THE HIGH COURT

[2023] IEHC 20

Record No. 2022/6528P

BETWEEN

EC

PLAINTIFF

- and -

HEALTH SERVICE EXECUTIVE AND PETER WHITTY

DEFENDANTS

NOTICE PARTIES

EX TEMPORE JUDGMENT of Ms. Justice Niamh Hyland delivered on 15 January 2023

Introduction

1. This is an application for an interlocutory injunction brought in the context of plenary proceedings whereby the plaintiff, a 42 year old man currently detained in the Acute Psychiatric Unit in Tallaght University Hospital, seeks various declarations that his treatment with depot neuroleptic (also known as anti-psychotic) medication without a lawful procedure for determining capacity is unlawful and in breach of s.57(1) of the Mental Health Act 2001 and in breach of his constitutional rights. The plaintiff separately seeks a declaration that his physical restraint by the defendants for the purpose of administering depot medication is unlawful and/or breaches the provisions of the Mental Health Commission Code of Practice on the use of Physical Restraint in

Approved Centres 2009. (That Code of Practice has now been replaced by the 2022 Code of Practice that came into force 1 January 2023).

2. A further declaration is sought to the effect that, if s.57(1) permits the treatment given on the basis of the capacity analysis carried out by the defendants, then that section breaches Articles 40.3.1 and 40.3.2 of the Constitution and breaches the plaintiff's rights under various provisions of the European Convention on Human Rights. Finally, a permanent injunction is sought restraining the defendants from administering depot medication to the plaintiff and/or restraining the plaintiff for the purpose of administering depot medication. Damages are also sought.

Factual Background

3. The plaintiff was born on 8 September 1980 and has a long-standing diagnosis of schizoaffective disorder with religious delusions and has been treated with antipsychotic medications for many years. He has recently been diagnosed with Multiple Sclerosis. He was admitted involuntarily to the Acute Psychiatric Unit of Tallaght Hospital pursuant to an admission Order dated 9 December 2022. That admission Order was affirmed by a Mental Health Tribunal on 21 December 2022 and the period of his detention was extended to 29 March 2023 by a renewal Order made on 23 December 2022. The renewal Order was affirmed by a Mental Health Tribunal on 11 January 2023. The plaintiff remains detained as an involuntary patient.

4. During his detention, the plaintiff has refused to take oral medication save for on one occasion. He has refused consent to the administration of depot antipsychotic medication. On 15 December 2022 he was restrained and administered a depot injection of the antipsychotic clopixol. The second defendant, Dr. Whitty, avers in his evidence by affidavit that he carried out an analysis of capacity and concluded that the plaintiff did not have capacity to consent. On 22 December, the plaintiff was again restrained,

and a further depot injection of the same drug was administered. Again, Dr. Whitty avers that he carried out an analysis of capacity prior to the administration of the drug and concluded the plaintiff did not have capacity to consent.

5. In both instances where the plaintiff was restrained, the form entitled "Clinical Practice Form for Physical Restraint" issued by the Mental Health Commission was completed and has been provided to me. It may be seen from the form in relation to the restraint on 15 December that the restraint was carried out by three persons, all of whom appear to be nurses. The plaintiff's hands were held by two staff members and the third staff member appears to have held the plaintiff's head. The restraint is authorised for a two-minute period for the purpose of administering the depot. The restraint is described as follows "*TMVA Level 1 assistance used to turn [the plaintiff] over to facilitate IM injection*". Dr. Whitty avers that restraint is graded on three levels in the hospital and Level 1 restraint is the minimum level of restraint. He anticipates the same level will be required for the next depot. He exhibits the hospital's policy on restraint. That policy is entitled "Physical Restraint in the Approved Centre" and states that it has been developed by the South Central Mental Health Service. It is a 12-page document setting out in detail the principles governing restraint. It is clearly updated on an ongoing basis. It notes, *inter alia,* that restraint should be used only in the best interest of the patient, where all other methods of therapeutic intervention have failed and for the shortest possible duration. It requires the completion of the Clinical Practice Form for Physical Restraint that I refer to above. It refers to staff being required to have a clear understanding of the Mental Health Commission Code of Practice on the use of Physical Restraint in Approved Centres (2022) discussed below. It is clear from the provisions of the Policy that restraint has been carefully considered by the hospital and

is only used in clearly identified circumstances and the use of same is monitored and recorded.

6. On 21 December correspondence issued from the plaintiff's solicitors challenging the administration of the depot medication and the restraint used. There was a further exchange of correspondence between the plaintiff's solicitors and the defendant's solicitors over the next number of days and no further medication was administered by depot. The plaintiff continued to refuse to take oral medication. It is clear from Dr. Whitty's evidence that, had it not been for the legal dispute that had arisen, further medication would have been administered on the basis that it was required for the treatment of the plaintiff.
7. On 11 January 2023 following what Dr. Whitty describes as a deterioration in the plaintiff's condition, Dr. Whitty indicated his intention to administer further medication to the plaintiff as soon as possible, preferably within the next 48 hours. It was in those circumstances that the application was made to the Court.
8. Certain matters are not in controversy in this application.
    - The plaintiff has not adduced any medical evidence to contest the clinical views expressed by his treating clinicians.
    - The plaintiff is not contending that he does not suffer from a mental disorder within the meaning of the 2001 Act.
    - The plaintiff is not challenging the lawfulness of his admission to hospital and or the renewal of the admission Order.
    - Finally, the plaintiff is not contesting the clinical opinion that he lacks capacity. However, counsel for the plaintiff indicates that he wishes to challenge the averment of Dr. Whitty that he carried out an assessment of capacity on 13 and 20 December and 9 and 10 January 2023 on the basis that the medical notes do not disclose such

an assessment. He has not sought to cross examine Dr. Whitty and no notice of cross examination was served by the plaintiff. In any case, it seemed to me that given that this is an interlocutory hearing, it is inappropriate that I have a hearing on a contested issue where it is not necessary for the resolution of the motion to decide the facts in question. I will therefore proceed on the basis of the undisputed capacity assessment of Professor Kelly. Any issues relating to the capacity assessments carried out by Dr. Whitty may be ventilated at the full hearing if it appears to the parties and the trial judge that same is necessary.

Application before the Court

9. The matter first came before O'Moore J. on an *ex parte* basis on 12 January 2023, whereby the plaintiff sought liberty to serve short notice of a motion for an interlocutory injunction returnable to 13 January 2023. The motion served sought an interlocutory injunction pending the determination of the proceedings restraining the defendants from administering depot medication to the plaintiff and from restraining the plaintiff for the purpose of administering depot medication. When the matter came before the Court on 13 January, O'Moore J. granted the relief sought until 4pm on 14 January 2023 and made Orders as to the filing of legal submissions and affidavits prior to that hearing. Those directions were observed.
10. The matter came before me as duty judge yesterday, 14 January. I reserved my decision to today's date and extended the Order of O'Moore J. restraining the defendant from administering medication and restraining the plaintiff for that purpose until the provision of my decision on the application.
11. There was substantial evidence before me, including the grounding affidavit of Mr. Llussa, solicitor, sworn 12 January 2023 and the exhibits, a supplemental affidavit of Mr. Llussa of the same date exhibiting medical records, an affidavit of Dr. Whitty,

consultant treating psychiatrist to the plaintiff, sworn 14 January 2023, and an affidavit of Professor Kelly, consultant psychiatrist, Tallaght University Hospital, sworn 14 January 2023. There were extensive exhibits to Mr. Llussa's first affidavit, including the material before the two tribunals convened under the Mental Health Act 2001 in respect of the plaintiff's detention in Tallaght Hospital. I was also handed in, by agreement, the medical notes from 13 January 2022 in respect of the plaintiff, so that I had an up-to-date picture of the plaintiff's medical situation, as well as the forms completed when depot medication was provided to the plaintiff against his wishes on 15 and 22 December 2022 (described below). Legal submissions were also provided on behalf of both parties. The matter was heard on the basis of this evidence and no oral evidence was adduced.

12. Both parties must be complimented for putting before the Court such well organised evidence and informative and wide-ranging submissions in an exceptionally short period of time.

Principles applicable to interlocutory injunctions

13. The case law on same has recently been restated by the Supreme Court in the case of *Merck Sharp & Dohme v Clonmel Healthcare Ltd.* [2020] 2 IR 1. At paragraph 65, the steps that should be followed when identifying whether an injunction should be sought are set out. The third principle identified by O'Donnell J. appears particularly relevant to me in this regard i.e. that if there is a fair issue to be tried (and it probably will be tried), the Court should consider how best the matter should be arranged pending the trial, which involves a consideration of the balance of convenience and the balance of justice. I am also mindful of his statement that the fundamental objective is to minimise injustice.

14. Given the urgency of this application, the defendants have accepted solely for the purpose of the application that the plaintiff has established there is a fair question to be tried, albeit that the defendants in their own words are "*deeply sceptical as to the strength of the legal arguments underpinning the overall proceedings*". They also accept that this is not a matter in which damages would be an adequate remedy. They also point to the fact that these are proceedings with a public law dimension and therefore the observations of Clarke J. in *Okunade v. Minister for Justice* [2012] 3 IR 152 are of assistance. In a linked point, the defendants emphasise that legislation, including s.57(1), must be presumed to be constitutional.

15. I agree that there are public law elements to this case, given that it involves a challenge to a matter regulated by the 2001 Act i.e. the assessment of capacity for the purposes of consenting to medical treatment. I place particular emphasis on Clarke J.'s dicta in *Okunade* that, when considering where the greatest risk of injustice would lie the Court should give all appropriate weight to the orderly implementation of measures that are *prima facie* valid.

Relevant factors identified by the parties

16. I turn now to the factors that each side contends will adversely affect the plaintiff if their position is not adopted.

17. The defendants identify the following detriment to the plaintiff if the application is granted. Dr. Whitty identifies that the plaintiff is acutely unwell and any delay in the administration of his depot medication will result in a deterioration of his mental state. He concludes that the plaintiff's mental state has already deteriorated, and he is becoming more paranoid, increasingly hostile, more unpredictable, is exhibiting challenging behaviour and making abusive comments. He has an increase in religious and persecutory delusions, believing that he is God. He has displayed overfamiliarity

and inappropriate behaviour with another patient, and his interference in her care required her to be transferred to another ward. He is violent and aggressive and has thrown a table and chair into a window and damaged a wall in the dining area of the ward. Dr. Whitty says the increase in violence is predictable given the plaintiff's past history and is attributable to the "hold" on his antipsychotic medication. I place particular emphasis on that last sentence. I am aware from the material before the Tribunal that the plaintiff's history includes an assault on his brother and a member of the Gardaí and that he has a record of assaultive behaviour. Dr. Whitty concludes that the main precipitating factor in his overall deterioration is probably the delay in administering the depot medication.

18. In addition, Dr. Whitty identifies three specific detriments to a continuing absence of the depot medication. First, he avers the delay will add to the length of time the plaintiff will be required to remain in hospital for treatment for his mental illness. I infer from that that he is referring to the time from when the plaintiff is treated and not that the plaintiff will recover without medication. Second, while depot is a slow release medication, he notes that in view of the plaintiff's deterioration and escalating violent and aggressive behaviours, there is a need now for rapid tranquilisation of the plaintiff by way of faster acting medication (typically given intramuscularly up to 3 times per day). Third, his treatment plan was identified as likely involving fortnightly depot medication but because of the gap in the provision of same, it is more likely that he will require a weekly depot antipsychotic to effectively treat his mental disorder.

19. A flavour of the type of challenges that the plaintiff's condition is causing may be seen from the medical notes of 13 January 2023 provided to me by agreement at the hearing. It notes the plaintiff continues to refuse oral medication. *"[The plaintiff] then stood at window of the nurses' station and hit the glass shouting "you black bitch/you nigger*

everything". The notes refer to him shouting that the staff had taken his wife away from him and that he was observed pacing up and down the ward side and tearful. Reference is made to the incident where he threw the table and chairs and flipped them over and damaged the wall and a plastic bench.

20. Moving now to the detriment identified by counsel for the plaintiff, he submits that continuing to treat the plaintiff and continuing to restrain him, against his wishes, will mean that the plaintiff is subjected to unlawful acts without his consent. It is argued that non-consensual treatment of the plaintiff in the absence of a proper determination of his capacity to consent to treatment is unlawful and breaches his rights to respect for his dignity and autonomy, mental integrity, privacy and fair procedures. It is argued that until there is a determination of capacity pursuant to a clearly defined procedure in accordance with law, the plaintiff's non-consensual treatment is unlawful and ought to be restrained.

21. A similar argument is made in relation to restraint to the effect that there is no lawful basis for the use of restraint in the forced administration of medication to the plaintiff. The invasive nature of being restrained and the negative impact this will have upon the plaintiff is relied upon though no medical evidence is provided in this respect.

22. There is no specific identification of the protections that the plaintiff argues ought to be in place, but it is suggested that there ought to be independent oversight of the decision in relation to capacity. A comparison is drawn with the process in place in wardship proceedings where the Court makes the ultimate decision as to capacity, albeit informed by medical evidence. In relation to restraint, the nature of the protections required are not specified. However, a submission is made that neither the Mental Health Code of Practice on Restraint (2009 or 2022) apply to the restraint. I therefore infer that an

argument is being made that there ought to be an applicable code of practice governing restraint but that there is not.

Decision on application

23. In respect of the arguability ground, I accept there is a fair issue to be tried both because it seems to me the plaintiff has met that threshold and the defendants have accepted there is a fair question to be tried. I do not consider damages would be an adequate remedy in the circumstances of this case. That brings me to the balance of justice analysis.

24. Somewhat unusually, the principal detriment relied upon by the plaintiff is the alleged illegality of the procedures, rather than detriments identified by reason of the treatments themselves. For example, the plaintiff does not allege that he will be medically disadvantaged by the treatment being provided, that it will slow his recovery, that there is a better form of treatment, that oversight by a court would result in the treatment being withheld, that a different form of restraint would be preferable or that exposing him to restraint would cause him long lasting harm. No medical evidence is put forward to controvert the medical evidence referred to above to the effect that the plaintiff very much requires the treatment to recover from the acute stage of his illness. In fact, the plaintiff does not cavil with the medical evidence that this treatment is in his best interests. Rather, counsel says the plaintiff should not be subjected to such treatment while waiting for a determination as to whether the treatment is legal because it may turn out that he was subject to unlawful treatment.

25. In fact, in every case where a plaintiff is seeking to restrain behaviour it alleges is unlawful by way of an interlocutory injunction, and the injunction is refused but the plaintiff's case upheld at the trial of the action, then *ipso facto*, the plaintiff will have been subject to the unlawful conduct. To support the case for an injunction, a plaintiff

will usually pray in aid additional detriment over and above the fact of being subject to unlawful conduct. For example, if the plaintiff's goods are being seized by a statutory body, a plaintiff might seek an injunction on the basis that pending trial, there will be an interference with the plaintiff's business with consequent financial implications.

26. Of course, the plaintiff is entitled to rely upon the possibility of being illegally subject to treatment without additional detriment as the basis for an injunction; but the absence of any additional detriment is a highly relevant factor in this case.

27. I have no doubt here that the balance of convenience and the balance of justice require that I refuse the relief sought by the plaintiff in its application for an interlocutory injunction for three reasons.

28. First, the detriment identified by the defendants far outweighs the detriment of the risk of being treated unlawfully identified by the plaintiff. When applying the 2001 Act, I am mandated under s.4 to act in the best interests of the plaintiff. The plaintiff is deteriorating and will continue to deteriorate in the absence of treatment. That will have very negative consequences for him, including the risk of him assaulting others with whatever consequences that might entail for him. He is experiencing all the distress caused by an acute psychotic episode. There would have to be a very good reason indeed to restrain treatment in those circumstances. No such reason has been put before me. There are also potential consequences for other patients and for staff in not treating him. One patient has already had to be moved to another ward because of his behaviour. Staff members are being subject to aggressive and abusive behaviour. Medication is highly likely to ameliorate those consequences. Those factors alone strongly point to refusing the relief.

29. In addition, there is another quite separate basis upon which I consider the balance of justice dictates that I lift the prevailing injunction. That is that, paradoxically, as

recognised by counsel for the plaintiff, by bringing this application, the plaintiff has ensured that there is independent oversight of the medical conclusion expressed by Professor Kelly that the plaintiff lacks capacity. Accordingly, in relation to the administration of treatment between now and the determination of the proceedings, there has been independent oversight from the Court of the determination of capacity.

30. In relation to restraint, even if the plaintiff is correct and the Code of Practice of the Commission whether of 2009 or 2022 does not apply to the restraint, I am aware from the evidence that the defendants are approaching any restraint required as if the Code of Practice applies. The defendants are also applying their Policy on Physical Restraint that draws on the Code of Practice. Therefore, any concerns about restraint being applied without the necessary safeguards do not arise in practice in respect of restraint required to be used between now and the determination of these proceedings.

31. Finally, returning to the dicta in *Okunade*, I am influenced by the fact that s.57(1) specifically provides for consent to be dispensed with in respect of treatment where a person is incapable of giving consent. That section enjoys a presumption of constitutionality. Certainly, on one interpretation of that section, that capacity assessment may be carried out by the treating psychiatrist. I fully accept that the plaintiff is advancing a different interpretation whereby he argues that there is no provision in s.57 as to how capacity should be determined. Nonetheless I must bear in mind the observation of Clarke J. that the Court should give appropriate weight to the orderly implementation of measures that are *prima facie* valid. *Prima facie*, s.57(1) permits a patient's consent to be dispensed with when they cannot consent. I have before me uncontested evidence that this plaintiff does not have capacity from Professor Kelly. Therefore, the administration of medication without the plaintiff's consent is *prima facie* valid. I should be slow to restrain an act done pursuant to statutory

provisions at the interlocutory stage. Here, no counter-veiling considerations have been identified to justify this.

Conclusion

32. In the circumstances it appears to me that it is overwhelmingly obvious that the balance of justice favours the lifting of the injunction and I will therefore refuse the plaintiff's application for further interlocutory relief in this respect.