Neutral Citation Number: [2009] IEHC 106

THE HIGH COURT

2008 1632 SS

IN THE MATTER OF AN INQUIRY PURSUANT TO

ARTICLE 40.4.2° OF BUNREACHT NA h╔IREANN

BETWEEN

V. T. S.

APPLICANT

AND

THE HEALTH SERVICE EXECUTIVE

AND

THE MERCY UNIVERSITY HOSPITAL LIMITED

AND BY ORDER

IRELAND AND THE ATTORNEY GENERAL

RESPONDENTS

JUDGMENT of Mr. Justice John Edwards delivered on 11 February 2009

Introduction

On 28th October, 2008, this court was asked by the applicant to open an inquiry pursuant to Article 40.4.2° of the Constitution of Ireland into the legality of the detention of the applicant's daughter, a 33 year old South African national, at the Mercy University Hospital in the City of Cork. The applicant's daughter is Ms. N.I. and will hereinafter be referred to as ôthe patientö. The patient is alleged to be detained unlawfully at the Mercy University Hospital, an institution operated by the second named respondent, in purported pursuance of an order made by a servant or agent of the first named respondent pursuant to s. 38 of the Health Act, 1947 as amended by s. 35 of the Health Act, 1953 which provides for the detention and isolation of a person suffering from an infectious disease who is a probable source of infection. The applicant claims that the patient's detention is unlawful and she seeks an order for the patient's release. The order in question was made on 11th December, 2007 and was made by the Medical Officer of Health for the Health Service Executive South, on the basis that the patient is a probable source of infection with an infectious disease, to wit tuberculosis (TB), and that her isolation is necessary as a safeguard against the spread of infection and that she cannot be effectively isolated in her home. The order specified that the patient be detained and isolated in a specialised negatively pressurized room within the Mercy University Hospital until certified by the said Medical Officer of Health that she is no longer a probable source of infection. The Court, having received evidence on affidavit concerning the patient's alleged detention, was satisfied to open an inquiry into the lawfulness of that detention pursuant to Article 40.4.2° of the Constitution.

The applicant claims, first, that the patient's detention is unlawful, and secondly, that if her detention is in fact lawful then the law authorising it, namely section 38 of the Health Act, 1947, is unconstitutional.

By Order of this Court dated the 28th October, 2008, the first and second respondents were directed to certify in writing the grounds of the patient's detention. The Court further ordered that Ireland and the Attorney General be joined to the proceedings as third and fourth named respondents respectively, having regard to the constitutional issue that has been raised. Since then, the first and second named respondents have duly certified in writing the grounds of the patient's detention and have sought, by the adduction of relevant evidence, to justify it as being in accordance with law. This applicant has contested this and has adduced evidence of her own in support of her contention that the patient is not lawfully detained. The Attorney General has argued the constitutional validity of the impugned section, and the applicant has argued its invalidity. The hearing lasted five days. The Court, mindful of the need for expedition in a matter involving the right to personal liberty, ruled on the 26th of November 2008 that the patient's detention was lawful, and in respect of the impugned section, which enjoys a presumption of constitutionality, that no case tending to rebut that presumption had been made out such as might justify it in stating a case for the opinion of the Supreme Court. I gave brief reasons for my decision ex-tempore and indicated that I would give more detailed reasons in a reserved judgment to be delivered later. I will now do so.

Moreover, it should be stated that I have, of my own motion, decided that it is appropriate to bring the very particular and unusual circumstances of the patient's case to the attention of the President of the High Court so that he might consider it the context of the wardship jurisdiction that is reserved to him. Accordingly, my judgment incorporates a much more detailed review of the evidence heard in the course of the inquiry than would otherwise be necessary.

The relevant statutory provisions

It may be helpful to an understanding of the issues in the case if I outline at this stage the relevant statutory provisions. They are as follows:-

(a) The principal statute with which we are concerned is the Health Act, 1947. Section 38 of the Health Act, 1947 in its original and unamended form stated:-

> (1) Where a chief medical officer is of opinion, either consequent on his own inspection of a person in the area for which such medical officer acts or consequent upon information furnished to him by a registered medical practitioner who has inspected such person, that such person is a probable source of infection with an infectious disease and that his isolation is necessary as a safeguard against the spread the infection, and that such person cannot be effectively isolated in his home, such medical officer may order in writing the detention and isolation of such person in a specified hospital or other place until such medical officer gives a certificate (for which no charge shall be made) that such person is no longer a probable source of infection.
>
> (2) Where an order is made under this section in relation to a person (in this subsection referred to as the patient), the following provisions shall have effect:-
>
> (a) the medical officer who made the order in this subsection referred to as the committing officer) shall forthwith send a copy of the order to the Minister and to the Health Authority for which he acts,
>
> (b) the committing officer, and also any other person, to whom the duty of acting under this section has been assigned by or with the consent of the Minister and who has been authorised in writing by the committing officer to act in the particular case, may detain the patient,
>
> (c) the person detaining the patient shall, on or before doing so –
>
> (i) produce for inspection by the appropriate person his written authorisation from the committing officer, if he is not himself the committing officer, and
>
> (ii) give to the appropriate person a copy of the order and a statement in writing of the right of appeal under paragraph (h) of this subsection,
>
> (d) if the patient, when detained, is outside the area for which the committing officer acts, the committing officer, may, with the consent of the chief medical officer of the area in which the person is detained, amend the order to allow for the patient's isolation in a hospital or other place convenient to the place where he is detained, and the order as so amended shall have effect accordingly,
>
> (e) where the committing officer amends the order, he shall forthwith send a copy of the order as amended to the Minister and to the health authority for which he acts and to the health authority of the area in which the patient is detained and to the appropriate person,
>
> (f) after the patient is detained, he shall be taken to the hospital or other place specified in the order and shall, subject to the provisions of this subsection, be there detained and isolated until the committing officer certifies that he is no longer a probable source of infection,
>
> (g) the person in charge of such hospital or other place shall afford to the committing officer all reasonable facilities for visiting such hospital or other place and examining the patient therein,
>
> (h) the patient (of the parent of the patient, where the patient is a child) may at any time appeal to the Minister in writing to direct the release of the patient.
>
> (i) the person in charge of such hospital or other place shall afford all reasonable facilities for the purposes of any appeal under paragraph (h) of this subsection, including where appropriate facilities for the inspection of any reports and records relating to the patient and available in such hospital or other place and the provision of copies of any such reports or records,
>
> (j) on receipt of an appeal under paragraph (h) of this subsection, the Minister shall give notice in writing of the date on which such appeal was received by him to the person making the appeal and to the person in charge of such hospital or other place,
>
> (k) if no determination of an appeal under paragraph (h) is made by the Minister and communicated to the person in charge of such hospital or other place within twenty one clear days from the receipt by the Minister of such appeal, such person shall release the patient and notify the committing officer of such release and if necessary arrange for conveyance of the patient to his usual place of residence,
>
> (l) if at any time the Minister directs the release of the patient, he shall be released by the person in charge of such hospital or other place in accordance with the direction and such person shall, if necessary, arrange for his conveyance to his usual place of residence
>
> (m) where an appeal is made under paragraph (h) of this subsection the Minister shall cause one of medical officers to examine the patient and report the result of such examination,
>
> (i) as soon as practicable after the appeal is received by the Minister, and
>
> (ii) at intervals thereafter not exceeding six weeks during the detention,
>
> (n) the person in charge of such hospital or other place shall provide all reasonable facilities for an examination under paragraph (m) of this subsection,
>
> (o) force may, if necessary, be used for the purpose of carrying out any provision of this subsection.

(3) In this section the expression "the appropriate person" means in relation to a patient –

(a) where the patient appears to be under sixteen years of age and his parent can be ascertained and reached within a time which is reasonable having regard to all the circumstances of the case – his parent,

(b) where the patient appears to be under sixteen years of age and his parent cannot be ascertained and reached within a time which is reasonable having regard to all the circumstances of the case – the person for the time being in charge of the patient,

(c) where the patient, being an adult person, is for any reason unable to act for himself – the person for the time being in charge of the patient,

(d) in any other case – the patient himself.

(4) A person to whom an order under this section relates who –

(a) resists being detained under this section or resists being brought under this section to the hospital or other place specified in the order, or

(b) wilfully misbehaves while detained in such hospital or other place,

(c) escapes or attempts to escape from detention under this section, or

(d) does not submit himself in a peaceful and orderly manner to the exercise of any power conferred by this section, shall be guilty of an offence under this section.

(5) A person who –

(a) prevents or attempts to prevent the detention under section of any person or the bringing under this section of any person to a hospital or other place for detention and isolation, or

(b) assists in an escape or an attempted escape of any person from detention and isolation under this section, or

(c) obstructs or interferes with the exercise of any power conferred by this section, shall be guilty of an offence under this section.

(6) A person who is guilty of an offence under this section, shall, on summary conviction thereof, be liable to a fine not exceeding fifty pounds or, at the discretion of the court, to imprisonment for a term not exceeding three months or to both such fine and such imprisonment.

(7) The cost of the maintenance and treatment of a person to whom an order under this section relates in the hospital or other place mentioned in the order (including the cost of anything done under paragraph (f), (k) or (l) of subsection. (2) of this section) shall be paid by the health authority for which the medical officer who made the order acts."

(b) Section 38 of the Health Act, 1947 was amended by s. 35 of the Health Act, 1953. The amendment is in the following terms:-

"An order made after the commencement of this section under subsection (1) of section 38 of the principal act shall have no effect unless, in addition to being signed by the chief medical officer, it is also signed by another registered medical practitioner."

(c) At the time of its enactment Ireland's public health services, such as they were, were administered in a very different way to the way in which they are administered today. At that time primary responsibility for the delivery of public health services rested with local government "health authorities" that were synonymous with the various county councils and borough corporations then existing throughout the country. These health authorities operated under the direction of the Minister for Health. In due course, and by virtue of the enactment of the Health Act, 1970, the local government health authorities were replaced by regional health boards and, even more recently, following the enactment of the Health Act, 2004, these health boards were in turn replaced by the Health Service Executive.

(d) At each relevant stage, the legislation giving effect to these changes contained provisions designed to effect, in so far as possible, a seamless transfer of statutory functions and powers from one form of health service administration to the next. In this regard it should be noted that Schedule 5 to the Health Act, 2004 contains *Savings and Transitional Provisions* which include a provision (No 4(2)) specifying that

"Any function under the Health Acts, 1947 to 1953 of a Chief Medical Officer may be performed on or after the establishment day by an appropriately qualified medical practitioner who is an employee of the executive and is designated in writing by it to perform such function."

(e) Section 29 of the Health Act 1947 provides:

"(1) The Minister may by regulation specify the diseases which are infectious diseases

(2) Regulations under subsection (1) of this section may exclude an infectious disease from the application of any particular section of this Part of this Act.

(3) The Minister may define a disease in regulations under this section in any manner which he considers suitable including, in particular, by reference to any stage of the disease or by reference to any class of

sufferers from the disease."

(f) In s. 2 of the Health Act, 1947 "the expression 'infectious disease' means primarily any disease included in regulations under subsection (1) of section 29 whether absolutely or by definition of a particular stage of such disease".

(g) The Infectious Diseases Regulations, 1981, SI 1981/390, as amended, are regulations made under s. 29 of the Health Act 1947 and all diseases currently specified as infectious diseases are listed in the Schedule thereto. Regulation 8 of those regulations, as amended by regulation 4(4) of The Infectious Diseases (Amendment) (No 3) Regulations, 2003, SI 2003/707 provides:

> "All the infectious diseases listed in the Schedule to these Regulations, except acute anterior poliomyelitis, cholera, diphtheria, paratyphoid, plague, severe acute respiratory syndrome (SARS), smallpox, tuberculosis, typhoid, typhus and viral haemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo) shall be excluded from the application of Section 38 of the Health Act 1947 as amended by Section 35 of the Health Act 1953 ."

The Ex Parte Application

The initial application to the court was an ex-parte application made at 10.30 a.m. on 28th October, 2008 grounded upon an affidavit of the applicant sworn on the 24th October, 2008 and documents exhibited therein.

The Applicant's Grounding Affidavit

In her affidavit the applicant deposed that she is a South African citizen and was only in the country for a limited period. It was her intention to return to South Africa on 30th October, 2008. She described how she gave birth to her daughter, the patient, in South Africa on 25th August, 1975. The applicant was aged just fifteen at that time. Following her birth the patient lived with the applicant's father and step mother while the applicant herself lived with her maternal grandparents. The patient reached the age of eighteen and went to live in Johannesburg with the mother of a friend known to the applicant as Lena. The applicant states that they became estranged but that she subsequently learned from Lena that the patient had married a man called E.I.. The patient became pregnant and travelled to Ireland during the course of her pregnancy in or about the month of August, 2001. The applicant's understanding is that it was their intention that E.I., a Nigerian citizen, would follow the patient to Ireland. He did not do so and he died in May, 2008. The applicant deposed that her daughter has remained resident in Ireland since her arrival in 2001. She gave birth to a daughter, I., in October, 2001. The patient subsequently became involved with another man and gave birth to a second daughter, S.L., in 2005. The man in question is Irish and resides in the Cork area. The first daughter I. is currently in the care of the Health Service Executive and is in a foster placement pursuant to an interim care order made under the Child Care Act, 1991 which was due to expire on 14th January, 2009. The second daughter S.L. resides with her father.

The applicant deposes that she understands, and has been advised by the patient's friend Lena, that the patient suffered from tuberculosis whilst she lived in Johannesburg. She spent six months in hospital at that time and the treatment was successful. The applicant goes on to state her understanding that the patient became ill while she was living in Ireland. The patient was admitted to the Mercy University Hospital in November, 2006. The applicant's understanding is that she had suffered an ectopic pregnancy for which she had been admitted initially to Erinville Maternity Hospital and that she was subsequently transferred to the Mercy University Hospital. She spent six weeks as an in-patient in the Mercy University Hospital. She was discharged on medication into the care of her general practitioner. The applicant believes that the patient had to be subsequently re-admitted to the Mercy University Hospital where she remained for some further time. The precise circumstances leading to her re-admission on this occasion are not clear. However, the applicant understands that the Health Service Executive became involved in the provision of care for the patient and her children at that time. Once again, details concerning the care provided are sparse. The applicant states that when the patient was discharged on this occasion she was provided with home help assistance. It is thought likely that the HSE were also providing childcare and family support services pursuant to s. (3)(3) of the Child Care Act, 1991. The patient has told the applicant that she remained and felt very unwell at the time. She went again to her general practitioner who suggested that she go to the accident and emergency department at the Mercy University Hospital. She did so and was admitted to the hospital under the care of Dr. Terry O'Connor, Consultant Respiratory Physician. The applicant does not specify the basis for this admission but it is clear from other evidence that the court has received that she was suspected as having tuberculosis. It has also subsequently emerged that, in addition to having tuberculosis, the patient is also infected with the human immuno-virus (HIV) and in fact has full blown AIDS. According to the applicant "at that time, it appeared that the authorities in Mercy University Hospital were unsure as whether or not (the patient's) condition was infectious or not (sic). The situation apparently changed on a day to day basis where persons would be required to wear masks on certain occasions and not on others". The applicant states that the patient became depressed at this time and her relationship with the father of her second daughter broke up. The applicant expresses the belief that the patient was not taking her medication regularly. The applicant learned that the patient telephoned a friend of hers, one R.N., asking to be collected from hospital. According to the applicant the patient was suffering hallucinations at the time. R.N. attended at the Mercy University Hospital and, after the patient had taken her discharge, brought the patient to her house.

The applicant states that she has been advised that a Dr. Dillon, Consultant Respiratory Physician at St. Finbarr's Hospital in Cork, was informed that the patient had discharged herself and this Dr. Dillon put in train the process of detaining her daughter. The applicant further deposed that she had not had an opportunity to see the order that purported to detain her daughter, but she understood that it was an order pursuant to s. 38 of the Health Act, 1947 as amended. She stated that she believed Dr. Dillon travelled with members of An Garda Síochána to the residence of R.N. and that the patient then went with them voluntarily to the Mercy University Hospital. The applicant's belief was that this occurred in November, 2007. The applicant states that the patient has remained in isolation at the Mercy University Hospital since. There is a guard sitting outside her door and all visitors and medical attendants entering her room are required to wear gloves and a mask.

The applicant has further deposed that for the majority of the patient's stay at the Mercy University Hospital she has not accepted any treatment or medications for tuberculosis, or otherwise. She believes that this is the case notwithstanding that the patient has been advised by the staff of the Mercy University Hospital that she would die in the absence of treatment for tuberculosis. The applicant has deposed that she was very concerned and upset about this. She has also been told that the patient has refused any form of x-ray, MRI, or blood test and that, as a consequence, it is impossible for anybody to be sure of her current health condition. She has deposed that her daughter looks well physically but that

she is very concerned at her mental state.

The applicant has stated that she travelled to Ireland in May 2008. At that time the patient was sleeping on a mattress on the floor of the bathroom adjacent to her hospital room. For a number of days the patient would not return to her hospital bed. It required a lot of persuasion to get her to do so and that the patient appeared on occasions to suffer from hallucinations. She spoke to phantom people on the telephone when it was clear that there nobody on the other side. She also spoke to people in the room who were not there. The patient asserted on one occasion during the applicant's visit in May that her former partner (the father of her second daughter) had been murdered by one of her friends and that they wanted to murder her too and to throw her in the river. According to the applicant the patient regularly talks to herself. The applicant has stated that she returned to South Africa in June, 2008 and, just recently, had returned to Ireland again for a limited period. She has expressed concern that her daughter is still detained in hospital without the benefit of tests or appropriate medical treatment. She is fearful for her psychiatric condition. She deposed that the patient remains intermittently in a low mood and can be aggressive. During the course of a recent visit by the applicant the patient appeared to talk to people who were not there and she continues to talk to herself regularly. The applicant described attending with her solicitor to see her daughter on the 16th of October, 2008. She stated that on that occasion the patient alleged that Dr. O'Connor was a liar and that he had raped the applicant in her presence and had held a gun to her head. According to the applicant she repeated this allegation several times. The applicant has articulated a concern that her daughter's mental condition requires to be appropriately evaluated and treated.

She explained that Dr. David Dunne, Consultant Psychiatrist, had recently seen the patient at her (the applicant's) request and a copy of Dr. Dunne's report was exhibited. Dr. Dunne subsequently gave detailed oral evidence to the court and I will review his evidence in due course. It is sufficient to note at this point in the chronology that Dr. Dunne has expressed the opinion in his report that there is a very strong possibility that the patient may not be capable of taking rational decisions and he has also expressed the view that she was not capable of giving instructions to a solicitor in the state in which he had found her. He has also opined that when he saw her the patient was exhibiting some sort of psychotic process or disorder, almost certainly a long term confusional disorder secondary to serious physical illness in the form of TB and HIV infection.

The applicant also alludes in her affidavit to information contained within the report of Dr. Dunne to the effect that the patient had been seen by a Dr. John Cooney, a Consultant Psychiatrist and the Clinical Director of the Mercy Hospital, who had stated that he was not sure about the patient's mental state but thought on the whole that it was best to assume that she was fit to take decisions.

The applicant went on to describe how she had instructed a solicitor to write to the solicitors for the first and second respondents, respectively, seeking information concerning her daughter's situation. It is sufficient to say that she had some difficulty in securing the information that she wanted because the first and second named respondents were concerned about the issue of patient confidentiality. She exhibited before the court a course of correspondence between her solicitors, and the solicitors for the first and second respondents respectively, and it is not necessary for the purposes of this chronology to review it in any detail. However, she had still not received sight of the original order detaining her daughter as of the date of the swearing of her affidavit and accordingly was unable to exhibit a copy of it before the court.

The remainder of applicant's affidavit is devoted criticisms of the legality of the patient's detention. It asserts that she is being deprived of liberty otherwise than in accordance with law. It further asserts violation of the patient's constitutional rights, including her rights to personal liberty and the protection of her family life. It further asserts violation of Articles 5 and 8 of the European Convention on Human Rights and Fundamental Freedoms. Specific criticisms are made of s. 38 of the Health Act, 1947, as amended, and in particular complaint is made that the appeal mechanism therein is inadequate, and there is no provision for an automatic independent review of the patient's detention. In substance the complaint made is that, in enacting s. 38 of the Health Act, 1947 without incorporating necessary safeguards, the State has failed to defend and vindicate the patient's rights. If the applicant is right about this, the section is unconstitutional. The applicant further asserts that even if existing safeguards are deemed sufficient, the section has not been operated in accordance with constitutional norms and with due regard to the rights of the patient. She complains in particular that her daughter's mental state means that she is not in a position to bring appeals or to seek a review of her position. The affidavit concludes with a prayer that the court should enquire into the legality of the patient's detention.

The applicant's affidavit having been opened to the court, I formed the view that it was appropriate that the court should inquire into the legality of the patient's detention and I made an order pursuant to Article 40.4.2° of the Constitution of Ireland requiring the first and second named respondents to certify in writing the grounds of the patient's detention and to appear before me at 4 p.m. on that same day, namely the 28th of October, 2008, at which time they would be afforded an opportunity of justifying the patient's detention. Further, and as previously stated, I directed that Ireland and the Attorney General be added as respondents. I further decided in the exercise of my discretion, having regard to what was known at that time about the patient's medical condition and the possibility of her being a source of infection, not to order the production of the patient before the court. I indicated that if it were necessary to hear from the patient herself, or if the patient herself wished to be heard in the course of the inquiry, the court would endeavour to facilitate that, either by convening a hearing within the Mercy University Hospital, or by means of the establishment of a video link between the Mercy University Hospital and Cork courthouse, where the court was then sitting.

The return and the certification in writing of the grounds of the detention
When the court sat 4 p.m. on 28th October, 2008 the first and second named respondents were each independently represented by solicitors and counsel. The third and fourth named respondents were also represented by solicitors and counsel. A certificate was produced on behalf of the second named respondent that is also relied upon by the first named respondent. The said certificate was in the following terms:

> " **Certificate**
>
> Pursuant to the Order of the High Court made herein on 28th day of October, 2008 I, Jim Corbett, Deputy Chief Executive of the Mercy University Hospital in the City of Cork certify in writing in the schedule hereto the grounds for the detention of N.I..
>
> Signed: Jim Corbett.

Dated: the 28th day of October, 2008

Schedule

I, Jim Corbett, Deputy Chief Executive of the Mercy University (sic) in the (sic) Cork certify as follows:

N.I. is detained in the Mercy University Hospital in the City of Cork pursuant to a detention order made under s. 38 of the Health Act, 1947 as amended, dated the 11th December, 2007.

I beg to refer to said order of 11th December 2007 and the report of Dr. Terry O'Connor referred to therein upon which pinned together and marked with the letter "A". I have signed my name prior to the swearing hereof.

Signed: Jim Corbett.

Dated: the 28th day of October, 2008.

The order referred to in the schedule to Mr. Corbett's certificate and exhibited marked with the letter "A" is in the following terms:-

"Health Act, 1947 – s. 38
ORDER

WHEREAS-

(1) I am Medical Officer of Health for the Health Service Executive South.

(2) I have been furnished with information from Dr. Terry O'Connor, a registered medical practitioner and Consultant Respiratory Physician, Mercy University Hospital in Cork, by way of the attached report dated 10th December, 2007 who has inspected and treated Ms. N.I.

(3) On the basis of that report I am satisfied that:

(i) She is a probable source of infection with an infectious disease to wit tuberculosis (T.B.) and

(ii) That her isolation is necessary as a safeguard against the spread of infection

(iii) That she cannot be effectively isolated in her home.

Now therefore I do make this ORDER that Ms. N.I. be detained and isolated in a specialised negative pressurised room within Mercy University Hospital until I give a certificate that she is no longer a probable source of infection.

Dr. Elizabeth Keane,

Medical Officer of Health,

Health Service Executive South

Dated 11th December, 2007.

I, Dr. Margaret B. O'Sullivan, a registered medical practitioner have considered the information as set out above and I have formed the opinion that Ms. N.I. is, on the basis of the information, a probable source of infection with an infectious disease, namely tuberculosis and that her isolation is necessary to safeguard against the spread of infection and that she cannot be effectively managed at home.

Dr. Margaret B. O'Sullivan,

Second Registered Medical Practitioner

as required by s. 35, Health Act, 1953.

(Signed: 11th December, 2007)."

There was attached to that document a medical report dated 10th December, 2007. This report took a form of a letter written on the letterhead of the Department of Respiratory Medication, Mercy University Hospital, addressed to Dr. Margaret O'Sullivan, Specialist in Public Health Medicine, Sarsfield House, Sarsfield Road, Cork. It is stamped as having being received in the HSE Department of Public Health on the 11th of December, 2007. The substantive part of the document is in the following terms:-

"Re: N.I. (D.O.B. 25/08/75)

Grt. William O'Brien Street, Apt. 2 Blackpool, Cork.

Diagnosis (1) Multi-drug resistant pulmonary tuberculosis
(2) HIV infection

(3) Cytomegalovirus and Retinitis

(4) Depression

Medications: (1) Omeprazole, 40 mgs once daily
(2) Moxifloxacin 400 mgs once daily

(3) Linezolid 600 mgs b.d.

(4) Trekator 500 mgs a.m./250 mgs p.m.

(5) Clarithormycin 500 mgs b.d.

(6) L-thyroxine 100 mcgs one daily.

(7) Vallergan 10 mgs b.d.

(8) Ganciclovir intravenously

Dear Dr. O'Sullivan,

This 32 year old South African Lady was originally admitted under my care on 19th October, 2006 with smear positive cavitatory pulmonary tuberculosis. On the basis of a history of HIV infection and previously treated TB from South Africa, we commenced her on six drugs because of concerns about the possibility of drug resistant tuberculosis.

She was discharged on the 26th October, 2006 but re-admitted on 30th November, 2006 with an etopic pregnancy and proceeded to laparotomy and left salpingectomy. She remained in hospital after this procedure and it emerged from her drug sensitivities which became available on 3rd January, 2007 that she had multi-drug resistant pulmonary tuberculosis with resistance to Isonizad, Rifampicin, Streptomycin, Ethambutol and Pyrazinmide.

Therefore her combination of anti-tuberculosis medication was adjusted to a more appropriate regime and she was ultimately transferred to St. Steven's Ward in St. Finbarr's Hospital on 6th February, 2007. She remained an inpatient in this setting until the 5th April 2007 when community based directly observed therapy was arranged for her.

Over the months that followed there were major difficulties with directly observed therapy for N.. There were many occasions where she was not present in her house for the medication to be observed and she had both left the city and the country without informing the community care nurses involved in her care. On this basis we arranged a multi-disciplinary meeting with N. in late August 2007 in the Department of Public Health, Sarsfield House, Sarsfield Road, Wilton. At this meeting I clearly indicated to her the importance of complying with her directly observed therapy and clarified that in the absence of compliance, we would need to complete the remainder of her therapy as an inpatient for a total duration of therapy of two years.

She was readmitted on this basis to the Mercy University Hospital on 20th September, 2007. N. felt that she was unable to cope at home and had expressed thoughts of extreme depression, including some suicidal ideation in the first instance. She was reviewed by the psychiatry team who felt that her main problem was one of distress with her physical and psychosocial stressors. Her behaviour became more inappropriate over the subsequent weeks and she became more depressed and upset. She has been reviewed by liaison psychiatry on a continuing basis but it is my opinion that her depression is reactive to her overall situation.

On 23rd November, 2007, she complained of some right-sided visual loss and was reviewed by the Ophthalmology Department at Cork University Hospital, who made a diagnosis of Cytomegalovirus Retinitis and suggested commencing her on Ganciclovir. However, by 27th November, 2007, she had refused all medication including her anti-tuberculosis and anti-viral therapies.

Therefore, the overall situation is as follows:

N. has HIV Aids with Cytomegalovirus Retinitis and multi-drug resistant tuberculosis and is at significant danger of becoming infectious in the absence of continued anti-tuberculosis therapy. I have explained this to her in detail. Furthermore, while she continues to refuse her anti-viral therapy, she is in danger of progressive loss of vision. At this point, she has refused her anti-tuberculosis therapy for the last ten days and it is my opinion, based on the extreme difficulties that we have had in convincing her to comply with her medication to date, that she will require in-patient supervised therapy for at least a further twelve months. This, needless to say, is assuming that she agrees to take her anti-tuberculosis therapy again. As she has refused her medication for the past ten days, we need to assume that she is potentially infectious again and she continues to be managed in a single room with negative pressure where all visiting staff are wearing respiratory protection. I see no circumstances in which her

overall situation can be managed on an outpatient basis at this point, and I am gravely concerned about her short to medium term prognosis while she continues to refuse her medication.

It is my opinion that we cannot effectively isolate this patient in the home setting, having previously tried this unsuccessfully. Furthermore, it is my opinion that there is a significant risk of transmission of infection to others in this case. Finally, the mortality associated with this infection would be up to 80% according to internationally published data.

Yours sincerely,

Dr. Terry O'Connor, M.D. MRCPI FCCP

Consultant Respiratory Physician."

The Oral Evidence

The evidence of Dr. Terry O'Connor

Dr. Terry O'Connor gave evidence on the evening of the 28th October, 2008. He stated that he is a Consultant Respiratory Physician with a special interest in tuberculosis. He is based predominantly in the Mercy University Hospital. He also spends some time in the South Infirmary and in St. Stephen's Hospital. He confirmed that Ms. N.I. is under his care. He stated that the lady in question is South African. She had been living in Johannesburg for some time prior to moving to Ireland. She was first admitted into the Mercy Hospital in the autumn of 2006 with open pulmonary infectious tuberculosis. He explained that tuberculosis is an air borne infection typically of the lung and of the larynx. A person who has tuberculosis transmits it by coughing. He said that the patient's circumstances raised a number of red flags in his mind for the presence of multi drug-resistant TB, which would be a much more serious and more fatal form of TB. First, he was particularly concerned that she had a history of HIV infection as well as tuberculosis. Secondly, she had a previously treated tuberculosis or at least partially treated tuberculosis. Thirdly, multi drug-resistant TB is endemic in sub-Saharan Africa, particularly South Africa. Dr. O'Connor stated that fully sensitive TB tends to be very treatable, and the three or four drugs that they use to treat it are very, very powerful, such that a patient is rendered non-infectious very quickly. Usually a total of six months of medication would be required. Multi drug-resistant TB is much more difficult to treat, much more expensive, and the treatments are much more toxic to the patient. The mortality associated with the disease would be much higher. It is about 50% in HIV negative populations. The data for HIV positive populations would be even higher again. So overall multi drug-resistant TB is a much more difficult contagious disease to treat. He was asked if it was linked particularly with certain parts of the world and he stated there are parts of the former USSR, South Africa and some eastern European countries, Latvia being one of them, in which multi drug-resistant TB is particularly prevalent. In South Africa the province of KwaZulu-Natal is one of the global epicentres of multi drug-resistant TB. Dr. O'Connor stated that the patient was highly infectious when she was first admitted to the hospital. He stated that the thing about TB is that it takes a long time to develop it and it takes a long time to treat it. The lead time is similar whether the infection is fully resistant TB or multi resistant TB. In order to determine drug sensitivity they have to grow the organism in a laboratory and it takes a long time to grow it in the laboratory. So based on the red flags that had been raised in his mind, he decided to start the patient on six drugs rather than the usual four. The patient had two young children at home who were also diagnosed with TB around this time. On the basis that she had two young children at home, they decided to discharge her from the hospital and allow her to return home, but she was encouraged to avoid contact with other individuals. Dr. O'Connor was not the physician responsible for treating the patient's children. In approximately November or December, 2006, having been recently discharged from hospital, the patient was re-admitted with an ectopic pregnancy, and it was around this time that Dr. O'Connor received the drug sensitivity results based upon the samples taken from her some weeks previously. These results indicated that she had, in fact, multi-drug resistant TB rather than the common-or-garden sensitive TB. He stated that the fact that she was in hospital with an ectopic pregnancy gave rise to a lot of concern because it indicated that the patient was sexually active. This was undesirable given her HIV background and also because she was potentially exposing another individual to TB through coughing, despite advice to the contrary. He stated that patients with multi- drug resistant TB require to be put on a cocktail of drugs, some of which are quite toxic, and you have got to take things much more slowly in terms of that patient being in the hospital without detention, that is just trying to manage the patient. He stated that it was necessary for the patient to take all of the drugs. Most people with an interest in TB will treat with at least five, if not six, drugs. These are much harder on the system, and much less effective against TB itself, which is why the course of treatment for multi-drug resistant TB takes two years rather than the normal six months in a fully sensitive case. He was asked if her HIV status flagged any issues for him in relation to her treatment. He replied that the instance of multi drug-resistant TB is much higher in patients who are HIV infected than in those who are not. He discussed the patient's case with a colleague who has an interest in HIV infection. Because of a combination of factors, namely, the patient's history of non-compliance with medication for HIV and repeated non-attendance at clinics, this colleague felt it would be inappropriate to treat the patient with anti HIV therapy. There was also another specific issue to be considered. If you have a patient whose immune system is very depleted and they have advanced TB, and you start them on anti-retroviral therapy for their HIV, they can get what is called an immune reconstitution syndrome. That is a clinical picture whereby somebody who is not that sick all of a sudden becomes very sick because their immune system is reacting to the TB. So for all of these different reasons Dr. O'Connor felt that the patient should not be commenced on anti-retroviral therapy. Dr. O'Connor agreed that, even allowing for the added complexities of multi drug-resistant TB, the complications of this were particularly complex. Dr. O'Connor added that even at this time there were problems in terms of monitoring the patient's TB status arising from intermittent refusals on her part to produce sputum samples. Because of this he was repeatedly required to perform bronchoscopy procedures in order to obtain direct culture samples. When asked by the court as to why this was happening, Dr. O'Connor expressed the view that it was a combination of a lack of appreciation by the patient of the seriousness of her situation, and probably a sense of persecution. He added:-

"You know, she had this very serious disease, and I think she probably had seen other people that she had known

who had had the more common or garden sensitive form, who were treated maybe in a more relaxed fashion, I guess, and she felt…my personal feeling is that she felt she was being persecuted."

He said that it was essential to obtain sputum samples from the patient for guidance as to progress of the patient's treatment. He would be looking for the transition from sputum samples being reported as positive, to one being reported as negative. He emphasised that such an occurrence would not necessarily mean that the patient is no longer infectious, or that they have completed their therapy, but it represented a marker for probable early success. He said that without sputum samples the progression of the patient from being infectious to being non-infectious cannot be gauged. Dr. O'Connor stated that through November and December of 2006, he and his team continued to manage the patient as an in-patient in the Mercy University Hospital and she was accommodated in a negatively pressurised room. He stated that this is a room where the air pressure within the room is lower than the air pressure outside of the room. Accordingly, if somebody opens the door of the room, air flows in rather than flows out. This is a protective mechanism used specifically in the management of multi drug – resistant TB cases. The use of such a mechanism is recommended by the World Health Organisation and by The Centre for Disease Control. He felt that gradually, over a period of months, the patient became either non-infectious or considerably less infectious than she was. Dr. O'Connor stated that he had a number of beds in St. Stephens Ward of St. Finbarr's Hospital where patients who needed to be continued to be managed as in-patients can be managed, and he arranged for the patient to be transferred there in February of 2007. After some further months arrangements were made for her to be discharged and monitored at home. To facilitate this, a system was put in place called directly observed therapy, whereby the patient's ongoing treatment was supervised to ensure that she was taking her medications. Initially she was required to attend at a nearby clinic, but after a short time the arrangement was changed to one in which the relevant health professionals would visit the patient at home and supervise her in the taking of her medications there. The patient commenced on the regime of directly observed therapy in early April, 2007 and in the early stages it seemed to be working well and was regarded as being a success. However, after a period of time difficulties were experienced in getting the patient to co-operate with the regime. Dr. O'Connor described occasions when health professionals would call to the house and, though they could hear people inside of the house, the door would not be answered. In relation to this the court inquired of the witness as to whether the patient was an asylum seeker and, perhaps, under some pressure from the immigration authorities. Dr. O'Connor expressed the belief that she was probably an asylum seeker. At this point, counsel for the applicant informed the court that her instructions were that the patient had been served with a deportation order. Dr. O'Connor also related that on two different weekends the patient went to the UK and the process of directly observed therapy could not be fulfilled by the public health team. Dr. O'Connor described how during the period when the directly observed therapy regime was in operation, his team would see the patient periodically at his out-patient clinic at the Mercy University Hospital, and on these occasions they would try and take a sputum sample from her. Dr. O'Connor then spoke about a continuing concern about a lack of understanding on the patient's part of the importance of compliance with her treatment regime, particularly in the light of the implications for the general public. He was asked to spell out what those implications were and he stated that while the transmission rate in the case of a patient infected with multi drug - resistant TB is no higher than it is in the case of the more common or garden drug sensitive TB, the mortality in the case of people who do develop multi drug - resistant TB is much higher. He emphasised that one in two people who contract this disease will die. He was asked whether if the patient did infect others it would be possible to trace the source of their infection back to her. He replied that there is a technology called RFP, which stands for Restriction Fragment Polymorphism that can be employed for that purpose, but unfortunately he did not have access to that technology. He stated that he was left to clinical intuition and patient interviews, that kind of thing. He was further asked if in the event that the patient was responsible for infecting others, and her movements were uncertain, whether it would be possible to contain the outbreak by the attempted tracing and isolation of persons with whom she might have had contact. He expressed the opinion that if the patient was highly infectious it would be impossible. He felt that at that time the patient in this case was probably not highly infectious as she had had many months of therapy following a prolonged period in hospital. The likelihood therefore was that she was much much less infectious than she had been, if she was infectious at all. Nevertheless, he regarded the reported incidents of her non-compliance with the regime of directly observed therapy to be worrying. As he put it "I became concerned that we were moving right backwards again, and that she would become infectious again". He told the court that it had been emphasised to the patient repeatedly that it was essential for her to comply with her treatment regime. He described regular meetings with the HSE's Department of Public Health at which the case was discussed, and he told the court that arising from ongoing concerns meetings were arranged with the patient on two different occasions for the purpose of re-emphasising and stressing in robust terms the importance of her compliance. He told the court that one of the purposes for which these meetings were set up, was to inform the patient of the powers available to them under the Health Act 1947, and "how we really did not want to get to a point where we would have to look at enacting the Act, but that it would be an option". According to Dr. O'Connor these meetings took place in or about late August, 2007. Thereafter she continued having directly observed therapy at home, and was provided with some further supports by the HSE's Department of Public Health. This continued until, in the words of Dr. O'Connor, "all of a sudden we had a phone call to say that she appeared in the A&E department ….(and)….. was having trouble coping at home, and I felt it best to just admit her and see where we could support her". It was confirmed that this event occurred on the 20th September, 2007. Dr. O'Connor stated that when he saw her on that date his impression was that she was at her wits end. He felt that she was probably depressed because of her situation. He added "I think she probably felt persecuted that so many people were chasing her all the time to make sure that she took all these medications, and probably was finding it difficult, back in the home situation, having been in hospital for so long with her two young children. I think a combination of those things and also the fact that, as I mentioned, she had a friend who, as I remember, was from Zimbabwe, who was diagnosed with fully sensitive TB, who took six months of treatment and that was it. This person was HIV negative, and my feeling was that N. kind of said, 'why am I being persecuted so much?' despite us explaining the differences repeatedly". Dr. O'Connor's evidence was that she then stayed in the hospital briefly and after a short time discharged herself. He contacted the Department of Public Health and they managed to track her down to a location in Middleton. She had called to a friend's house in Middleton. There were some young children in that house, and Dr. O'Connor stated that he and his colleagues were very concerned that she could potentially be exposing these and other young children to infection. He stated that at this point, having discussed the matter with the HSE's Department of Public Health, his feeling was that they "probably had no choice but to admit her back in to the hospital under the terms of this Act". When asked if she was still taking her medications he stated "No, she had stopped. In fact she has not taken her medication since that time". When asked why it was felt that there was no option to invoking the statutory power of detention, he stated "I felt it was inevitable that she would develop infectious TB again for a number of reasons. Firstly, that she had taken only twelve months of what is recommended to be a twenty four month therapy. Secondly, and most importantly, that she had advanced HIV; in fact, she had AIDS. She had two AIDS defining illnesses. She had both CMV retinitis, which is a viral infection of the eye and she was also exhibiting what is called a Credit CE4 Count". He explained that he was referring to an important blood cell count employed in the case of patients suffering from HIV/AIDS, and that a Credit CE4 Count is associated with very advanced end stage AIDS. He felt that with that level of immune system weakness she was

at increased likelihood of developing infectiousness in the context of her multi drug - resistant TB. In reply to a question from the bench, Dr. O'Connor stated that consideration was given to the making of an application to the High Court in the patient's own interest, and in the interest of the public, to have her medicated against her will but that this was not proceeded with, there being no precedent for such an application in a TB case. Dr. O'Connor confirmed that if she was taking her medication, and was taking it as prescribed for some period of time, that she would become non-infectious. He further expressed a reasonable degree of confidence that if she had started on her regime of medication at the moment she went into detention in December, 2007 she would be non-infectious at that stage (i.e. as of the date of his testimony), and would be out of hospital. The doctor stated he would like nothing better than to be able to release her from hospital, but felt that he could not do so in the public interest. He expressed dissatisfaction that the legislation apparently does not cater for the kind of impasse with which he and his team were now faced. He stated that, notwithstanding the patient's refusal of treatment he has been reviewing her situation regularly. He told the court that he sees the patient himself, once to three times a week. She has been in a negatively pressurised room since the date of her detention, and has attempted to escape on a number of occasions. As a result of that she now has a security guard on the door to prevent further escapes. He stated that many many hospital staff members had tried to convince the patient to co-operate with treatment, but that nobody has had any success in that regard. The patient will not even provide samples for diagnostic purposes. He informed the court that some of the chaplaincy staff in the hospital had attempted to act as advocates for the medical staff, but that even they had not been successful in persuading her to give a single blood sample or a sputum sample. Dr. O'Connor was then asked for his views as to the patient's ability to manage her affairs. He described how the patient's behaviour had become progressively more erratic, or to use his exact words, "more fluctuating", since her admission. He expressed the view that she did have the ability to manage her affairs the year previously, but he was not sure if she was now able to do so. He stated "I think there are times where she has spoken to a third person, a non-existent third person, and there are other times where she has been more subdued and lucid, and we are not sure whether there could be a physical basis for that, in that in this advanced state patients can get total AIDS dementia…or whether it is a reaction to her effective imprisonment for such a long time, or whether it is a combination of both". Dr. O'Connor was asked whether in the course of reviewing her clinically, his opinion as to the necessity to keep her in detention had changed. He stated that he reviewed that decision on a continuing basis but that it had not changed. Indeed, the circumstances giving rise to her detention in the first place had probably deteriorated. He emphasised that he was obliged to use the word "probably" because "we cannot really tell; we cannot even do the specific tests that allow us to tell whether she is more infectious or less infectious". Dr. O'Connor expressed a guarded prognosis in terms of the likelihood of her survival. However, contrary to expectations, she has actually flourished in the hospital setting. He stated that she has gained weight, and he is inclined to attribute this to the fact that her nutritional status is probably a lot better as an in-patient than as an out-patient. He was in no doubt that were she to be released from hospital, there would be a real danger of spreading an infection of multi drug – resistant TB to members of the public. He was asked what, in his view, was the optimum way in which he would like to be able to deal with the case. He stated:-

> "I think if we had an absolute commitment from the patient to take the prescribed therapy for the duration, and we could get her restarted, I think we would be looking at another two years from the day that happened, and I think a large proportion of it would need to be done as an in-patient."

He stated that absent that commitment he would be very reluctant to restart the mediation under any circumstances. He explained his reasons for this reluctance. He said that if a patient takes some medication on a Monday, and on Tuesday decides they do not want it, and they take it again on Wednesday, that would promote further levels of resistance in the form of TB that they have. He was asked if she started taking medication whether she would rapidly start to feel better and, perhaps, be more amenable to co-operating with the treatment regime. Dr. O'Connor did not think so. In his view it would take some time before she began to feel better. Dr. O'Connor was asked if it were possible to medicate her pursuant to a court order, how would that be done? Would she have to be sedated? What would happen? He stated that the optimal way of doing it would be to insert a PEG (Percutaneous Endoscopic Gastrostomy) tube, and to administer the medication through that. However, he would be concerned that if they put a PEG tube in, she would probably pull it out. He was asked if the patient gave any reason for refusing to take her medications. He stated it is hard to communicate with her at the best of times. He expressed the view that the patient has a low regard for him and implied that she blames him for her detention in hospital. He added "I think one of the reasons that she has hinted at, is that she took all the medications and that she took them for long enough, and that should be it, and she seems to have resolutely decided that she will not take any more". Dr. O'Connor concluded his evidence in chief by stating that he still holds the fears that caused him to call for the invocation of the statutory power of detention in this case.

Dr. O'Connor was then cross examined by counsel for the applicant. He was asked how she expressed her decision not to co-operate with treatment. Dr. O'Connor stated "She just simply refused. She would either not respond or just say no, that she is not going to take the medication". He agreed with counsel that as things stand he would never be in a position to give a certificate that she is no longer a probable source of infection. He was asked if there was any reason why the patient had not succumbed to Tuberculosis thus far, having regard to her HIV status. Dr. O'Connor was not able to say and he confirmed that he was unable to ascertain why it is that she appears to have rallied. He stated that "every day we are surprised by individual cases in medicine, but we have not been able to take her blood or even do the x-rays to see are things improving, or in which direction they are going. I think nutrition is a large part of it. I think in the community she was probably very malnourished, and I think in a hospital setting her nutrition is better. But even allowing for nutrition, based on the base line data, we would have expected that she would have deteriorated by now". He then added that it was important to take into account that she exists in a very sterile environment by virtue of the fact that she is accommodated in a negatively pressurised room. Accordingly, she was less likely to be exposed to the kind of diseases that people who have advanced HIV/AIDS succumb to. He was asked if he agreed with the patient's mother that the patient presents quite irrationally. He agreed that she did, adding "That's been my feeling from the start, in terms of the difficulties with compliance and the insight and understanding into the infectious nature of both her HIV and her drug resistant TB. I have alluded already to one instance of, you know, her lack of rationality in terms of the HIV, and there are certainly several other instances of that, and overall, the whole thing seems to have been very irrational in terms of how she has dealt with it, or how she has processed the information and the risks associated with these two diseases, but in particular, multi drug – resistant TB, which is our main concern". When probed for more detail on his views as to whether or not she is a person who is able to take care of her own affairs, Dr. O'Connor stated "I think increasingly less so. You know, she came from a background of probably a long history of struggling in South Africa, and also struggling in this country when she arrived with two young children to look after, but because of all that has been going on over the last few years, I think increasingly her ability to take care of herself and make her own decision has diminished. I alluded already to the two factors that I think that are playing a part here in the intermittent aspects of that decline, and to just reiterate those, that can be HIV dementia, that could be a real physical process, or it could a psychological or behavioural

response to her confinement. These are my opinions". When asked again about his views as to her capacity to manage her affairs at the time of which she was detained he stated "I think she was unable to cope, but I think her overall psychological situation has deteriorated since, and I would be surprised if it had not, given the circumstances of her confinement since". He was pressed as to whether he felt she is the type of person who could vindicate her own rights, who could see through a process of standing up for herself and dealing with people in authority. He replied "I would have generally thought so earlier, and I would have given specific thought earlier as to whether that was the case. Earlier into things, the answer is yes. I am increasingly conflicted based on my experience of her over recent months". Dr. O'Connor was then asked whether there had been any psychiatric assessment of the patient in the lead up to seeking a detention order in respect of her. He was unable to say but he confirmed that "We have endeavoured to have her reviewed formally by a psychiatrist repeatedly since her admission, and, you know, the feedback that we have had on a continuing basis is that she is capable of making her own decisions; that, even though she may be depressed, she is not incapable of making of her own decisions. For obvious reasons, we have wanted to do that because of the fact that we knew ourselves that this case would be looked at ultimately". When asked what he meant by that, he said "We knew this case could not go on for ever like this, and, you know, I guess we wanted to be absolutely sure that we were doing things in the right way with her, or at least as best we could". He was asked if, in relation to his own dealings with the patient, he found her somewhat irrational. It was put to him "Did you not experience the speaking to people who were not there, making bizarre accusations about people and the like, was that something that you experienced with her on a weekly basis?" He replied "Not on a weekly basis. There were moments when I came in when – her mood would fluctuate, and she would become very angry at times, and she would become physically violent with some of the other staff at times. It was almost like as if there were kind of bubbles at the top and then she would be lucid again for several days afterwards. And, you know, we felt collectively that this was, again, a reaction to her situation, and an understandable reaction to some extent. There were, certainly, probably two occasions where I found her talking to a third person who was not there". He gave an estimate that these occasions had occurred between three and six months previously. He further stated that those events "would have particularly precipitated us to ask the psychiatrist to come and see her". He confirmed that the refusal to take medication pre-dated those kind of behaviours. Dr. O'Connor accepted that her behaviour had disimproved and felt that it had to be viewed against the background of the two factors that he had mentioned previously, namely possible HIV dementia and reaction to her confinement. He also expressed the view that there might be cultural components to her behaviour as well. Dr. O'Connor was then asked about the views expressed in his report to Dr. O'Sullivan concerning the patient's mental state. It was put to him "You had significant concerns about her mental capacity at that stage, or should I say about her state of mind?" He replied "I think about her state of mind, much less so her mental capacity. I think she was depressed because of her overall situation, and also as a reaction to some of the medication she is on, or she was on, which are notoriously associated with depression; I felt those things were contributing in part to her inability to cope in the community". It was put to him that he had stated in his report to Dr. O'Sullivan that "Her behaviour became more inappropriate over the subsequent weeks. She became more depressed and upset. She was reviewed by liaison psychiatry on a continuing basis". He was asked whether at the time he expressed that opinion, anyone had asked him as to whether he had a view about whether the patient was capable of acting on her own behalf. He replied "No". That concluded Dr. O'Connor's evidence.

On the 29th October, 2008, the court heard the evidence of three witnesses namely, Dr. John Cooney, Dr. David Dunne and Dr. Margaret O'Sullivan. It is proposed to review the evidence of each in turn.

The evidence of Dr. John Cooney

Dr. John Cooney told the court that he holds the position of Clinical Director with the Health Service Executive since 1994. He has responsibility for the North Lee Mental Health Services in Cork City and for a portion of Cork County. He has 25 years experience in psychiatry. He said that he works primarily at the Mercy University Hospital and for the most part he sees patients on the general wards, that is the medical and surgical wards of the hospital. He explained that the psychiatric services at the Mercy Hospital are run by the HSE. The rest of the hospital is independent. It is a voluntary hospital. As he put it, his Unit is like "an island of the HSE within the Mercy Hospital". Dr. Cooney confirms that he had seen the patient at the centre of this case on three occasions. He expressed a reluctance to speak about her case as he did not have her permission to give evidence on her behalf. The court noted his difficulty, but suggested to him that it was both in the public interest and in the interest of the patient that he should give evidence to the inquiry. Dr. Cooney stated that he had no difficulty in cooperating with the court, but that he just wanted to record that he did not have the patient's permission. The doctor then stated that he was asked to see the patient in early December 2007, for the purpose of assessing "her ability to consent and her competence around the treatment positions". The request to see her came from Dr. Terry O'Connor. He was informed that she had a serious infection with tuberculosis, which was a resistant infection, which had not responded well to treatment up until that point in time, that she also had HIV infection, that she was a lady from South Africa, and that this was a part of the world where there were very high levels of these types of diseases and also very high levels of resistant forms of tuberculosis. He explained that he had three interactions in all with her. He characterised the first one as being reasonably satisfactory. The two subsequent ones were unsatisfactory from his point of view, as he was unable to do a detailed assessment on these occasions. His first interaction with her was in early December 2007, when she was in the Mercy University Hospital in a voluntary capacity. Although she was there in a voluntary capacity, she was talking about leaving at that stage and was refusing treatment or beginning to refuse treatment. The patient told Dr. Cooney that she was of the opinion that she was required to have treatment for a certain period of time, which was a year. She felt that she had done that, she had done more than that. She had kept her side of the bargain and now she felt that she was finished with the treatment, that she had done her bit. Dr. Cooney stated that when he saw her on this occasion she was in her isolation room. She was alone when he saw her and he was unaccompanied. He had a conversation with her, but he did not record the exact duration of it. He thought it was probably of around 40 minute's duration. In any event it was a reasonably lengthy interaction and it ended amicably. He stated that he was not dismissed, which was something that happened in his subsequent interactions. He was asked if he was aware, when the lady told him that she had done her bit, that she was not at that time adhering to her medication regime, despite admonishments that she should do so. Dr. Cooney confirmed that he was aware of that. He was asked if her refusal to take her medication was due to a sense of hopelessness on her part or was it the case that she simply did not care. In reply Dr. Cooney stated that when he saw her in December 2007, her mood was reasonably good. She was angry, she was annoyed and she was frustrated. She was talking about wanting to get out of hospital, to get home to her children and the sort of things that would be considered normal for somebody who was a patient in hospital. She felt that she had done what she was supposed to do in terms of treatment. She also felt that hospital had not done her good. She has an increasing blindness problem in one eye as a result of her AIDS. She felt that she had been quite well coming into hospital and that now as a result of the hospital's interventions she was going blind in one eye. She felt that this was proof of her need to get out of hospital. Dr. Cooney stated that he tried to gauge her experience in dealing with other people with tuberculosis infection and HIV infection, but that she did not really want to talk about that, except to tell him that she had known lots of patients who had had TB, who had had treatment, who had finished their treatment and who

were fine. He added that he suspected that she also knew lots of patients for whom that was not the case, but she was not willing to share that with him. In relation to her overall mental state, he felt that at that time, in early December 2007, she was not exhibiting any significant abnormalities and there was certainly nothing that would have led him to conclude on the basis of a reasonably decent interaction with her that she was incompetent. Dr. Cooney was asked if the patient understood the nature of his visit or why he was present. He stated that he explained to her that he had been asked by Dr. O'Connor to see her, that he was a psychiatrist and that he was there to try and decide was she mentally well. He stated that he did not go into the specifics of assessing her competence to take decisions but that, in any case, he was not just there for that purpose. There was also the question of whether or not she was depressed or otherwise mentally unwell. He stated that before he saw her in December 2007, she was previously know to his unit although he had not seen her himself. His Registrar has seen her in January 2007, and had had quite a detailed interview with her. The Registrars view at that time was that she had a significant degree of depression and he recommended anti-depressant medication. However, there was nothing in his note, and he would have discussed the case with Dr. Cooney at the time, suggesting any doubts as to her competence to take decisions. Dr. Cooney stated that after his interview with the patient in early December 2007, he dictated a letter to Dr. O'Connor setting out his views. His advice to Dr. O'Connor was along the lines that he could not see that she was incompetent to take decisions. Moreover, as far as he was aware, there was a presumption of competence in Irish law in the absence of anything to indicate the contrary and he would have advised Dr. O'Connor that that was the position. He explained later on that his understanding of the legal position was based upon his experience of having to deal regularly with patients detained under the Mental Health Legislation. In summary he felt that the patient was competent in terms of decisions regarding her treatment. He suggested to Dr. Cooney that it might be possible in terms of infectious disease control to detain her in hospital and that the Mercy University Hospital should seek legal advice around that. Finally, he stated that he expressed a willingness to see the patient again.

The next time that Dr. Cooney saw the patient was on the 22nd May, 2008. In the meantime she had discharged herself from hospital not long after he had seen her in early December 2007, and within a further short time had been returned to the Mercy University Hospital on foot of a detention order made under the 1947 Act. He next visited the patient on the 22nd May, 2008 pursuant to a further request from Dr. O'Connor seeking advice about her competence to take decisions and her mental state. When he saw her on the 22nd May, she was in an isolation room and subject to an infection control regime which made his job very difficult. Before going in to see her he was required to don protective clothing involving a very heavy mask, gloves and an apron. When he saw her on this occasion she was very angry. She was protesting against what was going on. She had barricaded herself into the en suite bathroom of her single room. She had brought in the mattress from her bed and was sleeping on the floor of the relatively small en suite. His interaction with her was very brief and conducted through a slightly ajar door leading from the en suite out into the main body of the bedroom. He was only able to speak with her for five minutes or less on this particular occasion. He stated that she told me to go away basically. He said that he tried to talk to her about her understanding of the treatment for her TB and her situation, but he really did not get any meaningful response from her. She simply did not want to talk to him and made that clear. Dr. Cooney's impression was that she was pretty much angry at everybody. His understanding was that she displayed the same sort of anger towards all of the staff around that time. In response to a question from the Bench as to whether she was psychotic, Dr. O'Connor felt that she was not. He stated, "If I can explain by giving an example. If she felt that she did not need treatment because God had told her she was cured, that would have a significant impact on my decision around whether she was competent or not. Her logic in believing that she no longer needed treatment was simply and understandably that she had gone….., as far as she was concerned, she had gone through the hoops."

At this point there was an intervention from the bench suggesting to the doctor that there was a difference between competence and capacity. It was suggested to him that one could be competent to make a decision but not capable of making a decision, that to be capable of making a decision you have to have the necessary information. He was asked was she capable of making an informed decision? Dr. Cooney replied that his information was that she had been advised repeatedly about her situation and that she had taken that on board, that she knew what they were telling her. He told the court that she was able to repeat back to him that "they tell me that I'm to have more treatment, but I have had enough". He thought that she had felt, to some degree, in the early parts of her treatment, coming in and out as an outpatient, that she was getting different advice from different doctors. It was true to say that she was on a very complicated treatment regime for her illnesses. So in one week, she might be told something and then, maybe a week later, she might be told something else. Dr. Cooney thought that she felt that she was a bit messed around by the services, that she had done her part and now they were telling her she still needed treatment. In his view she clearly knew that message and knew that from the very start but felt she had had enough and felt she would be better off out of hospital.

Dr. Cooney stated that it was not possible for him to have a broader discussion with her "and say well, you know, I know you feel you have done your bit and you have done your bit, but the advice is that you could infect other people; would you not think of the potential adverse consequences of that and how you might infect your loved ones, your friends, your neighbours? We never got the conversation onto that level. She did not want to go down that depth into it."

Dr. Cooney characterised her degree of protest as pretty extreme. He was asked if she was aware that if she accepts treatment the likelihood is that, after a reasonable period to time, she will become non-infectious and may be able to go home. Dr. Cooney replied that he did not think that that was the likely situation. It was then pointed out to him that Dr. O'Connor had given evidence to that effect. Dr. Cooney said that it was his understanding that, because of her combination of problems, she had a very poor prognosis with treatment or without treatment.

Dr. Cooney expressed the opinion that the patient was aware that if she accepted treatment she might be able to go home after a reasonable period of time but he hadn't discussed that with her directly. He felt that that was Dr. O'Connor's role as he was her respiratory physician. Dr. Cooney said that when he saw the patient most recently, about a week prior to the hearing, she actually looked better than he had seen her on the two previous occasions. She is eating better and has moved back to the hospital bed. She is co-operating at that sort of level. However, it was his understanding that she still refusing any investigation, blood tests, sputum tests, x-rays and so on. He said that when he went to review her recently, again at the request of Dr. O'Connor, he found that she had the T.V. on when he went into the isolation room. She very quickly found the remote control and turned off the sound, so they could have a proper conversation. He introduced himself again and explained the business. They had a brief conversation but as soon he turned to the treatment of her tuberculosis and her thinking about that, she turned into the wall and told him to leave. She stated that she did not want to speak with him. Following this meeting he could not see that there were any grounds for believing that she was incompetent to take decisions. Further, he emphasised that this encounter represented a far from ideal examination. She did not allow him to go into any detail and he was only making a best guess. He stated that he did have

an opportunity to talk with her mother a couple of days later. He stated that in the course of his conversation with the patient's mother, he tried to get information concerning the patient's pre-morbid personality. He also tried to acquire some understanding as to her background with a view to trying to place her ideas and her beliefs in a cultural setting. He stated that he formed the view, from talking with the patient's mother, that the patient was always quite a stubborn and headstrong person who tended to do her own thing and who had in the past led a somewhat irresponsible kind of lifestyle. The mother told him that she had tried to persuade the patient to accept treatment. The patient's mother also told Dr. Cooney that in the course of one of her visits to the patient she had put an aunt, who is a nurse in South Africa on the mobile phone to the patient, in the hope that this aunt would advise her and try to get her to co-operate with treatment. However, the patient had refused to listen to the aunt speaking on the phone and had promptly given the phone back to her mother. Dr. Cooney learnt from the patient's mother that the patient grew up in Johannesburg, which is a large city so that she would have had the sophistication of a person coming from a large city. It wasn't that she was from a very remote area where there might not have been a lot of public health knowledge or information available. Further, her mother confirmed that a number of people in their environment had both TB and HIV. The patient's mother also raised with Dr. Cooney the circumstance that in the course of one of her visits she had found the patient having a conversation with a non-existing person. Dr. Cooney expressed the view that there was cultural element to this. He stated that if any of us were in an isolation room for a year with very little interaction, it would be within the range of normal behaviour to talk to yourself or talk aloud or talk to people. He stated "it's a difficult one to be 100% certain of". He asked was he concerned about possible psychosis and said "Well, that's obviously – the question is whether this is definite evidence of a psychosis, and I'm not certain that it is. The mother advised that the patient told her that 'well you can't see her, but I can talk to [her]'. Normally somebody having auditory hallucinations would expect other people to share them. Such hallucinations had been described in cases of severe isolation such as lone yachtsmen, people like that, who have no company for periods of time, that people can – so I'm not certain about that. But my overall conclusion, again, would be because of the presumption of competence and because of the poor co-operation of the patient and really the inadequate mental state examination that I have been able to conduct last week and in May of this year, that I couldn't form an opinion that she was incompetent." Dr. Cooney was asked by the judge as to whether when he spoke of "the presumption of competence" he was talking about the legal presumption of competence or a medical presumption of confidence. He replied: "The legal presumption of competence". When asked if there was a medical presumption one way or the other and he stated: "Well, I presume, as a consultant psychiatrist, when I'm asked to see people, generally there is a question mark around that. If I meet someone in the street, obviously I am assuming that they are competent, but I deal with a lot of incompetent people in the nature of my work. So you would always have a question mark. If somebody tells me something that sounds unusual, my first or second thought would be: could this be a delusion, a false belief? Is this appropriate? Does the evidence support this as being reality? He stated that to arrive at a diagnosis of psychosis he would be looking for a timeframe. You would be looking for this to be a predominant effect for some several days. You wouldn't be just thinking of somebody having one solitary experience." He stated that he had asked the nursing staff on each of his visits to the ward as to how they found the patient, was she doing anything bizarre, was she doing anything that seemed to support that she was confused or bewildered ,and the nurses hadn't volunteered anything in that regard. He considered that to be very important. Further, Dr. O'Connor hadn't reported to him that the patient was exhibiting bizarre ideas or that she had been telling him of hallucinations or anything of that sort. Dr. Cooney had confirmed that he had had an opportunity of seeing Dr. Dunne's report. Dr. Dunne had seen the patient on the day after Dr. Cooney's most recent visit. He was asked to comment on Dr. Dunne's conclusion. Dr. Cooney said that he couldn't either agree or disagree with Dr. Dunne's conclusions. He did, however, point out that a once off assessment was limited in what it could do. That said, he acknowledged that Dr. Dunne had the advantage of having the patient's mother present for the interview and also that Dr. Dunne's interview with the patient went on for a fairly lengthy period of time, certainly far longer than Dr. Cooney's two interactions with the patient in 2008. Dr. Cooney felt that the patient does not have a mental disorder within the meaning of the Mental Health Act, 2001 which is defined as a mental illness, severe dementia or severe intellectual disability. That concluded Dr. Cooney's evidence in chief. He was then cross-examined by counsel for the applicant. He agreed with counsel that his assessments in May, 2008 and October, 2008 were not properly conducted psychiatric assessments by any means. He felt that his interaction with her in 2007 did constitute a reasonable assessment. He would not accept, however, that the brief encounters he had with the patient in 2008 were of no value. He stated "I wouldn't agree with that. I could not carry out a comprehensive psychiatric assessment but it could well be possible to conduct a psychiatric assessment in three minutes depending on the nature of the person's presentation". He went on to explain that he was satisfied that she did not have a delirium. He said that a delirium is a relatively short acute confusion state that would come on usually in the context of a significant medical illness, infection or perhaps intoxication. He stated "it would be most bizarre for somebody with a delirium when you go to talk to them, to say, "hold on a minute I will find my remote control and I will turn off the television". He agreed that when he saw the patient in October he hadn't seen her in the previous five months. It was suggested to him that following an interaction with her in October, lasting less than five minutes, it wouldn't have been possible for him to arrive at a view as to whether she was competent to take decisions or act on her own behalf. He replied: "I was looking to reach conclusions in the opposite sense in terms of her incompetence rather than her competence. Perhaps we are getting into semantics. I certainly would have liked to have had a much longer interaction with the patient. I think that's clear. I would have liked to have been able to discuss a range of situations with her, including her understanding of the infectious nature or not of her tuberculosis and of the danger to others. Asked by the bench whether it was possible that the patient does not understand fully the situation she is in, perhaps not for mental illness reasons but out of unwillingness to receive and take on board and appreciate the relevant information, the doctor said "denial is a very common defence mechanism that we all use when we hear bad news. At least initially. You know, 'It can't be true'. 'It isn't so'. 'That's wrong'. So anybody is going to use denial. Obviously it would be unusual to persist with denial, despite evidence to the contrary, over a long period of time". He was then asked whether, if persistence with denial was occurring over long period of time, that raised questions of a mental health nature. He said "obviously it does raise questions in that area, but I think, given my understanding that she is of a very stubborn disposition, you can see somebody, I think, without having a mental illness, digging their feet in and saying 'I'm not consenting to this, I want to go home, I have had my treatment.' I think you can do that without having a mental illness." Dr. Cooney confirmed that there was a security guard with the patient all of the time. It was suggested to him that given the fact that she wants to escape, her stance is entirely illogical. Moreover to date she hasn't initiated any process in terms of an appeal to the Minister which might lead to her release in hospital. He was asked if these facts gave him cause for concern about her competence. Dr. Cooney said that it didn't give him cause for concern. He felt that her views around TB treatment and AIDS treatment were influenced by the fact that she comes from South Africa. She had been treated there herself for tuberculosis in the past and she knew friends and other patients who had been treated there. Moreover it was his understanding that there is provision in South African law for compulsory detention and treatment of tuberculosis and she would know about that. He acknowledged that she might not appreciate subtle differences between Irish Law and South African Law. He speculated that a possible reason why she had not mounted an appeal was that a person might not mount an appeal if she believed deep down that her appeal wasn't going to succeed. Dr. Cooney was then asked when did he first hear that patient had been talking to herself. He

said that it was in the last couple of weeks. He stated that he had not been told of that previously by Dr. O'Connor. He wasn't aware in May of 2008 that there was any suggestion of strong evidence in support of hallucinations. He reiterated that on the second and third occasions that he had seen the patient, he had had very little chance to examine and assess her. However his opinion was based primarily on the relatively lengthy interview that he had with the patient in December, 2007 when she was far more co-operative with him and he suspected far more co-operative than she had been with Dr. Dunne. He characterised that assessment as quite a significant assessment and he stressed that the patient made her feelings and her logic clear to him at that stage. He asserted that while criticisms might be made of too much reliance being placed on his recent brief interactions with the patient, nevertheless "you must give a fair degree of credence to my experience in examining her because even if she has become more incompetent, which is debatable, I think her longstanding feelings or her well-established feelings around the treatment of her illness have to born in mind by the court as well". Questioned again as to the reasons why he had been asked to see the patient, Dr. Cooney stated it was quite a broad referral. There was a background history of depression. Patients with tuberculosis and patients with AIDS both have a much higher incidence of psychiatric illnesses. Moreover one of the most important aspects to the referral from Dr. O'Connor's point of view was to obtain an opinion as to the patient's ability to consent or to refuse treatment. He did not think that she was taking anti-depressant medication when he saw her in December, 2007. However, anti-depressants were being prescribed to her at that time. When asked if he was concerned about the fact that she wasn't taking her anti-depressant medication he stated that the reality is that a large number of people don't take the medications prescribed for them. That fact that she wasn't taking her medication wouldn't give him grounds to suspect that she was not competent to take decisions. He reiterated that she was refusing to take all medication and he stated "to be honest with you, her anti-depressant medication would have been the least of anybodies worries at that point in time. It would have been far more important that she was having her anti-tuberculosis medication and her AIDS related medications". He did not regard the fact that she was supposed to be taking anti-depressants, and yet wasn't taking them, as remarkable. Dr. Cooney regarded the fact that she was taking none of her medications as reflecting a lack of co-operation. It did not suggest a lack of competence to take decisions or incapacity on the part of the patient to act for herself. He stated that in 99.5% of cases not having a depression treated was not going to lead someone into a situation where they would become mentally incompetent. When asked if not having a depression treated would make her more vulnerable, he stated "I think I would have to make a distinction between the treatment and the illness. If you have a clinical depression, then people often have feelings of hopelessness, helplessness and can't see solutions and are unlikely to vigorously pursue very much. People with significant levels of depression find it hard to get out of bed in the morning, let alone go off and embark on a course of seeking legal advice etc. It's a fact of life that depression is a hugely common condition, you know at any one point in time affecting many of the population". He did not consider that depression would affect a person's capacity to make decisions and to make judgments unless they had quite a severe form of it. It would be extremely unusual within the diagnosis of depression to have what is called a psychotic depression, which is a particularly severe type of depression, where the person loses contact with reality and can have false beliefs or hallucinations. There was nothing in Dr. Cooney's assessment of the patient to support the diagnosis of psychotic depression. Dr. Cooney was of the view that it was not surprising or unexpected that a person in the patient's situation would choose not to fight against or challenge her detention. That was his experience in the case of patients detained under the Mental Health Legislation. A lot of his patients didn't want to go to the Mental Health Tribunal. Moreover these wouldn't necessarily be people who are psychotic. He felt it was not uncommon for people not to want to fight against the system. Dr. Cooney did not agree with the suggestion that the allegations made by the patient against Dr. O'Connor, and described in the applicant's affidavit, namely that he was liar, that he had raped the patient in the presence of her mother, and had held a gun to her head, were patently delusional allegations. He felt that they were explicable by the application of a very simple logic, namely that the best form of defence is attack. Her behaviour could possibly be explained in the context of creating a diversion and of not wanting to deal with questions that were being asked. He explained that he had had that experience lots of times with other patients, where somebody will throw in something that is totally off the topic as a mechanism to create a diversion because they don't want to talk about what it is that you are actually bringing up with them. He was asked if the allegations were open to any other interpretation. In reply to that he stated: "Well, obviously, you could conclude that this was an inappropriately held false belief which, in psychiatric terms, is a delusion, but you would have to see it in the cultural background as well, and in how people deal with situations. I am not sure … a lot of people in Irish culture will deal with allegations by slinging mud at the other person. It may be something in that context, I can't obviously be certain, I am just speculating."

It was put to Dr. Cooney that Dr. Dunne had stated in his report that Dr. Cooney's view was "that he was unsure, but thought on the whole, that it was best to assume the patient was fit to take decisions." Dr. Cooney said that he had not discussed the case with Dr. Dunne at all, though Dr. Dunne may have had access to correspondence between himself and Dr. O'Connor on the patient's file. He disagreed strongly with Dr. Dunne's paraphrasing of his opinion on the case.

Dr. Cooney was asked to comment on selected quotations from Dr. Dunne's report. In particular, the following quotation was put to him:-

> "I have severe doubts about this, but at the same time I am unable to say whether when she wasn't in the kind of state I saw today, she would be capable of taking decisions, but in the state I saw her today, in my opinion, she has some sort of psychotic process or disorder, almost certainly a long term confusional disorder secondary to serious physical illness in the form of TB and HIV positive, with the emotional trauma of knowing that neither her TB is getting better and also that she needs treatment for the HIV which perhaps she doesn't fully believe in, and so is trying to deny that she has it altogether. This will increase her tendency to get delirious or confused in the medical sense."

Dr. Cooney commented, "I think if you isolate somebody for a long period of time, it obviously is going to have an effect on their mental state. And you may end up in a situation when it has gone on for a long period of time, where people actually give up wanting to fight against it. I do not agree with much of what Dr. Dunne has put in his report."

He went on to disagree with the suggestion that the patient had a delirium, citing in support of his view his earlier observations concerning the patient's use of the TV remote control to facilitate the conversation between them. Dr. Dunne had related in his report that the plaintiff had spoken at "a ferocious speed and I could not make out one word she was saying". According to Dr. Dunne such fast talk can be characteristic of a delirium. Dr. Cooney disagreed that because the patient in this case was talking quickly it was suggestive of a delirium. He stated "I think you would have to look at where she is coming from, her background, her style of interacting, how she normally would talk with her mother and things like that, before you could reach a conclusion that this was bizarre". Dr. Cooney pointed to what he had actually said in the course of his recent letter to Dr. O'Connor setting out his conclusions as to the patient's mental state. He had

told Dr. O'Connor that it seemed to him that having regard to the presumption of competence that exists and, given the lack of any evidence of delusions affecting her judgment and the absence of any demonstrable confusion, that one must still presume she has mental competence. He was then asked whether, as a psychiatrist, looking at the length of time the patient has been in custody, the nature of that custody, the physical difficulties that she suffers from and the fact that she has a background of depression, he would have any concern as to her capacity to act on her own behalf at any level. He replied that he had not particularly considered that. He was then asked if the patient is an intelligent person, and he stated "I have no reason to suspect that she does not have normal intelligence". He did not know what her educational attainments were. He thought that she was literate but was not sure. He had no reason to believe that she was learning disabled in any way. Dr. Cooney was then asked to comment on Dr. O'Connor's evidence concerning an impression on his part that the patient's mental state had deteriorated over the last two years. Dr. Cooney stated that he did not hear Dr. O'Connor's evidence but that he did not disagree. He readily acknowledged that Dr. O'Connor had been seeing the patient for longer than he had and that he had also been seeing the patient very regularly. He felt in the circumstances that the court should give weight to Dr. O'Connor's evidence. However, he felt that the court should also take into account his (Dr. Cooney's) opinion based upon his three assessments. He acknowledged that his recent assessments had been very brief because of the patient's refusal to co-operate with him, but he emphasised that he was an experienced psychiatrist and stated "We can reach quite important conclusions on the basis of brief assessments with sufficient collateral history and support from others. So, I think, my reasonable detailed assessment of her of December of last year, I think that is an important thing for the court to take into account as well".

Dr. Cooney was then cross examined by counsel for the second named respondent. He said that he spoke to the patient in English, and that any difficulties they had were not language based, as far as he could tell. He felt that she was not disadvantaged by speaking in English, but that there was certainly a significant cultural element to her situation, and his. He was asked if the patient was severely depressed. He stated that when he saw her in December of 2007, he did not think she was severely depressed. He did not know if she was on anti-psychotic medication at any stage. He certainly did not recommend anti-psychotic medication for her. He was asked if he observed anything that would have led him to question the patient's judgment. He replied that from the very start her judgment was at issue. That was a given in the situation. However, taking bad decisions or exercising poor judgment does not equate to being incompetent to take decisions, or to being delusional. He was asked if he had seen anything that would lead him to change his opinion as to her mental state. In reply he said "Certainly I would be concerned by what the patient said to Dr. Dunne, that I just heard about this morning, and I would be interested to see if that becomes something that she retains and repeats over a long period of time, because then – I am certainly not saying that my opinion is absolutely 100%. I can only give the court my best opinion as it stands. But if the patient is saying increasingly bizarre things that are persisting over a long period of time and maintaining that in the light of evidence to the contrary, and arguments to the contrary, obviously I would have to take that on board over a due course". He reiterated his view that the bizarre things that the patient was saying might possibly be a diversionary technique and that they might also possibly be evidence of psychosis. However, in his view it was not possible to say that she was psychotic on the basis of one episode. The patient needed to be kept under observation and he needed to keep in mind that there may be something new developing. Unfortunately her illnesses have a very poor prognosis and her illnesses also have a significant correlation with dementia and other mental health problems. It was therefore perfectly conceivable that she would develop dementia and other mental health problems. That was why he expressed a willingness to Dr. O'Connor to see the patient again at any time should they feel that she was in a delirium or that she was beginning a dementing process. Having been asked by the bench about the patient's ability to assimilate information given to her for the purpose of making an informed decision, a proper decision and a rational decision, Dr. Cooney said "from my point of view, if somebody is faced with a complex decision to make, if you give them a whole load of information, which is increasingly becoming the fashion, and the requirement from a medicological point of view, you actually end up with the patient saying 'For God's sake doctor, just tell me what you would do if it was your mother. I do not want all this information'". Dr. Cooney explained his approach in that situation, he said "we would look at someone and say 'Look, can you explain to me what it is the doctors have advised you?', and if that person can give me a reasonable account of what the doctor's advice has been, and say 'I have heard their advice and I am not taking it ……..' ". It was pointed out to Dr. Cooney by the bench that the lady's position seemed to be ambivalent. On the one hand she does not want to stay in hospital, but on the other hand she will not listen to the information which would enable her to leave hospital. Dr. Cooney countered "Well, she will not take advice". He was asked if there was a difference and he said "I think so". He acknowledged that the patient was under great stress and that there were a lot of stressors in her life, both medical stressors and social stressors. He said there is clearly evidence that the longer a person spends in a situation, the more they get into a sort of learned helplessness mode, so that if the door is opened eventually and somebody says "You are free to go" she might feel "I am too scared to go" or "I am too frightened. This is what I know and this is what I kind of tolerate". Dr. Cooney related that he understood from Dr. O'Connor and the nurses on the one hand, and from the patient's mother on the other hand, that the patient's interest in her children had significantly reduced. This contrasted with her attitude when Dr. Cooney met her first. Dr. Cooney felt that this was due to a loss of contact with the outside world having been in isolation for a year in circumstances where she has minimal interaction with other human beings who are, in any event, all masked, gloved and wearing aprons. That concluded Dr. Cooney's testimony.

The evidence of Dr. David Dunne

The court then heard testimony from Dr. David Dunne. Dr. Dunne was known to the court. He is a consultant psychiatrist and psychotherapist with very many years of experience. He explained that he was asked by the applicant's solicitor to carry out an assessment of the patient, and that he did so on the 23rd October, 2008. The purpose of his examination was to assess the patient with respect to her capacity to take decisions and her general mental health. He confirmed that he had been present in court during the testimonies of both Dr. O'Connor and Dr. Cooney respectively. He described his own examination of the patient. He had a consultation with her in her isolation room. He stated that there was a lot of concern in the hospital for his welfare. One of the nurses told him that she would have to come into the room with him in case accusations were made against him by the patient. He was also required to gown up and wear a mask, and he was given glasses or goggles in case the patient spat in his eyes. He was told that there was a genuine risk that this might happen. He was also told that the patient had attacked people before. Before he went into the room he was told that the patient's mother was already there and he was asked how did he feel about that, and he replied that he thought it was a good thing. He stated that the patient's mother stayed throughout his assessment and he felt that was helpful. Dr. Dunne told the court that in the course of his conversation with the patient she informed him that she had been sexually assaulted by Dr. O'Connor, that this had happened in front of her mother and a number of other people, including Dr. O'Connor's wife, who is called Eileen and who she said worked in the kitchen in the ward. He said it was very hard in the course of the interview to get the patient away from this. She would come back to it spontaneously. Dr. Dunne said he subsequently established afterwards from the patient's mother that there were times when she was mostly alright, but that there were days when she talked to somebody else (i.e. a non-existent person). Dr. Dunne said the patient's mother

also told him about an event in May, "when she got so suspicious or whatever, that she took the mattress and slept on the bathroom floor". Dr. Dunne said that he tried to talk to the patient about other things, apart from treatment, for the purpose of seeing if she had some sort of organic mental condition and to test her orientation. She was extremely resistant and would not answer simple questions like, roughly how long was she in the Mercy, how long was her mother with her, how often had she been visited. He said that this can be a sign of somebody who has an organic brain condition and he digressed to explain that he had significant experience in dementia, having run the first dementia unit in the public service in Ireland. He said that persons with organic mental conditions tried to hide it and will not answer your questions. So the fact that the patient in this instance did not answer the questions raised queries in his mind as to why this was so. He learned later from the nurses that there were times when the patient appeared to talk to a third party. The nurses were not sure whether this was a psychotic thing, or whether she just did this when she did not want to talk to them. It was clear that this had been going on for some time. The picture was not consistent with what are sometimes called functional psychiatric disorders such as, schizophrenic disorder or persistent paranoid disorders which are differentiated from schizophrenic disorders. On balance therefore, he did not feel that she was demented. He was concerned, however, that she might possibly be delirious. He explained that in delirium, which is the old name, it is now called confusional disorder, your awareness of your surroundings varies and the symptoms vary. They can come and go and wax and wane. He felt that delirium was quite a strong possibility in this case, but he is not certain that it is there. He also had regard to alternative possibilities and in particular – was she feigning? Had she reason for feigning? In this context he stated that he was not aware at the time that she is the subject of a deportation order, and only picked that up from listening to Dr. O'Connor's evidence. He explained that as a psychotherapist he has been trained to regard everything that people do as communication. So, he was looking at her behaviour and the things that she was saying to him very closely. On the one hand there was clear evidence that she wanted to get out of the place, but on the other hand there seemed to be evidence that she wanted to stay in it. He said you could hypothesise that she was actually creating a situation to ensure that she would be kept in hospital and he asked himself, would she have a reason for that? He continued "I felt, well, if she thought she was dying and, having incurable illnesses, two very serious illnesses, that she had not much hope, that maybe she decided that she was going to be looked after. That could create a situation. That was one possibility". He referred to the Diagnostic and Statistical Manual of the American Psychiatric Association Version 4 (otherwise DSM 4), which differentiates malingering from a fictitious disorder. He stated that "in both cases people feign mental or physical illness, but in malingering it is done like, to get a passport, or to get civil damages or to get into hospital or something, whereas fictitious disorder is feigning it so that you can [adopt] the sick role, and be looked after". In any case he had these two possibilities in mind, namely that she was on the one hand possibly delirious and on the other hand possibly feigning and he then observed her to be talking very very quickly. People who are delirious or confused sometimes do this. At this point he was of the view there was a strong possibility that she was delirious. He also considered the possibility that she was suffering from a degree of sensory depravation by virtue of her isolation and the fact that the only contact she had was with people who were masked and gowned. Such sensory deprivation can cause people to become psychotic. He bore this in mind as another possibility. He said that although she talked freely about what she claimed had happened to her (the allegations concerning Dr. O'Connor etc), and her mother being present witnessing it and all the rest, she would stop talking whenever he attempted to steer the conversation onto the topic of her treatment. He also said that he asked her did she want to go to court and get out of the hospital, and he got a very vague answer from her. He said "She sort of said she wanted to get out there, but she did not want to go to court". It was a very vague kind of answer which implied to him that she was ambivalent, and that she had reasons for wanting to stay in the Mercy as well as for wanting to get out of the Mercy. Dr. Dunne felt she was very disheartened about her illnesses, because he asked her several times why she did not take the treatment, and on occasion she did say that she had seen other people get better. He had the impression that she felt that she was kind of a hopeless case and was in despair.

Dr. Dunne stated that he was very conscious about personality and cultural issues. He had experience of working with people from different cultures in the UK and realised the importance of appreciating their different backgrounds. Nevertheless, he remained of the view that there is a strong possibility that she was delirious or had a confusion state at the time that he saw her. He reiterated that he based this view not just on the nature of the statement or allegations that have been made, but also on the fact that the patient had been avoiding his questions which were directed at establishing her orientation in time. He said that people with organic brain damage sometimes tried to cover up the fact that they don't have reasonable information. They would be aware that they don't have it. They hide it. This is more so with dementias. People with dementias tried to cover up their bad memory by changing the conversation. But if you ask them what day it is. They don't want to answer. It indicates a certain defensiveness, that they don't want their lack of ability or their incapacity to be spotted by whoever is trying to examine them. He stated it was quite striking how the patient changed the conversation any time he got onto the subject of orientation, even in an informal way. He said this in itself means nothing but added to the extraordinary statements that she had made, it made him think that she could be a bit out of touch and delirious. There was then the third feature of the manner of her speech. He stated that she started to talk so quickly as to become incoherent, and then she would talk in her own language, though sometimes that was to the mother, but some of it, he thought, was also directed at him. He said that when he is talking about fast talk, he is talking about incredibly quick talk, which was quite different from the way that she spoke most of the time. Certainly, she was under great emotional stress. He felt that the overall presentation fits with the delirium theory, where a person can be out of touch for a short period of time and then come back in touch. Dr. Dunne said that he spent approximately an hour with the patient. He then went to his office and dictated his report there. His bottom line is that he considers that there is a high possibility, but he would not go so far as to say a probability, that that patient is delirious. Asked if he was diagnosing her as delirious, he said that he was fairly close to it but he would like to have more information. The correct way of putting it was that he was very suspicious that she is suffering from delirium, but he was not definite. Dr. Dunne was then asked to comment on her capacity to make rational decisions, and to seek a vindication of her rights. Dr. Dunne's opinion was that in the state she was in when he saw her, no matter what its cause, she would not have been capable of giving instructions to anybody. She was not in a rational state. Dr. Dunne was asked about what he knew concerning her previous psychiatric history. His previous knowledge was based upon what was contained in Dr. O'Connor's report on foot of which the decision to detain her was based, and also on the evidence that he had heard given by previous witnesses. He said that Dr. O'Connor's report had set out a history of suicidal ideation, that she was unable to cope at home and that she had expressed thoughts of extreme depression. Further, it was stated that her behaviour had become more inappropriate and she had become more depressed and upset. He was now aware from the evidence that she had not been taking any medication at all, including anti-depressant medication, since in or about the time of her admission. He did not think the issue of whether or not she took her anti depressants was very important. The more important question was whether the depression could have interfered with her decision making abilities. He said that depression can, in some people affect their judgments. In other cases it does not. He said that a lot of depressed people become indecisive, and they also tend to have a gloomy outlook. However, he was in agreement with Dr. Cooney, that the type of depression he was speaking about was very different from psychotic depression, where the depression is so severe that the patient is totally out of touch with reality. He was not speaking about that. He did feel that the more

usual kind of depression could affect her capacity to make decisions and to make judgments. He said you would have to sit down and look at it and look at what was being decided upon. Different people could be affected in different ways. Depression might affect their capacity to take certain kinds of decisions and not others. He concluded "it's not something you could be too clear [on], and certainly it is not something I would hazard an opinion on". Dr. Dunne stated that before he entered the patient's room, he was expecting to have difficulty with the patient on account of the fact that she had been isolated for nearly a year. Asked whether the isolation regime might have affected or worn down her capacity to act for herself, he stated "there would be two elements to it, not just the isolation but the fact that she was looked after". He then endeavoured to explain what he meant. He says that if you don't use a muscle it becomes atrophied. Similarly, if you become unused to taking decisions and get into a dependent or sick role, then it becomes more difficult to take decisions when that is required. He was asked if the fact that she had on a previous occasion barricaded herself into the bathroom, having dragged in her mattress to sleep on it, and would only communicate through a crack in the door, gave him cause for concern. He said he would be concerned. He had had people do that. Some people would do it just because they are angry, and some would do it maybe to get attention, and yet others would do it because they were paranoid. He said it was important to try and work out the explanation. He was asked if the patient gave him any explanation as to why she was not taking her medication and refusing to submit to tests. He said "Yes, she did. She said that she had had it and it hadn't done her any good. She was angry, and she said she was angry about it." He said that he tried to ascertain if there was a despair element to her presentation. It was implicit in what she was saying that she did not see a future, and he stated that anger can be a cover up for despair or depression. He was asked by the Bench if one can have a level of despair which so debilitates you that you cannot function in the normal way and, if so, does that come within the parameters of any known syndrome or mental illness. He said that normally this comes under what are known as depressive disorders. If you look at the early stages of those states, they are often seen to be proceeded by anger. He felt that her anger could be due to that. It could also be due to just frustration, partly in being locked up, but also frustration at the fact that the treatments were not working as they had for her friends. He felt it was clear from the evidence of Dr. O'Connor that she had a kind of suspicious attitude all along. He agreed with Dr. O'Connor's characterisation of it as a persecution complex. So he felt her anger could have been due to frustration. On the other hand, she could be in fear and her anger could act as a protection against admitting to herself as to what a grim situation she was in. He said she was even angry about the possibility of having AIDS and she said to him "I couldn't have AIDS". Dr. Dunne was of the view that there was little prospect of anybody getting through to the patient. He referred to the fact that Dr. O'Connor had said that very many people had spoken to her, including the chaplain, but that nobody had succeeded in persuading her. In his view it would have to be somebody who she would see in a special way. Even though she has regard for her mother, and her mother has a high regard for her and is very concerned for her, she won't listen to her mother. Dr. Dunne's view was that if you are to have influence with people, you have to be something in their eyes, and he was unaware of anybody who had the necessary degree of influence with the patient, that is, somebody by whom she would be guided or be prepared to listen to. He felt it was very undesirable from the point of view for her mental health, that she should remain in long term isolation, especially if she wants to get out. But, he added, "At the moment I don't know what the hell anyone can do. It's an impossible situation, and I have sympathy with everybody in it." Dr. Dunne felt that the only way that she wouldn't be in danger of developing a serious psychiatric illness in the future is if she herself feels she is dying and that she wants to be there because she is being cared for. He acknowledged that it is possible that that is what the patient is at but considers that his other theory, namely that she is suffering from delirium, represents a stronger possibility. That concluded Dr. Dunne's evidence in chief. He was then cross examined by counsel for the first named respondent.

Dr. Dunne confirmed that the circumstances in which he saw the patient were not particularly conducive to a full and comprehensive psychiatric assessment. He felt a gown, a mask and goggles was not helpful. Nevertheless he was able to make conduct with her and was amazed at how friendly she was when they were chatting about ordinary things. They spoke about the weather and ordinary things. She wasn't totally out of touch. She had a television. He was making friendly conversation with her, trying to get her at her ease and they were fine until she starting talking about what he characterised as "this rape business". Asked about the level of her intelligence, he said that he didn't think that she was stupid or that she had an intellectual disability. He suspected her level of literacy might be low. He confirmed that she had no difficulty in engaging with him using English. He said that when he tried to explain to her about this court case, and that if she really wanted to get out of the hospital she should get involved in it, she didn't seem to take in what he was saying. That made him think that either she didn't want to get involved, or, more likely, that she didn't understand. Dr. Dunne said that she didn't want to discuss the basis upon which she was in hospital. When he attempted to discuss that subject she would get angry and she would turn away and say she didn't want to talk about those things. She would then start to talk at great speed and he didn't know what she was on about. Dr. Dunne was asked if he was of view that the patient understood the information that had been imparted to her but was just refusing to accept it. He said that she was refusing to accept that she has AIDS. She understood that she had been told that she had AIDS. She also understood the diagnosis of TB. Dr. Dunne agreed that she knew the ramifications of it of it, the effect it might have on her health and how it might affect other people. However, he stated that she didn't seem to understand why it was that the treatment hadn't worked and why she should go on with it. He also said that what she didn't seem to understand was the legal side of it. As far as her AIDS was concerned he stated "I suddenly realised that it was a pure denial, her rejection of this, and a very angry rejection." Pressed in respect of the matter, he confirmed that she knew that she had been diagnosed with AIDS, however, she was saying very angrily "I don't have it". Dr. Dunne acknowledged that he would have liked to be able to observe the patient over a period of a few months, to have chatted with her, to have talked regularly to the nurses, to the ward cleaner and to all of the people who had contact with her on her on-going basis, in order to form a better picture. It was put to Dr. Dunne that while Dr. Cooney had expressed a similar desire to have more involvement with the patient, he did not share Dr. Dunne's views about her. Dr. Dunne said, "I know, and I want to make it plain… that other views are as good as mine at the present time. I would regard them as that. Even though I am stressing my opinion fairly strongly, I am recognising that you can make arguments against it which are equally strong." He thought it was clear from Dr. Cooney's testimony and the report that he had made to Dr. O'Connor, that when he saw the patient in December, 2007 he didn't see her in the same state that she was in when he (Dr. Dunne) saw her. In that regard he thought it was of significance that Dr. O'Connor was of the view that she was fit to take decisions in November or December, 2007 but that he now had doubts about her fitness to do so. Dr. Dunne said "you could make different interpretations of the state she was in when I saw her and I considered all the interpretations. In the end I decided that probably at this stage, for a variety of reasons, but most of all the chronic sickness, and the severe sickness, and the fact that they are infectious types, she is probably subject to come and go, changes in the level of her awareness, and the hallucinatory experience does occur in the confusing states". He added "The problem is… there isn't enough information to be too definite about it". It was suggested to Dr. Dunne that if the patient was delusional the extent of her delusions was unclear as well. Dr. Dunne responded "If she was acting out and making up the story that she gave me, she is a very good actress because she was carried away by it and she seemed to believe. But the other thing was… she talked so quickly as to become incoherent and then relapsed into her own language and then she was defensive. I

thought she was defensive anyway. About my exploring her orientation in time." …. "All of that would fit with her try to cover an organic state which is interfering with her abilities". He also attached significance to the fact that others observed changes from time to time. Her mother's accounts and the nurse's accounts were very clear and they were remarkably similar. She was grand most of the time and fully in touch with you and then she would be talking away to somebody who wasn't there. Everyone was asking the same question "was this real or not?" Nobody has ever answered it, but it would fit in with a delirium.

Dr. Dunne was then cross-examined by counsel for the second named respondent. It was suggested to him that the kind of defensive behaviour he was speaking of occurred in the case of people who had organic brain damage which didn't seem to be the case here. Dr. Dunne stated that you can have your brain misfunctioning due to an acute infection, without having dementia. He further stated that people with AIDS can have their mental functioning distorted in many ways. He was asked if he would accept that if the patient wasn't feeling picked on before, she might very well be feeling picked on now and be defensive as a result. He replied "I would accept that at the beginning, and that she has been consistent in refusing treatment and that she knew what she was doing when she refused it at the beginning, or appeared to. Whether she was fully rational then or not is another matter. But she wasn't subject to a psychiatric disorder. But I think that there is a possibility that she has developed a psychiatric disorder. That is what I am saying." Dr. Dunne was asked about the patient's anger. He acknowledged that it is fair to say that the lady is very angry. He added that he had also said that anger can actually, although it is a part admission, be a sort of defence mechanism against despair and depression. It was put to him that anger is a standard reaction to any loss and that in and of itself it was not unusual. He agreed that it was not unusual. He added that "In itself it isn't necessarily pathological and it isn't in a lot of people. There are occasions when it becomes pathological." Referring specifically to the patient's anger he stated "Now, the problem that I see with this lady is that -- I mean, there is the personality factor. If there's also a confusion factor, which I think there is,… it's going to make it very difficult for her to be helped, and I don't at the moment --see a way to help her to cope, some kind of programme that would resolve the situation." He agreed that the patient has an awful lot to accept and he commented that the people who are in that state can be very irrational. He was asked to comment on the fact the patient is subject to a deportation order, and the fact that she was very definite in stating to Dr. Dunne that she didn't want to go back to South Africa. He stated that that " …would be a reason for staying in the Mercy, and would be a reason for feigning. She could also be feigning because she feels she is going to die, and it is creating a situation where she has to be kept in, this and all of the rest. But I don't think she is. I think the odds are against that." When asked if the patient understood the nature of having full blown AIDS and the nature of having TB and what that would mean, Dr. Dunne confirmed that she does understand that. However, he added "when a person is confused, it doesn't necessarily mean that they don't understand, that they are totally confused about everything, or totally out of touch with everything; they are not." Dr. Dunne was asked if the plaintiff's presentation could be explained by a very very angry, very frustrated stubborn person who is afraid and simply doesn't want to face up to the consequences of what her fate appeared to be. He agreed that this was a possible explanation "to a degree; only what I saw in that room didn't quite fit with that". He elaborated that he discerned an element of lack of understanding, which was not just there because the patient was in a highly emotional state. He said he was offering that view not just as a psychiatrist, but as someone who had practiced psychotherapy. The patient "struck me more like somebody who was on the organic side, on the confusional side, on the purely emotional side." He explained that because emotion comes into confusional states; not alone do people with confusion get more emotional but stress from emotional distress can increase someone's capacity to become confused, or to get into confusion from time to time. He was asked whether it would be completely unheard of for somebody speaking in their second language, who was under great emotional stress and in difficulty, to revert to their native language. Dr. Dunne answered in the negative. That concluded his testimony.

Further evidence of Dr. Cooney

Dr. Cooney had remained throughout Dr. Dunne's testimony. The court, taking the view that what it was engaged upon was the conduct of an inquiry rather than the hearing of an adversarial cause, indicated that it would be grateful to receive all possible assistance on the difficult question of the patient's mental state. In the circumstances the court enquired of Dr. Cooney if he wished to add anything in the light of what Dr. Dunne had had to say. Dr. Cooney offered some additional remarks and in the course of doing so stated that he had hoped that Dr. Dunne might be able to give a slightly more holistic view of her situation. He added: "I think we have to see her in the light of holistically where she is coming from, and her dealings with the Irish Courts so far, giving a very biased view. The Irish Courts are sending her back to South Africa. The Irish Courts have taken her children off her and the Irish Courts have locked her up in a hospital, so I am not sure, if you were coming from that background, that when you are given an opportunity to come to court to fight your case, you would necessarily be jumping up to take it". He also expressed the view that it might have been to her advantage to keep quite about her past treatment for tuberculosis and HIV and to deny that "because if she is coming to Ireland and saying 'I have got AIDS and I have TB, a type of highly resistant TB' that is going to make her a lot more likely, she may well feel, to be deported. Promptly, as well.". Dr. Cooney felt that these aspects of her background had not been adequately taken into account. He also stated that he didn't think that it was fair to say that she had been in isolation. There had been hundreds of people in to see her. It was not like she is inside a white walled cell. She had lots of incursions, admittedly brief, into the room. He agreed that persons visiting her in a room were unfortunately gowned and goggled. However, she had visits from her children and from social workers in her hospital room. She had children's drawings which he presumed were by her own children, pinned up on the wall and around her bed. She had some of the comforts of home. While her situation was far from ideal, she was not in the same in the situation as a lone yachtsman going around the world; she was not subjected to that level of deprivation. His sense was that cultural differences were possibly a significant factor. He said he would pose the question, is it a common way of dealing with problems where she comes from to attack and make to allegations against the person confronting you, as way of taking a lot of their creditability away. That might well be a cultural thing. He said "I think, in a situation where you talk to a strange psychiatrist, who has come in as part of a legal process, and I presume about whom you would be highly suspicious, to deal with that person with your mother present, by breaking into your mother tongue, may well be along the lines of saying 'What the hell is he doing here?' or 'He has got to get out of here' or, she may well have been saying things about Dr. Dunne. I would be much more concerned if she was talking with Dr. Dunne in private and started breaking into her mother tongue". Dr. Cooney stated that he never experienced her using any other language. Dr. Cooney felt that Dr. Dunne had also failed to take into account how physically well the patient is in fact at the present time. She is well nourished, has a good appetite, and is caring for herself quite well. There was no bad body odour or anything like that from her. That is not typical of a person suffering from depression. It is more typical of somebody who has given up. There were none of those sort of markers. He did not think that Dr. Dunne's theory of the patient suffering intermittent or transient episodes of delirium was likely. That concluded Dr. Cooney's further evidence.

Further evidence of Dr. Dunne

Dr. Dunne was in turn given an opportunity to reply briefly to Dr. Cooney's additional remarks. His only additional comment

was that although there was a clear disagreement between himself and Dr. Cooney the disagreement between them was not quite as big as it looked. He accepted that intermittent episodes of delirium would be very unusual. Notwithstanding that it was very unusual, he remained of the view that it was a distinct possibility in this particular case.

The evidence of Dr. Margaret O'Sullivan
The next witness was Dr. Margaret O'Sullivan who was examined in chief by counsel for the second named respondent. She stated that she is a registered medical practitioner and that she qualified in 1982. She is a specialist in public health medicine with the Department of Public Health in Cork, employed by the HSE. She produced the original "Section 38 Order" relating to the patient, namely the order dated the 10th December, 2007. She was asked to explain her part in the invocation of s. 38 against the patient. She stated that she works in the area of health protection. In the course of her work she is involved in the surveillance, prevention and control of infectious disease, including TB. The patient's case was notified to her in October of 2006 and, as with all cases of TB, her contacts were traced, tested, treated where necessary, and followed up appropriately. Dr. O'Sullivan stated that in this particular case Dr. Terry O'Connor, Consultant Respiratory Physician, had requested their assistance at an early stage in managing the patient by means of directly observed therapy, as his team were having difficulty in getting her to comply with her medication regime. According to Dr. O'Sullivan that persisted for quite a period and there were increasing difficulties with the patient which culminated in her refusal to co-operate with any treatment. Dr. O'Sullivan stated that it had reached the stage in December of 2007 where Dr. O'Connor had felt it necessary to contact the Department of Public Health to express a high level of concern with the position then obtaining, and to say that he felt that s. 38 needed to be invoked. Dr. O'Sullivan said that her department then consulted their legal advisors who advised them as to what needed to be done. Specifically they were advised that Dr. O'Connor needed to stipulate certain facts with regard to the patient in a formal communication to them. Dr. O'Sullivan acknowledged that the formal order was prepared by Dr. Elizabeth Keane, the Medical Officer of Health, whom she knows and works with. The s. 38 order was produced and identified by Dr. O'Sullivan who confirmed that she was the co-signatory on the document. It was signed on the 11th December, 2007. The judge asked the witness why it was that the s. 38 order merely named the patient but did not state any address for her. Dr. O'Sullivan could not say, beyond stating that the patient was the only case of that name that her department had had notified to them as a case of TB. Moreover she was aware of the patient's medical circumstances from a report sent to her by Dr. O'Connor her treating physician. She had that report at the time that she signed the order. She was asked what happened to the order after it was signed, She replied that it was sent to the Minister for Health. It was both faxed and posted to the Minister for Health, and it was also sent to various personnel in the HSE and specifically, Professor Brendan Drumm, Chief Executive Officer; Dr. Jim Kiely Chief Medical Officer and Dr. Pat Doorley Director of Population Health. The witness stated that she did not fax the document personally, but she was present in the office when it was faxed by a member of the secretarial staff. A telephone call was made afterwards to make sure that it was received. Dr. O'Sullivan stated that the patient was not in hospital when the order was made. She confirmed that the patient had to be detained by a member of An Garda Síochána. She was asked how the order was notified to her and how it was executed. She stated that the patient was discovered to be in Middleton, and both she (Dr. O'Sullivan) and the senior medical officer who had been involved with the patient's directly observed therapy (a Dr. Dillon), travelled to Middleton to see her. The patient was given the written order and it was also explained to her. She was then brought to the Mercy University Hospital by An Garda Síochána. Dr. O'Sullivan stated that she had no indication that the patient was not literate but she cannot confirm the position one way or the other. She stated that Dr. Dillon explained to the patient what the document contained and that she had the right to appeal. When asked what regime was put in place with a view to safeguarding the patient's rights once she had been brought to the hospital, Dr. O'Sullivan stated she was in very close communication with social workers all of the time and we were informed that she was repeatedly advised about her right to appeal. When asked if any regime was put in place to review the patient's case periodically, not just with respect to her respiratory problems, but also with respect to her mental health and all of that, so as to obtain a holistic view of her situation, Dr. O'Sullivan replied that the patient was under Dr. O'Connor's care. The witness stated that she and her colleagues were very concerned when they heard that the patient was refusing to take treatment. They wrote to Professor Drumm, Dr. Kiely and Dr. Doorley once again, setting out their concerns about the gravity of the situation, about the fact that the legislation contained no provisions for review of a case, and about the fact that the patient was going to be indefinitely detained for so long as she refused treatment. The witness confirmed that the reality of the position is that the patient is going to die in the Mercy University Hospital unless she consents to treatment. Dr. O'Sullivan confirmed that Dr. Dillon is a senior medical officer with the Department of Public Health and that she works mainly in the TB contact tracing service.

Dr. O'Sullivan was cross examined by counsel for the applicant. She was asked to produce the letter that she had referred to in her evidence in chief, namely the letter addressed to Professor Drumm, Dr. Kiely and Dr. Doorley expressing the concerns of herself and her colleagues. She did so. It is a letter dated the 18th January, 2008, and it is in the following terms:

> "RE – TB case, detention and isolation Order: Health Act 1947, - section 38 [patient Ms. N.I.]
>
> Dear Professor Drumm,
>
> We wish to bring to your attention that an order was made on the 11th December, 2007, in accordance with the above Act, for the detention and isolation of the above named patient in a specialised negative pressure room at Mercy University Hospital (MUH). This followed a request for the order and the furnishing of information from Dr. Terry O'Connor, Consultant Respiratory Physician, MUH.
>
> The patient has been a patient of Dr. O'Connor since October, 2006 when she was diagnosed with smear positive cavitatory pulmonary TB. She had been on directly observed therapy in the community with which there were major difficulties. Since the end of November, 2007 she has refused all treatment. Legal advice was obtained prior to proceeding with the order.
>
> The order was on the basis that the patient
>
> • Is a probable source of infection (multi – drug resistant pulmonary TB case; not compliant with treatment)

- Her isolation is necessary as a safeguard against the spread of infection and
- She cannot be effectively isolated in her home.

This patient continues to refuse all anti – tuberculous treatment. She was given a copy of the order at the time. She has been advised of her right to appeal. It is our understanding that the order holds until the case can be certified as no longer being a source of infection. No appeal has been taken as yet.

To our knowledge, few such orders have been made previously in Ireland. However, what really needs to be highlighted is that there would appear to be no precedent for such a case to refuse all treatment of their condition. The situation therefore presents extremely challenging ramifications because of a potentially indefinite time frame of detention and isolation.

While this order is addressing the potential dangers to the general public, it clearly has major implications for the place of detention i.e. MUH and the staff at that hospital. It is particularly tragic on humane grounds.

We are highlighting the above to you in view of the gravity, complexity and unprecedented nature of the situation. In addition, it is probably right to urge that the content and application of this Act be reviewed, giving its obvious shortcomings when refusal of treatment is an issue.

Yours sincerely

Dr. Elizabeth Keane, Director of Public Health

Dr. Margaret B. O'Sullivan, Consultant in Public Health Medicine

c.c. Dr. Terry O'Connor, Consultant Respiratory Physician, Mercy University Hospital, Cork

Mr. Pat Madden, Chief Executive, Mercy University Hospital, Cork

Mr. Gerry O'Dwyer, Hospital Network Manager, Aras Slainte, Wilton Road, Cork

Dr. Kevin Kelleher, Assistant National Director of Population Health – Health Protection, Health Service Executive, 31 Cassons Street, Limerick."

Dr. O'Sullivan testified that no written response was received to that letter. There were apparently verbal communications between officials of the Department of Health, and officials of the Health Service Executive, centering on the need to obtain legal advice and the need for guidance generally. Dr. O'Sullivan was asked if the issue of assessing the patient's mental capacity or her ability to act on her own behalf ever came up. She stated "we asked that repeatedly, and what we were being told was that she was fit." Dr. O'Sullivan was asked the following questions by the judge. "Was there any arrangement put in place that some person would act as an advocate on her behalf, you know, to, I suppose, negotiate with the Mercy Hospital who are detaining her, issues relating to her welfare, to her rights, to her entitlement to appeal, to accessing things like legal advice? I mean, as I understand it, she is of limited financial means. She is a foreign national, there are huge cultural problems. There is a language problem. There is a literacy problem. There is an asylum dimension to this thing. She apparently is the subject of a deportation order. She faces multiple multiple adversities, and therefore one would think that if this very draconian power is being implemented that some regime would be put in place to provide minimum safe guards for her rights. Was anything done in that regard?" Dr. O'Sullivan replied "Dr. Dillon… certainly visited her…a couple to times early on in the period, and there were a number of meetings in the hospital as well. I was not at any of those". She went on to state that she understood that the chaplaincy was actively involved with the patient. She was unable to say whether that was occurring in a structured way or whether it was ad hoc. She was asked who had responsibility for overseeing the case, and she said it was herself and Dr. Keane. Dr. Keane was the Chief Medical Officer in the terminology of the Act, and the main signatory to the order. She was the co-signatory. She was asked by the judge who on an ongoing basis was responsible for ensuring the welfare of the patient and vindicating her rights. The witness stated that she did not know. When pressed, she stated that the patient was under the care of the respiratory physician in the hospital and she had social workers working with her. She also had the chaplaincy service and numerous other allied health workers. However, the public health department's role was concerned primarily with the public interest. With regard the patient's welfare and rights she said there "were ongoing meetings in Mercy University Hospital" convened by Dr. Terry O'Connor. She was not at any of those meetings. When asked if anybody had considered the possibility of seeing if the patient could be taken into wardship she replied "not by us". Dr. O'Sullivan was unable to say who physically handed the order to the patient. She presumed it was the guards, but it might have been Dr. Dillon. She was certainly aware that Dr. Dillon spoke with the patient. That concluded Dr. O'Sullivan's evidence.

On the 30th of October, 2008 the court heard evidence from Dr. Elizabeth Keane, Dr. Anna Dillon, Ms. Marie Buckley and Mr. Colman Rutherford.

The evidence of Dr. Elizabeth Keane

Dr. Keane stated that she is a consultant in public health medicine. She was appointed Director of Public Health to the Southern Health Board region in 1995 and following the changeover to the HSE in 2004 she became Director of Public Health for HSE South. As part of her job she acts as Medical Officer of Health for the counties of Cork and Kerry which counties comprise the functional area of HSE South. Dr. Keane stated that she has a letter of appointment specifying that she has been appointed to act as a Medical Officer of Health. She was asked if the letter designates her in writing to

perform the functions of a chief medical officer for the purposes of the Health Acts, 1947 to 1953. She stated that she didn't know that. The court then stated that it would require proof of such designation and counsel for the first named respondent undertook to provide such proof in due course. Subsequently counsel handed into Court a document on HSE letterhead entitled "Delegation Order", dated 1st June 2007, and under the signature of Dr. Patrick Doorley, National Director of Population Health. This document purports inter alia to " …sub-delegate to Dr. Elizabeth Keane all functions related to … the Chief Medical Officer of Health (as set out in the Health Acts 1947-2005 or any other legislation or regulations made thereafter, as amended, restated, revoked or replaced from time to time) for the HSE South region, i.e. Counties of Cork & Kerry."

Dr. Keane stated that she had been made aware of the patient's case by Dr. Sullivan and by Dr. Dillon. She had been briefed on the difficulties that had been encountered in getting the patient to comply with her medication regime. She herself became involved with the case in December of 2007. She received Dr. O'Connor's report of the 10th December, 2007, which was an up-dated version of a somewhat similar letter dated 5th December, 2007 that she had also received from him. The letter of the 5th of December 2007 had had to be up-dated to take account of changed circumstances. She discussed Dr. O'Connor's letter of 10th December, 2007 with him in the course of a tele-conference and also took advice from the HSE's legal advisors. As a result of all of this she became satisfied that the patient was a probable source of infection, that she had an infectious disease which was one of those that were listed in the Schedule of Infectious Diseases, that her isolation was necessary because of the risk of spread of the disease, and that the patient couldn't be isolated in her own home. It was Dr. O'Connor's specific advice that the most appropriate place for her was in the Mercy University Hospital because they had a negatively pressurized room. Dr. Keane stated she had never previously been involved in a s. 38 case. They were very very rare. Her department obtained legal advice because they were very aware of the gravity of the situation and the invoking of s. 38 was considered to be a measure of last resort. She was aware that in the past and in other cases certain of her colleagues had threatened to invoke the section and this had resulted in the patients concerned complying with what was required of them so that an order was never actually made. She had initially hoped that that might happen in this case too. The s. 38 order was produced to her and she identified her signature on the order. She stated that the order was based on the report that she had received from Dr. O'Connor. This was appropriate because he is a respiratory physician and he was the patient's consultant. She was asked why there was no address for the patient set forth on the face of the order. She explained that the reason for this was that the patient had absconded from hospital at the time that the order was made and they did not have an address for her. She was tracked down through her social worker and with the assistance of the Gardaí. There was an accompanying letter of notification addressed to the patient at Great William O'Brien Street, Blackpool, Cork, her last known address. As to her whereabouts for service of the order, they were provided with an address through the Gardaí in Middleton. Dr. Dillon went with the Gardaí to Middleton for the purpose of executing the order. When the order was served on the patient she was not given Dr. O'Connor's letter of the 10th of December, 2007. She was only served with the single page constituting the s. 38 order itself, and the letter of notification dated 11th December, 2007. The letter of notification was in terms:-

"Dear Ms. I.,

Information has been furnished to me by a registered medical practitioner, following an inspection by him/her that:-

i you are a probable source of infection with an infectious disease, respiratory tuberculosis (TB),

ii that your isolation is necessary as a safeguard against the spread of infection,

iii that you cannot be effectively isolated in your home.

Consequent on this information, I have made an order that you be detained and isolated in the Mercy University Hospital in Cork until such time as I certify that you are no longer a probable source of infection.

As required by subs. (2) (c) (ii) of the above provision –

(a) I enclose a copy of the order herewith and

(b) I give you this statement in writing that you may at any time appeal to the Minister for Health in writing to direct your release.

Yours sincerely,

Dr. Elizabeth Keane,

Medical Officer of Health."

Dr. Keane was aware that both the order and the letter were handed to the patient by Dr. Dillon but she was not personally present when this was done. She has not any contact with the patient since she was detained in the Mercy University Hospital but Dr. O'Connor has.

Dr. Keane was cross-examined by counsel on behalf of the applicant. She confirmed that Dr. O'Connor wrote to her on the 5th December, 2007 about the patient because at that time the patient was threatening to take her own discharge. That letter was overtaken by events when the patient actually discharged herself and Dr. O'Connor had to write an amended letter of the 10th December, 2007. It was Dr. Keane's understanding that Dr. Dillon explained to the patient about the statutory appeal mechanism when she delivered the letter of notification to her. The only information that she personally gave to the patient was that contained in the letter of notification. That letter was written on the basis of advice given to her by the HSE's legal advisors. She had asked Dr. Dillon to execute the order because she herself had never met the patient, whereas Dr. Dillon had a relationship with the patient. She thought it would be better for the patient to see a familiar face. She did not authorise Dr. Dillon in writing to go and detain the patient. She understood that the Gardaí were going to detain the patient and that Dr. Dillon was going to hand the order to the patient. She was asked if she authorised the Gardaí in writing to detain the patient. She replied that they had a copy of the order. She stated that the patient was served personally on the advice of the HSE's legal advisors. Both the order and the letter were read to her by Dr. Dillon just in case she was unable to read. She said Dr. Dillon was very familiar with the case. She did not give Dr.

Dillon any instructions in writing. She was asked by the judge if she gave Dr. Dillon authorisation in writing pursuant to s. 38 (2)(b) of the Health Act, 1947 and she said no. Further, she was unaware if Dr. Dillon was assigned by or with the consent of the Minister to perform the duty of acting under s. 38. The patient went with Dr. Dillon and the Gardaí to the Mercy University Hospital, which is the place of detention specified in the order. Dr. Keane was asked: "After she had been committed on foot of your order, did you put any regime in place to ensure that she had somebody to act as an advocate on her behalf, to assist her in the event that she wanted to make appeal? Did you put in place any system for continuingly reviewing her situation?" …… "As the committing officer, did you take any steps to ensure that, on an on-going basis, her rights would be vindicated?" Dr. Keane stated: "Yes, we understood from Dr. O'Connor that the patient had access to free legal aid and was encouraged to seek their advice. She was under the care of Dr. O'Connor while she was in the Mercy." Dr. Keane was asked how frequently she reviewed the patient's case and how she stayed in touch with the case. She stated "we would have got regular reports from Dr. O'Connor and from the Mercy, and particularly in January when she had been detained for a period of three or four weeks at that stage, we were very concerned…". The reason they were so concerned was that the patient was still refusing to comply with testing or treatment. She stated that they wrote their concern to the Minister and others. That concluded Dr. Keane's evidence.

The evidence of Dr. Annette Dillon

The next witness was Dr. Annette Dillon. She was examined in chief by counsel for the first named respondent and stated that she is a senior medical officer in the HSE Service, working particularly in the area of infectious diseases. She is involved in tracing the contacts of tuberculosis patients. She first met the patient in October, 2006. She was a contact of a case at that time, and Dr. Dillon referred the patient to Dr. Terry O'Connor in the Mercy University Hospital. She was initially treated in hospital for a number of months, and then she was allowed home. Dr. Dillon said they put in a programme of directly observed therapy in the patient's home and she was supported by public health nursing, social workers and home helps. Her GP was also quite involved. They had regular meetings about her progress. She was in and out of the Mercy University Hospital on a number of occasions. At the end of November, 2007 the patient's GP and Dr. Dillon's team noticed that she was not coping that well. Further, she was not complying with the directly observed therapy. On some days the nurses would call and she would not be there. She was also finding it hard to cope with her children. The patient went into hospital voluntarily in mid November of 2007 under Dr. Terry O'Connor. At the end of November, 2007, she refused further treatment. Dr. Dillon called to see her in the hospital at that time, and also discussed the case with Dr. O'Connor. They were very concerned about the patient's condition. Then, at the beginning of December, the patient stated that she wanted to leave hospital. This was a cause of very grave concern from a public health point of view as MDR TB can be very infectious. Dr. Dillon's evidence was that she reported to Dr. Keane. She and Dr. Keane discussed the case in the days leading up to the 11th December. They began to contemplate the making of an order under s. 38 but it was the last thing they wanted to do if it could be avoided. Dr. Dillon learned on the morning of the 11th of December, 2007, that the patient had discharged herself at 7.00pm on the previous evening. She then had a discussion with Dr. Keane, Dr. O'Sullivan and the social workers involved in the case. She subsequently went from her clinic to the Department of Public Health and met there with Dr. O'Sullivan and Dr. Keane. They discussed certain legal advice that had been received and Dr. Dillon was then given a document, namely the s. 38 order that had been executed by Dr. Keane and co-signed by Dr. O'Sullivan. She was also given the notification letter. She was told that both the order and the letter had to be given to the patient. They were initially uncertain as to the patient's whereabouts. However, Dr. Dillon was aware that that patient had a South African friend and, after making certain inquiries, she ascertained that the patient was staying with her friend in Middleton. She, and her colleague Dr. O'Sullivan, contacted the Gardaí at Middleton and requested their assistance in executing the order. They then travelled to Middleton Garda Station and went through the order with members of An Garda Síochána there. Dr. Dillon and Dr. O'Sullivan then went to an apartment in Middleton accompanied by two Gardaí. The patient was not there when they arrived and so they returned to Cork. Later that evening Dr. Dillon received a call to say that the patient had been located in Baylink Road, Middleton. Dr. Dillon went directly to that address and rendezvoused with three members of An Garda Síochána. Dr. Dillon went into the building accompanied by a female Garda and spoke to the patient. She told the patient that she needed to come back into hospital and have her medication, both in her own interest and in the interests of others. The patient was told that she had pulmonary TB and that it could be passed onto others. She was also told that, as the lady with whom she was staying had a small baby, she could be placing that baby in danger. The patient's initial reaction was that she wanted to stay where she was. Dr. Dillon then told her that she had an order for her detention. Dr. Dillon stated that she then went through the order with the patient. Dr. Dillon said "I spoke to her, you know, saying that this order was in place. I mean, obviously she couldn't…I had to go through it quite a lot because, you know, she didn't fully understand. She understood that it was probably best for her to come back into hospital, and I spoke to her at length about that, and then I said that this order had been drawn up because she had left the hospital and signed her own discharge. And basically went through it". Dr. Dillon stated that she went through Dr. Keane's letter of the 11th December, 2008, to the patient and she also went through the order. She explained that they had got information from Dr. Terry O'Connor that she could have been a probable source of infection, that her isolation was necessary, and that the order was drawn up by two doctors, Dr. Keane and Dr. O'Sullivan, and that under this order she would have to come back into hospital. Dr. Dillon said she did not ever use the word "detained". As she put it, "I went through it with her, just saying that, really, she would have to come back in". Dr. Dillon stated that she gave both the letter and the order to the patient.

Dr. Dillon was asked by the judge if the patient had been told what it meant for her to be ordered, as opposed to being asked, to go back into hospital, namely, that she could be subjected to serious punishments including imprisonment if she did not comply. Dr. Dillon said she did not go through that with her. She did, however, tell the patient that she could appeal against the order. The patient was initially told about that when Dr. Dillon met her in Middleton. According to Dr. Dillon the patient was actually conveyed to the hospital in a Garda car accompanied by the female Garda. Dr. Dillon followed behind in her car. Dr. Dillon saw the patient again on the following day in the Mercy University Hospital and on that occasion she suggested to the patient that she might like to consult a solicitor and take legal advice. The doctor stated that she called to see the patient on a few occasions in subsequent days. On the day following her detention she explained to her again about the appeal, but the patient did not seem to be interested at that stage.

Dr. Dillon was cross examined by counsel on behalf of the applicant. She accepted that she had not been authorised in writing to detain the patient. She said that she had been verbally authorised to do so. She said that on the first occasion that she went to serve the order she was accompanied by Dr. O'Sullivan. On the second occasion she went without Dr. O'Sullivan. She understood that the order had to be served on the patient. Dr. Dillon confirmed that the patient was admitted in the middle of November, 2007 because her GP had found her to be quite distressed and she did not seem to be coping well with her children. There were also issues around compliance with the directly observed therapy in that, the public health nurses were reporting problems. She was asked if these things coming together did not raise concerns as to the patient's ability to cope by herself in the community. Dr. Dillon agreed that they did but stated that a lot of supports had been put in place, like public health nursing and home help. Nevertheless she acknowledged that it was indeed

difficult for the patient, as the patient does not have an extended family here. Dr. Dillon agreed that from mid November, 2007 until early December, 2007 there were increasing concerns about the patient's compliance with her medication regime. Moreover, she was beginning to refuse medication, even in hospital. When asked if she was concerned about the patient's depression, Dr. Dillon said that she was not looking after the patient in the hospital setting and she was not fully aware of her psychiatric status. Dr. Dillon said it was a joint decision between the lawyers and the doctors as to who exactly was to be served with the order. They got legal advice about the order. The lawyers decided on the actual wording of the order and how it should be brought about. It was a joint legal and medical decision as to who was served. She was told by Dr. Keane to serve the patient with a copy of the order. She was not personally involved in the decision as to who should be served. She did serve the patient. She reiterated that she told the patient that she could appeal. She also reiterated that she told the patient that she was entitled to have legal advice if she wanted it, and she offered to organise this. She also testified that she offered to talk to the social workers on the patient's behalf if she wanted her to do that. Dr. Dillon said the patient did have access to a telephone. As far as she could remember, the patient had her own mobile phone. Dr. Dillon was asked "how did you explain the Minister for Health to her?" She said "I read out the last paragraph here (referring to the notification letter). Again, you know, obviously her writing to the Minister for Health is going to be quite difficult. So it would be better to do it through a solicitor". She was asked if the patient knew the name of the Minister for Health or even understood the concept of a Minister for Health. She replied "I suppose on that evening I went through the appeal, you know, that she could appeal it legally. But being not from this country, from a foreign country, I suppose, the whole concept of Ministers and all that, you know, was something. She would not have fully known who the Minister for Health was and that. So I explained to her that she could appeal it, but that it was better to get a solicitor". Dr. Dillon was asked by the judge if she herself gave the patient any explanation about the Minister for Health and what her role is, and how she may be contacted. The judge asked her "[D]oes she even know where she [the Minister] is based? It is all very fine saying you can appeal to the Minister for Health. I mean, is she in Cork, Dublin, Galway? How is someone who is of poor education, doubtful literacy, in detention in a hospital, without an extensive social network, in a wholly alien environment, how is she supposed to access the Minister for Health? I mean, was she given the Minister's address?" Dr. Dillon stated that she did not give the patient the address of the Minister. She added that it was because of the factors mentioned by the judge, and the fact that the patient had no extended family here, that she had offered to contact the social workers and get them involved. She was aware that the social workers did become involved subsequently with the patient and also that "pastoral care people were quite involved". She believed that case conferences were held from time to time and that the patient herself was a participant in some of them. She was asked if she could identify the social worker or social workers in question, and she referred to Ms. Marie Buckley, social worker, as having been involved. Dr. Dillon was asked about the discussion she had had with the patient concerning her possible procurement of legal advice. Dr. Dillon said that she asked the patient if she had access to a solicitor, being an asylum seeker here. She did not seem to be interested. Dr. Dillon characterised her as "just very disinterested and just resigned to the fact that she was going to stay there".

Dr. Dillon was asked if the patient had a full appreciation of the gravity of her situation. She stated: "I think she was a little bit depressed, but that she was able to make decisions." Dr. Dillon stated that it was quite upsetting to see the patient have to go back into hospital in the circumstances in which she was returned there, and they were concerned that she was still refusing her treatment. She seemed to be getting problems with her eyes and she was blaming the TB treatment. She felt there was nothing that the tablets could do for her anymore. She kept talking about her children. She wanted to go back and see them. However, she did not seem to want to help herself to get out of hospital. She made no connection between her wish to see her children and the possibility of appealing the order. She just kept going on about how the medication was not helping her. When it was suggested to Dr. Dillon that the patient was an entirely passive player, Dr. Dillon did not fully agree. She emphasised that the patient had taken her own discharge only a day or two beforehand. She added "and then I think when it was explained to her that she would have to come back into hospital, for her own treatment, for her own health, and also that she could be a risk to others, that this Act was going to come into play, - she accepted that. And it was explained to her that she could appeal. It was also explained at length that if she started taking her tablets again that she would improve and that she would then be, I suppose, left out of hospital, and that again, you know, supports would be included for her, and we would do what we could to help her be at home". Dr. Dillon's testimony was that she had limited involvement with the patient thereafter. She continued to visit the patient every month or every few weeks. During these visits she would try to persuade her to start taking her medication again. She would also talk to the patient about her children and would see how she was getting on. The patient was primarily under the medical care of the Mercy University Hospital and Dr. Terry O'Connor. She was involved with some of the multi disciplinary meetings that were held from time to time in the hospital. These were convened by the social work department. The purpose of the meetings was to see how the patient was progressing. Dr. Dillon was asked by the judge whether these meetings merely facilitated a process whereby relevant professionals were brought up to speed with different aspects of the patient's case, or, alternatively, if it was the case that decisions were taken at these meetings as to how she would be managed in the future. Dr. Dillon indicated that both things happened at these multi disciplinary meetings. When asked who the decision maker was, she said that the patient's clinician would have been the main decision maker. The clinician was identified as Dr. Terry O'Connor. They did discuss the issue of a possible appeal by the patient at these meetings. They also discussed the possibility of her obtaining legal advice. There was never a legal representative at these meetings. Dr. Dillon thought that the patient herself may have been at some of the meetings. When asked how this was facilitated, namely, whether she was allowed out of her room, whether she was gowned and masked, or if everybody else was gowned and masked, Dr. Dillon could not remember clearly. She thought, however, that the patient's attendance at meetings must have occurred before the patient had attempted to escape and a security guard was placed on her door. Then, upon further reflection Dr. Dillon expressed uncertainty as to whether the patient had been at any meetings. She said that she would have to double check the position. In any case the social worker would be able to give that information. That concluded Dr. Dillon's evidence.

The evidence of Ms. Marie Buckley

The next witness called was Ms. Maria Buckley, who is a social worker at the Mercy University Hospital. Ms. Buckley told the court that she had been dealing with the patient in the course of her work since 2006. She has seen her on a very regular basis since she was detained pursuant to the s. 38 order. She visits her in her isolation room at least six times a week. Sometimes she visits her out of hours to bring her food that she has requested. Ms. Buckley told the court that she looks upon the patient's case as being a very sad situation. Prior to her detention, Ms. Buckley had worked towards ensuring that the patient could be at home with her children. She did everything she could to get the relevant services on board in order to provide her with necessary support. The patient was sometimes quite lax about her medications, for various reasons. Sometimes she would claim that she had been too tired to take them, or that she had forgotten to take them. She was being monitored closely while she was in the community.

Following the patient's detention in hospital Ms. Buckley was concerned with facilitating access to her children, which was

quite difficult. She tried to ensure that the patient had regular visits with her children.

The patient had particular requirements because of her illness. A lot of her clothing had to be disposed of, so new clothing had to be purchased regularly. However, she did not have an income as such and Ms. Buckley put in place arrangements that provided the patient with an income of her own to spend on her day to day requirements. She stated "a lot of us were putting in our own money to buy her things at that point …. but then we got funding on board".

As regards the medication issue, Ms. Buckley was constantly urging the patient to consider taking her medication. She would tell her "if you took your medication, you could be at home". She used to say to her "you are here, you do not need to be here, you could be at home with your children if you took your medication".

Ms. Buckley agreed that although English is not the patient's native language she is competent in English. Moreover, she stated that although the patient seemed to be an intelligent girl sometimes things did not seem to click with her. She thought that cultural differences might partially account for her not understanding. Ms. Buckley was unsure as to the extent of her literacy skills. She stated that the patient never had occasion to write anything. All she ever had to do was give her signature. Her understanding of the position with respect to the patient's immigration status is that she is in "limbo" because of her illness. When asked as to how frequently she had spoken to the patient about the importance of taking her medications, Ms. Buckley estimated that she had broached the subject with her on between 50 and 100 occasions. Ms. Buckley said that she also explored other possibilities with the patient, in the hope of progressing her situation somehow or other. She spoke to the patient about the possibility of going back to South Africa because there is good treatment there now. She asked her if she would like to return to her mother in South Africa and if would she be willing to do that. She said that the patient would not entertain any of these possibilities.

Ms. Buckley was asked by the court whether, because the patient is a failed asylum seeker, she might have suspected Ms. Buckley's motives in suggesting her possible return to South Africa, and whether she might perhaps have regarded Ms. Buckley as part of the general immigration machinery that was trying to get her out of the country. Ms. Buckley said that nobody knew what the patient's thinking was.

The witness was asked whether she had ever raised with the patient the possibility of her appealing to the Minister for Health. Ms. Buckley said that she did. This arose in July. At that point they (the social work department) were urged to advise the patient of her rights. Up until then the emphasis was really on her wellbeing. As far as Ms. Buckley was concerned she was detained lawfully and her job was to make the patient's situation as bearable as possible. The witness was asked if the patient had a full appreciation of the gravity of her situation. Ms. Buckley recalled on one occasion talking to her about the legality of it and about the law and how serious it was. She said she often spoke to her as a mother would speak to a daughter and she said "For God's sake, would you ever just see what this is? You are here under the law. You are not going anywhere until you decide to co-operate". She was asked if the patient appreciated that by trying to escape or by not co-operating she might actually end up with a criminal record, or even spend time in jail. Ms. Buckley stated that the patient was very confused on occasions. On more than one occasion she was very very confused. She thought that on the day she absconded she firmly believed that she had a right to leave.

Ms. Buckley was asked to describe the circumstances in which the issue of an appeal came up in July. She said that a letter came into the office from one of the doctors in the public health department of the HSE requesting that the patient would be informed of her right to appeal against her detention. Ms. Buckley stated that up until that point she had not spoken with the patient about this.

Ms. Buckley said that at a certain point she had urged the patient to seek legal advice through the Legal Aid Board, but the patient refused. Up until then there had been no attempt to discuss with the patient the legality of her situation because the social workers had believed that she could access a solicitor if she wanted to. The basis for this belief was the fact that there had previously been a child protection issue with respect to the patient's children, and it was known to the social work department in the Mercy University Hospital that she had obtained legal representation in relation to that matter.

At any rate Ms. Buckley went on to give more details of her attempt to get the patient to seek legal advice through the Legal Aid Board. On her own initiative Ms. Buckley made contact with a Ms. Aoife Byrne, Secretary of the Legal Aid Board, at Pope's Quay in Cork. This happened in or about the month of May, 2008. She stated: "I spelt out the situation to her, that the patient is detained here at the Mercy, and I would like to explore her entitlement to appeal". According to Ms. Buckley she was told that someone from the Legal Aid Board would come back to her, but they never did. She rang them again and she was told that the patient was not entitled to legal aid because she was due for deportation. Ms. Buckley rang again and pressed the case and the Legal Aid Board sent her an application form for the patient to complete. Ms. Buckley then filled in as much of the form as she could with the patient and asked the patient to sign it. The patient refused to sign it. Ms. Buckley thought that she did not understand the content of the application. She did not understand it on the day.

Ms. Buckley said that she discussed with her colleagues in the office the difficulty she was having in getting legal representation for the patient. One of her colleagues, Catherine Richardson, said that she knew a solicitor and would have a discussion with him about the matter. However, she forgot about it and had to be reminded and that gave rise to delay. The latter events happened in or about the month of June 2008.

Then in July 2008 the issue of advising the patient concerning her right of appeal cropped up. The witness said "this notification came in, and it urged that social work should be advising the patient of her rights, and at that time it became very real to me then that really, yes, something should be done".

It is important to digress at this point to state that Ms. Buckley did not have the letter to which she had referred with her in court. The court asked if this could be forwarded separately for the court's consideration and counsel for the HSE undertook to arrange for this to be done. The court subsequently received the letter in question under cover of a letter from the first named respondent's solicitors date the 31st October, 2008. The letter in question is a letter from Dr. Elizabeth Keane, addressed to Mr. Pat Madden, Chief Executive Officer, Mercy University Hospital, dated the 9th July, 2008. The letter is in the following terms:-

> "RE: Section 38, Health Act 1947

Dear Pat,

Further to your communication (20th June, 08) in relation to the above, legal advice was sought from Mr. Diarmuid Cunningham, Comyn Kelleher Tobin, Solicitors (copy attached). Mr. Cunningham advised that the case 'should be brought specifically to the attention of the Department of Health and Children, the body with the legislative capacity to effect change'. Based on this advice we asked Dr. Kevin Kelleher, Assistant National Director Health Protection, to bring this to the attention of the Minister for Health and Children. Dr. Kelleher has informed me that he has already had discussions with Mr. Chris Fitzgerald, Principal Officer, Department of Health and Children and that the legislation was in the process of being reviewed. He indicated that a formal letter (as per draft from Mr. Cunningham) would also be sent to the Minister for Health and Children (copy attached). Dr. Kelleher has also suggested that the patient's social worker might again advise her of the right to appeal the order and to facilitate her should she wish to exercise that right.

Yours sincerely"

This letter was c.c.'d to Dr. Terry O'Connor; Dr. Margaret O'Sullivan; Mr. Rory Conway of Conym Kelleher Tobin, Solicitors, and Mr. C. Rutherford, Senior Social Worker.

Returning to Ms. Buckley's testimony, she stated that in response to this letter she organised a multi disciplinary meeting. She was asked by the judge if any lawyer attended this meeting, and in reply she said it "risk management" at the hospital were involved. She was asked what did she mean by "risk management", what class of professional was this risk manager. The witness thought that the individual who attended the meeting was the liaison officer between the hospital and its solicitors. She identified this person as being a Mr. Kieran Murphy. It was confirmed to the court that Mr. Murphy is a qualified but non practising lawyer.

Prior to the meeting, Ms. Buckley spoke to Dr. O'Connor and expressed the view to him that she felt in an awkward position because on the one hand she was employed by the hospital on the one hand, and on the hand she having to adopt the role of advocate on behalf of the patient (against the hospital). Dr. O'Connor was sympathetic to her dilemma. He said he would "be quite happy for this whole law to be addressed" and said as much at the meeting. Kieran Murphy was present at the meeting and Ms. Buckley's understanding was that he was going to go from the meeting to the hospital's solicitors to discuss the matter.

Following the multi-disciplinary meeting the witness visited the patient on four different occasions and brought with her on each occasion a draft letter addressed to the Minister for Health for the patient to sign. Unfortunately, the patient would not sign it.

The draft letter in question was produced for the court's consideration. It was annexed to a letter sent by the witness's superior, Mr. Colman Rutherford, Principal Social Worker, to Mr. Pat Madden, Chief Executive Officer of the Mercy University Hospital on the 1st August, 2008. Mr. Rutherford's letter was in terms:

"Dear Mr. Madden

I refer to Dr. Elizabeth Keane's letter of the 09/07/08 in relation to the above named patient. In this she outlines Dr. Kevin Kelleher's suggestion that the patient's social worker might advise her of her right to appeal her detention under s. 38 of the Health Act 1947. I spoke with N.I. today, (31/07/08) in relation to this matter. Ms. I. has been in good spirits for the past few days. This seemed an appropriate time to attempt the task. Ms. Buckley, the allocated MSW and I, had two separate discussions with Ms. I.. In the first I simply outlined the appeal process and that this would safeguard her rights. However, she was not happy to sign the attached note. This seemed to be linked to her conviction expressed during the interview that she was not sick and had become a patient at the hospital merely because she had been visiting. Although pleasant and engaged there was a paranoid edge to her conversation. Later in the afternoon Ms. Buckley, social worker and I returned to Ms. I.. On this occasion Ms. Buckley with whom the patient has a very good relationship asked if Ms. I. wished to write in her own words her attitude to her detention. This was also declined on the basis that Ms. I. had not gone to school and could not write. She also declined to allow either of us to write on her behalf, saying she did not want to leave the hospital because she had nowhere to go.

It may be that in the coming days Ms. I. will reconsider her position. However, the current situation is that she has, as suggested by Dr. Kevin Kelleher, been further advised of her right to appeal the order but has declined to do so.

Yours sincerely"

The attached draft letter was addressed to Ms. Mary Harney TD, Minister for Health and Children, Hawkins House, Dublin 2 and was in the following terms:-

"RE: Ms. N.I. C/O Mercy University Hospital, Cork

Dear Minister,

As you know I am currently detained by the HSE under s. 38 of the Health Act 1947, since 11/12/2007. I wish to apply to you to review this detention pursuant to s. 32(2)(h) of the Act.

Yours sincerely,

N.I.

c.c. Mr. Pat Madden, CEO, Mercy University Hospital, Cork

Dr. Terry O'Connor, Consultant Respiratory Physician, Mercy University Hospital, Cork

Dr. Elizabeth Keane, Director of Public Health, HSE, Cork"

The letter was typed on the letterhead of the Mercy University Hospital Social Work Department and dated Thursday, 31st July, 2008. The words "not sent" are endorsed upon it in handwriting.

Ms. Buckley stated that she had said to the patient "At least N., if we ask the Minister to look at it, something might happen" but she was totally disinterested. Ms. Buckley said that she spoke to the patient in very plain language. She said to her "you know this means you could be at home with her children. However, the patient replied "I am not going anywhere from here because I have nowhere to go". Ms. Buckley then responded "But N., what do you mean, you have nowhere to go?" She said "My home is gone".

Ms. Buckley explained that the patient was aware at that stage that a month previously her flat been given up by the HSE. The HSE was no longer paying for it. Ms. Buckley said she told the patient "N., you know, I can organise to get other accommodation for you. That's not a problem, you know, sure we have done that for you in the past". Ms. Buckley stated that she felt the patient had lost faith in humanity and possibly didn't trust her. Ms. Buckley also stated that she felt that it was partly to do with the level of the patient's cognitive ability. Ms. Buckley didn't think the patient had the ability to work it out in her head. Ms. Buckley reiterated that she broached the question of a possible appeal on four separate occasions with the patient. On two of those occasions she went to see her with principle social worker and on two occasions she went by herself. Ms. Buckley was asked if the patient was offered any other assistance in regard to the appeal and she said "No", I think we were waiting to see what the hospital's solicitors were going to do". She received no communication from the hospital's solicitors concerning what she was expected to do in terms of appraising the patient as to her rights, apart from the right of appeal.

Ms. Buckley was asked if there was issue in relation to the ability of the patient to sign the draft letter. She stated there was never an issue in relation to her ability to sign. Her willingness to sign was a different matter. For instance, there were often times when her social welfare cheques would need to be signed and she would refuse to sign them. She would say no and dismiss her (Ms. Buckley). Then on another day, she would quite happily sign four in a row. It would depend on what frame of mind she was in. The witness was asked by the judge whether she thought the patient was exhibiting "inexplicable irrationality" or whether she thought her behaviour was to do with issues of trust and confidence. Ms. Buckley's view was that it was the former. The witness was asked if she had offered to help the patient in any way apart from drafting a letter of appeal for her. She stated that she knew that the patient was in telephone contact with her mother, and so she contacted the mother. Ms. Buckley said: "So I asked her for her mother's telephone number, in order that I could contact her mother. And she wanted me to anyway. So I was to liaise with her mother. Just generally, I was reminded by my principal that confidentiality was an issue there, so I was very careful not to relay the patient's diagnosis or perceived diagnosis to her mother. I asked her mother if she would consider coming to visit her daughter, and she said she would love to, but she couldn't afford it. So I went to her daughter, to the patient, on one of her lucid days, that I thought she was very together in her head, and there were some days like that, and I asked her to consider "would you pay from your fund for your mother to come?" and she was quite happy to do that at the time. And she was very happy when her mother came the first time. But her mother came and saw her situation, and I gather was quite distressed by it."

Ms. Buckley went on to explain a difficulty that she has had with respect to the case. She told the court that as a social worker, she is trained to take the patient's rights into account, and to respect the patient's decisions. Moreover, as far as the hospital was concerned, the patient was compos mentis. However, Ms. Buckley had her doubts about the patient's mental state and raised this persistently at the multi-disciplinary meetings. She was aware that the patient wasn't suffering from a mental disorder as far as Dr. Cooney was concerned. She made Dr. Cooney aware of her reservations by writing her observations in the patient's medical charts. Whenever an incident or event occurred that give her concern, she wrote it in the chart. She explained that "I had it in my heart that she wasn't of sound mind". At the same time she was aware that the patient was deemed to be compos mentis and she felt that this obliged her to respect the patient's decisions. Accordingly, she didn't feel it appropriate to pressurize the patient unduly. She then added: "The appeal, as far as I was concerned, wasn't the huge issue. The huge issue, really was to safeguard the patient's rights under the order she was under. That was, I felt, my brief".

Ms. Buckley explained that she felt that the patient was misunderstood. There was a lot of misunderstanding around her condition. She was perceived to be very aggressive and very bold and uncooperative. She saw the patient the first day and to her the patient seemed to be a nice enough woman and a great mother with her children. She had not had any difficulty with the patient and while she was aware that other people wore goggles when visiting her because the patient had spat in people's faces, she herself never wore goggles when going in to see her. She said that the patient could be dismissive and she knew when to move away and to leave the room in order not to upset her. Ms. Buckley said that she

never wanted to upset her. She gave the following example: "For instance, if I would urge her to allow me to take her washing out of the room, she would refuse. She would say no. Now, it would have been much better if we could have cleared the room of her laundry in order to keep it clean and keep the environment right. She would refuse. I would imagine other people might have pushed her a bit and that could cause her to be more angry". She was asked if she was aware that some of the chaplains had gained the patient's confidence to a degree. She confirmed that she was aware of that and that there were three chaplains involved with her. She stated that the patient was nominally a Methodist but was probably agnostic if she was thinking rationally. Ms. Buckley stated that the three chaplains that she was referring to were all Roman Catholic. One was a nun, one a priest and one a lay person. The witness was then asked if she had had problems in raising concerns, or issues she felt needed to be canvassed, at the multi-disciplinary meetings. She stated "at every meeting I raise the issue of her mental competence. I ask, you know, could she have a brain scan, just so we could assess, because there was a mention that she possibly might have an AIDS dementia and one of my colleagues was familiar, she said, with that from previous work she had done, and that the patient showed all the symptoms of AIDS dementia. So, I was asking if she could have a brain scan. I was asking if she could be assessed, and out of that, she was assessed again by the psychiatrist and deemed to be compos mentis again. A brain scan, they felt, wouldn't be on the cards. It wouldn't be safe to try to – for her to have a brain scan". Ms. Buckley said that for the most part the issues raised at the multi-disciplinary meetings related to "co-operation and collaboration between all of us involved, that we were sure to be doing the right thing for her". That concluded Ms. Buckley's examination in chief.

She was then cross-examined by counsel for the applicant. Ms. Buckley was asked about the occasion, on which she visited the patient accompanied by Mr. Rutherford as described in Mr. Rutherford's letter to Mr. Madden of the 1st August, 2008. Mr. Rutherford had stated in that letter "I outlined simply the appeal process and that this would safeguard her rights". Ms. Buckley was asked to describe exactly what happened. She said "I felt Mr. Rutherford was explaining the technicalities of it, you know, that you have right to write to the Minister and tell the Minister that you are being held here and you have a right to ask the Minister to look at your situation. And I think I interjected then, at that point, to say, you know, 'Ms. I., you could go home from here', you know, in a very human way". She was asked about the sentence in Mr. Rutherford's letter which stated "this seemed to be linked to her conviction expressed during the interview that she was not safe and had become a patient of the hospital, merely because she had been visiting". She didn't recall that. She was then asked to comment on Mr. Rutherford's assertion that "Although pleasant and engaged, there was a paranoid edge to her conversation". Ms. Buckley said that that accorded with her recollection. The patient was defensive and not very trusting. The witness was asked by the judge if she agreed with Dr. O'Connor's view that the patient had something of a persecution complex. Ms. Buckley said she noticed that in her from day one. She noticed this ever before she perceived the patient as having a mental incapacity. Ms. Buckley was asked for her view of the patient's assertion that she could not write. The witness wasn't sure if she could or not. She felt that she had had some schooling, the equivalent of education to maybe second or third class. She was satisfied that, although she may not have been educated to very high standard, the patient was intelligent. The witness was asked about her earlier assertion that some things didn't seem to click with the patient. She was asked what did she mean by that and she stated "Sometimes, she seemed vague. I could be talking to her about anything, really. I often tried to have just normal, everyday, conversation with her…about where she lived. I was familiar with where she lived and where the children were at school or whatever. But sometimes there was this vagueness about her. And I couldn't assess what that was about". The witness agreed that this was a source of on-going concern for her. She felt that the patient had difficulty comprehending her situation and things that were being told to her. There were times when she believed the patient didn't really understand what was happening. The witness was asked by the judge if her apparent disinterest in leaving hospital could be due to paranoia on her part that the offer was not without strings attached. In other words, that she might end up having to face her deportation order, or that she might have to face other adversities, whereas she was in a safe environment while in the hospital. She was specifically asked to comment on Dr. Dunne's speculation that the patient might be feigning though not in the malingering sense. The witness replied "Judge, that thought has occurred to me on occasions, I have wondered about it. I often times addressed her as you would address, maybe, a family member, again to say, "For God's sake, what is this about? Do you want to stay here? Is it that you are afraid of being deported?" I would speak very plainly to her and at that point, she would dismiss me again. But then there were other occasions when I heard things from her, or saw her behave in ways that seemed very abnormal to me". The witness then added "In the early days, after her detention, she began talking about a snake being in her, that there was a snake had taken up position in her, and she would talk about what the snake was doing, how it was wriggling, what it was doing. Then she developed a, kind of, an obsessive compulsive thing around her nose, and around what was up her nose, and what she did with it. And she would repeat this. It was cyclical, over and over and over again. It was at that point that I actually contacted the priest and asked him to visit her, when she was talking about the snake and spiritual things." Ms. Buckley said that she frequently came across the patient talking to somebody who wasn't in the room. She estimated that these kinds of things happened on four of the six times a week that she would visit the patient. Although at that stage she was unable to use a mobile phone, she would often be seen talking into a mobile phone, supposedly to her ex-partner although he was not on the phone. Ms. Buckley described the sorts of bizarre behaviour that she had observed. She stated that on one occasion she had arranged an access visit between the patient and her daughter. She was suddenly bleeped and asked to go urgently to the patient's room. The witness said "She had her daughter, who I know who she was just mad about and adored, caught by the hair and wasn't letting her out of the room, and there was a lot of upset going on. Outside people were crying, there was a lot of security guards there and she had her daughter caught in the room. So, when I went into the room, the room was flooded. Two taps were on in her en suite, and it was the stopper was in. So, there was about an inch and a half or two inches of water in the room." … "So, the first thing, I went in and I greeted her and I went straight in to turn the taps off and then I came over and I distracted her, and Eileen the pastoral care worker was in the room as well and very upset. So, she quickly got the daughter out and I was left in the room with her, and when she realised the daughter was being taken, she kicked and screamed, and tried to grab the door, to go after her daughter to get her back, and security stopped that and let me out."

The witness couldn't recall for certain if she had made a note in the patient's medical file concerning this incident. She thought that she probably had done so but couldn't be 100% sure. She said that the patient was very confused "an awful lot of the time". She felt there was a spiritual dimension to the case and that was why she called the priest in. At one point she wondered if the patient was possessed or may have believed that she was possessed. She agreed with the judge that witchcraft and that sort of thing is very prevalent in traditional religions in Africa. She said that she discussed the case with a member of her team and her colleague thought it could be Voodoo.

Ms. Buckley reiterated that she raised her concerns at the multi-disciplinary meetings that were held from time to time. She described the history of these meetings stating "Initially, the meetings were started up between myself and the pastoral care sister. We were concerned really about her unwillingness to engage with the nursing staff and the cleaners in her room, and her room was becoming disorganised and all of that. So, we started these meetings, so, we would invite

Dr. Dillon from the chest clinic in St. Finbarr's, we invited the public health nurse who had been involved in her care when she was in the community, because the thinking was that would go back into the community, perhaps, at some stage, if she agreed to take her medication. Dr. O'Connor was always present, the pastoral care people were present, myself, perhaps my colleague from our department, as well, Catherine who had worked with her, we were all present". She added the hospital's risk manager, Mr. Murphy also attended. However, the psychiatrist was never present. Ms. Buckley was asked if she had ever had the opportunity to discuss the patient's case with Dr. Cooney. She said that he did not. She added "What I was being told was that she was compos mentis and the psychs, as we would say in the hospital, considered her to be compos mentis". She was aware that Dr. Cooney had seen the patient in the early days and that he saw her again in the interim at the witness's request. She recalled the incident that Dr. Cooney had spoken about in his evidence where the patient had barricaded herself into her bathroom. The issue was dealt with by Ms. Buckley arranging for the hospital carpenter to remove the door between the patient's bedroom and her bathroom. That concluded Ms. Buckley's evidence.

The evidence of Mr. Colman Rutherford

The final witness in the case was Mr. Colman Rutherford, Principal Social Worker. He confirmed that day to day social work involvement with the patient was the responsibility of Ms. Buckley. He was Ms. Buckley's supervisor. He said that the circumstances of this case represented a unique situation in his experience. There were two dimensions to the case with which he was concerned. One concerned child protection issues – the patient's children were in care - and the other was the patient's own welfare. He was aware that the Legal Aid Board had acted for the patient in respective of the child care issues. She didn't have legal advice in terms of her own situation. He stated "there wasn't any effort by ourselves to seek legal advice directly for her. I suppose the action that we took was to seek legal advice for her mother, and that was primarily in relation to the child protection matters". He confirmed that if the patient had wanted to have access to a solicitor, they would have facilitated that. However, their main effort was to try and facilitate an application to the Minister. He then described the circumstances in which he had written the letter of 1st August, 2008. It was written in direct response to a suggestion made by Dr. Kevin Kelleher which had been reported in the letter from Dr. Keane to the CEO of the hospital. The correspondence had been copied to him and the suggestion was acted upon. They identified a period when the patient was in good form in order to approach her. When asked why it was necessary to wait until she was in good form, he stated that the patient's mood was quite labile, that there were days when Ms. Buckley would be dismissed without a hearing, that there were days when the patient was more confused and less able to understand what they were trying to say to her. For this reason they waited "until there had been an established period of good form, if you like, when she might be open to hearing what we were saying to her". He was asked how he canvassed the issue with the patient. He said "We did this in two parts. Both myself and Marie Buckley went on both occasions. On the first occasion, I took the lead in talking to Ms. N.. She, Marie, introduced us, I explained who I was, I explained, as I have said in the letter, that there was a simple procedure, that she could apply to the Minister to have somebody review what was happening to her in terms of being in hospital and having to stay there". He confirmed that the consequences of a review were explained to her. She was told that all she needed to do was to sign the pro-forma letter that had been prepared. The judge asked Mr. Rutherford the same question that he had asked Ms. Buckley, namely, whether he thought the patient was exhibiting "inexplicable irrationality" or whether he thought her behaviour was to do with issues of trust and confidence. Mr. Rutherford felt it might be an issue of trust and confidence in him because he was a stranger to her. She was being presented with this option by a stranger. It was for this reason that they went back on the second occasion and this time Ms. Buckley took the lead and he was merely in the room. He described how on this second occasion "we took a more general approach. … we asked her to you want to write something? Do you want to say in your own words that you don't want to be in here, or that you want this review, or that you want something to happen?". She said she couldn't do that and that she couldn't write. So then we suggested to her, "If you just say to us, you want this appealed, you don't want to be here, we can then write and appeal on that basis". Mr. Rutherford said she said very clearly to them that she didn't want to appeal because she had nowhere to go. He specifically recalled Ms. Buckley seeking to reassure the patient and offering to arrange accommodation for her. He said that this detail stuck out very clearly in his mind, because he himself wasn't entirely sure that what Ms. Buckley had offered would in fact have been possible. At any rate, the offer was made. Notwithstanding this offer, the patient was adamant that she didn't want to do anything about appealing the order. Mr. Rutherford was of the view that the patient understood what the appeal process involved and she understood how it could be accessed. He felt she was able to think about that and to say that she didn't want to leave the hospital, that she had nowhere to go. He felt she knew what she was saying when she said she didn't want to appeal.

Mr. Rutherford added: "We have speculated as whether there was a benefit to her staying in the hospital, if only out of not having to address the issues of finding new accommodation or settling into a new accommodation or having to deal with the issue of deportation, if that was in front of her." He thought that there might be an element of denial and avoidance. He was asked for his views concerning whether the Social Work Department had a role to play in vindicating the patient's rights. He said "I think the Social Work Department, and in fairness the other staff in the hospital as well, have been very keen to try and vindicate the patient's rights, and that has sometimes been very difficult because her behaviour has sometimes been very challenging". The Social Work Department was primarily concerned with her day to day welfare. What he characterised as "the high level problems, the high level issues about the detention, its legality, the appropriateness," were dealt with at a high level within the hospital. He was asked if the issue of an advocate for the patient's rights had ever arisen. He said "I think advocacy of her rights has been on-going theme within the hospital. Maybe primarily by ourselves and by pastoral care, but it is very much an issue that has been live to all staff. It was pointed out to Mr. Rutherford by the judge that the hospital was the detainer and he was asked if any effort had been made to bring in somebody independent. He replied that there had not, as far as he was aware. He was asked if any reviews had been carried out of the patient's detention. Mr. Rutherford said that the multi-disciplinary meetings to some extent formed a review process but that there was actually a more formal review currently underway. This has been undertaken by a Dr. Neil Brennan, a consultant physician. Mr. Rutherford was asked if the question of comprehensive outside psychiatric review had been considered. It had not. It was suggested to him that it might be appropriate to seek a comprehensive re-evaluation of the patient's psychiatric status by an outside team, given the differences of professional opinion between Dr. Cooney and Dr. Dunne. Mr Rutherford replied "I suppose". However, he added "Not to be pedantic about it, but I think the situation is that the psychiatric review is requested by the consultant in charge of her care and is made back to him. So, essentially, it is for him to decide where that comes from". That concluded Mr. Rutherford's evidence in chief.

Under cross examination by Counsel for the applicant he agreed that his team did regard aspects of the patient's behaviours as irrational and that they did have concerns about her mental capacity. He said "I wouldn't want to say at all that we think, that I thought, that she was functioning in a normal way". He was asked if he thought she was capable of acting on her own behalf and he said "We clearly tried to address the business of was she capable of acting on her own

behalf, and the issue that you have raised is the same issue that we came upon. If she understood the process that was available, if she understood that it was being offered to her, and it was being offered in a way that was designed to try and be accessible and to be agreeable to her, and then she refused that. For that purpose, it maybe not for any other, but for that purpose, she had made a decision that was competent." He felt that her behaviour was certainly strange. He thought that she was clearly disturbed and clearly distressed. That concluded the oral evidence in the case.

It is important to record that on the instructions of the Court, a message was communicated to the patient via one of the Mercy University Hospital chaplains, advising her of the inquiry then being conducted, and extending an invitation to her to give evidence, or otherwise to address the Court, via a video link from the Mercy University Hospital. The patient did not respond to the invitation.

The matter was then adjourned to the 17th of November, 2008 to enable the parties to file detailed legal submissions.

Supplemental Evidence on Affidavit
At the sitting of the Court on the 17th of November, 2008, Counsel for the third and fourth named respondents, namely, Ireland and the Attorney General, sought leave to file an affidavit, sworn by a professor of microbiology, elaborating on the nature of the public health risk. The Court acceded to this application and received an Affidavit of Wim Meijer sworn on the 17th of November, 2008.

The Affidavit of Wim Meijer
Professor Meijer is an Associate Professor of Microbiology and is Subject Head of Microbiology in the School of Bio-Molecular and Bio-Medical Sciences at University College Dublin. He deposed as follows:

1. I have a BSc and MSc in Biology from the University of Groningen, the Netherlands, and obtained a PhD from that University in 1990 following research in physiology and molecular biology in bacteria. Following Post-Doctoral work in The Ohio State University, I lectured Microbiology in the University of Groningen from 1991-1997. I have lectured in University College Dublin in the Department of Microbiology since that date. I was appointed Subject Head of Microbiology in the School of Biomolecular and Biomedical Sciences in 2005 and Associate Professor of Microbiology in 2006. I am also a principal investigator in the UCD Conway Institute and Dublin Molecular Medicine Centre. In addition, I have served on the Microbiology Committee of the Health Research Board, Enterprise Ireland and the European Union.

2. I have specialised knowledge about Tuberculosis and related microorganisms, which is part of my area of research and teaching. This includes the pathogenesis, proliferation and dissemination of TB.

3. I have been informed that the daughter of the applicant has been detained as she is a probable source of infection of Multi (or Multiple) Drug Resistant Tuberculosis (MDR-TB) and that detention is considered necessary to isolate her. I have not examined the applicant's daughter nor have I considered any information relating to her -1 make this affidavit for the purpose of explaining the general position regarding the infectiousness of MDR-TB and prognosis for persons infected therewith and not to comment on the individual case before this Honourable Court.

4. In my opinion, the existence of a power to detain a person with certain infectious diseases is necessary to prevent the spread of such diseases. A growing number of other experts, including Dr. Mario Raviglione, Director of the WHO Stop TB Department, have expressed the view that governments need the right, if necessary, to confine people with certain infectious diseases, including TB. The WHO Handbook for National TB Control Programmes, Implementing the WHO Stop TB Strategy, WHO, 2008 provides at page 128, that:

> "... legislation should provide for certain extraordinary situations where involuntary compliance with key measures is required to protect public health, subject to appropriate safeguards (e.g. mandatory medical examination, isolation, quarantine) or where other measures such as contact tracing may be necessary."

The guidelines of the United States' Centres for Disease Control and American Thoracic Society recommend isolation of infectious TB patients. (CDC. Essential components of a tuberculosis prevention and control program: recommendations of the Advisory Council for the Elimination of Tuberculosis. MMWR 1995; 44(No. RR-11):1--16.; American Thoracic Society, CDC, Infectious Diseases Society of America. Control of tuberculosis in the United States. Am Rev Respir Dis 1992;146:1623--33.).

5. Detention under the Health Act, 1947 (as amended) is permissible in respect of the following diseases:

- acute anterior poliomyelitis,
- cholera,
- diphtheria,
- paratyphoid,
- plague,
- severe acute respiratory syndrome (SARS),
- smallpox,
- tuberculosis,
- typhoid,
- typhus,
- viral haemorrhagic fevers (Lassa, Marburg, Ebola, Crimean Congo).

6. Due to the infectiveness and prognosis for persons infected with the diseases listed above, I consider that it is necessary, from a medical point of view, that there be a power to detain persons who are sources of infection of these diseases.

7. Tuberculosis (TB) is a disease that can be transmitted by tiny airborne droplets. If a person who is infectious with TB coughs or sneezes, a person in his or her immediate vicinity may become infected. While repeated contact is usually required for infection, it is not necessary. The means of infection with MDR-TB or XDR-TB (extensive drug resistant TB) is the same as for drug susceptible TB. HIV and TB are synergistic infections, meaning that the risk of infection and developing tuberculosis is higher in the HIV-positive or immuno-compromised populations and the prognosis for such patients is worse than for immunocompetent patients.

8. MDR-TB takes at least four times as long (2 years) to treat than TB and has a higher mortality rate due to the resistance of the causative bacteria to the front line drugs isoniazid and rifampin. It has spread worldwide. It is estimated by the World Health Organisation that there are up to 1.5 million cases of MDR-TB and that there are approximately 420,000 new infections and 116,000 deaths each year. The outcome for persons with MDR-TB is significantly poorer than for those with drug susceptible TB.

9. MDR-TB, which emerged from MDR-TB, is resistant to isoniazid and rifampin, and in addition is resistant to any fluoroquinolone and at least one of three injectable second-line drugs (i.e., amikacin, kanamycin, or capreomycin). XDR-TB is virtually untreatable, and as a consequence the mortality rate is very high. Drug resistance emerges as a consequence of incomplete or inconsistent treatment with antibiotics, which is particularly relevant in unsupervised MDR-TB patients, bearing in mind that treatment of these individuals takes approximately 2 years of consistent antibiotic treatment. Lapses in treatment stimulate the emergence of drug resistance.

10. In summary, incomplete or inconsistent treatment with antibiotics of MDR-TB patients creates a risk of the emergence of XDR-TB - which is virtually untreatable.

11. The 4th Report of the WHO I IUATLD Global Project on Anti-Tuberculosis Drug Resistance Surveillance, Anti-Tuberculosis Drug Resistance in the World, 2008 states that XDR-TB has been recorded in 45 countries. The WHO regards XDR-TB as a serious emerging threat to global public health, particularly in countries with a high incidence of HIV.

12. The potential spread of such a virulent airborne disease as MDR-TB and in particular XDR-TB is one of the worst nightmare scenarios for epidemiologists, conjuring up images of numerous TB sanatoria that were common in Europe and the United States prior to the development of antibiotic treatment. The potential risk to the public from MDR-TB or XDR-TB is significantly more serious than the risk to the public of diseases such as MRSA.

13. In my opinion the public health risks associated with MDR-TB and XDR-TB are very serious. While MDR-TB can be treated, although at high cost and over a long period of time, XDR-TB, which may emerge from MDR-TB, is virtually untreatable. Viewing the matter from a public health viewpoint, it is my clear professional opinion that, for the State to safeguard public health, it must have the power to isolate and detain patients diagnosed with a highly infectious disease as specified in the Health Act of 1947 (as amended)."

That concluded the evidence in the case.

The Issues

This is an inquiry under Article 40.4 of the Constitution. The terms of reference of the inquiry were framed by Article 40.4.2°,which requires the Court *to forthwith enquire into the complaint and after giving the person in whose custody the person is detained an opportunity of justifying the detention, order the release of such person unless satisfied that he is being detained in accordance with law*. Accordingly the Constitution only allows for two possible outcomes. These are that the Court would either (i) find the detention of the patient to be lawful, declare it to be so and (subject to the possible reference of a constitutional question to the Supreme Court under Article 40.4.3°, as hereinafter discussed) close the inquiry or (ii) find the detention of the patient to be unlawful, declare it to be so and order her immediate release. Moreover, in the event of it finding that the patient was in unlawful detention the Court would not have the option of staying her release or attaching conditions to her release.

While this case has raised a variety of issues to do with matters of public policy; the risk of epidemic; the public interest both local and national; the adequacy of existing legislation; the need to balance the public's right to protection with the patient's rights to liberty, to bodily integrity, to self determination, and to privacy; the patient's mental capacity and ability to take decisions; cultural difficulties; the legal requirement of consent to medical treatment, possible limits on the right to refuse medical treatment; whether the patient might be medicated against her will in any circumstances and, if that were possible, the theoretical means by which she could be treated involuntarily; possible invocation of the wardship jurisdiction; and so on, this Court is constrained in that it can only have regard to those issues to the extent that they have a bearing on the legality of the patient's detention. Save to that limited extent, they are not matters to be appropriately considered within the bounds of an inquiry under Article 40.4, and, although they might be legitimately canvassed in other proceedings on another day, there are not, in so far as the Court is aware, any such proceedings presently in being.

There is one other action open to the court and I have previously alluded to it. Article 40.4.3° of the Constitution provides:

"3° Where the body of a person alleged to be unlawfully detained is produced before the High Court in pursuance of an order in that behalf made under this section and that Court is satisfied that such person is being detained in accordance with a law but that such law is invalid having regard to the provisions of this Constitution, the High Court shall refer the question of the validity of such law to the Supreme Court by way of case stated and may, at the time of such reference or at any time thereafter, allow the said person to be at liberty on such bail and subject to such conditions as the High Court shall fix until the Supreme Court has determined the question so referred to it."

Accordingly, in the event that I were satisfied that the patient's detention is in accordance with a law but that such law

is invalid having regard to the provisions of this Constitution, I would be obliged to refer the question of the validity of that law to the Supreme Court by way of case stated.

It seems to me therefore that the issues that the Court has to consider are as follows:

(1) Was the patient detained, and does she continue to be detained, in accordance with a law? In the particular context of this case, these questions embrace a number of sub-questions, namely:

(a) Under what law, if any, was the patient detained initially, and under what law, if any, might her detention be authorised on an on-going basis?

(b) In terms of the patient's initial detention, did the detainer act intra vires the law in question, and in accordance with principles of constitutional justice?

(c) In terms of the patient's continuing detention, is the detainer continuing to act intra vires the law granting power of detention, and is that power being operated constitutionally on an on-going basis?.

(2) If the patient's continuing detention is in accordance with an otherwise lawful power of detention, is the law purportedly authorising that detention valid or invalid having regard to the provisions of the Constitution?

Submissions

All of the parties have provided me with extensive written legal submissions and have referred me to case law on which they rely. Moreover, I received detailed oral submissions from Counsel on behalf of the various parties over two days on the 17th and 18th of November, 2008. I am most grateful for this assistance.

I do not propose to review the submissions and authorities comprehensively in the course of this judgment but will refer to them as necessary in course of addressing the issues for decision that I have identified.

The legal basis for the patient's detention

The patient is presently being physically detained at the Mercy University Hospital in the City of Cork. It is clear from the Certificate presented by Jim Corbett to which I have previously referred that she is being detained there purportedly in pursuance of an Order made by under s. 38 of the Health Act, 1947 as amended.

I am satisfied that, subject to the issue of its constitutional validity, the aforementioned s. 38 does provide, to those who may within the terms of the section lawfully invoke it, a statutory power of detention in respect of a person who is a probable source of infection with an infectious disease and whose isolation is necessary as a safeguard against the spread the infection, in circumstances where that person cannot be effectively isolated in his or her own home. Accordingly, the power of detention relied upon does exist, and the Court is satisfied that legislation creating it was in force at all material times and that it remains current. It is therefore necessary to consider whether s. 38 was properly invoked, both in terms of vires and with respect to principles of constitutional justice.

The initial detention – issues as to vires and constitutional justice

The power to make a detention order under s. 38 is reserved to a chief medical officer as defined in s. 2 of the Health Act, 1947. Under s. 2 of that Act "the expression 'chief medical officer' means a county medical officer for a county and a city medical officer for a county borough. That definition was of course directly relevant to the system of health administration that existed in 1947. It is of only indirect relevance now. Nevertheless, the Court is satisfied that, by virtue of provision 4(2) of Schedule 5 to the Health Act, 2004, entitled *Savings and Transitional Provisions*, the functions of such chief medical officer may be performed, within the dispensation of health administration that obtains today, by an appropriately qualified medical practitioner who is an employee of the Health Service Executive and is designated in writing by it to perform such function. I am satisfied on the evidence that Dr. Elizabeth Keane, who made the s. 38 Order in this case, is an appropriately qualified medical practitioner who is an employee of the Health Service Executive. I am further satisfied on the basis of the "Delegation Order", dated 1st June 2007, to which I have referred previously, that she is designated in writing to perform the functions of chief medical officer throughout the HSE South region, i.e. throughout the county of Cork (to include the county borough of Cork) and the county of Kerry respectively. Accordingly, Dr. Keane was a person who could lawfully invoke the power of detention under s. 38 in appropriate circumstances.

The first point of challenge by the applicant relates to the validity of Dr. Keane's opinions.

The applicant points out that it was a prerequisite to a lawful detention under s. 38(1) that Dr. Keane should have formed valid opinions that (i) the patient is a probable source of infection with an infectious disease; (ii) her detention and isolation is necessary as a safeguard against the spread of infection, and (iii) she cannot be effectively isolated at home. Moreover, the section requires that such opinions should have been based:

(a) upon Dr. Keane's own inspection of the patient, or

(b) upon information furnished to her by a registered medical practitioner who has inspected the patient.

The applicant submits that while the section allows for the utilisation of either first hand information (i.e. information gathered in the course of a personal inspection of the patient) or alternatively, second hand information (i.e. information furnished by a third party registered medical practitioner who has inspected the patient) in the formation of the three required opinions, in each case Dr. Keane was obliged to the personally evaluate the information in question, and to base her opinions upon her evaluation of that information. It is contended that the evidence establishes that Dr. Keane did not inspect the patient personally and that she relied instead upon the inspection of Dr. Terry O'Connor. It is further

contended, however, that Dr. Keane did not personally evaluate the information gathered by Dr. O'Connor. Rather, she unquestioningly and uncritically adopted opinions formed by Dr. O'Connor. It was submitted that in the circumstances Dr. Keane could not be said to have independently formed, and to have bona fide held, the three required opinions.

The Court is satisfied on the evidence that this submission must be rejected. The letter of Dr. Terry O'Connor to Dr. Margaret O'Sullivan dated the 10th of December, 2007, presented a very detailed clinical picture concerning the patient's illnesses, the risks associated therewith, the need for her isolation, and the impracticality of managing her at home. Dr. Keane, who considered that letter amongst other information, did not uncritically and unquestioningly adopt the views of Dr. O'Connor. The evidence establishes that she discussed the contents of his letter with him in the course of a teleconference, and that she also sought legal advice on the case from the HSE's legal advisors. She clearly gave detailed consideration to the information supplied by Dr. O'Connor and formed her own opinions about it. The fact that her opinions accorded with Dr. O'Connor's opinions is hardly surprising, but it is irrelevant.

Having formed the three requisite opinions Dr. Keane was entitled under s. 38(1) of the Health Act, 1947 as amended to order in writing the detention and isolation of the patient in this case in a specified hospital or other place until she gives a certificate that the patient is no longer a source of infection. She duly issued an order in writing dated the 11th of December, 2007 ordering that Ms. N.I. be detained and isolated in a specialised negative pressurised room with Mercy University Hospital until she gives a certificate that the patient is no longer a source of infection.

I have considered the form of the order. It is not a masterpiece of legal drafting in as much as it fails to specify either an address for the proposed detainee, or an address in respect of the specified hospital. Although it was contended by Dr. Keane that the reason why it merely names the patient and does not further describe her was uncertainty as to her address after she took her own discharge from hospital, the evidence establishes that they had a last known address for her, namely Great William O'Brien Street, Blackpool, Cork. That being the case there no reason why she could not have been described in the order as "N.I., recently of Great William O'Brien Street, Blackpool, Cork." Moreover, no explanation whatever was given for the failure to provide an address for the specified hospital. Notwithstanding these criticisms, I am satisfied that the defects mentioned are not fatal defects. Nobody has seriously contended that, in the circumstances of this case, the order could be construed as relating to anybody other than the patient, or that the specified hospital cannot in fact be located. The order is in writing as required by the statute; it clearly expresses both the legal and factual basis for the order; it is clear in its intended effect; it is signed and dated by Dr. Keane and, as required by section 35 of the Health Act, 1953, it is also signed by a second registered medical practitioner, namely Dr. Margaret O'Sullivan. Accordingly, I am satisfied in all the circumstances that the form of the order was adequate.

A second point is then made by the applicant which has more substance than the first.

Section 38 (2)(b) provides that when an order has been made under s. 38 in relation to a person the medical officer who made the order, referred to as the committing officer, and also any person to whom the duty of acting under s. 38 has been assigned by or with the consent of the Minister and who has been authorised in writing by the committing officer to act in the particular case, may detain the patient.

The applicant correctly contends that no person other than those prescribed in section 38 (2)(b) may detain a person under s. 38. Dr. Keane made the order in this case and was, accordingly, the committing officer. However, she did not personally detain the patient. Rather, Dr. Annette Dillon detained N.I. on 11th December 2007 with the assistance of members of An Garda Síochána. The applicant says that neither Dr. Dillon, nor either of the Gardaí in question, was a person to whom the duty of acting under s. 38 had been assigned by or with the consent of the Minister. Moreover, none of them were persons who had been authorised in writing by the committing officer to act in the particular case. The applicant is correct on both counts.

The applicant makes the further point that Section 38 (2)(c)(i) provides that the person detaining the patient shall, on or before doing so, produce for inspection by the appropriate person his written authorisation from the committing officer, if he is not himself the committing officer. It is contended that compliance with this provision is mandatory and requires production for inspection by "the appropriate person" as defined in s. 38(3) of the detainer's written authorisation from the committing officer if he is not himself the committing officer. As neither Dr. Dillon, nor the Gardaí, had authorisations in writing from Dr. Keane, they could not have complied with this requirement. Once again the applicant is correct.

Accordingly, although a valid order existed for the detention of the patient pursuant to s. 38 of the Health Act, 1947, as amended, that order was not validly executed in the first instance. Despite the fact that they were physically in possession of the said order, and purportedly served it on the patient, neither Dr. Dillon, nor the Gardaí who accompanied her, were lawfully entitled to detain the patient because they were not persons properly authorised to execute the order. Moreover, they were consequently unable, and therefore did not, comply with the requirement specified in s. 38 (2)(c)(i). In these circumstances their purported detention of the patient at Middleton on the evening of the 11th of December, 2008 was unlawful. Moreover, the patient remained in unlawful detention while she was being conveyed by Garda car to the Mercy University Hospital.

Further criticism is made by the applicant of the manner in which s. 38 (2) (c) (ii) was purportedly complied with. This provision requires the detainer to give to the appropriate person a copy of the order, and a statement in writing of the right to appeal under s. 38 (2)(h). Although it was the subject of controversy under a separate heading, the Court is satisfied that the appropriate person, in the circumstances of this case, was the patient herself. It was contended that the s. 38 order was not properly served on the patient because, since it refers in the body of the order to "the attached report" of Dr. Terry O'Connor dated the 10th of December, 2007, the complete order must be construed as including both the curial document and its intended attachment. The evidence establishes that only the curial document was served. The intended attachment was not served. While I agree that, ideally, the attachment should have been served, I am not satisfied that the failure to do so constituted a breach of the first requirement in s.38 (2)(c)(ii). The patient was made aware in the curial document of the existence of the report of Dr. O'Connor dated the 10th of December, 2007 and of the reliance that was being placed upon it. She was therefore provided with sufficient information to enable her, or her advisers, to request a copy of it, should they wish to.

I am satisfied that Dr. Keane's letter to the patient of the 11th of December, 2007, which was served on her at the same time as the order, contained a statement in writing of the right to appeal under s. 38 (2)(h) and constituted sufficient compliance with the second requirement in s. 38 (2)(c)(ii).

It was further submitted that before complying with the provisions of section 38 (3) (c) it is necessary that the person detaining the patient be in a position to make a judgement, and that they should actually make a judgement, as to whether the patient "is for any reason unable to act for himself " (or herself). This is to ascertain in any particular case whether the appropriate person is the patient herself or "the person for the time being in charge of the patient" as referred to at section 38 (3)(c). It was suggested that it is fundamental to the operation of s. 38, having regard to the purpose of that section, that proper and careful consideration be given by the detaining person as to who is the appropriate person within the meaning of the section for the purposes of notification of the right of appeal to the Minister.

The applicant contends that the only evidence with regard to any assessment of N.I.'s mental condition prior to the making of the order was the evidence of Dr. Cooney, Psychiatrist, to the effect that he had advised Dr. O'Connell that N.I. was in a position to consent to medical treatment. That would seem to be correct. The Applicant argues that such evaluation would be required on any occasion where the making of an order under section 38 is contemplated, but particularly in this case having regard to what the first named Respondent already knew of N.I.. Such knowledge included the history with regard to her mental state, the fact that her two children had been taken into care, the fact that she was a foreign national with no family support, the uncertainty with regard to her state of literacy and education, her erratic attitude to the taking of medication, and her refusal to take medication at that stage either for her physical condition or for her depression. It is contended that the failure of Dr. Keane (and her subordinates who were involved in attempting to execute the order) to assess whether there was reason to believe that the patient might be unable to act for herself fundamentally undermines the lawfulness of the detention.

The Court does not consider that there is any substance in this point in the circumstances of this case. The patient was seen by Dr. Cooney at Dr. O'Connor's request just before Dr. O'Connor wrote to Dr. O'Sullivan on the 10th of December, 2007. Her capacity to take decisions was assessed and she was found to be capable at that point. Moreover, Dr. O'Connor specifically alluded in his letter to the fact that the patient had been reviewed by the psychiatric team and stated that they had concluded that the patient's main problem was distress due to physical and psychosocial stressors. He further expressed the personal view that she was depressed. As previously stated the Court is satisfied that Dr. Keane considered this letter in detail, and that she subsequently discussed it with Dr. O'Connor. There was nothing specific to trigger any alarm in Dr. Keane's mind as to the patient's ability to act for herself at the time she made the detention order. The same comment applies with respect to the involvement of Dr. O'Sullivan and Dr. Dillon, respectively.

The applicant has sought to argue that the irregularities associated with the execution of the s. 38 order that rendered the patient's initial detention unlawful had the effect of tainting everything that occurred thereafter. According to the applicant the patient has been in continuous unlawful detention from the outset on account of these irregularities. This Court does not agree with that submission. The crucial factor is the existence of a lawful s. 38 order. Although the means by which that order was purportedly executed were unlawful, the failures in that regard would not have operated to invalidate or undermine the lawfulness of the order itself. The order predated in time the unlawful acts on foot of which the patient was detained. Accordingly, the patient's detention, although initially unlawful, became lawful once she was delivered into the custody of the staff at the Mercy University Hospital who were directly authorised by the s. 38 order to isolate her there in a specialised negatively pressurised room.

The continuing detention – issues as to vires and constitutional justice
It remains to be considered as to whether, having regard to the considerable lapse of time since she was committed to the Mercy University Hospital, the patient remains in lawful detention. It is clear that the Court must look beyond issues of procedural or technical compliance with the enabling statutory provision and adopt the approach of the divisional High Court (Laffoy, Kelly and Geoghegan JJ) in the case of *The Application of Gallagher (No. 2)* [1996] 3 I.R. 10. That case concerned an inquiry under Article 40.4.2° into the detention of the applicant under s. 2 of the Trial of Lunatics Act, 1883. Giving judgment, Laffoy J. observed at page 31:

> "Article 40, s. 4, sub-s. 2 enjoins this Court, upon a complaint being made that a person is being unlawfully detained, to forthwith enquire into the complaint and after giving the person in whose custody he is detained an opportunity to justify the detention, to order the release of such person from such detention unless satisfied that he is being detained in accordance with law. It is well settled that the expression 'in accordance with law' in Article 40, s. 4 does not mean simply in accordance with a statutory provision; adopting the words of Henchy J. *in King v. Attorney General* [1981] I.R. 233 at p. 257, it means
>
> > 'without stooping to methods which ignore the fundamental norms of the legal order postulated by the Constitution . . .'"

In the course of his judgment in the same case Kelly J. said:

> "In the instant case, it is accepted that the warrant under which the applicant is held is a good one. *Prima facie*, therefore, the applicant is in lawful detention and is not entitled to his release. But the mere fact that the warrant under which he is held is in order is not necessarily determinative of the legality of his detention. The Court is authorised in an appropriate case to look behind the warrant which authorises a person's detention and consider the circumstances under which such person is being held. If such circumstances involve serious breaches of the applicant's constitutional rights, the detention can be so impaired as to make it unlawful. In the present case, the applicant has chosen to make his complaint under Article 40 and so the Court must now examine his position to see if there have been serious breaches of his constitutional rights so as to entitle him to release."

Moreover, in his judgment in the same case Geoghegan J. stated (at page 16 of the report) that:

> "….it is well established that in appropriate cases the High Court may go behind the face of the documentation and may consider the circumstances under which the applicant is being held. If the conditions under which the applicant was being held involved serious and fundamental breaches of the applicant's constitutional rights, the detention could be so tainted as to render it unlawful, notwithstanding the apparent validity of his detention on the documentation produced. In such circumstances the applicant would be entitled to an order for his release."

Accordingly, this Court must now focus on whether the power of detention in the present case is being operated in accordance with principles of constitutional justice. The Court is concerned, in particular, to ascertain whether the detainer is paying sufficient regard to the constitutional and other rights of the patient and whether her rights are being adequately respected, defended and vindicated.

Sub-subarticles 1° and 2°, respectively, of Article 40.3 of the Constitution of Ireland provide:

> "1° The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.
>
> 2° The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen."

Certain of the citizen's personal rights, such as the right to liberty, are enumerated within the Constitution while other such rights, being un-enumerated personal rights, have been identified by the superior courts. The question whether non - citizens may rely on the personal rights guaranteed by article 40.3 has been considered in a number of cases including *The State (Nicolaou) v. Attorney General* [1966] I.R. 567; *The State (McFadden) v. Governor of Mountjoy Prison (No 1)* [1981] I.L.R.M. 113 and *In re Article 26 and the Illegal Immigrants (Trafficking) Bill, 1999* [2000] 2 I.R. 360. The position is that while non-citizens have been held to be entitled to the benefit of many of the important personal rights guaranteed under the Constitution, there has not been a comprehensive statement of principle from the Supreme Court confirming that non-citizens have that entitlement in the case of every personal right. However, many constitutional lawyers hold the view, with which I am sympathetic, that the personal rights guaranteed under Article 40.3 are "natural", in the sense of being inherent to human personality and accordingly antecedent to the Constitution. If that is so, it would follow that non-citizens should be entitled to the benefit of them. It is not necessary for me to express a definitive view on this issue for the purposes of this case. I do consider, however, that the following rights must be regarded as constitutionally guaranteed to the patient in this case, namely the right to liberty, the right to bodily integrity, the right to be treated with human dignity, the right to self determination, the right to family life, the right to privacy, the right to litigate and the right to fairness of procedures in the administration of the law.

One of the features of the personal rights guaranteed under the Constitution is that they do not confer absolute entitlements. They cannot do so, for as Kenny J. said in *The People v. Shaw* [1982] I.R. 1 at p 63:

> "There is a hierarchy of constitutional rights and, when a conflict arises between them, that which ranks higher must prevail. This is the law for the exercise of all three powers of Government and flows from the conception that all three powers must be exercised to promote the common good: see the preamble to the Constitution. The decision on the priority of constitutional rights is to be made by the High Court and, on appeal, by this Court. When a conflict of constitutional rights arises, it must be resolved by having regard to (a) the terms of the Constitution, (b) the ethical values which all Christians living in the State acknowledge and accept and (c) the main tenets of our system of constitutional parliamentary democracy."

Moreover, Griffin J. in his judgment in the same case stated, at p. 56:

> "The existence in a Constitution of certain guaranteed civil, as distinct from natural, fundamental human rights does not mean that a person is entitled to insist on a particular guaranteed right to the exclusion or disregard of another person's guaranteed right, or of the common good. Indeed, many of the guaranteed personal rights under our Constitution are expressly limited in their application. But even where there is no such express limitation, it is a fundamental canon of construction, as well as being a phenomenon of every legal order, that rights, whether constitutional or merely legal, are prone to come into conflict with one another to such an extent that in particular circumstances one of them must yield right of way to another. If possible, fundamental rights under a Constitution should be given a mutually harmonious application, but when that is not found possible, the hierarchy or priority of the conflicting rights must be examined, both as between themselves and in relation to the general welfare of society. This may involve the toning down or even the putting into temporary abeyance of a particular guaranteed right so that, in a fair and objective way, the more pertinent and important right in a given set of circumstances may be preferred and given application."

Consistent with this, the guarantees in sub-sub articles 1° and 2° of Article 40.3 are qualified, respectively, by the phrases ôso far as practicableö and ôas best it mayö. Further, the right of citizens, as human persons, to equality of treatment before the law which is guaranteed in Article 40.1 is expressly qualified by the statement:

> "This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function."

The power of detention contained in s. 38 of the Health Act, 1947 is far reaching indeed. As well as impinging directly on the personal liberty of its subject it has the potential to impinge directly or indirectly upon other personal rights constitutionally guaranteed to that person, e.g. the right to be treated with human dignity, the right to individual privacy and the right to family life, to name but some. It is essential therefore to consider the legislative object of the power in question, the class of persons who may potentially be the subject of it, the general public interest, the duties and obligations upon those who may exercise the power, and the interests and rights of the particular patient in this case.

It is clear to the Court that the primary object of the s. 38 power of detention is to provide a safeguard against the spread of particular infectious diseases amongst the general population by facilitating, where necessary, the compulsory effective isolation of a person who is suffering from such a disease. The expression "infectious disease" is defined in section 2 of the Health Act 1947 as meaning primarily any disease included in regulations under subsection 1 of s. 29 whether absolutely or by definition of a particular stage of such disease. Although many diseases are included in such regulations the Minister has, within the regulations, scheduled only certain of those diseases for the purposes of s. 38. At present these are the diseases listed in Regulation 8 of the Infectious Diseases Regulations, 1981, as amended by regulation 4(4) of The Infectious Diseases (Amendment) (No 3) Regulations, 2003.

The key criterion is the need to ensure "effective" isolation. The section expressly provides that the power may only be invoked in cases where the patient cannot be effectively isolated in their own home. It is implicit in the section that the legislature intended that the power should be invoked sparingly and that it should not be resorted to save where

absolutely necessary. It is difficult to conceive of any circumstances where it would be necessary to invoke the power save in the case of patient non co-operation with a proposed regime of isolation. Even in a case where a patient's home is physically, or otherwise, unsuitable to provide effective isolation, it would be unnecessary to invoke the s. 38 power of detention in the case of a co-operative patient. He or she could simply be admitted to, and isolated within, a hospital or other suitable place on a voluntary basis.

The class of persons who may potentially be the subject of a section 38 detention order is therefore comprised of non co-operative persons suffering from one or more of the infectious diseases listed in Regulation 8 of the Infectious Diseases Regulations, 1981, as amended by regulation 4(4) of The Infectious Diseases (Amendment) (No 3) Regulations, 2003.

As regards the public interest, the diseases listed in Regulation 8 are all very serious diseases. The development of an epidemic or pandemic involving any of them would be a disaster. Tuberculosis is one of the listed diseases. It is clear from the evidence of Dr. O'Connor, and the affidavit of Prof Meijer, that ordinary drug resistant TB represents a significant public health risk in itself. It is moderately contagious and, although not difficult to treat, requires a lengthy period of treatment. It also has a significant mortality incidence. However, in the case of MDR-TB, which the patient in the present case is suspected to have, treatment of the infection is much more difficult, much more protracted, and it has a much higher mortality incidence. Further, and much more sinisterly, incomplete or inconsistent treatment with antibiotics of MDR-TB patients creates a risk of the emergence of XDR-TB which is virtually untreatable. The patient in this case, who is believed to suffer from MDR-TB, has had incomplete or inconsistent treatment of her condition with antibiotics. Prof Meijer characterises the potential spread of a virulent airborne disease such as MDR-TB, and in particular XDR-TB, as being "one of the worst nightmare scenarios for epidemiologists, conjuring up images of numerous TB sanatoria that were common in Europe and the United States prior to the development of antibiotic treatment". He says that the potential risk to the public from MDR-TB or XDR-TB is very serious, and is significantly more serious than the risk to the public from diseases such as MRSA. The Court is satisfied on the basis of the evidence that it has received that the patient, for so long as she remains infectious, represents a grave danger to the general public unless she effectively isolated. Accordingly, there is a significant public interest dimension to this case.

I now turn to the duties and obligations of a chief medical officer (or a medical officer of health, such as Dr. Keane, performing the functions of a chief medical officer) towards a person who is the subject of an order made under s. 38. As I have said the power of detention provided by s. 38 of the Health Act, 1947 represents a significant impingement upon the constitutional rights of the person against whom it is invoked. There must be due recognition of this at all stages and it is incumbent on the person invoking s. 38 to take positive steps to ensure respect for, and the vindication of, the subject patient's rights to the greatest extent possible consistent with the need to protect the public against the spread of disease. Regrettably, the Court has been forced to the conclusion, on the evidence that it has heard, that Dr. Keane has focussed primarily on the public health risk and has given little or no thought to how the unfortunate patient's constitutional rights might be respected or vindicated. The patient had been in detention for almost eleven months when the matter came before this Court, and there was no care plan in place for this patient to ensure the vindication of her rights. Indeed, Dr. Keane had given no thought whatever to it, nor did she think it was her responsibility to ensure that such a plan was put in place. While it is understandable that Dr. Keane would entrust primary care of the patient to Dr. O'Connor and his team now that she is in isolation in a negatively pressurized room at the Mercy University Hospital, Dr. Keane was required to be, and remains, centrally involved. The patient will remain in isolation until she, Dr. Keane, is in a position to certify that the patient is no longer a probable source of infection. Accordingly, she is obliged to stay in close touch with the primary care team and to maintain the case under constant review. Moreover, Dr. Keane is the person who is ultimately responsible for not just for the physical care of the patient but for all aspects of the patient's welfare. Her responsibility in this regard is an onerous one. She must ensure that the patient's rights are impinged upon to the very minimum extent necessary. She is required to vigilant and pro-active to ensure that the patient's rights are respected and vindicated in so far as is possible. Her duty in that regard is all the greater in circumstances where the patient is particularly weak and vulnerable and the statutory provision containing the power of detention is an old one that provides little or nothing in the way of built in safeguards for the protection of the patient's rights. It is unfortunately the case that s. 38 does not incorporate many of the safeguards that one might reasonably expect to see in a more modern piece of legislation e.g., it does not provide for regular periodic reviews of the patient's case, or for the provision of an independent advocate for the patient.

The patient in this case is particularly weak and vulnerable. She is believed to have not just one, but two, life-threatening medical conditions, namely full blown AIDS and MDR-TB. She is a foreign national in a foreign land with no family network here and no significant social network here. She faces a deportation order. Her children are in care. Although of normal intelligence she is almost certainly of limited education. While she understands and speaks some English it is not her first language. Her literacy skills, if any, are uncertain. She is detained in a highly controlled environment with limited opportunities for interaction with other persons. Those she does have contact with, with the exception of her children, and her mother who has only recently had an opportunity to visit her, are culturally alien to her. All of her visitors must wear masks, gowns and gloves. Some also wear goggles. There is a security man at her door around the clock. She is sometimes depressed. She continues to refuse treatment and in this respect, and in some other respects from time to time, is not behaving rationally. There is, though it can be put no higher than this at the present time, a question mark over her capacity to take decisions in her own interest. She is presumed to be compos mentis but only on the basis of a limited, and less than wholly satisfactory, psychiatric evaluation. That presumption, like all presumptions, may be capable of being rebutted. There are huge cultural issues at play as well as issues of trust and confidence. The patient unquestionably faces numerous adversities, though some of these are of her own making.

The responsibilities, of which I have spoken, although personal to Dr. Keane, also rest upon the first and second named respondents. Notwithstanding the Court's criticisms of her for focussing too much on the public health risk and not sufficiently on the rights of the patient, I am satisfied that at all times Dr. Keane acted in good faith, and that she did so within the scope of her job as Director of Public Health for HSE South and Medical Officer of Health for the Counties of Cork and Kerry. The HSE therefore shared, and continue to share, her responsibilities towards the patient and are obliged to support the doctor in her role, not least by providing her with comprehensive and reliable legal advice concerning what to do in the very unusual situation of the s. 38 power needing to be invoked and, where necessary, by providing her with material and administrative assistance.

In the Court's view, the second named respondent as the physical custodian of the patient has parallel responsibilities with those of the first named respondent in respect of the patient's non-medical welfare. It goes without saying that it has primary responsibility for her medical welfare.

It is noted that the HSE's legal advisors were consulted at the outset by Dr. Keane, and that some advice was provided. It is impossible to assess the adequacy of the advice given without further information. However, the evidence establishes that legal assistance was rendered in terms of drafting the order; that there was advice concerning the need to effect adequate service as required by the Act; that there was advice concerning the need to make the patient aware of what was happening in layman's language; that there was advice concerning the need to ensure that the patient could have access to legal advice if she wanted to avail of it, and advice concerning the need to ensure that the patient was aware of her right to appeal. I find that this advice was by and large complied with either at the time of, or in the immediate aftermath of, the patient's detention. However, thereafter Dr. Keane and her team, and to a lesser extent those responsible for the patient's care at the Mercy University Hospital, seem to have adopted the attitude that those boxes were ticked, and there was little appreciation that the obligation to take positive steps to respect and vindicate the rights of the patient was an on-going one. There is nothing in the evidence before me to suggest that legal advice was received concerning the need to the formulate a specific care plan aimed at ensuring respect for and, in so far as practical, the vindication of the patient's personal rights on an ongoing basis. If such advice was indeed received, it wasn't acted upon. It was only after some weeks, when contrary to expectations, the patient was continuing to refuse treatment that people became worried at the apparent open-endedness of the situation and the unanticipated spectre that the patient might remain in detention until she dies. This concern provoked the letter of the 18th of January from Dr. Keane to Professor Brendan Drumm, to which I have previously referred, and the subsequent correspondence between senior officials in the HSE and the Department of Health, culminating in Dr. Kevin Kelleher's suggestion, months later, that the social workers concerned with the patient's case should revisit with her the possibility of an appeal to the Minister.

The Court has already criticised the absence of a rights based care plan for the patient in this case. Although the various professionals concerned with her welfare are all well disposed towards her, are caring, and are doing their best in a very difficult situation, their approach to her non-medical welfare has been ad hoc and largely unplanned. There have been failures on account of this. To give just one example, the evidence establishes that the patient has from time to time resisted detention, has attempted to escape, has wilfully misbehaved and has not submitted to the exercise of s. 38 powers "in a peaceful and orderly manner". Yet it has never occurred to anybody, either before or since, to advise the patient of the implications of these behaviours, that each one of them constitutes a criminal offence under s. 38 (4), attracting a potential custodial sentence of up to three months in jail. The Court would ask how, in the absence of this information, it could be contended that the patient's right to self determination is being respected? To make a proper decision a person has to have all necessary information.

While the patient is aware that she is being forcibly denied her liberty, she is seemingly unaware that her right to freedom of expression within the hospital is restricted by law. Despite the desperateness of her situation, she cannot even shout out in frustration. If she does so, she potentially commits the criminal offence of failing to submit to her isolation "in a peaceful and orderly manner". Does her right to human dignity not entitle her to be appraised of the full implications of her situation?

A similar comment could be made with respect to section 38 (2)(o) which provides that "force may, if necessary, be used for the purpose of carrying out any provision of this subsection". There is no evidence that the patient has been advised of this feature of the circumstances in which she is detained. It is possible that if, out of frustration or otherwise she becomes unruly, she could be forcibly restrained. Does she realise this? Has anybody told her?

Now while the Court accepts that it is inherently unlikely that this patient would ever be prosecuted for a s. 38(4) offence, that is not the point. The point is that no one has sat down to work out, or to plan, exactly what information the patient needs to have, how it is to be communicated, how issues of trust and confidence tending to undermine effective communication are to be addressed, what special skills may be necessary to ensure effective advocacy both with and on behalf of the patient, and who is to have responsibility for it. There have been ad hoc efforts by Dr. Dillon, Dr. O'Connor, Dr. Margaret O'Sullivan, and the social workers (particularly Marie Buckley and Mr. Rutherford) but there has been no plan. The multi-disciplinary case conferences provide individual workers with a means of ventilating concerns about aspects of the patient's welfare and are a good innovation in so far as they go, although the absence of a regular psychiatric input is a matter of some concern. However, nobody seems to be in overall charge of the non-medical facets of the case.

At the end of the day the Court is less concerned with historical failures than with the current situation. Because of the increasing level of concern at the apparently open-endedness of the patient's detention there has lately been an increase in engagement with the whole question of ensuring respect for, and vindication of, the patient's rights. This has not happened on any formal or planned basis but largely on an ad hoc basis. Nevertheless it has happened. The question of a possible appeal has been revisited with the patient by Ms. Buckley and Mr. Rutherford. The question of providing a non legal advocate for the patient has been explored and to some extent progressed. The bringing of her mother to Ireland from South Africa has helped in negotiating some of the cultural barriers and has provided the patient with a social and familial contact from within her own culture. Ms. Buckley has, on her own initiative, re-explored with the patient the possibility of obtaining legal advice, though so far to no avail. The very fact that this inquiry has been initiated, and is being supported by the patient's primary carers is testimony to the new engagement that I have referred to. Accordingly, on balance, I am satisfied that notwithstanding past failures, the patient's constitutional rights are now being sufficiently respected and vindicated to enable the Court to express the view that her detention is, at this time, lawful. There is, however, room for considerable improvement in terms of the formulation of a specific rights based care plan, and the implementation of a system of regular periodic reviews not just of the patient's medical situation but of all aspects of her welfare.

The validity of s. 38 having regard to the provisions of the Constitution
Having decided that the patient's continuing detention is in accordance with an otherwise lawful power of detention, namely s. 38 of the Health Act, 1947 as amended, I must now consider whether that provision is valid or invalid having regard to the provisions of the Constitution?

The Applicant's Submissions
The applicant contends that s. 38 is invalid having regard to the provisions of the Constitution in as much as it fails to provide sufficient safeguards to ensure that the personal rights of weak and vulnerable persons, such as the patient in this case, are defended and vindicated. The applicant complains specifically about the absence of provision for periodic reviews of the patient's case, the inadequacy of the existing appeal mechanism, the existence of built in and systemic obstacles rendering it extremely difficult for a weak and vulnerable person to secure vindication of their rights (e.g., no formal mechanisms by means of which the courts can be accessed or by means of which legal representation can be

secured), and no provision for the appointment of an independent advocate to promote the rights and defend the interests of weak and vulnerable persons.

The applicant acknowledges that the provision in question enjoys a presumption of constitutionality, by virtue of having been enacted post 1937. Moreover, there is an acceptance of the principles articulated so clearly by Walsh J. in *East Donegal Cooperative Livestock Market Limited v. Attorney General* [1970] I.R. 317, where he said at p. 341:

> "At the same time, …, the presumption of constitutionality carries with it not only the presumption that the constitutional interpretation or construction is the one intended by the Oireachtas but also that the Oireachtas intended that proceedings, procedures, discretions and adjudications which are permitted, provided for, or prescribed by an Act of the Oireachtas are to be conducted in accordance with the principles of constitutional justice. In such a case any departure from those principles would be restrained and corrected by the Courts."

Notwithstanding this, the applicant contends that s. 38 is so deficient in necessary safeguards that the presumption of constitutionality is to be regarded as having been rebutted. It was submitted that s. 38 is fundamentally deficient in making no provision whatsoever for an ongoing structured review of the patient's condition and treatment and further, for outside independent review and oversight of the welfare and treatment of the patient and her status as a probable source of infection.

In support of these contentions Counsel for the Applicant has cited a number of cases where either, on the one hand, the absence of statutory safeguards has been deprecated, or, on the other hand, the presence of statutory safeguards has been lauded.

Counsel referred the Court *to RT v. Director of the Central Mental Hospital* [1995] 2 I.R. 65. This involved a case stated to the Supreme Court as to whether section 207 of the Mental Treatment Act, 1945 was invalid, having regard to the guarantee of personal liberty protected in Article 40.4.1 of the Constitution. In that case an Order had been made under section 207 of the Act of 1945 directing the transfer of the Applicant to the Central Mental Hospital, Dundrum. The Court having conducted an examination of the full circumstances, found that the detention was lawful pursuant to section 207 of the Mental Treatment Act, 1945 but went on to consider whether the section was unconstitutional. Costello P. said the following at pages 78/79 of the report:

> "Is s. 207 unconstitutional?
>
> The applicant's constitutional right to liberty is central to this case. It is to be found in Article 40, s. 4, sub-section 1. This article provides that no citizen shall be deprived of his personal liberty save in accordance with law. This does not mean that the Oireachtas is free to enact any legislation it wishes trenching on the guaranteed right. It is however well established that legislative restrictions on the citizen's liberty must be in accordance with the fundamental norms of the legal order postulated by the Constitution. (See *King v. Attorney General* [1981] I.R. 233). These fundamental norms are manifold — that with which this case is concerned is the constitutional requirement that the State should defend and vindicate the citizen's personal rights, and these include the right to liberty. So, if it can be shown that a law fails to defend and vindicate the right to liberty it infringes a fundamental norm of the legal order postulated by the Constitution and will be invalid as trenching on the rights guaranteed by Article 40, s. 4, sub-section 1.
>
> The right to liberty is, of course, not an absolute right and its exercise is in fact and in many different ways restricted by perfectly valid laws, both common law and statutory. Adjudication on a challenge to restrictive laws will be helped by considering the object and justification advanced in support of the law. It is obvious that if the object of the law is to punish criminal behaviour different considerations will apply than when the impugned law has a totally different object, such as the welfare of the person whose liberty is restricted. 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 citizens 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 standards set by the Recommendations and Conventions of International Organisations of which this country is a member."

The judgment then sets out various criticisms of the section taken from a Department of Health Green Paper in which the Department had expressed the opinion that the section was "seriously defective".

Costello P. listed particular further defects that he could identify, including the following:-

> "(4) There are no safeguards to protect the patient against a possible error in the operation of the section. The only professional opinion on the question of the suitability of the Central Mental Hospital is that of the Inspector. There are no procedures for the review of his opinion.
>
> (5) There are serious defects not only in the transfer procedures but also in the provision which enables indefinite detention in the Central Mental Hospital. There is no practical way in which a transferred patient can procure his re-transfer or his liberty or have his continued detention reviewed.
>
> These defects in the statutory procedures have serious legal consequences as they directly impinge on the constitutional right to liberty of temporary patients. Such patients have a right to their liberty, at most, eighteen months after the reception order which restricted their liberty was made. If transferred under the section then they

> may be detained there lawfully after the expiration of that period for an unlimited time which, as this case eloquently demonstrates, may extend over many years. The defects in the section are such that there are no adequate safeguards against abuse or error both in the making of the transfer order, and in the continuance of the indefinite detention which is permitted by the section. These defects, not only mean that the section falls far short of internationally accepted standards but, in my opinion, render the section unconstitutional because they mean that the State has failed adequately to protect the right to liberty of temporary patients. The best is the enemy of the good. The 1981 reforms which would have remedied the defects were not brought into force because more thorough reforms were being considered (para. 16.13 of Green Paper). The prolonged search for excellence extending now for over fourteen years has had most serious consequences for the applicant herein."

For these and the other reasons stated in his judgment the learned President expressed the clear view that s. 207 was unconstitutional, and sent forward a case stated for the opinion of the Supreme Court. However, prior to the matter coming on for hearing the applicant was discharged from the Central Mental Hospital, as a result of which the President withdrew the case stated.

Commenting on the judgment of Costello P. in the *R.T*. case, in J.*H. v. Vincent Russell, Clinical Director of Cavan General Hospital, The HSE and Mental Health Commission* (Unreported, High Court, 6th February, 2007), Clarke J. said that the Mental Health Act, 2001 "was the means adopted to address those difficulties" (i.e. those difficulties that Costello P had referred to or identified). Since then the scheme and the provisions of Mental Health Act 2001 have been scrutinised by the High Court in several cases, and in that regard were reviewed in great detail by Charleton J. in the course giving judgment on an inquiry pursuant to Article 40.4.2° of the Constitution in a case of *T O'D v. Kennedy & Others* [2007] 3 I.R. 689. Having reviewed the scheme of the Act the learned Judge said at p. 699:

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

Moreover, speaking specifically of s. 4 of the 2001 Act, and the extent to which a mental health tribunal acting under section 18(1) of the 2001 Act should have regard to it, the learned judge said at p. 703/704 of the report:

> "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. I note that s. 4(2) specifically requires that the patient, or proposed patient, should be heard and that his or her rights should be considered in making any decision under the Act of 2001. It may be argued that the principle of *audi alteram partem* would be implied in any event into s. 18(1) but that, it appears to me, is not of itself a sufficient answer to a specific statutory provision that is designed to bring to the attention of non-legal personnel who are administering a form of detention, the fundamental principles upon which their decision making should pivot. In addition, any possibility that medical people might ignore the rights of a patient to such matters as dignity, bodily integrity, privacy and autonomy are also given prominence under s. 4(3) of the Act of 2001 by requiring these to be addressed. These principles apply to all aspects of patients' care in this context. I could not hold that a mental health tribunal, which is set up by the Mental Health Commission, itself specifically charged with ensuring that the best interests of mental patients are upheld, would be entitled to make any decision without bearing in mind the interests of the person whose treatment is at issue and the risks of those who may be harmed in consequence. Were it to be the case that a tribunal set up under s. 18 had ignored the rights of such a patient, then this court, on a judicial review application, would have authority to intervene. The Mental Health Tribunal under s. 18 is acting as an integral part of the scheme of protection of patients, and prospective patients, under the Mental Health Act 2001."

The applicant contends that it is instructive to contrast the regime under the Mental Treatment Act, 1945 so criticised by Costello J., with the new regime under the Mental Health Act, 2001. Her Counsel has submitted that in the light of these cases the Court should regard it as being the law that where an Act of the Oireachtas allows a significant impingement on a person's right to liberty in the interests of preventing the spread of infectious disease, that power, in order to be consistent with the State's constitutional guarantees under Article 40.3., must be tempered by the provision within the legislation of appropriate safeguards aimed at ensuring the vindication of the detainees personal rights in so far as is practical.

The Court was further referred to the case of *Sean Croke v. Charles Smith & Others (No. 2)* [1998] 1 I.R. 101 in which Budd J., having formed the view in the course of an inquiry pursuant to Article 40.4.2° of the Constitution, that s. 172 of the Mental Treatment Act, 1945 was invalid having regard to the provisions of the Constitution, forwarded a case stated to the Supreme Court under Article 40.4.3°. The Supreme Court, in considering the constitutionality of the powers of detention conferred by s. 172 of the Mental Treatment Act, 1945, examined the entire scheme of the Act set out at pages 126 and 127 of the judgment including any safeguards and other protections for the rights of detained persons afforded by the Act. The Supreme Court took the view in *Croke v. Smith (No 2)* that the section was not constitutionally flawed because of the safeguards contained in the Act, which safeguards were outlined in the course of the Court's single judgment by Hamilton C.J. The Chief Justice said at p. 131 of the report:

> "While it may be desirable that the necessity for the continued detention of the person, in respect of whom a chargeable patient reception order has been made, be subject to automatic review by an independent review board as provided for in the Mental Treatment Act, 1981, which has not, unfortunately, after fifteen years, been brought into force by the Minister, the failure to provide for such review in the Act has not been shown to render the provisions of the Act of 1945, and in particular s. 172 thereof, constitutionally flawed because of the safeguards contained in the Act, which have been outlined in the course of this judgment. If, however, it were to be shown in some future case, that there had been a systematic failure in the existing safeguards, and that the absence of

such a system of automatic review was a factor in such failure, that might cause this Court to hold that a person affected by such failure was being deprived of his constitutional rights."

The Chief Justice further observed at p. 133 that:

"The necessity for the continued detention of a patient, to whom s. 172 of the Act applies, must be regularly reviewed to ensure that he or she is not being unnecessarily detained.

The applicant relies on these passages as further supporting her contention that unless adequate safeguards are incorporated within a piece of legislation that purports to authorise the deprivation of a person's liberty, that legislation must be regarded as constitutionally flawed.

The Court was also referred to *Gooden v. St Otteran's Hospital* [2005] 3 I.R. 617. However, save to the extent that it confirmed the essential paternal character of the legislation under review, namely s. 184 and s. 194 of the Mental Treatment Act, 1945, it seems to be of doubtful precedent value having regard to Hardiman J.'s remark in that case viz:

"I do not regard the present decision as one which would necessarily be helpful in the construction of any statutory power to detain in any other context."

The Court was also referred to J.*B. v. The Mental Health (Criminal Law) Review Board & Ors* (Unreported, High Court, Hanna J., 25th July 2008). In that case Hanna J. took the view that s. 13(8) of the Criminal Law (Insanity) Act, 2006, as amended, was also an essentially paternal provision. He stated:

"Such an approach must inform and direct the interpretation of the Act of 2006. The statutory framework is designed to promote the care and well being of the applicant and persons in his position. It is both empowering and protective. The Board must review each case of a person coming within the scope of the Act of 2006 at regular intervals, not more than six months apart. I have already described in brief some of the features of the scheme of the Act. However, it is important to note that the Board is enjoined to have regard to the welfare and safety of the applicant and to the public interest. (See s. 11(2) of the Act of 2006 cited above)."

This is relied upon as being a further example of necessary in-built safeguards, the like of which, the applicant says, are conspicuously absent in the case of the power under s. 38 of the Health Act 1947, as amended.

It was further argued by the applicant that if the reference to "information" in section 38(1) is to be interpreted as embracing material other than clinical information, medical records or test results capable of being independently reviewed by a Chief Medical Officer prior to forming an opinion, the provision in question is fundamentally deficient in as much as that would effectively allow the detention and isolation of a person based only on the opinion of one registered medical practitioner. Moreover, if the Act of 1953 is to be read as requiring no more than the signature of another registered medical practitioner who has not examined the patient, such provision does not in any way cure the aforementioned deficiency.

The applicant says that because it is implicit in section 38 that any authorised detention should only be for the shortest period necessary to protect the public, the failure of the section to provide for regular reviews, or to specify any review period whatsoever, except in circumstances where the patient herself has appealed to the Minister, represents a fundamental flaw. It takes no account of the wide range of potential difficulties or adversities that a weak and vulnerable patient might face in initiating such an appeal. Moreover, the applicant says there is an illogicality inherent in section 38 in as much as when the detainer is dealing with a person who is "for any reason unable to act for himself" he is permitted to serve the order and relevant notices on the person "then in charge of the Applicant". However, when it comes to a possible appeal to the Minister it is arguable that by virtue of section 38 (2)(h) such an appeal cannot be initiated by the person "then in charge of the Applicant", and that it can only be initiated by the Applicant himself. It would seem that unless the patient is a child, for whom a specific statutory exception is made, the section does not allow a person other than the patient to initiate the appeal process.

The applicant also contends that the failure of the section, which comprises the entirety of the statutory scheme that empowers the detention and isolation of a person who is a probable source of infection, to make any provision for the entirely foreseeable circumstance of a patient refusing to be tested or treated, represents a further serious flaw.

It was further submitted that, in the event of an appeal to the Minister, section 38 (2)(o) could potentially be used to force a person in the patient's position to submit to an examination by the Minister's medical examiner, and that this theoretical possibility might inhibit such a person from availing of the right of appeal in the section, and that this could not be constitutional. (The Court does not consider that the fear raised in this submission represents a tenable or realistic concern, having regard to the *East Donegal* case, and it has only been included for completeness.)

It was further submitted that there is nothing whatsoever in section 38 to oblige the detainer to provide treatment for a person who is detained and isolated. Section 38(7) does provide that the cost of the maintenance and treatment of a person to whom an Order under this section relates shall be paid by the Health Authority of which the Medical Officer who made the order acts. However, s. 38(7) is an enabling provision. It does not impose a duty on the detainer to provide the detainee with any treatment. It was submitted that section 38 is entirely deficient in this respect and unconstitutional as failing to respect the patient's rights to life, to bodily integrity and to human dignity.

Finally, the applicant has contended that while it is accepted that the balancing of the rights of the individual and the public interest may result in the curtailment of the individual's personal rights, in particular circumstances, s. 38 is nevertheless so deficient in terms of the absence of specific provisions for the protection of the patient's rights, for review of detention, for independent oversight, for treatment, and the provision of a meaningful appeal mechanism, as to render it unconstitutional.

The Third and Fourth Named Respondents' Submissions
The arguments of the third and fourth named respondents may be summed up as follows:

Section 38 of the Health Act, 1947 enjoys a presumption of constitutionality. It is an aspect of the presumption of constitutionality that public servants will act in accordance with the duties imposed upon them by law. As Walsh J. said in *East Donegal Cooperative Livestock Market Limited v. Attorney General* [1970] I.R. 317, at p. 341:

> "At the same time, …, the presumption of constitutionality carries with it not only the presumption that the constitutional interpretation or construction is the one intended by the Oireachtas but also that the Oireachtas intended that proceedings, procedures, discretions and adjudications which are permitted, provided for, or prescribed by an Act of the Oireachtas are to be conducted in accordance with the principles of constitutional justice. In such a case any departure from those principles would be restrained and corrected by the Courts."

If a doctor fails to appreciate that element of her duty, the doctor may be criticised, but not the law. The *maxim ignorantia juris haud excusat* must apply.

Having regard to the presumption of constitutionality that exists with respect to s. 38, the onus lies on the applicant to establish clearly that the section is repugnant to the Constitution.

They refer to the objects of s. 38, and contend that they are essentially benign in nature and that, as in *Re Philip Clarke* [1950] I.R. 235, the provision is to be regarded as paternal and as designed for the protection of the citizen and the promotion of the common good.

They further contend that the power to detain a person who poses a danger to the public by reason of being a probable source of infection, and who must be isolated but who cannot be isolated at home, is one of the fundamental rights of the State. In support of this they rely on *Osheku v. Ireland* [1986] I.R. 733, where Gannon J. said at 746:

> "There are fundamental rights of the State itself as well as fundamental rights of the individual citizens, and the protection of the former may involve restrictions in circumstances of necessity on the latter. The integrity of the State constituted as it is of the collective body of its citizens within the national territory must be defended and vindicated by the organs of the State and by the citizens so that there may be true social order within the territory and concorde maintained with other nations in accordance with the objectives declared in the preamble to the Constitution."

This passage was cited with approval by the Supreme Court in *Laurentiu v. Minister for Justice* [1999] 4 I.R. 42, 90 and in *In Re Article 26 Reference and the Illegal Immigrants (Trafficking) Bill, 1999* [2000] 2 I.R. 360. Moreover, detention under s. 38 was an example given by Hardiman J. in *Minister for Justice v. Butenas* [2008] IESC 9 of the "strictly limited circumstances in which the State is entitled to make provision for the detention of a person, not convicted of a criminal offence, where bail is not an option."

In the course of their submissions Counsel for the third and fouth named respondents pointed to certain specific features of the s. 38 power as being of importance, and as representing safeguards. They say that the requirement that the Chief Medical Officer should form the requisite opinions is not delegable, although the Chief Medical Officer may form his opinion on the basis of information provided by another registered medical practitioner who has inspected the patient. The amendment effected by s. 35 of the Health Act, 1953 should be interpreted as requiring the opinion as well as the signature of the second registered medical practitioner. In forming that second opinion he/she is entitled to rely on information provided by another registered medical practitioner who could be either the Chief Medical Officer (where he/she had inspected the patient personally) or a third party registered medical practitioner who has inspected the patient. It is pointed out that the requirement for two opinions to support a detention on medical grounds originated in the mental health context. However, since the diagnosis of a physical illness, such as tuberculosis, is usually less subjective or open to divergence than the diagnosis of a psychiatric illness, the requirement of a second opinion in the s. 38 context provides significant additional protection for a proposed detainee.

Moreover, if the basis for the detention ceases, the chief medical officer is required to certify that the detained person is no longer a source of infection. Counsel submits that this is in itself a significant safeguard.

While a more modern piece of legislation would be likely to contain a greater level of safeguards to ensure respect for and vindication of the detainee's rights, it is contended that there are sufficient safeguards within section 38 to render it constitutional. It was submitted that the appeal process represents another important safeguard for the person detained. Moreover, regardless of any right of appeal she may have under s. 38, she has a right of immediate access to the courts through the mechanism of seeking an enquiry into the legality of her detention under Article 40.4.2° of the Constitution, if there is reason to believe that her rights are not being respected, defended or vindicated. And, as this case demonstrates, she does not have to invoke that right herself. It can be invoked on her behalf.

It was very strongly urged that this was the approach adopted by the Supreme Court in *Sean Croke v. Charles Smith & Others (No. 2)* [1998] 1 I.R. 101 and great reliance was placed on this decision, which they say requires close critical analysis.

An appropriate starting point for the suggested analysis is to consider the section of the judgment entitled "*Power of Detention*" commencing at p. 125 of the report. The Chief Justice said:

> "Whilst the powers of detention conferred by s. 172 of the Act on the persons named in subs. (2) of that section are extensive invalid having regard to the provisions of the Constitution, must have regard to:-
>
> (a) the objectives of the Act and the other provisions thereof;
>
> (b) the safeguards and other protections afforded by the Act; and
>
> (c) the fact that
>
> (i) the powers of detention therein contained relate only to persons in respect of whom a chargeable

patient reception order has been made;

(ii) before a chargeable patient reception order can be made in respect of any person, the formalities mandated by ss. 163 and 171 of the Act must be complied with;

(iii) these sub-sections require that before a chargeable patient reception order may be made, an application for such an order must be made in accordance with the provisions of s. 163 of the Act which requires that a registered medical practitioner must examine the patient and certify that he is a person of unsound mind, is a proper person to be taken in charge and detained under care and treatment and an examination of the patient by the resident medical superintendent or other medical officer of the hospital acting on his behalf who before making an order must be satisfied as a result of such examination that the person is of unsound mind and is a proper person to be taken in charge of and detained under care and treatment;

(iv) such person may only be detained while he remains a person of unsound mind and in need of care and treatment;

(v) he or she may be discharged by "proper authority";

(vi) such proper authority includes the resident medical superintendent of the institution in which the patient is being detained, the Minister for Health, the High Court upon an application in accordance with the provisions of Article 40.4.2 and the President of the High Court in the exercise of his jurisdiction in lunacy matters or by any other judge of the High Court designated by the President thereof to exercise such jurisdiction;

(vii) the resident medical superintendent is obliged by s. 218 of the Act to discharge a patient when he is satisfied that he has recovered and by virtue of the provisions of s. 220 of the Act is entitled to discharge the patient upon the application of any relative or friend of a person detained provided he is satisfied that the person detained will be properly taken care of;

(viii) in accordance with the provisions of s. 222 of the Act the Minister may, if he so thinks fit, by order direct the discharge of a person;

(ix) the powers and discretions given to the resident medical superintendent and the Minister in regard to the discharge of patients must be exercised in accordance with the principles of constitutional justice and are subject to review by the courts in the event of failure to so act."

Counsel for the third and fourth named respondents submits that the passages relied upon by the applicant have to be understood in the context of the approach just outlined. Moreover, the true significance of the passages relied upon is only to be appreciated within the context of the following more extensive quotation (within which those passages appear). The Chief Justice said at p. 131 et seq:

> "While it may be desirable that the necessity for the continued detention of the person, in respect of whom a chargeable patient reception order has been made, be subject to automatic review by an independent review board as provided for in the Mental Treatment Act, 1981, which has not, unfortunately, after fifteen years, been brought into force by the Minister, the failure to provide for such review in the Act has not been shown to render the provisions of the Act of 1945, and in particular s. 172 thereof, constitutionally flawed because of the safeguards contained in the Act, which have been outlined in the course of this judgment. If, however, it were to be shown in some future case, that there had been a systematic failure in the existing safeguards, and that the absence of such a system of automatic review was a factor in such failure, that might cause this Court to hold that a person affected by such failure was being deprived of his constitutional rights.
>
> If they so fail, their decisions are subject to review by the High Court, whether by way of an application for judicial review or by way of a complaint made to the High Court in accordance with the provisions of Article 40.4.2 of the Constitution.
>
> The Court is further satisfied that the detention of a patient does not require automatic review by an independent tribunal because of the obligation placed on a person in charge of a district mental hospital to discharge a patient who has recovered. Inherent in this section is the obligation placed on the resident medical superintendent to regularly and constantly review a patient in order to ensure that he or she has not recovered and is still a person of unsound mind and is a proper person to be detained under care and treatment. If such review is not regularly carried out, in accordance with fair procedures and rendering justice to the patient then the intervention of the court can be sought because of the obligation placed on the resident medical superintendent to exercise the powers conferred on him by the Act in accordance with the principles of constitutional justice.
>
> There is no doubt that the provisions of s. 172 of the Act empowers the persons, set forth in sub-s. (2) thereof, to deprive a person, in respect of whom a chargeable patient reception order has been made, of his liberty.
>
> By virtue of the provisions of Article 40 of the Constitution, the State, however, in its enactments is obliged to have due regard to differences of capacity, physical and moral, and of social function.
>
> The Mental Treatment Act, 1945, was, as stated in the preamble thereto, "An Act to provide for the prevention and treatment of mental disorders and the care of persons suffering therefrom . . ."
>
> As stated by the Supreme Court in *In re Philip Clarke* [1950] I.R. 235, the legislation was "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 well-being of the public generally".
>
> The purpose of s. 172 of the Act was to provide for the detention of persons of unsound mind and certified to be proper persons for detention under care and treatment.

> The State, including the Oireachtas, is obliged by virtue of the provisions of Article 40.3.1 in its laws to respect, and as far as practicable by its laws to defend and vindicate the personal rights of the citizen but in its laws is entitled to have due regard to differences of capacity and the particular requirements of citizens, particularly those suffering from incapacity including mental disorders.
>
> Do the provisions of s. 172 of the Act, having regard to the citizen to whom it is applicable, constitute a failure by the Oireachtas to respect and, as far as practicable, defend and vindicate the personal rights of such citizens?
>
> In view of the requirements set forth in ss. 163 and 171, which do not of themselves constitute an attack upon the personal rights of the citizen affected thereby or a failure to defend and vindicate such rights, the Court is satisfied that it has not been established that the provisions of s. 172 constitutes a failure by the Oireachtas to respect and, as far as practicable, to defend and vindicate the right of such citizens affected thereby.
>
> In being so satisfied, the Court has had regard to the presumption of constitutionality which the Act is entitled to enjoy and in particular the presumption that the Oireachtas intended that the proceedings, procedures, discretions and adjudications by the resident medical superintendent, the Inspector of Mental Hospitals and the Minister permitted by the Act are to be conducted in accordance with the principles of constitutional justice and in particular with regard to the principle thereof that no person should be unnecessarily deprived of his liberty even for a short period.
>
> This requirement places a heavy responsibility on these officers to ensure that no person detained pursuant to the provisions of s. 172 of the Act is detained for any period longer than is absolutely necessary for his proper care and treatment and that the safeguards provided for in the Act be stringently enforced. The necessity for the continued detention of a patient, to whom s. 172 of the Act applies, must be regularly reviewed to ensure that he or she is not being unnecessarily detained.
>
> Decisions made in this regard are not decisions made in the administration of justice but the decision makers are obliged to act in accordance with the principles of constitutional justice and to have regard to the constitutional right to liberty.
>
> Consequently, the Court is satisfied that it has not been established that the provisions of s. 172 of the Mental Treatment Act, 1945, are invalid having regard to the provisions of the Constitution and will so answer the question referred to it by the High Court in accordance with the provisions of Article 40.4.3 of Bunreacht na hÉireann."

It was submitted on behalf of the third and fourth named respondents that, correctly understood*, Croke v. Smith (No. 2)* decided that, while it was desirable that the detention of a person under the Mental Treatment Act, 1945 be the subject of an automatic review by an independent board the fact that such review was not provided for in the 1945 Act did not render it, and in particular s.172 thereof, unconstitutional.

They contend that the Supreme Court also had regard to the presumption that decisions taken under the Mental Treatment Act, 1945 were to be made in accordance with the principles of natural and constitutional justice and that the decision makers were to have regard to the constitutional right to liberty.

Counsel for the third and fourth named respondents further say that while it must be acknowledged that a person detained under s. 38 is entitled to legal advice, the legislation is not rendered unconstitutional by the failure of it to refer to that entitlement. They *cite D.P. v. Governor of the Training Unit* [2001] I.R. 493 in support of this proposition. They further argue that a person detained under s. 38 has no entitlement to have their legal representation funded by the State, and cite *State (O) v. Daly* [1977] I.R. 312 as authority for this.

They further argue that while s. 38 does not expressly provide that the person detained thereunder shall be treated, it is clear from s. 38(7) that the Oireachtas envisaged the treatment of the person detained. Moreover, it is readily acknowledged that any detained person has the right to be provided with necessary care and treatment. Again, relying on *D.P. v. Governor of the Training Unit* they say the legislation is not rendered unconstitutional by the failure of it to refer to that entitlement. However, and notwithstanding this argument, they say that the applicant lacks *locus standi* and cannot try to impugn the constitutionality of s. 38 on this specific ground given that Ms. I. has been offered and has refused medical treatment.

Finally, they submit that the provision contained in s. 38 (2)(o) is constitutionally unobjectionable and proportionate having regard to the acute public interest in the avoidance of infection. They accept that the provision is to be construed narrowly, that force can only be resorted to if it is "necessary" to do so "for the purpose of carrying out any provision of [s. 38(2)]", and that it is implicit that only the minimum force "necessary" will be employed.

Decision of the Court on the constitutional validity of s. 38

Having given detailed consideration to the arguments on both sides, I am satisfied that that the applicant has failed to discharge her burden of proof with respect to the alleged constitutional invalidity of s. 38 of the Health Act, 1947, as amended. I am further satisfied that the arguments in support of the section's validity put forward by the third and fourth named respondents are correct in law. The section enjoys a presumption of constitutionality. Further, and as an aspect of that, the court must have regard to the presumption that decisions taken under s. 38 will to be made in accordance with the principles of natural and constitutional justice and that the relevant decision makers will have regard to the constitutional right to liberty. The power created by section 38 supports an important public interest objective, namely, it assists in safeguarding against the spread of particular infectious diseases amongst the general population by facilitating, where necessary, the compulsory effective isolation of a person who is suffering from such a disease. I am satisfied that the provision is therefore benign, and that it is of an essentially paternal character.

While it might be desirable that the section should contain more specific safeguards towards the defence and vindication of a detainee's personal rights, the absence of such safeguards does not, of itself, render the section unconstitutional. A detainee may have recourse at any time to the High Court within the context of Article 40.4.2° of the Constitution for the purpose of seeking an inquiry into the lawfulness of his or her detention. The combination of (i) such safeguards as

already exist within the section, (ii) the presumption that the section will be operated constitutionally, and (iii) the existence of a readily accessible remedy for the person affected if it is not in fact operated constitutionally, provides an adequate level of protection for the personal rights of detainees. I therefore dismiss the claim of constitutional invalidity.