THE COURT OF APPEAL
(CIVIL)

Record No. ---------

Between: -

L

Appellant

and

THE CLINICAL DIRECTOR OF ST PATRICK'S UNIVERSITY HOSPITAL and ANOR

Respondents

and

THE ATTORNEY GENERAL

Notice Party

and

THE IRISH HUMAN RIGHTS AND EQUALITY COMMISSION

Amicus Curiae

OUTLINE SUBMISSIONS OF THE AMICUS CURIAE

A. INTRODUCTION

Background

1. This is an appeal against two judgments of the High Court delivered on 24 January 2012 and 14 December 2012 respectively. In the first judgment, it was held that the Appellant was not unlawfully detained in St Patrick's University Hospital between 12 October 2011 and 24 November 2011. In the second judgment, a series of declarations of incompatibility pursuant to section 5 of the European Convention on Human Rights ('ECHR') Act 2003 sought by the Appellant in respect of findings made by the Court in the January judgment were refused on the grounds that, not having been unlawfully detained, the Appellant lacked standing to seek the declarations sought. The facts are set out in the submissions of the parties and in the judgments of the Court below.

2. In this Appeal, the Appellant seeks, *inter alia*, declarations that he was unlawfully refused permission to leave/detained by the Respondent while a voluntary patient, and, presumably in the alternative, that such rules of law as

rendered his alleged detention lawful as a matter of national law are incompatible with Article 5 ECHR.

3. The Respondents deny that the Appellant was detained at all, and submit that the remarks made by the Court in its January judgment as to the definition of voluntary patient and the powers of responsible consultant psychiatrists effectively to detain voluntary patients under sections 28(2) and 29 of the Act of 2001 are *obiter dicta*.

The amicus curiae

4. The Irish Human Rights and Equality Commission ('the Commission') was granted liberty to appear in this appeal as *amicus curiae* in accordance with section 10(2)(e) of the Irish Human Rights and Equality Commission Act 2014 by Order of the President dated 21 June 2017. The Commission also appeared as *amicus curiae* in the second hearing in the Court below.

5. The role of an *amicus curiae* is to assist the Court in determining the issue before it: see *HI v. Minister for Justice, Equality and Law Reform* [2003] 3 IR 197, 203. Under section 10(2)(e) of the Irish Human Rights and Equality Commission Act 2014, the Commission's statutory function including making application for liberty to appear as amicus curiae in proceedings 'that involve or are concerned with the human rights or equality rights of any person.' Human rights, in this context, is defined in section 2 of the Act as follows:

> *(a) the rights, liberties and freedoms conferred on, or guaranteed to, persons by the Constitution,*
> *(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, and*
> *(c) without prejudice to the generality of paragraphs (a) and (b), the rights, liberties and freedoms that may reasonably be inferred as being—*
> > *(i) inherent in persons as human beings, and*

(ii) necessary to enable each person to live with dignity and participate in the economic, social or cultural life in the State;

6. Section 2 defines dignity as follows:

> *"dignity" means, in relation to a person, the inviolable intrinsic value, equal to other persons, that the person has and includes the recognition by other persons of such value with respect of that person.*

7. The Commission has identified, in its respectful view, as the principal human rights and equality rights issues arising in this appeal:

   (a) whether the Appellant was deprived of his liberty by the Respondents while a voluntary patient; and, if so;

   (b) whether such deprivation of liberty was unlawful.

8. The Commission notes that these issues fall to be considered by reference to the provisions of the Constitution and other national law, including the ECHR Act 2003. Importantly, section 3(1) of the Act of 2003 provides that every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions, including Article 5 ECHR. The term 'organ of the State' is defined in section 1 of the Act to include a tribunal or any other body … which is established by law or through which any of the legislative, executive or judicial powers of the State are exercised. The Respondents in this case may exercise powers under the Mental Health Act 2001. Their roles are publicly funded and they provide a public service. The Commission submits that the Respondents are organs of the State for the purposes of section 3 of the Act of 2003.

B. LIBERTY AND MENTAL DISABILITY

9. Article 40.4.1 of the Constitution provides:

> *No citizen shall be deprived of his personal liberty save in accordance with law.*

10. As a general proposition, the Commission's view is that the personal rights provisions of the Constitution should be interpreted as providing a level of protection for human rights, including the right to liberty, equal to or greater than the level of protection provided by the ECHR.

11. It is acknowledged that there are rare situations in which the ECHR provides a supplementary level of protection through, in the first instance, the framework of the Act of 2003. In the present context, for instance, the Supreme Court held in *Croke v. Smith (No 2)* [1998] 1 IR 101, that Article 40.4.1 of the Constitution did not require automatic review by an independent tribunal of the patient's detention, something the Strasbourg Court had held to be required by Article 5 ECHR in *X v. United Kingdom* [1981] 4 EHRR 350. Mr Croke then brought an application to the European Court of Human Rights which Ireland resolved by way of friendly settlement. In recognition of the Article 5 ECHR obligation, the Mental Health Act 2001 provides for automatic reviews of admission and renewal orders by independent mental health tribunals.

12. Article 5(1) ECHR provides, in relevant part:

> *Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:*
> *(e) the lawful detention of ... persons of unsound mind ...*

13. Mental disability does not result in any diminution of the personal rights recognised by the Constitution: see *AM v. Kennedy* [2007] 4 IR 667, 676, and

mutatis mutandis, In re a Ward of Court (withholding medical treatment) (No. 2) [1996] 2 IR 79, 126.

14. The same is true with respect to the rights guaranteed by the ECHR. In her judgment for the Supreme Court of the United Kingdom in *Cheshire West and Chester Council v. P and Another* [2014] AC 896, Lady Hale observed, at 919:

> *45. In my view, it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities. Far from disability entitling the state to deny such people human rights: rather it places on the state (and on others) the duty to make reasonable accommodation to cater for the special needs of those with disabilities.*
>
> *46 Those rights include the right to physical liberty, which is guaranteed by article 5 of the European Convention. This is not a right to do or to go where one pleases. It is a more focused right, not to be deprived of that physical liberty. But, as it seems to me, what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage*

15. The UN Convention on the Rights of Persons with Disabilities 2006, 2515 UNTS 3 ('UNCRPD') referred to by Lady Hale in *Cheshire West* was signed by Ireland on 3 March 2007. While the UNCRPD has not yet been ratified or

incorporated, the State's signature of the treaty entails a commitment that it will refrain from acts which will defeat its objects and purposes: see Vienna Convention on the Law of Treaties 1969, ITS No 4 of 2006, art 18. The purpose of the UNCRPD as set out in Article 1 is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.' The UNCRPD, which emerged under strong influence from NGOs and people with disabilities, aims to achieve this purpose by bringing about a 'paradigm shift' in the human rights of persons with disabilities: see C Murray, 'Moving Towards Rights-Based Mental Health Law: The Limits of Legislative Reform' (2013) 49 *Irish Jurist* 161**.** Article 14 UNCRPD, which concerns liberty and security of the person, provides:

> *States Parties shall ensure that persons with disabilities, on an equal basis with others:*
> *a) Enjoy the right to liberty and security of person;*
> *b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.*

16. It will readily be understood that this provision goes beyond even what is required by Article 5 ECHR, envisaging, for example, that a person with disabilities posing a danger to others should be dealt with as anyone else in that situation, and that there would be an end to involuntary commitment solely for the purposes of treatment: see Guidelines on Article 14, UN Committee on the Rights of Persons with Disabilities, September 2015, paragraphs 6-9.

17. In *MX v. Health Service Executive* [2012] 3 IR 254, 282 the High Court held that the UNCRPD contains guiding principles in the identification of standards of care and review for persons with mental disabilities, and may inform how our Constitution is interpreted and applied. Accordingly, in the Commission's submission, the Court's approach should be informed by the provisions of the UNCRPD to the extent that they are not inconsistent with Irish law.

18. The starting point for analysing an alleged deprivation of liberty must be, therefore, an acknowledgement that persons with mental disabilities are no less entitled to the protection of their liberty than anyone else.

C. DEPRIVATION OF LIBERTY

19. In the Commission's respectful submission, Irish and European jurisprudence indicates that the notion of deprivation of liberty comprises both an objective and a subjective element. The objective element is the person's confinement in a restricted space for a significant length of time, while the subjective element, consists of the person's lack of valid consent to the confinement: see *Kane v. The Governor of Mountjoy Prison* [1988] IR 757, 768 and *Storck v. Germany*, App No 6160/03, ECHR 2005-V, § 74.

Objective element

20. In order to determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors such as the type, duration, effects and manner of implementation of the measure in question. This formula was established by the European Court of Human Rights in *Guzzardi v. Italy*, App No 7367/76, 6 November 1980, § 92 and followed in successive case including *HM v. Switzerland*, App No 39187/98, ECHR 2002-I, § 42, *Storck v. Germany*, cited above, § 71 and *Stanev v. Bulgaria*, App No 36760/06, ECHR 2012-I, § 115. It was also approved by Lord Kerr in the Supreme Court of the United Kingdom in *Cheshire West and Chester Council v. P and Another* [2014] AC 896, 928.

21. The formula has since been adopted by the Supreme Court, though without express reference to the Strasbourg jurisprudence. In *SMcG and JC v. Child and Family Agency* [2017] 1 IR 1, the Court considered whether the remedy provided for in Article 40.4.2 could be used to secure the return of children unlawfully removed from their parents. The Court held, at 23:

> *In considering whether or not the circumstances involve deprivation of liberty, the starting point must be the concrete situation of the individuals concerned. One must have regard to a range of criteria, including the type, duration, effects and manner of implementation of the District Court order. The situation was, in fact, that the children were placed under the complete supervision and control of the CFA. They would not have been free to leave the custody of the persons in whose care they were placed.* (emphasis added)

Subjective element

22. A person can only be considered to have been deprived of his liberty if, in addition to the objective element discussed above, he or she has not validly consented to the confinement in question.

23. For instance, in *DPP v. Pringle, McCann and O'Shea*, Unreported, Court of Criminal Appeal, O'Higgins CJ, 22 May 1981, pp 98-100, the Court of Criminal Appeal was satisfied that a murder suspect who had been brought to hospital by Gardaí had remained there of his own volition to receive medical treatment and had not therefore been detained there against his will.

24. The same requirement appears in Strasbourg jurisprudence. In *HM v. Switzerland*, cited above, the Court was satisfied that the applicant had validly consented to remain in the care home to which she had been transferred, and that she had not been deprived of her liberty.

Capacity to consent

25. All adults, including persons suffering from mental disorders, should be presumed to have decision-making capacity unless there is clear and convincing evidence to the contrary: see *In re a Ward of Court (withholding medical treatment) (No. 2)*, cited above, at p 127.

26. This approach is consistent with Article 12(2) UNCRPD, which provides:

> *States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.*

27. That having been said, the European Court of Human Rights has warned that medical practitioners are required to pay particular attention to the validity of decisions made by a person whose mental health is questionable: see *M v. Ukraine*, App No 2452/04, 19 April 2012, § 75.

28. Six principles applicable to capacity assessments were set out by the High Court in *Fitzpatrick v. FK* [2007] 2 IR 7. Although that case involved capacity to refuse medical treatment, there is no obvious reason why they ought not equally to apply, *mutatis mutandis*, to situations where the issue is capacity to consent to confinement, bearing in mind that capacity is issue and time specific. The principles identified by Laffoy J, at p 40, are:

> *(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, for example, factors of the type referred to by Lord Donaldson in In re T . (Adult: refusal of medical treatment) [1993] Fam. 95, 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*

W.L.R. 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. The former may be evidence of lack of capacity. The latter is irrelevant to the assessment.

(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".

29. A person who, by reason of a mental disability, does not have capacity to consent to confinement cannot be considered to have validly agreed: see *Storck v. Germany*, cited above, § 76 and *HL v. United Kingdom*, App No 45508/99, ECHR 2004-IX, §§ 90-93.

Voluntary consent

30. Where a person with a mental disability has capacity to consent to confinement, it is necessary to ensure that his or her consent is both free and informed: see *Fitzpatrick v. FK*, cited above, at 21.

31. In order that any form of consent should be free, it must be truly voluntary: see *JM v. St Vincent's Hospital* [2003] 1 IR 321, 325 and *Fitzpatrick v. FK*, cited above, at p 21. This requirement is also reflected in the HSE's National Consent Policy, 2016, at p 23.

32. Clearly, a consent motivated by fear, stress or anxiety, or a consent or conduct which is dictated by poverty or other deprivations does not constitute a valid consent: see *G v. An Bord Uchtála* [1980] IR 32, 74. In this regard, the Commission notes that the UN General Assembly has observed in its Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, UN Doc A/RES/46/119, 17 December 1991, at principle 11(2), that in order to be free, consent must be obtained 'without threats or improper inducements.'

33. In the present case, the High Court held, at paragraph 50 of the January 2012 judgment, that:

> *[A] wide margin of appreciation ought to be allowed to clinicians when faced with a patient who expresses a wish to leave, to not immediately permit him to do so, in order to provide an opportunity to discuss matters with him with a view to persuading him to once again cooperate*

in his own best interests, rather than simply accepting the expressed wish at face value immediately, and discharging him there and then.

34. In its December 2012 Judgment, the Court emphasised again, at paragraph 43, that:

> *[I]t was within the margin of appreciation to be permitted that a discussion should take place with the applicant rather than simply release him onto the street immediately upon his indicating a wish to leave.*

35. While there can be no objection to a clinician discussing a treatment plan with a patient, the Commission submits that where the purpose of the discussion is to obtain consent to confinement, deference to clinical judgment must be qualified so as to acknowledge the institutional context and the relative positions of the discussants. The context is crucial, for as Mills and Mulligan observe in *Medical Law in Ireland* (2017 Bloomsbury Dublin) (3rd edn) at p 123:

> *In institutional settings, such as prisons or psychiatric hospitals (or indeed in general hospitals, where the institutional aura surrounding the clinician can be very great), a person's 'voluntary 'consent may be more apparent than real.*

36. On this subject, the Department of Health's National Advisory Committee on Bioethics cautioned in September 2012 as follows:

> *From an ethical perspective, a person who gives unambiguous consent to entering a mental health care facility and receiving care which restricts his/her liberty is not considered to be unfairly detained. There is, however, a distinction to be made between apparent and actual consent. In order for detention to be deemed genuinely voluntary, a patient must make the decision to enter a mental health care facility unconstrained by coercion and the patient, once admitted, must be free to discharge himself/herself. However, in practice voluntary detention*

may not always be genuinely voluntary. The patient who admits himself/herself might not retain full control over his/her care and may face certain procedural and administrative obstacles to discharging himself/herself. Critics have suggested that voluntarism in the fear of compulsion actually represents coercion and that a patient may agree to enter or stay in hospital only because s/he knows that the alternative would be the use of compulsory measures e.g. involuntary detention under the MHA and fear of the potential stigmatisation attached. Some research has shown that many people admitted to mental health facilities on a voluntary basis do not actually believe that they are free to leave. Even in situations when there is no overt coercion, consent to admission or continued hospitalisation might still reflect a person's deference to the mental health care providers' perceived position of authority or to the well-meaning wishes of family or friends.

37. The opinion of the National Advisory Committee on Bioethics underscores the need for vigilance by clinicians – and by reviewing national courts – as to the possibility that the consent of voluntary patients to remain in hospital may not be genuinely voluntary. The situation is inevitably complicated by the fact that the definition of 'voluntary patient' in section 2 of the Act of 2001 does not contain any reference to the actual preference of the patient, something that has been criticised by the Irish Human Rights Commission, the UN Human Rights Committee, the UN Committee against Torture and the Council of Europe's European Committee on the Prevention of Torture: see IHRC, Policy Paper concerning the definition of a 'voluntary patient' under s. 2 of the Mental Health Act 2002, February 2010; UNCCPR, Concluding Observations on Ireland, 19 August 2014, UN Doc CCPR/C/IRL/CO/4, paragraph 12; UNCAT, Concluding Observations on Ireland, 17 June 2011, UN Doc CAT/C/IRL/CO/1, paragraph 28; and CPT, Report on Ireland, 20 February 2011, CPT/Inf (2011) 3, paragraph 117.

Informed consent

38. A person can give informed consent if he or she has been provided with information as to the nature, purpose and effect of the measure proposed and the consequences of accepting or rejecting it in the context of the choices available (including any alternative) at the time the decision is made: see *Fitzpatrick v. FK*, cited above, at p 40.

39. The information provided to the person must be full, accurate and comprehensible: see *M v. Ukraine*, cited above, § 76.

40. The central justifications for a stringent information requirement are the Constitutional values of dignity, self-determination and autonomy: see *MX v. Health Service Executive*, cited above, at p 279. These values are also inherent in the ECHR and the UNCRPD.

Key features of deprivation of liberty

41. In *Cheshire West and Chester Council v. P and Another*, cited above, Lady Hale reviewed the Strasbourg jurisprudence and considered whether there could be an acid test for deprivation of liberty. While she concluded that no such test could be constructed, she observed that there were particular features of a person's concrete situation on which a reviewing court should focus, and held, at p 920, that the key features were whether 'the person concerned was under continuous supervision and control and was not free to leave.'

Was the Appellant was deprived of his liberty?

42. The High Court found, at paragraph 18 of the December 2012 judgment, that the Appellant had capacity to consent to his confinement, and that he did consent. The Court did not consider at all whether the consent given by the Appellant was truly voluntary or adequately informed. The Court's conclusion was that he was never deprived of his liberty.

43. Applying the principles set out above to this question, the Commission notes that Dr ------ was satisfied that the Appellant had capacity to consent to the restrictive treatment plan he had devised. The Commission submits that presumption of capacity was appropriate in the circumstances, and that, because capacity is issue and time specific, the Court was entitled to defer to the clinician's view as to whether or not there was sufficiently clear and convincing evidence to rebut that presumption.

44. Turning then to the question of the Appellant's objective situation, the Commission notes that while he was a voluntary patient as defined in the Act of 2001 in the Respondents' hospital, the Appellant was accommodated in the locked Special Care Unit, and that as such he was not free to move about the hospital or its grounds unaccompanied. Leaving aside for a moment the question of his periodic agreements to remain in hospital, it appears that whenever he asked to leave, permission was refused by his treating team, and that whenever he attempted to leave, he was prevented by staff from doing so.

45. Turning finally to consider the Appellant's periodic agreements to remain in hospital, the Commission notes the context in which those agreements were made. The Appellant had for several months been subjected to a regime involving regular restraint in the same unit. He was prescribed strong anti-psychotic and anxiety-relieving medication at the material time, though he was intermittently non-compliant. On 21 November 2011, when he agreed again to remain as a voluntary patient, the Appellant had been both restrained and medicated (he told his solicitor he had been forcibly sedated, but Dr ----- said he agreed to take the medication). On the morning of 22 November 2011, he again demanded to leave, but after taking medication, agreed to stay. Dr ----- frankly acknowledges, in his supplemental affidavit at paragraph 15, that the change in the Appellant's desire was attributable to the effect of the drugs. The Appellant was told to expect an assessment from Dr ----- in respect of which there was a delay. A statutory requirement as to the information to be given to him and his solicitor were not complied with. Whenever the Appellant met with his solicitor, he told her that he wished to leave the hospital.

46. Looking at the Appellant's subjective situation in context, and placing special weight on his repeated instructions to his solicitor that he wished to leave the hospital, the Commission concludes that, in all the circumstances, it is difficult to see how the Appellant's consent to remain in hospital can be said to have been both truly voluntary and fully informed.

47. On the basis of the foregoing, the Commission submits that there are objective and subjective indicia of deprivation of liberty present in Appellant's case. To paraphrase Lady Hale, he was under the continuous supervision and control of the Respondents, and was not free to leave in a meaningful sense. Accordingly, it is the Commission's respectful submission that the Appellant was deprived of his liberty by the Respondents at the material times. The question then is whether his detention was lawful.

D. LAWFULNESS OF DETENTION

48. Two parallel statutory regimes provide for the possibility of detention of adults with mental disabilities in Ireland outside of the criminal context. First, the Act of 2001 provides for the involuntary admission of persons suffering from mental disorders in approved centres. Second, the President of the High Court may detain wards of court in the exercise of his wardship jurisdiction under section 9 of the Courts (Supplemental Provisions) Act 1961: see *In re AM* [2017] IEHC 184, Kelly P, 27 March 2017. The wardship jurisdiction ensures that persons who do not suffer from mental disorders but are of unsound mind and incapable of managing their affairs can still be detained if the Court is satisfied that their welfare requires it. It appears that, following the judgment of the Supreme Court in *In re FD (No 2)* [2015] 1 IR 741, recourse is no longer had to the inherent jurisdiction of the High Court to detain vulnerable adults who lack capacity but who cannot for one reason or another be detained under the Act of 2001. This jurisdiction is still exercised with respect to minors: see with respect to minors, *DG v. Eastern Health Board* [1997] 3 IR 511 and, with respect to vulnerable adults, *Health Service Executive v. VF* [2014] 3 IR 305.

49. As a matter of constitutional law, either a detention is in accordance with law or it is not: see *The People (Director of Public Prosecutions) v. Howley* [1989] ILRM 629, 635.

50. When the word 'lawful' is used in Article 5 ECHR, it refers to an obligation to conform to the substantive and procedural rules of national law: *Medvedyev v. France*, App No 3394/03, ECHR 2010-III, § 79. Of course, section 2 of the Act of 2003 requires that in interpreting and applying any statutory provision or rule of law, a court shall, in so far as is possible, subject to the rules of law relating to such interpretation and application, do so in a manner compatible with the State's obligations under the ECHR provisions.

51. Given that the Appellant was not detained in wardship or pursuant to any inherent jurisdiction of a court, it remains to be considered whether he was detained in accordance with the Act of 2001.

52. On the basis that the High Court found that the Appellant was not in fact detained, it appears that the remarks made by the Court in the January 2012 judgment as to the powers of a responsible consultant psychiatrist to decline to discharge a patient under section 28(2) and 29 of the Act of 2001 were *obiter dicta*. Indeed, the comments made as to the definition of 'voluntary patient' are expressly identified as such at paragraph 11 of the December 2012 judgment. However, for the sake of completeness, the Commission submits that neither sections 28(2), section 29, nor any rule of common law, can be relied upon to provide a lawful basis for the deprivation of the liberty of a voluntary patient. Such deprivations of liberty would lack the procedural safeguards against abuse or error required by the Constitution: see *RT v. The Director of the Central Mental Hospital* [1995] 2 IR 65. Even if, *pace Croke v. Smith (No 2)* [1998] 1 IR 101, Article 40.4.1 of the Constitution does not require automatic independent reviews of detention, deprivation of liberty on the basis of sections 28(2) and 29 would be contrary to Article 5 ECHR, which does contain such a requirement, and which requires, additionally, that the law governing conditions for deprivation of liberty be accessible, clearly defined, and foreseeable in its application: see *Medvedyev v. France*, cited above, § 80.

Essentially, Article 5 ECHR requires that national law provide appropriate safeguards against arbitrary deprivation of liberty: see *M v. Ukraine*, cited above, para 58. Plainly, detention under sections 28(2), section 29 or common law would provide no such safeguards.

53. The Commission further submits that no interpretation of sections 28 or 29 of the Act of 2001 based on the 'paternalistic' purposes of the statute can provide a legal basis for *de facto* detention of voluntary patients. On the contrary, it is the Commission's respectful submission that the paternalistic approach sometimes taken by the Irish courts in the interpretation and enforcement of the Act – an approach which is justified by reference to the 'best interests' obligation in section 4 and which reached its apogee in the judgment of the Supreme Court in *EH v. Clinical Director of St Vincent's Hospital* [2009] 3 IR 774 - is difficult to reconcile with the modern philosophy of 'personalisation' enshrined in the UNCRPD. At home and abroad, personalisation, not paternalism, is the 'prevailing idea and concept,' to borrow the words of Walsh J in *McGee v. Attorney General* [1974] IR 284, 319. For instance, the Report of the Expert Group on the Review of the Mental Health Act 2001 to the Department of Health (2015) states:

> *The Expert Group was clear from its first meeting that a substantial shift away from the often paternalistic interpretation of mental health legislation by the Courts is required in order to comply with the European Convention on Human Rights(ECHR) and the United Nations Convention on the Rights of Persons with Disabilities (CRPD).*

54. The Commission submits that any reliance on paternalism in the application of the Act must be qualified, or counter-balanced, by reference to the principles of autonomy, self-determination, liberty and equality, which are the values of the Constitution as much as they are the values of the UNCRPD.

55. The Commission submits very respectfully that, to the extent that the judgment of the High Court in *MMcN and LC v. Health Service Executive* [2009] IEHC 236, Peart J, 15 May 2009, is authority for the proposition that section 29 and

the rules of necessity at common law provide lawful grounds for the detention of voluntary patients without recourse to the procedures provided for in Part 3 of the Act, such proposition is incorrect: there was, the Commission submits, no lawful basis to distinguish the cases of those applicants, who were suffering from dementia and lacked capacity to consent to their confinement, from the applicant in *HL v. United Kingdom,* cited above, who also lacked capacity to decide whether or not to remain in hospital as a voluntary patient.

56. This conclusion does not mean that the Appellant's detention could not have been lawfully achieved. Plainly, sections 23 and 24 of the 2001 Act could have been invoked and, if the conclusion had been reached that the Appellant could not have been detained under the Act of 2001, e.g. on the basis that he was not suffering from a mental disorder as defined in the Act, an application could have been made to detain him in wardship. But, unlike the High Court, a clinician has no inherent power to detain a patient for the purpose of discharge where that patient is otherwise not detainable in the interests of his own safety or the safety of others: on the High Court's power in this regard, see *FX v. Clinical Director the Central Mental Hospital* [2014] 1 IR 280.

57. Accordingly, it is the Commission's respectful submission that the Appellant's detention by the Respondents was unlawful, and that the reliefs at (ii), (iii), (iv) and (v) of the Notice of Appeal should be granted.

58. Entitlement to a declaration of incompatibility under section 5 of the Act of 2003 arises only where no other remedy is available: see *IS v. Minister for Justice, Equality and Law Reform* [2011] IEHC 31, Hogan J., 21 January 2011, para 9. In the circumstances, there is no basis for any such declarations.

E. OTHER ISSUES

Non-compliance with section 28(3) of the Act of 2001

59. In addition to his complaints in relation to his detention, the Appellant complains that the Second Named Respondent did not comply with section 28(3) of the Act of 2001 in that he did not furnish the Appellant or his solicitor

with a notice of discharge as required by that provision. In respect of this complaint, the High Court held:

> *Counsel for the respondents submits that while it has been accepted that the second respondent failed to give a copy of the revocation order to the legal representative, the applicant has not pointed to any prejudice or injustice which has resulted from that failure to strictly adhere to the provision of s. 28(3) of the Act of 2001. I am satisfied that this is correct, and I do not consider it necessary to make any declaration in that regard.*

60. In the respectful submission of the Commission, the High Court erred in finding that the Second Named Respondent's non-compliance with the statutory formality could be excused simply because there was no injustice to the Appellant. As the Commission has argued, there was real injustice to the Respondent in the sense that he was thereafter unlawfully detained, with his solicitor, who was automatically appointed under statute, unaware of his situation.

61. The Commission submits that it is in the public interest and in the best interests of persons having contact with the mental health system that the procedures prescribed in the Act of 2001 be strictly observed by clinicians and rigorously enforced by the Courts: see *WQ v. Mental Health Commission* [2007] 3 IR 755, *AM v. Kennedy* [2007] 4 IR 667, *MD v. Clinical Director of St Brendan's Hospital* [2008] 1 IR 632. Whatever the effect of procedural non-compliance on the lawfulness of detention, it is clear from the judgment of the Supreme Court in *RL v. Clinical Director of St Brendan's Hospital*, Unreported *ex tempore* judgment of Hardiman J, 15 February 2008, that breaches of the Act of 2001 should not lightly be excused.

Delay in Dr -----'s Report

62. The Appellant complains that the delay in the proper consideration of his transfer to an open unit and/or arranging for a risk assessment to be carried out

constituted a breach of his right to privacy and/or right to receive medical treatment in the least restrictive environment as guaranteed by the Constitution and the ECHR. Having considered the complaint, the High Court held, at paragraph 64 of the December 2012 judgment:

> *I have no doubt that in an ideal world such an assessment should take place without any avoidable delay. But delays do happen for all sorts of reasons. In this case it appears to have resulted from the heavy workload endured by Dr. ----- who apparently is one of only four consultant forensic psychiatrists in this State. I have no evidence from which to conclude that during that period of time the applicant was treated other than appropriately in the special care unit which is where it was considered that he should be treated and where he had agreed to be treated, save for the few occasions where he expressed the contrary. I am not satisfied that it would be appropriate to make any declaration that such delay as occurred breached the applicant's rights referred to in the applicant's statement of grounds.*

63. While the Appellant's complaint is included in the Notice of Appeal, it is not addressed in detail in the submissions of any of the parties, and, subject to the Court, the Commission does not propose to make any submissions with respect to it.

Damages

64. Subject to the Court, the Commission does not propose to make submissions with respect to the Appellant's claim for damages.

F. CONCLUSION

65. For the reasons set out above, the Commission submits that the Appellant was unlawfully deprived of his liberty by the Respondents at the material times.

Colin Smith BL

Michael Lynn SC

21 December 2017

(6,774 words)