THE HIGH COURT

WARDS OF COURT

[WOC No. 9013]

IN THE MATTER OF A.M.

A PROPOSED WARD OF COURT

BETWEEN

HEALTH SERVICE EXECUTIVE

APPLICANT

AND

A.M.

RESPONDENT

JUDGMENT of Mr. Justice Kelly, President of the High Court delivered on the 27th day of March, 2017

Introduction
1. The applicant (HSE) seeks to have the respondent (A.M.) made a ward of court. The application is opposed by A.M. on legal grounds. He does not challenge the medical evidence which has been put before the court which is to the effect that he is a person of unsound mind and is unable to manage his affairs. Such is his state of mental health that he needs to be detained in the only hospital suitable for his condition namely, the high secure unit of the Central Mental Hospital.

History
2. Extensive affidavit evidence has been placed before the court setting out A.M.'s long history of charges, convictions and detentions both in prisons and mental hospitals since the beginning of this century. It is not necessary to set them out in detail; a summary is sufficient.

3. The most serious offence that A.M. was charged with was murder by stabbing. He was found guilty of manslaughter and in February 2004 was sentenced to ten years imprisonment. That was reduced to seven years on appeal.

4. In January 2008 A.M. committed serious assaults on his treating consultant psychiatrist and his treating clinical psychologist.

5. A.M. was transferred to the Central Mental Hospital in January 2008 and has been there ever since. He has been under the care of Dr. Damian Mohan, Consultant Forensic Psychiatrist at that institution. He was due to be released at the conclusion of his sentence on 11th November, 2016.

6. In the light of his medical condition as attested to by Dr. Mohan, Professor Henry G. Kennedy, the Clinical Director of the Central Mental Hospital and Dr. John O'Mahony, Consultant Psychiatrist, it was clear that there could be no question of A.M. being released because of the risk that his mental illness posed to the public and to himself.

7. Accordingly, on 7th November, 2016 an application was made to me for a temporary detention order. The application was made in the context of an intended petition to have A.M. taken into wardship. I made such an order on that date. I also directed that one of the Court's medical visitors assess A.M. and report to the court on his findings.

8. The matter was made returnable before me three days later and on that occasion A.M. was represented. I continued the detention order, gave directions for the exchange of affidavit evidence and submissions and listed the case for hearing in January, 2017. This is my reserved judgment on foot of that hearing. In the meantime I directed the continued detention of A.M. at the Central Mental Hospital.

Mental condition
9. Dr. Damian Mohan, A.M.'s treating psychiatrist, has placed extensive affidavit evidence before the court. It sets out the entire history of A.M. with the psychiatric services of the State over many years. Much of his hospitalisation has been in the Central Mental Hospital and he has been there continuously since 2008.

10. In anticipation of the possibility of A.M.'s release at the conclusion of his latest sentence of 10 years imprisonment imposed in 2009, Dr. Mohan conducted a capacity assessment which he avers to in his affidavit of 8th November, 2016. This is what he says:-

> *"… A.M. continues to present with evidence of chronic paranoid schizophrenia which is characterised by prominent negative symptoms and limited insight. He lacks insight into the risk of violence associated with the relapse of his mental illness and regarding his functional impairments. He holds unrealistic expectations regarding his future ability to live independently. Furthermore, his condition is associated with significant cognitive deficits which have been identified by various assessments.*
>
> *43. I say and believe that A.M.'s performance during his most recent psychological assessment in October 2016 was consistent with that of a man with a moderate intellectual disability. Psychological and occupational assessments have*

also highlighted the concerns regarding the impact of A.M.'s mental illness on his daily functioning. Neuropsychological testing has revealed that A.M. has severely impaired executive functioning. These findings were also reflected in the assessments of the occupational therapist.

44. I say and believe that it is my clinical opinion that A.M. lacks capacity to make decisions regarding his care and treatment."

11. Dr. Mohan then set forth in detail a risk assessment of the factors faced by A.M. if he were to continue in a secure setting and those which he would face if he did not continue placement in a secure therapeutic setting. He states his conclusion concerning A.M.'s position as follows:-

"47. I say and believe that A.M. lacks the capacity to manage his financial affairs or live independently in the community. He has a low level of executive functioning and it is such that he would not have the requisite ability to budget or plan his activities of daily living. He would be at serious risk of neglect.

48. A.M. will require a highly supported and highly structured placement to ensure even the most minimal response to treatment. I say and believe that the Central Mental Hospital is the only facility in the State that can safely and adequately meet the needs presented by A.M.'s paranoid schizophrenia.

49. If A.M. does not remain within the secure setting of the Central Mental Hospital it is likely that he would not comply with treatment and would deteriorate rapidly. This would put his health, safety and welfare at immediate and serious risk. In such circumstances A.M. would also pose a significant risk to others.

50. I say and believe that A.M. meets the criteria for wardship. However, it is the unequivocal view of his treating team that it is vital that A.M. remain in the Central Mental Hospital pending the conclusion of same. If A.M. was to be discharged it is my clinical opinion that he would disengage with therapeutic services causing a rapid deterioration in his mental health placing his life at risk.

51. I say and believe that the HSE have exhausted all efforts to come up with an alternative solution in order to secure A.M.'s safety and welfare in the event of his release. In light of his complex presentation, the importance of continuity of care is central to any such plan. The option of placing him in alternative approved units with extra staff and input from the clinicians already involved in his care was explored. However, the clinicians with responsibility for the said unit do not believe it is appropriate or possible to manage A.M. safely in such a setting. This is particularly so in light of the fact that none of the consultant psychiatrists involved in his care to date, who would have in-depth knowledge of his significant care needs from a clinical perspective, are attached to the said unit."

12. Dr. Mohan's view is shared by Dr. John O'Mahony, a consultant psychiatrist who also swore an affidavit. He confirmed that A.M. has a diagnosis of paranoid schizophrenia, with clear cognitive impairment and functional disability. He carried out an assessment of A.M. on 19th October, 2016. He found A.M. to lack a useful degree of insight into his condition and the need for treatment. His recommendation was that A.M. will require a highly supported and highly structured placement such as the Central Mental Hospital to ensure even the most minimal response to treatment. The deficits identified by Dr. O'Mahony seriously impair the capacity of A.M. to live outside such a highly structured and secure setting. If A.M. is not able to avail himself of that facility it is likely that he will not comply with treatment and the potential outcome of non-compliance will place his safety, health and possibly that of others in peril. Dr. O'Mahony further expressed the view that the Central Mental Hospital is the only facility in the State that can safely and adequately meet the needs presented by A.M.'s paranoid schizophrenia. He likewise expressed the view that the HSE has exhausted all efforts to come up with an alternative solution in order to secure A.M.'s safety and welfare in the event of his release. He said as follows:-

"In light of his complex presentation, the importance of continuity of care is central to any such plan. The option of placing him in alternative approved units with extra staff and input from the clinicians already involved in his care was explored. However, the clinicians with responsibility for the said unit do not believe it is appropriate or possible to manage A.M. safely in such a setting. This is particularly so in light of the fact that none of the consultant psychiatrists involved in his care to date, who would have in-depth knowledge of his significant care needs from a clinical perspective, are attached to the said unit."

13. Two affidavits were also sworn by Professor Henry G. Kennedy. The first of these was sworn on 8th November, 2016. Having set out A.M.'s extensive history of charges and convictions, the latest being for the serious assaults on the clinical psychiatrist and psychologist in 2008, he addressed A.M.'s need for therapeutic security. Professor Kennedy said this:-

"A.M. requires care and treatment in conditions of therapeutic security for several persuasive reasons which include the following:

(i) A.M. has a history of the most serious acts of violence including two convictions for grave acts of violence (one homicide and one stabbing penetrating a body cavity causing near permanent incapacity).

(ii) A.M. is only partially recovered from the mental state that led to such serious violence;

(iii) A.M. has spent much of his most recent sentence not only in the Central Mental Hospital, the national secure forensic mental health hospital, but also in the most intensive care unit in the Central Mental Hospital;

(iv) There is a continuing risk of opportunistic absconding or escaping;

(v) A.M. requires restriction and monitoring of access to weapons;

(vi) A.M. represents a specific risk to members of his family against whom he has made threats in the past and represents a specific risk of grave harm to clinicians who might treat him against his wishes notwithstanding that such treatment is essential for his own safety, health and welfare;

(vii) A.M. has a history of previous serious violence even at a time when he was not actively deluded or hallucinated;

(viii) A.M. represents a very high risk/threat of serious violence to staff in hospital other than in a secure setting."

14. Professor Kennedy goes on:-

> *"A.M. requires inpatient care and treatment in appropriate conditions of therapeutic security which can only be provided in the Central Mental Hospital."*

15. He then deals with the risk of discharge into the community or any other facility and says the following:-

> *"If discharged to the community, past experience demonstrates that A.M. would, within a short period of time, discontinue medication. On discontinuing medication it is likely he would relapse over a period of days if not weeks. Upon relapse he would once again be in the mental state that led to two grave acts of violence. He could not safely be cared for in any setting where he had the option of discontinuing medication and he would represent a danger of grave harm to those attempting to care for or treat him including members of his family. Moreover, upon relapse A.M. would present as a significant danger to himself."*

16. The professor then addresses the issue of where A.M. should be detained. He says as follows:

> *"The Central Mental Hospital is the only hospital in the State providing care at medium and high levels of therapeutic security with specialist forensic psychiatrists, psychologists, social workers, occupational therapists and forensically trained mental health nurses. Conditions of physical, relational and therapeutic safety and security applying at the Central Mental Hospital cannot be provided in any other hospital in the State and these are the levels required to safely care for and treat A.M."*

17. Professor Kennedy expresses his conclusions in the following terms:-

> *"I say and believe that the HSE have exhausted all efforts to come up with an alternative solution in order to secure A.M.'s safety and welfare in the event of his release. In light of his complex presentation, the importance of continuity of care is central to any such plan. The option of placing him in an alternative approved unit with extra staff and input from the clinicians already involved in his care was explored. However, the clinicians with responsibility for the said units do not believe it is appropriate or possible to manage A.M. safely in such a setting. This is particularly so in light of the fact that none of the consultant psychiatrists involved in his care to date, who would have in-depth knowledge of his significant care needs from a clinical perspective, are attached to the said units.*
>
> *A.M. will require a highly supported and highly structured placement to ensure even the most minimal response to treatment. I say and believe that the Central Mental Hospital is the only facility in the State that can safely and adequately meet the needs presented by A.M.'s paranoid schizophrenia and related cognitive impairment.*
>
> *If A.M. does not remain within the secure setting of the Central Mental Hospital it is likely that he would not comply with treatment and would deteriorate rapidly. This would put his health, safety and welfare at immediate and serious risk. In such circumstances, A.M. would also pose a significant risk to others.*
>
> *I say and believe that the HSE has exhausted all efforts to come up with an alternative solution in order to secure A.M.'s safety and welfare in the event of his release."*

18. The second affidavit of Professor Kennedy was sworn on 12th December, 2016. In the meantime a hearing had taken place before me on 10th November, 2016. A.M. was represented at that hearing and I gave directions which permitted of Professor Kennedy's second affidavit to be sworn and an opportunity to A.M. to file any replying affidavit. In the event no replying affidavit was filed by A.M.

19. At that hearing it was indicated that the line of argument which would be pursued by lawyers on behalf of A.M. was to the effect that if he needed to be detained further, such detention should be by reference to the provisions of the Mental Health Act 2001 rather than pursuant to a detention order made under the Wardship jurisdiction of this court. It was in the context of that line of argument that Professor Kennedy swore his second affidavit of 12th December, 2016.

Professor Kennedy's second affidavit

20. At the commencement of his affidavit Professor Kennedy says this:-

> *"I wish to underline to the court that despite every effort made on the part of the HSE to put in place an arrangement to accommodate A.M. in an alternative approved centre, it has not been possible to do so. This is due to the level of risk posed by A.M. and the inability of any approved unit, other than the CMH, to accommodate him safely. In such circumstances,* ***no other approved unit is prepared to take A.M. even for an interim period pending his return to the Central Mental Hospital****." (My emphasis)*

21. The deponent then presents what he describes as an overview of the Central Mental Hospital. This is what he says:-

> *"It is a public health facility and is a central part of the HSE's national forensic mental health service. This in turn is an integral part of the HSE's mental health services for Ireland. The CMH is a specialist mental hospital providing treatment for persons with mental disorders in conditions of special therapeutic security. The national forensic mental health service based in the CMH is organised to facilitate special treatment and the recovery of mentally disordered persons. It is correct to say that there are close links between the hospital and the criminal justice and prison systems. However, that does not detract from the fact that its purpose is to provide health services and that it is a hospital.*
>
> *In essence, the role of the CMH is to provide forensic psychiatric services to individuals who are a danger to other people in a setting of therapeutic security. I believe that it bears emphasis that the CMH's services are for people who are a danger to others. Thus, for example, detention in the CMH would not be appropriate or indeed necessary for a person who is simply suicidal or a danger to themselves. The hospital's role and raison d'etre in relation to individuals who need to be hospitalised is to treat those who cannot be treated in an unsecure setting."*

22. He then deals with referrals made to the Central Mental Hospital which is a tertiary or referral hospital. This is what he says:-

"Patients are referred to the CMH from other facilities by the following routes:-

(i) if a person has a severe mental illness such as schizophrenia and is charged with a minor offence, then PICLS (Prison Inreach and Court Liaison Service) engages in a process of liaison with the person, their family, the local mental health service for the area in which that person resides, the person's solicitor and the garda prosecuting the case with a view to providing non-custodial, therapeutic disposal options for the court. In the majority of cases such individuals are already known to their local mental health service and the therapeutic option suggested by PICLS is the option chosen by the court.

(ii) If a person on committal to the remand prison is found to have a severe mental illness and is charged with a serious offence, and following a risk assessment a decision is made that treatment can only be provided in conditions of special therapeutic security then such patients are transferred to the CMH under s.15 of the Criminal Law (Insanity) Act 2006 by the direction of the Governor of the prison.

(iii) If a sentenced prisoner is found to have a mental disorder and is in need of admission to the hospital, then they are transferred to the CMH under s.15 of the Criminal Law (Insanity) Act 2006 – by the direction of the governor of the prison.

(iv) The CMH also admits those persons committed under s.4 (unfit to stand trial) and s.5 (not guilty by reason of insanity) of the Criminal Law (Insanity) Act 2006. Patients are transferred from approved centres under s.21(2) of the Mental Health Act 2001.

(v) Section 10(1) of the Mental Health Act 2001 hereafter referred to as the 2001 Act prohibits the direct admission to the CMH from the community of persons detained under the Mental Health Act. Section 21(2) of the 2001 Act has replaced s.208 of the Mental Treatment Act 1945. Section 21(2) of the 2001 Act provides for the transfer of a patient in an approved centre to the CMH for the purpose of obtaining special treatment or where such a transfer would be for the benefit of the individual. It is the need for specialist treatment which determines a patient's suitability for placement in the CMH.

I say and believe that the 2001 Act also acknowledges the CMH to be in a unique position in that it provides for separate and distinct procedures where it is proposed to transfer a ***detained patient*** *from an approved centre to the CMH. Specifically s.21 provides that where the clinical director of an approved centre is of the opinion that it would be for the benefit of a* ***patient detained in that centre****, or that it is necessary for the purpose of obtaining special treatment* ***for such a patient****, to transfer him or her to the CMH, and proposes to do so, the aforementioned clinical director must notify the Commission in writing of the proposal and the Commission shall refer the proposal to a tribunal. Where a proposal is referred to a tribunal under s.21, the tribunal is required to review the proposal as soon as may be but not later than 14 days thereafter and shall either (i) if satisfied that it is in the best interest of the health of the patient concerned, authorise the transfer of the patient concerned, or (ii) if it is not satisfied, refuse to authorise it."*

23. Professor Kennedy's affidavit then deals with the clinical review of referrals at the Central Mental Hospital and sets out in detail the way in which the hospital is set up and managed. He deals with how patients are processed through that hospital and its treatment regime. The affidavit also deals with the levels of therapeutic security of which there are three in number. They are high security, medium security and low security.

24. The affidavit then turns to A.M. and his necessity for therapeutic security. The conclusion which is reached by Professor Kennedy is that A.M. needs, under almost every heading, the highest levels of therapeutic security which are available only at the Central Mental Hospital.

25. His affidavit then makes an assessment of the level of therapeutic gain made by A.M. at the hospital and concludes that there is "*currently no evidence of progress to the point where A.M. could progress beyond a medium secure unit and in practice he has not succeeded in progressing beyond a high secure unit for any sustained period as yet even with the benefit of Clozapine treatment*".

26. The affidavit then treats of A.M.'s recovery in a forensic setting. Amongst other things he concludes that A.M. represents such a high risk of absconding that he can only leave a high secure setting under the close supervision of two or more members of staff and it is possible that a known potential victim might be at serious harm if again he was at liberty (including members of his immediate family). A.M.'s dynamic risk is rated at the top level because risk in the community would be substantially higher than risk in hospital.

27. Finally, the affidavit considers both the suitability of an alternative approved unit and the efforts made to identify such. This is what Professor Kennedy swore to:-

"I say and believe that A.M. has a history of the most serious acts of violence including two convictions for grave acts of violence. This includes a history of serious violence (his manslaughter conviction) at a time when he was not actively deluded or hallucinated. As outlined in detail above, despite spending several years in the CMH, A.M. is only partially recovered from the mental state that led to serious violence. Moreover, he has spent much of his most recent sentence not only in the CMH but also in the most intensive care unit in the CMH. A.M. remains a continuing risk of opportunistic absconding or escaping and a specific risk to members of his family and clinicians who might treat him against his wishes. He also represents a high risk threat of serious violence to staff in hospital other than in a secure setting.

Conditions of physical, relational and therapeutic safety and security applying at the CMH cannot be provided in any other hospital in the State and these are the levels required to safely care for and treat A.M. The CMH is the only hospital in the State providing care at medium and high levels of therapeutic security with specialist forensic psychiatrists, psychologists, social workers, occupational therapists and forensically trained mental health nurses. It is the unanimous and unequivocal opinion of all the treating consultant psychiatrists involved in A.M.'s care, that the CMH is the only facility in the State capable of managing his care in a safe therapeutic environment.

Efforts to identify an alternative approved unit

*I say and believe that I am informed that in the months prior to A.M.'s pending release, the HSE began to explore all options for the purpose of trying to identify a mechanism whereby A.M. could be transferred to an alternative acute unit pending his return to the CMH****. I am informed that options were explored including sending A.M. to another***

> ***approved unit with additional staff accompanying him from the CMH. In light of the risk that A.M. presents, I am informed that no clinical director was prepared to stand over the level of risk that such a situation would present to A.M., its staff and other patients. In such circumstances, the HSE has indeed exhausted all alternative options. It is not possible to accommodate A.M. in any other approved unit even for a limited period of time****. Accordingly, the HSE has brought the within proceedings seeking to make A.M. a ward of court to safeguard his health and welfare so that he can continue to avail of treatment in appropriate conditions of therapeutic security which can only be provided in the CMH." (My emphasis)*

28. All of this uncontroverted evidence demonstrates that full consideration was given to the possibility of A.M.'s detention pursuant to the Mental Health Act 2001 ("the Act") but such was not thought to be possible.

The Medical Visitor's Report
29. Dr. Malcolm Garland was the Medical Visitor who was asked to undertake an examination of A.M. Dr. Garland holds a membership of the Royal College of Physicians of Ireland, a membership of the Royal College of Psychiatrists, and a doctorate in medicine. He is a consultant psychiatrist in the HSE, Northern Area and is fully registered on the Medical Council's Specialist Register. He conducted his examination of A.M. and reported to the court on 9th November, 2016. The relevant parts of his report to the court read as follows:-

> *"He (A.M.) demonstrated no active ("positive") positive symptoms or signs of psychosis – he neither complained of or exhibited – hallucinations, delusions or thought disorder. His basic cognitive functions (memory, orientation) were intact. There were no signs of elation or depression.*
>
> *Quite apparent, however, were the presence of very significant negative symptoms of chronic schizophrenia – cognitive disorganisation, poor social communication, emotional blunting, lack of insight. Practically, this manifested as little sense of remorse/true understanding for his past actions, a diminished sense of the actions he must take to maintain wellness and an almost non-existent sense of his vulnerability to relapse. He was minimally concerned about the lack of a plan, should he be discharged from hospital. He spoke vaguely about staying in a homeless hostel "somewhere". He felt he would have no problem self-managing, requiring little more than a supply of medication and visiting a clinic. In keeping with his numerous serial assessments by different specialists, I would concur that A.M. is not capable of independent living and the risk of discharge would pose a potential catastrophic risk to others."*

30. In dealing with the suitability of the Central Mental Hospital and the manner in which A.M. is being treated Dr. Garland said this:-

> *"This is the national forensic treatment centre. While of the Victorian era, it is suited well for the purpose of providing a treatment setting for A.M. He resides currently in the High Secure Unit – Unit 4. He shares this space with five other patients and six staff. He has his own room. He has ample access to open air and leisure activity. I believe he is being very well taken care of."*

31. The Medical Visitor then goes on to express his opinion that A.M. is of unsound mind and incapable of managing his affairs. He does, however say "*… as there is a possibility for clinical improvement over months or years, this opinion should not necessarily be regarded as permanent and may suit review at a future time. As things stand, I am completely supportive of wardship for A.M.*".

The Issue
32. Notwithstanding an opportunity for affidavit evidence to be led on the part of A.M. none such was forthcoming. Consequently, all of the evidence given on behalf of the applicant and the Courts Medical Visitor is accepted. There is thus no doubt but that the respondent requires to be detained in the only hospital suitable for his condition which is the High Secure Unit of the Central Mental Hospital.

33. The issue that has been argued before me is a purely legal one. It is contended that the applicant has failed to make out a case for taking A.M. into wardship because it is neither necessary nor appropriate to do so. Counsel for A.M. alleges that the effect of this application is to "*circumvent the provisions of the Mental Health Act 2001, and the safeguards contained therein, without any particular or cogent reason having been advanced for such a course of action*". This is a rather surprising contention given the failure to controvert a single word of the extensive affidavit evidence put before the court. In the course of submissions it was also accepted that A.M. satisfies the criteria for admission to an approved centre as provided for under the Act.

The Legal position
34. A number of conditions have to be met before a person can be taken into wardship. The court must be satisfied that the person is of unsound mind and is incapable of managing his or her own person and affairs. The court must also be satisfied that it is appropriate and necessary to make the person a ward of court in order to protect his or her person and or property. The jurisdiction is discretionary (see *In Re D* [1987] (I.R. 449)).

35. In this case I am not concerned with the exercise of any inherent jurisdiction since I am dealing with an adult who has mental incapacity. The jurisdiction is statutory. This is clear having regard to what was said by Laffoy J. in *Re FD* [2015] 1 I.R. 741. At para. 32 of her judgment she said:-

> *"On this appeal the issue was whether there exists, alongside the wardship jurisdiction expressly vested by statute in the High Court, an inherent jurisdiction, which exists outside the wardship jurisdiction, to enable and regulate the protection of the property of a person who may lack mental capacity. As was established with clarity by the decision of this court in In Re D [1987] I.R. 449, the current jurisdiction of the High Court in matters involving mental incapacity is the jurisdiction expressly vested in the High Court by the Oireachtas by virtue of subs.1 of s.9 of the Act of 1961 and exercisable in the manner stipulated in ss.2 of that section. Neither the nature of the High Court's judicial function nor its constitutional role in the administration of justice, in my view, permits the recognition of an inherent jurisdiction in the High Court to make provision for the protection of persons with mental incapacity outside the wardship process. …."*

36. The contention which is made here is that the court ought not to exercise its discretion in favour of the making of a wardship order but rather should permit the statutory provisions of the Mental Health Act 2001 to be operated.

37. At the forefront of the written submissions of the respondent is the contention that the effect of this application is to circumvent the provisions of the Mental Health Act 2001 without any particular or cogent reason having been advanced for such a course of action. Insofar as it might be said that that implies some form of *mala fides* on the applicant I am satisfied that there is no basis whatsoever for such a contention.

The Act
38. This Act provides for the involuntary admission to and detention in approved centres of persons suffering from mental disorders. Section 4 makes it clear that in making a decision under the Act for the admission to a centre or in respect of the care or treatment of such a person it is that person's best interests that are to be the principal consideration. Due regard is, however, to be given to the interests of other persons who may be at risk of serious harm if the relevant decision is not made.

39. Section 8 of the Act prescribes the criteria for the involuntary admission of patients to approved centres. A person has to be suffering from a mental disorder as defined in the Act. It is not permissible to involuntarily admit a person to an approved centre by reason only of the fact that the person is suffering from a personality disorder or is socially deviant or is addicted to drugs or intoxicants.

40. Section 9 of the Act prescribes the persons who may apply for involuntary admission. It also specifies persons who are disqualified from making an application in respect of a person.

41. Section 10 of the Act is of some importance in the context of this application. It provides as follows:-

> *"(1) Where a registered medical practitioner is satisfied following an examination of the person the subject of the application that the person is suffering from a mental disorder, he or she shall make a recommendation (in this Act referred to as "a recommendation") in a form specified by the Commission that the person be involuntarily admitted to an approved centre* ***(other than the Central Mental Hospital****) specified by him or her in the recommendation.*
>
> *(2) An examination of the person the subject of an application shall be carried out within 24 hours of the receipt of the application and the registered medical practitioner concerned shall inform the person of the purpose of the examination unless in his or her view the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition.*
>
> *(3) A registered medical practitioner shall, for the purposes of this section, be disqualified for making a recommendation in relation to a person the subject of an application—*
>
> *(a) if he or she has an interest in the payments (if any) to be made in respect of the care of the person in the approved centre concerned,*
>
> *(b) if he or she is a member of the staff of the approved centre to which the person is to be admitted,*
>
> *(c) if he or she is a spouse or a relative of the person, or*
>
> *(d) if he or she is the applicant.*
>
> *(4) A recommendation under subsection (1) shall be sent by the registered medical practitioner concerned to the clinical director of the approved centre concerned and a copy of the recommendation shall be given to the applicant concerned.*
>
> *(5) A recommendation under this section shall remain in force for a period of 7 days from the date of its making and shall then expire." (My emphasis)*

42. As is clear from its terms s.10 (1) prohibits the direct admission of a person suffering from a mental disorder to the Central Mental Hospital. A.M. was until the expiry of his term of imprisonment detained at that hospital.

43. Section 21 of the Act deals with the transfer of patients. Subsection 1 provides that where the clinical director of an approved centre is of opinion that it would be for the benefit of a patient detained in that centre or that it is necessary for the purpose of obtaining special treatment for such patient that he or she should be transferred to another approved centre other than the Central Mental Hospital the clinical director may arrange for the transfer of the patient to the other centre with the consent of the clinical director of that centre.

44. Subsection 2 provides as follows:-

> *"2(a) Where the clinical director of an approved centre –*
>
> *(i) is of opinion that it would be for the benefit of a patient detained in that centre, or that it is necessary for the purpose of obtaining special treatment for such a patient, to transfer him or her to the Central Mental Hospital, and*
>
> *(ii) proposes to do so,*
>
> *he or she shall notify the Commission in writing of the proposal and the Commission shall refer the proposal to a tribunal."*

45. In the following subsection it is provided that the tribunal is required to review the proposal as soon as may be but no later than 14 days thereafter and it may either authorise the transfer of the patient or refuse to do so.

Comment
46. These statutory provisions make it clear that it is possible to transfer a patient already detained from one approved centre to another. It is also possible to transfer from an approved centre to the Central Mental Hospital provided the procedure prescribed in s.21 is carried out. But what does not appear to be possible under the Act is a transfer from the Central Mental Hospital under one legal regime to that same hospital under the provisions of the Act. Thus, in the present case, A.M. was detained at the Central Mental Hospital on foot of a sentence of imprisonment until 11th November, 2016. It was not possible to operate the provisions of the Act to bring about his direct transfer to the same hospital under the regime prescribed under the Act having regard to the terms of s.10 of the Act. Thus, it would have been necessary to seek to have him admitted to an approved centre and then attempt to operate the provisions of s.21 so as to bring about his transfer from that approved centre back to the Central Mental Hospital. The uncontroverted evidence of Professor Kennedy demonstrates that although enquiries were made in an endeavour to do this, no approved centre was prepared to admit A.M. even for a limited period.

47. The respondent, in his written submission, contended that instead of applying for wardship, the following procedure should have been followed so as to permit him to be detained under the provisions of the Act. I quote this directly from the written submissions:-

> *"(i) Prior to 7th November, 2016 (the date upon which an application was first brought before the court) an "authorised officer" of the HSE would have applied to a registered medical practitioner for a recommendation that the respondent be admitted to an approved centre (s.9 of the Act of 2001).*
>
> *(ii) The registered medical practitioner would have arranged, within 24 hours, to examine the respondent. This could have been done at the CMH in Dundrum (s.10 (2) of the Act).*
>
> *(iii) The registered medical practitioner would have made a recommendation that the respondent be admitted to an approved centre other than the CMH (s.10 (1)).*
>
> *(iv) This recommendation would have remained in force for seven days and so there would have been ample time to apply to the High Court for an order similar to the one applied for and obtained on 7th November, 2016 directing that the respondent reside in the short term at the CMH until further order of the court (s.10(5)).*
>
> *(v) Normally under s.13 the person concerned is conveyed to the approved centre.*
>
> *(vi) Where the clinical director of the approved centre receives the recommendation he or she arranges for a consultant psychiatrist to examine the person (s.14).*
>
> *(vii) The respondent would then have been examined at the CMH by a consultant psychiatrist attached to the approved centre who would travel to the CMH for that purpose and an Admission Order would have been signed (s.14(1)(a)). It is submitted that this could all have been achieved by the week of 14th November, 2016 at the latest.*
>
> *(viii) The Admission Order would have authorised the detention of the respondent in the approved centre for 21 days. He would remain at the CMH.*
>
> *(ix) Within 24 hours of the making of the order the Mental Health Commission would have been informed and the respondent would have received notice in writing of the making of the Admission Order (s.16(1)(a) and (b)). The notice in writing to the patient would have informed him that he (a) is being detained pursuant to s.14, (b) is entitled to legal representation, (c) will be given a general description of the proposed treatment to be administered to him or her during the period of his or her detention, (d) is entitled to communicate with the Inspector of Mental Health services, (e) will have his detention reviewed by a tribunal in accordance with the provisions of s.18, (f) is entitled to appeal to the Circuit Court against a decision of a tribunal under s.18 if he is the subject of a renewal order, and (g) may be admitted to the approved centre concerned as a voluntary patient if he or she indicates a wish to be so admitted (s.16(2)) (and that it is clinically appropriate).*
>
> *(x) As soon as possible the Mental Health Commission would have been obliged to (a) refer the matter to a tribunal consisting of a legally qualified chairperson, a consultant psychiatrist and a third member; (b) assign a legal representative to represent the respondent unless he propose to engage one, (c) direct in writing referred to in this section as a "direction" a member of the panel of consultant psychiatrists established under s.33(3)(b) to –*
>
> > *(i) examine the respondent*
> >
> > *(ii) interview the consultant psychiatrist responsible for the care and treatment of the respondent, and*
> >
> > *(iii) review the records relating to the respondent,*
> >
> > *in order to determine in the interest of the respondent whether the respondent was suffering from a mental disorder and to report in writing within 14 days on the results of the examination, interview and review to the tribunal to which the matter has been referred and to provide a copy of the report to the legal representative of the respondent.*
>
> *(xi) The independent psychiatrist must be allowed access to a patient and to relevant documents and it is a criminal offence to impede him or her (s.17 (4)).*
>
> *(xii) As a matter of probability this could all have been accomplished by the week of 21st November, 2016.*
>
> *(xiii) Meanwhile if, as would have been highly probable, a view were to have been taken by the clinical director of the approved centre that a transfer to the CMH would have been appropriate under s.21 (2) of the Act this process could have been set in train.*
>
> *(xiv) The tribunal asked to conduct a review of this decision would as a matter of probability also have concluded its task by the week of 21st November, 2016. Although effect would not have been given to this decision for fourteen days or possibly somewhat longer to allow for a possible appeal (however unlikely) (s.19) it is clear that as a matter of probability the decision would have been implemented in advance of Christmas 2016. A renewal order would also have been made in the interim.*
>
> *(xv) Accordingly, by this stage the respondent would have been detained in the CMH in accordance with the terms of the Act of 2001.*
>
> *(xvi) The respondent would be the beneficiary of regular statutory review by an independent mental health tribunal (each review being preceded by an assessment by an independent consultant psychiatrist under s.16). He would be under the general monitoring of the Mental Health Commission. He would have access to the Inspector of Mental Health Services.*
>
> *(xvii) The respondent's treatment would have to conform to the provisions of ss.56-60 of the Act of 2001. Seclusion and restraint would be subject to s.69 and rules made by the Commission and this would be safeguarded*

by criminal sanction."

48. This elaborate and unrealistic procedure suggested on behalf of the respondent fails to take into account the evidence, which is uncontroverted, and in particular the evidence of Professor Kennedy. His testimony makes it clear how unworkable the proposal is.

49. It furthermore envisages the involvement of the High Court in making an order of the type contemplated at para. (iv). It describes that order as one "*directing the respondent to reside in the short term at the CMH*". That is a rather euphemistic description. It would be a detention order. Under what jurisdiction could the High Court make a free standing detention order of that type save in the context that it did in the present case, namely, an intended wardship application? Under the procedure which is suggested there would be no invocation of the wardship jurisdiction but apparently the High Court would be invited to make a free standing detention order in respect of the respondent. No legal basis for such an order exists in my view.

50. I am satisfied that this suggested procedure was not possible having regard to the factual evidence and in the absence of any legal basis for a detention order to be made by this court. Such an order could only be made in the context of a wardship application given that the respondent is an adult of unsound mind.

51. There is nothing contained in the Act which interferes with the jurisdiction of this court under s.9 (1) of the 1961 Act. Neither expressly nor by implication is the jurisdiction conferred under s.9 (1) of the 1961 Act fettered or diluted by the provisions of the Act. They are two separate jurisdictions albeit that they both deal with persons of unsound mind. The legislature has chosen to have these two separate jurisdictions exist in parallel and either may be used as appropriate. It is a question of which is the more appropriate or effective in a particular case. That will fall to be decided on a case by case basis.

52. Having regard to the facts of this case, I am quite satisfied that the more appropriate procedure to have followed was the one which actually was followed namely, the invocation of the wardship jurisdiction of this court under s.9 of the 1961 Act. I am also satisfied that the alternative suggested procedure set out in elaborate detail and reproduced in this judgment was one which was not appropriate or possible. In any event it would involve the High Court in making an order concerning A.M. which would not have been legally justified.

Post detention treatment

53. In paras. (xv), (xvi) and (xvii) of the extract from the respondent's written submissions which I have reproduced it is pointed out that if he were to be detained under the Act he would be the beneficiary of regular statutory review by an independent Mental Health tribunal and would be under the general monitoring of the Mental Health Commission. He would also have access to the Inspector of Mental Health services. Furthermore, his treatment would have to conform to the provisions of ss. 56-60 of the Act and seclusion and restraint would be subject to s.69 and rules made by the Commission.

54. It was suggested in argument that these rights are superior to any rights which he would have if detained as a ward of court.

55. I am not persuaded that there is any merit in this argument. Wards of Court who are detained pursuant to the exercise of the jurisdiction conferred under s.9 of the 1961 Act have their rights just as effectively secured and respected as if detained pursuant to the procedure set out in the Act.

56. First, the detention of a ward pursuant to s.9 has to be operated in a manner consistent with the Constitution and with the European Convention on Human Rights. This is achieved in part by a system of regular review. Certainly since I took up my present office I have made it clear that any orders made for the detention of a ward of court must be subject to regular reviews at least every six months. In many cases a shorter period of review has been ordered. On such review there is an entitlement on the part of the ward to appear and or to be represented. Each review involves a report being presented to the court by the treating consultant psychiatrist, the contents of which are made known to the committee of that ward. If necessary, the psychiatrist will be required to give oral evidence. If I have any doubts concerning the report presented it is open to me to order a Medical Visitor to conduct an examination and to make a separate and independent report to me on the condition of the Ward.

57. In addition, detention orders made under the wardship jurisdiction are just that. They do not authorise the use of restraint unless such an order is specifically sought and then it is granted only on appropriate evidence as to its necessity being tendered.

58. Furthermore, all detention orders are made with liberty to all interested parties to apply on very short notice. Certainly never more than 48 hours notice is required in order to apply to court. In practice it is often a much shorter notice period that is involved.

59. Indeed, I believe it may be said, that in some respects the entitlements of a ward of court subject to a detention order are superior to those of a person detained under the Act. A long term detainee under the Act has his position reviewed every 12 months. The review period for a ward of court is never more than 6 months. In addition, the ward of court has immediate access to the High Court if any change in circumstances occurs whereas there is no such automatic entitlement to a patient detained under the Act.

Conclusion

60. The provisions of the Act do not in any way interfere with or dilute the statutory wardship jurisdiction vested in the court pursuant to s.9(1) of the 1961 Act.

61. These two statutory jurisdictions exist side by side. Both seek to address the wellbeing of persons of unsound mind. It is a question in every case as to which of the two jurisdictions more appropriately addresses the needs of an individual person.

62. For the reasons which I have already given, I am satisfied that the Health Service Executive in invoking the wardship jurisdiction in this case did so appropriately. It did so in circumstances where on the facts and having regard to the statutory provisions, it was not feasible to operate the provisions of the Act in the case of the respondent.

63. It is both necessary and appropriate that the respondent be detained pending further order of the court in the Central Mental Hospital which is the only facility which has a sufficient degree of security to ensure his safety and the safety of the persons caring for him.

64. As the respondent meets the necessary criteria for admission to wardship I now make that order.

65. I am also satisfied that the rights of the respondent as a ward of court detained at the Central Mental Hospital pursuant to court order are no less than those of a person detained at that same institution pursuant to the provisions of the Act. Accordingly, the order made for his detention will continue and will be the subject of a review by this court which will be carried out on Monday, 26th

June, 2017 at 11.00am. Meanwhile there is liberty to all parties to apply should any change in circumstances occur between this and then.