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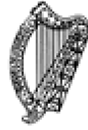

THE COURT OF APPEAL

Record Number: 2023/77

Binchy J. Neutral Citation Number [2023] IECA 244

Allen J.

Burns J.

BETWEEN/

LW and RL

APPELLANTS

- AND -

THE HEALTH SERVICE EXECUTIVE

RESPONDENT

JUDGMENT of Ms. Justice Tara Burns delivered on the 9th day of October, 2023.

1. This is an appeal against the judgment of the High Court (Meenan J.) [2023] IEHC 48, who made a Declaration in favour of the appellants to the effect that:-

> *"the respondent is under a continuing duty to provide LW with the appropriate mental health treatment and services in accordance with law, in particular the provisions of s. 7 of the Health Act 2004 (as amended)"*

2. Section 7 of the Health Act 2004 (as amended) provides, *inter alia*:-

> *"7. (1) The object of the Executive is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.*
>
> *(2) Subject to this Act, the Executive shall, to the extent practicable, further its object.*
>
> *…*
>
> *(5) In performing its functions, the Executive shall have regard to—*
>
> *…*
>
> *(d) the resources, wherever originating, that are available to it for the purpose of performing its functions, and*
>
> *(e) the need to secure the most beneficial, effective and efficient use of those resources…"*

3. That such a Declaration is appealed against might be considered surprising as a reasonable interpretation of that Declaration could be considered as confirming the duty on the respondent to provide the first named appellant with appropriate mental health treatment relevant to his medical needs having regard to s. 7 of the Health Act 2004.

4. A range of orders were sought before the High Court but were refused as the court found, having regard to *TD v. Minister for Education* [2001] 4 IR 259, that it had a limited role and jurisdiction in relation to the reliefs sought and therefore the appropriate order which could be made by the court was restricted in terms of what was sought by the appellants.

5. The refusal by the High Court to grant the actual reliefs sought, together with the Declaration granted, are the orders which are appealed by the appellants. However, what occurred after the Declaration was granted is of importance as the correct interpretation and implementation of the Declaration is also in dispute with the factual situation pertaining to the implementation of the Declaration being relied upon in terms of the relief sought.

Background

6. The first named appellant has been diagnosed as suffering from a personality disorder and paranoid schizophrenia characterised by persecutory delusions. He has a serious history of random violence against members of the public and prison officers. He also has a long history of polysubstance abuse. Schizophrenia cannot be cured but can be treated and involves the administration of anti-psychotic injections together with other psychological supports to include cognitive behavioural therapy and mental health assessments.

7. The first named appellant had been provided with this treatment when he was detained in prison where he was serving long sentences in relation to a number of very serious assault offences. He was administered with anti-psychotic injections and received regular counselling and support from a psychologist on a weekly basis and a psychiatrist on a bi-weekly basis. Whilst the appellant has a very violent and dangerous disposition, it was considered that he made sufficient progress with this treatment that the high level security conditions which his detention entailed were reduced.

8. The appellant was due to be released from prison in August 2019 and clearly would require ongoing mental health treatment in the community. Prior to his release, Dr Frank Kelly, Consultant

Psychiatrist with the National Forensic Mental Health Service who had been involved with the first named appellant when he was detained in prison, referred the first named appellant to the North Dublin Community Mental Health Team (CMHT) which provides integrated care in the community for persons with mental health problems. The first named appellant's GP, Dr. Wallace, also made this referral after significant involvement with the first named appellant and consultation with Dr. Kelly. The CMHT refused to accept the first named appellant for treatment due to the very high risk of violence associated him. Dr. Robert Daly, consultant psychiatrist and executive clinical director of the CMHT stated at paragraph 13 of his affidavit:-

> *"The risk of violence associated with the first named [appellant] were and remain, in my opinion at a very high level to such an extent as to [make] (sic) delivery of the services that the first named [appellant] seeks in the […] service impossible. He is documented as using very extreme and diverse forms of violence since an early age, of having routinely carried weapons in the community and having used them indiscriminately with criminal and lethal intent."*

At paragraph 14 of his affidavit, Dr. Daly set out factors which led to the decision to reject the referral of the first named appellant as:-

- *"During the 8 months prior to his release from prison the first named [appellant] was detained in the violence reduction unit in [] Prison.*
- *In addition to schizophrenia, the first named [appellant] is also considered to have Dissocial Personality Disorder and Impulse Control Disorder.*

- *The first named [appellant] has a significant history of polysubstance abuse which included abuse of alcohol, cocaine and benzodiazepines. His criminal history is largely associated with these abuses. These risks are heightened while he is in the community.*
- *He is documented as having routinely carried weapons while in the community which were carried for purposes that were stated by him to include personal protection because of his peer group.*
- *His history of violence was considered to be reactive and as the years have progressed has increased in severity.*
- *His history of violence continued while in prison during which time he is accredited with 275 disciplinary reports including assaults on prisoners and staff, with the majority of his violence directed towards staff.*
- *He has a history of threats towards staff in prison and in the violence reduction unit.*
- *That violence was used by him as the dominant way of meeting his needs and that it was a core part of his identity.*
- *That his use of violence was impulsive, reactive and used to regulate his self-esteem.*
- *He used weapons for profit/gain and to control situations.*
- *His violence was considered to be a form of excitement for him.*
- *He was a high risk of violence if he used substances, associated with criminal peers or encountered unexpected changes and in circumstances of grudge.*
- *He is considered to be at high risk of lethality with capability to target individuals but also has a tendency to deploy violence indiscriminately."*

Dr. Daly also averred to the fact that there was no lawful basis for the CMHT to require the first named appellant to be searched prior to his entry to the service; to be restrained if the necessity arose; or to have his personal liberty restricted. Having regard to these reasons, Dr. Daly was of the opinion that the first named appellant was of such an extremely high risk to the staff and service users of the CMHT that he could not be accepted as a patient.

9. The National Forensic Mental Health Service does not have a role in the care of mentally unwell persons in the community, including persons released from prison. However, Dr. Kelly continued to be involved with the first named appellant after he was released from prison, as a care regime was not in place. Dr. Kelly began administering anti-psychotic (depot) injections to the appellant in September 2019 which initially were administered every three months. This was a very informal arrangement which took place at the first appellant's residence, and on one occasion in an out-patients facility managed by the National Forensic Mental Health Services. This arrangement was intended as a stop gap measure until a formalised care plan was put in place. In June 2021, Dr. Kelly stopped administering these depot injections to the first named appellant. The definitive reason for this is not averred to in the affidavits, although the suggestion is that he was advised to do so by his director, the clinical director of the National Forensic Mental Health Services. Dr. Kelly also was on long term sick leave during this period. Whatever the reason, for a six month period, Dr. Kelly did not administer the injections. During this period, the second named appellant, on occasion, took that responsibility. Dr. Kelly became engaged with the first named appellant again in January 2022 and recommenced providing the first named appellant with depot injections, although on a less regular basis. Dr. Kelly unfortunately passed away suddenly in September 2022.

10. The first named appellant's situation was summarised in an extremely insightful letter dated 18 November 2021 from Dr. Stephen Monks, Consultant Forensic Psychiatrist and Dr. Lisa McLoughlin, Consultant Forensic Psychiatrist, both of the National Forensic Mental Health Service, to Professor Kennedy, then Clinical Director of the National Forensic Mental Health Service. While this letter was not exhibited in an affidavit, agreement had been reached between the parties prior to the hearing in the High Court that this letter, along with a number of other letters, could form part of the evidence in the matter without further proof. Relevant portions of the letter state:-

> *"As you are aware, LW,…, has a long standing history of violence which has been underpinned by a severe personality disorder and chronic abuse of illicit drugs. Prior to his release from prison in August 2019 he had 115 charges on his criminal record. The majority of his offences are violent in nature. He has 51 charges for Assault, 6 charges for Threats to kill and 9 charges for Possession of Weapons. [LW] has a history of both reactive and instrumental violence. His use of violence began at a young age and has escalated in severity over time. He has routinely carried weapons in the community.*
>
> *LW has a history of substance misuse. He began abusing substances (alcohol, cocaine, Benzodiazapines) at the age of thirteen. His substance misuse escalated over the course of his adolescence. Much of LW's community based violence has been perpetrated under the influence of substances.*
>
> *LW also has a severe personality disorder characterised by dissocial and emotionally unstable traits: Impulsivity; Low frustration tolerance; Emotional regulation difficulties; Need for*

stimulation/proneness to boredom; Lack of remorse/guilt; Early behavioural problems; Criminal versatility; Disregard for social norms.

Recent records from his GP and A&E attendance suggest that he continues to engage in substance abuse and violent behaviour.

[LW]'s history of extremely violent offending commenced at an early age. In 2007, aged 18, he was sentenced to 13 years for such offences. He perpetrated multiple violent assaults while in prison receiving 275 P19 disciplinary reports many of which were for violet behaviour….

He was diagnosed with schizophrenia in 2017 in prison….His history of violence predates his diagnosis of schizophrenia by many years but as such schizophrenia represents an additional risk factor for violence…

…

In summary

[LW] is a man with schizophrenia, severe personality disorder and substance use disorder. He has a long history of violent assaults and carrying weapons and presents a chronic high risk of volatile, unpredictable, high lethality violence. Safely managing his psychiatric treatment needs – which at a minimum would be to administer and monitor his depot antipsychotic medication and review his mental state periodically – would require a level of secure community forensic mental health provision that does not exist and is not possible within the current physical, procedural or relational security resource of the National Forensic Mental Health Service community operations.

As per your comments in the multiagency meeting of October 2019 we would fully agree with your observations:

- *LW presents an exceptional risk*
- *The local mental health service understandably feel that it is not safe for them to provide a service to LW*
- *Usher's Island is not safe or resourced for this level of risk.*
- *The National Forensic Mental Health Service does not have a resource for a safe way of managing this type of patient in the community*
- *The National Forensic Mental Health Service cannot work with uncontrolled serious risk*
- *Dr Kelly's arrangement for providing LW with a depot injection is not safe*
- *As managers we are obligated to consider staff safety.*

As you have noted, the provision of psychiatric care and treatment for LW – a released prisoner – lies outside the normal structure of the National Forensic Mental Health Services. There has been no change in the planning or resourcing of the NFMHS since he was released from prison. We cannot identify any safe way to manage the risk within the current organisation resourcing and structure and as we understand it there has been no further progress by the HSE since the multiagency meeting of October 2019 in creating an appropriate or safe mental health service to meet the treatment needs of LW or other released prisoners who may have similar treatment needs and risks.

Under these circumstances, having carefully considered our ethical and contractual obligations, and on foot of this assessment of LW's treatment needs and risks, it remains the case that although we fully appreciate the need for LW to receive treatment this needs to be delivered in a way that ensures the safety of treating clinicians and other HSE staff. To proceed without the appropriate level of therapeutic security or risk management plan in place to adequately mitigate the identified risk of high lethality violence, would put the safety, health and welfare of a number of HSE employees at significant risk. At this juncture we do not believe it is safe to conduct any further clinical assessment or treatment in the absence of the necessary resources and safeguards."

11. The first named appellant avers to being anxious to engage in psychiatric and psychological supports. He wishes to have his medical condition controlled such that he will not re-engage in violent behaviour. Since his release from prison in 2019, he has engaged well with the various professionals and agencies he has had interaction with, namely his GP, Dr. Kelly and the residential team where he resides. However, there are matters of concern. He has continued to use cocaine and cannabis and continues to have violent ruminations.

12. Prior to the hearing in the High Court, an offer was made by Dr. Brenda Wright, Consultant Forensic Psychiatrist and Interim Executive Clinical Director of the National Forensic Mental Health Service to discuss the first appellant's medication with him.

13. On the morning of the opening of the hearing in the High Court, the respondent indicated by letter that arrangements had been made for the continued administration of the depot injections for December

and January at the Central Mental Hospital subject to certain conditions being met by the first named appellant.

14. After the High Court proceedings concluded, the appellants' solicitor wrote to the respondent's solicitor asking for clarification as to what services would be provided to the first named appellant in light of the Declaration of the High Court. The first named appellant had continued to receive depot injections administered by Dr. Wright at the Central Mental Hospital on an *ad hoc* basis since the hearing before the High Court. Dr. Wright also engaged in video consultations with the appellants prior to the depot injections being administered and regularly followed up with the first named appellant's G.P. A substantive reply was sent on behalf of the respondent which detailed the various supports which were in place and actions which had been taken in relation to the first named appellant. It was asserted on behalf of the respondent that that first named appellant continued to receive appropriate mental health treatment and services in all the circumstances.

15. The first named appellant's solicitor replied posing the question:-

> *"why in the exceptional circumstances of [LW's] situation, can he not receive the services of a multi-disciplinary team in the [Central Mental Hospital] while he is in attendance on the campus."*

High Court

16. The core substantive reliefs sought before the High Court were:-

> *"1. An Order by way of judicial review quashing the continuing refusal of the respondent refusing L.W.'s application for community based mental health services. In the alternative, an*

order of mandamus compelling the respondent to consider and determine L.W.'s application for community based mental health services.

2. A Declaration that the respondent erred in law and in excess of jurisdiction and/or had no legal basis for determining that L.W. was not entitled to community based mental health care.

3. A Declaration that the respondent has failed to vindicate L.W.'s rights to bodily integrity and equality due to its failure to provide a means by which L.W. can access the mental health supports and treatment that he needs, otherwise than by being admitted to a mental hospital as an involuntary patient or being returned to prison.

4. A Declaration by its refusal the respondent has discriminated against L.W. contrary to Article 14 of the European Convention on Human Rights, by treating him unequally before the law in an unjustified manner.

5. A Declaration that the failure of the respondent to provide L.W. with the urgent mental health supports and treatment that he needs, amounts to invidious discrimination against L.W., contrary to Article 40.1 of the Constitution and contrary to the respondent's obligations under s. 3 of the European Convention on Human Rights Act, 2003, to vindicate L.W.'s rights under Article 14 ECHR.

6. A Declaration that in the exceptional circumstances of L.W.'s case as outlined that he enjoys a constitutional right to community based medical care and/or a right to be assessed for same."

17. Clearly the aim of the reliefs sought by the appellants before the High Court was that the first named appellant gain access to appropriate community based mental health services. The appellants asserted that the refusal to provide this service resulted in the appellants' constitutional rights to equality and bodily integrity being breached.

18. The High Court found that the appellants had failed to establish that he had been treated unequally as he failed to identify an appropriate comparator who had been treated differently to him and in fact relied on his circumstances as being exceptional. With respect to the asserted breach of his right to bodily integrity, the High Court found that as this was not an absolute right, the decision to refuse this treatment was not in breach of his right to bodily integrity as the refusal was both reasonable and proportionate in the circumstances and open to Dr. Daly to make. The High Court also found that Article 8 and 14 of the European Convention on Human Rights were not breached.

19. However, the High Court found that s. 7 of the Health Act 2004, as amended, was engaged. Owing to the first named appellant's mental health condition and propensity to violence, there was a duty on the respondent to protect the public by providing the first named appellant with appropriate mental health treatment and services.

Appeal before this Court

20. The appellants have appealed the refusal by the High Court to grant the reliefs sought and the Declaration granted on the grounds that the trial judge, in substance, failed to determine what level of mental health treatment was lawful and appropriate and where those services should be provided to the first named appellant; failed to find that there had been a breach of the first named appellant's constitutional rights pursuant to Articles 40.1 and 40.3 of the

Constitution; and failed to consider whether a breach of the first named appellant's rights under Article 8 in conjunction with Article 14 of the European Convention on Human Rights existed.

21. While a number of declarations were sought in the Notice of Appeal, Counsel for the appellants indicated at the hearing before us that the reliefs which were sought were the Declarations set out at 3 and 5 in paragraph 16 above.

Preliminary Objection

22. An issue arose in the appeal before this Court as to whether the case being made on appeal was comprised within the case which had been pleaded and argued in the High Court. The relief which was sought before this Court, in essence, was that the first named appellant should be accepted as an outpatient of the Central Mental Hospital and receive the entire package of psychological supports, to include cognitive behavioural therapy at that facility. This was not the case which was made in the High Court, where the claim squarely was that the respondent was under a duty to provide the first named appellant with community based mental health services. The Central Mental Hospital is not such a service being a secure facility with access to its services regulated by statute and available only in a limited defined context. When Counsel for the appellants was challenged about this difficulty, his response was to the effect that the Central Mental Hospital was brought into the equation by the respondent at the High Court hearing and that the appellants did not care where the appropriate treatment was provided once it was provided at some facility.

23. I accept that the Central Mental Hospital was introduced into the equation by the respondent when an *ad hoc* service to be provided by Dr. Wright was offered to the first named appellant in the course

of the High Court hearing, and by the continuation of the provision of that service since the High Court Declaration. However, as this is an appeal from judicial review proceedings, it is not appropriate that a case not pleaded or argued before the High Court should now be determined by this Court. In *AP v. Director of Public Prosecutions* [2011] 1 IR 729, the Supreme Court held that the High Court fell into error by analysing issues which fell outside the statement of grounds, in the absence of an order amending the grounds or consent to same. Denham J explained at pp 734-735:-

> *" When an applicant seeks leave to apply for judicial review he does so on specific grounds stated in the statement required. On the ex parte application for leave the High Court Judge may grant leave on all, or some, of the grounds sought or may refuse to grant leave. The order of the High Court determines the parameters of the grounds upon which the application proceeds. The process requires the applicant to set out precisely the grounds upon which the application is to be advanced. On any such application the High Court has jurisdiction to allow an amendment of the statement of grounds, if it thinks fit. Once an application for leave to appeal (sic) has been granted the basis for the review by the court is established.*
>
> *...*
>
> *... A court, including this court, is limited in a judicial review to the grounds ordered for the review on the initial application, unless the grounds have been amended."*

24. The instant case is a good example as to why this is so. In the appeal before us, submissions were made regarding the conditions for admissibility to the Central Mental Hospital and whether the first named appellant could be treated there. None of these arguments

featured in the High Court, nor could they have, as the grounds for the relief sought was the refusal of community based treatment by the respondent. As an appellate court, this Court cannot determine issues which were not a feature before the trial court. This Court acts as an appeal court and not a court of first instance and therefore is bound by the pleadings and the case made before the High Court. This is particularly the case in judicial review proceedings where the High Court, and this Court on appeal, are limited to the grounds permitted at the *ex parte* leave stage. In the instant case, the grounds on which leave was granted related only to the failure to provide community mental health services, as opposed to treatment in the secure facility of the Central Mental Hospital.

25. A further difficulty for the appellants in terms of the relief which they now seek in relation to the Central Mental Hospital is that the very reasons which restricted the jurisdiction of the High Court also restricts the jurisdiction of this Court. Like the High Court, this Court cannot direct an action which interferes with the separation of powers (*TD v. Minister for Education* [2001] 4 IR 259) nor should it interfere with the decisions regarding prioritisation of a treating physician (*D.H. v Ireland* [2000] WJSC HC 3812) and *E.T. v. Clinical Director of the Central Mental Hospital* [2010] 4 IR 403). Neither should it interfere with the clinical judgment of a treating physician such that it would direct what treatment a patient should receive (*D.H. v Ireland*). While the appellants urge that they are not looking for prioritisation for the first named appellant and that the additional request of the provision of psychological support in the Central Mental Hospital cannot be a significant cost, these are not appropriate matters for the Courts to enquire into or become engaged with. Having regard to each of these principles, I am in agreement with the trial judge that the Court is limited with respect to what it can direct the respondent to provide to the appellant.

26. Finally, it is not appropriate for this Court to engage, on appeal, in an analysis of how the High Court's Order should be interpreted or implemented. In the first instance, an appeal in judicial review proceedings is not an appropriate method to determine whether the respondent is in breach of the High Court Order made in those proceedings. Further, an evidential deficit exists with respect to any such enquiry by virtue of the fact that this is an appeal process. There is no evidence before the Court regarding what has been provided to the first named appellant since the High Court Order was declared or whether all the treatment which has been provided to the first named appellant amounts to compliance with the duty to provide appropriate mental health treatment in accordance with s. 7 of the Health Act 2004. These are matters which – if in issue – are properly to be determined by a different set of proceedings rather than on appeal from the court which ordered them.

27. For all of these reasons, I am of view that this Court cannot make an Order requiring the respondent to provide cognitive behavioural therapy and other psychological supports to the first named appellant in the Central Mental Hospital.

28. The only case which the Court can consider is the case as pleaded in the High Court which relates to the refusal by the respondent to provide community based mental health services to the first named appellant.

Alleged Breach of Constitutional Rights

Article 40.1

29. Article 40.1 of the Constitution provides:-

"All citizens shall, as human persons, be held equal before the law. This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function".

30. The appellants argue that the first named appellant is being discriminated against because of a disability, namely a disposition to violence arising from his medical condition. It is argued that he is being treated differently to another person who suffers from schizophrenia because of the risk of violence which he presents with. This is submitted to be unequal treatment as violence is a manifestation of the medical condition which he suffers from which the respondent must facilitate rather than utilising as an excuse. Comparison with a prisoner was also suggested in that a prisoner with the same condition and violent manifestations as the first named appellant would be able to access a full suite of treatments (as the first named appellant had done when in custody) compared to the first named appellant who was now not in a custodial setting. It was also submitted that the appellants did not have to identify an appropriate comparator.

31. The respondent argues that a breach of the first named appellant's Article 40.1 rights does not arise; that the appellants have failed to identify an appropriate comparator who is treated more favourably than the first named appellant; that the risk of violence which he presents with is not a disability arising entirely from his medical condition but is also related to his polysubstance abuse; that the right to be treated equally is not an absolute right; and that the difference in treatment in the instant case is justified and is not invidious treatment having regard to the risk of violent behaviour which he poses to other patients and staff.

Discussion and Decision

32. Not the least difficulty for the appellants in this regard is that the first named appellant describes his situation as "exceptional" and "novel". These are apt descriptions having regard to the evidence in the case which refers to this situation not having arisen previously, although it may arise in the future. Accordingly, identifying an appropriate comparator is difficult if not impossible for the appellants.

33. The first named appellant is not comparable to another person diagnosed with schizophrenia because of the high level of risk of violence which he poses. The risk of violence is the differentiating feature between himself and such a person. Neither is he comparable to a prisoner with the same condition and violent manifestation as himself as such a person is in a secure setting and subject to a different legal regime in terms of liberty. This causes a difficulty in terms of asserting that he is being treated unequally to a comparable person. While the first named appellant asserts that he does not have to identify an appropriate comparator, the law says otherwise. As stated by O'Donnell J (as he then was) in *MR and DR (minors) v. An t-Ard Chláraitheoir* [2014] 3 IR 533 at paragraph 241:-

> *"[a]ny assertion of inequality involves identifying a comparator or class of comparators which it is asserted are the same (or alike), but which have been treated differently (or unalike)."*

In *Minister for Justice and Equality v. O'Connor* [2017] IESC 21, O'Donnell J. stated at paras 21-22 of the judgment:-

> *"The essence of an equality claim is the sense of injustice that someone experiences when a person similarly situated is being treated differently and normally more favourably and in*

particular if the circumstances are suggestive of a discriminatory ground related to a person's human personality…. It is difficult then to see how there could be a breach of the entitlement to equality before the law unless another person in a directly similar situation was provided with markedly superior services, and particularly if the basis of the distinction was questionable."

34. The case law establishes that an appropriate comparator must be established for an equality claim to be successful. The first named appellant is not in a position to do that due to the unique characteristics with which he presents. Furthermore, the difference in treatment to another person suffering schizophrenia is justified on the basis of the high level of risk the first named appellant poses to care providers and other patients. With respect to a prisoner with a similar condition and manifestation, the difference in treatment is justified by reference to the different restrictive conditions such a person is held under. Having regard to the evidence in this case, there is an objective and reasonable basis to treat the first named appellant differently to the comparators he has identified. Accordingly, unequal treatment is not established and a breach of Article 40.1 of the Constitution or Article 8 in conjunction with Article 14 of the European Convention of Human Rights does not arise.

35. The appellants assert that the risk of violence which is relied upon is a manifestation of his medical condition and therefore a disability which he suffers from. It is submitted that the first named appellant is being discriminated against on the basis of a disability, this being prohibited by the Convention on Rights of Persons with Disabilities. Surprisingly, there is limited specialist medical evidence before the Court in relation to the first named appellant's condition. However, having regard to the letter written jointly by Consultant Forensic

Psychiatrists, Dr. McLoughlin and Dr. Monks, it is clear that their opinion is that schizophrenia is not the sole cause of the first named appellant's violent disposition and that there are many other reasons for this. On the basis of the evidence, I am of the opinion that his violent disposition is not solely a manifestation of schizophrenia such that it should be considered as a disability. Accordingly, the question of whether a breach of the Convention on Rights of Persons with Disabilities does not arise.

Right to Bodily Integrity

36. The appellants rely on the first named appellant's right to bodily integrity within the context of an equality claim. As I have determined that the equality claim falls at the first hurdle, as an appropriate comparator cannot be identified, it is nevertheless appropriate that I should consider whether the first named appellant's right to bodily integrity and access to appropriate medical treatment pursuant to Article 40.3.2 of the Constitution has been breached.

37. Article 40.3.2 of the Constitution provides:-

> *"The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights pf every citizen."*

38. The difficulty with respect to the alleged breach of this constitutional right is that the right to bodily integrity is not an absolute right. The *State (C) v. Frawley* [1976] IR 365 is particularly relevant to the instant case where it was held that the right to bodily integrity did not extend to a right to the best possible healthcare. Finlay P. stated at pp 372 – 373 of his judgment:-

"The real failure in this duty alleged against the respondent is that he has failed to provide the special type of institution and treatment which was recommended by Dr. McCaffrey as a long-term treatment and that, to an extent, imprisonment in any other form is directly harmful to the progress of the prosecutor's condition of personality disturbance. A failure on the part of the Executive to provide for the prosecutor treatment of a very special kind in an institution which does not exist in any part of the State does not, in my view, constitute a failure to protect the health of the prosecutor as well as possible in all the circumstances of the case. If one were to accept in full all the assumptions upon which Dr. McCaffrey's opinion is based, it could be shown that there was a failure of an assumed absolute duty to provide the best medical treatment irrespective of the circumstances. I am satisfied, as a matter of law, that no such absolute duty exists.

It has been urged on behalf of the prosecutor that the respondent cannot be excused from his duty to provide this very specialised type of psychiatric treatment on the grounds of the non-availability of the appropriate facilities since that non-availability flows from an unconstitutional failure on the part of his superiors to provide this specialised type of institution with appropriate staff. Even though the number of persons suffering from a condition even generally akin to that of the prosecutor may be as low as six, not all of whom are in custody, a description of the progress and consequence of the prosecutor's disturbance and the nature of his life in prison would make the availability of appropriate long-term treatment most desirable as a matter of compassion.

However, it is not the function of the Court to recommend to the Executive what is desirable or to fix the priorities of its health and welfare policy. The function of the Court is confined to identifying and, if necessary, enforcing the legal and constitutional duties of the Executive. I cannot conscientiously hold, no matter where my sympathy might lie, that an obligation to provide for prisoners in general the best medical treatment in all the circumstances can be construed as including a duty to build, equip and staff the very specialised unit which Dr. McCaffrey has recommended and which might be appropriate to the needs of the prosecutor and four or five other persons. Therefore, I am satisfied that the first main contention of the prosecutor fails."

39. The established risk which the first named appellant poses to other patients and staff presents a justifiable reason not to provide the first named appellant with the treatment which he seeks and which, in any event, he does not have an absolute right to.

Order of the Court

40. The question arises as to what the appropriate order of this Court should be. It is difficult to understand exactly what the appellants seek from these proceedings in addition to or in place of the Declaration already granted by the High Court. Counsel for the appellants insisted that the appellants are not seeking to direct what treatment should be administered in addition to the depot injections. At a minimum, he argues that an up-to-date full mental health assessment should take place which would advise all necessary future treatments. In many ways it is difficult to see how carrying out such an assessment is not covered by the terms of the High Court Declaration already granted. As I have previously stated it is not appropriate that this Court engage in an assessment of what the High

Court Order requires. Other means exist for that issue to be determined. Accordingly, I am of the opinion that in the circumstances of the case, it is appropriate that the High Court Order be affirmed by this Court as the first named appellant is entitled to to the provision of appropriate health care within the constraints of s.7 of the Health Act 2004.

41. For these reasons, the appeal must be dismissed.

42. The appellants have been entirely unsuccessful in their appeal. Accordingly, the usual rule that costs follow the event should apply which would result in a cost order of the appeal against them. However, if they wish to contend otherwise, I would give them leave to file and serve a short written submission – not exceeding 1,000 words - within fourteen days of the delivery of this judgment, in the event of which I would allow the respondent fourteen days to file and serve a response, similarly so limited.

43. As this judgment is being delivered electronically, Binchy and Allen JJ. have authorised me to say that they agree with it.