THE HIGH COURT

[2024] IEHC 564

Record No. 2023 / 336MCA

In the matter of Article 40.3 and 40.4 of the Constitution

and

In the matter of the inherent jurisdiction of The High Court

Between

HEALTH SERVICE EXECUTIVE

Applicant

and

H.H.

Respondent

Judgment of Mr. Justice Conor Dignam delivered on the 3rd day of October 2024

INTRODUCTION

1. The core issues raised in this case are whether nasogastric feeding including under restraint constitutes "treatment" within the meaning of the Mental Health Act 2001 and/or whether it can be lawfully administered under that Act. The Court was asked to make an Order under its inherent jurisdiction permitting nasogastric feeding under restraint to be administered to the respondent if the Court decided that it was not "treatment" within the meaning of the Act or could not be lawfully administered under the Act but for the reasons discussed below it is not necessary to consider this except in a general sense.

2. The matter comes before the Court as follows.

3. The respondent is a young adult. Unfortunately, she suffers from an eating disorder and the medical view at the relevant time was that nasogastric feeding including under restraint, or the possibility of it, was an important part of her treatment plan.

4. There was a considerable volume of material before the Court, including several affirmations of the respondent's treating consultant psychiatrist and affidavits sworn by her Guardian ad Litem who was appointed by the Court. The Court also had the benefit of reports from other experts. I have considered all of this material. Neither side asked that the Court hear oral evidence and therefore the matter was dealt with on the basis of the affidavit evidence, including these expert reports.

5. The respondent has no wish to be the subject of legal proceedings and is entitled to the greatest degree of privacy possible consistent with the constitutional requirement that justice be administered in public. I have, therefore, sought to limit the discussion of her diagnosis and course of treatment as much as possible but it is necessary to refer to them to some extent as they are part of the factual context in which the legal questions arise. I have anonymised the respondent and will refer to her as "H.H." or "the respondent". I have also anonymised the respondent's placement and treating psychiatrist as to refer to them by name would risk the identification of the respondent. I refer to the treating psychiatrist as "Dr. M.A." and to the placement as "the unit", "the hospital" or "the approved centre".

6. In September 2023 the respondent was admitted as an emergency to a specialist eating disorder unit. She was diagnosed with an acute eating disorder. She was treated medically and referred for urgent outpatient management. Over the course of the following month, notwithstanding weekly attendance in outpatients, her condition continued to deteriorate and, following a further drop in her weight, she was admitted (by agreement) to a specialised eating disorder bed in the hospital. At that point she was in the high-risk category for a life threatening event according to the "*Medical Emergencies in Eating Disorder Guidance*" ("MEED Guidance") (to which I refer further below) and at risk of what is called "refeeding syndrome", which can lead to seizures and death and requires close monitoring during early refeeding.

7. Shortly after her voluntary admission, the respondent expressed an intention to discharge herself. Her clinicians were of the view that she was unable to understand that she remained at high risk of a significant adverse event and that she lacked capacity. In those circumstances, the HSE commenced these proceedings by way of an Originating Notice of Motion seeking various reliefs under the Court's inherent jurisdiction, including Orders providing for the detention of the respondent in the approved centre/hospital for the purpose of providing care and therapeutic services and for permission to the staff to provide treatment including nasogastric feeding under sedation and/or restraint if necessary.

8. The HSE moved what was formally an ex parte application on the 12th October 2023, though the respondent was in attendance remotely. I appointed Mr. Niall McGrath, solicitor, as Guardian ad Litem and made the motion returnable for the following day, the 13th October 2023. On the return date, the substantive part of that application was adjourned to the 17th October 2023 in circumstances where the HSE had decided that if the respondent attempted to leave the unit the procedures under the Mental Health Act 2001 would be utilised and therefore the Orders detaining her were not required at that point in time. The respondent was again in attendance remotely.

9. The respondent was in fact detained under section 23 of the Mental Health Act 2001 ("the 2001 Act") on the 12th October 2023 and was admitted as an involuntary patient on the 13th October 2023 pursuant to section 24 of that Act. Sections 23 and 24 apply to persons who are voluntary patients in an approved centre and indicate a wish to leave the centre. The provisions of sections 15 to 22 of the 2001 Act apply as they apply to a person detained under an admission order pursuant to section 14. The detention was on the basis that the respondent was suffering from a mental disorder within the meaning of section 3(1)(a) and (b) of the 2001 Act.

10. The application to the Court was listed and adjourned from time to time over the course of October, November and December.

11. A renewal order under the 2001 Act was made on the 3rd November 2023. This order was revoked by a Mental Health Tribunal on the 20th November 2023 for reasons which are not directly relevant to the current issues. The respondent remained in the unit as a voluntary patient (though, it seems only with significant support from the ward staff) but there was a sudden and, according to the treating psychiatrist, massive resurgence in her eating disorder symptoms leading to a significant loss of weight over a short space of time. The respondent suggested that she could not recover on a voluntary basis and she was again detained as an involuntary patient on foot of an admission order of the 29th November 2023.

12. This admission order was made on the basis that the respondent suffered from a mental disorder within the meaning of section 3(1)(b)(i) of the 2001 Act. The admission order was reviewed by the Mental Health Tribunal on the 18th December 2023 and the Tribunal affirmed the order on the basis that the respondent suffered from a mental disorder on the basis of section 3(1)(b). The fact that she was admitted on the basis of section 3(1)(b) is of some significance to the HSE's arguments discussed below.

13. Unfortunately, notwithstanding this admission order of the 29th November 2023, the respondent was unable to engage with her care plan, and on the 5th December 2023, on the application of the HSE, I granted interim orders under the Court's inherent jurisdiction permitting the medical and nursing staff at the hospital/approved centre to carry out such

medical and/or psychiatric assessment and/or treatment including under reasonable sedation, force and/or restraint, as they considered in the exercise of their clinical judgment to be in the best health and welfare interests of the respondent, including nasogastric feeding.

14. The HSE were direct with the Court from the beginning in stating that there was a jurisdictional question in relation to the making of Orders in respect of nasogastric feeding including under restraint under the Court's inherent jurisdiction. The HSE told the Court that it could only make such Orders under its inherent jurisdiction if the Oireachtas had not provided for such intervention on a statutory basis and therefore the application for relief was being made in order to obtain relief (i) on an interim/interlocutory basis pending that jurisdictional issue being heard and determined, which would of necessity take some time, and (ii) on a longer term basis in the event that the Court determined that nasogastric feeding including under restraint was not provided for on a statutory basis. As I understand it, up to now in all cases where nasogastric feeding was proposed in respect of a patient suffering from an eating disorder, the HSE sought the Court's permission under its inherent jurisdiction and this jurisdictional point has not been determined. However, the HSE's primary position in this case is that nasogastric feeding including under restraint is provided for on a statutory basis because it is "treatment" under section 2 and section 57 of the 2001 Act. Thus, the first questions before the Court are whether nasogastric feeding including under restraint is "treatment" within the meaning of the Act and/or whether it can be lawfully administered under the Act. In its Points of Claim and written submissions, the HSE seeks a declaration "*that nasogastric feeding, including nasogastric feeding under restraint, which is administered to remedy and ameliorate the mental disorder (or its consequences) of an adult who is an involuntary patient under the Mental Health Act 2001 constitutes "treatment" for the purposes of sections 2 and 57 of that Act.*" In reality, on the facts of this case, the question is whether nasogastric feeding under restraint, and not simply nasogastric feeding, is "treatment" for the purposes of those sections. In the alternative, the HSE seeks various Orders providing for the detention and treatment of the respondent, including with nasogastric feeding under restraint, under the Court's inherent jurisdiction.

15. In those circumstances, the relief was granted under the Court's inherent jurisdiction pending a hearing on this legal issue. The Court directed the exchange of written submissions and Points of Claim and Points of Defence. The Guardian ad Litem sought directions from the Court as to the role he should play in respect of the issues arising. Given the importance of the matter for this respondent and its potential to impact on clinical practice and other individuals I indicated that it would be very helpful to the Court for the Guardian ad Litem to assume the role of a legitimus contradictor and, while having an obligation to convey the views of the respondent, to also engage with the legal issues. The Guardian did so and provided extremely significant assistance to the Court. This included obtaining independent psychiatric evidence in respect of the respondent and in respect of the broader issues and carefully addressing the Court on the legal issues.

16. The interim/interlocutory Orders were continued on various dates until this jurisdictional question came on for hearing. I should say that the respondent was in attendance (remotely) at all of the various hearings and I heard from her Guardian ad Litem. The Guardian ad Litem very clearly conveyed the views of the respondent and the respondent was always invited to address the Court. I am satisfied that her views have been heard throughout these proceedings both through the Guardian ad Litem and through her attendance at each hearing.

17. Initially, after the making of this Order, nasogastric feeding was only required on one occasion (on the 6th December 2023, the day after the making of the Order). Restraint was not needed on that occasion. It seems the respondent felt that the making of the Order granted her an ability to engage in recovery in a way which had not previously been possible and that the legal mandate relieved the pressure sufficiently that she could psychologically allow herself to engage with recovery (per Dr. M.A.'s Second Supplemental Affirmation dated the 15th January 2024)(see further below). The nasogastric tube was removed between the 6th December and the 21st December 2023, though the Orders remained in place. Unfortunately, in January 2024, there was a deterioration and nasogastric feeding was used on multiple occasions between the 15th January and the 31st January 2024 including eight occasions under restraint. I deal with what this involves in general and with what it involves for the respondent later in this judgment. This had a stabilising effect but nasogastric feeding continued to be necessary. Dr. M.A. made a Fourth Supplemental Affirmation on the 28th February 2024 and at that date the respondent had had nasogastric feeding on thirty-six occasions since the Order of the 5th December 2023. Twenty-three of these were without restraint and thirteen were delivered to the respondent under restraint leading Dr. M.A. to make the point that the majority of the feeds had been administered without restraint and without physical resistance from the respondent.

18. The matter was heard on the 1st and 8th March 2024. In light of some of the matters raised, it was adjourned for mention for the purpose of considering whether the Attorney General should be joined to the proceedings. The Mental Health Commission had previously been informed of the proceedings by the HSE and had decided not to seek to become involved. I subsequently decided it was not necessary to join the Attorney General at that stage and judgment was reserved. The matter was kept under review by the Court after the hearing due to the nature of the interim/interlocutory Orders which had been made and which continued pending judgment. In Dr. M.A.'s absence whilst on leave, another consultant psychiatrist on the team, swore an affidavit exhibiting a report of the 15th March 2024. She reported that no nasogastric feed using restraint had been necessary since the 28th February 2024 and that in fact the NG tube had been removed.

19. Ultimately, nasogastric feeding was removed from the respondent's treatment plan on the 27th March 2024, the Orders were discharged on the 28th March 2024 (by Quinn J) and the

respondent's involuntary admission was revoked by Dr. M.A. on the 4th April 2024. The respondent remained in the unit for a short period thereafter. In those circumstances, I asked the parties to address me on the question of mootness and I heard submissions on this issue. I indicated that I was satisfied, notwithstanding this development, that I should proceed to determine the matter and give judgment and that I would give my reasons in this judgment. In those circumstances, any discussion of the respondent's circumstances must be taken to refer to the position as they were on the date I reserved judgment.

MOOTNESS

20. The question of mootness was considered by the Supreme Court in *Odum & ors v The Minister for Justice and Equality* [2023] IESC 3, [2023] 2 ILRM 164. Some care must be taken when applying this judgment to the current case as O'Donnell CJ made it clear that the decision was concerned with possible mootness in the context of appeals to the Supreme Court. He said *"…it must again be stressed that this decision addresses the implications of mootness for an appeal that is before this Court. It follows from everything I have said in the course of this judgment that quite different considerations will apply to cases that become moot before they are heard at first instance and, potentially, to many appeals before the Court of Appeal which might not present underlying issues of the kind in question here."* However, while remaining cognisant of those comments and that different considerations apply in this Court, *Odum* is of considerable assistance.

21. The rationale of the mootness doctrine was set out in *Borowski v Canada [1989] 1 S.C.R. 342* (indorsed in *G v Collins [2004] IESC 38*, *Lofinmakin v Minister for Justice [2013] 4 IR 274* and *Odum*). I return to this at paragraph 34 below.

22. The general rule is that a court should not determine an action which is moot. However, it was held in *Odum* (and, indeed, is long-established) that even where a case is technically moot, there remains a discretion in a court to proceed to hear the case (paragraph 10 of *Odum*).

23. It seems to me that the first step is to determine whether these proceedings are moot and, if so, whether I should proceed to give judgment in the exercise of that discretion.

24. I am in fact not satisfied that the proceedings are truly moot. I should emphasise that this is very much a marginal decision for the reasons which I turn to shortly.

25. The definition of mootness is given in *Borowski v Canada*. Denham CJ confirmed in *Lofinmakin* that *Borowski* "*reflects the law of this jurisdiction*" (see also *Odum*). Mootness was defined in the following terms:

> "An appeal is moot when a decision will not have the effect of resolving some controversy affecting or potentially affecting the rights of the parties. Such a live controversy must be present not only when the action or proceedings is commenced but also when the court is called upon to reach a decision. The general policy is enforced in moot cases unless the court exercised its discretion to depart from it."

26. O'Donnell CJ noted in *Odum* that Hardiman J in *G v Collins* and Murray CJ in *O'Brien v Personal Injuries Assessment Board (No. 2) [2006] IESC 62* cited Tribe on *American Constitutional Law* (3rd Edn, Foundation Press 2000) that:

> "…A case is moot, and hence not justiciable if the passage of time has caused it completely to lose "its character as a present, live controversy of the kind that must exist if the Court is to avoid advisory opinions on abstract propositions of law…"

27. Some care must be taken when referring to American authorities as the doctrine of mootness operates different under American law. Nonetheless, the first question for this Court is whether this application has lost "*its character as a present, live controversy*" or whether the Court's decision on the application will not have the effect of "*resolving some controversy affecting or potentially affecting the rights of the parties*" in light of the removal of nasogastric feeding from the respondent's treatment plan and her discharge from the hospital.

28. The evidence contained in Dr. M.A.'s report of the 11th April 2024 and the Guardian ad Litem's affidavit of the 18th April 2024 is that it was likely that the respondent would relapse and would require further admission and treatment. I do not propose to quote at length from Dr. M.A.'s report but it has to be said that it was not at all a positive picture. Importantly, he emphasised that the cessation of nasogastric feeding should not be construed as a sign of significant recovery and went on to say:

> "It is the impression of my team, and shared by [the respondent's] family, that [the respondent] will likely relapse without the support of inpatient care. It is highly likely that further periods of admission will be indicated in the future and that this may again necessitate an involuntary treatment framework."

29. I was satisfied on the basis of the evidence that there was a likelihood of the need for a readmission and treatment and that it therefore could not be said that there was no longer a "live controversy" or a live controversy "*potentially affecting the rights of the [respondent]*" in existence.

30. It is important to say that the "potential" that a party's rights might be affected is by no means open-ended in considering whether a matter is moot. To treat it as such would be to effectively set at nought the doctrine of mootness. However, regard must be had to the

particular context. The health, and in particular mental health, context in this case is particularly important. It would be entirely artificial to draw a bright line whereby it could be said that a patient required treatment on one day and did not require treatment the next. Even on the facts of this case, the respondent's presentation and need for certain forms of treatment varied over a relatively short period of time in late 2023 and early 2024.

31. Thus, I was satisfied that the application was not moot. I had considerable reservation about this conclusion because, on one view, it could be said that the need for Orders on this particular application was spent and if nasogastric feeding was required at a point in the future, that should be the subject of a separate application. However, in circumstances where the discharge had occurred so shortly before I had to determine the matter of mootness and where the evidence made it clear that it was likely that readmission would be required (which I understood to mean relatively shortly after the discharge), that seemed to me to be too artificial in the context of health and mental health matters. Thus, on balance I was satisfied that there remained a controversy potentially affecting the respondent's rights.

32. However, despite this conclusion I also propose to go on to consider the matter as though it is in fact moot, i.e. to consider whether I should proceed to give judgment in the exercise of the Court's discretion. I do so for two reasons: firstly, in case I am wrong in my conclusion that it was not moot; and secondly, time has passed between the expressions of those opinions by the doctor and judgment being reserved. This seems to me to be of potential relevance to the question of whether or not it is moot. My understanding of the evidence was that it was likely that the respondent would require admission and treatment relatively shortly after her discharge. However, a number of months have passed and I have not been informed that the respondent has required admission or treatment (and therefore I am presuming that she has not). It seems to me that for those reasons I should proceed to consider the matter as though it was moot.

33. That a court has discretion to proceed with a matter which is technically moot is long-established and was clearly stated in *Odum*. It is also well established that the Court should be slow to proceed with a matter (either to hear it, or, when it has already been heard, to give judgment) where it is moot. O'Donnell CJ said in *Odum* (paragraph 30), when contrasting the position in this and other common law jurisdictions with the position in America:

> "…In this jurisdiction however, it is clear that mootness is a matter of judicial discretion and cannot be said to be mandated by the Constitution or any other provision of law, albeit, as will be discussed, the law on standing and mootness in Ireland is clearly influenced by constitutional considerations, most obviously the separation of powers."

He went on in paragraph 32 that:

> "Second, however, it is apparent that a core principle can be identified as justifying a principle of mootness in common law jurisdictions. That principle is based on the importance in the common law system of the resolution of cases which can be characterised as present, live controversies. As set out in *Borowski*, this is central to the principle of mootness, because of the interlinked factors of a requirement of a full adversarial context for a legal decision; the management of scarce and expensive court resources; and in cases likely to become precedents, the desirability, and perhaps necessity, of avoiding purely advisory opinions. The strength with which these factors will apply in a particular case will determine the issue of whether a trial or appeal is moot, and the related question of whether, even if moot, the trial, or appeal should nonetheless proceed."

34. The "interlinked" factors referred to by O'Donnell CJ were identified in *Borowski* when setting out the rationale for the doctrine of mootness:

> "The first rationale for the policy with respect to mootness is that a court's competence to resolve legal disputes is rooted in the adversarial system. A full adversarial context, in which both parties have a full stake in the outcome, is fundamental to our legal system. The second is based on the concern for judicial economy which requires that a court examine the circumstances of a case to determine if it is worthwhile to allocate scarce judicial resources to resolve the moot issue. The third underlying rationale of the mootness doctrine is the need for the Courts to be sensitive to the effectiveness or efficiency of judicial intervention and demonstrate a measure of awareness of the judiciary's role in our political framework. The Court, in exercising its discretion in an appeal which is moot, should consider the extent to which each of these three basic factors is present. The process is not mechanical. The principles may not all support the same conclusion and the presence of one or two factors may be overborne by the absence of the third, and vice versa."

35. McKechnie J in *Lofinmakin* also set out a number of matters which a court should consider in the exercise of its discretion. The Court reached a different conclusion in *Lofinmakin* to that in *Odum* but I do not understand O'Donnell CJ to have disapproved of these matters. McKechnie J said:

> "(vii)matters of a more particular nature which will influence this decision include:-
>
> (a) the continuing existence of any aspect of an adversarial relationship, which if found to exist may be sufficient, depending on its significance, for the case to retain its essential characteristic of a legal dispute;
>
> (b) the form of the proceedings, the nature of the dispute, the importance of the point and frequency of its occurrence and the particular jurisdiction invoked;
>
> (c) the type of relief claimed and the discretionary nature (if any) of its granting, for example, *certiorari*;

(d) the opportunity for further review of the issue(s) in actual cases;

(e) the character or status of the parties to the litigation and in particular whether such be public or private; if the former, or if exercising powers typically of the former, how and in what way any decision might impact on their functions or responsibilities;

(f) the potential benefit and utility of such decision and the application and scope of its remit, in both public and private law;

(g) the impact on judicial policy and on the future direction of such policy;

(h) the general importance to justice and the administration of justice of any such decision, including its value to legal certainty as measured against the social cost of the status quo;

(i) the resource costs involved in determining such issue, as judged against the likely return on that expenditure if applied elsewhere; and

(j) the overall appropriateness of a court decision given its role in the legal and, specifically, in the constitutional framework."

36. Many of these reflect the three rationales set out in *Borowski*.

37. I have considered all of these matters and am satisfied that the balance strongly favours me proceeding to determine the matter even if the application is moot. I do not believe it necessary to address each of the factors in turn in explaining why I reach this conclusion.

38. As noted above, the evidence was that it was likely that the respondent will likely relapse and require admission and treatment. The parties have not informed me that there has been any change in that prognosis and I am therefore proceeding on the basis that this remains the case. The significance of this is that in the event that the respondent does require treatment the Court will then have to determine this issue. That would, once again, be in circumstances of some urgency. It is preferable that this complex issue be determined with the benefit of full argument and consideration by the court rather than in urgent or relatively urgent circumstances. The Court has had the benefit of detailed and thoughtful submissions from the HSE and the Guardian ad Litem. It has also had the benefit of independent expert evidence obtained by the Guardian ad Litem, which was of significant value to the HSE and the Court. It would be extremely difficult to obtain such evidence in circumstances of urgency. The Court must also have regard to the fact that Dr. M.A. states in his report of the 11th April that the respondent (in common with many people with severe eating disorders) struggles with uncertainty and that for the respondent "*…the legal process over the past 7 months was a notable source of distress before and after her myriad legal obligations under two separate legal frameworks. This included meeting multiple solicitors, multiple second opinion assessments, and multiple court/tribunal dates. These obligations were a clearly identifiable*

destabilising factor at multiple stages throughout her admission. It is my hope that in the future there is a clearer legal pathway to establishing the necessary safe legal governance of patients in similar cases of severe illness." In the event that the respondent does require admission and treatment, the need for further proceedings if the Court does not give judgment in this application would risk unnecessarily becoming a destabilising factor because a new application would have to be brought and heard. This can not always be avoided but it can be in circumstances where the Court has already heard detailed evidence and legal submissions.

39. Even if it transpires that the respondent does not require admission or treatment, there are strong reasons why the point should be determined. Unfortunately, applications for Orders permitting nasogastric feeding under restraint are not entirely uncommon in the wardship and inherent jurisdiction lists. The jurisdiction point having now been raised by the HSE, it is a point which will require to be determined most probably sooner rather than later. It will require to be determined because respondents to such applications are entitled to know where they stand, and the HSE and treating clinicians are entitled to know what they must do in such cases. McKechnie J identifies "*the nature of the dispute, the importance of the point and frequency of its occurrence*" as a factor be considered. The mere fact that a point might, or even will, come up in the future is not a good enough basis in itself for dealing with a matter which is moot but the nature of this point and the manner in which it will come up is significant. As noted in the previous paragraph, it would be likely to arise in circumstances of urgency. That would mean that the Court would have to determine the matter in a very short space of time without the benefit of full and detailed argument, or the same thing as happened in this case would occur, i.e. the necessity for the nasogastric feeding would come to an end before a full hearing or the determination of the matter, even if they were expedited. The consequence of this is that the courts would have dealt with the matter under its inherent jurisdiction even though the court might ultimately conclude that it does not have such a jurisdiction. That application might also then be said to be moot. Furthermore, if it was determined that nasogastric feeding is provided for under the 2001 Act then the HSE and the clinicians could have just proceeded with treating the patient rather than having to make applications to court. One of McKechnie J's factors was "*the opportunity for further review of the issue(s) in actual cases.*" For these reasons the opportunity for a full review in a future case would be limited.

40. It is of significance that the applicant is the Health Service Executive, a public body with particular functions in respect of the health service. The HSE urged the Court to proceed to give judgment. As discussed above, applications for orders in respect of nasogastric feeding are not uncommon. Thus, the question of whether such orders are necessary or whether the 2001 Act applies might have a significant impact on the functions and responsibilities or the HSE and clinical teams dealing with a patient suffering from an eating disorder. It also follows that there is significant potential benefit and utility in having the matter determined.

41. I also note that the respondent has indicated her desire for the Court to determine the issue in order to reduce uncertainty for other persons who might suffer from an eating disorder. This can not in itself be determinative but it is something that I take into account.

42. Thus, in my view, a consideration of the factors, whether in the terms set out by McKechnie J or, more recently, by O'Donnell CJ, leads to the conclusion that the balance favours the Court proceeding to determine the matter, even if technically moot. It is useful to address the three rationales in *Borowski* referred to by O'Donnell CJ. It is of significance that the "mootness" in this case has arisen after a full hearing. The reason why the "*adversarial context, in which both parties have a full stake in the outcome*" is so important is to ensure that the Court has the benefit of arguments from parties who are fully invested so that the matter can be fully considered. This factor is of less importance in a case in which the matter has become moot after the hearing because the matter has already been fully argued (though it remains important because it may have an impact on whether or not there might be an appeal). In this case, the Court had the benefit of written submissions and full argument over the course of two days, including from the Guardian ad Litem who sought guidance from the Court as to the role he should play in the proceedings. The second factor, judicial economy and scarce judicial resources is, of course, a fundamental issue because the courts must have regard to the interests and rights of all litigants and the expenditure of time and resources on a case that is moot will have an impact on other litigants. This factor applies to the allocation of hearing time and to the allocation of time for the preparation of a judgment. The significance of the latter can not be underestimated, particularly in a complex and sensitive matter. The preparation of a judgment in one case delays the preparation and delivery of judgment in another. That has to be considered and therefore this leans against devoting judicial time to writing a judgment in a case which is technically moot. Nonetheless, this must be balanced with a number of other factors including the fact that the matter was heard over the course of two days and therefore considerable resources have already been devoted to the case, which would effectively be set at nought unless a decision is given, and secondly, the fact that, as discussed above, the point will have to be determined sooner rather than later. This means that if a decision is not given in this case further expenditure of additional court and judicial resources will be required, which will have an impact on other litigants. This, of course, can not be determinative but it does have to be factored into the balance. The third factor, judicial restraint applies in all cases. The courts should not determine matters which do not require to be determined. Furthermore, if there was any question of the Court finding the section to be unconstitutional, for example, this would lean very heavily against a judgment being delivered where the dispute has become moot. For the reasons set out below, I do not do so in this case.

43. Thus, when those factors are weighed in the balance, it seems to me that the balance weighs heavily in favour of proceeding to determine the matter even if it is technically moot.

ISSUES NOT IN DISPUTE

44. The exchange of Points of Claim and Points of Defence crystallised the issues. The parties are in agreement in relation to most of the factual and legal matters. They agree, or at least are not in dispute, in relation to the following matters (some of these are more directly relevant to the question of the Court's inherent jurisdiction).

44.1 There is agreement that the respondent has at all times been suffering from a mental disorder within the meaning of section 3(1) of the 2001 Act by reason of an eating disorder and has been amenable to involuntary detention pursuant to the 2001 Act.

44.1.1 As set out above, for much of the relevant period the respondent was involuntarily admitted to an approved centre pursuant to the 2001 Act. As noted above, the respondent was detained under section 23 of the 2001 Act on the 12th October 2023 and an admission order was made on the 13th October 2023 on the basis that she was suffering from a mental disorder under section 3(1)(a) and (b). This admission order was renewed on the 3rd November 2023. This renewal order was revoked by the Mental Health Tribunal on the 20th November 2023. This revocation was due to the fact that the incorrect date for the expiration of the renewal order was stated in the order and had nothing to do with the substance of whether the respondent was suffering from a mental disorder. She was then admitted by admission order of the 29th November 2023 on the basis that she was suffering from a mental disorder under section 3(1)(b)(i). Thus, although the renewal order of the 3rd November 2023 was revoked and the respondent was therefore not an involuntary patient for a period of time (between the 3rd November and the 29th November), it is clear that she was amenable to admission even during that period and was in fact readmitted under the provisions of the Act on the 29th November 2023 and remained so at the time of the hearing.

44.2 It is not in dispute that at all material times the respondent lacked the capacity to make decisions in respect of her treatment for the eating disorder and was incapable of giving consent in respect of such treatment.

44.2.1 I am satisfied on the basis of the evidence that this is the case. Dr. M.A., the respondent's treating consultant, states at paragraph 16 of his Supplemental Affirmation made on the 21st December 2023, that "*As detailed in my report, at this point the Respondent lacks capacity to make decisions regarding her [eating disorder] treatment on the basis that her judgment is significantly compromised and she is unable to appropriately weigh up information.*" He expressed the view in his report dated the 19th December 2023, which is exhibited to his affirmation, that the respondent's insight

into the severity of her illness remained challenging, that she was reluctant to honestly share information about her ongoing difficulties out of fear that it would result in unforeseen consequences, that she tended to have unrealistic expectations about how rapidly 'recovery' would be achieved and often expressed a readiness to return home after the briefest periods of stability. In his Second Supplemental Affirmation (made on the 15th January 2024), Dr. M.A. dealt with the question of capacity at paragraph 11. It is not necessary to recite the full paragraph. He stated, inter alia, "*In my view, at this point the Respondent continues to lack capacity to make decisions regarding her [eating disorder] treatment on the basis that her judgment is significantly compromised and she is unable to appropriately weigh up information. Although there has been some development of insight and evidence of recovery focussed intention, [the respondent] continues to demonstrate impaired judgment as to the severity of her illness, the relevance of recovery, and her expectations for the future…*" In the report which was exhibited to this affirmation, Dr. M.A. expressed the view that in addition to meeting the criteria in section 3(1)(b), she probably also met the criteria in section 3(1)(a) of the 2001 Act. He also restated this view in his Third Supplemental Affirmation made on the 31st January 2024 in which he exhibited a report of the 24th January 2024.

44.2.2 The Guardian ad Litem asked an independent consultant psychiatrist, Dr Natasya Nor, for her opinion. Dr. Nor provided a report on the 23rd February 2024 in which she found that the respondent continued to suffer from a particular eating disorder, and remained at risk of sudden death should she continue to engage in specified behaviours. She concurred with the capacity assessment of Dr. M.A. in his report of the 24th January 2024 and with the opinion that the respondent met the criteria for mental disorder in section 3(1)(b)(i) and (ii). She stated, inter alia:

> *"7.1 [The respondent] may present with some understanding of the information that was provided to her with regards to her eating disorder diagnosis, risk profile, and benefits of treatment. However, due to the severity of her condition and despite recently much improved BMI, her body weight remains low with significant wish on her part to maintain the low BMI as a "harm reduction" approach, it is extremely likely that her cognitive function is impaired thus negatively impacting on the ability to process and retain information and her decision making ability.*
>
> *7.2 Despite verbal expression of willingness to adhere to a treatment plan on inpatient and outpatient basis, [the respondent] has not displayed the ability to follow through with her intention to fully adhere to the treatment plan. She continues to struggle with her rigid [eating disorder] thinking and continues to engage with eating disorder behaviours resulting in necessary refeeding via NG tube. She did not demonstrate that she was capable to <u>fully</u> process and balance the risks and benefits of her actions in engaging with eating disorder behaviours and the likely decision to leave the approved centre if she* (sic) *her status change to voluntary patient.*

7.3 In my opinion, [the respondent] displayed significant lack of insight into her condition. I believe that due to the severity of [the eating disorder] based on her current clinical presentation, she does not currently have the capacity to make sound judgment and decision regarding her physical and mental health needs which include the ability to consent or to refuse treatment at present time…"

44.2.3 The matter was kept under review after the hearing and, in Dr M.A.'s absence whilst on leave, another consultant psychiatrist on his team, provided a report and swore an affidavit. She expressed very similar views to those of Dr. M.A.. This, of course, can not be determinative in circumstances where it post-dates the hearing, but the fact that it is consistent with the evidence that was before the Court at the time of the hearing is corroborative of the views of Dr. M.A. and Dr. Nor.

44.2.4 There is also some support for the conclusion that the respondent lacked capacity in the opinions expressed by the independent consultant psychiatrists engaged for the purpose of reviews by the Mental Health Tribunal (and indeed in the reports Dr. M.A. prepared for the 2001 Act procedures) in that they conclude that the respondent was suffering from a mental disorder within the meaning of section 3(1)(b), which involves a finding that her judgment is impaired by her illness. However, this could not be determinative as those doctors were not conducting a capacity assessment per se.

44.2.5 I am therefore satisfied that the respondent lacks capacity (or, more properly, lacked capacity at the time of the hearing) to make decisions in respect of her treatment.

44.3 It is accepted by the Guardian ad Litem that the respondent's treatment plan included the option of using nasogastric feeding as a last resort and that it would be administered under least restrictive practice principles. It is also accepted that this approach is in accordance with authoritative international guidelines and the requirements of section 4 of the 2001 Act (which essentially requires all parties to act in the best interests of the respondent).

44.4 It is not disputed that nasogastric feeding may constitute a form of medical treatment for the eating disorder from which the respondent is suffering. It is important to note that while the Guardian ad Litem does not dispute that it may constitute a form of medical treatment for the eating disorder from a clinical perspective, this does not amount to an acceptance that it is "treatment" within the meaning of the Act or that it is "treatment" which can be lawfully administered under the Act.

44.5 It is not disputed that it is a treatment that may be administered to a patient under medical supervision relating to the care and rehabilitation of the patient intended for the purposes of ameliorating a mental disorder.

44.6 It is not disputed that it is a medical procedure which, albeit invasive, is ancillary to, and part of the procedures necessary to remedy and ameliorate the respondent's mental illness or its consequences.

44.7 I am satisfied that these (44.3 – 44.6) are fully supported by the evidence. I return to this below.

44.8 It is not disputed that nasogastric feeding and its availability as part of the respondent's treatment plan was necessary to safeguard the life of the respondent, to restore her to health, to alleviate her condition and/or to relieve her suffering. I also return to this below. This reflects the terms of section 57 of the 2001 Act.

44.9 The parties also agree that if nasogastric feeding does not come within the definition of treatment in section 2 and 57 of the 2001 Act and such feeding cannot be administered to the respondent on an involuntary basis under section 57 then the Court has an inherent jurisdiction to authorise its administration and to make related Orders.

ISSUES IN DISPUTE

45. Where the parties are in disagreement is whether nasogastric feeding including under restraint constitutes "treatment" within the meaning of the Act or whether it can be lawfully administered under the Act. The HSE contends that:

(i) Nasogastric feeding comes within the definition of "treatment" in sections 2 and 57 of the 2001 Act.

(ii) It can be lawfully administered to the respondent on an involuntary basis including under sedation and/or restraint pursuant to section 57 of the 2001 Act.

(iii) Any administration of nasogastric feeding pursuant to the 2001 Act must comply with the requirements of section 4 of the 2001 Act.

(iv) Any administration of nasogastric feeding, whether pursuant to the 2001 Act or pursuant to the inherent jurisdiction, must comply with the requirements of the Constitution and the European Convention on Human Rights.

46. The Guardian ad Litem agrees that if nasogastric feeding can be administered under the 2001 Act then it must comply with the requirements of section 4 of that Act and the Constitution and the European Convention on Human Rights ("the ECHR") (i.e. points (iii) to (iv)). However, his primary position is that nasogastric feeding is not "treatment" within the meaning of section 2 of the Act and can not be lawfully administered pursuant to section 57 of that Act and therefore section 4 does not apply.

47. The following case is pleaded in the Guardian ad Litem's Points of Defence:

47.1 It is not accepted that nasogastric feeding comes within the definition of "treatment" in sections 2 and 57 of the 2001 Act. I return to the basis for this below.

47.2 Alternatively, if it does come within that definition, the Act does not comply with the Constitution (the right to autonomy, dignity, bodily integrity, protection from inhuman and degrading treatment and the right to fair procedures as protected by Article 40.3) or the ECHR (the right to privacy under Article 8).

47.3 It is not accepted that nasogastric feeding can be lawfully administered to the respondent on an involuntary basis (and/or under restraint) pursuant to section 57 of the 2001 Act. I also return to the basis for this below.

47.4 Alternatively, if it can be, then the Act does not comply with the Constitution or the ECHR and the provisions just mentioned.

47.5 It is accepted that if nasogastric feeding can be lawfully administered to the respondent on an involuntary basis, such feeding must comply with the requirements of section 4 of the 2001 Act.

47.6 While it is not pleaded in the Points of Defence, the basis for the contention that nasogastric feeding is not encompassed in the definition of "treatment" in section 2, or that it cannot be lawfully administered under section 57, is that there are no adequate safeguards in respect of the administration of such intervention and therefore, having regard to the Constitution and the ECHR, those sections are not properly interpreted as including nasogastric feeding including under restraint.

48. As noted above, the parties agree that if nasogastric feeding including under restraint does not come within the definition of "treatment" in the 2001 Act or can not be lawfully administered under the Act then the Court has an inherent jurisdiction to authorise its

administration. The HSE takes the position that in those circumstances the Court would have to make a full suite of Orders, including detention Orders. The Guardian ad Litem does not accept that to be the case. In short, the HSE pleads that the inherent jurisdiction would have to entirely supplant the 2001 Act in the case of the respondent, whereas the Guardian ad Litem's position is that the Court may make Orders pursuant to its inherent jurisdiction relating to nasogastric feeding but it is not necessary for the Court to make Orders relating to the detention of the respondent because they may continue to be made under the 2001 Act. Essentially, the respondent would be detained under the 2001 Act but the administration of nasogastric feeding would be under the Court's inherent jurisdiction. It follows from my decision on the interpretation question that it is not necessary or appropriate to decide this particular issue.

QUESTIONS TO BE DETERMINED

49. On that basis, I accept that a useful summary of the issues which first have to be determined is that provided in paragraph 19 of the HSE's written submissions:

> "19.1 First: as a matter of common law, whether NG feeding constitutes a form of medical treatment?
>
> 19.2 Second: as a matter of statutory interpretation, if NG feeding is a form of medical treatment, whether it comes within the definition of "*treatment*" in s.2 of the 2001 Act?
>
> 19.3 Third: if NG feeding is "treatment" within the meaning of s.2 of the 2001 Act, whether it can be administered on an involuntary basis (and/or under restraint) pursuant to s.57 of that Act."

50. These are, of course, interrelated. Nonetheless, subject to the following qualification, they provide a useful framework for analysis. The Order that was sought was to permit nasogastric feeding under sedation and/or restraint, if necessary, and the factual circumstances are that feeding was administered under restraint (on some of the occasions; the other instances took place under the possibility of restraint if the respondent resisted). The Court can only decide matters in concrete factual circumstances and in light of the relief that was sought. Thus, the focus of this judgment is whether nasogastric feeding under restraint constitutes treatment within the meaning of the 2001 Act. It is necessary to make this point because, as I understand the evidence (referred to below), there are cases in which a person may not have capacity to consent but they nonetheless cooperate. That does not reflect the factual circumstances here and therefore the question of whether nasogastric feeding in those circumstances constitutes treatment within the meaning of section 2 and/or section 57 will

have to be determined in an appropriate case. This may be a distinction without a difference but that is a matter for another case.

51. I return to the parties' respective positions on these issues below but first it is necessary to put these questions in context. I first set out the statutory context and then consider nasogastric feeding including under restraint in general and its use in the respondent's case.

STATUTORY CONTEXT

52. I do not propose to set out all of the sections of the 2001 Act that are of relevance. The following sections are of most direct relevance to the issues in the case. I will have to refer to a number of other sections during the course of the discussion.

53. Section 2 of the Mental Health Act 2001 (the definition section) provides, inter alia:

> "2(1) In this Act, save where the context otherwise requires—
>
> "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;"

54. MacMenamin J in *HSE v MX [2012] 1 IR 81* held that this definition of "treatment" is "*not intended to be all-encompassing*" and that the words used are illustrative (paragraph 53 of his judgment). However, it is clear that administration of the intervention must be "*intended for the purpose of ameliorating a mental disorder.*"

55. Section 3 defines "mental disorder". It provides:

> "(1) In this Act "mental disorder" means mental illness, severe dementia or significant intellectual disability where—
>
> (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
>
> (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and

(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent…"

56. Section 4 provides for a "best interests" test. It provides:

"(1) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration to the interests of other persons who may be at risk of serious harm if the decision is not made.

(2) Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this subsection.

(3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy."

57. Section 56 provides:

"In this Part "consent", in relation to a patient, means 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) the consultant psychiatrist 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."

58. Section 57 provides:

"(1) The consent of a patient shall be required for treatment except 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.

(2) This section shall not apply to the treatment specified in section 58, 59 or 60."

59. It is not suggested that the administration of nasogastric feeding falls under any of section 58, 59 or 60. However, as those sections refer to different forms of treatment, it may be helpful to set them out. I will have to refer to section 60 throughout this judgment. It will be noted that, unlike section 57, these contain what have been described as "safeguards".

60. Section 58 provides

> "58(1) Psycho-surgery shall not be performed on a patient unless—
>
> (a) the patient gives his or her consent in writing to the psycho-surgery, and
>
> (b) the psycho-surgery is authorised by a tribunal.
>
> (2) Where it is proposed to perform psycho-surgery on a patient and the consent of the patient has been obtained, the consultant psychiatrist responsible for the care and treatment of the patient shall notify in writing the Commission of the proposal and the Commission shall refer the matter to a tribunal.
>
> (3) Where such a proposal is referred to a tribunal under this section, the tribunal shall review the proposal and shall either—
>
> (a) if it is satisfied that it is in the best interests of the health of the patient concerned, authorise the performance of the psycho-surgery, or
>
> (b) if it is not so satisfied, refuse to authorise it.
>
> (4) The provisions of *sections 19* and *49* shall apply to the referral of a matter to a tribunal under this section as they apply to the referral of an admission order or a renewal order to a tribunal under section 17 with any necessary modifications.
>
> (5) Effect shall not be given to a decision to which this section applies before—
>
> (a) the expiration of the time for the bringing of an appeal to the Circuit Court, or
>
> (b) if such an appeal is brought, the determination or withdrawal thereof.
>
> (6) In this section "psycho-surgery" means any surgical operation that destroys brain tissue or the functioning of brain tissue and which is performed for the purposes of ameliorating a mental disorder.

61. Section 59 deals with electro-convulsive therapy. It provides, inter alia:

> "59(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either—

(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or

(b) where the patient is unable to give such consent—

(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules…"

62. Section 60 reflects section 59(1). It provides:

"Where medicine has been administered to a patient for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either—

(a) the patient gives his or her consent in writing to the continued administration of that medicine, or

(b) where the patient is unable to give such consent—

(i) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

and the consent, or as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained."

63. Section 69 provides:

"69(1) A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the

rules made under *subsection (2)*, to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1,500.

(4) In this section "patient" includes—

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient."

NASOGASTRIC FEEDING IN EATING DISORDERS

Medical Treatment

64. As noted at paragraphs 44.4 and 44.6 above, it is not disputed (i) that nasogastric feeding including under restraint may constitute, from a clinical perspective, medical treatment for the eating disorder from which the respondent is suffering, and (ii) that it may be an intervention which is necessary to remedy and ameliorate an individual's mental illness. This is significant because the definition of "treatment" in section 2 is that it "*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***" (emphasis added). I am satisfied that the position of the parties is supported by the evidence.

65. Dr. M.A. says at paragraph 15 of his Second Supplemental Affirmation (15th January 2024)

> *"a. A necessary part of ameliorating a patient's mental disorder is to manage and ameliorate the adverse physical impacts on them of the symptoms of that mental disorder, including any symptoms which may pose a threat to the patient's life. Malnutrition or even starvation are among the adverse consequences experienced by patients as a result of their eating disorder. Treating those symptoms by appropriate weight restoration and supervised nutritional rehabilitation is therefore a part of treating and ameliorating their mental disorder. NG feeding, including under restraint, is sometimes the clinically necessary and appropriate method of administering a programme of refeeding or nutrition, or at least a part of such a programme.*

b. The starvation and malnutrition caused by an eating disorder can result in physical harm to a patient and can present acute medical risk, but it also adversely affects the brain and cognitive functioning. As a consequence, the psychological symptoms of an eating disorder and its associated pathological thinking (e.g. rigidity, irrational false beliefs) and actions can become more severe and the patient is less amenable and responsive to curative psychological therapy and treatment. The provision of nutrition through refeeding (including NG feeding if oral refeeding is not possible or sufficient) can reverse these processes and thereby ameliorates the effect of the eating disorder on the patient's thinking and behaviour and improves their ability to benefit from other forms of mental health treatment and support for their eating disorder.

c. For patients who do not present with acute medical risk or whose cognition is not impacted by the effects of starvation and malnutrition, the knowledge that their treating team has the lawful authority to administer NG feeding involuntarily if necessary to do so as part of their overall treatment plan (and/or their experience of their treating team actually doing so if that necessity arises) can itself in some cases operate to ameliorate a patient's eating disorder because it provides them with a compelling reason to co-operate with a clinically recommended programme of oral or NG refeeding or nutrition without which they would feel unable to do so, e.g. in their view it takes the personal responsibility for deciding to eat out of their hands or gives them "permission" to accept oral or NG refeeding without the same level of guilt or other adverse reaction as they might suffer if they did not understood (sic) *themselves to be under a legal or practical compulsion to either accept the oral or NG refeeding or undergo NG feeding under restraint."*

66. Thus, Dr. M.A.'s evidence is that nasogastric feeding may be an intervention which is necessary to ameliorate an individual's mental illness for three reasons: (i) to manage and ameliorate the adverse physical impacts on the patient of the mental disorder; (ii) to reduce or reverse the effect of the eating disorder on the patient's thinking and behaviour, which can be made more severe by the starvation and malnutrition caused by an eating disorder, and thereby improve their ability to benefit from other forms of mental health treatment; and (iii) the availability of nasogastric feeding as part of the treatment plan, even where it is not used, can in some cases operate to ameliorate a patient's eating disorder because it can render them able to cooperate with a programme of oral feeding or nutrition. Some doubt is cast on whether the first of these can be said to be intended for the purpose of ameliorating the mental disorder (because it is addressing the consequences rather than the disorder) (see *Dunne, Anorexia nervosa & the law, legal mechanisms for involuntary treatment in Ireland, Medico-Legal Journal 2023, Vol. 91 (2) 93-97*). However, even if that is correct (and I am not be taken as accepting that it is correct), I am satisfied that the second and third are clearly intended for the purpose of ameliorating the disorder.

67. The Guardian ad Litem asked Professor Brendan Kelly, consultant psychiatrist, to address a number of matters including whether, from a medical perspective, nasogastric feeding including under restraint constitutes a form of medical treatment and he provided a report in which he addressed those matters. As noted above, the parties agreed that the matter should proceed on the basis of the affidavits and reports. In the covering letter to his report, Professor Kelly states "*Overall, my report states that nasogastric tube feeding is widely used as part of treatment for severe eating disorders across many jurisdictions, and sometimes involves use of restraint…*" In his report dated the 16th February 2024, he states, "*From a clinical perspective, nasogastric tube feeding constitutes a form of medical treatment that is widely endorsed and accepted as such, and which can be lifesaving in severe eating disorders. On this basis, it is important that patients who lack decision-making capacity have access to this treatment on an equal basis with people who have decision-making capacity.*" He also referred to a report of the UK Royal College of Psychiatrists on "*Medical Emergencies in Eating Disorders: Guidance on Recognition and Management*" (updated in October 2023) (referred to as the "MEED Guidance"). This includes nasogastric tube feeding as one of the services which it recommends that a specialist eating disorders inpatient service should be able to offer. Dr. M.A. confirms in his affirmation of the 15th January 2024 that his team applies the MEED Guidance. Professor Kelly notes that the MEED Guidance also compares "*current evidence-based guidelines for eating disorders*" in other jurisdictions and concludes that nasogastric tube feeding is an internationally recognised treatment for severe eating disorders. Professor Kelly also notes that the MEED Guidance states that "*the patient should be offered food or prescribed dietary supplements in the first instance. If the patient is unable to achieve sufficient intake after 24 hours, NGT feeding should be considered in collaboration with the patient (as much as possible)...*" He noted that the MEED Guidance states that nasogastric feeding should be considered if the patient is unable to achieve sufficient oral fluid and nutritional intake from food or sip feeds to stabilise and restore physical health, if the patient is unable to eat at all but is accepting of nasogastric feeding, if there is life threatening weight loss, or where there is an immediate danger to the patient due to physical deterioration, or the patient presents with clinical or biochemical instability, including those associated with refeeding syndrome. Professor Kelly also notes that the MEED Guidance is endorsed by the Council of the Academy of Medical Royal Colleges, which represents all the Medical Royal Colleges and Faculties in the United Kingdom, the Royal College of Physicians of Ireland, and the Royal College of Surgeons in Ireland, and concludes that the guidance provided in the report, including its endorsement of nasogastric feeding as a medical treatment for severe eating disorder, is therefore broadly endorsed across the medical profession. He also refers to the UK National Institute for Health and Care Excellence 2020 Guidelines on "*Eating disorders: recognition and treatment*", and notes that they refer to "refeeding" as a "treatment" and recognise the need for feeding without consent in some circumstances.

68. Professor Kelly also states that, in his clinical opinion, nasogastric feeding falls within the definition of "treatment" in the 2001 Act. This, however, is a legal question.

69. It is also clear from the HSE Model of Care for Eating Disorder Services (January 2018) that nasogastric feeding is seen as part of the clinical treatment for some persons suffering from an eating disorder. Section 7.4.4, "*Medical interventions in ED treatment*" notes that some people will require medical admission in order "*to initiate refeeding (including nasogastric refeeding) for acute malnutrition, or less commonly as a form of intensive treatment.*" The Model of Care specifically considers nasogastric feeding at section 7.4.5.3 where it says:

> "Although oral feeding is the route of choice of refeeding of restrictive EDs, there is consensus that refeeding by a non-oral method may need to be considered in a small number of patients who have been unable to tolerate oral refeeding for physical or emotional reasons and who are medical unstable. **The nasogastric ('tube') feeding route is the recommended route for non-oral refeeding for patients with anorexia nervosa** (NICE full draft guidelines, 2016). Patient and parent/carer consent for this is crucial and, in the absence of either of these an appropriate legal framework should be considered (see Section 13). Key to this issue is the treatment setting and the training of nursing and medical staff…" [emphasis added]

70. It is also worth noting that it was held in *Re a Ward of Court (No. 2)* [1996] 2 IR 79 that artificial feeding is medical treatment, at least in the context of that case.

71. I am therefore satisfied that the evidence establishes that nasogastric feeding is, from a clinical perspective, a medical treatment for eating disorders, including the eating disorder with which the respondent is suffering, and is an intervention which may be necessary to remedy and ameliorate the mental illness of a person who is suffering from an eating disorder.

Delivery of nasogastric feeding

72. Dr M.A. and Professor Kelly also dealt with what the delivery of nasogastric feeding may involve, including where sedation and/or restraint is necessary. This is key to the issue in this application. Dr. M.A. says at paragraph 16 of his affirmation of the 15th January 2024:

> "16. For the purposes of the intended hearing currently listed for 06 February 2024, I have been asked to describe the physical process of administering NG feeding under restraint. I say as follows:

a. In all cases there is the application of a principle of least restrictive option for the patient. This typically begins with an offer of normal oral meal plan, progression to oral nutritional supplement (ONS), and finally to NG feeding.

b. In all cases, patients have access to a written plan with clear detail of their meal plan and the progression to ONS and NG stages. The detail and rationale is clearly explained to all patients.

c. The application of involuntary NG feeding can vary widely from patient to patient, or for the same patient at different stages in their illness. This can range from cooperative acceptance (albeit in the context of involuntary order) to high level physical restraint by multiple members of staff, with or without the addition of supplemental sedative medication such as benzodiazepines. There are also a range of other lower-level interventions that may be employed which are too numerous to list but may include hand-holding to prevent deliberate pulling of the NG, or restricted access to toilet after feeds to prevent purging, or enforced bedrest to reduce exercise.

d. If progression to NG feeding is necessary, steps are always taken to support the use of NG feeding with minimal need for physical restraint. This always involves the offer to accept NG feeding without resistance. Sedative medication is typically offered where patients experience high levels of distress. Where NG feeding with restraint is considered necessary, a plan is developed to reduce the frequency of the restraint (i.e. larger energy content per feed to reduce the frequency of feeds).

e. Where it is anticipated that recurrent progression to NG feeding is anticipated there is consideration at an MDT level (i.e. input from consultant psychiatrist, senior ward nurses, senior dietician, and senior psychologist) about a person-centred management approach. This meeting will determine details of the NG plan for example: whether the NG tube would be best removed after each use, or remain in situ, the role for sedating medication, the most appropriate level of psychological support for the patient, and the anticipated practicalities of the physical restraint.

f. Episodes of restraint occur in the patient's private room, and all efforts are made to ensure the patient's safety, privacy and dignity.

g. Restraint for NG is applied with an appropriate, patient-specific level of intensity and with minimal use of force as necessary to safely insert the tube and administer the feed.

h. Restraint for NG feeding may vary significantly in terms of duration, although at the extreme end it may last for 30 minutes or longer. This is reflective of the intricacy of tube placement, as compared with restraint for other reasons in approved centres which typically take less than 30 minutes.

i. Following each individual episode of restraint the details are recorded in the patient clinical note, and in the clinical practice physical restraint form. This form must be reviewed/signed

by the responsible consultant psychiatrist within 24 hours. Medical review takes place within 2 hours of the restraint. Formal MDT review happens within 24 hours for all restraints to identify if there are any possible ways to reduce the frequency/intensity, and broader MDT care planning meetings occur weekly in all cases to identify if there are any new or unexplored care needs."

73. Professor Kelly agreed with Dr. M.A.'s account. He drew a distinction (which is reflected in paragraph (c) above) between different categories of patients: (i) involuntary patients who lack the decision-making capacity to consent to nasogastric feeding but cooperate with it (albeit without agreement or under formal protest), and (ii) involuntary patients who lack the decision-making capacity to consent to nasogastric feeding and do *not* cooperate with it, requiring physical restraint in order to administer the treatment. He also stated that:

> "There is significant variation in each person's requirements and pathway in nasogastric feeding. In general, this treatment involves exhausting all less restrictive options initially, developing a written plan with the patient, using as little physical restraint as possible (if any), placing a thin tube from the nose to the stomach, checking tube placement, and administering food through the tube. This can be done within an appropriately equipped and staffed psychiatry inpatient unit ('approved centre'). It can be done relatively quickly if the person cooperates with the procedure (e.g., if they cooperate under protest, but do not physically resist), but it can also require physical restraint for up to 30 minutes or longer (e.g., if the person does not cooperate at all)…
>
> In practice, the duration of each feeding episode, their frequency, and the overall duration of treatment varies significantly between patients depending on the severity of their condition, their degree of cooperativeness, and their response to this and other simultaneous interventions (such as psychological therapy). One 2018 study in Denmark found that patients receiving involuntary tube feeding in anorexia nervosa averaged 70 episodes of involuntary tube feeding per patient, with a median duration of 164 days overall…"

74. As noted above, the respondent has at times not resisted the nasogastric feeding and on other occasions has not cooperated and has required restraint. She has therefore fallen within each of the categories identified by Professor Kelly.

75. Professor Kelly also expressed the view that in addition to the placement of the placement or insertion of the tube and the administration of food, there is a need for other forms of care such as psychological therapy, monitoring of mental and physical health in response to treatment, and use of physical restraint if needed.

Risks

76. Professor Kelly also dealt with the risks of nasogastric feeding. The first relates to the challenge of refeeding at a rate that is optimal for each individual: proceeding too slowly places the patient at risk of nutritional deficiency and death and proceeding too rapidly risks "refeeding syndrome" which is a potentially fatal complication. The second risk relates to the actual placement of the nasogastric tube. The third type of risk relates to the use of physical restraint. This type of risk is associated with the use of restraint in any context. He emphasised that all of these types of risks can be very well managed and even taken together they do not outweigh the "*substantial, lifesaving benefits of refeeding in cases of severe life-threatening eating disorder.*"

Safeguards

77. Professor Kelly also dealt with the question of safeguards for the use of nasogastric feeding. He described the issue of safeguards as "*of key importance and should be considered at several levels.*" I return to what Professor Kelly says about safeguards because it forms part of the HSE's arguments about the adequacy of safeguards.

NASOGASTRIC FEEDING FOR THE RESPONDENT

78. As noted above, it is either accepted or is not disputed that nasogastric feeding including under restraint is a medical procedure which is part of the procedures necessary to remedy and ameliorate the respondent's mental illness or its consequences and that its availability as part of the respondent's treatment plan is necessary to safeguard the life of the respondent, to restore her to health, to alleviate her condition and to relieve her suffering. I am satisfied that this is supported by the evidence and that the administration of nasogastric feeding including under restraint is an appropriate medical intervention for the respondent.

79. Dr. M.A. sets out the general rationale for and benefits of nasogastric feeding in an appropriate case at paragraph 15 of his affirmation of the 15th January 2024 (quoted at paragraph 63 above) and these must be taken as applying to the respondent.

80. He also says in his affirmation of the 15th January 2024 that:

> "12. …the Multidisciplinary treatment plan for the Respondent is that she remains in hospital for treatment of her [eating disorder] to afford her the best opportunity to fully recover from her illness, followed by ongoing treatment as an outpatient. This will continue to include regular

nursing support, psychiatric review, and individual sessions with Psychology, Dietetics, Social Work, and Occupational Therapy, as well as team meetings with the Respondent and her family.

13. The treatment plan continues to include the option of using nasogastric feeding, but this will only be considered as a last resort and will be administered under least restrictive practice principles. It is formulated that in the absence of the NG order, the treatment plan would no longer be effective and that it is essential in maintaining her recovery."

81. Dr. M.A. had explained in his affirmation of the 7th December 2023 that during the initial phase of the respondent's involuntary admission she found the "involuntary" aspect of the process a source of comfort and focus and that she granted herself permission to engage in regular eating since she felt that it was a legal necessity to do so. He was discussing feeding in general rather than nasogastric feeding specifically but this reflects what he said at paragraph 15(c) of his affirmation of the 15th January (quoted at paragraph 72 above) in respect of nasogastric feeding. Unfortunately, the involuntary aspect was removed following the revocation of the renewal order on the 20th November 2023 and there was a sudden resurgence in the respondent's eating disorder symptoms and even when she was once again involuntarily admitted on the 29th November 2023 she was unable to engage with her care plan in a meaningful way. This was the immediate background to the application to administer nasogastric feeding. In relation to nasogastric feeding specifically, he said that the making of the Order by this Court on the 5th December 2023 permitting such feeding had meant that the respondent felt that the legal mandate had granted her an ability to engage in recovery in a way which had not previously been possible.

82. Dr. Natasya Nor was asked by the Guardian ad Litem to provide a second opinion regarding the treatment of the respondent. Dr. Nor is a Consultant Psychiatrist and the Clinical Lead for Dublin North City and County Adult Specialist Eating Disorders Team. She provided a report (23rd February 2024) and made a number of recommendations including that the main focus of the respondent's treatment was inpatient weight restoration through safe refeeding as outlined in the MEED Guidance, that weight restoration be supplemented and accompanied by nursing, psychological, occupational therapy and dietetic interventions to be delivered by eating disorders trained clinicians, to continue with Fluoxetine, close monitoring, and limited access to the bathroom or toilet after feeding. She did not expressly refer to nasogastric feeding in those terms in her recommendations but did express the view that the respondent continued to require "*compulsory treatment in the inpatient setting in a specialised eating disorder bed,* and that "*it remained necessary and appropriate for compulsory treatment to be provided to the respondent as provided by the Orders under the Court's inherent jurisdiction*". This reference to "*compulsory treatment…as provided by the Orders under the Court's inherent jurisdiction*" is, of course, a reference to nasogastric feeding and, therefore, it is clear that Dr. Nor was recommending the continuation of nasogastric feeding including under restraint or the continued availability of same.

83. On the basis of the evidence of Dr. M.A. and Dr. Nor, the independent consultant psychiatrist, I am satisfied that the position taken by the parties is correct.

84. Dr. M.A.'s evidence is that between the 5th December 2023 and the 28th February 2024, nasogastric feeding was administered thirty-six times, twenty-three without the need for restraint and thirteen under restraint where the respondent physically resisted. He set out in his affirmation of the 28th February 2024 that in accordance with the Mental Health Commission's Code of Practice on the Use of Physical Restraint (which I discuss below) the following steps were taken in respect of each instance of feeding under restraint:

a. following each individual episode of restraint, the details pertaining to the use of restraint were recorded in the patient clinical note, and in the clinical practice physical restraint form;

b. administration of nasogastric feeding under restraint triggers a rigorous review process, was carried out by the relevant clinical team members at the approved centre in respect of each individual episode of nasogastric feeding under restraint, as follows:

   i. A short review is carried out with the respondent directly following the administration of the nasogastric feeding under restraint;
   ii. A physical health review is conducted within three hours of the episode;
   iii. A second review of the administration of the intervention is conducted by a consultant within twenty-four hours;
   iv. A review by the full multi-disciplinary team is carried out within five days of the administration of the nasogastric feeding under restraint;
   v. The respondent's care plan is reviewed and, where necessary, is updated;
   vi. The relevant documentary records in respect of those reviews are shared with the Mental Health Commission.

85. Dr M.A. exhibited the records documenting the instances of feeding under restraint. They set out several details in relation to each instance including the circumstances and reason for the administration of the feed, the start and end time and duration, and the alternatives to nasogastric feeding considered. The records show that most of the instances took between 2-3 minutes with some lasting for 5 and 7 minutes. It is worth illustrating the process by reference to examples. It is noted in relation to one instance (on the 26th January 2024):

"1 to 1 nursing support given, offered oral supplement as per plan, support and encouragement given to try help person accept feed without restraint.

Person was in their own private room. Was brought from a standing position to sitting position. Staff stood in front of her to monitor airways and communicate throughout with her. Privacy and dignity maintained. Staff administered NG feed. Staff sat either side and used level 2 hold. 1 to 1 nursing support and time to ventilate feelings, informal debrief, emotion support. Had medical exam within two hours of restraint."

86. In another note, on the 17th January 2024, it was recorded that a medical examination took place within two hours of the restraint and there was "no injury".

GENERAL POINTS

87. A number of general points may be derived from the above which are relevant to the questions of statutory interpretation:

(i) Nasogastric feeding is an established medical intervention and treatment for persons suffering from an eating disorder. It is not used in all cases, but it (or its availability) may, in certain cases, be necessary to remedy and ameliorate the person's mental illness;

(ii) It is an invasive procedure as it involves the insertion of a tube into the patient's body. It is acutely invasive where the person does not cooperate, as it also involves restraint while placing the tube and during the feed.

(iii) As such, it carries with it a risk of injury including from the insertion of the tube and the use of restraint. Indeed, this is clear from Dr. Kelly's report and from Dr. M.A.'s evidence that a physical health review is carried out within three hours of each episode and the notes which show that a medical examination took place to confirm that there was no injury. It also carries with it a risk of a degree of upset or trauma. Such a risk would seem to follow from the imposition of feeding on a patient suffering from a restrictive eating disorder and undoubtedly follows from the use of restraint. It is stated in the Mental Health Commission's Code of Practice on the Use of Physical Restraint 2022 (to which I return) that "*The use of physical restraint may increase the risk of trauma and may trigger symptoms of previous experience of trauma. Therefore, it should only be used in rare and exceptional circumstances as an emergency measure*".

(iv) The evidence establishes that nasogastric feeding under restraint or its availability was an appropriate medical intervention for the respondent.

88. The administration of any treatment without consent would be an interference with the patient's rights. However, the invasive nature of nasogastric feeding, particularly when administered under restraint, is of very particular relevance and is of central and determinative importance to this judgment. In circumstances where the patient does not have capacity to consent, as in this case, it is a direct and particularly significant interference with the person's rights under the Constitution and the European Convention on Human Rights ("the ECHR"). MacMenamin J in *MX v HSE* identified the rights which are interfered with by the administration of involuntary treatment as "*the plaintiff's personal capacity rights, including the right to self-determination, right to bodily integrity, right to privacy, right to autonomy, right to dignity and right to equality before the law; that what was necessary was to achieve the maximum protection which was practicable.*" I see no reason to disagree with this formulation.

89. That is the general context in which the questions of statutory interpretation must be considered.

THE POSITIONS OF THE PARTIES

90. At the heart of the case is the correct interpretation of section 2 and section 57 of the 2001 Act.

91. Before turning to the parties' positions on the correct approach to interpretation and the proper interpretation of the sections, it would be useful to address two questions which are at the heart of the discussion as to the proper interpretative approach and the correct interpretation, i.e. the questions of the need for safeguards and, if safeguards are required, the nature of any such safeguards.

92. Before doing that it would be helpful to briefly refer to *HSE v MX [2012] 1 IR 81* and the subsequent case of *MX v HSE [2012] 3 IR 254* given that they played a central role at the hearing.

93. In *HSE v MX [2012] 1 IR 81 ("HSE v MX")* the defendant was an involuntary patient in the Central Mental Hospital. She suffered from paranoid schizophrenia and a borderline personality disorder which caused her to be a danger to herself and others. She was being administered a number of medications. The medical position was complicated by a potential life-threatening adverse reaction to some of the medication which involved the unpredictable idiosyncratic destruction of the patient's white blood cells. A decline in white blood cell count can have a potentially fatal outcome where, ultimately, a patient may succumb to infection. As a result of this risk, it was clinically necessary to obtain regular blood samples from the

defendant by means of venepuncture in order to detect the possibility of an adverse reaction. Thus, the clinicians were of the clinical view that the medication was necessary and the regular blood samples were necessary in order to safely administer that medication. The defendant objected to the taking of the blood samples. This meant that she would have to be restrained in order for the blood samples to be taken. The doctors assessed that she did not have capacity to make decisions regarding her welfare.

94. The HSE applied to the Court in order to be able to administer the drug regime including taking the blood samples. It bears observing that the reliefs that were sought were slightly unusual. The relief that was sought was either an Order directing "*the defendant undergo treatment deemed necessary by her treating doctor for the purpose of securing the defendant's best medical and welfare interests, including the administration of anti-psychotic medication and any ancillary blood tests considered appropriate, and directing the use of the minimum necessary force and restraint if required*" (per the Irish Report) or for orders "*to permit the administration of a drug regime which necessitated the taking of blood samples ancillary to that regime*" (per the judgment). Neither of these were necessary if the taking of blood samples in the circumstances was "treatment" within the meaning of the Act. In fact, MacMenamin J dealt with the matter on the basis that the substance of what was in issue was whether section 57 encompassed the taking of blood samples ancillary to medication, i.e. was it "treatment" which could be lawfully administered on the correct interpretation of section 57 (see paragraph 11 and 35 of his judgment – in paragraph 35 he identified the question as "*…whether the health professionals have the legal power or authority under the Act of 2001 to actually restrain patients for this purpose, or to draw blood under medical supervision in circumstances such as those which arise here. Is this "ameliorating a medical disorder"?*"). Nonetheless, the nature of the relief that was sought undoubtedly entered into the determination of the case as ultimately the Order that was made was one granting permission for the administration of the medication together with the taking of blood samples, which was, strictly speaking, not necessary if it was "treatment" within the meaning of the Act.

95. The "treatment" was the administration of medication. So the issue was whether the ancillary drawing of blood was "treatment". It was submitted on behalf of the defendant that "*treatment*" should be strictly or narrowly interpreted and that it did not include the taking of blood samples as sought by the plaintiff. The HSE argued that the Act should be given a broad purposive interpretation and therefore did include the ancillary taking of blood samples.

96. MacMenamin J held that "treatment" in section 2 of the Act was ambiguous and capable of being interpreted broadly or narrowly; as the Act was designed for the protection of vulnerable people, and as the Court was under a duty to apply a hierarchy of constitutional values, giving priority to which came highest, and the constitutional values of life and health came higher than autonomy and liberty, it should be given a purposive or broad interpretation;

and it should be interpreted as permitting the "treatment", including the taking of blood samples. He also held that as the evidence showed that the medication was necessary to restore the defendant's health and to alleviate her condition, an interpretation that excluded the taking of the blood samples would mean that those treating the defendant to restore her health through the administration of medication would be precluded from taking measures that were necessary to safeguard her life and that this would be an absurd interpretation.

97. It was submitted by the defendant that the Act was repugnant to the Constitution and incompatible with the ECHR (though declarations to that effect were not sought) because it failed to safeguard the defendant's rights by not providing for an independent tribunal to determine whether she lacked the capacity to consent to treatment or whether the treatment being administered or proposed was appropriate, and failed to provide for the designation of an independent person to represent her in respect of issues where consent would be required. However, it does not seem to have been argued that the absence of these "safeguards" had to be taken into account in the interpretative process.

98. MacMenamin referred to the issue of safeguards at various points in his judgment including paragraphs 75-77 and following paragraphs where he identifies the arguments that were made on behalf of the defendant about the Act's failure to adequately safeguard her rights under the Constitution and the Convention. He noted that there had been no challenge to the constitutionality of the Act and a declaration of incompatibility had not been sought and held that such issues could only be tried in concrete evidential circumstances where the matters were fully pleaded and that it might be necessary to put the Attorney General and the Irish Human Rights Commission on notice (see paragraph 87).

99. In *MX v HSE [2012] 3 IR 254* ("*MX v HSE*"), MacMenamin had to squarely consider whether or not the absence of sufficient safeguards rendered the relevant provisions unconstitutional or non-compliant with the Convention.

100. The patient (the respondent in *HSE v MX*) by way of plenary proceedings sought a number of declarations, including that the finding that she lacked capacity should be subject to an independent review, that the HSE should have to show that the proposed treatment (including the blood tests) was necessary before an independent tribunal or court, and that section 57 was repugnant to the Constitution and was incompatible with the ECHR.

101. The challenge to section 57 was brought on the basis that the plaintiff was being treated under that section. However, at that stage the plaintiff had been receiving medication for in excess of three months. MacMenamin J therefore held that the challenge to section 57 was misconceived because, at that stage, section 60 was applicable. He did go on to consider the position under section 60 of the 2001 Act It will be recalled that section 60 provides for the situation where a person has been receiving medication for in excess of three months and,

unlike section 57, does include an express safeguard in that it requires that the continued administration of the medicine be authorised by another consultant psychiatrist. This is an important distinction between the instant case and *MX v HSE*.

102. MacMenamin J once again held that the correct interpretative approach was a broad purposive approach (see paragraph 26 of his judgment).

103. MacMenamin J held that the vindication of the rights involved (the right to self-determination, bodily integrity, privacy, autonomy, dignity and to equality before the law) "*to a sufficiently high level was necessary because of the serious incursion*" into those rights which arose in the case of persons subject to orders made under section 60. He said that "*[D]ecisions of that type, involving the continued administration of an involuntary drug regime and the taking of blood samples, required in the words of the European Court of Human Rights "heightened scrutiny"…*"

104. MacMenamin J rejected the challenge. He did so on the basis that (i) the law does not require a mandatory or automatic review by a tribunal or court, and (ii) by the application of the double construction rule or its equivalent under section 3 of the European Convention on Human Rights Act 2003. He held that none of the impugned provisions were repugnant to the Constitution or incompatible with the ECHR but that procedures which had been adopted in purported compliance with section 60 "*are to be applied in a constitutional manner…"* His decision (and therefore its significance for the current case) must, of course, be understood by reference to the claims that were made. Insofar as directly relevant to this case, these include the claim that the statutory procedure was unconstitutional or incompatible with the ECHR because it did not provide for any adequate independent review of whether the defendant lacked capacity or of the treatment, in particular that there was no automatic review before an independent tribunal or court.

105. As referred to above, he rejected this on the basis that while an independent review was required, this did not have to be a mandatory ongoing court review and the requirement was met by the requirement in section 60 for an independent second opinion to be obtained. This was fundamental to his decision. He described this as a safeguard.

Safeguards

Requirement for safeguards

106. There was no dispute between the parties about the general requirement that a provision permitting nasogastric feeding under restraint in order to vindicate the right to health

or life must be accompanied or balanced by safeguards in order to vindicate the individual's other constitutional and ECHR rights.

107. As noted by MacMenamin J at page 109 of his judgment in *HSE v MX* , Costello J stated in *RT v Director of Central Mental Hospital [1995] 2 IR 65* in respect of the 2001 Act's predecessor:

> "The reasons why the Act of 1945 deprive persons suffering from mental disorder of their liberty are perfectly clear. It does so for a number of different and perhaps overlapping reasons – in order to provide for their care and treatment, for their own safety, and for the safety of others. Its object is essentially benign. But this objective does not justify any restriction designed to further it. On the contrary, the State's duty to protect the citizens' rights becomes more exacting in the case of weak and vulnerable citizens, such as those suffering from mental disorder. So, it seems to me that the constitutional imperative to which I have referred requires the Oireachtas to be particularly astute when depriving persons suffering from mental disorder of their liberty and that **it should ensure that such legislation should contain adequate safeguards against abuse and error in the interests of those whose welfare the legislation is designed to support**. And in considering such safeguards regard should be had to the standard set by the Recommendations and Conventions of International Organisations of which this country is a member." [emphasis added]

108. MacMenamin J stated at paragraph 69 of his judgment in *MX v HSE* that the decision in *X v Finland (App. No. 34806/04 [2012] 1 MHLR 318* "*…clearly establishes that adequate safeguards must be placed in legislation apparently permitting a patient's involuntary detention and involuntary treatment...*"

109. In *X v Finland,* the European Court of Human Rights ("the ECtHR") had to consider the statutory procedure for the involuntary confinement of an individual to a psychiatric hospital and whether the procedure contained adequate safeguards. The case primarily concerned the procedures concerning involuntary admission and detention (albeit in the context that the admission order contained an automatic authorisation to administer treatment). However, the ECtHR made clear at paragraphs 220-222 that safeguards were necessary in respect of the decision to administer treatment. The Court said, inter alia:

> "220. The Court considers that forced administration of medication represents a serious interference with a person's physical integrity and *must accordingly be based on a 'law' that guarantees proper safeguards against arbitrariness*…
>
> 221. On these grounds the Court finds that the forced administration of medication in the present case was implemented without proper legal safeguards. The Court concludes that, even if there could be said to be a general legal basis for the measures provided for in Finnish law, the absence of sufficient safeguards against forced medication by the doctors deprived

> the applicant of the minimum degree of protection to which she was entitled under the rule of law in a democratic society...
>
> 222. The court finds that in these circumstances it cannot be said that the interference in question was "in accordance with the law" as required by article 8§2 of the Convention. There has therefore been a violation of article 8 of the Convention."

110. MacMenamin J repeated the need for safeguards at paragraph 94 of his judgment where he said, "*I fully agree that the interference with a patient's rights, in cases like the present, is so serious to require adequate safeguards against arbitrariness…*"

111. MacMenamin J did note that many of the cases he referred to were concerned with the right to liberty (and the right to fair trial) rather than the personal capacity rights affected by the administration of treatment without consent. He said at paragraph 58:

> "[58] However, it is noteworthy that these observations, very understandably on the facts, deal with the interpretation and application of the statutes predominantly in the context of the right to liberty and the right to fair trial. The position here is distinct. The case before this court does not concern the right to liberty or fair trial, but rather, the plaintiff's entitlements *while* being treated in involuntary care."

112. Indeed, the fact that the cases dealt with detention rather than treatment was touched on by the parties in the course of the hearing of this application.

113. However, I am satisfied that this has no bearing on the question of whether safeguards in respect of treatment are necessary. Indeed, this is reflected in paragraph 59 and 94 of MacMenamin J's judgment. Having noted at paragraph 58 that the judgments he referred to were concerned with the right to liberty and noting that the MX case concerned "*the plaintiff's entitlements while being treated in involuntary care*", he said at paragraph 59:

> "[59] I do not think there is anything inconsistent with the avowedly paternalistic nature of the legislation or that jurisprudence, insofar as they concern liberty, **in also ensuring that the wishes and choices of a person suffering from a disability, while under such care, should be guaranteed in a manner which, "as far as practicable" (to use the phrase adopted in Article 40.3.1 of the Constitution), vindicates his or her personal capacity rights**. The interpretation of the Constitution in this area of the law should be informed by, and have regard to international conventions. This principle of interpretation, of course, applies *a fortiori* in relation to the regard which, as a matter of law, must be had to decisions of the European Court of Human Rights; see ss.2 to 5 of the European Convention on Human Rights Act 2003." [emphasis added]

114. It will, of course, be recalled that *HSE v MX* only concerned the question of treatment and MacMenamin J said at paragraph 94 (also quoted above) that:

> "I fully agree that the interference with a patient's rights, in cases like the present, is so serious to require adequate safeguards against arbitrariness…"

115. The fact that a decision is in respect of treatment rather than deprivation of liberty (or indeed that both are affected) may be relevant to the question of whether such safeguards as are in place are adequate having regard to the particular scheme. However, the question of whether the safeguards are adequate is a separate question to whether safeguards are required at all.

Nature of the safeguards

116. Considerable guidance as to the nature of the safeguards which might be required is given by MacMenamin J in his judgment in *MX v HSE*. I have touched on this earlier in this judgment.

117. Of course, some care must be taken when considering the judgment because, as just discussed, many of the cases referred to by MacMenamin J relate primarily to safeguards in respect of the deprivation of liberty rather than questions relating to treatment and therefore the nature of the safeguards required may be different.

118. Some care must also be taken due to the fact that the case that was being made in *MX v HSE* was that there was an entitlement to an automatic review by an independent tribunal or court. As will be recalled, in question in *MX v HSE* was section 60. That requires that the authorisation of a second consultant psychiatrist be obtained where medication has been administered for in excess of three months. It was claimed that this was an inadequate safeguard because it was not an automatic review before an independent tribunal or court. The Guardian ad Litem in this case does not contend that there must be a such a review before a tribunal or court but simply some mandatory independent review which allows for an independent "qualitative assessment" of the treatment.

119. What safeguards may be required must be informed by the nature and extent of the interference with the individual's rights. As discussed above, the administration of any medical treatment without consent amounts to an interference with the patient's rights but, as in the *MX* cases, the intervention in question in this case is a particularly significant interference with such rights. MacMenamin J stated at paragraph 72:

> "The vindication of these rights to a sufficiently high level is necessary because of the serious incursion into bodily integrity and the other personal capacity rights which arises in the case of persons who are subject to orders made under s.60 of the Act of 2001. Decisions of this type, involving the continued administration of an involuntary drug regime and the taking of blood samples require, in the words of the European Court of Human Rights, "heightened scrutiny."

120. This judgment must be understood in the context of the nature of the particular intervention in question.

121. It seems to me to follow from the decision in *MX v HSE* that, as a minimum, one of the safeguards that is required is a form of independent review of the decision in relation to treatment. At paragraph 81 of his judgment, MacMenamin J concluded that "*that the plaintiff is entitled to both an independent review…*" and at paragraph 85 said "*…Decisions as to involuntary medical treatment must be subject to the rule of law, and must be independently reviewed. They must be capable of being assessed by a court, and cannot be arbitrary.*"

122. He held that the need for authorisation from a second consultant psychiatrist (who is independent) was sufficient to satisfy the requirement for an independent review. As discussed, *MX v HSE* involved a challenge to section 60 of the 2001 Act on the basis that it did not provide for adequate safeguards, including that it did not provide for an adequate independent review. It was claimed that there was a right to an automatic review by a tribunal or court. MacMenamin J rejected the challenge on the ground that while the patient does have a right to an independent review, section 60 provides for an adequate independent review (the opinion of another consultant psychiatrist required under the section). He held that a mandatory ongoing court review was not required and held that what was required, from a court involvement point of view, was access to the courts, independent of any state agency. At paragraph 94, he held:

> "I fully agree that "the interference with a patient's rights, in cases like the present, is so serious to require adequate safeguards against arbitrariness. What is necessary is a clearly defined procedure, in accordance with law, which vindicates Convention rights to privacy and autonomy involving proper clinical decision making procedures. I believe such safeguards are to be found in section 60 through the requirement for a second opinion from an independent consultant, in relation to the proposed treatment, at regular three month intervals, together with such changes as may be necessitated by this judgment."

Thus, fundamental to his decision was the requirement in section 60 for an independent second opinion. He described this as a review and held that under section 60, the right to independent review was already a "*recognised statutory procedural right*" (see paragraph 70). He said at paragraph 51 that a right of independent review is "*a statutory right provided by section 60 itself.*" He described the section as providing "*for a mechanism whereby the plaintiff's rights and those of the community, can be balanced and protected.*"

123. Section 60 does not expressly provide for the second consultant psychiatrist to be independent of the treating psychiatrist. This was not considered by MacMenamin J but this is explained by the fact that he heard detailed evidence of the operation of the section 60 procedure and that under those procedures the second psychiatrist is clearly independent of the treating psychiatrist (see paragraphs 20-22 of his judgment). MacMenamin J clearly proceeded on the basis that section 60, when applied in a constitutional manner, requires the second psychiatrist to be independent from the treating psychiatrist. He said at paragraph 5 of his judgment:

> "As will be explained, the court does not conclude that any of the statutory provisions impugned are inconsistent with the Constitution. The conclusion is, rather, that procedures which have been adopted in purported compliance with s.60 of the Act of 2001 are to be applied in a constitutional manner, which process, in this specific category of cases, involves a right to independent review and assisted (rather than substituted) decision making. The incursion into the plaintiff's constitutional rights is very significant. It involves medical treatment against her will. The conclusion is that it is only in this manner can the rights of the plaintiff under the Constitution be vindicated "as far as practicable"; Article 40.3 of the Constitution…"

124. That the second psychiatrist must be independent of the treating psychiatrist is also consistent with the decision in *X v Finland*, in which the ECtHR considered the Finnish procedure for involuntary admission and noted that the medical evaluation leading to admission and detention was done by two doctors of the same hospital. The Court said:

> "…The patients do not therefore have an opportunity to benefit from a second, independent psychiatric opinion. The Court finds such an opportunity to be an important safeguard against possible arbitrariness in the decision-making where the continuation of confinement to involuntary care is concerned."

125. Thus, at the core of MacMenamin J's judgment was the requirement that there be an independent review, but he was satisfied that same was sufficiently provided for by section 60 when applied in a constitutional manner so as to require a second opinion from a doctor who was independent of the treating doctor.

126. It will, of course, be recalled that section 57 does not contain an equivalent provision.

127. It seems to me to follow from this judgment that the administration of nasogastric feeding must at a minimum be accompanied by the safeguard of an independent review of the treatment in addition to access to the courts to challenge such decisions (see paragraph 85 of the judgment, quoted at paragraph 121 above, where MacMenamin J said "*…Decisions as to*

involuntary medical treatment must be subject to the rule of law, and must be independently reviewed. They must be capable of being assessed by a court, and cannot be arbitrary." The question for the Court in this application is whether any safeguards which are place are adequate to lead to the conclusion that the correct interpretation of section 2 and/or and 57 encompasses nasogastric feeding under restraint, and in particular whether there is provision for an adequate review.

128. I should emphasise two points.

129. First, my conclusion that an independent review is required is not a reflection on the treating doctor or team in this case. MacMenamin J touched on this in his judgment in *HSE v MX*. At paragraphs 3-6 he said, inter alia:

> "[3]…Traditionally, in our law, the views of experts in the discipline have justifiably received great weight and respect. In this jurisdiction, we are fortunate enough that we can place a high degree of trust in our clinicians. This is based on both that tradition and modern-day experience.
>
> [4] Internationally, however, abuses in psychiatry are not unknown; in some countries it has been used as a mechanism for state oppression of legitimate dissent. As in all disciplines, including the law, psychiatry is in a state of constant evolution where even consensus views of a quarter of a century ago might now be questioned.
>
> [5] Also, as in all disciplines, there is a possibility of honest error, for subjective opinion supervening over what should be accepted as established, objective diagnostic criteria, even on issues as vital as legal capacity...
>
> [6] …denial or deprivation of procedures to a vulnerable person can have radical consequences, including a loss of many civil rights…"

It was submitted to MacMenamin J that a strict or narrow interpretation should be given to the Act because the "best interests" test in section 4 of the Act can be vague and imprecise and in some circumstances *"..might allow for a long series of invasive procedures without adequate safeguards*" He said at paragraph 44:

> "There is much force in this submission. In so observing, I mean no reflection on the treating psychiatrists in this case. However, one must have regard to other contingencies, in other cases, and other institutions… As has been found in other jurisdictions, trust, without mechanisms of review and verification, may be abused."

Furthermore, Costello J in *RT v Director of Central Mental Hospital* noted the need for "*safeguards against abuse and error*".

130. Second, I appreciate that the evidence is that each episode of nasogastric feeding with restraint is followed by a review by a consultant psychiatrist within 24 hours and a review by the full multi-disciplinary team within 5 days. The clinicians engaged in these processes are obliged to exercise their independent judgment. However, as discussed above, one of the matters which caused the ECtHR to conclude that the safeguards were not adequate in *X v Finland* was that the second opinion was given by another doctor in the same hospital as the doctor who made the relevant decision (in that case the decision to admit, which carried with it an automatic authorisation to treat).

Parties' positions

131. Initially (in its written submissions), the HSE's position in relation to the correct interpretative process was that the sections should be interpreted independently of a consideration of the adequacy of any safeguards. Therefore, the written submissions did not address the questions of whether and what particular safeguards might be necessary to ensure the administration of nasogastricc feeding under the Act in compliance with the Constitution and the Convention. This was partly in reliance on what was described as "*…the approach taken by the Court in HSE v MX [2012] 1 IR 81 of leaving over consideration of adequacy of safeguards to a subsequent – and potentially, differently constituted – hearing*" (paragraph 22 of the HSE's written submissions).

132. However, its position (in relation to the correct interpretative process, not the actual interpretation) evolved during the proceedings in response to the written submissions delivered on behalf of the Guardian ad Litem.

133. The Guardian ad Litem's position in those submissions (and at the hearing) as to the correct interpretative approach was that a consideration of the adequacy (or inadequacy) of any safeguards must be part of the process of interpreting section 2 and section 57. This was put in various ways, including that "*…the definition of "treatment" cannot be severed from the issue of safeguards in the context of the statutory interpretation exercise in which the Court is engaged*" and that "*in considering whether the Court should make the Declaration sought by the HSE, that the preferred approach is to consider the entire statutory scheme. These submissions suggest that a consideration of the issue of safeguards cannot be decoupled from the meaning of "treatment" under the 2001 Act.*" It was submitted that the entire statutory scheme must be considered when engaging in the interpretation of section 2 and section 57, and at paragraph 38 of the written submissions it was submitted that "*…when section 2 is considered having regard to its relationship with the statutory scheme as a whole (including*

section 57 and the absence of safeguards in respect of "treatment", including treatment which is delivered to a person who lacks capacity, in respect of which they do not consent and which will be administered under restraint), there must be doubt as to whether section 2 captures nasogastric tube feeding."

134. The Guardian ad Litem also relied on the double construction rule and its equivalent in section 2 of the European Convention on Human Rights Act 2003.

135. At the hearing, Senior Counsel for the HSE indicated that, having considered the Guardian ad Litem's written submissions, the HSE now accepted that the question of safeguards is an important part of the Court's interpretative function and indicated that they were not pushing the approach that the safeguards are a separate matter to be considered at a later stage. He explained that paragraph 87 of the judgment in *HSE v MX* was important from the point of view of the Court understanding the approach initially taken by the HSE (i.e. in its written submissions) but they now accepted the force of the Guardian ad Litem's argument that in order to deliver a constitutionally and Convention-sound interpretation of "treatment", it may be necessary to consider the question of safeguards as part of the interpretative process. The HSE's position was stated as being that for the Court to find, in discharging its interpretative function, that the definition of "treatment" includes the delivery of nasogastric feeding under restraint it would need to be satisfied that it could be done in a Constitution and Convention-compliant manner and that clearly requires that safeguards are in place, and that the question is whether the safeguards that are provided for within the Act and outside the Act are sufficient to allow that interpretation to be sound.

136. The entire focus of the oral submissions on behalf of the HSE was therefore on the safeguards that are in place. It was submitted that those safeguards were sufficient. Thus, the approach taken by the HSE at the hearing was that the Guardian ad Litem was correct in relation to how the interpretative exercise should be conducted but that the interpretation of "treatment" as including nasogastric feeding including under restraint was constitutionally and Convention-sound because there are adequate safeguards in place.

137. In those circumstances, the focus of this judgment is on whether, having regard to what the HSE have identified as safeguards, the correct interpretation of section 2 and section 57 is that nasogastric feeding under restraint is "treatment" and/or can be lawfully administered section 57.

138. However, I will have to briefly say something about the interpretative process because, in the HSE's reply, further reference was made to the HSE's position being that the question of safeguards might be better left over to be tried in a second set of proceedings but that, if the HSE was wrong on this, its engagement with the safeguards showed that there were adequate safeguards. This appears to suggest that the HSE was, at least to some extent, maintaining

the position that the sections should be interpreted without regard to the question of safeguards, i.e. the approach adopted in *HSE v MX*.

139. On the substantive issue of the correct interpretation, the HSE submitted that the reasoning and decision in *HSE v MX* are determinative of the question of whether nasogastric feeding is encompassed in the definition of "treatment" "*and compel a finding that NG feeding falls within the meaning of "treatment" as defined in the 2001 Act.*" The HSE's submissions set out in detail the basis upon which this was contended, including important findings by MacMenamin J at pages 101-106. Emphasis was placed on the finding at page 105-106 of that judgment that:

> "The court in its interpretation of the Act of 2001 and in the assessment of the defendant's best interests, should allow for a medical procedure which, albeit invasive, is ancillary to, and part of, the procedures necessary to remedy and ameliorate the mental illness or its consequences. Clearly "treatment" could not include measures or procedures which are entirely unrelated to a patient's mental illness."

140. As discussed above, it was also submitted that there are adequate safeguards in place to interpret section 2 and/or section 57 as including nasogastric feeding.

141. On the substantive issue of the correct interpretation, the Guardian ad Litem did not dispute that from a clinical perspective, nasogastric feeding constitutes medical treatment, and that it may be an intervention which is necessary to remedy and ameliorate an individual's mental illness, but submitted that there are inadequate safeguards in respect of the delivery of nasogastric feeding under restraint, and the Act is therefore properly interpreted as not including such intervention within the meaning of "treatment" or at least treatment that may be lawfully administered under section 57. This follows, it is submitted, from an interpretation of the sections which has regard to the nature of the rights involved and the Constitution and the ECHR. Alternatively, it arises from the application of the double construction rule or its equivalent in section 3 of the 2003 Act. It was accepted that MacMenamin J had held in *HSE v MX* that a broad or purposive approach should be adopted to the 2001 Act, but it was submitted that even within such an approach, a provision which provides for the administration of an invasive intervention such as nasogastric feeding under restraint in the absence of safeguards would be contrary to the Constitution and ECHR.

APPROACH TO INTERPRETATION

142. The 2001 Act directly and fundamentally impacts on constitutional and Convention rights, including, for example, the right to liberty, the right to life, and the right to bodily

integrity. The administration of what is a particularly invasive intervention directly engages those fundamental rights.

143. In my view, in relation to such an Act, which directly concerns matters regulated by the Constitution and the ECHR, the approach to interpretation advanced by the Guardian ad Litem, ie. that the Constitution and the ECHR, and therefore the adequacy of safeguards for those rights, must be taken into account as part of the interpretative process, is the correct approach. In my view, counsel for the HSE was correct to acknowledge the force in the Guardian ad Litem's argument on this point.

144. It is long-established that statutory provisions must be interpreted in light of the provisions of the Constitution. This is particularly so where the provisions relate to matters which are regulated by the Constitution. This arises from the presumption of constitutionality. The requirement to have regard to the Constitution and the ECHR operates on a number of different levels: for example, as between two interpretations, one of which is of doubtful constitutionality whilst the other has no such doubts attached to it, the Court may readily conclude that the latter is the correct interpretation (see *Croke v Smith (No. 2)[1998] 1 IR 101 (see paragraph 61 of HSE v MX)*); alternatively, where a number of possible interpretations are open, all of which are constitutional, the Court may conclude that the correct interpretation is the one which best accords with the Constitution. The double construction rule may also be of application in certain instances.

145. It seems to me that this is consistent with the approach to statutory interpretation which was recently set out in *Heather Hill Management Co CLG v An Bord Pleanála [2022] IESC 43* and *A, B and C v The Minister for Foreign Affairs and Trade [2023] IESC 10*.

146. The correct approach to statutory interpretation was set out by Murray J on behalf of the Supreme Court in *Heather Hill*, in particular at paragraphs 105-116. Given the acceptance by the HSE of the force of the Guardian ad Litem's argument as to the interpretative approach it is not necessary to quote at length from these paragraphs. It suffices to refer to the summary given by Murray J at paragraph 73 of his subsequent judgment in *A, B & C (A Minor) v The Minister for Foreign Affairs and Trade [2023] IESC 10*.

147. In that paragraph, he said:

> "73. In answering these questions, it is to be remembered that the cases – considered most recently in the decision of this court in *Heather Hill Management Company and anor v An Bord Pleanála* [2022] IESC 43, [2022] 2 ILRM 313 – have put beyond doubt that language, context and purpose are potentially in play in *every* exercise in statutory interpretation, none ever operating to the complete exclusion of the other. The starting point in the construction of a statute is the language used in the provision under consideration, but the words used in that

> section must still be construed having regard to the relationship of the provision in question to the statute as a whole, the location of the statute in the legal context in which it was enacted, and the connection between those words, the whole Act, that context, and the discernible objective of the statute. The court must thus ascertain the meaning of the section by reference to its language, place, function and context, the plain and ordinary meaning of the language being the predominant factor in identifying the effect of the provision but the others always being potentially relevant to elucidating, expanding, contracting or contextualising the apparent meaning of those words."

148. The Constitution and the ECHR are clearly part of the legal context of the words of a statute which is directly concerned with, and impacts on, fundamental constitutional and ECHR rights and therefore are part of the context within which those words must be read and understood.

149. In *Heather Hill*, Murray J accepted that reference could be made to the Aarhus Convention in interpreting the section in question as it was seeking to give effect to that Convention. He noted that it was held by Murray J (as he then was) in *Crilly v T&J Farrington Ltd* [2001] 3 IR 251 (at page 291) that when interpreting a statute which is to give effect to an international treaty the court can have regard to the meaning of relevant provisions of the treaty concerned. Murray J went on at paragraph 180 of his judgment in *Heather Hill* to say that in light of Article 29.6 of the Constitution "*…this approach does not enable the over-riding of the clear words of an Act*" but that "*'if one of the meanings which can reasonably be ascribed to the legislation is consonant with the treaty obligations and another or others are not, the meaning which is consonant is to be preferred' Salomon v Commissioners v Customs and Excise [1967] 2 QB 116 at p.143…*" This is, of course entirely consistent with a contextual approach. It seems to me that the same reasoning applies to the Constitution and Convention.

150. It seems to me that to adopt an approach to the interpretation of a statutory provision which directly and fundamentally impacts on constitutional and Convention rights, such as the rights in question in this case, without having regard to those instruments, would be to disregard a very significant part of the legal context of the statutory provision.

151. Furthermore, in this particular instance, the 2001 Act itself makes the Constitution an integral part of the statutory scheme and context through section 4. It provides at subsection (3) that in making a decision under the Act concerning the care or treatment of the person due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy. Therefore, even remaining within the four corners of the Act itself, the protection and vindication of the identified constitutional and ECHR rights must be treated as part of the context.

152. I do not believe that the approach of considering the Constitution and the ECHR as part of the relevant context is inconsistent with the interpretative approach adopted by MacMenamin J in *HSE v MX*.

153. Firstly, it was pointed out by Senior Counsel for the HSE that at paragraph 52 of his judgment MacMenamin J set out what was in substance a *Heather Hill* approach. MacMenamin J said at paragraph 52:

> "Should such an approach [strict or literal approach that is adopted in criminal cases] apply here in light of the rights issues involved? In what follows, I now focus on an analysis of the precise words of the definition of "treatment"; this will be followed by a consideration of other provisions in the Act of 2001 as an aid to interpretation. I will then consider the constitutional values which are embodied in the Act as an aid to such interpretation. Finally, I will return to the question of interpretation of the Act in a manner "compatible with constitutional duties" and those obligations which arise "under the Convention provisions" (s.2 of the European Convention on Human Rights Act 2003"). Here it will be necessary to at least identify matters arising from the duty of every organ of State, including the plaintiffs, and this court, to perform its functions in a manner compatible with the obligations under the Convention provisions…
>
> I preface what follows by the observation that the word "treatment" in the section is ambiguous. It is capable of being interpreted broadly or narrowly. It is necessary then to look at the purpose of the enactment. It is to be presumed that the interpretation which gives effect to the purpose of the Act is that intended by the legislature; section 5 of the Interpretation Act 2005. The meaning best promotes the purpose is that to be favoured; see Dodd *"Statutory Interpretation in Ireland* (2008 Tottel) *at para. 6.15…"*

154. As indicated in that passage, MacMenamin J did in fact have regard to the Constitution and the ECHR in the interpretative process. That is clear from paragraphs 56 – 61 which appear under the heading "*Interpreting the Act in accordance with the constitutional rights engaged*". In the circumstances of that case, he did so to a large extent for the purpose of deciding the correct interpretative approach rather than specifically when determining the precise interpretation (see paragraphs 41 and 56-62). That is because of the way the case was argued. The main dispute in *HSE v MX* about the correct interpretative approach was as to whether the Court should adopt a narrow or broad purposive approach. It appears to have been contended that the Act was unconstitutional or incompatible with the ECHR because of the absence of adequate safeguards rather than that the section should be interpreted in a particular way due to the absence of safeguards (as is argued in this case). At paragraph 87, MacMenamin J held that because it was argued that the Act was therefore unconstitutional or non-compliant with the ECHR, the question of the absence of safeguards was a matter to be dealt with in another case involving the Attorney General. Therefore, he did not decide the issue in question here, i.e. that the question of safeguards should be considered as part of the context.

155. Thus, I do not believe that the interpretative approach contended for by the Guardian ad Litem is inconsistent with the decision in *HSE v MX* because the approach urged by the Guardian ad Litem was not the issue in that case. If the approaches are inconsistent then I am bound to follow the approach in *Heather Hill* and *A, B & C (A Minor)*.

156. Of course, I am bound by *HSE v MX* to, insofar as relevant and necessary, interpret the Act in a broad, purposive manner. This is not inconsistent with *Heather Hill* or *A, B & C (A minor)*. The requirement to do so and the requirement to have regard to the Constitution and the ECHR in the interpretation of the sections are not necessarily mutually inconsistent.

157. The Guardian ad Litem also raised the double construction rule and its equivalent under section 3 of the European Convention on Human Rights Act 2003. The question of how these rules sit with this contextual approach was not explored at the hearing and I therefore do not consider this particular issue here. For the reasons which follow I do not believe it is necessary to consider the matter under the double construction rule or its equivalent in section 3. It is also important to note O'Donnell J's comments in *Defender Ltd v HSBC France* [2021] 1 IR 516, 1 ILRM *Supreme Court, 3rd July 2020)*(referred to in *A, B & C*) where he said at paragraph 99:

> "…there are some difficulties with applying this interpretive approach at this point in the proceedings and by reference only to the arguments of the plaintiff and the defendant. The double construction rule arises most naturally when there is a direct challenge to the constitutionality of a statute and where the possibility of a differing, but constitutional, interpretation may arise. However, where the constitutionality of an Act of the Oireachtas is challenged, the Attorney General is a mandatory party to the proceedings. It is at least possible that the Attorney General might advance arguments – and possibly adduce evidence – showing that the first interpretation, presumptively deemed unconstitutional is in fact constitutional and, indeed, intended. If the double construction rule is applied in private law proceedings between private parties it is possible that an unjustified unconstitutionality will be assumed and an unjustified interpretation accepted, which moreover would become applicable generally, defeating the legislative intention."

158. These proceedings, of course, are not strictly speaking, "*private law proceedings between private parties*" and therefore those comments do not apply with the same force, but, nonetheless, where the Attorney General is not a party to the proceedings and I find it unnecessary to determine the matter by the application of the double construction or section 3 of the 2005 Act, it seems to me that I should not consider those rules.

159. In my view, the correct approach to determining whether section 2 or section 57 includes nasogastric feeding under restraint, must involve regard being had to the provisions of the Constitution and the ECHR. That involves a consideration of whether there are adequate safeguards. As discussed above, in light of the position taken by the HSE – correctly in my view – this is the real focus of the dispute.

INTERPRETATION OF SECTION 2 AND 57

160. Before considering the interpretation of section 2 and section 57 I should refer to the submission of the HSE that *HSE v MX* has effectively decided the issue. It was submitted that the reasoning and decision in that case are determinative of the question of whether nasogastric feeding under restraint is encompassed in the definition of "treatment" and "*compel a finding that nasogastric feeding falls within the meaning of 'treatment' as defined in the 2001 Act*". I do not accept that this is correct. As is clear from above, *HSE v MX* and *MX v HSE* are, of course, relevant and of considerable assistance but neither compels a particular outcome in this case. Firstly, the medical issue in question in the *MX* cases was different and this interacts with the legal position. The medical issue was the necessity for regular blood tests ancillary to the administration of medication. The legal question in *HSE v MX* was not whether the medication was "treatment" but whether the ancillary blood tests could fall within the meaning of "treatment". The medication was clearly treatment, and this led to the conclusion that it would be a wholly absurd interpretation that the doctors would be able to administer medication to treat the mental illness but not be able to take blood samples to ensure that the medication would not cause the patient's death. Secondly, while it did not have to be considered in the *MX* cases, the fact that the principal treatment was the administration of medication meant that it would only fall within section 57 for a limited amount of time of three months before it was captured by section 60 and the safeguard contained therein. The administration of nasogastric feeding is not subject to any such limitation. Thirdly, as discussed at length above, while MacMenamin J in *HSE v MX* had regard to the Constitution and ECHR, he was not asked to determine the correct interpretation in light of the alleged inadequacy of the safeguards. Fourthly, when, in *MX v HSE*, he did have to consider the constitutionality and ECHR-compliance of the Act in light of the alleged inadequacy of the safeguards in place in *MX v HSE* he was considering section 60 rather than sections 2 and 57 which are at issue in this case. Section 60, unlike section 57, does in fact contain an express safeguard. He was therefore considering a fundamentally different statutory provision. This is a fundamental difference between the two cases.

161. Thus, while there are some similarities in that both interventions are invasive and an interference with a number of constitutional rights, there are also significant differences between the two situations. It seems to me therefore that I must consider whether, on the proper interpretation of section 2 and/or section 57, the involuntary administration of nasogastric feeding under restraint constitutes "treatment" or can be lawfully administered under the Act.

162. There would be considerable merit to taking section 2 and 57 together. This is essentially the approach adopted by the Guardian ad Litem and to some extent by the HSE. The two sections are interconnected both because the definition of "treatment" in section 2 itself encompasses the notion of the "administration" of something and also because section 57 must, of course, be understood by reference to the definition of "treatment" contained in section 2. On this latter point, it is worth noting that section 57 appears to apply to a broader range of "treatments" than are specified in section 2 in that it appears to apply to treatments other than ones intended for the purpose of ameliorating a mental disorder. This was not explored at the hearing, but nothing turns on it in this case in circumstances where there is no dispute, and I am satisfied, that nasogastric feeding in certain circumstances (including this case) is intended to ameliorate the mental disorder. Thus, on one view, the core question is whether "treatment" as used in both sections includes nasogastric feeding under restraint and therefore the two sections should be taken together. However, it seems to me that the more correct way of approaching the interpretative process is to treat each section separately, though being cognisant that each are part of the other's relevant context. This is because it is entirely possible, on the level of principle, that the definition in section 2 could be interpreted as including nasogastric feeding under restraint but section 57 might be properly interpreted as not permitting its administration. In other words, different considerations apply to the question of whether something is or is not "treatment" within the meaning of section 2 and to the question of whether, even if it is "treatment", it is something which is authorised to be administered on the proper interpretation of section 57. I therefore address the two sections individually, while at all times having regard to the other as part of that exercise.

163. In interpreting the sections, regard must be had to section 5 of the Interpretation Act which provides:

> "(1) In construing a provision of any Act (other than a provision that relates to the imposition of a penal or other sanction) –
>
> (a) that is obscure or ambiguous, or
>
> (b) that on a literal interpretation would be absurd or would fail to reflect the plain intention of –
>
> (i) in the case of an Act to which paragraph (a) of the definition of "Act" in section 2(1) relates, the Oireachtas, or
>
> (ii) in the case of an Act to which paragraph (b) of that definition relates, the parliament concerned,
>
> that provision shall be given a construction that reflects the plain intention of the Oireachtas or parliament concerned, as the case may be, where that intention can be ascertained from the Act as a whole."

164. In summary, I conclude that on balance nasogastric feeding under restraint does constitute "treatment" within the meaning of section 2, but that section 57 is not properly interpreted as applying to nasogastric feeding under restraint or permitting its administration

without consent. In relation to section 2, I am of the view that the ordinary and natural meaning of the words (supported by other factors) clearly point to nasogastric feeding being "treatment" and that while a consideration of the constitutional (and ECHR) position shows that there are inadequate safeguards in respect of its delivery, this does not compel or permit a departure from the ordinary and natural meaning of the words as supported by those other factors. Section 57 is concerned on the other hand with the administration of the treatment without consent and the adequacy of safeguards is much more central to the question of whether, on the proper interpretation of the section, it applies to that treatment. The mere fact that something is "treatment" is not determinative of the interpretation of section 57 and whether that treatment can be lawfully administered under that section.

165. I am satisfied that nasogastric feeding is, as a matter of the general or common law, a form of medical treatment. That is clear from *Re a Ward of Court (No. 2)* [1996] 2 IR 79.

166. In the interpretation of a statutory provision, the "*first and most important port of call are the words of the statute itself, those words being given their ordinary and natural meaning*" (McKechnie J in *DPP v. Brown [2019] 2 IR 1* quoted at paragraph 106 and repeated at paragraph 215 of *Heather Hill*). Murray J went on to say at paragraph 115 of his judgment in *Heather Hill* that:

> "the words of a statute are given primacy within this framework as they are the best guide to the result the Oireachtas wanted to bring about. The importance of this proposition and the reason for it, cannot be overstated. Those words are the sole identifiable and legally admissible outward expression of its members' objectives: the text of the legislation is the only source of information a court can be confident all members of parliament have access to and have in their minds when a statute is passed. In deciding what legal effect is to be given to these words their plain meaning is a good point of departure, as it is to be assumed that it reflects what the legislators themselves understood when they decided to approve it."

<u>Interpretation of section 2</u>

167. The words of section 2 when given their ordinary and natural meaning, particularly, though not solely, in a medical context, support the interpretation that nasogastric feeding including under restraint is "treatment" within the meaning of that section. Section 2 provides that "*treatment…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.*" As discussed above, there is no dispute between the parties, and the evidence clearly establishes, that nasogastric feeding including under restraint may constitute a form of medical treatment for an eating disorder and is a treatment which may be administered for the purpose of ameliorating the disorder.

168. Thus, giving the words in section 2 their ordinary and natural meaning, they clearly suggest that nasogastric feeding under restraint is a form of treatment within the meaning of the Act.

169. The Act is silent (other than in section 69) on the subject of restraint for the purpose of administering a medical intervention or treatment. This is a notable omission. However, it follows from the judgments in *HSE v MX* and *MX v HSE* that the need for restraint does not in itself mean that the intervention is not "treatment".

170. Of course, the words in a particular section must be understood in the overall context of the language of the statute. There is nothing in the express language of the rest of the Act which suggests that the words in section 2 should be given anything other than their ordinary and natural meaning.

171. They must also be understood in the context of the purpose of the statutory scheme. MacMenamin J held that the Act should be given a broad purposive interpretation. The purpose of the 2001 Act and its predecessor, the Mental Treatment Act 1945, has been considered in a number of cases including, for example, *Gooden v St Otterans Hospital [2005] 3 IR 617* and *EH v Clinical Director of St. Vincents Hospital [2009] 3 IR 774* (referred to in *MX v HSE*). In *Gooden*, McGuinness J said pages 633 and 634:

> "In In re Philip Clarke [1950] I.R. 235 the former Supreme Court considered the constitutionality of s. 165 of the Act of 1945. O'Byrne J. who delivered the judgment of the court, described the general aim of the Act of 1945 at pp. 247 to 248 thus:-
>
> > "The impugned legislation is of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and well-being of the public generally. The existence of mental infirmity is too widespread to be overlooked, and was, no doubt, present to the minds of the draftsman when it was proclaimed in Article 40.1 of the Constitution that, though all citizens, as human beings are to be held equal before the law, the State, may, nevertheless, in its enactments, have due regard to differences of capacity, physical and moral, and of social function. We do not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others." [emphasis added]

In *EH v Clinical Director of St Vincents Hospital*, Kearns J said that he could not see why a different approach should be taken to the 2001 Act. MacMenamin J described the 2001 Act as a statute "*designed for the protection of vulnerable persons*". It was on that basis that he decided that it should be construed in a purposive or broad manner.

172. This purpose tends to support an interpretation which flows from the ordinary and natural meaning of the words and which encompasses a medical treatment for the mental

disorder for which the person has been involuntarily detained and therefore supports an interpretation which includes nasogastric feeding including under restraint in the definition of "treatment".

173. Thus, there are clear pointers in the Act itself to this being the correct interpretation of "treatment" within section 2.

174. As discussed above, the Constitution and the Convention must also be considered as part of the context. A consideration of these instruments in fact offer support both for the interpretation arising from the ordinary and natural meaning of the words, i.e. that it is "treatment", and for the contrary interpretation that nasogastric feeding under restraint does not constitute "treatment" within the meaning of section 2.

175. MacMenamin J in *HSE v MX*, in determining whether the Act should be given a narrow or broad interpretation, noted that the "*duty of the court is to apply a hierarchy of constitutional values embodied in the statute, giving priority to that which comes highest*" (paragraph 60). He said at paragraph 59 and 60:

> "[59] The defendant enjoys a constitutional right to protection from inhuman or degrading treatment…; she enjoys a right to bodily integrity…such that she should be protected from unnecessary physical invasive treatment. But when one adopts the Constitution as a framework of reference for interpretation, it is clear that the primary constitutional values engaged are the necessity for safeguarding the patient's life and health. I think this applies in the context of the word "treatment"…I find that at present the vindication of these rights must take precedence over autonomy and liberty. I emphasise the word "balance" however, it must be applied on the facts of the case and at the time this judgment is delivered. In all of this, it must be recollected fair procedures have been employed in these hearings"
>
> [60] The duty of the court is to apply a hierarchy of constitutional values embodied in the statute, giving priority to that which comes highest…"

176. Adopting the reasoning in paragraphs 59 and 60, the application of a constitutional hierarchy offers constitutional support for the interpretation arising from the ordinary and natural meaning of the words. If one takes the Act as being directed towards the vindication of the patient's rights to life and health then this tends to support the interpretation that nasogastric feeding even under restraint, when directed towards promoting the health and life of the patient, is a "treatment" within the meaning of the Act.

177. However, regard must also be had to the fact that the Constitution and the ECHR require that there be adequate safeguards for the patient's other rights. I go on to explain that the safeguards in respect of the administration of nasogastric feeding under restraint are

inadequate to properly protect and vindicate the patient's rights, but in my view that does not compel an interpretation of section 2 which departs from the ordinary and natural meaning of the words and which is supported by a consideration of the purpose of the Act and those other constitutional considerations. Murray J said at paragraph 116 of *Heather Hill*:

> "…However – and in resolving this appeal this is the key and critical point – the '*context'* that is deployed to that end and '*purpose'* so identified must be clear and specific and, where wielded to displace the apparently clear language of a provision, must be decisively probative of an alternative construction that is itself capable of being accommodated within the statutory language."

He made similar comments at paragraph 214 of his judgment in *Heather Hill* and, at paragraphs 179-182, he said, in relation to the approach of using an international treaty to assist in the interpretation of a provision which seeks to give effect to the treaty, that "*this approach does not enable the over-riding of the clear words of an Act.*"

178. In my view, while the inadequacy of the safeguards is of fundamental importance in the scheme, it is not sufficient to "*displace the apparently clear language*" or to 'over-ride the clear words' of section 2. Even if one takes it that the section is reasonably open to two interpretations, in circumstances where the Constitution provides support to both interpretations I do not believe that it can said that the interpretation of section 2 contended for by the Guardian ad Litem accords better with the Constitution than the one arising from the ordinary and natural meaning of the words of section 2 supported by the other factors just discussed. This is because the definition of "treatment" in section 2 in itself does not interfere with or offend against any of the respondent's rights and, therefore, the question of the adequacy of the safeguards is not of central importance to the interpretation of section 2; it is only the administration of the "treatment" that interferes with and might offend against the respondent's rights and, therefore, the question of safeguards is of far greater significance in the interpretation of section 57 and indeed is decisive.

Interpretation of section 57

179. Of course, the starting position for the interpretation of section 57 is that it permits the administration of an intervention that falls within the definition of "treatment" in section 2. For the reasons just discussed, I am satisfied that that definition encompasses nasogastric feeding including under restraint. This supports an interpretation of section 57 that it applies to the administration of nasogastric feeding under restraint. That interpretation is also supported by the consideration of the purpose of the Act and the application of a hierarchy of constitutional rights approach.

180. However, as stated by Costello J in *RT v Director of Central Mental Hospital* the objective of the Act does not justify any restriction designed to further it. As touched on above, the weight of the considerations apply differently in relation to section 57. The formulation of section 57 makes clear that the Oireachtas was acutely conscious that the imposition of any form of medical treatment without consent is a significant interference with those rights. Nasogastric feeding under restraint is, as is clear from the evidence referred to above, a very significant interference with the patient's personal rights under the Constitution and the ECHR. It is an intervention which is invasive in nature, may and on occasion does require restraint, is upsetting or traumatic for the patient and may cause physical injury.

181. Thus, as discussed above, such intervention requires adequate safeguards for the protection and vindication of those rights. It follows that in the process of interpreting a provision which permits the administration of such a treatment without consent and under restraint far greater weight must be given to a consideration of the safeguards in respect of the intervention than when interpreting the definition section. In short, the question is whether in the absence of such safeguards, the legal effect of section 57 properly interpreted could be to permit the administration of such treatment, or whether, to use language which is warned against by Murray J in *Heather Hill*, this could have been the intent of the Oireachtas.

182. This is the point advanced in the Guardian ad Litem's submissions and largely accepted by the HSE. The HSE's position is that there are adequate safeguards.

183. The starting point therefore is an analysis of the measures which are advanced as safeguards. In light of my conclusion, on the basis of *MX v HSE*, that an independent review is a minimum form of safeguard , this must be a particular focus of the analysis.

Safeguards

184. There are no express safeguards in section 2 (one would not expect them to be in section 2) or in section 57. This may be contrasted with sections 58, 59 and 60, all of which deal with forms of medical treatment and contain express safeguards, and, indeed, with the sections dealing with detention in the form of admission and renewal orders. Perhaps the most relevant comparison is with section 60. As discussed above, it provides that if medication has been given for a period of in excess of three months, the continued administration of that medication must be approved by the responsible consultant psychiatrist **and** must be authorised by another consultant psychiatrist on a form prescribed by the Mental Health Commission. This process must be undergone every three months.

185. The HSE accepts that there are no express safeguards in section 2 or 57, but submits that one must take the Act as a whole for the purposes of considering whether there are

adequate safeguards in place. I accept that this is correct. It follows directly from the approach set out in *Heather Hill* and *A, B & C*. The Court must examine the words in their overall context.

186. The HSE also submitted that the Court must also look to measures in place outside of the Act, such as access to the courts, the presumption of constitutionality, and Codes of Practice and Codes of Ethics, for the purpose of determining whether there are adequate safeguards in place to permit the Court to interpret the Act as encompassing nasogastric feeding under restraint, and that these safeguards within the broader system mean that there are adequate safeguards in the legal system. The Guardian ad Litem submitted that these should not be considered by the Court in interpreting section 2 and section 57, i.e. it was submitted that any safeguards must be contained within the Act. Alternatively, it was argued that they were not adequate.

187. I am of the view that the "safeguards" do not have to be contained in the Act itself. It seems to me to follow from the contextual approach to interpretation set out in *Heather Hill* that regard must be had to relevant matters which are outside the Act and which may constitute safeguards. As Murray J put it, the Court must construe the words, inter alia, in the legal context in which it was enacted (paragraph 78 of his judgment in *A, B & C*). Related matters outside of the Act are part of that legal context. Of course, "context" is not open-ended. Not all matters can be considered to be part of the relevant "context" for the purpose of interpreting a statutory provision. I do not believe that I need to consider the parameters of what may or may not constitute "context" in light of my conclusions below. Secondly, it also follows from *Silver v. United Kingdom [1983] 5 E.H.R.R. 347 Application No. 5947/72* that safeguards do not have to be contained in the Act itself. The ECtHR said at paragraph 90 that:

> "The applicants further contended that the law itself must provide safeguards against abuse.
>
> The Government recognised that the correspondence control system must itself be subject to control and the Court finds it evident that some form of safeguards must exist. One of the principles underlying the Convention is the rule of law, which implies that an interference by the authorities with an individual's rights should be subject to effective control. This is especially so where, as in the present case, the law bestows on the executive wide discretionary powers, the application whereof is a matter of practice which is susceptible to modification but not any Parliamentary scrutiny (see paragraph 26 above).
>
> ***However, the Court does not interpret the expression 'in accordance with the law' as meaning that the safeguards must be enshrined in the very text which authorises the imposition of restrictions***. In fact, the question of safeguards against abuse is closely linked with the question of effective remedies and the Court finds it preferable to take this issue into account in the wider context of Article 13 (see paragraphs 111-119 below)." [emphasis added]

188. The ECtHR went on to say at paragraph 113 that:

> "The principles that emerge from the Court's jurisprudence on the interpretation of Article 13 include the following:
>
> (a) where an individual has an arguable claim to be the victim of a violation of the rights set forth in the Convention, he should have a remedy before a national authority in order both to have his claim decided and, if appropriate, to obtain redress;
>
> (b) the authority referred to in Article 13 may not necessarily be a judicial authority but, if it is not, its powers and the guarantees which it affords are relevant in determining whether the remedy before it is effective;
>
> (c) **although no single remedy may itself entirely satisfy the requirements of Article 13, the aggregate of remedies provided for under domestic law may do so**;
>
> (d) neither Article 13 nor the Convention in general lays down for the Contracting States any given manner for ensuring within their internal law the effective implementation of any of the provisions of the Convention – for example, by incorporating the Convention into domestic law.
>
> It follows from the last-mentioned principle that the application of Article 13 in a given case will depend upon the manner in which the Contracting State concerned has chosen to discharge its obligation under Article 1 directly to secure to anyone within its jurisdiction the rights and freedoms set out in section 1." [emphasis added]

189. I take each of these categories, the internal and external, in turn, though I hasten to add that the internal and external matters can not be neatly divorced from each other and, indeed, can not even be neatly categorised as such: for example, the presumption of constitutionality can not be considered as separate from an Act to which it applies; nor can the right of access to the courts to challenge a step taken pursuant to an Act be thought of as entirely distinct from the Act itself; indeed even a doctor's function under the Act must be exercised in accordance with the doctor's Code of Ethics or any applicable Code of Practice and, as such, has elements of an internal and external safeguard. Nonetheless, it is a useful framework within which to consider the various measures which the HSE submits are safeguards. The point is that measures which are provided for in the Act are internal safeguards and measures which are provided for by the general law and other instruments are external to the Act and the Court must have regard to both. I should also add that part of the HSE's case is that when examining the adequacy of the safeguards, the Court must consider each one separately but must also consider them cumulatively. I have done so. For the purpose of discussion I consider each of the internal matters and then the external matters.

190. The HSE's arguments in relation to the matters which constitute safeguards reflect the evidence of Professor Kelly given in response to the Guardian ad Litem's request to address

what, if nasogastric feeding falls within the definition of treatment in the 2001 Act, "*particular safeguards might be necessary to ensure its administration*" and whether these are "*adequately addressed in the current iteration of the 2001 Act.*" These are, of course, partly matters of law, but there is a clinical element to them and I am satisfied that Professor Kelly is properly qualified to express an expert opinion on the clinical element of those questions. Professor Kelly notes that the issue of safeguards is "*of key importance*" and explains the safeguards which are in place. I do not propose to set them out as I address them when considering the HSE's submissions. As noted above, Professor Kelly distinguished between involuntary patients who do not have capacity but who cooperate with nasogastric feeding and involuntary patients who do not cooperate with it, requiring physical restraint in order for it to be administered. He expressed the view that "*the existing safeguards outlined above are sufficient for the former group, who do not require physical restraint for nasogastric feeding.*" It is, of course, the second category with whom this judgment is most concerned. Professor Kelly expressed the view that "*For the latter group, additional safeguards are needed. There are already some precedents for additional safeguards for specific interventions for involuntary patients under the 2001 Act. For example, in addition to the more general safeguards for all involuntary patients outlined above, the 2001 Act offers additional safeguards for, and 'heightened scrutiny' of, certain specific involuntary interventions, including administration of medication for more than three months to an involuntary patient in the absence of consent (requiring a second opinion), electroconvulsive therapy for an involuntary patient in the absence of consent (requiring a second opinion), and psychosurgery for an involuntary patient (requiring a Mental Health Tribunal).*" It will, of course, be appreciated that none of these apply to the administration of nasogastric tube feeding. In relation the latter, Professor Kelly identified that there is a 'Code of Practice on the Use of Physical Restraint'. Professor Kelly also referred to the fact that healthcare services and establishments have various complaints processes and mechanisms and that inpatient psychiatric facilities are inspected by the Inspector of Mental Health Services with respect to "*standards or premises, care and practices.*"

191. Senior Counsel for the HSE pointed to the fact that section 4 of the 2001 Act requires that in making a decision concerning the care or treatment of a person under the Act, the best interests of the person shall be the principal consideration and that due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy as part of the overall safeguards afforded by the Act. It was submitted that this obligation to act in the patient's best interest with due regard to those rights is an overarching safeguard which infuses all of the other safeguards.

192. It was correctly accepted on behalf of the HSE that there is no provision providing for a specific review of the "treatment" in the 2001 Act. However, it was submitted that there is considerable safeguarding scaffolding in the entire scheme of the Act and Senior Counsel for the HSE helpfully brought the Court through the long title to the Act, the definition of "treatment" in section 2, and through sections 3, 4, 9 (sub-sections (4) and (5) in particular),

10 (sub-sections (1) and (2) in particular), section 14 (sub-section (1) in particular), 15 (sub-section (1) and (3)(b) in particular), 16 (subsection (1) and (2)(c) in particular), 17 (subsection (1) in particular), 18 (subsection (1) in particular), and 19 (subsection (1) in particular). These are the detailed provisions concerning, inter alia, applications for involuntary admission (section 9), the decision in relation to whether to make a recommendation for involuntary admission (section 10), the decision whether to make an admission order (section 14), the effect of an admission order (section 15), the requirement to give notice of the making of an admission order to the patient and the Mental Health Commission (section 16), the referral of the admission order to a Mental Health Tribunal by the Commission and the appointment by the Commission of a legal representative and an independent psychiatrist (section 17), the review of an admission order or renewal order by the Mental Health Tribunal (section 18), and the availability of an appeal to the Circuit Court (section 19). He described these provisions as "safeguarding provisions". They, and others, are included in a list of "*[S]ignificant protections*" under the 2001 Act given by MacMenamin J in his judgment in *Health Service Executive v AM [2019] 2 IR 115* (paragraph 92) (with which the other members of the Supreme Court, O'Donnell and Dunne JJ) agreed). That case was not directly concerned with the question of treatment under section 57. The general point made on behalf of the HSE was that there is detailed protection for the individual's rights provided for in each of these sections when taken separately and together.

193. Thus, it is submitted that the respondent's rights are given considerable safeguards in the provisions dealing with the making and review of admission orders or renewal orders.

194. I have no difficulty whatsoever in accepting that these provisions offer considerable protections and safeguarding to an individual who it is proposed to be detained and who is detained under the Act. However, the question is whether they offer adequate safeguards in respect of the administration of treatment to the person and, in particular, whether they provide for an adequate form of independent review of the question of "treatment" having regard to the nature of the treatment in question.

195. It was submitted by the HSE that this legal structure does indeed offer adequate safeguards in the case of a person admitted on the grounds that he is suffering from a mental disorder within the meaning of section 3(1)(b) because "treatment" is central to the finding that the person is suffering from a mental disorder under that ground. This, it is submitted, means that there is a consideration of the "treatment" at all stages, including, crucially in the context of the arguments in this case, during a review of an admission or renewal order or an appeal to the Circuit Court. The HSE submitted that in such cases, the Mental Health Tribunal, in carrying out its review of an admission order or a renewal order, or the Circuit Court on appeal, could and must consider the need for and appropriateness of the treatment being given. Essentially, it was submitted that in a section 3(1)(b) case, from the moment of an application

for involuntary admission, "treatment" is central to all considerations and that no determination to admit the individual to the approved centre or to continue her detention there can be made separate from the question of the need for and appropriateness of the treatment.

196. The HSE also referred to what actually occurs at Mental Health Tribunal reviews of admission and renewal orders and said that the documentation in this case supports the case that the Mental Health Tribunal must, and does, review the "treatment" in section 3(1)(b) cases. He referred to the record of the decisions of the Tribunal in this case dated the 18th December 2023 and the 4th January 2024 in respect of the admission order of the 29th November 2023 and the renewal order of the 18th December 2023 respectively. It was submitted by the Guardian ad Litem that there was an insufficient evidential and factual basis upon which I could conclude that reviews by Mental Health Tribunals comprise a review of the treatment or that the reviews in this case did so. Senior Counsel for the Guardian ad Litem made the point that there was in fact no evidence as to what actually occurs at Mental Health Tribunals (other than, of course, the record of the hearings in this case). I do not believe it is necessary to resolve this. From the point of view of statutory interpretation I think I have to consider the matter on the basis of what the statutory provisions say but, in any event, I am satisfied that even on a consideration of these documents I must conclude that the Mental Health Tribunal review is not an adequate review of the "treatment" to amount to an adequate safeguard.

197. I propose to consider the statutory provisions first and will then refer to the documents. As set out above, section 3(1)(b) provides that a person suffers from a mental disorder if *"(i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or* ***would prevent the administration of appropriate treatment*** *that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent*" [emphasis added]. The HSE emphasises the centrality of "treatment" to section 3(1)(b) and contrasts it with section 3(1)(a) which does not contain a reference to "treatment". It provides that "mental disorder" means mental illness, severe dementia or significant intellectual disability where "*because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons*". The HSE argues that as "treatment" is so central to an admission or renewal order on the basis of section 3(1)(b), when the Mental Health Tribunal comes to review the admission or renewal order, they must and do review the treatment to be or being provided and that this is an independent review. They also emphasise that the Act provides that as part of the Tribunal review process an independent consultant psychiatrist must examine the individual and must provide a report, that the Tribunal

has a consultant psychiatrist as a member, and the individual is legally represented before the Tribunal.

198. I do not accept that the statutory provisions involve a review by the Mental Health Tribunal of the specific treatment(s) being administered. What is provided for (insofar as is relevant to the current discussion), even in cases involving admission on the basis of section 3(1)(b), is whether the person requires appropriate treatment in a general sense and whether a failure to admit or renew would prevent the administration of appropriate treatment. That function does not require an assessment or review of the specific treatment or, as it was put by the Guardian ad Litem, a "qualitative assessment" of specific treatment. Indeed, it is impossible to see how the statutory provisions could be interpreted as providing for a specific review of the treatment. For example, in the case of an admission order, that would require the admitting doctor to say in advance of the person even being admitted precisely what treatment was going to be given. Often this would be before the doctor or the treating team even had an opportunity to carry out a detailed assessment of the patient. This is reflected in section 16(2) of the 2001 Act which requires a consultant psychiatrist who makes an admission or renewal order to give a notice to the patient containing certain information. This includes information about proposed treatment but only requires a "*general description*" of the proposed treatment. All of this supports the view that what is to be reviewed and determined is whether the patient requires appropriate treatment in a general sense and whether he would not get such treatment if he is not admitted to or retained in an approved centre.

199. I was also directed to section 17 which provides that where a matter is referred to a Tribunal, an independent consultant psychiatrist must determine whether the patient is suffering from a mental disorder and provide a report for the Tribunal. However, as what has to be addressed by the independent consultant psychiatrist is whether the person is suffering from a mental disorder, for the reasons just discussed, this does not require an assessment or a review of the specific treatment.

200. I was also directed to the fact that the Tribunal has a consultant psychiatrist as one of its members and that the patient is legally represented before the Tribunal. These are, of course, considerable safeguards but they do not go the question of what is to be reviewed or assessed by the Tribunal.

201. Senior Counsel for the HSE also directed me to the right of the patient to seek a review under section 15(3)(b) and the right of appeal to the Circuit Court from a determination of the Tribunal (section 19). Again, both of these are safeguards but the same considerations apply.

202. Section 15(3) entitles a patient who is detained pursuant to a renewal order for a period exceeding three months, or his legal representative, to apply to have his detention reviewed by a Tribunal in accordance with the provisions of section 18. Section 18(3)(d) (as it

applies to such a review) provides that the Tribunal shall affirm the order if satisfied that the patient is suffering from a mental disorder. Thus, on an application under section 15(3)(b), the Mental Health Tribunal only considers whether the patient is suffering from a mental disorder (i.e. in accordance with the provisions applying to automatic reviews by the Tribunal). It therefore seems to me that my reasoning in respect of a review under section 18 must also apply here.

203. Similarly, an appeal to the Circuit Court from a decision of the Tribunal may be brought on the grounds that the patient is not suffering from a mental disorder. Section 19(4) provides that on such an appeal, the Circuit Court shall *"(a) unless it is shown by the patient to the satisfaction of the Court that he or she is not suffering from a mental disorder, by order affirm the order, or (b) if it is so shown as aforesaid, by order revoke the order."* Thus, leaving aside the question of the burden of proof, the Circuit Court's function on an appeal is to determine whether the person is suffering (or not suffering) from a mental disorder. This is, in essence, the same function as the Tribunal and therefore my comments above apply here also.

204. The HSE also submitted that the documentary evidence in relation to the reviews in this case support the general argument that reviews in section 3(1)(b) cases comprise a review of the treatment and that such reviews were carried out in this case. I do not accept either of these points.

205. An admission order was made on the 29th November 2023 and was referred for review by the Mental Health Tribunal. The admission order was affirmed by the Mental Health Tribunal on the 18th December 2023 on the basis of section 3(1)(b)(i).

206. The Tribunal had before it a report in the prescribed form which was prepared by an independent consultant psychiatrist on the 11th December 2023 (a few days after the insertion of the nasogastric feeding tube on the 6th December 2023 and the delivery of a feed). The form asked the doctor to "*Please outline any change in the patient's condition since the commencement of their involuntary admission*". The doctor stated that *"…A High Court Order was sought to provide NG feeding if necessary, this was granted. NG tube was inserted on 06.12.2023. As of 11.12.2023, she is noted to be managing her meal plan, coping well with court ordered NG – serving as a motivator to engage with meal plan…"*. It was also recorded in the report that Dr. M.A. had told the independent consultant psychiatrist that the respondent's inability to rationalise receiving treatment under the admission order had "*prompted return to the High Court and the granting of a High Court order to provide NG feeding. Dr. M.A. said that the NG was put in place yesterday and there is a dietetics agreement to balance her calorific intake with NG supplementation.*" These are statements of fact or simply record what Dr. M.A. said and do not amount to the independent psychiatrist's opinion in relation to nasogastric feeding. At section 16 of the form the doctor was asked to list "*relevant aspects of the patient's treatment*". Nasogastric feeding was not listed.

207. In section 17 of the Tribunal's decision (in which the Tribunal is required to set out the submissions made to it and the reasons for its decision) the Tribunal referred to treatment, including nasogastric feeding, but it did so by way of recording the submissions or evidence. For example, it recorded that the respondent's legal representative had indicated that her preference was to be an out-patient but that the respondent had "*benefitted from being detained under the order because it enabled her to engage with the treatment…[the respondent] stated that "the order has 'provided a mental permission' to [her] to recover and accept the treatment.*" It also recorded that "[*Dr. M.A.] explained that High Court intervention was necessitated to enable the medical team to initiate nasogastric feeding if it was required. [Dr. M.A.] stated that this procedure was used once and it is a last resort. [The respondent] explained that she did not wish to be fed in this manner however she realised it could be a consequence if she did not follow the treatment plan. [Dr. M.A.] stated that [the respondent] was progressing since her admission however he stated that they had yet to reach a 7 day period of stability. [Dr. M.A.] confirmed that he had signed the order on the basis of the therapeutic criteria.*" This simply records the evidence. There was no review of the nasogastric feeding. Furthermore, the Tribunal affirmed the admission order on the basis that the respondent's condition remained at a severe level and meant that without an admission order in place the respondent's judgment was so impaired that failure to affirm the admission order would lead to a serious deterioration in her condition or would prevent the administration of treatment that can only be given by the admission. In doing so, the Tribunal accepted that the respondent would not adhere to the treatment programme prescribed by Dr. M.A. without the order being in place. The conclusion that a failure to affirm the admission order would, inter alia, prevent the administration of treatment that could only be given by the admission could not even be a reference to the nasogastric feeding because that was being provided on foot of an order of this Court rather than on foot of the admission order, as acknowledged by the Tribunal.

208. The fact that the Tribunal did not review the treatment is also reflected, and perhaps more strikingly so, in the documentation relating to the review of the renewal order of the 18th December. This was made after the Court had made the interim/interlocutory order on the 5th December 2023 and after a nasogastric feed had been administered. The renewal order was made on the basis that the respondent continued to suffer from a mental disorder under section 3(1)(b)(i). There is no reference on the face of the renewal order to nasogastric feeding or the possibility thereof (though there was in the notification given to the respondent). The renewal order was reviewed by the Tribunal on the 4th January 2024 and they affirmed the order on the basis that the respondent was suffering from a mental disorder within the meaning of section 3(b)(i). There is no reference at all to nasogastric feeding, to the possibility of same, or even to the existence of the Court Order permitting same, in the Tribunal's decision.

209. There is reference to nasogastric feeding in some of the documentation preceding the review hearing. For example, in the notice given to the respondent pursuant to section 16(2), under the heading "*a general description of the proposed treatment to be administered to him or her during the period of his or her detention*", it is stated: "*Physical health monitoring; Dietetics, Psychology, Social work, Nursing, occupational therapy; Separate legal orders in place for nasogastric feeding if necessary.*" Furthermore, a report was prepared by an independent consultant psychiatrist on the 2nd January 2024 for the purpose of this review. This was a detailed report. In the section headed "*Give a clinical description of the patient's current mental condition*", the doctor records that the respondent "*said she was currently under High Court orders to have enforced naso-gastric feeding should she restrict her eating, and that this order had helped her to decide to eat according to the meal plan. She had had two hearings and spoke at the first hearing. She seemed very unbothered by this, a 'belle indifference'…"* The doctor also recorded in respect of the respondent's "*attitude to treatment and her likely compliance with it in the future*" that "*She initially agreed to psychiatric treatment then wished to leave the hospital, hence the involuntary detention under the Mental Health Act 2001. This restrictive setting has been greatly helped by the extant High Court Orders which she reported as having psychologically contained her to the extent that she could begin to adhere to the meal plan….The restrictive setting of both High Court orders and Mental Health Act have been described to me by the patient as having assisted her to decide to eat in circumstances where her life was at risk from the blood disturbances arising from the mental illness.*" She also recorded that Dr. M.A. explained to her the "*relevant legal framework which obtains here, and which is allowing him to treat [the respondent] in the in-patient unit. This is Mental Health Act 2001 and High Court orders [the latter allow enforced naso-gastric refeeding but not detention in the unit.*" The doctor concludes "*I agree with [Dr. M.A.] that the detention requirements of the Mental Health Act 2001 are fulfilled. [The eating disorder] is a mental illness characterised and operationalised in both DSM and ICD; the respective American and the European diagnostic manuals of mental illnesses. I believe the in-patient psychiatric treatment will probably benefit her and ameliorate her condition, and that failure to admit her would lead to serious and immediate risk for her. I found [the respondent] to be a lovely and clever young woman in partial remission of her illness, with limited insight, clearly still at immediate physical risk from her strong tendency to want to purge, and her difficulty voluntarily to adhere to meal planning.*" These are the only references to nasogastric feeding in the report.

210. There is some level of engagement with or assessment of the treatment in these passages. However, elsewhere, where one would expect some consideration of, or reference to, the specific treatment if the doctor was conducting a review of it, there is no reference to it. For example, it is particularly noteworthy that at section 16 of the report under the heading "*Please detail other relevant aspects of the patient's treatment (non-pharmacological, ECT etc*)" there is no express mention of treatment by nasogastric feeding where it is simply stated "*Expert treatment intervention from consultant psychiatrist [Dr. M.A.], dietetic [nutritionist],*

specialist nursing care." Nor is there any mention of a nasogastric feed having been administered on the 6th December.

211. In any event, in circumstances where the Tribunal did not refer to nasogastric feeding, the possibility of it, or even the existence of the Court Order permitting its administration, it can not be concluded that the Tribunal reviewed the nasogastric feeding.

212. I want to emphasise that these comments are not a criticism of any of the doctors or, indeed, of the Tribunals. Rather, their conduct and the contents of the documents reflect what I consider to be the procedures put in place by the statutory provisions in relation to admission and renewal orders.

213. In all of those circumstances, even if regard is had to what happened in the Mental Health Tribunal review process, I do not believe that the evidence supports a conclusion that there is or was an independent substantive or qualitative review of the specific treatment.

214. As noted above, the HSE's primary point in relation to the adequacy of safeguards is that the safeguards provided for within the Act, i.e. those just set out, are sufficient, but they also say that it is not a requirement that such safeguards be available within the Act itself, and that there are other safeguards outside the Act and within the broader system which, taken together and taken together with the safeguards in the Act, mean that there are adequate safeguards in the legal system which means that the Act, properly interpreted, encompasses nasogastric feeding under restraint.

215. The HSE referred to a Code of Practice made by the Mental Health Commission under section 33(3)(e) of the 2001 Act. Section 33(1) identifies the principal function of the Mental Health Commission as being "*…to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres…*". Subsection 3(e) provides that the Commission shall "*prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health service.*" In September 2022, the Commission made a revised "*Code of Practice on the Use of Physical Restraint*". It is important to note that this Code relates to the use of restraint rather than to specific treatments. The Code of Practice defines "*physical restraint*" as "*the use of physical force (by one or more persons) for the purpose of preventing the free movement of a person's body when the person poses an immediate threat of serious harm to self or others.*" The effect of the Code of Practice is that in order for a centre to be in compliance with the Code, certain steps must be taken when restraint is used, which the HSE describes as a "safeguards". The Code of Practice requires that "*all uses of physical restraint should be clearly recorded in the person's clinical file"* and

"*in the Clinical Practice Form for Physical Restraint*" and the form should be placed on the patient's clinical file and made available to the Mental Health Commission on request.

216. This revised Code replaced an older Code of Practice. That original Code did not refer at all to the use of physical restraint in the use of nasogastric feeding. The new Code includes at Appendix 2 a template clinical practice form upon which certain details relating to an instance of physical restraint are to be recorded. One of the details to be recorded is the reason for the instance of restraint. It states a number of possible reasons and the applicable one must be ticked. Two of the reasons contained in Appendix 2 of the new Code are *"[t]o administer medication/treatment (excluding nasogastric feeding)"* and *"[t]o administer nasogastric feeding."* It is a slightly odd feature of the Code that while the administration of nasogastric feeding is listed in the template clinical practice form, it is not referred to in the body of the Code. Nonetheless, the inclusion of these two possible reasons in the template form does seem to suggest that, unlike the 2018 Code of Practice, the Mental Health Commission envisages restraint being used for nasogastric feeding. Professor Kelly expresses the view in his report that as Anorexia Nervosa has the highest mortality rate of any psychiatric illness "*it is clear that severe, life-threatening eating disorder 'poses an immediate threat of serious harm to self'.*" I have to confess to having doubts on the basis of the evidence referred to above about whether the risk of harm to self has the immediacy required to meet the definition of restraint in the Code of Practice (indeed, this appears to be adverted to by Dr. Kelly where he refers to Draft Heads of Bill which propose defining physical restraint as to more clearly include "treatment" as a reason for physical restraint). I will, however, proceed for the purpose of this discussion on the basis that it does. Thus, Professor Kelly says (and this was adopted by the HSE), that an additional safeguard is provided for, i.e., the formal recording on a specific form which is placed on the person's clinical file which should be available on request. He also states that in his clinical experience, the Inspector of Mental Health Services inspects such forms during inspections.

217. I am not satisfied that these safeguards amount to adequate safeguards. Firstly, there is no evidence before the Court of what happens following the recording of such instances and inspection of the records, particularly in relation to the underlying nasogastric feed, i.e., the reason for the restraint. For example, there is no evidence that it leads to any independent review of the treatment itself. Professor Kelly's evidence that the forms are inspected by the Inspector of Mental Health Services does not constitute evidence that there is a review of the treatment. Mere recording could not be adequate unless it leads to review. Secondly, Senior Counsel for the HSE brought my attention to the important qualification (which was also dealt with by Professor Kelly) that there is no legal obligation to comply with Codes of Practice made under section 33(3). The Code itself states that it was made for "*the guidance of persons working in the mental health service*". In the "Introduction" it was noted that since the earlier Code, *"[T]here have been significant and progressive developments in mental health care in*

the intervening years. International developments around human rights, the advancement of person-centred care, and evidence demonstrating that restrictive practices can have harmful physical and psychological consequences have changed how these practices are viewed." It also states in its "Introduction" section that, inter alia "*The 2001 Act does not impose a legal duty on staff working in mental health services to comply with Codes of Practice, but best practice requires that they be followed to ensure the 2001 Act is implemented consistently by staff working in mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings. The Mental Health Commission considers that adherence to the Code of Practice will encourage continual efforts to avoid, reduce and, where possible, eliminate restrictive practices.*" It is important to note that the evidence is that the centre in question does adhere to the Code of Practice. However, the fact that the Code is not legally binding is a factor which goes to its adequacy as a safeguard for the purpose of the interpretation of section 57. This must be contrasted with rules made under section 69 of the 2001 Act. Section 69(2) provides that the Mental Health Commission shall make rules for the use of seclusion and mechanical means of bodily restraint and sub-section (3) provides that a person who contravenes a rule made under the section shall be guilty of an offence. It is also important to note in passing that section 69 expressly refers to the use of seclusion or mechanical means of bodily restraint for the purposes of treatment whereas the body of the Code of Practice does not (though the template Clinical Practice Form does).

218. Senior Counsel for the HSE also referred to the various professionals' Codes of Ethics. These are, of course, a safeguard for patients as they ensure high professional and ethical standards but there are two principal difficulties in viewing them as an adequate safeguard in the context of the current discussion. Firstly, there was no evidence as to what those codes contain. In particular, there was no evidence before the Court as to whether they impose any ethical obligation on the relevant clinician to ensure that there is an independent review, either by way of second opinion or other type of review, of decisions in relation to nasogastric feeding. Secondly, while professional codes do act as a safeguard and we are fortunate to have a medical profession who abide by and often exceed such high professional standards, the reality is that some professionals, albeit a tiny minority, do not do so. More importantly, even professionals who abide by high standards can make honest mistakes. The purpose of legal safeguards is to guard against the incapacitous patient's rights being breached through either contingency.

219. It must be emphasised that the HSE's argument was that all of these factors must be taken together and taken with an element of the presumption of constitutionality.

220. Senior Counsel for the HSE pointed to the fact that one aspect of the presumption of constitutionality is the presumption that any person implementing the Act or the procedures thereunder will act constitutionally. It was held by Walsh J in *East Donegal Co-operative Livestock Mart Ltd v Attorney General [1970] IR 317* (at page 341) (see also *Re Article 26 and*

the Regulation of Information (Services outside the State for Termination of Pregnancies Bill [1995] 1 IR 1) that:

> "…the presumption of constitutionality carries with it not only the presumption that the constitutional interpretation or construction is the one intended by the Oireachtas but also that the Oireachtas intended that proceedings, procedures, discretions and adjudications which are permitted, provided for, or prescribed by an Act of the Oireachtas are to be conducted in accordance with the principles of constitutional justice. In such a case any departure from those principles would be restrained and corrected by the Courts."

221. It was submitted that this amounted to a safeguard because it governs how persons involved in operating the statutory procedures must act (or rather how the Court must presume they will act). However, it seems to me that this could only act as an adequate safeguard if the statutory procedures (or perhaps even the non-statutory procedures such as a Code of Ethics) provided for an independent review. In that case, it would act as a presumption that such review would be conducted properly and in accordance with the Constitution. However, the statutory procedures do not do so and there is no evidence that the non-statutory procedures do so. I do not believe that the presumption can allow the Court to interpret section 57 as containing a requirement for an independent review or as imposing an obligation on, for example, the responsible consultant psychiatrist to obtain a second opinion in respect of the treatment. This is particularly so in light of the contrast between section 57 and section 60. I do not believe that the presumption leads or can lead to the Court interpreting section 57 as including the same or a similar requirement as in section 60 in circumstances where the Oireachtas included an express requirement in section 60 but did not do so in section 57. In my view, that would involve the Court in fashioning a different statutory scheme to the one determined by the Oireachtas. Murray J warned against this in the context of the double construction rule at paragraphs 90-92 of his judgment in *A, B & C (A Minor)*.

222. Thus, I do not accept that the presumption of constitutionality can lead to a conclusion that there would or must be an independent review of the "treatment". Even if it can be presumed that the approved centre and its staff will operate the procedures set out above absolutely correctly this can not amount to an adequate safeguard in circumstances where those procedures do not provide for an adequate independent review.

223. One of the safeguards pointed to by the HSE is the availability of rapid access to the courts. Counsel also correctly made the point that an effective remedy is a safeguard within the meaning of article 13 of the Convention. Article 13 provides that "*Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.*" In *Silver v UK*, the ECtHR considered the question of safeguards against abuse of the power to control prisoners' correspondence (which was at issue in the case) in the

context of article 13. The Court said at paragraph 90 that "*…the question of safeguards against abuse is closely linked with the question of effective remedies and the Court finds it preferable to take this issue into account in the wider context of Article 13…*". I was referred to *EC v Health Service Executive [2023] IEHC 20*, an ex tempore judgment of Hyland J, as an illustration of how quickly a person can have access to the courts in order to challenge or to seek to restrain the alleged wrongful administration of treatment. In that case, the plaintiff alleged that the proposed administration of medication was unlawful for a number of reasons (the substance of the argument is not directly relevant to the current discussion) and sought an injunction to restrain its administration pending trial. An application for short service of the injunction application was made on the 12th January 2023. That was granted, with the motion returnable for the following day, the 13th January. On that date the Court granted the relief until 4pm on the 14th January 2023. The injunction application was heard on that date (a Friday) and Hyland J delivered her judgment the following day, the 15th January 2023. Thus, the plaintiff had very rapid access to the courts and the interlocutory matter was determined within three days. In that case, the challenge to medication was brought and there was a determination within three days.

224. Access to the courts is undoubtedly an essential safeguard but it is in fact a minimum safeguard. That is clear from *X v Finland* and *MX v HSE*. However that does not mean that it is in itself an adequate safeguard. It is at least doubtful that access to the courts by way of judicial review or an application under Article 40.4 of the Constitution could in itself be adequate. It was held by Hogan J (with whom Peart and Gilligan JJ agreed) in *AB v Clinical Director of St Loman's Hospital [2018] 3 IR 710* (per the headnote):

> "3. That the jurisdiction of the High Court in applications brought pursuant to Article 40.4.2 by patients who were involuntarily detained under the 2001 Act was confined to ensuring that the admission or renewal order was valid on its face and that there was no violation of constitutional rights or other serious legal error in the making of the order…
>
> 4. That judicial review proceedings could not satisfy the requirement that the patient had the opportunity of an independent review of his detention. While the High Court could subject a refusal to exercise the power to discharge a patient under s.28(1) of the 2001 Act to review, such review would not be a review on the merits of the decision and the High Court could not effectively declare in such proceedings that the patient no longer suffered from a mental disorder."

225. Leaving aside questions about whether the availability of judicial review or Article 40 proceedings would constitute an adequate review, it is clear from MacMenamin J's decision in *MX v HSE* (paragraph 75) that access to the courts is just one of the necessary safeguards. He said at paragraph 81 of his judgment that *MX* was entitled to "*an independent review*" and went on at paragraph 85 to say that decisions as to treatment "*must be subject to the rule of law,*

and must be independently reviewed. They must be capable of being assessed by a court, and cannot be arbitrary." Thus, MacMenamin J clearly held that there must be an independent review **and** access to the courts. It must also be recalled that the Oireachtas believed it necessary and appropriate to provide for additional safeguards in relation to various specified forms of treatment, including the administration of medication.

226. Thus, I am satisfied that an independent review is not provided for. This absence of the minimum safeguard of an independent review must be taken into account and balanced with these other factors which support an interpretation of section 57 as encompassing nasogastric feeding under restraint.

Conclusion re section 57

227. As discussed above, the absence of this safeguard is not sufficient to depart from the ordinary and natural meaning of the words in section 2 when all of the other contextual factors are taken into account. The ordinary and natural meaning of the words and these other factors (the purpose of the Act and the application of a hierarchy of constitutional rights) also support an interpretation of section 57 which encompasses the administration of nasogastric feeding under restraint. However, it seems to me that the question of safeguards is fundamental to the proper interpretation of section 57 and the absence of an independent review has a much more significant weight in the range of relevant factors in respect of section 57 than in respect of the definition section. I am satisfied that, in the absence of that safeguard, the legal effect of section 57 properly construed is that it does not encompass nasogastric feeding under restraint, because if that was the intended effect of the provision, it would have been accompanied (either within or outside the Act) by safeguards and in particular by a provision for independent review.

228. If the effect of this interpretation were to preclude a person who requires nasogastric feeding from obtaining that treatment then this could not be the proper construction of the section because that would not accord with the constitutional imperative to ensure that a person who lacks capacity would receive treatment. However, the Court has an inherent jurisdiction to make Orders to ensure that a person's lack of capacity does not prevent them from obtaining treatment which is necessary to vindicate their right to life. Thus, the fact that section 57 does not apply to nasogastric feeding under restraint does not preclude a person who requires such intervention from receiving it.

229. Of course, it is open to the Oireachtas to make a statutory provision for the administration of nasogastric feeding under restraint accompanied by the necessary safeguards. The nature of such a review is in the first instance a matter for the Oireachtas. The 2001 Act already provides for different types of independent reviews in respect of different

decisions: for example, it provides for a detailed review hearing process before a Mental Health Tribunal in respect of admission and renewal orders; it provides for a review by a Mental Health Tribunal of a proposal to perform psycho-surgery on a patient (section 58); and provides for a review (in the form of authorisation by a second consultant psychiatrist) of a proposal to administer electro-convulsive therapy (section 59) or the continuation of medication after a period of three months (section 60). It is a matter for the Oireachtas in the first instance to determine what type of review should be provided for and, indeed, to determine matters such as at what stage(s) or frequency they should occur and the Court must be careful not to trespass on the functions of the legislature. The question for the Court was whether there was adequate provision for a review and, being satisfied that there was not, it should not go any further.

INHERENT JURISDICTION

230. This matter came before the Court as an application under the Court's inherent jurisdiction. It was submitted (and agreed by the parties) that in order for the Court to be able to make an Order under its inherent jurisdiction it would have to be satisfied that the 2001 Act did not provide for the administration of nasogastric feeding. The HSE's position was that the administration of nasogastric feeding including under restraint was provided for under the Act but that if I concluded that it was not, then an Order under the Court's inherent jurisdiction to permit, inter alia, the administration of nasogastric feeding was sought.

231. I have concluded that the administration of nasogastric feeding under restraint is not provided for under section 57. Thus, the Court's inherent jurisdiction is available. However, it is a jurisdiction which must only be exercised in specific factual circumstances and on foot of a live application. In light of the factual circumstances outlined above, there is no application before the Court under its inherent jurisdiction and I therefore do not need to consider whether or not it would be (or would have been) appropriate to exercise it in this case. This also means that it is not necessary to determine the question of whether or not, if the Court were to make an Order permitting nasogastric feeding, it would have to make a full suite of Orders including providing for the detention of the respondent or whether that jurisdiction can be used to supplement the provisions of the 2001 Act.

RELIEFS

232. I will hear from the parties in relation to the precise Orders which should be made. My provisional view is that I should make a declaration that nasogastric feeding under restraint which is administered to remedy and ameliorate the mental disorder of an adult who is an involuntary patient under the 2001 Act constitutes "treatment" for the purposes of section 2 of

the Act (I do not believe that I should include reference to "or its consequences" as sought in the Points of Claim) and that I should refuse the declaration that it constitutes "treatment" for the purpose of section 57. The declaration sought is set out at paragraph (I) of the Points of Claim. My provisional view is that I should not make any Orders in respect of the relief sought in the Notice of Motion (and at (II) of the Points of Claim) in circumstances where I have not considered the relief sought under the Court's inherent jurisdiction in light of the removal of nasogastric feeding from the respondent's treatment plan and her discharge from the hospital/approved centre. However, I will hear from the parties on these matters.