Neutral Citation Number: [2010] IEHC 62

THE HIGH COURT

2009 246 MCA

IN THE MATTER OF S. 73 OF THE MENTAL HEALTH ACT 2001, AND

IN THE MATTER OF INTENDED PROCEEDINGS

BETWEEN

A. L.

INTENDED PLAINTIFF

AND

THE CLINICAL DIRECTOR OF ST. PATRICK'S HOSPITAL AND THE MENTAL HEALTH COMMISSION

INTENDED DEFENDANTS

JUDGMENT of Mr. Justice Clarke delivered the 11th of March, 2010

1. Introduction

1.1 The intended plaintiff ("Ms. L.") has in recent years suffered from mental illness from time to time. At varying stages she has been both a voluntary and an involuntary patient, generally under the control of the first named defendant ("the Clinical Director"). In circumstances, which it will be necessary to outline further in the course of this judgment, it currently appears that during one period when Ms. L. was apparently an involuntary patient, the proper procedures necessary to justify her detention as such an involuntary patient had, in a very fundamental way, not been complied with.

1.2 It is in those circumstances that Ms. L. now wishes to bring proceedings for damages arising out of what she claims was her unlawful detention in those circumstances. Because of the provisions of s. 73 of the Mental Health Act 2001 ("the 2001 Act"), Ms. L. is not entitled to bring these proceedings without the leave of this Court. Ms. L. has sought such leave which was opposed by the Clinical Director, but consented to by the Mental Health Commission ("the Commission"). This judgment is directed towards the issues which arose on that application. In those circumstances, it is appropriate to turn first to the provisions of s. 73 of the 2001 Act.

2. Section 73

2.1 As pointed out earlier, proceedings such as those which Ms. L. wishes to bring cannot be instituted without leave of this Court. However, s. 73(1) of the 2001 Act provides that such leave shall not be refused unless this Court is satisfied:-

> "(a) that the proceedings are frivolous or vexatious, or
>
> (b) that there are no reasonable grounds for contending that the person against whom the proceedings are brought acted in bad faith or without reasonable care."

2.2 Section 73 of the 2001 Act is, in some respects, similar to the former s. 260(1) of the Mental Treatment Act 1945 ("the 1945 Act"), which also provided that proceedings of the relevant type could not be instituted save by leave of this Court. However, s. 260(1) of the 1945 Act provided that such leave should "not be granted unless the High Court is satisfied that there are substantial grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care".

2.3 It will immediately be seen that there are two significant differences between s. 73(1) of the 2001 Act and s. 260(1) of the 1945 Act. First, s. 73 of the 2001 Act reverses the onus of proof. Under s. 260 it was necessary for the person wishing to initiate proceedings to establish that there were substantial grounds for contending bad faith or lack of reasonable care. Under s. 73 the court is required to give leave unless the court is satisfied that the proceedings are frivolous, vexatious or that there are no reasonable grounds for asserting bad faith or lack of reasonable care.

2.4 Second, it is to be noted that, while s. 260 required the intending plaintiff to show substantial grounds for the contentions which underlie the intended proceedings, s. 73 contains no such requirement.

2.5 However, it seems to me that the jurisprudence of the courts in relation to s. 260 of the 1945 Act remain, potentially, of relevance in a consideration of s. 73 save where that jurisprudence is concerned with those aspects of the relevant sections which are materially different. In particular, the terms "bad faith or without reasonable care" appear in an identical form in both sections.

2.6 On that basis, it seems to me to be clear that the term "without reasonable care" should be interpreted as applying not just to an absence of proper medical care, but also as applying to an obligation to use care in ensuring that persons are not in unlawful custody. For example, in *Melly v. Moran & Anor* (Unreported, Supreme Court, O'Flaherty J., 28th of May, 1998), the Supreme Court allowed an appeal from a decision of this Court, under s. 260 of the 1945 Act, refusing leave to bring proceedings. It is clear from the judgment of O'Flaherty J. that the Supreme Court was of the view that the facts of the case concerned disclosed a "*prima facie* want of reasonable care". The allegation in that case was described by O'Flaherty J. as being to the effect "that there was a want of reasonable care in the filling out of the form by the doctor and by the hospital authorities in accepting it as sufficient". For the purposes of the current discussion, the precise nature of the alleged want of care is not particularly relevant. However, it is clear that the Supreme Court were satisfied that there was a *prima facie* basis for alleging substantial grounds of want of care in the procedures relating to the detention of the plaintiff concerned.

2.7 Thus, at the level of principle, it seems clear that it is open to a plaintiff to seek to allege that there was a breach of duty of care on the part of a doctor or hospital arising out of the procedures, followed or not followed in the course of putting in place the necessary measures required to procure the detention of a patient. Any such want of care is, it seems to me, therefore, a type of want of care which came within s. 260 of the 1945 Act and also comes, at the level of principle, within s. 73 of the 2001 Act.

2.8 It is also worthy of some note that the Supreme Court, in *Blehein v. The Minister for Health and Children & Ors* [2008] I.E.S.C. 40, determined that s. 260 of the 1945 Act was inconsistent with the Constitution. The basis for that decision was the fact that s. 260 confined a plaintiff to proceedings arising out of a lack of *bona fides* or a want of reasonable care, which restriction was found by the Supreme Court to be disproportionate. The fact that a similar restriction is to be found in s. 73 must, at least, raise some questions about the constitutional validity of the identical restriction contained in s. 73. However, given that I am satisfied that the sort of claim which Ms. L. wishes to bring in these proceedings comes within the "want of reasonable care" parameters as specified in s. 73, it does not seem to me that the question of the application of the jurisprudence identified in *Blehein* to the 2001 Act arises on the facts of this case.

2.9 Finally, it should be noted that no suggestion is made in these proceedings that the proceedings are frivolous or vexatious. Neither is there any suggestion on the part of Ms. L. that either of the defendants acted in bad faith. Shorn of those aspects of s. 73, the question which I must ask myself is whether I am satisfied that there are no reasonable grounds for contending that either or both of the defendants acted without reasonable care. This is, of course, something of a double negative. I should grant leave unless I am satisfied of that matter. It follows that leave should be granted, save in cases where it has been demonstrated that there is no reasonable basis for the allegation that any relevant defendant acted without reasonable care. Where, therefore, there is any legitimate basis on which a court might arguably conclude that a relevant defendant had acted without reasonable care, then it follows that leave must be granted.

2.10 Having identified those general principles, it is next appropriate to turn to the specific facts on which Ms. L. wishes to base her case.

3. The Plaintiff's Case

3.1 Much of the factual basis for the case which Ms. L. wishes to bring does not appear, at this stage, to be in dispute. In order to place those facts in context, it is necessary to say something about the statutory regime now applicable to the detention of persons whom it is considered are in need of psychiatric treatment. Section 14 of the 2001 Act makes provision for admission orders which may be made by a consultant psychiatrist who has carried out an examination of the person concerned, and who is satisfied that that person is suffering from a mental disorder.

3.2 Under s. 15 of the 2001 Act, an admission order authorises the reception, detention and treatment of the patient concerned for a period of not more than twenty one days from the date of the making of the order. Section 15 also provides for a renewal order, being an extension of an original admission order. A renewal order can last initially for a period not exceeding three months. Section 15(3) provides for a further extension of six months and further extensions again not exceeding twelve months. For the purposes of this case, it is important to note that Ms. L. was originally the subject of an admission order in respect of which no complaint is made. She was also the subject of an initial renewal order for a period of three months in respect of which no complaint is made. She was then the subject of a second renewal order for a period of six months, which is at the heart of her complaint.

3.3 In that context, it is next necessary to note that s. 16 requires a consultant psychiatrist, who has made an admission order or a renewal order to send, within twenty four hours, a copy of the relevant admission or renewal order to the Commission and also to notify the patient concerned of the making of the order concerned, together with certain details of the rights of the patient. There is no suggestion that the relevant consultant psychiatrist in this case failed to comply with the obligations set out in s. 16. In particular, it seems clear that the relevant notice was sent to the Commission within the twenty four hour period stipulated in the section.

3.4 Section 17 provides that the Commission, following receipt of a copy of an admission order or a renewal order, should set in place the machinery necessary for the convening and conduct of a tribunal to consider whether the admission or renewal order concerned should be affirmed or revoked. Unfortunately, it is at this point in the process that something went amiss. Subsequent to problems emerging (to which I will subsequently refer), the Commission appointed PriceWaterhouseCoopers to review the facts. On the basis of a report produced by those consultants, it seems that while the renewal order concerned (or more accurately a copy thereof) was received by fax by the Commission with its receipt being logged, the relevant official within the Commission was not informed of that receipt so that none of the machinery for the establishment or progress of the conduct of a Mental Health Tribunal occurred in Ms. L's case. It is in that context that the Commission accepts that a case has been made out for a want of care in relation to it.

3.5 It would seem that Ms. L. remained in the care of the Clinical Director for the duration of the six month period concerned, notwithstanding the fact that none of the procedures mandated by s. 17 were carried out. In those circumstances it is, to say the least, arguable that Ms. L. was in unlawful detention for at least a significant portion of that period. The problem only came to light when, at or around the expiry of the relevant six month period, it was considered appropriate to make a further renewal order which would, this time, have been for a further period of twelve months. The fact that no tribunal had been constituted to consider Ms. L's case six months earlier then came to light. In fairness to the Commission it should be recorded that it made arrangements, on an extra statutory basis, for Ms. L. to receive legal advice at that stage. In fact, it would appear that Ms. L. continued receiving treatment on a voluntary basis for some time thereafter.

3.6 It is against that background that Ms. L. asserts that the Clinical Director (or those for whom the Clinical Director may be vicariously liable), were guilty of a want of care. In that regard reliance is placed on the fact that the Clinical Director or a psychiatrist working with the Clinical Director in the same institution, together with other senior administrative staff, would, in the ordinary way, have been involved in the process of the tribunal had it been set up. Section 17(1)(c) of the 2001 Act requires the Commission, once a tribunal is established, to nominate a member of a panel of consultant psychiatrists established under s. 33(3)(b) of the 2001 Act to examine the patient concerned, interview the consultant psychiatrist responsible for the care and treatment of the patient and review the records relating the patient for the purposes of reporting on the mental condition of the relevant patient. Thus, it is argued on behalf of Ms. L. that the Clinical Director or other senior staff within the relevant institution ought to expect to be required to facilitate the examination of a patient who is detained and being treated by that institution, ought in addition be interviewed by the nominated consultant psychiatrist, and ought be required to facilitate the nominated psychiatrist by making relevant

medical records available to that psychiatrist. It is argued that it ought to have become clear to senior staff at the institution concerned that no Mental Health Tribunal had been established when none of those items actually occurred. In addition, s. 18 requires that notice in writing of the decision of a tribunal should be given to, amongst others, the consultant psychiatrist responsible for the care and treatment of the patient concerned. It is further argued that the Clinical Director or his senior staff ought to have become aware that no tribunal had, in fact, taken place when no notice of the result of the tribunal's considerations was received. Certain other provisions of the legislation are relied on which it is unnecessary to specify in any detail here.

3.7 In summary, the case made on behalf of Ms. L. is to the effect that there is a duty of care on a Clinical Director who is detaining a patient as a result of an admission or renewal order. That duty of care is said to extend to circumstances where the Clinical Director, or those for whose actions the Clinical Director may be responsible, or other senior staff of the relevant institution, could be said to be in a situation where they knew or ought to have known that there was a problem concerning the continued validity of the detention of the patient concerned. It is not, as I understand it, Ms. L's case that there is any necessarily pro-active obligation on the Clinical Director or his staff. Rather it is said that the complete absence of any of the expected interaction with the Clinical Director or his staff should have alerted those persons to the fact that there was a problem. In those circumstances, it is argued that there was a want of care which contributed to what is said to have been the unlawful detention of Ms. L.. In those circumstances it is further said that Ms. L. is entitled to damages. Against that it is next appropriate to turn to the case made on behalf of the Clinical Director.

4. The Clinical Director's Case
4.1 It should be noted immediately that no case is made on behalf of Ms. L. to the effect that she received anything other than fully appropriate medical care while being treated, whether as a voluntary or an involuntary patient, by the Clinical Director and other staff of the relevant institution. The case for want of care is clearly confined to the procedural and administrative matters to which I have referred.

4.2 Counsel for the Clinical Director noted, quite correctly, that there was no suggestion to the effect that any of the obligations under the 2001 Act which expressly lie on the Clinical Director or other staff of the institution were breached. No criticism is made of the original admission order or the renewal orders in themselves. No suggestion is made that there was a failure on the part of the institution to notify the Commission. So far as s. 17 and s. 18 are concerned it is pointed out, correctly so far as it goes, that the express statutory obligations to be found in those sections lie on the Commission or a tribunal established by the Commission. Those statutory provisions do not place any direct obligation on the Clinical Director or staff of the institution concerned, save an obligation to co-operate.

4.3 In those circumstances, it is said that there could be no basis for maintaining a claim based on want of care as against the Clinical Director. Rhetorically, counsel asked what could the Clinical Director have done? At what point should the Clinical Director have acted? Attention was drawn, in that context, to the fact that the relevant provisions of the 2001 Act (s. 18, subs. (2) and (4)) allow a period of between 21 and 49 days for the making of a decision by a tribunal. At what point, counsel queried, would an obligation fall on the Clinical Director or other relevant staff to raise the matter?

4.4 In those circumstances it is suggested that there are no reasonable grounds for contending that the Clinical Director acted without reasonable care.

5. Analysis
5.1 It is important to emphasise that I am not, at this stage, dealing with the merits of the proceedings. Rather, for the reasons which I have set out, I am concerned solely with the question of whether it has been established on behalf of the Clinical Director that there are no reasonable grounds for contending that the Clinical Director acted without reasonable care.

5.2 In substance the real issue between the parties, on this application, concerns the duty of care. It is asserted on behalf of Ms. L. that a Clinical Director or relevant senior staff have a duty of care to take action when circumstances arise which ought bring their attention to the fact that there is a problem with the validity of a relevant patient's detention. It was accepted on behalf of the Clinical Director that there might well be a liability in circumstances where relevant staff were *actually* aware of such a problem. However, it is said that no such liability can arise where the only case which can be made is that relevant staff ought to have been so aware.

5.3 I am afraid I cannot agree. It is not for me on this application to reach any final determination as to the extent of the duty of care which lies on a Clinical Director or other relevant senior staff. Rather, I have to determine at this stage whether there is no reasonable basis or grounds for the contentions made on behalf of Ms. L.. The precise extent of the duty of care, if any, which may lie on a Clinical Director or relevant senior staff in circumstances where it might be said that they ought to have known that there had not been a tribunal (or any other circumstances which might render continued detention invalid) is a matter of legitimate debate. That there was no contact by the Commission or a tribunal which contact, it might be argued, could reasonably have been expected in circumstances where a tribunal had been constituted and proceeded in an orderly fashion, is not disputed as a fact. A consideration of the existence of any such duty of care is a matter for the trial. At this stage I should confine myself to finding that it is arguable that a duty of care along the lines submitted on behalf of Ms. L. exists. It certainly cannot be said that there are no reasonable grounds for asserting that such a duty of care does exist.

5.4 If such a duty of care is held to exist then there is, in my view, a credible factual basis put before the court on which it would be open to the court to conclude that any such duty had been breached.

5.5 There would, of course, be other issues which might well arise at the trial. There is the fact that Ms. L. was apparently happy to continue as a voluntary patient when the problem was discovered. However, it seems to me that such matters are likely to fall in to a similar category to the facts, analysed by O'Flaherty J. in *Bailey v. Gallagher* [1966] 2 I.L.R.M. 433, which were deemed to be important factors in the assessment of damages if the action is allowed to proceed. The very brief period of time during which it might be said that the plaintiff in that case was in unlawful detention being the fact in point. If, however, Ms. L. can persuade the trial court that a duty of care along the lines asserted exists and that it has been breached, there can be little doubt but that Ms. L. would be entitled to some damages.

5.6 Before concluding I should also note that the Commission made submissions to the Court in favour of leave being granted as against the Clinical Director. There can be little doubt but that the Commission has an interest in seeking to

have the Clinical Director "share the burden" of any liability that might be established in favour of Ms. L.. In the event that both the Commission and the Clinical Director are found to have been in breach of duty, then it will obviously be for the trial court to determine, not only the amount of damages to which Ms. L. should be entitled, but how those damages are to be dealt with in the sense of any relevant contribution or indemnity as and between the Commission and the Clinical Director. Those matters are again issues which can only be properly be dealt with at the trial.

6. Conclusions

6.1 For the reasons which I have sought to analyse I am, therefore, satisfied that it has not been established that there are no reasonable grounds for suggesting that the Clinical Director and those for whom he may be responsible acted without reasonable care.

6.2 It follows that leave should be granted.