THE HIGH COURT

Record No. 2011/9548P

Between:

[redacted]

Plaintiff

and

THE HEALTH SERVICE EXECUTIVE

Defendant

and

THE ATTORNEY GENERAL
THE IRISH HUMAN RIGHTS COMMISSION

Notice Parties

OUTLINE WRITTEN SUBMISSIONS OF THE HUMAN RIGHTS COMMISSION (Amicus Curiae)

The Role of the Human Rights Commission.

1. This submission is filed by the Human Rights Commission as *amicus curiae*, pursuant to the Order made by Mr. Justice MacMenamin on the 21 October 2011, which Order granted the Commission leave to appear in these proceedings in accordance with section 8(h) of the *Human Rights Commission Act 2000*. Section 8(h) empowers the Commission to apply to the High Court and to the Supreme Court to be joined as *amicus curiae* in proceedings that pertain to the human rights of any person and to appear as such on foot of an Order of the Court. The term "human rights" is defined in the Act of 2000 as meaning:

   (a) the rights, liberties and freedoms conferred on, or guaranteed to, persons by the Constitution, and
   (b) *the rights, liberties or freedoms conferred on or guaranteed to, persons by any agreement, treaty or convention to which the State is a party.*'

Introduction

2. The submissions herein are made in light of the submissions made on behalf of the Plaintiff and the submissions made on behalf of the Health Service Executive but not those of Ireland and the Attorney General whose submissions are to be submitted at the same time as those of the *Amicus Curiae*.

3. The *Amicus Curiae* notes that there does not appear to be, in respect of any matter relevant to the Constitutional and Convention issues, any material dispute as to the facts. Accordingly, the *Amicus Curiae* proposes to adopt the summary of facts as set out in the submissions of the Plaintiff herein and will simply refer to them as and when the need arises.

4. In its submissions the *Amicus Curiae* will focus on whether the treatment of a person with a mental disability under Section 57 of the Mental Health Act 2001, when read in light of other statutory provisions, may contravene human rights standards, as established by the European Convention on Human Rights and the Convention on the Rights of Persons with Disabilities. The *Amicus Curiae* submits that these standards should inform the interpretation and application of Article 40.3 of the Constitution.

5. By way of general introduction it is the *Amicus Curiae*'s understanding that the Health Service Executive decided in December 2010 to seek the guidance as to whether certain forms of medical procedures could be lawfully administered to the Plaintiff in circumstances where she objects to the treatment but it is alleged lacks the capacity to consent. Indefinite permissive orders from the Court were sought in proceedings number 2010/11126P. The *Amicus Curiae* submits that the HSE was correct to seek the guidance of the Court on these matters where justifiable concerns regarding the treatment of the Plaintiff and the legal permissibility of ongoing treatment were raised.

6. Thus since December 2010 the High Court has been exercising, on a periodic basis, its inherent jurisdiction to oversee the ongoing treatment of the Plaintiff, including by directing receipt of medical reports thereon (the Court having delivered its Judgment in proceedings number 2010/11126P on 29 July 2011 (the "Judgment") and permitted the bringing of this action). In the Judgment, the Court considered that "*the constitutional and Convention rights engaged are quite fundamental. What is at stake here includes the prohibition of inhuman and degrading treatment, the right to autonomy and liberty, the right to fair procedures and rights to an effective remedy and to prohibition on discrimination*."

7. It is also the *Amicus Curiae*'s understanding that Section 57 of the 2001 Act does not have the benefit of being part of an overall comprehensive legislative code addressing the law of mental capacity and reflecting human rights standards, but is rather a stand alone provision that must rely on its own terms for its validity. The only other legislative provisions dealing directly with mental capacity are the now outdated Lunacy Regulation (Ireland) Act 1871 and the procedure set out under Orders 65 and 67 of the Rules of the Superior Courts, which it is generally accepted, is an inappropriate statutory basis to seek vindicate the rights of persons with mental disabilities who may lack capacity to consent to treatment[1] although the *amicus* notes the submission of the Health Service Executive, in this respect.[2]

[1] See Law Reform Commission, 'Consultation Paper on Law and the Elderly' (LRC (CP 23 –) 2003), and Law Reform Commission consultation paper Vulnerable Adults and the Law of Capacity, Law Reform Commission CP 37 – 2005.

[2] In this regard it is noted that the Commissioner of Human Rights of the Council of Europe; Thomas Hammerberg issued a discussion paper entitled "*Who Gets to Decide? Right to legal capacity for persons with intellectual and psychological disabilities.*" Comm DH/ Issue paper (2012) 2, Strasbourg, 20 February 2012, in which he makes a number of recommendations in light of Article 12 of the CRPD, one of which is that each member State should "Abolish mechanisms providing for full incapacitation and plenary guardianship"(at p. 5).

Consent to Treatment: Statute Law

8. Domestic statute law, in general, is largely silent on the issue of consent to treatment. The Health Act 1953, section 4 (1) provides:

> "Nothing in this Act or any instrument thereunder shall be construed as imposing an obligation on any person to avail himself of any service provided under this Act or to submit himself or any person for whom he is responsible to health examination or treatment."

9. This is an express statutory assertion that there is no obligation to avail of any health service, merely because it is provided free of charge, or, indeed, in express terms to submit to "health examination or treatment". Sub-section (2) then goes on to provide what is, in effect, a statutory right of conscientious objection to treatment:

> > "Any person who avails himself of any service provided under this Act shall not be under any obligation to submit himself or any person for whom he is responsible to a health examination or treatment which is contrary to the teaching of his religion."

10. Thus, merely because a person avails of a free health service does not oblige him or her to submit to any examination or treatment to which (s)he objects on religious grounds.

11. The Non-fatal Offences against the Person Act, section 23 (1) (which is identical in its terms to the English Family Law Reform Act 1969 section 8) provides:

> > "The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian."

12. Quite apart from its particular application to persons under the age of 18, this recognises the common law position that (a) treatment without consent constitutes a trespass to the person, (b), ordinarily, one must be of full age to give an effective consent, (c), in the case of minors, parents and guardians are lawful proxy consent-givers and (d) capacity to give consent is presumed, subject (usually) to having attained one's majority or (in the case of this provision) 16 years of age.[3]

[3] By way of observation, sub-section (2), for its part, goes on to amplify (non-exhaustively) what such "treatment" may entail:

> "In this section "surgical, medical or dental treatment" includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment."

13. Non-consensual touching – of whatever nature, be it therapeutic or non-therapeutic – in addition to being tortious, is also a criminal offence. The offence of assault is committed if a person is touched non-consensually;[4] the offence of assault causing harm is committed if the person is touched non-consensually and is harmed by the touching.[5] There is no requirement that the person be harmed by the touching in an assault, *simpliciter*.[6] However, in each case, the consent of the person touched seems to be a sufficient defence.[7]

14. More generally, section 22 of the Act of 1997 provides that its provisions are subject "to any enactment or rule of law providing a defence, or providing lawful authority, justification or excuse for an act or omission" preserving the common law defences of self-defence, defence of third parties and/or property, consent (within limits)[8] – and apparently in the area of medical treatment – lawful authority and necessity. It would appear, therefore, that the default position of the Act of 1997 is that medical interventions (if they cause serious harm) are *prima facie* unlawful; their lawfulness is thereafter a matter of defence: they must be consensual, justified (which is not explored further as a concept) and necessary, although how this may be reconciled conceptually with the language and thrust of section 4 of the Act is not immediately obvious.

Consent to Treatment: the Common Law Dimension

15. The classic exposition of the basis of the requirement to obtain consent to therapeutic intervention (and the tortioius consequences which flow from default, in that regard) is found in the pithy expression of Cardozo J in *Schloendorff v Society of New York Hospital* 105 NE 92 (NY, 1914), where he stated:

Thus, unlike the definition of treatment in the Mental Health Act 2001 section 1, it clearly and expressly extends the ambit of "treatment" to "any procedure . . . which is ancillary to any treatment" and suggests that the draughtsman was mindful of the fact that (as is undoubtedly the case) many treatments may have associated – and necessary – associated procedures. Finally, for completeness, sub-section (3) which provides:

> "Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted"

while not *ad rem* the issues in the present case, seems to recognise, implicitly, the common law position in relation to consent: (a) the common law does not exclude a child from giving consent and (b) the concept of "Gillick-competence" (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112), subject to whatever Constitutional and/or Convention limits that might apply to that species.

[4] Non-fatal Offences against the Person Act 1997 section 2.

[5] Non-fatal Offences against the Person Act 1997 section 3. Harm is defined (in section 1) as "harm to body or mind and includes pain and unconsciousness".

[6] Subject to the defence provided in sub-section (3) which exculpates, in essence, ordinary day to day social contacts, that have no real application to medical interventions.

[7] This should be contrasted with the provisions of the Non-fatal Offences against the Person Act 1997 section 4 (assault causing serious harm, i.e. "an injury which creates a substantial risk of death or which causes serious disfigurement or substantial loss or impairment of the mobility of the body as a whole or of the function of any particular bodily member or organ" – which might be said also to describe some serious therapeutic interventions) where the issue of consent is irrelevant. In this context, see: *R. v. Brown* [1993] 2 All ER 75 (HL) and *Laskey & or*s v UK *Application no. 21627/93; 21628/93; 21974/93* 19 February 1997.

[8] *Supra*.

> "Every human being of *adult years* and *sound mind* has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault." (*emphasis* added)

16. As a general principle, accordingly, exercise of one's right of self-determination (not solely in the area of therapeutics) depends on one's age (generally, but subject to what has already been set out, having reached one's majority) and capacity – generally cognitive/executive capacity – (irrespective of that age). Although necessary, they are not sufficient for the proper exercise of that right. In addition, information as to what is proposed to be done (to put it at its most general) is also necessary.

17. Although the former Supreme Court in *Daniels & anor. v Heskin* [1953] IR 73 (and, especially, *per* Kingsmill Moore J (at 87)) adopted a paternalistic view of patients (refusing, as he put it, to admit "any abstract duty to tell patients what is the matter with them", a view not necessarily shared by Lavery J, dissenting, (with whom Murnaghan and O'Byrne JJ agreed) in the same case (at 80)), a duty of disclosure was clearly recognised by the Supreme Court in *Walsh v Family Planning Services & anor*. [1992] 1 IR 505 (SC) (see, *per* Finlay CJ at 510).[9] As to how the standard of disclosure was to be determined was not resolved in *Walsh*[10] until the decision of Kearns J (as the then was) in the High Court in *Geoghegan v Harris* [2000] 3 IR 536, an approach subsequently affirmed by a unanimous Supreme Court in *Fitzpatrick v Whyte* [2008] 3 IR 551.

18. The underlying rationale for the duty is expressed in passages from the decision of the House of Lords in *Chester v Afshar* [2005] 1 AC 134 approved by the Supreme Court in *Fitzpatrick*: there, Lord Hope had stated (at para. 86):

> "I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on."

19. Lord Bingham, with whom Lord Hoffman agreed, stated (at para. 5):

> "The existence of such a duty is not in doubt. Nor is its rationale: to enable adult patients of *sound mind* to make for themselves decisions intimately affecting their own lives and bodies." (*emphasis* added)

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[9] See, also, *Rogers v Whitaker* (1992) 175 CLR 479 at 49. In *In the matter of A Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 IR 100, O'Flaherty J asserted (at 129) that it was there was no dispute but that "that consent to medical treatment is required in the case of a competent person (cf. *Walsh v Family Planning Services Ltd.* [1992] 1 IR 496(HC) 505(SC)) and, as a corollary, there is an absolute right in a competent person to refuse medical treatment even if it leads to death."

[10] Or in the following cases of *Farrell v Varian* (unreported, High Court (O'Hanlon J) 19 September 1994), *Bolton v Blackrock Clinic Ltd & ors*. (unreported, Supreme Court (Hamilton CJ, Barrington, Murphy JJ) 23 January 1997, *rev'g*. Unreported, High Court (Geoghegan J) 20 December 1994) or *Reid v Beaumont Hospital Board & anor.* (unreported, High Court (Johnson J) 18 July 1997).

20. In a passage, quoted with approval by Kearns J (as he then was), from the decision of the High Court of Australia *Rosenberg v. Percival* [2001] HCA 18 (at para. 145), the nature of the obligation of disclosure was re-cast in a broader rights-based context, which has, at its core, respect for the dignity of the individual:

> "The rule [requiring disclosure of material risks] recognises individual autonomy which should be viewed in the *wider context of an emerging appreciation of basic human rights and human dignity which requires informed agreement to invasive treatment*, save for that which might be required in an emergency or otherwise out of necessity." (*emphasis added*)

21. The thrust of the Australian exposition focuses on respect for individual autonomy and respect for the dignity of the individual, as a matter of basic human rights. Whereas capacity is presumed insofar as it refers to "informed agreement" (and the US and English formulations refer to persons of "sound mind") that does not detract from the general, and underlying, rationale: at common law, the requirement to obtain consent to a therapeutic intervention engages a person's human rights.

Consent to Treatment: the Constitutional Dimension

22. In *In the matter of A Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 IR 100 (SC), Hamilton CJ observed (at 124), reflecting the common law position, that there was "no doubt but that the Ward, if she were mentally competent, had the right, if she so wished, to forego . . . treatment or, at any time, to direct that it be withdrawn even though such withdrawal would result in her death". He expressly agreed with the (extra-judicial) views expressed by Costello J (as he then was) in an article entitled *The Terminally Ill: The Law's Concern* (1986) XXI Ir. Jur. (n.s.) 35, and which engrafted Constitutional considerations on to that position, where he had stated:

> ". . . there are very powerful arguments to suggest that the dignity and autonomy of the human person (as constitutionally predicated) require the State to recognise that decisions relating to life and death are, generally speaking, ones which a competent adult should be free to make without outside restraint, and that this freedom should be regarded as an aspect of the right to privacy which should be protected as a 'personal' right by Article 40.3. I. But like other 'personal' rights identified by the Courts, the right is not an absolute one, and its exercise could in certain circumstances be validly restricted. For example, in the case of contagious diseases, the claims of the common good might well justify restrictions on the exercise of a constitutionally protected right to refuse medical treatment. But in the case of the terminally ill, it is very difficult to see what circumstances would justify the interference with a decision by a competent adult of the right to forego or discontinue life saving treatment."

23. He was satisfied (at 126) that if she were mentally competent the Ward "would have, in the circumstances of her condition, the right t*o forego the treatment or to have the treatment discontinued and that the exercise of that right would be lawful and in pursuance of her constitutional rights*" (emphasis added), there being no countervailing considerations to justify restriction of the exercise of her Constitutional rights. However, by reason of her mental incapacity, the Ward was unable to exercise that right. Hamilton CJ continued (at 126):

> "The loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution, including the right to life, the right to bodily integrity, the right to privacy, including self-determination, and the right to refuse medical care or treatment.
>
> The Ward is entitled to have all these rights respected, defended, vindicated and protected from unjust attack and they are in no way lessened or diminished by reason of her incapacity."

24. O'Flaherty J could not find (at 130):

> " . . . any constitutional or other rationale for making . . . a finding [that by reason of her mental incapacity the Ward's Constitutional rights (to bodily integrity and privacy) had been lost]. On the contrary, I believe that it would operate as an invidious discrimination between the well and the infirm." (Cf. *O'Brien v, Keogh* [1972] IR 144)."

25. Denham J (as she then was), in a reprise of the general propositions relating to consent and capacity, stated (at 156):

> "Medical treatment may not be given to an adult person of full capacity without his or her consent. There are a few rare exceptions to this e.g., in regard to contagious diseases or in a medical emergency where the patient is unable to communicate. This right arises out of civil, criminal and constitutional law. If medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights. The consent which is given by an adult of full capacity is a matter of choice. It is not necessarily a decision based on medical considerations. Thus, medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decision for their own reasons.
>
> If the patient is a minor then consent may be given on their behalf by parents or guardians. If the patient is incapacitated by reason other than age, then the issue of capacity to consent arises. In this instance, where the patient is a ward of court, the court makes the decision."

26. Later, she continued (at 158):

> "To continue . . . treatment is as much a decision as not to do so. If the decision is to continue medical treatment, a consent has to be given . . . . If the decision is to cease the medical treatment, a consent . . . has also to be given . . .
>
> It is not pertinent whether the treatment is ordinary or extraordinary medical treatment. Consent of the adult with capacity is necessary for either ordinary or extraordinary medical treatment."

27. In a passage of relevance to non-consensual treatment of an incapacitated person, Denham J observed (at 158):

> "However, the nature of the medical treatment here is pertinent to the ward's condition. The medical treatment is invasive. This results in a loss of bodily integrity and dignity. It removes control of self and control of bodily functions. When medical treatment is ingested, inhaled or applied then there is a voluntary co-operative effort by the patient and each time a voluntary effort occurs the patient reveals to their carers their continuing consent to treatment which invades the integrity of the body. When the treatment is administered by a tube or a needle, the element of co-operation by the patient is lost. Normally, the benefits of such invasive treatment are clearly in a patient's best interest, but they are given to a patient in ways in which the individual has no control and are fundamentally different to non-invasive treatment. Whilst an unconscious patient in an emergency should receive all reasonable treatment pending a determination of their best interests, invasive therapy should not be continued in a casual or ill considered way."

28. As to the Constitutional issue involved, she was clear (at 156): "The requirement of consent to medical treatment is an aspect of a person's right to bodily integrity under Article 40, s. 3 of the Constitution." Elsewhere (at 163) she stated: "Part of the right to privacy is the giving or refusing of consent to medical treatment."[11]

29. Acknowledging that the equality provisions of the Constitution required that if the Ward were of full capacity (as she was of full age), she would be required to consent before medical treatment were to be given to her, Denham J stated (at 159):

> " . . . all citizens as human persons are equal before the law. This is not a restricted concept, it does not mean solely that legislation should not be discriminatory. It is a positive proposition.
>
> The right to equality arises in recognition that citizens are human persons. It exists as long as they are human persons. A citizen is a human person until death.
>
> Due regard may be had to differences. *It may be that in certain instances a person may not be able to exercise a right. But the right exists*. The State has due regard to the difference of capacity and *may*

[11] Elsewhere, Denham J alluded to the requirement for respect for the dignity of the individual (at 163) and a "right of choice" (at 164) perhaps more reflective of a requirement for respect for individual autonomy, even when its exercise is necessarily limited.

envisage a different process to protect the rights of the incapacitated. It is the duty of the Court to uphold equality before the law. It is thus appropriate to consider if a method exists to give to the insentient person, the ward, equal rights with those who are sentient."(*emphasis* added)

30. In this passage, if the expression "persons incapacitated for whatever reason" were to be substituted for "the insentient person, the ward" and "persons who are not incapacitated" for "sentient" the focus on the nature of the Constitutional obligation as a generic obligation is sharper. [12]

31. As a general proposition, therefore, there is, accordingly, a clear obligation on the organs of the State to respect, defend and vindicate and to protect from unjust attack the Constitutional rights (and which the common law – and the criminal law – as set out, ordinarily protects) of a person who lacks decisional capacity in the area of treatment. Whether the necessity to obtain consent to treatment arises from a person's Constitutional right to bodily integrity, privacy, self-determination or a free-standing right to refuse medical care or treatment, or "a right of choice", is of less importance than the fact that it arises from Article 40.3 of the Constitution. In the alternative, it is predicated on the requirement of respect for the dignity of the individual and/or, arising from the foregoing, respect for individual autonomy, even where the exercise of such autonomy may, as a matter of practicality, be limited. These constitutional standards are informed by international standards. Thus Murray CJ in *Roche v Roche*[13], drew in aid the Council of Europe Convention on Human Rights and Biomedicine and the Charter of Fundamental Rights of the European Union in considering the constitutional standard under Article 40.3.3 of the Constitution, consequently holding that "the human embryo is generally accepted as having moral qualities and a moral status".[14]

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[12] Denham J stated (at 163): "Merely because medical treatment becomes necessary to sustain life does not mean that the right to privacy is lost, *neither is the right lost by a person becoming insentient*. *Nor is the right lost if a person becomes insentient and needs medical treatment to sustain life* and is cared for by people who can and wish to continue taking care of the person. Simply *it means that the right may be exercised by a different process*. The individual retains their personal rights. The right to privacy is not absolute. It has to be balanced against the State's duty to protect and vindicate life. However, "… *the individual's right to privacy grows as the degree of bodily invasion increases*". See *In re Quinlan* (1976) 355 A. 2d. 647" (*emphasis* added)

[13] [2010] 2 IR 321.

[14] Murray CJ stated: "I think it can be said that the human embryo is generally accepted as having moral qualities and a moral status. However else it may be characterised the fertilisation of the ovum is the first step in procreation and contains within it the potential, at least, for life. It has present in it all the genetic material for the formation of life. Its enactment and use cannot be divorced from our concepts of human dignity. The Council of Europe Convention on Human Rights and Bio Medicine with a view to, inter alia, preventing the misuse of biology in medicine which may lead to acts endangering human dignity prohibits, in Article 18, the creation of human embryos for research purposes. Article 3 of the Charter of Fundamental Rights of the European Union prohibits the use of embryos for the cloning of human beings as does a declaration of the United Nations. Such provisions and the fact that many countries regulate and protect the manner and circumstances in which in vitro embryos may be created and dealt with, reflect the ethical and moral status of embryos as being inextricably associated with human dignity. There is inevitably within the ambit of that moral appreciation of the embryo much debate particularly concerning the parameters of regulatory measures and what should be permitted and what should be prohibited"; [2010] 2 IR 321 at 350-351.

32. The question then necessarily arises as to whether or not the process provided for in the Mental Health Act 2001 section 57 protects the rights of the mentally incapacitated or violates the constitutional right to equality or other Constitutional norms.

The Mental Health Act 2001 section 57

33. The definition of "consent" in section 56 of the Act of 2001, being consent obtained freely without threats or inducements, where (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment and (b) (s)he has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment, conforms, essentially, to the requirements of a valid consent (voluntarily given, by a person with sufficient capacity following the proper disclosure of sufficient information) at common law.

34. It should be observed, however, that the consent provisions of the Act of 2001 only apply to "patients", i.e. persons involuntarily detained pursuant to an Admission Order or a Renewal Order. In relation to all other persons, *viz*. so-called voluntary patients, it must be the case the ordinary common law and statutory provisions apply.

35. Section 57 (1), for its part, makes the requirement to obtain a patient's consent to treatment the default position. It then, carves out from that general proposition, an entitlement to treat non-consensually:

> "where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent".

36. Two issues are, accordingly, raised by the sub-section: (a) the question of the necessity for the treatment (which is a matter solely for the responsible consultant psychiatrist's opinion) and (b) the patient's capacity to give consent. Examining the syntax of the sub-section, this second issue is free-standing and not immediately contingent on the psychiatrist's opinion (although it may, in practice, often be – or if not on his or her sole opinion, on that of a multi-disciplinary assessment). If this interpretation is correct, the plain language of the sub-section does not provide <u>any</u> mechanism for the assessment of capacity or lack of capacity arising by reason of a patient's mental disorder. At best, it reduces to the consultant psychiatrist's assessment.

37. In his consideration of the provisions of the Mental Treatment Act 1945, section 207,[15] in *RT v Director of the Central Mental Hospital* [1995] 2 IR 65, Costello P stated, as follows (at 81):

> "The defects in the section are such that there are no adequate safeguards against abuse or error both in the making of the transfer order, and in the continuance of the indefinite detention which is permitted by the section. These defects, not only mean that the section falls far short of internationally accepted standards but, in my opinion, render the section unconstitutional because they mean that the State has failed adequately to protect the right to liberty of temporary patients."

38. Having found that the applicant, in that case, was being detained in accordance with law, but that the law was invalid having regard to the provisions of the Constitution, the question of the validity of the section was referred to the Supreme Court by way of case stated pursuant to the provisions of Article 40.4.3^{o} of the Constitution. Prior to the date fixed for the hearing in the Supreme Court, the reporter's note indicates, the applicant was discharged from the Central Mental Hospital, as a result of which the President of the High Court withdrew the case stated. Accordingly, there was no final determination of the question of the constitutionality of the section.

39. In the subsequent decision in *Croke v Smith (No. 2)* [1998] 1 IR 101, the Supreme Court reversed the decision of the High Court (Budd J), in a case stated in respect of the constitutional validity of section 172 of the Act of 1945, while approving the general principles enunciated by Costello P in *RT*. Budd J, too, had found that the detention of the applicant in the Central Mental Hospital was in accordance with law, *viz*. section 172, but that the section was invalid having regard to the provisions of the Constitution.

40. One of the defects in section 207 identified by Costello P in *RT*, and which led him to conclude that it failed to pass constitutional muster, was that there was no practical way in which a person detained pursuant to that section could have his continued detention reviewed (at 80). The absence of such review was not sufficient, however, in *Croke v Smith (No. 2)*, for the Supreme Court to conclude that section 172 (which did not provide for a review of detention either) was invalid, when taken in the context of the other "safeguards" identified in the Act[16] and the obligations stated to be on detainers, in the context of the involuntary detention of the mentally ill. Hamilton CJ stated as follows (at 122-123):

> "It must be presumed however that the Oireachtas intended, when giving to the resident medical superintendent the power of detention, and to him and the Minister the power of discharge, that the permitted discretions and adjudications given to them are to be exercised in

[15] Section 207 provided that a patient in a mental health facility, who was charged with committing an offence while there but who, at trial, was found to be unfit to plead, was to be transferred to the Central Mental Hospital as a person of unsound mind on foot of such finding.
[16] Specifically, sections 218, 220. 222, 237, 239 and 266 of the Act of 1945.

accordance with the principles of constitutional justice and that any departure therefrom would be restrained and corrected by the courts.

In the exercise of the powers conferred and the obligations imposed by the Act, the resident medical superintendent and the Minister are obliged to act in accordance with the principles of constitutional justice, are not entitled to act in an unlawful manner, are not entitled to act arbitrarily, capriciously, or unreasonably and must have regard to the personal rights of the patient, including the right to liberty which can be denied only if the patient is a person of unsound mind and in need of care and treatment who has not recovered and must be particularly astute when depriving or continuing to deprive a citizen, suffering from mental disorder of his or her liberty.

It is important that any person exercising any power or discretion under the Act, which touches on the rights of a patient, should be conscious, not only of the wording of the power or discretion which the statute appears to confer upon him or her but also of the constitutional rights of the patient which the statute presumes that he or she will respect when purporting to exercise that power or discretion.

There is a statutory and constitutional obligation on the resident medical superintendent and the Minister to discharge a person detained as a chargeable patient when he is satisfied that such patient has recovered.

In addition, it must be presumed that in the enactment of the Act and in particular s. 172 thereof and the provision therein providing for "discharge by proper authority", that the Oireachtas was conscious of and had regard to the constitutional obligation on the courts to protect as best they may from unjust attack and in the case of injustice done, to vindicate the life, person, good name and property rights of every citizen, including in particular citizens suffering from mental disorders and to the jurisdiction of the President of the High Court in lunacy matters and that "discharge by proper authority" included a power by the court and the President of the High Court to order the discharge of a patient detained who had recovered or who has been otherwise unlawfully detained and consequently was being detained other than in accordance with the provisions of the Act." (*emphasis* added)

41. Decisions pursuant to section 172 were not considered to be decisions made in the administration of justice but, nevertheless, Hamilton CJ noted (at 132): "the decision makers are obliged to act in accordance with the principles of constitutional justice and to have regard to the constitutional right [in this case] to liberty."

42. Hamilton CJ noted (at 131):

> "The Court is satisfied that, in exercising the powers conferred on them by the Act of 1945, the resident medical superintendent and the Minister are not engaged in the administration of justice and that no judicial intervention is necessary or required unless they or either of them fail to comply with the requirements of fair procedures and

constitutional justice or fail to have regard to the constitutional right to liberty of the patient.

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

If they so fail, their decisions are subject to review by the High Court, whether by way of an application for judicial review or by way of a complaint made to the High Court in accordance with the provisions of Article 40.4.2 of the Constitution."

43. Insofar as the Supreme Court was satisfied that the detention of a patient pursuant to section 172 of the Act of 1945 did not require automatic review by an independent tribunal because of the obligation placed on the detainer to discharge a patient who has recovered, it noted (at 131-132):

> "Inherent in this section is the obligation placed on the resident medical superintendent to regularly and constantly review a patient in order to ensure that he or she has not recovered and is still a person of unsound mind and is a proper person to be detained under care and treatment. If such review is not regularly carried out, in accordance with fair procedures and rendering justice to the patient then the intervention of the court can be sought because of the obligation placed on the resident medical superintendent to exercise the powers conferred on him by the Act in accordance with the principles of constitutional justice. There is no suggestion that such a review is not carried out."[17]

44. Arising from the foregoing, notwithstanding:

(a) the presumption of constitutionality which the Act of 2001 is entitled to enjoy,

(b) the presumption that the Oireachtas intended that "the proceedings, procedures, discretions and adjudications"[18] permitted by the Act are to be conducted in accordance with the principles of constitutional

[17] The Mental Health Act 2001 itself was a direct consequence of the "friendly settlement" agreement reached between the State and the Applicant in the proceedings *Croke v Ireland* (Application No. 33267/96) 21 December 1996 before the European Court of Human Rights

[18] See, Hamilton CJ in *Croke v Smith* (No. 2) [1998] 1 IR 101 at 132.

justice (and, in particular, with regard to the principle that no person should be unnecessarily treated non-consensually even for a short period),

(c) that this, accordingly, places a heavy responsibility on consultant psychiatrists and other persons treating involuntarily detained patients to ensure that no person is treated non-consensually pursuant to the provisions of section 57 for any period longer than is absolutely necessary for his or her proper care,

(d) the presumption that the other safeguards in the Act will be stringently enforced,[19] and

(e) that it is to be implied that the necessity for the continued non-consensual treatment of a patient, to whom section 57 applies, must be regularly reviewed by the detainer/treater to ensure that (s)he is not being unnecessarily treated as such,

the question nevertheless arises as to whether this constitutes sufficient protection and vindication of a person's Constitutional rights,[20] including those relating to the determination of the person's capacity (to consent to treatment),[21] and having regard to the Constitutional rights necessarily

[19] For example, sections 52, 52 and 55 (in relation to the Inspector of Mental Health Services and Inquiries).

[20] See, for example, the comments of Hogan J in *G v District Judge Murphy* & ors [2011] IEHC 445 at paras. 28 - 29.

[21] See, *Fitzpatrick v FK* [2009] 2 IR 7 at 40 – 42, where Laffoy J stated:

"On the basis of the foregoing analysis of the authorities from other jurisdictions and having regard to the constitutional framework within which the capacity question must be determined in this jurisdiction, it seems to me that the relevant principles applicable to the determination of the capacity question are as follows:

(1) There is a presumption that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse medical treatment, but that presumption can be rebutted.

(2) In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment whether -

(a) by reason of permanent cognitive impairment, or

(b) temporary factors, . . .

the test is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made.

(3) The three-stage approach to the patient's decision-making process adopted in *In re C (Adult: refusal of medical treatment*) [1994] 1 WLR 290 is a helpful tool in applying that test. The patient's cognitive ability will have been impaired to the extent that he or she is incapable of making the decision to refuse the proffered treatment if the patient-

(a) has not comprehended and retained the treatment information and, in particular, has not assimilated the information as to the consequences likely to ensue from not accepting the treatment,

(b) has not believed the treatment information and, in particular, if it is the case that not accepting the treatment is likely to result in the patient's death, has not believed that outcome is likely, and

(c) has not weighed the treatment information, in particular, the alternative choices and the likely outcomes, in the balance in arriving at the decision.

(4) The treatment information by reference to which the patient's capacity is to be assessed is the information which the clinician is under a duty to impart - information as to what is the appropriate treatment, that is to say, what treatment is medically indicated, at the time of the decision and the risks and consequences likely to flow from the choices available to the patient in making the decision.

(5) In assessing capacity it is necessary to distinguish between misunderstanding or misperception of the treatment information in the decision-making process (which may sometimes be referred to colloquially as irrationality), on the one hand, and an irrational decision or a decision made for irrational reasons, on the other hand. The former may be evidence of lack of capacity. The latter is irrelevant to the assessment.

affected by such determinations - more particularly, where the relevant norms are informed by the State's obligations pursuant to the European Convention on Human Rights and Fundamental Freedoms[22] and the Convention on the Rights of Persons with Disabilities.

45. Thus, for example, how is an incapacitated person (irrespective of labouring under any other disadvantage such as illiteracy, poor educational attainment, being non-English speaking) to seek to vindicate his or her rights if (s)he is unable, by virtue of his or her incapacity (and/or any other such disadvantage), to access the courts? In the instant case, it is noted that it was the detainer and treater who initiated the court proceedings and, even then, they were not served on the Plaintiff, in circumstances of her incapacity, but rather on the solicitor appointed to represent her in (separate and unrelated) mental health tribunal hearings, concerned only with the propriety of her detention, not her treatment while detained.

46. It is respectfully submitted by the *amicus*, that the very process by which the Plaintiff's claim came before the Court demonstrates a frailty in section 57 in relation to the equality provisions of Article 40.1 of the Constitution, in that it was wholly dependent on the actions of the Defendant. That it came before the Court might be described as merely fortuitous; similarly, determinations of capacity pursuant to the Lunacy Regulation (Ireland) Act 1871 and the procedure set out under Orders 65 and 67 of the Rules of the Superior Courts proceedings might also be described as fortuitous, insofar as applications, in that regard, usually come about because the person whose capacity is to be inquired into has a next of kin or other person sufficiently concerned to make the application.[23] If there is no such next of kin or other concerned, person, or, if the institution[24] (as in this case) elects or omits not to bring the matter to the attention of the Court, there is no practical manner in which an incapacitated person can seek to have his or her personal rights guaranteed under the Constitution vindicated. Thus, inadvertently, and unintentionally, persons similarly situated are not subject to equal treatment: one category of incapacitated persons, *viz*. those without sufficiently concerned next of kin or those in the care of institutions which, for whatever reason, do not seek a formal determination of capacity, where lack of capacity is suspected and treatment is considered necessary, are placed at

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(6) In assessing capacity, whether at the bedside in a high dependency unit or in court, the assessment must have regard to the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of the proffered treatment. In the private law context this means that, in applying the civil law standard of proof, the weight to be attached to the evidence should have regard to the gravity of the decision, whether that is characterised as the necessity for "clear and convincing proof" or an enjoinder that the court "should not draw its conclusions lightly".”

[22] In this context, it merits noting that in *Sean Croke v Ireland* [1999] 1 MHLR 118, the complaint of the applicant – who was the unsuccessful applicant in *Croke v Smith (No. 2)* – that our domestic legislation providing for the involuntary detention of persons suffering from mental illness failed to comply with Article 5 of the European Convention was deemed admissible by the European Court of Human Rights and on 21 December 2000 the case was struck out, having been settled. The State, in that settlement, expressly acknowledged the applicant's legitimate concerns in relation to the absence of an independent formal review of his detention under the mental health legislation. The settlement was reached not very long after the publication of the Mental Health Bill 1999 (which became the Mental Health Act 2001).

[23] See, for example, *JM v St. Vincent's Hospital* [2003] 1 IR 321.

[24] See, in the context of a child, *Temple Street v D & anor* [2011] IEHC 1 (Hogan J).

a real disadvantage without objective justification compared with the other category of incapacitated persons who have.[25] Otherwise stated, the Court must inquire into whether there has been a difference in treatment between a person in the Plaintiff's situation who suffers a mental disability, who has no next friend or advocate and whose consent to treatment is expressly required under section 57 but who is considered by the consultant psychiatrist incapable of so consenting and a) a person who suffers a similar mental disability but has a next friend or advocate in like situation or b)_a person who suffers a mental disability but who is legally presumed incapable of consenting because of his or her status (such as a Ward of Court) but who would theoretically require the permission of the Court in relation to any proposed invasive medical treatment.

47. Vindication of important Constitutional rights should not depend on happenstance.

48. The absence of any mechanism in section 57 whereby a person detained in an approved centre suspected of lacking capacity may have his or her capacity formally determined and/or whereby the medical and legal propriety of that person's treatment – whether when initiated or while being continued – may be subject to automatic review (where the very nature of incapacity may well require that there be periodic review and independent assessment of the necessity for further non-consensual treatment) represents a failure to have proper regard to the rights and interests of this category of persons whose mental capacity is in doubt, it fails to provide a mechanism by which any finding of incapacity may be challenged and stands in stark contrast to the position of other persons whose capacity may be in doubt, as already outlined.

49. As in *RT*, there are no safeguards against error or abuse in the operation of the section and the absence of external review of decisions made by a consultant psychiatrist in relation to capacity and/or, consequentially, non-consensual treatment, it is submitted, fail to respect and, as far as practicable, defend and vindicate the personal rights of the patient, particularly those rights already adumbrated, in this regard. Further, differential treatment on the basis of a person's status, attributes or access to justice means that particular attention turns to the procedural safeguards present in the procedure. Where there is an absence of safeguards, for example in relation to potentially indefinite medical treatment under section 57, even in the context of section 60, the burden on the Defendant is high to demonstrate that the means adopted to pursue a legitimate aim meet proportionality requirements under either Article 14 of the ECHR and/or Article 40.1.[26]

[25] See, *G v District Judge Murphy* & ors [2011] IEHC 445, paras. 30-33.

[26] *Glor v. Switzerland,* judgment 30 April 2009. The European Court found that discrimination based on disability status came within the scope of Article 14 of the ECHR, considering *inter alia*, the principles espoused in the Convention on the Rights of Persons with Disabilities. See also *G v District Judge Murphy* & ors, [2011] IEHC 445.

RELEVANT PRINCIPLES OF INTERNATIONAL LAW

Recognition of capacity

47. The starting point for consideration of the human rights raised in this case is the legal capacity of persons in the Plaintiff's situation. The concept of legal capacity has been significantly developed under Article 12 of the Convention on the Rights of Persons with Disabilities ("CRPD") and may be regarded as one of the cornerstones of that Convention. Article 12 provides in part:

> 1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
> 2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
> 3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
>
> …
>
> 5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

48. Other provisions of the CRPD are referred to in the Plaintiff's submissions and will not be repeated here to avoid duplication. That the interpretation of Constitutional provisions should be informed by international standards is also urged in the Plaintiff's submissions and insofar as this is a matter regularly urged on the Courts by the Commission, those submissions are adopted by the *Amicus Curiae*.

49. In addition, attention should be drawn to Recommendation No. R (99) 4 of the Committee of Ministers of the Council of Europe on principles concerning the legal protection of incapable adults (adopted on 23 February 1999) which provide, insofar as is relevant, as follows:

> *Principle 2 – Flexibility in legal response*
> "1. The measures of protection and other legal arrangements available for the protection of the personal and economic interests of incapable adults should be sufficient, in scope or flexibility, to enable suitable legal response to be made to different degrees of incapacity and various situations.
> . . .
> 4. The range of measures of protection should include, in appropriate cases, those which do not restrict the legal capacity of the person concerned."

Principle 3 – Maximum reservation of capacity
"1. The legislative framework should, so far as possible, recognise that different degrees of incapacity may exist and that incapacity may vary from time to time. Accordingly, a measure of protection should not result automatically in a complete removal of legal capacity. However, a restriction of legal capacity should be possible where it is shown to be necessary for the protection of the person concerned.
2. In particular, a measure of protection should not automatically deprive the person concerned of the right to vote, or to make a will, or to consent or refuse consent to any intervention in the health field, or to make other decisions of a personal character at any time when his or her capacity permits him or her to do so. ..."

Principle 6 – Proportionality
"1. Where a measure of protection is necessary it should be proportional to the degree of capacity of the person concerned and tailored to the individual circumstances and needs of the person concerned.
2. The measure of protection should interfere with the legal capacity, rights and freedoms of the person concerned to the minimum extent which is consistent with achieving the purpose of the intervention . . . ."

Principle 13 – Right to be heard in person
"The person concerned should have the right to be heard in person in any proceedings which could affect his or her legal capacity."

Principle 14 – Duration, review and appeal
"1. Measures of protection should, whenever possible and appropriate, be of limited duration. Consideration should be given to the institution of periodical reviews.
. . .
3. There should be adequate rights of appeal."

50. The *amicus* observes that the submissions of the Health Service Executive suggest that the question of the Plaintiff's lack of capacity, in the present case, is issue specific; however, it also notes that the evidence adduced, on its behalf, suggests a global impairment of capacity. Recognition of legal capacity as identified in Article 12 of the CRPD and in the Judgment of the European Court of Human Rights in *Shtukaturov v. Russia*[27] is fundamental to human 'personhood' and freedom. It protects the dignity of persons as well as their autonomy; their ability to act, have legal recognition of their decisions on an equal basis with others, in other words, take charge of their own lives. These decisions span "*all aspects of life*" in both the private and public sphere such as the development of personal relationships, medical treatment, finance and asset management, the right to vote and be elected etc. The main obstacle to understanding disability rights generally and mental disability rights specifically is the all-too-easy assumption that

[27] Application No. 44009/05, 27th June, 2008.

disability simply equates with a lack of capacity. This assumption is then used to restrict the legal capacity of persons with a disability, potentially in a discriminatory way. In large part this assumption rests on stereotypes and exaggerates the effects of disability. That is, it fails to see the person behind the disability and fails to treat the person as a rights-bearing "subject", rather than an "object" to be managed and cared for. Recognition of legal capacity under Article 12 of the CRPD may thus be viewed as a gateway to realising the dignity inherent in persons with mental disability which goes hand in hand with the principle of free and informed consent (see further below).

51. According to the CRPD, legal capacity entails the right to "*recognition everywhere"* as persons before the law (Article 12.1 CRPD) and it extends the right to be recognised before the law "*on an equal basis with others"* in "*all aspects of life"* (Article 12.2 CRPD). The entire thrust of Article 12 is a paradigm shift away from the negation or restriction of the legal capacity of persons with disabilities, towards the functional approach, where every person is assumed to have capacity irrespective of having a disability, whilst also recognising that the person may need "support" to exercise that legal capacity and that specific safeguards must be established, particularly where "supported decision making" occurs (Article 12.4 CRPD). [28]

52. While there may be discussion as to whether Article 12 CRPD leaves any room for substituted decision-making on behalf of a person with a disability, and it is arguable that it does not, it is clear from the analysis of various human rights standards below that there are a number of decisions which are so fundamental to the person that they are protected by human rights law in absolute terms. Any form of substituted decision-making, by which third persons (such as custodians), institutions (such as courts) or a combination of both replace or overrule the will of the person concerned or substitute the absence of free and informed consent in such decisions, based on the person's disability, is absolutely prohibited by the CRPD in certain cases and may not be subject to any restriction. This is the case with certain extreme forms of treatment such as the sterilisation of a man or a woman who has not given free and informed consent, or objects to the procedure. In this context the UN Special Rapporteur on torture has expressed concern that "*intrusive and irreversible medical treatments without their consent (e.g. sterilisation, abortion and interventions aiming to correct or alleviate a disability, such as electroshock treatment and mind-altering drugs including neuroleptics) when perpetrated against persons with disabilities, remain invisible or are being justified, and are not recognized as torture, inhuman or degrading treatment*".[29] The Special Rapporteur goes on to express the view that acceptance of involuntary treatment and involuntary confinement run counter to the provisions of the CRPD.[30] The Special Rapporteur has linked medical treatment of persons with disabilities with torture or ill-treatment where the treatment is "*of an intrusive and irreversible nature, when they lack a therapeutic purpose, or aim at correcting or*

[28] Article 12.3 of the CRPD creates particular State obligations in respect of supported decision making.
[29] *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A/63/175, July 28, 2008, at paras. 40 to 41.
[30] *Ibid*. at para 44.

alleviating a disability". This ties in to Article 14(1)(b) of the CRPD which goes beyond Article 5 of the ECHR in stating that there must be a therapeutic purpose insofar as otherwise "the existence of a disability shall in no case justify a deprivation of liberty". Torture or ill-treatment will occur where the medical treatment is "*enforced or administered without the free and informed consent of the person concerned*"[31].

The principle of free and informed consent

53. Issues of medical treatment engage both Article 3 of the ECHR (Prohibition of torture and prohibited ill-treatment) and Article 8 of the ECHR (Right to respect for private and family life) and the issue of consent is an important component in this regard.[32] In the case of *V.C v Slovakia*,[33] the European Court of Human Rights reiterated the principle as follows:

> "In several cases the Court has examined complaints about alleged ill-treatment in the context of medical interventions to which detained persons were subjected against their will. It has held, *inter alia*, that a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading. The Court has nevertheless taken the view that it must satisfy itself that a medical necessity has been convincingly shown to exist and that procedural guarantees for the decision exist and are complied with (for a recapitulation of the relevant case-law see *Jalloh v.Germany* [GC], no. 54810/00, § 69, ECHR 2006-IX, with further references).
>
> In order for treatment to be "inhuman" or "degrading", the suffering or humiliation involved must in any event go beyond the inevitable element of suffering or humiliation connected with a given form of legitimate treatment (see *Labita*, cited above, § 120).
>
> Finally, the Court reiterates that the very essence of the Convention is respect for human dignity and human freedom. It has held that in the sphere of medical assistance, even where the refusal to accept a particular treatment might lead to a fatal outcome, the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with his or her right to physical integrity (see *Pretty v. the United Kingdom*, no. 2346/02, §§ 63 and 65, ECHR 2002-III; *Glass v. the United Kingdom*, no. 61827/00, §§ 82-83, ECHR 2004-II; and *Jehovah's Witnesses of Moscow v. Russia*, no. 302/02, § 135, ECHR 2010...)."[34]

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[31] *Ibid*, at para. 47.

[32] See e.g. *Pretty v. The United Kingdom*, Application no. *2346/02*, 29 April 2002, para 63, which states that: "In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention". See also *Herczegfalvy v Austria*, Application no. 10533/83, 24 September 1992, paras 82-83 and 86, where the Court concluded that medical treatment without consent is not contrary to Article 8 if the State can convincingly show that it was necessary and the individual lacked capacity to give informed consent

[33] Application no. 18968/07, Judgment 8 November 2011.

[34] *V.C v Slovakia*, Judgment 8 November 2011, at para 103 to 105.

54. The principle of free and informed consent in relation to medical treatment has wide spread acceptance, both under the Constitution, as set out heretofore, and international human rights instruments.

55. In principle, free and informed consent is a precondition to any medical intervention. The 1994 World Health Organization Amsterdam Declaration on Patients' Rights requires informed consent as a prerequisite for any medical intervention, guaranteeing also the right to refuse or halt medical interventions.[35] Most importantly, the European Convention on Human Rights and Biomedicine, which entered into force in 1999, states that "*An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it*".[36] The Universal Declaration on Bioethics and Human Rights was adopted by UNESCO's General Conference on 19 November 2005, and also confirms the requirement for free and informed consent in relation to any "preventive, diagnostic and therapeutic medical intervention."[37]

56. Further, the obligation to obtain free and informed consent is enshrined in the Charter of Fundamental Rights of the European Union. Article 3 provides that "*Everyone has the right to respect for his or her physical and mental integrity. In the fields of medicine and biology, the following must be respected in particular: the free and informed consent of the person concerned, according to the procedures laid down by law*".[38] As noted, both these conventions were called in aid by Murray CJ in *Roche v Roche*[39] in order to assist the interpretation of the Constitutional position.

57. The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("UN Special Rapporteur on the right to health") has given a purposive interpretation to consent stating that "*informed consent in health […] is an integral part of respecting, protecting and fulfilling the enjoyment of the right to health*".[40]

58. The general principle of free and informed consent and its strict application takes on particular importance in cases of sterilisation. The UN Special Rapporteur on the right to health considers that "*While consent for simple procedures may sometimes be implied by a patient, more complex, invasive treatments require explicit consent.*"[41] Blood tests are clearly an invasive procedure, and depending on the level of resistance by the person

[35] ICP/HLE 121 (1994), Article 3.
[36] Article 5 of the Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine: Convention on human rights and biomedicine, Oviedo, 4.IV.1997. Although Ireland has yet to ratify the convention, its provisions are increasingly taken into account by the European Court of Human Rights in its jurisprudence.
[37] See Article 6- Consent.
[38] Article 3 of the Charter of Fundamental Rights of the European Union (2000/C 364/01).
[39] [2010] 2 IR 321.
[40] *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, August 10, 2009, A/64/272, at para. 18.
[41] *Ibid.* at para. 13.

concerned may have considerable consequences for the autonomy of the person.

59. In addition, the obligation on a medical practitioner to seek free and informed consent must be combined with the right of the patient to receive adequate information about his or her medical state and the medical treatment proposed.[42] While the application of the general principle of free and informed consent may be difficult to ensure in certain situations, for example in cases of urgency where the person concerned is unconscious, in which circumstance there may be justification for dispensing with consent, it should nonetheless be clearly underlined that this principle applies to persons with disabilities in the same terms as for a person without a disability and that the difficulty of overcoming practical barriers in securing free and informed consent cannot justify a law or practice that automatically substitutes for the free and informed consent of the person concerned.

60. The CRPD clearly states that one of the principles on which it is based is "*Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons*" (Article 3). Article 12 of the CRPD should be read in conjunction with Article 25(1)(d) which provides: "*health professionals* [must be required] *to provide care of the same quality to persons with disabilities as to others, <u>including on the basis of free and informed consent</u> by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care*" (emphasis added).

61. The UN Special Rapporteur on torture confirms that "*Article 25 [of the CRPD] recognizes that medical care of persons with disabilities must be based on their free and informed consent*". He further states that "*Thus, in the case of earlier non-binding standards, such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (resolution 46/119), known as the MI Principles, the Special Rapporteur notes that the acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities*".[43] Similarly, the UN Special Rapporteur on the right to health affirms that the CRPD obliges States to "*provide persons with disabilities equal recognition of legal capacity, care <u>on the basis of informed consent</u>, and protection against non-consensual experimentation; as well as prohibit exploitation and respect physical and mental integrity*"[44] (emphasis added). This is discussed further below.

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[42] Article 5 of the Convention on human rights and biomedicine. The ECtHR noted in *K.H. V Slovakia*, Judgment of 28 April 2009, a case concerning "effective access to information concerning [the applicants] health and reproductive status" (at para. 44) that "…protection of medical data is of fundamental importance to a person's enjoyment of his or her right to respect for private and family life as guaranteed by Article 8…" (at para. 55). In addition to a breach of Article 8, the Court also found a breach of Article 6 insofar as the Applicants were limited in their ability to bring a civil claim in relation to alleged forced sterilisation.

[43] *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A/63/175, July 28, 2008, at para. 44.

[44] *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, August 10, 2009, A/64/272, at para. 72.

62. The MI Principles, referred to above, set out detailed standards for ensuring a patient's informed consent after appropriate disclosure to the patient of adequate information in a form and language understood by the patient on:

- The diagnostic assessment;
- The purpose, method, likely duration and expected benefit of the proposed treatment;
- Alternative modes of treatment, including those less intrusive; and
- Possible pain or discomfort, risks and side-effects of the proposed treatment.[45]

63. Under these standards, medical practitioners must ensure that consent is free from coercion from family members or other interested parties and that the presentation of health information is adapted to the specific needs of the patient in order to facilitate informed consent. Information needs to be accessible and understandable and not merely imparted in a universal manner. This is critical in relation to persons with mental disabilities. Therefore it is essential that appropriate safeguards are in place to support free and informed consent and to protect the right to be involved in one's own medical decision making.[46]

64. Accordingly, if free and informed consent of the person concerned cannot be obtained, intrusive medical interventions such as sterilisation or invasive procedures may not be carried out.

65. It should be recalled that lack of consent may be due to the determination that the person is found not to be legally capable under national law.

Substituted decision making

66. Article 12(4) of the CRPD provides:

> States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

Article 12(4) of the CRPD thus recognises that in some circumstances the "exercise of legal capacity" may be supported or possibly, *in extremis,*

[45] United Nations General Assembly Resolution, *The protection of persons with mental illness and the improvement of mental health care*, 17 December 1991, A/RES/46/119 at Principle 11(2).

[46] *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, August 10, 2009, A/64/272, at para. 44.

substituted. Where this occurs, it is vital that the legal framework "provide for appropriate and effective safeguards" as specified above. These safeguards require to be considered in turn.

Safeguards to prevent abuse

67. Article 12(4) refers to appropriate and effective safeguards in accordance with international human rights law. Generally stated, such safeguards become more rigorous where the vulnerability of the individual increases. Safeguards for vulnerable individuals in institutions usually include adherence by personnel to national guidelines or codes of conduct, strict record keeping, involvement of and observance of next friend and family consultation protocols and independent oversight by a judicial or other authority.[47]

Respecting one's rights, will and preferences

68. Where it is suspected that a person lacks capacity, legislation should provide in a clear and transparent manner for how a determination of the individual's capacity is to take place, what the consequence of that determination will be and how it will be time and issue-specific in accordance with the "functional approach" to disability now recognised as the appropriate approach to capacity issues. For persons in the Plaintiff's situation, such a legal process can only presently occur under the cumbersome Wards of Court system. While the accepted medical evidence in this case suggests that the Plaintiff lacks the capacity to consent to treatment, at the same time she is not a ward of court and appears to actively object to her treatment. In those circumstances, it is submitted there is a presumption [at common law] that the individual, such as the Plaintiff has capacity. If this is correct and there is a presumption that the person has capacity (as required under Article 12(1) of the CRPD), their right to free and informed consent suggests that there should be no intrusive medical treatment against their will where they articulate that they do not consent to same. In relation to safeguards to ensure that measures relating to the exercise of one's legal capacity respect the rights, will and preferences of the person, the only manner in which such intrusive treatment may properly occur under relevant constitutional standards in those circumstances, it is respectfully submitted, is by specific order of the High Court, in the absence of capacity legislation, notwithstanding the provisions of section 57. The independent oversight of the High Court imports some necessary safeguards against "abuse" as referred to in Article 12 of the CRPD.

Ensuring measures ….are free of conflict of interest and undue influence

69. This articulation stresses that the procedure under which a medical practitioner may employ invasive medical treatment must be subject to adequate safeguards. As the Plaintiff points out in her submission (at paragraphs 8-9), Section 57 compares unfavourably to Sections 58-60 of the 2000 Act. Section 57(1) provides that: "*The consent of a patient shall be required for treatment except where in the opinion of the consultant*

[47] See for example the Health Information and Quality Authority, *National Quality Standards, Residential Services for People with Disabilities*, 2009.

psychiatrist responsible … the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent." Section 2 of the 2001 Act defines "treatment" as follows: "*Treatment in relation to a patient, includes the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder*." Thus the opinion of the consultant psychiatrist that the conditions prescribed in section 57(1) are met, suffices. It is difficult to identify how allegations of conflict of interest and/ or undue influence can be defended by the consultant psychiatrist acting *bona fide* in accordance with section 57(1) where there are no procedural safeguards or codes of conduct to which s/he may subscribe.

70. The procedural safeguards available under sections 58-60 of the Act in relation to psycho-surgery (to be authorised by a tribunal (section 58), electro-convulsive therapy (second consultant psychiatrist to agree: section 59) or medication prescribed over 3 months (second consultant psychiatrist to agree: section 60) are in contrast to the lack of second opinion or oversight under section 57. That is not to state that those provisions of the 2001 Act meet international standards (the *Amicus Curiae* does not propose to address the point) but it is noted that those safeguards have been supplemented by Codes and guidance promulgated by the Mental Health Commission which form an additional layer of safeguards.[48]

Ensuring measures ….are proportional and tailored to the person's circumstances

71. One difficulty in the current case is that due to the complicating physical health risks of the medication being prescribed to the Plaintiff, namely, a potentially life threatening adverse reaction, the intrusive medical treatment being undertaken to address these risks, identified by the Court in its Judgment as taking constitutional priority (the right to life), may or may not be proportionate over time insofar as the Plaintiff's condition may change in the future depending on the Plaintiff's prognosis. It is submitted that the reference to proportionality here should be in the terms specified by the European Court in *Shtukaturov.* While the Court has determined in its Judgment of July 2011 that the treatment to date has been proportionate, the Judgment relates to the period up to that point in time and as noted, the situation of the Plaintiff may change. It is unlikely that following the Court's Judgment in this case, that this Court will be exercising supervisory oversight in 1, 2 or 5 years' time. However the supervisory jurisdiction of this Honourable Court is cited by the Defendant as a material defence to these proceedings (see Defence paras 6 and 15), begging the question as to whether section 57 can be regarded as being constitutional in the absence of such judicial supervision. In addition, one may ask, how can proportionality

[48] See the *Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities* and the *Code of Practice on the Use of Physical Restraint in Approved Centres*; Mental Health Commission, October 2009. See also *Rules Governing the Use of Electro-Convulsive Therapy - Version 2* and the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint – Version 2*; Mental Health Commission, October 2009

be assessed in the absence of procedural safeguards under section 57 when the question of whether the treatment is tailored to the person's circumstances is likely to change over time? As noted above, the treatment should be proportionate to the legitimate aim sought to be achieved and to demonstrate that this is so, procedural safeguards must be present.

Measures … apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body

72. The issue of proportionality of measures tie in directly to the question of the time period under which intrusive medical treatment against a person's consent should be permitted. It also ties into the requirement for a regular review by a competent, independent and impartial authority or judicial authority. In this case, the High Court is acting as the regular review body, however this may not be appropriate in other cases or indeed in the medium to long term. If there was capacity legislation on the statute book which provided for determinations of legal capacity and which provided authority for an independent body to review intrusive medical treatment as arises in this case, it may be that section 57, when read with those safeguards, would be constitutional. When read without those safeguards, however, section 57, it is submitted, is more vulnerable to challenge.

The *amicus* observes that insofar as the Health Service Executive, in its submissions, might, impliedly, rely on a defence of necessity, the conclusions of the European Court of Human Rights in *HL v United Kingdom*[49] are apposite.

Stanev v Bulgaria

73. The most recent consideration of the application of the Convention to cases involving a person's lack of capacity is the Grand Chamber Judgment in *Stanev v Bulgaria*[50] (cited in the Plaintiff's supplementary submissions) where the Court built on its earlier Judgment in *Shtukaturov* to hold that fair trial rights under Article 6(1) apply to determinations in relation to capacity. The Court stated:

> " . . . the Court observes that in most of the cases before it involving "persons of unsound mind", the domestic proceedings have concerned their detention and were thus examined under Article 5 of the Convention. However, it has consistently held that the "procedural" guarantees under Article 5 §§ 1 and 4 of the Convention are broadly similar to those under Article 6 § 1. In the *Shtukaturov* case, in determining whether or not the incapacitation proceedings had been fair, the Court had regard, mutatis mutandis, to its case-law under Article 5 §§ 1 (e) and 4 of the Convention." (citations omitted)

74. It continued (at para. 233) "that proceedings for restoration of legal capacity are directly decisive for the determination of "civil rights and obligations".

[49] *H.L. v. United Kingdom* HRC MHLR (2005) 40 E.H.R.R. 761, [2004] 1 M.H.L.R. 236.

[50] (Application no. 36760/06) 17 January 2012, See, however, also, the judgment in *DD v Lithuania* (Application No. 13469/06), Judgment 14 February 2012.

Article 6 § 1 of the Convention is therefore applicable . . . .” The Court further held (at para. 241) that the right to ask a court to review a declaration of incapacity

> “is one of the most important rights for the person concerned since such a procedure, once initiated, will be decisive for the exercise of all the rights and freedoms affected by the declaration of incapacity, not least in relation to any restrictions that may be placed on the person’s liberty (see also *Shtukaturov*, . . .). The Court therefore considers that this right is one of the fundamental procedural rights for the protection of those who have been partially deprived of legal capacity. It follows that such persons should in principle enjoy direct access to the courts in this sphere.”

75. Insofar as access to a court is concerned, the Grand Chamber noted (at para. 242) that the State remains free to determine the procedure by which such direct access is to be realised. Although it conceded that it would not be incompatible with Article 6 for national legislation to provide for certain restrictions on access to court in this sphere, with the sole aim of ensuring that the courts are not overburdened with excessive and manifestly ill-founded applications, it continued:

> “[n]evertheless, it seems clear that this problem may be solved by other, less restrictive means than automatic denial of direct access, for example by limiting the frequency with which applications may be made or introducing a system for prior examination of their admissibility on the basis of the file.”

76. More importantly, it stated (at paras. 244-245):

> “244. The Court is also obliged to note the growing importance which international instruments for the protection of people with mental disorders are now attaching to granting them as much legal autonomy as possible. It refers in this connection to the United Nations Convention of 13 December 2006 on the Rights of Persons with Disabilities and to Recommendation No. R (99) 4 of the Committee of Ministers of the Council of Europe on principles concerning the legal protection of incapable adults, which recommend that adequate procedural safeguards be put in place to protect legally incapacitated persons to the greatest extent possible, to ensure periodic reviews of their status and to make appropriate remedies available.
> 245. In the light of the foregoing, in particular the trends emerging in national legislation and the relevant international instruments, the Court considers that Article 6 § 1 of the Convention must be interpreted as guaranteeing in principle that anyone who has been declared partially incapable, as is the applicant’s case, has direct access to a court to seek restoration of his or her legal capacity.” (internal references omitted)

In *Stanev*, the Court held that there had been a violation of Article 6 § 1 as direct access of the kind required by the Convention was not guaranteed with a sufficient degree of certainty.[51]

The *amicus* stresses, in the context of the procedural protections referred to, that it is not being contended that the actual non-consensual treatment of an incapacitated person must be authorised or supervised by a judicial or quasi-judicial process, and agrees with the submission of the Health Service Executive that there is no authority for such a proposition. The requirement arises in the form of supervisory oversight of such decisions.

Conclusion

77. The *Amicus Curiae* submits that human rights standards, as established by the European Convention on Human Rights and the Convention on the Rights of Persons with Disabilities should inform the interpretation and analysis of the Constitutionality section 57 of the Mental Health Act 2001.

78. Non-consensual treatment constitutes a tort and a criminal offence, subject to specific and limited defences. Our Courts recognise that the common law requirement, that for a consent to be valid and lawful, there must be prior disclosure of adequate information, engages issues of respect for individual autonomy and respect for the dignity of the individual, as a matter of basic human rights. Non-consensual treatment also violates a person's Constitutional rights, be they identified as a right to bodily integrity, privacy or otherwise and engages that person's Convention rights, including Articles 3, 6, 8 and 14.

79. A person lacking capacity to consent is not, by reason of that incapacity, deprived of those Constitutional (or Convention) rights; nor is the State relieved of its obligations to respect, defend and vindicate and to protect from unjust attack the Constitutional rights (and which the common law – and the criminal law – ordinarily protects) of such a person.

80. The *Amicus Curiae* submits that the Mental Health Act 2001 section 57 does not afford sufficient protection and vindication of the Constitutional rights of a person who lacks capacity to consent to treatment, and having regard to the Constitutional rights necessarily affected by a determination of lack of capacity, more particularly, where the relevant norms are informed by the State's obligations pursuant to the European Convention on Human Rights and Fundamental Freedoms and the Convention on the Rights of Persons with Disabilities. It further submits that it does not sufficiently ensure the guarantee of equality provided by Article 40.1 of the Constitution.

[51] In the discussion paper "*Who Gets to Decide? Right to legal capacity for persons with intellectual and psychological disabilities.*" Comm DH/ Issue paper (2012) 2, Strasbourg, 20 February 2012, The Commissioner for Human Rights recommends that each State: " Review judicial procedures to guarantee that a person who is placed under guardianship has the possibility to take legal proceedings to challenge the guardianship or the way it is administered as long as guardianship regimes still remain valid" (at p. 5).

81. The *Amicus Curiae* also submits that section 57 fails to provide any procedural mechanism, as required by Articles 6 and 8 of the Convention, for the determination of legal capacity, including the right to ask a court to review a declaration of incapacity, however made, and violates the rights guaranteed thereby.

Ciaran D Craven BL

24 February 2012