[2025] IEHC 86

THE HIGH COURT

[HMCA 2024/201]

IN THE MATTER OF N.D. AND IN THE MATTER OF THE INHERENT JURISDICTION OF THE HIGH COURT

BETWEEN:

HEALTH SERVICE EXECUTIVE

APPLICANT

AND

N.D. (A PERSON LACKING CAPACITY (NOT SO FOUND) REPRESENTED BY HIS GUARDIAN AD LITEM)

RESPONDENT

JUDGMENT of Mr. Justice Barry O'Donnell delivered on the 18th day of February, 2025

INTRODUCTION

1. This judgment concerns issues that arose in connection with orders made by the court permitting the applicant (*the HSE*) to detain and treat the respondent at the Central Mental Hospital (*the CMH*). The orders made include an uncontested order pursuant to section 27 of the Civil Law (Miscellaneous Provisions) Act, 2008 which prohibited the publication or broadcast of any matter that identifies the respondent. This was on the basis that the respondent

is a person who suffers from a medical condition and his medical circumstances are of central relevance to the proceedings. Accordingly, I have used the initials "*N.D.*" to describe the respondent.

2. Following an initial ex parte application, the respondent was represented by a guardian *ad litem*, who also had acted as his legal representative in the context of statutory proceedings. Since the initial orders were made by this court, the proceedings have been the subject of regular reviews at which the court was provided with up-to-date medical evidence, all of which supported the proposition that the orders should be continued. It is important to note that on each occasion when the orders were renewed, the legal representatives for the respondent did not consent to the application by the HSE to have the orders continued. Quite properly, in light of the medical evidence regarding the respondent's condition, there was no objection by the respondent to the making of the orders, or any positive application to discharge the orders.

3. Initially, the issues that the court was asked by the respondent to address included the central question of whether the court had a power pursuant to section 9 of the Courts (Supplemental Provisions) Act, 1961 (*the 1961 Act*) to make the orders that had been sought by the HSE. The court had made the orders on the basis of the inherent jurisdiction of the High Court, however the legal representatives made extensive submissions that the issues could be resolved using the statutory jurisdiction. Judgment was reserved following a full hearing, and the court decided to postpone making a decision as a judgment was expected in an appeal before the Court of Appeal in which the question of the status of section 9 of the 1961 Act in the light of the commencement of the Assisted Decision-Making Capacity Act, 2015 (*the 2015 Act*) was to be addressed. That case was *In the matter of KK, the Child and Family Agency v. KK* [2024] IECA 242, and judgment was delivered on the 11 October 2024. The decision made

in the Court of Appeal effectively resolved one of the central points made on behalf of the respondent; and it confirmed, contrary to the position adopted on behalf of the respondent, that the court could not make the orders sought by reference to section 9 of the 1961 Act.

4. This case was further adjourned with the orders continuing to allow the parties to consider that judgment. Following that consideration, the respondent submitted a list of issues that he submitted were part of this case and which were not addressed in the Court of Appeal judgment. In this judgment I have addressed the issues that arose and were argued in the original application. I have addressed some but not all of the issues later raised by the respondent. The issues not addressed are matters that I consider went beyond the parameters of the case that was argued before the court, and that it would be more appropriate to address those issues in a case where the issues were live and properly argued. While there is a strong justification for seeking to resolve issues around the continued operation of the inherent jurisdiction of the High Court to make orders providing for the detention, treatment and care of persons who lack capacity, there are equally strong reasons for the court to avoid providing advisory opinions and to restrict judgments to the legal and factual matters that arise in each particular application.

5. As explained in more detail below, the court has concluded that the HSE application was correct, and that the orders sought, granted and that have been continued from time to time since the commencement of the proceedings were justified by reference to the evidence and the law.

BACKGROUND

6. The evidential basis for the HSE application was largely uncontested. N.D. is a man in his mid-60s who suffers from serious mental illness, with a long-standing diagnosis of schizophrenia. Part of his profile includes a history of violence perpetrated in clinical settings. N.D. was an involuntary patient in a hospital in the west of the country for a period until September 2013, when he was transferred to the CMH as an involuntary patient pursuant to the provisions of section 21(2) of the Mental Health Act 2001 (*the 2001 Act*). Section 21(2) of the 2001 Act provides for the transfer of patients from an approved centre to the CMH where certain conditions are met and a statutory process involving independent review by a Mental Health Tribunal has taken place. Hence, his detention and treatment in the CMH arose and continues in a civil law context and not in connection with any criminal process. He has remained as a patient in the CMH since that time.

7. The CMH is a tertiary specialist mental hospital that provides treatment for adults with mental disorders in conditions of special therapeutic security. The CMH is the only facility in the State that can provide this form of secure therapeutic input. The CMH does not provide treatment to persons who do not need to be involuntarily detained.

8. Until the 22 April 2024, N.D. was being treated and detained pursuant to the provisions of the 2001 Act. On that date, the most recent Renewal Order made under the 2001 Act was reviewed by a Mental Health Tribunal. As part of that statutory process, it became apparent that N.D. had not been provided with the form of notification that is a mandatory requirement pursuant to section 16 of the 2001 Act. A failure to comply with the requirements of section 16 of the 2001 Act has long been identified in the case law as a serious procedural failure which

can form a valid basis for revoking an admission or renewal order. Thus, the Mental Health Tribunal decided that the Renewal Order had to be revoked. The effect of that decision was that *prima facie* N.D. would be free to leave the CMH. As will be explained later, unlike the position where admission or renewal orders in other approved centres are revoked on procedural grounds, there is no statutory mechanism available to permit a patient in the CMH to be treated as a voluntary patient or directly re-admitted to that hospital.

9. Accordingly, shortly after the decision was made by the Mental Health Tribunal, the HSE made an urgent *ex parte* application to this court seeking orders pursuant to the inherent jurisdiction of this court for the detention and treatment of N.D. at the CMH. That application was supported by detailed medical evidence.

10. In summary, the evidence explained N.D.'s history of mental illness and the difficulties and risks associated with his particular medical circumstances; that N.D. lacked capacity to make decisions regarding his treatment for his mental illness; and, that the exceptional needs of N.D. could only be safely delivered in the specialised secure therapeutic environment of the CMH.

11. As part of the application invoking the inherent jurisdiction of this court, the HSE also sought to have a guardian *ad litem* appointed in respect of N.D. Initially the court was asked to appoint an independent solicitor with experience in this area of practice. N.D. later expressed a preference to have Ms. Anna Cogan appointed as his guardian *ad litem*. Ms. Cogan is a very experienced solicitor in mental health law and practice and had acted as N.D.'s legal representative for some time in the context of his admission pursuant to the 2001 Act. That substitution was not opposed by the HSE, and it seemed appropriate therefore to appoint Ms.

Cogan as the guardian *ad litem*. In turn, Ms. Cogan instructed experienced senior and junior counsel to act on her behalf.

12. These proceedings are civil proceedings in which the applicant seeks orders that engage the constitutional rights of affected persons, and where the applicant must bear the burden of proving that the orders sought are lawful, justified on the evidence and proportionate. Nevertheless, despite being structured as adversarial proceedings, there is an inquisitorial element to the process. Even if matters are not raised by the respondent, the court must make sufficient inquiries to ensure that it is fully satisfied as to the appropriateness of the orders sought.

13. The role of a guardian *ad litem* in proceedings under the inherent jurisdiction of the court is of critical importance, both in terms of forming a central pillar in the legal protection for affected persons, and in terms of assisting the court by ensuring that relevant matters are brought to the attention of the court. The role of guardian *ad litem* differs somewhat from that of a legal representative under 2001 Act procedures. Put briefly, the task of the guardian is twofold: first the guardian must seek to ascertain as best they can the wishes and preferences of the respondent and convey those wishes to the court; and second the guardian must seek to provide an independent view to the court on the application that is under consideration. There is scope for tension between those two tasks.

14. The court, accordingly, must be assured that the guardian *ad litem* is able to bring considerable expertise to the discharge of the assigned tasks. Part of the task, where appropriate, is to test not only the evidential basis for the application but also to test the legal basis for the application, and to consider if the proposed intervention is proportionate and just.

For instance, even if the invocation of the inherent jurisdiction is entirely warranted, it may be the case that it would be possible and practicable to achieve the desired result of protecting the constitutional rights of the affected person by less restrictive measures than those initially proposed.

15. In this instance, Ms. Cogan discharged her obligations in a fair and balanced way. Ultimately, the court is fully satisfied that the orders sought were warranted and lawful. Nevertheless, the orders impinge on the liberty and bodily integrity rights of a vulnerable citizen. Given the relevant paucity of authority on the role of the inherent jurisdiction following the commencement of the 2015 Act, it was necessary and appropriate that the application was subjected to a proper level of scrutiny.

THE EVIDENCE

16. Before addressing the various legal arguments, I will set out the essential evidence that was put before the court and the findings of fact that I have made. In that regard, it was striking that there was a very large degree of consensus from the witnesses – all of whom are experts in the field of psychiatry. In this case, there were no applications to cross examine the witnesses and there was no dispute on the core material facts.

17. The medical evidence for the hearing came from a variety of experts. Dr Mark Joynt is a consultant forensic psychiatrist attached to the CMH and at the relevant time had been the clinician responsible for N.D.'s care from April 2023. Additional evidence was available from Dr Brenda Wright, who also is a consultant forensic psychiatrist and holds the post of Clinical Director of the CMH. The court had a report from Professor Narayanan Subramanian who

carried out an independent assessment for the guardian *ad litem*. Professor Subramanian is a consultant psychiatrist and Adjunct Clinical Associate Professor of Psychiatry in the University of Limerick. Finally, it can be noted that in the course of the proceedings before the Mental Health Tribunal in April 2024 a report had been obtained from Dr Helen Barry, a consultant psychiatrist. The report was prepared in her capacity at the time as an independent psychiatrist as required by s. 17 of the 2001 Act. That report formed part of the documentary evidence in the case. I will simply note that Dr Barry's findings were entirely consistent with the general thrust of the other psychiatric evidence. The medical evidence was set out in affidavits and reports and was extensive; I have endeavoured to summarise the evidence below.

Dr Joynt

18. Dr Joynt's evidence set out the general psychiatric history of N.D. This included an initial admission in March 2009 leading to a transfer to an approved centre in the West of Ireland in August 2012. Dr Joynt noted that N.D. was referred to the CMH after an allegation of a serious assault on a fellow patient and a second alleged assault on a nurse, and he was transferred to the CMH pursuant to s. 21(2) of the 2001 Act on the 22 July 2013. At the time of the hearings, N.D. was placed on the Claremont Unit within what was described as the "medium cluster" of the hospital.

19. In terms of background history, N.D. had a history of alcohol abuse, which he downplayed. His psychiatric diagnosis is of treatment resistant paranoid schizophrenia dating back to his late adolescence. According to Dr Joynt, N.D.'s schizophrenia is characterised by significant positive, negative and neurocognitive symptoms. During periods of relapse, he is known to become suspicious, argumentative, hostile and develops persecutory delusional beliefs. While the illness is treatment resistant, he has shown a partial response to clozapine

and his positive symptoms become less intense. Clinically he presents with profound impairment of insight into his illness and need for treatment and continues to be significantly burdened by chronic negative symptoms with neurocognitive deficits.

20. In terms of capacity, Dr Joynt noted that N.D. has very limited insight into his mental illness or the need for ongoing care and treatment. He noted that that feature is the most common predictor of non-adherence to treatment, and it predicts higher relapse rates, increased number of involuntary treatments, poorer psychosocial functioning, aggression and poorer outcome of illness. Dr Joynt was of the view that N.D. lacked capacity to understand his condition in a meaningful sense and to take steps to receive appropriate treatment.

21. Dr Joynt expressed the view that if N.D. was discharged from the CMH to the community, he would very likely disregard medical advice and not seek out continued treatment. He would be unlikely to avoid alcohol misuse which in turn significantly raises his risk profile. He would likely discontinue taking his anti-psychotic medication and would quickly relapse with a high risk of violence to others and he would also become a danger to himself. In addition, if N.D. was to be discharged to a less secure environment than the CMH, Dr Joynt believed that this would place health care workers and clinicians in such centres at risk of harm; and, if he was in a position to leave that setting, members of the public would be at serious and immediate risk of harm and N.D. would very likely place himself at risk of injury.

22. According to Dr Joynt, the effects of N.D.'s mental illness, including his cognitive impairments, are such that his capacity to give consent to treatment and care is severely compromised. He is unable properly to understand, retain, balance, consider and critically weigh information so as to reach a balanced view and make an informed decision on critical

aspects of his care and habitation and to regulate his daily living and behaviour. N.D. remains largely insight-less into his condition and his need for ongoing treatment.

23. Dr Joynt was of the view that N.D. remained very unwell and had not reached a stage in his rehabilitation where he understood the importance of taking medication and on discharge being abstinent from drugs or alcohol. If he were released, he would inevitably fail to adhere to his medication regime and non-compliance with his medication and/or likely substance abuse would render him at greater risk of danger to others.

24. Dr Joynt noted that insofar as N.D. expressed a view that he would prefer to stay in the hospital on a voluntary basis, this was not a capacitous decision. According to Dr Joynt, N.D.'s illness was of such gravity that, notwithstanding his ostensible agreement to remain in the CMH, in order for him to be properly treated he needed to be detained, and orders were required to regulate his detention, care, treatment and restraint where necessary for his own protection and for the protection of others. Dr Joynt noted that every patient in the CMH is necessarily an involuntary patient, and that the organisation of the hospital is exclusively to cater for the cohort of patients who require therapeutic security.

Dr Wright

25. Dr Brenda Wright is a consultant forensic psychiatrist and the Clinical Director of the CMH. In her affidavit she described the role and operation of the CMH, which she described as "*a central part of the HSE's national forensic mental health service*". She noted that the CMH is a specialist mental hospital providing treatment for persons with mental disorders in conditions of special therapeutic security and is the only secure forensic hospital in the State which operates as a tertiary level service within the HSE. The service specifically addresses

the needs of individuals with severe mental disorder who have exceeded the capacity of secondary mental health services.

26. Dr Wright made clear that the CMH does not offer a service to patients who do not need to be involuntarily detained. The hospital is operated so as to treat patients who, like N.D., cannot be treated in a non-secure setting. Dr Wright described the treatment routes by which patients are referred to the CMH, and these include (a) sentenced or remand prisoners who are found to have severe mental illness; (b) persons committed under s. 4 or s. 5 of the Criminal Law (Insanity) Act, 2006 who have been found either unfit to stand trial or not guilty by reason of insanity and require inpatient psychiatric treatment; and, (c) patients who can be transferred from approved centres in the civil system pursuant to s. 21(2) of the Mental Health Act, 2001. She noted that under the 2001 Act, the direct admission of patients to the CMH from the community is not permitted. It is the need for specialist treatment which determines a patient's suitability for a transfer from an approved centre to the CMH.

27. In common with Dr Joynt, Dr Wright expressed the view that N.D. is not yet ready for discharge from the CMH and that he remains largely insight-less into his own condition and his need for ongoing treatment and care. She also agreed that N.D. lacks the capacity to make any key decisions surrounding his health care and rehabilitation, including any decision to remain in or leave the CMH. Aside from the fact that the CMH is not structured to provide care on a voluntary basis, Dr Wright was of the view that any decision by N.D. to remain in the hospital would be a decision made in the absence of capacity.

28. Dr Wright described N.D.'s lack of engagement with therapeutic interventions including interventions related to alcohol and substance abuse and offending behaviour and she

noted that he continued to suffer from a delusional belief that he was the subject of persecution while an inpatient in his local approved centre. For the reasons set out in her affidavit, Dr Wright expressed the clear view that N.D. continues to present as a risk to others and to himself. Finally, Dr Wright agreed with Dr Joynt that in the event that N.D. was permitted to take his discharge from the hospital, or discontinue his medication while in the hospital, this would likely lead to rapid deterioration in his condition. She also noted that N.D. has a very high level of care needs which were being addressed through a plan of comprehensive multi-disciplinary support. She noted that N.D.'s illness is sufficiently severe that he continues to require inpatient care in a secure setting and that in the absence of continued secure inpatient care and treatment his conditions would likely seriously deteriorate and prevent the administration of appropriate treatment as well as increasing the risk of violence to others significantly.

29. Later in her affidavit, Dr Wright provided more detail on her view that N.D. could not be treated as a voluntary patient within the CMH, and she explained why she considered that that option was not ethical, reasonable or realistic. First, she noted that the organisation of the CMH is arranged exclusively to cater to the cohort of patients who require a high level of therapeutic security. In that regard, it was not feasible or safe to have any patient in the population of the hospital who was not subject to the same controls and restrictions as other patients. Second, she noted that as part of his therapeutic programme, N.D. availed of some supervised community leave. That accompanied leave in the community was managed by specialist staff who are specially trained to safeguard N.D. while he is on permitted leave. His staff have authority to intervene should he decide to seek to abscond or display violence to a member of the public. Those protective measures would not be available if N.D. had the status of a voluntary patient. Moreover, if, in the course of a supervised community leave visit, N.D. decided not to return to the CMH or to act in an unsafe manner towards the member of the

public, the staff would be powerless to stop him. Hence if N.D. was permitted to remain in the CMH as a voluntary patient, the community leave which he currently enjoys could not reasonably and safely be accommodated which in turn would unnecessarily deprive him of an important part of his rehabilitative treatment pathway.

30. Finally, Dr Wright observed that in the absence of orders or some legal basis for this, it would not be possible for the hospital to address appropriately and therapeutically the situation that would arise if N.D. while remaining within the hospital declined his medication. As noted above, Dr Wright predicated all of her observations on the fundamental point that N.D. did not have the capacity to decide whether or not to take a discharge from the CMH because of his underlying condition and likewise did not have a capacity to decide whether to remain in the hospital for the same reasons.

Professor Subramanian

31. Professor Subramanian prepared a report on behalf of the guardian *ad litem*, and is not connected to the CMH. He carried out an examination of N.D. and his records. He noted that N.D. was of the view that he did not need anti-psychotic medications as he did not believe he had a psychotic disorder. He also advised Professor Subramanian that he denied the accounts of events that led to his transfer to the CMH and that staff in the previous approved unit were exaggerating things. N.D. reported to Professor Subramanian that he did not want to stay in the CMH any longer.

32. The opinion formulated by Professor Subramanian was that due to his continued lack of insight into his mental illness N.D. was at high risk of relapse within a short period if he became non-compliant with psychiatric medications, particularly his anti-psychotic

medications. In addition, there was a significant possibility of N.D. being a risk to others in the event of a relapse of psychotic symptoms and the risk of him relapsing on alcohol misuse could not be ruled out. Professor Subramanian was also of the opinion that N.D. lacked the capacity to consent to the treatment of his mental disorder with psychiatric medications and does not have the capacity to consent to admission either on his own or with the assistance of a co decision- maker or a decision-making assistant due to his mental disorder.

33. Professor Subramanian also expressed a preference that N.D. would benefit from further assessment of his cognitive impairment including CAT / MRI brain scan to rule out vascular or other types of dementia in light of his presentation.

Supplemental Report

34. In a supplemental report and affidavit, Dr Joynt confirmed his previous views and set out his analysis of risk factors. These include risk of harm to others. In that regard, having described previous instances that were recorded as having occurred, Dr Joynt explained that N.D.'s risk of violence was adequately managed in his current placement. Of note, Dr Joynt observed that N.D. continued to describe a delusional understanding of the circumstances leading to his transfer and to express paranoid persecutory delusional beliefs regarding staff at his previous treating hospital. According to Dr Joynt, if N.D. was discharged from the CMH it could be anticipated that he would become non-complaint with his medication and there would be a rapid escalation in risk to others.

35. Dr Joynt identified a risk of substance abuse and particularly a risk of return to alcohol use in the community and a risk of non-compliance with treatment. In that regard, Dr Joynt expressed the opinion that the risk of non-compliance with treatment is high in less supervised

settings. Currently N.D.'s medication is administered under supervision in his current environment. Non-compliance with medication would be associated with a high risk of deterioration of his psychosis and the risk of violence would rise significantly. In terms of the risk of relapse or deterioration, Dr Joynt expressed the view that N.D. had a diagnosis of treatment resistance schizophrenia, he was maintained on clozapine and, with that mediation, he has had a period of relative stability. However, he continues to describe a delusional understanding of the circumstances leading to his transfer and to express paranoid persecutory delusional beliefs regarding staff at his previous treating hospital. Accordingly, Dr Joynt believed that in the absence of treatment with clozapine, N.D.'s risk of deterioration was extremely high and exposure to destabilisers such as stress and substances would also increase the risk of deterioration. Finally, Dr Joynt refers to a risk of self-neglect which is a function of N.D.'s overall neuro-psychological ability, which is in the profoundly impaired range. N.D. requires regular encouragement in prompting to tend to his personal hygiene and to engage in physical activity and he would be at serious risk of self-neglect outside of a supportive setting.

36. Dr Joynt expressed the opinion that N.D. was benefiting from his course of treatment at the CMH. First, he has access to medical treatment including clozapine which has led to a demonstrative improvement in his mental state. The continued administration of this treatment is likely to continue to alleviate his psychotic illness. Secondly, he believes that N.D. continues to benefit from a highly supported environment of regular multi-disciplinary input, including nursing, occupational therapy, social work, primary care and the input of the visiting metabolic service, which includes physiotherapy support and consultant led physical health care. N.D. receives regular support and prompting to attend to his self-care and engage in a programme of exercise.

37. Dr Joynt expressed the opinion that given N.D.'s high level of care needs and in light of the evidence of significant difficulties in an environment with the lesser degree of multi-disciplinary support, N.D.'s needs could not be appropriately met at a treatment setting other than the CMH at the time. Dr Joynt noted that N.D. had been referred to a potential new service but that was not yet open to receiving patients. In those circumstances there was no alternative less restrictive clinical setting that would be appropriate at the present time. Even if short-term placements were available in other centres, which they were not, it would not be clinically appropriate to transfer N.D. as this would interrupt the care and treatment he was receiving in the CMH and would not be in his interests. Overall, Dr Joynt was of the view that orders permitting the continued treatment of N.D. in the Central Mental Hospital were clinically necessary, appropriate and proportionate to his clinical circumstances and care needs.

38. On the basis of the foregoing, the court is satisfied as to the following:

a. N.D. has a longstanding diagnosis of treatment resistant schizophrenia, which has responded to treatment with the anti-psychotic clozapine in the sense that certain of the positive symptoms of his illness can be somewhat mitigated.

b. In addition to his medical diagnosis, N.D. has a history of alcohol misuse and violence. N.D. also suffers from a degree of cognitive impairment, albeit that the precise reason for the impairment is not fully clear.

c. N.D. has significant treatment needs. He requires to be treated and managed in a highly structured and therapeutic secure environment and cared for with specialised multi-disciplinary inputs in order to protect and maintain his health and welfare, and life. Currently, those treatment needs are being met in the CMH.

d. There is no other available facility capable of meeting N.D.'s clinical needs and providing the same level of care. Clinically, even if a suitable alternative facility was available, a move to an alternative medical facility is contrary to N.D.'s interests as it would disrupt and harm his current relatively stable condition.

e. N.D. does not accept the medical view of his illness. He lacks insight into the nature of his illness, the risk of alcohol use, the need for treatment – particularly the need for anti-psychotic medication, and he does not accept that previously he engaged in violent and threatening behaviour in the approved centre where he was treated prior to his transfer to the CMH.

f. N.D. lacks capacity to make decisions regarding the medical care required to treat his illness and also lacks capacity to make a decision to be admitted to or discharged from the CMH.

g. In the absence of an appropriate regime for his involuntary care and treatment, N.D. is at high risk of a serious relapse in his medical condition, and there is a material risk that he will present a risk to the lives and welfare of others in the event of such a relapse. Moreover, a relapse caused by a failure to adhere to medical advice would be seriously damaging to N.D.'s own life, health and welfare.

h. If he was in a position to make a choice, it is likely that N.D. would leave his treatment centre and/or discontinue taking his anti-psychotic medication and/or resume alcohol misuse. Those risks are described by those who have assessed and treated N.D. and are grounded in his established history and his more recently expressed views.

39. It can be noted that lack of capacity (or a seriously impaired capacity) to make a decision such as whether to be admitted to hospital or to receive medical treatment is a threshold issue for the invocation of the inherent jurisdiction.

THE ARGUMENTS

40. The HSE position was relatively straightforward. First, it was argued that there was no basis for treating N.D. as a voluntary patient. This was a function of the position of the CMH as a highly specialised medical facility that did not admit or treat voluntary patients. In addition, as explained by Dr Wright, (a) treating N.D. on a voluntary basis carried an appreciable risk that he would cease taking anti-psychotic medication and suffer a harmful relapse of psychotic illness, (b) without a legal regime to regulate his conduct or to permit the CMH lawfully to intervene, N.D. could not enjoy the full panoply of treatments and interventions that he required, including the therapeutically beneficial regime of community visits, and (c) perhaps most importantly, predicated on his established lack of capacity to make decisions on admission or discharge from the CMH, N.D. could not truly or properly consent to remain in the CMH for voluntary treatment.

41. Second, when the Mental Health Tribunal revoked his most recent Renewal Order under the provisions of the 2001 Act, there was no legal mechanism for the direct admission of N.D. to the CMH. This was an analogous situation to that described by MacMenamin J. in the Supreme Court in *Health Service Executive v. AM* [2019] 2 IR 115 *(A.M.)* On the civil law side, the 2001 Act only provides for the admission of patients to the CMH by way of a transfer from an approved centre, which itself involves a process of statutory structuring and hurdles. Hence, if an alternative pathway was not available N.D. would have had to have been released from

the CMH, re-admitted to an approved centre, the process for transfer to the CMH would have to be undertaken, and then N.D. would be admitted. That process likely would prove extremely difficult given that N.D. was unlikely to be admitted to an approved centre because of the complexity and extent of his treatment needs and risk profile. In addition, the process that would have to be undertaken would be detrimental to and disruptive of N.D.'s current treatment, and not in his clinical interests.

42. Third, the HSE argued, by reference to the judgment of Hyland J. in *KK,* that following the commencement of the 2015 Act it was not possible to ground an application for the detention and treatment of N.D. in the powers described in section 9 of the 1961 Act.

43. Fourth, and following from the above, the HSE argued that the position of N.D. in the CMH could be regularised and regulated by way of the inherent jurisdiction of the High Court. In that regard, and by analogy with the manner in which similar orders were structured under the former wardship jurisdiction, and which in turn were approved of by the Supreme Court in *A.M.*, it was possible to structure any orders made under the inherent jurisdiction in a way that N.D. would benefit from the same range of procedural safeguards that he enjoyed when he was an involuntary patient pursuant to the provisions of the 2001 Act.

44. Hence the HSE submitted that the court had jurisdiction to make the orders sought and that, by reference to the evidence, the orders should be made and continued.

45. Counsel for the guardian *ad litem* started from the premise that that the views of Dr Joynt on the undesirability of a short term move to an approved centre were not being contradicted, and that the best solution would be for N.D. to remain in the CMH. The argument

was that this could be achieved by N.D. remaining in the CMH as a voluntary patient. In the event that N.D. expressed an intention to leave the CMH it would then be open to the clinical director to invoke the procedures in sections 23 and 24 of the 2001 Act and re-admit N.D. as an involuntary patient. An ancillary argument was made that the "policy" of the CMH to not admit voluntary patients was unlawful and amounted to a fettering of its discretion and/or contradicted section 29 of the 2001 Act, which confirmed that voluntary patients can be admitted to approved centres.

46. Alternatively, if the "voluntary patient" arguments were not in their favour and the court was satisfied as to N.D.'s lack of capacity, it was argued that the inherent jurisdiction was not an appropriate mechanism to address the situation. In that regard the submission was that the inherent jurisdiction could only be invoked where there was no satisfactory statutory mechanism, and that in this case the appropriate statutory mechanism was that expressed in section 9 of the 1961 Act.

DISCUSSION

47. In the first instance, the concrete situation of N.D. has been set out above. The court is fully satisfied that N.D. is an extremely vulnerable citizen who lacks capacity to make decisions regarding whether he should be admitted to or discharged from the CMH and to make decisions on his medical care and treatment within the CMH. The evidence clearly establishes that he will suffer considerable harm and detriment without some form of intervention to bring about or regularise his detention, care and treatment within the CMH, and that there is no suitable alternative setting available to meet his needs.

48. Second, I am satisfied that N.D. cannot be treated as a voluntary patient within the CMH. The primary reason for this finding is that N.D.'s treatment needs are complex and include the necessary administration of antipsychotic medication; those medical needs cannot be addressed by his mere presence within the CMH. As N.D. lacks capacity to make healthcare decisions, any assent to his presence in the CMH would not amount to a lawfully effective consent to his treatment.

49. In addition, I do not agree that section 29 of the 2001 Act provides a lawful basis for his treatment in the CMH. Section 29 of the 2001 Act certainly confirms the general proposition that a patient can be treated on a voluntary basis in an approved centre, and the CMH is an approved centre within the meaning of that term in the 2001 Act. However, it is clear that the Oireachtas intended admission to the CMH to be subject to particular and specific rules and processes that operate over and above the rules and processes that apply to treatment in other approved centres.

50. The provisions of section 21(2) of the 2001 Act make it clear that a patient cannot be admitted directly to the CMH. Instead, a specific process is required to be undertaken which includes a hearing by a Mental Health Tribunal. In those premises, section 29 of the 2001 Act can be seen as essentially preserving the principle of voluntariness and the entitlement of a patient to be admitted as a voluntary patient in much the same way as obtained prior to the commencement of the 2001 Act. However, that was not the position with the CMH. I am satisfied that the general provisions of section 29 when read in light of the specific provision made in section 21(2) for admissions to the CMH cannot be seen as operating as a mandate for the proposition advanced by the respondent in this case. Section 21(2) of the 2001 Act

constitutes a recognition by the Oireachtas of the distinct character of the CMH and the particular service provided there.

51. In those premises, it is not necessary to engage with the arguments that the CMH is operating an impermissible blanket policy. However, I have to observe that the argument was not convincing in light of Dr Wright's evidence of the particular specialised services and admission routes that characterise the CMH, and the observations made that the same level of treatment could not be afforded to N.D. if he was a voluntary patient.

52. The absence of a statutory mechanism to permit N.D.'s continued treatment in the CMH without the potentially damaging effects of having to release him to the community, re-admit him to an approved centre – if an approved centre could be identified that would be willing to make such an admission (which is highly unlikely in light of N.D.'s clinical needs and profile) – and then engage in the statutory process for re-admission to the CMH operates as a form of lacuna or gap in the statutory scheme that validly can lead to the invocation of the inherent jurisdiction.

53. Third, it is clear from the judgment of the Court of Appeal in *KK* referred to above that following the commencement of the 2015 Act, section 9 of the 1961 Act no longer operates to permit orders for detention and/or treatment to be made in respect of adult persons who lack the capacity to make the requisite decisions. Hence, in addition to the fact that the 2001 Act does not provide a mechanism to allow for N.D.'s continued treatment in the CMH, the Court of Appeal has made clear that section 9 of the 1961 Act - the potential alternative statutory route which was available prior to the commencement of the 2015 Act – no longer operates to ground a decision to detain a vulnerable adult who lacks capacity.

54. The decision in *KK* concerned an appeal from a judgment given by Hyland J. in the High Court reported as *Child and Family Agency v KK* [2023] IEHC 306. In that decision, Hyland J. held that the High Court no longer had a jurisdiction to make detention orders pursuant to s. 9 of the 1961 Act, and this was on the basis that this provision was fundamentally inconsistent with the new regime provided for by the 2015 Act. The High Court did hold that the court enjoyed an inherent constitutionally derived jurisdiction to make detention orders should the circumstances warrant that course of action, and that existence of that jurisdiction had been preserved expressly by s. 4(5) of the 2015 Act. However, the sole issue before the Court of Appeal was whether the s. 9 jurisdiction had in fact survived the enactment of the 2015 Act.

55. In his judgment in the Court of Appeal, Hogan J. considered a number of matters, including the historical background to the wardship jurisdiction. In addition to the important historical decisions on the wardship jurisdiction, the Court referred to more recent Supreme Court decisions including *Re A Ward of Court* [1996] 2 IR 79, *Re FD* [2015] 1 IR 741, and *AC v Cork University Hospital* [2020] 2 IR 38. In considering the historical backdrop to the wardship jurisdiction, the Court of Appeal noted that the original powers exercised by the Lord Chancellor which were delegated by the Crown under sign manual originally were in the form of a crown prerogative and that while aspects of that jurisdiction were regulated by statute the "full amplitude of that jurisdiction essentially rested on case law and (at least prior to 1922) prerogative practise".

56. The Court of Appeal confirmed the understanding that the original wardship jurisdiction extended to the commitment and detention of persons of unsound mind and that by virtue of the operation of s. 19 of the Court of Justice Act, 1924, s. 9 of the Courts of Justice

Act, 1936 and s. 9 of the Courts Supplemental Provisions Act, 1961, the wardship jurisdiction and the associated power to commit and detain persons of unsound mind had a statutory basis, or at least a statutory acknowledgment prior to the enactment of the 2015 Act. The court also noted that, as clarified in the decisions of the Supreme Court in cases such as *Re D* [1987] IR 449 and *Eastern Health Board v MK* [1999] 2 IR 99, the operation of the wardship jurisdiction did not rest on concepts of crown prerogative but rather was exercised by reference to constitutional considerations arising from the judicial duty expressed in Article 40.3.3 to protect the person and property of the ward.

57. For the reasons explained in his judgment and which do not need to be rehearsed in any detail in this judgment, Hogan J. concluded that notwithstanding the fact that the 2015 Act contained no express repeal of s. 9 of the 1961 Act, and in fact the s. 9 jurisdiction in respect of minors was unaffected by the changes, there were substantial reasons why the Court was compelled to conclude that the continued operation of the 2015 Act regime and the wardship jurisdiction (insofar as it provided for the commitment and detention of persons of unsound mind) were mutually incompatible.

58. In essence, although the matter necessarily was considered in far more detail in the judgment, the Court of Appeal concluded that the entire thrust of the 2015 Act was to favour the phasing out of wardship and to introduce a new regime, expressed in Part 10 of the 2015 Act, for the statutory detention of persons who lacked capacity and who suffer from a mental disorder. The Court of Appeal found that the s. 9 jurisdiction could not congruently be operated in respect of a fresh application to detain a ward after the commencement date of the 2015 Act. Accordingly, the court affirmed the view of Hyland J. that the High Court no longer enjoyed a

detention power onto the s. 9 jurisdiction in respect of adult wards where the proceedings were commenced after the commencement date of the 2015 Act, being the 23 April 2023.

THE INHERENT JURISDICTION

59. Section 4(5) of the 2015 provides that "*Nothing in this Act shall affect the inherent jurisdiction of the High Court to make orders for the care, treatment or detention of persons who lack capacity.*"

60. In *A.M*, the Supreme Court addressed the power of the High Court exercising the wardship jurisdiction to make orders for the detention and treatment of a person in the CMH. In the course of the judgment, MacMenamin J. addressed the question of the continued availability of the inherent jurisdiction in cases where detention or treatment orders were sought for a person who lacked capacity. As noted by the Court:

> *"[75] The existence of an inherent jurisdiction was expressly recognised by this court … in D.G. v. Eastern Health Board [1997] 3 IR 511, at p.524 … Hamilton C.J. explained that it was a power which should be recognised in extreme and rare occasions, when a court is satisfied that it is required for a short period in the interests of the welfare of the child, and that there is, at the time, no other suitable facility. The majority of the full Court held that the courts have jurisdiction to do all things necessary to vindicate the personal rights of the citizens (see The State (Quinn) v. Ryan [1965] IR 70). …*
>
> *[76] This jurisdiction has also been used in rare occasions in the case of adults when it has been shown that there is a legislative lacuna; that such an adult was of unsound mind; that their mental disorder was of such a degree warranting*

compulsory confinement; and where the validity of the continued confinement depended on the persistence of such disorder (see Health Service Executive v. O'B [2011] IEHC 73, [2011] 1 IR 794). As is obvious the Health Service Executive was the applicant in O'B, where it sought to assert, and rely on, inherent jurisdiction (see also Health Service Executive v. F. [2014] IEHC 628, [2014] 3 IR 305; the protections necessary are discussed in Health Service Executive v. F. [2014] IEHC 628 and in S.S. (a minor) v. Health Service Executive [2007] IEHC 189, [2008] 1 IR 594)."

61. The Court went on to consider the case of *Re F.D.* [2015] 1 IR 741, in order to address an argument that *Re F.D*. had the consequences effectively of ruling out applications under the inherent jurisdiction in the case of adults of unsound mind (as that term was used in the caselaw). MacMenamin J. found that the judgment was not intended to address the operation of "*the original jurisdiction of the courts when fundamental constitutional rights were at stake*", and went on to conclude that:

"[90] Applications invoking an inherent jurisdiction may, therefore, be made, but only in exceptional cases."

62. While the observations in *A.M.* on the inherent jurisdiction were *obiter dicta*, I consider that they amount to compelling authority as to the continued vitality of the doctrine. The application of the inherent jurisdiction in cases following the commencement of the 2015 Act was considered in detail in *In the matter of KK* [2023] IEHC 565 (*K.K. No. 2*). That judgment was given at a later stage in the proceedings that earlier had given rise to the judgment that was the subject of the appeal in *Child and Family Agency v. KK* [2024] IECA 242. It can be recalled that, in its judgment, the Court of Appeal was clear that it was not addressing the issues around

the inherent jurisdiction. Accordingly, the later judgment of Hyland J. continues to represent the legal position as expressed by the High Court in a recent decision that is fully analogous to the present case. Being in full agreement with that judgment I can see no reason why it should not be followed for the purposes of this judgment.

63. In *K.K. No.2*, Hyland J. explained how the inherent jurisdiction can operate to provide a lawful basis for the detention and treatment of adults who lack capacity but who do not fall within the remit of the detention powers in the 2015 Act or other statutory provisions. The court noted that, pending the adoption of legislation providing for such matters, applications could continue to be made pursuant to the inherent jurisdiction. For the purposes of the position following the commencement of the 2015 Act, Hyland J. in *K.K. No. 2* highlighted that while proceedings under the inherent jurisdiction are separate from and not to be treated as proceedings under or governed by the 2015 Act, that did not prevent the court from taking account of the principles identified in and which underpin the new statutory scheme.

64. Hyland J. observed that one of the objects of the 2015 Act was to identify the manner in which capacity should be assessed and that there was no longer any basis for the type of *"all or nothing"* approach to capacity that characterised the former wardship jurisdiction. Instead, the focus had to be on the particular type of decision that a person needed to make, a functional capacity approach. I should note that, as is evident from the evidence in this case, the various experts considered the type of decisions that N.D. needed to make, being, primarily, whether to stay in hospital and whether to accept treatment, including medication. N.D.'s capacity was appraised by reference to criteria that reflect the new statutory test (which, in turn, reflects the tests used in recent decades): (a) whether the person is able to understand the information relevant to the decision, (b) whether the person is able to retain that information long enough

to make a voluntary choice, and (c) whether the person is able to use or weigh that information as part of the decision making process. Again, I am satisfied that the experts in this case directed themselves to and applied the proper criteria for determining capacity.

65. The court in *KK No.2* also addressed the type of matters that could justify the making of a detention order, which involves balancing the various constitutional rights that may be impacted. Without exhaustively setting all the potential rights at issue in this case, it is clear that the orders sought impact on *N.D.'s* rights to liberty and autonomy. In turn those rights need to be considered in the light of the potential damage to his rights to life and health, and his right to bodily integrity. In this case, I am satisfied that the detention is justified by reason of the fact that without the orders that were sought and granted, N.D. would not have received the level of medical care that he required, and it was likely that this would swiftly result in a very serious deterioration in his mental health and a relapse of his psychotic illness. That deterioration was described as being at the very serious end of relapses, and potentially involved very significant harm to N.D.'s health.

66. Finally, for the purposes of this case, an important feature of the *K.K. No. 2* was its treatment of the safeguards that must be in place where orders of this type are contemplated. That treatment drew on the analysis of similar safeguards identified by the Supreme Court in *A.M.* As noted in *A.M.*, where the court makes orders concerning a ward of court that have analogous effects to an admission or renewal order under the Mental Health Act 2001, it is necessary to ensure essentially that the affected person is afforded similar procedural safeguards to those that would be available under the 2001 Act. In *K.K. No 2*, two particular matters were identified.

67. First, there was a need for proper evidence of lack of capacity in the form of medical evidence, and preferably from two separate sources one of whom is independent of the party seeking the orders. It can be noted that there may be cases where the urgency of the case means that a second independent medical report cannot be obtained quickly and where any delay will likely result in avoidable harm to the respondent. In those cases, it is always possible for such evidence to be obtained after the initial orders and in time for an initial prompt *inter partes* hearing. It may also be the case that the court appointed guardian *ad litem* will be satisfied that the medical situation is clear cut and there is no need for a further report. In any event, where an order is obtained urgently on the basis of a single medical report or a number of medical reports from the moving party this will not prevent additional evidence being adduced at a later stage.

68. In this case, as set out above, there was ample medical evidence to explain the nature and severity of N.D.'s illness, the effects of his illness on his capacity to make the relevant decisions, and the reasons why the court should make orders for his detention and treatment in the CMH.

69. Second, as noted above it is essential that the person affected by the orders made is facilitated with representation. Here, drawing on the detailed analysis of O'Malley J. in *A.C. v. Cork University Hospital* [2020] 2 IR 38 and the treatment of representation and participation in the 2015 Act, Hyland J. made clear that real and appropriate efforts must be made to ensure that the respondent is afforded an opportunity to participate in the process that impacts significantly on their rights. In this case, the court appointed guardian *ad litem* was in a position both to bring N.D.'s views to the attention of the court, and N.D. was able to observe the proceedings remotely and given an opportunity to make his views known to the court. In

addition, the guardian made substantial legal arguments that ensured that the legal basis for the orders sought were subject to proper scrutiny, which was of considerable assistance to the court.

70. In general terms, there must be representation for the respondent, regular periodic reviews at which there is adequate evidence of the continuing need for and proportionality of the orders that are sought to be continued, there must be evidence of the general welfare and medical circumstances of the respondent and particularly there should be evidence if any powers of restraint were used, and there should be liberty to apply at short notice in the event of any material change in circumstances.

CONCLUSION

71. In all the circumstances, the court is satisfied as to the legal and evidential basis for the orders made in this case, and that the orders properly fell to be made by reference to the inherent jurisdiction of the court.

72. This is a case in which there is a statutory lacuna, or gap. At the time when the issues that gave rise to this case arose, N.D. clearly was a vulnerable person who required to be treated in the CMH and not elsewhere. Even if there was a basis for his continuing to be treated at the CMH as a voluntary patient – and I have found that there was not – he lacked capacity to make decisions on his medical care and treatment, and particularly whether to remain in the CMH and whether to continue to be treated with clozapine, and therefore could not make a competent decision to receive that treatment. The principal difficulty was there was no statutory mechanism within the 2001 Act regime that could be utilised to bring about a situation in which N.D. could continue to be treated in the CMH. Likewise, as Hyland J. had found and the Court

of Appeal later confirmed, the HSE could not rely on section 9 of the 1961 Act to seek orders to ensure that N.D.'s could continue to be treated at the CMH. Hence, the inherent jurisdiction provided the only lawful mechanism available to ensure that N.D.'s constitutional rights could be vindicated.

73. In those premises the court is fully satisfied as to the basis for the making and later continuation of the orders providing for N.D.'s detention and treatment. As noted, the case will continue to be the subject of regular reviews and as part of those reviews the HSE will have to adduce sufficient evidence on each occasion to justify any application to continue the orders. The guardian *ad litem* will continue in her role, and all parties have liberty to apply in the event that there is any issue or material change in circumstances that should be brought to the attention of the court before the next scheduled review.

74. As this judgment does not lead to any need to revisit or amend the orders that are in place and have been in place since the commencement of the proceedings, I will address any issue as to costs or further matters on the next occasion when the case is listed for scheduled review.