Neutral Citation Number: [2011] IEHC 326

THE HIGH COURT

JUDICIAL REVIEW

2010 11126 P

BETWEEN

THE HEALTH SERVICE EXECUTIVE

PLAINTIFF

AND

'M. X.' (A PERSON OF UNSOUND MIND NOT SO FOUND) REPRESENTED

BY HER SOLICITOR

DEFENDANTS

JUDGMENT of Mr. Justice John MacMenamin delivered on 29th day of July, 2011

1. Protecting and vindicating the rights of vulnerable people suffering from mental incapacity poses challenges for legislators, courts, and especially the caring professions.

2. A person suffering from such incapacity continues to enjoy individual rights such as the exercise of freewill, self-determination, freedom of choice, dignity and autonomy (see *In Re Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79). Speaking generally, the exercise of such rights by all citizens, whether in the private or public domain, is predicated upon, and informed by, clear understanding and cognition; an ability and make decisions in one's best interest having regard to the interests and rights of others. Where consent to particular forms of medical treatment, and the capacity to give that consent, arise, the issues of capacity and cognition are fundamental. In very exceptional cases, the nature of a patient's condition may entirely deprive them of the ability to give expression to any decision-making capacity. Such a situation arose in *Re Ward of Court (No. 2).*

3. But circumstances may also exist where, for example, the very nature of a mental illness clouds understanding, and where the task of decision-making for a patient becomes difficult. Then, where there is a want of capacity to make such decisions, psychiatrists have often found themselves in a position where it was they alone who were cast in the role of having to make choices in the patient's best interest, albeit, where possible, in consultation with colleagues and family members. Traditionally, in our law, the views of experts in the discipline have justifiably received great weight and respect. In this jurisdiction, we are fortunate that we can place a high degree of trust in our clinicians. This is based on both that tradition and modern day experience.

4. Internationally, however, abuses in psychiatry are not unknown; in some countries it has been used as a mechanism for state oppression of legitimate dissent. As in all disciplines, including the law, psychiatry is in a state of constant evolution where even consensus views of a quarter of a century ago might now be questioned.

5. Also, as in all disciplines, there is a possibility of honest error, for subjective opinion supervening over what should be accepted as established, objective diagnostic criteria, even on issues as vital as legal capacity. A finding of incapacity can have substantial legal and social consequences, and involves a serious curtailment of rights. This has led to diverse approaches. Some international bodies, such as both the Committees of Ministers of the Council of Europe and the United Nations, have sought to adopt universally applicable procedures, intended to ensure that the voice and views of a patient are not only heard but considered. The philosophy behind these international instruments is to ensure that guarantees of equality before the law are given effect (see Article 12 of the United Nations Convention on the Rights of People with Disabilities to which reference is made later in this judgment). In many countries. these values have been given concrete form in the shape of legislation. In 2008 the Government of the day published the proposed heads of the Mental Capacity and Guardianship Bill 2008. This was criticised by health professionals. To date the Bill has not become law. Even a superficial consideration of the learned discussion on some of the issues leaves one with the sense that there exists a substantial gap in understanding between those who seek a "rights-based" approach, and others who lay emphasis upon the challenges in taking care of patients on a day-to-day basis (see (2008) 14. 1 Medico Legal Journal of Ireland 14). It is important to remember that it is doctors, not lawyers, who can cure patients.

6. But, on the other hand, denial or deprivation of procedures to a vulnerable person can have radical consequences, including a loss of many civil rights (see the decision of the European Convention on Human Rights ("the Convention") in *Shtukaturov v. Russia,* [2010] E.C.H.R. 292 for an apt illustration).

7. In *Shtukaturov*, the European Court of Human Rights ("ECtHR") had to deal with legal capacity and enforced hospitalisation and treatment without consent. The applicant had been diagnosed with schizophrenia, and had been deprived of his legal capacity in a decision made without his knowledge at the request of his mother who had become his legal guardian. He was legally prohibited from challenging the decision in the Russian courts, and was subsequently placed in a psychiatric hospital. The ECtHR held that "the existence of a mental disorder, even a serious one, cannot be the sole reason to justify full incapacitation". The court held that domestic legislation must provide for a "tailor made response". The court found that highly abridged the decision-making process depriving him of his legal capacity constituted a disproportionate interference with his private life. In *Winterwerp v. Netherlands [*1979] 2 E.H.R.R. 387 the ECtHR ruled that the capacity to deal with one's property was a civil right and protected by the Convention. The right to fairness of procedures is also engaged.

8. This case deals with an intended procedure for the treatment of the defendant whom I will call M.X. As will be seen, many of the matters briefly touched on above arise for consideration in this sad case.

9. M.X. was born in 1962. She is currently an involuntary patient in the Central Mental Hospital ("C.M.H."). Pursuant to the provisions of the Mental Health Act 2001 ("the Act of 2001"), she was transferred there some four years ago suffering from serious psychiatric

complaints which caused her to be a source of danger and risk, not only to herself, but also to others. It is necessary therefore to remember at all points that she is seriously ill.

10. M.X has a long and very complicated forensic history. Prior to her current admission to the C.M.H. in 2007 she was previously an in-patient there. In that year her detention was found to be unlawful. She was admitted to St. John of God's Hospital, but then transferred from there back to the C.M.H. on the 24th May, 2007. There she remains, as what is termed a "civil" patient, *i.e.* a person neither prosecuted nor convicted of any criminal offence. She is not, therefore, subject to the procedures and safeguards outlined in the Criminal Law (Insanity) Act 2006.

11. The application which is brought in this case is as a result of the concerns felt by the doctors who are treating her. They have sought guidance from the court as to whether certain forms of medical procedure which they deem necessary to ameliorate their patient's disorder can be lawfully administered. It is important to emphasise therefore that the treating doctors in this case have the welfare of their patient as their primary concern. Thus, what is sought in this case is, essentially, guidance as to statutory interpretation and application.

The Primary Diagnosis
12. The defendant's primary diagnosis is that she suffers from paranoid schizophrenia and a borderline personality disorder. This condition is particularly severe. It is associated with the risk of extreme violence to others, including children. At the time an interim application was originally brought in December, 2010 she was very unwell and it was thought that a number of months would elapse before her recovery.

The Problems Arising from the Intended Treatment Regime
13. In the latter half of 2010, the doctors originally began to encounter difficulties in treatment. They were administering a number of drugs to counteract the defendant's psychiatric condition. As part of this, it was necessary, for reasons which will be explained, to obtain blood samples. M.X objected to this. However, she was found by the doctors not to have the capacity to make decisions regarding her own welfare. Through her lawyers she has indicated that she does not consent to this course of treatment, and has made her position clear to those advising her.

14. The medical position is further complicated by a potential life-threatening adverse reaction. This is what is termed the unpredictable idiosyncratic destruction of the defendant's white blood cells which occurred in response to three different anti-psychotic drugs which were administered to her. This reaction is known as an "agranular oxytosis reaction". A decline in white blood cell count can have a potentially fatal outcome where, ultimately, a patient may succumb to infection.

The Interlocutory Applications
15. Because of these concerns, in December, 2010, an interim application was made to this Court to permit the administration of a drug regime which necessitated the taking of blood samples as an ancillary to that regime. Interlocutory applications followed, and ultimately the case proceeded to full hearing. On an interim and interlocutory basis this court granted permission for the administration of the treatment and the taking of blood samples, but only in circumstances where there was an entirely independent verification by an independent psychiatrist, Dr. Ian Bownes, who works outside the jurisdiction. This was done so as to verify that the medical regime was for the patient's benefit. It should, in no sense, be seen as any reflection on the treating doctors. Dr. Bownes was identified by the defendant's legal advisors, and thus there was no question as to his independence. He indicated that the course of treatment envisaged was entirely appropriate and in the patient's welfare. On the basis of this evidence this court permitted the treatment to proceed.

The Definitions of Treatment: "Mental Disorder" and "Mental Illness"
16. In what follows, it is now necessary to consider a number of definitions contained in s. 2 and s. 3 of the Mental Heath Act of 2001 (the Act), and the identifiable effect of a range of criteria to be relied on by clinicians in decision-making, which are identified in section 4.

17. The term "treatment" is defined at s. 2 in the following manner:-

> "'Treatment', in relation to a patient, includes the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder."

"Mental disorder" is defined at s. 3 of the Act in the following way:-

> "(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
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> (b) (i) because of the severity of the illness, disability or dementia, the judgement 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)* –
>
> 'mental illness' means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgement 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." (*Emphasis added*).

18. That the defendant is suffering from such a disorder is not in question. The intent of the treatment was and is undoubtedly to ameliorate her condition. In making decisions as to care and treatment, the Act seeks to apply a "best interests" test. The question is

whether that test, in conjunction with the term "treatment", is overly general or "open-ended". What procedural safeguards are contained in the Act? I will return to this later.

19. Section 4 of the Act of 2001 provides:-

> "(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.
>
> (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. How does that Act apply here? One first looks to the expert opinions expressed within this statutory framework. A "best interests test" may have objective and subjective dimensions. In the first, one looks to what steps are actually necessary as a remedy; in the second, one looks to the patient's view, both now and if she had had the capacity to make judgements in her own interest. Dr. Paul O'Connell, the consultant psychiatrist who has treated the patient for some time, explains that the proposed treatment for the patient, including the giving of anti-psychotic medication, is directed towards relieving her mental disorder. It is not in dispute that the treatment is, in this sense, in her "best interest". The problem, however, lies with what accompanies the treatment. For this patient, the drawing of blood should form part of or be ancillary to the actual administration of anti-psychotic medication. Such medication cannot be safely administered to the defendant without blood tests being conducted at regular intervals in order to detect the possibility of an adverse reaction. The uncontested medical evidence, therefore, is that the administration of the medication – even if differentiated from the procedure as a whole – would ameliorate the mental disorder from which the defendant is suffering, and that the associated blood tests are necessary to safeguard her life, to restore her to health, to alleviate her condition and relieve her suffering.

21. Does the law allow for a broad reading of the word "treatment" when those treating a patient conclude she cannot consent? How far does a medical decision that treatment is warranted in the patient's best interest go when the patient cannot object because she lacks the capacity to do so?

22. As a first step, one turns next to the definition of consent contained in the Act. That definition is rather circular. Section 56 provides:-

> "In this Part 'consent', in relation to a patient, means consent obtained freely without threats or inducements, where –
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> (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
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> (b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment."

23. But, as has been mentioned earlier, the medical and psychiatric view is that the defendant lacks the capacity to consent; thus, by reference to s. 56(a), the court must proceed on the basis that she, as a patient, is incapable of understanding the nature, purpose and likely effects of the proposed treatment.

24. In such circumstances s. 57 comes into play. It provides:-

> "(1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
>
> (2) This section shall not apply to the treatment specified in *section 58 , 59 or 60*."

25. Subsection (2) deals with the question of safeguards for certain forms of very serious medical procedures laid down under the Act. It does not contain similar review provisions with regard to "treatment".

26. In considering the terms of the Act of 2001, it was necessary, even at the interlocutory stages, to balance the patient's right to life, dignity, autonomy and her welfare interests. I concluded that the balance favoured the administration of such treatment on an interlocutory basis. These are, of course, constitutional values, but these are embodied in statutory form in the framework of the 2001 Act. They were considered in depth in *Re Ward of Court (No. 2)*. The irony of the current situation is that the medical consensus is that the course of treatment, to which the patient so strongly objects, is undoubtedly in her own best interest. It is a classic "Catch 22" situation.

27. The dilemma facing the treating clinicians was, and is, that, in order to treat the defendant's schizophrenia appropriately and safely with anti-psychotic medication, it is necessary to continuously monitor her. This, in turn, necessitates obtaining a full blood count ("fbc") at regular intervals in order to safeguard against any potentially fatal risk of a sudden drop in white blood cell count. The minimum standard considered appropriate in these circumstances is to adopt a system similar to the monitoring regime used for patients who are treated with an anti-psychotic drug called clozapine. This involves monitoring on a weekly basis. Additional tests would be required in the event that the patient demonstrated any sign of sepsis such as fever, malaise or upper respiratory symptoms. The risk of a decline in white blood cell count is idiosyncratic; it does not depend on the dosage of the anti-psychotic medication, or on the duration of the treatment. Consequently, this reinforces the need for ongoing monitoring.

The Procedures Involved

28. The procedure which the hospital proposes to continue requires venepuncture (that is the obtaining of blood samples from a vein by syringe). Such samples, comprising between 5 and 10 millilitres of blood, are to be collected by a medical practitioner or nurse who has training and expertise. It is necessarily invasive. The defendant unfortunately is unwilling to cooperate. Therefore, it has been deemed necessary that she be restrained by nursing staff and that her arm be secured in a form of physical restraint while the samples are being taken. Were the patient to struggle, the doctor attempting to collect the blood might be unable to obtain a safe venepuncture. The patient might need to be sedated. In such circumstances the procedure might have to be undertaken at St. Vincent's Hospital under anaesthetic advice or supervision. As can be seen, therefore, the choices involved are both complex and stark.

The Risks Attached to Ongoing Treatment
29. The risks associated with drawing a blood sample from a patient are potential bruising and laceration, along with a low level of pain. However, in the circumstances of this case, in the absence of restraint, there is also the risk of third party injury to medical or nursing staff by the patient's violent reaction. This could result from needle stick injuries. In the event that sedation or anaesthesia are required, there would be additional risks, most notably those associated with respiratory complications. Furthermore, the use of anti-psychotic medication may, in itself, trigger a decline in white blood cell count (leukopaenia). Some anti-psychotic drugs appear to be better tolerated by the defendant than others. The most notable of these are called olanzapine, quetiapine and chlorpromazine. The current treatment of choice is a drug called zuclopenthixol. The patient has previously received an extensive range of oral anti-psychotic medications, some of which have been associated with a decline in white blood cell count. Such medications have been associated in the literature with serious neuromotor side effects. In the case of the defendant, the approach is necessarily limited by the severity of her psychosis including, unfortunately, the risk of substantial violence arising from non-compliance.

30. Dr. O'Connell says that the particular range of events that have given rise to this case are, in his experience, exceptional. There is a risk that if the patient's white blood cell count declines to a significant extent it might be necessary to seek assistance from a specialist in haematology. There remains the risk that the hospital staff will have to calibrate and balance the use of the medication (which may lower the white blood cell count) in tandem with haematological support directed to elevating that count. He states his firm intention is to do everything that is clinically appropriate in what is, both for him and his colleagues, a challenging and serious case.

The Patient's Capacity to Consent
31. The treating psychiatrists testify that they have given lengthy consideration as to whether or not the defendant currently has the capacity to consent to, or refuse, the blood tests proposed in relation to monitoring her anti-psychotic condition. In our law, gathering and accessing the evidence and the procedure for determining of capacity are often a purely medical matter. There have been cases where the matter has come into closer legal focus such as *Fitzpatrick v. F.K.* [2009] 2 I.R. 7. In other systems it has been found to engage procedures necessitating a decision by a legal or quasi-legal forum. This may involve the appointment of a personal advocate or guardian to vindicate the patient's rights and interests. The availability of appropriate modes of determination, review and appeal are serious issues. In the instant case, the position has been addressed in the first instance by obtaining Dr. Bownes's views. As an independent psychiatrist, he has affirmed that the defendant lacks the capacity to make judgements in her own medical interest. The consequence of this is that, for present purposes, and in present circumstances, the court must approach matters on the basis that the defendant is not capable of fully understanding the nature, purpose and likely risks of the proposed treatment. Her want of understanding is said to be made up of different components. The clinical view is that she cannot form a balanced judgement in relation to the treatment being afforded to her. She continues to see the staff and treating psychiatrists as a threat. She is said to be delusional, and while she does not admit to hallucinating, there is a strong view that she is, in fact, doing so.

Dr. Harry Kennedy's Evidence
32. Dr. Harry Kennedy, the well-known consultant forensic psychiatrist, is the Executive Clinical Director of the National Forensic Mental Health Service in the Central Mental Hospital. He corroborates this evidence as to want of capacity. He states that the defendant's schizophrenia is treatment – resistant and has responded fully only to medication by clozapine. The defendant cannot tolerate clozapine due to the rare but recognised side effect of suppression of white blood cells. She also has had partial reactions to other anti-psychotic drugs.

33. Dr. Kennedy describes other elements of the defendant's symptoms which are relevant to the question of her own life and safety, and the life and safety of others. Specifically, the defendant has homicidal preoccupations arising from persecutory delusions and hallucinations. Unfortunately, these focus particularly on children in general, and sometimes, in particular, on the children of those who come into contact with her. Then, she loses insight and lacks the capacity to give or withhold consent to treatment. She becomes agitated, attacking doctors and nurses and causing them significant injuries. On some occasions, it was decided that she should be placed in seclusion for her own safety and that of others. This seclusion has sometimes been for prolonged periods and, the court has been told, monitored by the Inspectorate of Mental Health Services. There is no evidence yet before the court as to the length of these placements. However, such placements necessarily involve a serious deprivation of rights. Concern as to public safety or well-being does not lead to an entire abrogation of constitutional rights. There is no evidence that there has been any such abrogation in this connection, however.

34. The witnesses point out that at times in the past the defendant actually permitted blood tests. What triggered the original application to this court was her refusal of medication; as a result she went unmedicated. Her physical and mental condition deteriorated. She had received her last full white blood count two weeks prior to the first application to this court in December, 2010. She had received injections of clopixol on a number of dates in late November, but no further medication was then administered because of her objection. The clopixol injections had been administered after a second opinion from Dr. Brendan Kelly, a consultant psychiatrist in the Mater Hospital.

35. Dr. Kennedy draws attention to the fact that while the Act of 2001 may permit treatment without consent, there is a possibility it may not permit the drawing of a blood sample from the defendant without such consent. This is because the definition of the term "treatment", contained in the Act, allows for the administration of remedies intended for the purpose of ameliorating a "*mental*" disorder. The question arises as to whether the health professionals have the legal power or authority under the Act to actually restrain patients for this purpose, or to draw blood under medical supervision in circumstances such as those which arise here. Is this "ameliorating a medical disorder"?

Additional Risks in Administering Treatment
36. That there are other hazards is shown by the fact that the patient is at some risk of harming herself as well as others. She has placed implements and potential weapons in and about her person. She has planned assaults on medical professionals, one of which had the potential for a fatal outcome. She has thrown cups of hot coffee or water over staff members. In the past it appears she harboured thoughts of killing her own son and daughter. She is now subject to an intensive regime of nursing. It is thought her ultimate goal might be to fatally injure some of the medical persons involved in her treatment. The patient has a history of suicidal

ideation and still has some homicidal intent towards her son and daughter. She had attempted to assault those involved in her care with sometimes dangerous implements. This necessitated remedial action from health professionals.

The Defendant's Personal Circumstances
37. This is not a case where the application is brought by family members. The form of treatment proposed here is that suggested by doctors, not the family. The defendant is separated from her husband who has remarried. She has two children. Her son has unfortunately been admitted for long term psychiatric care. She has substantial difficulty in relating to those who otherwise would be close to her. She is occasionally visited by relations but, it appears the day-to-day task of taking care of her has, for a considerable time past, fallen mainly on the hospital staff. The evidence is that while she may be able to register and retain treatment information, her judgement is nonetheless impaired by her overarching persecutory delusions, within which she regards her treatment from psychiatrists and nurses as threats and sources of mockery to her.

38. As a result of her illness, the defendant is in an isolated position. She is undoubtedly a vulnerable person. Her detention is involuntary and necessary. She is not a ward of court. The decision as to incapacity bears on other decisions where, if she had full capacity, she would be entitled to decline the treatment on the basis of her right to autonomy, as recognised in *Re Ward of Court (No. 2).* The determination in this case as to capacity is "decision specific", but there is no evidence as to its range beyond this case. In this jurisdiction a determination as to incapacity in this type of case does not require court approval, even though there may be a loss of fundamental rights. From the standpoint of a patient, there is a duty to ensure and to maximise patient autonomy and to protect those who lack such capacity. On the evidence in this case, the clinicians are not in any doubt as to the patient's incapacity, nor can the court be. Thus the court is in a position to make a best interests assessment based on their views. But such choices undoubtedly involve a curtailment of the right to liberty and autonomy (see *North Western Health Board v. H.W.* [2001] 3 I.R. 622). Clinicians and courts must have regard, not only to the individual position of the patient, but the extent to which any right may be curtailed or abridged, based on duties to the patient, to others or to the public at large. The values engaged here involve the necessity to protect life and health and the protection of other interests including those of third parties, perhaps the prevention of suicide and the maintenance of ethical integrity.

Does "Incapacity" Prevent Bringing Proceedings by a Patient?
39. A further difficulty which arises in this case is that the court is not in a position to identify a person (other than her lawyers) who could act in the informal capacity as "personal guardian" or support decision-maker, a position proposed for the protection of vulnerable persons in the Mental Incapacity and Guardianship Bill 2008. The determination as to the defendant's incapacity is, here, psychiatric, one that is undisputed.

40. However, in other cases, and even perhaps this one, there may arise an additional uncertainty; that is the extent to which a patient can be deemed to have capacity even to instruct a solicitor and counsel in circumstances where she has been found to suffer from incapacity. I do not raise this point in any spirit of criticism in this case. However, it is a point which has been raised and considered in decided authorities (see the judgment of the Supreme Court in *E.H. v. The Clinical Director of St. Vincent's Hospital and Others* [2009] 3 I.R. 774).

The Defendant's Case on the Legal Issues
41. It will be recollected that the kernel of this case is as to the interpretation of the term "treatment". Counsel for the defendant submitted that the term must be strictly or narrowly interpreted, and that such a construction is necessary in light of the fact that there are at stake here, the curtailment of a number of fundamental rights and interests without adequate procedural safeguards being embodied in the statute. The Act contains no safeguards or review procedure with regard to the term "treatment". This is in contrast to its provisions with regard to "medicine" where there are such mechanisms. By way of illustration in the case of medicine one can turn to s. 60 of the Act of 2001. This provides as follows:-

> "60.Where medicine has been administered to a patient for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the *administration of that medicine* shall not be continued unless either –
>
> (a) the patient gives his or her consent in writing to the continued administration of that medicine, or
>
> (b) where the patient is unable or unwilling to give such consent –
>
> (i) the continued *administration of that medicine* is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
>
> (ii) the continued *administration of that medicine* is authorised (in a form specified by the [Mental Health] Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,
>
> and the consent, or as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained." (*Emphasis added*).

The safeguard is clearly for the *administration of medicine*.

42. The Act is silent on any review for "treatment". The theoretical and perhaps real consequences of this in other cases could be serious. In that it could result in an endless series of fbc tests, necessitating restraint, against the patient's strong objection. This would raise the question whether a patient was being exposed to inhuman and degrading treatment prohibited by the Constitution and Article 3 of the Convention. Should "treatment" then be strictly construed? This again raises the question of fair procedures including *audi alterem* and a right of review or appeal.

43. The defendant's case is that it is not permissible for the courts to engage in a form of "legislation" by adopting an over-purposive interpretation of the term "treatment", thereby permitting the taking of samples in the absence of legal protections. This is so no matter how benign the motivation may be, as here. It is contended that the "best interests" test in s. 4 can be vague and imprecise. In other circumstances it might allow for a long series of invasive procedures without adequate safeguards. Counsel submits that it is not permissible, even for "benign" reasons, to engage in the rewriting of a statute, and that in certain circumstances a court must favour a strict or narrow interpretation in the vindication or protection of fundamental rights.

44. There is much force in this submission. In so observing, I mean no reflection on the treating psychiatrists in this case. However, one must have regard to other contingencies, in other cases, and other institutions. The difficulty with a simple purposive

interpretation is that it might become too wide. There are a range of "treatments" which might be permissible without safeguards. As has been found in other jurisdictions, trust, without mechanisms of review and verification, may be abused.

Safeguards in Other Instances such as Psychosurgery, Electro-Conclusive Therapy and for Children
45. It is true, of course, that certain forms of *procedure*, as defined in the Act, are subject to legal safeguards. Section 57(1) deals with forms of treatment not requiring consent. This is subject to the exceptions of section 57(2). But these are not relevant here. The first, identified as s. 58 of the Act, is psychosurgery, which is not to be permitted unless the patient gives his or her consent in writing and then that is submitted to and authorised by a tribunal, the treating psychiatrist having first notified the Mental Health Commission in writing of the proposal. A tribunal to which such a decision is referred by the Mental Health Commission may either permit it or refuse it. Decisions of this nature are subject to an appeal to the Circuit Court. Psychosurgery is defined as meaning any surgical operation that destroys brain tissue or the functioning of brain tissue and which is performed for the purposes of ameliorating a mental disorder (section 58(6)).

46. Similarly, s. 59 provides for safeguards in the case of a programme of electro-convulsive therapy.

47. Section 61 contains similar provisions in relation to the administration of *medicine* to children for the purposes of ameliorating their mental disorder. While the side bar heading in the Act to that section refers to "*treatment*" of children in respect of whom an order under s. 25 is in force", I can find nothing in the Act which equates the terms treatment and the administration of medicine. Indeed, the contrary is the case.

48. For completeness, I also refer to s. 69 of the Act, which provides as follows:-

> "(1) A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under *subsection (2),* to be necessary for the purposes of treatment, or to prevent the patient from injuring himself or herself or others and unless the seclusion of restraint complies with such rules.
>
> (2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient."

The Approach to Literal Interpretation
49. *Salinas de Gortari v. Smithwick* [1999] 4 I.R. 223 is an illustration of the strict or literal approach to interpretation where fundamental rights are engaged. Such interpretation of a statute led to a lacuna or omission in the context of provisions allowing for evidence taken by a District Judge in Ireland to be used in a foreign criminal investigation. The omission was that, although witnesses could be compelled to give evidence, they could not subsequently be held in contempt for a failure to answer a question put to them during such procedure. McGuinness J. considered that a power to find and punish for contempt, not provided for in the legislation, could not be "read into" the section as it would be an impermissible writing of the Statue and thus "offend against the principle of strict interpretation of penal statutes". The reference to a penal statute is important as it imports with it the concepts of criminal process, and the risk of pain and punishment. Fundamental rights are engaged such as that of liberty and fair procedures.

50. Counsel for the defendant here submits that such interpretation should be given to the term "treatment" because what is essentially at issue are rights of self-determination, human autonomy and liberty (*In Re Ward of Court (No.2)*). The defendant has been denied these constitutional rights and a right to full, fair procedures. Thus it is submitted such interpretation would demand that the common law presumption in favour of statutory construction to protect liberty be applied to protect and vindicate her rights. Of course, such a common law presumption is now to be read in the light of the constitutional provisions which place such fundamental rights on a constitutional plane.

51. In *Director of Public Prosecutions v. Gaffney* [1987] I.R. 173 Henchy J., speaking in the context of a statutory power of an arrest, one which obviously curtailed the right to liberty, said at p. 181:-

> "[T]he right of arrest without warrant given by s. 49, sub-s. 4 of the [Road Traffic Act] 1961 [is a] substantial [invasion] of the personal rights enjoyed before the enactment of these provisions and there should not be attributed to Parliament an intention that such personal rights were to be curtailed further than the extent expressed in the Statute."

The Process of Interpretation to be Applied
52. Should such an approach apply here in light of the rights issues involved? In what follows, I now focus on an analysis of the precise words of the definition of "treatment", this will be followed by a consideration of other provisions in the Act as an aid to interpretation. I will then consider the constitutional values which are embodied in the Act as an aid to such interpretation. Finally, I will return to the question of interpretation of the Act in a manner "compatible with constitutional duties and those obligations which arise "under the Convention provisions" (s. 2 of the European Convention on Human Rights Act 2003). Here it will be necessary to at least identify matters arising from "the duty of every organ of State, including the plaintiffs, and this Court, to perform its functions in a manner compatible with the obligations under the Convention provisions (s. 3 of the European Convention on Human Rights Act 2003). The court is enjoined to "take notice" of judgments of the ECtHR and decisions of the Committee of Ministers established under the statute of the Council of Europe in this process. In interpreting the law, in applying a Convention provision, the court must take due account of the principles laid down in such judgments or declarations (s. 4 of the European Convention on Human Rights Act 2003).

I preface what follows by the observation that the word "treatment" in the section is ambiguous. It is capable of being interpreted broadly or narrowly. It is necessary then to look to the purpose of the enactment. It is to be presumed that the interpretation which gives effect to the purpose of the Act is that intended by the legislative, s. 5 Interpretation Act 2005. The meaning that best promotes the purpose is that to be favoured. See *Statutory Interpretation in Ireland* – David Dodd, Tottel, P. 6.15.

The Words of the Section
53. The first striking feature of the definition of "treatment" is that it is not intended to be all encompassing. The words used are illustrative: the definition "treatment" includes the identified measures which <u>may</u> be "physical, psychological *or other*". There may also be other remedies not enumerated or identified in the Act. One test of the intent of the legislature is whether a definition is intended to exclude as well as include – is there an identification by way of limitation? Here the answer is no. These are not words of

delimitation but illustration. The intent of the legislature is evident by virtue of the fact that the term "treatment" is not exclusively defined, but rather contains a number of illustrations as to forms which such treatment may take for the purposes of ameliorating a mental disorder. There may be "other" remedies. One cannot read this definition as reflecting an intent to preclude other forms of treatment not enumerated in the section. The consequence of the interpretation urged on behalf of the defendant in this case would be, in fact, to preclude the possibility of the form of remedial treatment envisaged here used as an ancillary to the regime of "medicine" because of the risks inherent in having one without the other.

Construing the Definition of "Treatment" in the Light of Other Provisions in the Act: The Legislative Intent
54. When one turns to other provisions of the Act of 2001 there is reinforcement for a broader interpretation. Ultimately, the values or rights at stake, be they expressed in constitutional or statutory terms, are the values of "health" (s. 57(1)) and of life itself. The measures to restore the defendant's health, if not appropriately monitored, might place life at risk. Here, the terms of s. 57 of the Act of 2001 are particularly *á propos*. To reiterate, it provides:-

> "The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard *the life of the patient*, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering …[when] the patient concerned is incapable of giving such consent."

Thus, for reasons I will now explain, the intent of the Oireachtas in this Act is to give priority to the constitutional values of the patient's life and health. The effect of this section is that a clinician may administer "treatment", regardless of capacity or incapacity in cases of necessity where life is at stake.

55. The evidence before the Court is that the "treatment" is necessary to restore the patient's health and to alleviate her condition. It is to relieve her suffering. Surely it would be an absurd and certainly unintended interpretation, that those treating the defendant to restore her health would be precluded from taking such measures as were necessary in order to safeguard the *life* of the patient in so doing? (See s. 5 Interpretation Act 2005).

Interpreting the Act in Accordance with the Constitutional Rights Engaged
(a) The hierarchy of values

56. While section 4(2) of the Act of 2001 enjoins clinicians when making decisions concerning care or treatment to have "due regard" to the rights of that person to "dignity, bodily integrity, privacy and autonomy", these statutory provisions must, in this case, be read in accordance with the constitutional status which is given in the Act to the value of a patient's life as prioritised.

57. I now briefly refer to legal authorities which identify this ordering or harmonising of the value of the patient's life.

58. As long ago as the *Attorney General v. X* [1992] 1 I.R. 1, Finlay C.J. observed that there may be instances where it is necessary to prioritise constitutional rights, and were there to be an interaction of such rights not capable of being harmonised, then a right to life would take precedence over any other right.

59. The defendant enjoys a constitutional right to protection from inhuman or degrading treatment (see *The State (C) v. Frawley* [1976] 1 I.R. 365); she enjoys a right to bodily integrity (*Ryan v. The Attorney General* [1965] I.R. 294), such that she should be protected from unnecessary physical invasive treatment. But when one adopts the Constitution as a framework of reference for interpretation, it is clear that the primary constitutional values engaged are the necessity for safeguarding the patient's life and health. I think this applies in the context of the word "treatment". In the balance, and on the facts om this case, it is the duty of the court to make the best interests decision. The patient lacks the capacity to make decisions in accordance with the terms of the Act. The court must apply an objective test as to best interest. There is no evidence that the defendant's wishes would be otherwise if she enjoyed full capacity. The evidence coercively shows that the proposed medical regime is in her best interest, at this time. I find that at present the vindication of these rights must take precedence over autonomy and liberty. I emphasise the word "balance" however, it must be applied on the facts of the case and at the time this judgment is delivered. In all this, it must be recollected fair procedures have been employed in these hearings.

60. The duty of the court is to apply a hierarchy of constitutional values embodied in the statute, giving priority to that which comes highest. I think that there is recognition of this reality in the decision of the Supreme Court in *Croke v. Smith* [1998] 1 I.R. 101. There, Hamilton C.J. spoke of the obligations to respect and to uphold the rights of persons with incapacity. He observed that those vested with the powers and obligations under such Acts must "act in accordance with the principles of constitutional justice, and are not entitled to act in an unlawful manner, are not entitled to act arbitrarily, capriciously or unreasonably and must have regard to the personal rights of the patient, including the right to liberty which can be denied only if the patient is a person of unsound mind and in need of care and treatment who has not recovered and must be particularly astute when depriving or continuing to deprive a citizen, suffering from mental disorder of his or her liberty."

61. *Croke* is authority for the proposition that legislation in this category should be interpreted in accordance with the Constitution, should favour the validity of the provisions of the Constitution in cases of doubt, and that such legislation should have regard to the fact that the presumption of constitutionality carries with it, not only the presumption that the constitutional interpretation or construction was that intended by the Oireachtas, but also that the legislature intended that procedures, permitted under the Act, will be conducted in accordance with the principles of constitutional justice (see the judgment of Hamilton C.J. at p. 123 of the report). This again raises the issues of fairness in decision-making on fundamental matters.

(b) Authorities on purposive interpretation

62. A further feature of the constitutional framework of the Act of 2001 necessitates recognition of what is termed in the Constitution itself as a recognition of "differences of capacity, physical and moral and in social function" (Article 40.1). This has consequences for the process of interpretation.

63. This Court is constitutionally enjoined and bound to apply the doctrine of precedent. There is clear authority as to the manner in which statutes designed for the protection of vulnerable persons should be interpreted. They are generally to be construed in a "purposive" manner or broad manner in the interests of the patient. In this context I will use both terms as it is the broad interpretation which gives effect to the legislative intent for purpose. This would not always be so. This approach is perhaps best identified in the judgment of O'Byrne J. in *In Re Philip Clarke* [1950] I.R. 235 in language which now might be thought to be very much of its time:-

> "The impugned legislation is of a paternal character clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and wellbeing of the public generally. The existence of mental infirmity is too widespread to be overlooked, and was no doubt present in the minds of the draughtsmen when it was proclaimed in Art. 40.1 of the Constitution that, although all citizens, as human beings, are held to be equal before the law, the State may, nevertheless, in its enactments have due regard to differences of capacity, physical and moral and of social function. We do not see how the common good would be promoted or the dignity and freedom of the individual ensured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others."

64. That our courts are to adopt a purposive interpretation was recently re-affirmed by the Supreme Court in *E.H. v. The Clinical Director of St. Vincent's Hospital & Ors*. [2009] I.R. 774; *Gooden v. St. Otteran's Hospital* (2001) [2005] 3 I.R. 617; and in *T.O'D. v. Kennedy* [2007] 3 I.R. 689. In the latter case, Charleton J. put matters in this way at p. 703:-

> "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 of 2001 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."

65. This a well established approach to interpretation. It is, of course, to be viewed in the light of the guarantee contained in the same article of the equality of all citizens before the law.

Summary and Conclusion
66. I have sought to construe the section by analysis of its intent, by reference to the Act as a whole, by reference to the constitutional values involved and by reference to decided authority. On these approaches, the balance falls squarely in favour of a purposive interpretation.

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

68. Thus, applying these principles, I consider the obtaining of fbc's as part of, and ancillary to the treatment and medicine regimes in this case is lawful, in the patient's best interest, and in accordance with the Act. As will be explained, there is a proviso to this finding. It is not to be interpreted as open-ended. I will first refer briefly to persuasive authorities from other jurisdictions which assist on the question of interpretation and reinforce the conclusions just outlined.

Persuasive Foreign Authorities on the Same Question
69. An illustration of this same interpretative method can be seen from a number of United Kingdom authorities. The legislation there more easily allows for a purposive interpretation of permissible forms of treatment. Originally this was the United Kingdom Mental Health Act 1983, later amended. The task of those interpreting that legislation was eased, because in that the Act it was provided that a patient suffering from a mental illness might be admitted in circumstances which would make it appropriate for him or her to receive "medical treatment in a hospital" (section 20(4)). The term used in that, and later amending legislation, was quite frequently that of "*medical* treatment for *mental* disorder" (see, for example, s. 57(1)) of the same Act. "Treatment" was defined in s. 145 of the legislation as "medical treatment" including nursing and also including "care habilitation and rehabilitation under medical supervision". I should observe that the facts of this case are not entirely dissimilar from the decision of the Court of Appeal in *R. (on the application of Wilkinson) v. Broadmoor Hospital* [2002] 1 W.L.R. 419

70. Nonetheless, a number of the observations by courts in the neighbouring jurisdiction are of some assistance in identifying circumstances in which a broad interpretation may be permissible, and when it is not.

71. In *B. v. Croydon Health Authority* [1995] Fam. 133, the Court of Appeal had to consider whether tube feeding a patient with a psychopathic disorder who was refusing to eat constituted medical treatment for the purposes of the Mental Health Act 1983. Hoffman L.J. rejected the argument that every individual element of the treatment being given to the patient must be shown to be directed to his mental condition as being "too atomistic". He expressed the view that one has to look at the treatment as a whole, so that *a range of acts, ancillary to the core treatment*, would fall within the definition. The court emphasised that it was not necessary that every act which formed part of the treatment must, in itself, be likely to alleviate or prevent a deterioration of the disorder. For instance, nursing and care concurrent with the core treatment, or as a necessary prerequisite to the treatment, or to prevent the patient from causing harm to himself or to alleviate the consequence of the disorder, were all, in that court's view, capable of being ancillary to a treatment calculated to alleviate or prevent a deterioration of the disorder. The judge observed at p. 139:-

> "It would seem strange if a hospital could, without the patient's consent, give him treatment directed to alleviating a psychopathic disorder showing itself in suicidal tendencies, but not without such consent to be able to treat the consequences of a suicide attempt."

72. In the same case, Neill L.J. observed the difficulty in practice for those who treated a patient to draw a clear distinction between procedures, or parts of procedures, which were designed to treat the disorder itself, and those procedures, or parts of which were designed to treat its symptoms and *sequelae.* This too is an identification of the general parameters which come within the range of contemplation of treatment under the Act of 2001.

73. Further illumination can be obtained from the judgment of Charles J. in the case of *G.J. v. The Foundation Trust and Others* [2010] 3 W.L.R. 840. By that time, the term "medical treatment" had been further referred in amending legislation (give ref.) so as to read:-

> "(1). . . 'medical treatment' includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care, but see also subsection (4) below . . ."

> "(4)Any reference in this Act to medical treatment in relation to mental disorder, shall be construed as a reference

to medical treatment the purpose of which is to alleviate or prevent worsening of, the disorder or one or more of its symptoms or manifestations."

74. In dealing with these definitions, Charles J. considered that:-

> (a) A range of acts ancillary to the core treatment of the mental disorder may be considered to fall within the definition of medical treatment for medical disorder;
>
> (b) Treatment for mental disorder may include treatment for the symptoms of mental disorder;
>
> (c) Treatment for mental disorder may also include a treatment for the physical consequences of a mental disorder;
>
> (d) If there is no proposed treatment for the core mental disorder it will not be lawful to detain a patient to treat the physical consequences of his disorder;
>
> (e) Treatment for physical disorder will not be treatment for mental disorder where the physical disorder is unconnected with the mental disorder;
>
> (f) If the physical disorder is unconnected with the mental disorder, then the treatment of the physical disorder can only be considered "treatment for mental disorder" if such treatment is likely to directly affect the mental disorder.

Summarising the position in the light of the provisions in the U.K, Charles J. said at para. 54:-

> "I agree that from the above propositions it can be concluded that: (a) whilst treatment for mental disorder can include both medical and surgical treatment for the consequences of mental disorder- such as treatment for self-injury or self-poisoning; (b) this principle or approach does not extend to the medical or surgical treatment of unrelated physical conditions where that treatment will not impact on the pre-existing mental disorder." (See also *NHS Foundation Trust v. P.S.* [2010] 2 F.L.R. 1236). (See generally, Hale, *Mental Health Law,* (5th ed, 2010), pp. 196 *et seq.)*

Safeguards

75. The Constitution and the Convention are significant in two separate ways. In a "positive" sense they lead to an interpretation consistent with the values enshrined in the Constitution and the ECHR itself. In a negative or protective sense, it raises the question as to whether other measures or safeguards are necessary in order to ensure compliance with the Constitution and the Convention. The constitutional and Convention rights engaged are quite fundamental. What is at stake here includes the prohibition of inhuman and degrading treatment, the right to autonomy and liberty, the right to fair procedures and rights to an effective remedy and to prohibition on discrimination. In this case, one might well ask, whether, if at all, the rights which are in question and procedures to vindicate them could differ whether they be derived under the Constitution or the Convention. Here it may be apposite to recollect Costello J.'s observation in *Doyle v. Croke* (Unreported, High Court, Costello J., 6th May, 1988) that the courts should seek to correlate the nature of the fair procedures and the nature of the scope of the decision to which they relate.

76. On behalf of the defendants it has been pointed out that under the Convention the safeguards which might arise in cases of this type (and in this case) include: Article 3, prohibition of torture; Article 5, right to liberty and security; Article 6, right to fair trial on matters of civil rights; Article 8, right to respect for private family life; Article 13, right to an effective remedy; Article 14, prohibition of discrimination; these rights may arise for consideration if the Act itself, or perhaps if our law as to inherent jurisdiction of the courts, do not provide for procedures for the vindication of such civil rights. If such safeguards are necessary are they found within the four walls of the Act? A court is not entitled to legislate, however it may be that there are exceptional circumstances where, even in the absence of legislation, the court may invoke its inherent jurisdiction in an individual case so as to give effect to constitutional or Convention duties. But this cannot supplant the need for legislation where it is necessary. Just as it is the duty of a court to apply the law, it may be necessary for the legislature to legislate. Only in exceptional cases a court may resort to inherent jurisdiction, or perhaps to identify a less formal or less expensive mode of procedure which might ensure guarantees are vindicated.

77. As can be seen, this judgment is confined to the issue of interpretation of the statute. It is important to emphasise, however, that this was not the entire range of the defendant's case.

78. It remains, therefore, to deal further with the statutory safeguards which are contained in the Act. In one sense this issue arises almost independently of whatever interpretation is put on the term "treatment", be it strict or purposive. In another sense, however, it is necessary that the Act be interpreted and applied in accordance with the Constitution and decisions of the ECtHR which give expression to the values contained in that instrument. With respect to the constitutional rights involved, it might be thought that the passage which I have quoted earlier from Croke has necessary consequences.

79. The extent to which a court should have regard to international instruments was touched on in the decision of Costello P. in *R.T. v. Director of Central Mental Hospital* [1995] 2 I.R. 65. That judge expressed himself in this way.

> "The reasons why the Act of 1945 deprives persons suffering from mental disorder of their liberty are perfectly clear. It does so for a number of different and perhaps overlapping reasons – in order to provide for their care and treatment, for their own safety, and for the safety of others. Its object is essentially benign. But this objective does not justify any restriction designed to further it. On the contrary, the State's duty to protect the citizen's rights becomes more exacting in the case of weak and vulnerable citizens, such as those suffering from mental disorder. So, it seems to me that the constitutional imperative to which I have referred requires the Oireachtas to be particularly astute when depriving persons suffering from mental disorder of their liberty and that it should *ensure that such legislation should contain adequate safeguards against abuse and error in the interests of those whose welfare the legislation is designed to support. And in considering such safeguards regard should be had to the standard set by the Recommendations and Conventions of International Organisations of which this country is a member." (Emphasis added).*

80. There has been, therefore, some emphasis on the standards which are laid down by organisations of which this State is a member. In the case of medical treatment without consent, the Act of 2001 provides for both a temporal limitation and a periodic independent medical review in the case of psychosurgery (s. 58); electro-convulsive therapy (s. 59); and administration of medicine (s. 60). These have been cited earlier.

81. The extent and depth of the rights which may be engaged have been identified in the United Nations Convention on the Rights of Persons with Disabilities and in Council of Europe instruments.

82. Article 12 of the above mentioned Convention specifically recognises the right to equal recognition before the law for persons with disabilities. It provides, at sub-article 2:-

> "States parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."

Thus in that instrument States are enjoined to take appropriate measure to provide to persons with disabilities the support which they may require in exercising their legal capacity; to ensure that all measures relating to the exercise of such capacity provide for appropriate, effective safeguards to prevent abuse; to act so that such safeguards should ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, to ensure the decision-makers are free of conflict of interest and undue influence, the decisions are proportional, tailored to the person's circumstances; apply for the shortest time possible; and are subject to regular review by a competent independent and impartial authority or judicial body. (See also Recommendation (99)4e on Principles Concerning the Legal Protection of Incapable Adults adopted by the Committee of Ministers on 23rd February, 1999.

83. Counsel for the defendant submits that the Act of 2001 fails adequately to safeguard the defendant's rights under the Constitution and the Convention because it fails to provide for an independent tribunal to determine whether:-

> (a) the patient lacks the capacity to consent to treatment;
>
> (b) whether the treatment being administered, or proposed, is appropriate; and
>
> (c) fails to provide for the designation of an independent person to represent the patient in respect of issues where consent would be required.

However I must point out there has been no challenge to the constitutionality of the Act, nor has a declaration been brought that it is incompatible with the Convention.

84. In the course of arguments and submissions, I have been referred to a number of authorities and commentaries. These include the decision of the ECtHR in *Shtukaturov v. Russia*, already referred to, and Article 12 of the United Nations Convention on the Rights of Persons with Disabilities, wherein it was pointed out the E.U. is an active participant in the drafting of the Convention; and the Council of Europe Committee of Ministers Recommendation REC (2004) 10 concerning the protection of human rights and dignity of persons with mental disorder. Counsel submits that it must be "convincingly shown" that treatment which is prima facie degrading is a "medical necessity" (*Herczegfalfy v. Austria* (1992) 15 E.H.R.R. 437, para. 82). It is also submitted that in order to provide convincing evidence that the restraint is of medical necessity, state authority must show that all other reasonably available treatments have been tried, but failed. It is suggested that no such evidence has been advanced in the affidavits relied on by the plaintiff here.

85. Despite the finding of lack of capacity by the defendant's own independent psychiatrist, her solicitor and counsel are instructed that she regards herself as being aware of the treatment and competent to challenge it. It is submitted on behalf of the defendant that the doctors treating the plaintiff should not have been permitted to remove her right to consent to treatment on the basis of a finding of lack of capacity without an independent review as to whether this finding was correct, or without the designation of a person to represent the defendant on the issue of capacity; that no adequate procedural safeguards were deployed to protect the patient's right to capacity; that Article 6(1) of the Convention is engaged in such determination of these matters and that whether a person has capacity to refuse or consent to medical treatment constitutes determination of a "civil right". It is contended that these decisions engage Article 6 considerations, and that determinations of capacity involve consideration of Articles 6 and 8 of the Convention. It is contended that the right to choose whether to receive medical treatment is a right that falls within the ambit of "private life" as protected by Article 8 of the Convention, such that it is a right protected by Article 6; and, additionally, one that has protections set out in Article 8(2). Thus, it is contended, an interference with an Article 8 right must, if it is to be lawful, be (i) in accordance with law; (ii) be necessary or proportionate; and (iii) be in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights of freedoms of others. The defendant's case is that in this jurisdiction there is no statutory or other mechanism by which a decision of a consulting psychiatrist that a patient is incapable of consent may be reviewed. The defendants have contested certain aspects of the procedures.

86. I have not been provided with any substantial degree of evidence as to seclusion. It has been stated on affidavit that the defendant must be placed under restraint for the treatment, but no evidence has been adduced either way as to whether other methods were tried. There is a shortage of evidence on this point. With regard to seclusion, it has been stated that the defendant has, on occasion, been placed there, but there is no evidence as to how frequently or under what circumstances.

87. Regardless of any issue of *locus standi* which may arise, a determination of rights can only take place in concrete evidential circumstances where a court, at whatever level, has the opportunity of hearing the relevant facts. The issue should, be properly and fully pleaded. The issues which are raised here are important. The case is without direct precedent and as such in my view it may be desirable to invite the Attorney General and the Irish Human Rights Commission to consider whether they wish to participate and to be fully placed on notice of the questions which are engaged. But this is for the future. The questions which arise here, the defendants urge, concern whether or not the Act is compatible with the obligations of the State under the Convention provisions. Before a court decides whether to make a declaration of incompatibility the Attorney General and the Human Rights Commission must be given notice of the proceedings in accordance with the rules of the court. The Attorney General shall thereupon be entitled to appear in the proceedings and to become a party thereto as regards the issues of the declaration of incompatibility (s. 6 of the European Convention on Human Rights Act 2003). The matter may then be dealt with by this, or another court if necessary. A court must proceed cautiously when invited to invoke inherent jurisdiction to address a possible are of omission in the law, in circumstances where the rights of other parties, the public interest, the common good and the rights of the State itself may be involved. As a preliminary I will give the parties the opportunity to consider this judgment and to identify precisely the issues the court is to decide. I would also remark that as hereto applied inherent jurisdiction procedure may be expensive and inappropriate to deal with the range of day-to-day matters which necessarily face health professionals daily. For the moment, I also direct that this court will be provided with reports from the psychiatrists involved as to the course of the treatment so far and its outcome. I will hear submissions from parties as to what further procedural steps should now be taken to ensure that the relevant interests are represented and the appropriate issues addressed.