UK. T. may well be deemed to have a disability within the meaning of the Disability Act 2005. "Disability" is defined in section 2 of the 2005 Act in relation to a person as meaning "a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment". Such a person can apply for an assessment which shall be carried out under s. 8, when implemented, of the Disability Act 2005. This assessment shall determine what disability the person has and what health and educational services are required to meet the needs of that person. This puts obligations on the HSE to provide services for a person with a disability based on the assessment by the HSE of their needs. Counsel for the HSE has noted throughout this case that there is no attempt to deny the provision of a service such as Nua Healthcare to T. upon his return to this jurisdiction.

77. It seems to this Court that T. is entitled to a legitimate expectation that the established practice of a step down regime would be monitored by this Court to ensure his best welfare interests in accordance with settled practice in this area. It would appear, therefore, to be the case that any public body involved in this case may not depart from an established practice without giving notice. T. should continue to receive extensive care. While this care will not have the same security features as the care he received in the United Kingdom, it is a step down option to ensure the vindication of his constitutional rights. The guardian *ad litem* knows T. very well and may also be available from time to time to assist him with decision making as an advisor in order to vindicate his legal rights. The guardian as per guardian does not need to continue in that role given that he does have litigation capacity but she may be an advisor to T.

78. Dr. Ó Domhnaill described himself as having seen many patients with the same diagnoses as T. and he said that he would be

optimistic for his future despite his limited capacity to make decisions regarding his healthcare. Dr. Ó Domhnaill sees potential to develop to a greater degree of capacity with time and treatment. He also notes that T. is currently as stable as he ever has been and that he is hopeful for his future progress. This Court notes that he was found sufficiently stable to be transitioned back to Ireland by the psychiatrists responsible for his care in England and the Court is optimistic about his transition.

79. This Court has carefully considered all of the legal submissions in this case. This Court notes the submissions in particular on behalf of T.'s mother and full account is taken of the views and wishes of the family as well as of the guardian *ad litem* and other interested parties. This Court has noted the submissions of counsel in relation to the case of *HSE v. J.O'B*. [2011] IEHC 73 and while there are similarities between the instant case and the case just cited, this Court is of the view that in the instant case there is a dispute as to whether there is a lack of capacity or a limited capacity. It is clear that T. will need assistance regarding decisions concerning his personal care and wellbeing and it is in dispute as to whether or not he is detainable under the Mental Health Act, 2001. In *HSE v. V.F*. [2014] IEHC 628, McDermott J. found that a woman had an acquired brain injury which was the result of her alcohol misuse over the years and it was described as moderate to severe. The judge was satisfied that she "does not have the capacity to decide essential life matters for herself" and made an order detaining her in a facility run by Nua Healthcare. In the case of T., matters are not quite so clear-cut. It appears to this Court from the medical evidence that now is as good a time as any to transition T. and it is, at this point, that it would have the maximum chance of success and this Court is mindful of the obligation to be proportionate at all times with regard to a decision with such monumental long-term effects.

80. It is the view of this Court, as is set out in this Court's recent decision of *HSE v JB* (Unreported, High Court, delivered 6th October, 2016), that the presumption of capacity can only be rebutted if the person is unable to:

- understand the treatment information

- retain said information long enough to make a decision as to their treatment

- weigh alternative treatment options

- communicate their decision

This Court wishes to emphasise that capacity does not require that the individual makes the decision that the professionals deem to be the correct decision but that the patient can come to a reasoned conclusion. This Court prefers and accepts the medical opinion of Dr. Feeney regarding T.M.'s capacity. Dr. Feeney found T.M to have a degree of capacity limited and coupled with a borderline intellectual disability. This Court concludes that this does not put this case in the same category of cases where the High Court has used the inherent jurisdiction to detain adults.

81. There have been several complex legal issues raised by the various parties in this case. Counsel on behalf of T.M. has stated that this Court does not have an inherent jurisdiction to detain an adult lacking capacity. Considering the fact that T.M. is no longer in detention since 24th October, 2016 this Court does not find it necessary to determine this issue.