THE HIGH COURT

[Record No. 2026 36 MCA]

[2026] IEHC 498

Between

HEALTH SERVICE EXECUTIVE

Applicant

and

MM (A PERSON LACKING CAPACITY NOT SO FOUND REPRESENTED BY HER GUARDIAN AD LITEM)

Respondent

MENTAL HEALTH COMMISSION

Notice Party

Judgment of Mr. Justice Dignam delivered on the 22nd day of July 2026

TABLE OF CONTENTS

INTRODUCTION

1. These proceedings are directly concerned with the validity and applicability of an advance healthcare directive executed by the respondent ("Ms. M"), with Ms. M's capacity at the time of the hearing to make decisions in relation to psychiatric treatment and treatment for physical health conditions, the HSE's authority to administer treatment for those physical health conditions, and the Court's jurisdiction to make Orders providing for the administration of treatment, including under restraint and/or sedation if necessary.

2. The issues require detailed consideration of certain provisions of the Assisted Decision-Making (Capacity) Act, 2015 (the "2015 Act"). This Act has been described by Hogan J as "*the most fundamental change in the legal regime governing vulnerable persons in well-nigh 150 years*" (*The Child and Family Agency v KK [2024] IECA 242*). Among the many significant changes brought about by the 2015 Act was the introduction of provisions for binding advance healthcare directives ("AHD") and these provisions form the focus of much of this judgment.

3. Barniville P considered the provisions relating to advance healthcare directives in *Governor of a Prison v XY [2023] IEHC 361*. This was in a very different context and concerned different issues. To the best of my knowledge, the relevant provisions have not been the subject of any other written judgment. I am therefore very grateful to the parties for their very considered and helpful written and oral submissions. The issues, particularly those relating to the interpretation of those provisions of the 2015 Act, are novel and difficult. The submissions which were made, and the manner in which they were made, were extremely helpful.

4. I made an order that the proceedings be heard otherwise than in public. I did so because section 92(7) of the 2015 Act provides that hearings under Part 8 of the Act shall be heard and determined otherwise than in public. Relief was also sought under the court's inherent jurisdiction which is not subject to section 92(7). It was not possible to entirely separate out the different reliefs. I therefore decided that the proceedings in their entirety should be heard in camera (see *Governor of a Prison v XY*). It is appropriate that I make this judgment public in circumstances where it involves some matters which are not covered by any in camera rule and some questions of broader public interest and application. I have taken steps to anonymise the judgment to remove any details which might tend to identify Ms. M. I did permit

a bona fide member of the press to attend and report on the proceedings subject to certain conditions for the reasons set out in a ruling on the first day of the substantive hearing, the 20th March 2026.

Background

5. I propose to summarise the facts as briefly as possible to identify the issues. I will consider the facts and the evidence in greater detail later in the judgment when discussing the issues arising.

6. Ms. M is a forty-five year old woman. She has a history of bi-polar disorder for which she required hospitalisation in 2006 and 2009. On the first of those occasions, she suffered a manic episode which entailed high mood, increasing activity levels, and disrupted sleep. This was treated with psychiatric medication during a three-month admission in hospital. Following discharge, she discontinued her psychiatric medication in 2008 and suffered a relapse of mania in 2009. She spent approximately three months in hospital on this occasion also.

7. Ms. M reports that her mental health was stable for an extended period of time. On the 6th January 2023, she presented for an assessment at Hospital A as a new patient. She had regular reviews since then. She was under the care of Dr. D or her team. It appears that during these reviews she informed the medical staff that she had reduced her psychiatric medication from the prescribed levels. This was contrary to medical advice. In May 2025, Ms. M told staff that she had reduced it further. Ms. M stopped taking her psychiatric medication at some point, but it is unclear precisely when she did so.

8. On the 6th November 2025, Ms. M executed an advance healthcare directive (provided for under section 84 of the 2015 Act), using the template provided by the Decision Support Service. I return to the terms of this AHD shortly, but for the moment it is relevant to note that Ms. M stated in the AHD that she did not want to receive any type of psychiatric medication. The validity and/or applicability of this AHD is at the core of these proceedings.

9. On the 24th December 2025, while she was on a Christmas visit to her parents, Ms. M called An Garda Síochána. An ambulance was called and she was brought and admitted to hospital (Hospital B) on an involuntary basis under the Mental Health Act

2001 (the "2001 Act"). On the admission order of that date, Ms. M's presentation was described as follows:

> "[Ms. M] is acutely manic, displaying signs of mania e.g. elated mood, tangential thought form, grandiose delusions, irritable, difficult to interrupt. She doesn't have insight into her illness. Thinks she is in hospital because there is a communication error, believes everyone is very tired as they don't understand. She needs inpatient admission to administer essential treatment, which is likely to alleviate her symptoms: failure to do so will deteriorate her mental illness."

The admitting doctor was satisfied that she had a mental disorder on the basis of section 3(1)(b) of the 2001 Act.

10. I understand this admission order was confirmed by a Mental Health Tribunal on the 12th January 2026 on the basis that Ms. M was a person suffering from a mental disorder within the meaning of section 3(1)(b) of that Act.

11. A renewal order was made on the 13th January 2026. This order stated that Ms. M:

> "..is acutely manic, grandiose delusions, pressured speech, irritable, tangential thought form, has no insight into illness and needs inpatient treatment to administer mood stabilising medication, which is likely to alleviate her symptoms, failure to do so will deteriorate her mental health further."

12. On the 14th January 2026, Ms. M was transferred to Hospital A, which is closer to her home.

13. Following her original admission to hospital on the 24th December 2025, no psychiatric medication was administered due to the existence of the AHD. It is also necessary to note at this stage that Ms. M also suffers from diabetes, high blood pressure and cholesterol. She was not taking her medications for these conditions and was not consenting to monitoring for her diabetes.

14. On the 22nd January 2026, the HSE issued the instant proceedings and brought an ex parte application seeking, inter alia, the appointment of Mr. David McCoy as Guardian ad Litem and orders in relation to service of the Originating Notice of Motion. I appointed Mr. McCoy and the motion was made returnable for the following day, the 23rd January 2026. On the 26th January 2026, I made interlocutory Orders permitting the administration of such medical treatment as was in Ms. M's treating doctor or

psychiatrist's opinion necessary for the purpose of securing her best medical treatment and welfare interests, including the administration of medication, including anti-psychotic medication, the extraction of blood for testing and monitoring glucose testing. I also made directions in respect of the exchange of written submissions to prepare the matter for a full hearing. The Guardian ad Litem also indicated that it was his intention to obtain an independent psychiatric report on the issue of Ms. M's current capacity and her capacity at the time that she executed the AHD.

15. There was a slight delay in obtaining that report and the matter had to be adjourned from its original hearing date. It was heard on the 20th and 23rd March 2026.

16. Ms. M received psychiatric medication from when the interlocutory Order was made.

17. There were a number of medical reports before the Court at the hearing and I refer to their contents during the course of this judgment. I also had the benefit of affidavit and oral evidence from Dr. D, affidavits and a joint statement of Ms. M's parents, attendance notes of Mr. McCoy with two individuals who witnessed Ms. M signing the AHD, and affidavits of Mr. McCoy, the Guardian ad Litem.

The advance healthcare directive

18. Ms. M completed the advance healthcare directive on the 6th November 2025 using the template provided by the Decision Support Service. Her signature was witnessed by two friends, Ms. A and Ms. V.

19. The AHD form contains a number of specific sections.

20. Section 2 is headed "*Healthcare Treatments I Do Not Want to Receive*". The section contains three fields which must be completed by a directive-maker. The first is "*Specific treatment I do **NOT** want to receive*". The second is "*Specific circumstances in which this **refusal** is to apply.*" The emphasis appears in the original. Ms. M completed these fields respectively as follows:

> "I do not want to be medicated with any type of psychiatric medication.
>
> I want this to apply in all circumstances unless I change my mind at some point."

21. The third field in section 2 contains two statements: "*I want this to apply even if my life is at risk because of this refusal*" and "*I do not want this to apply if my life is at risk because of this refusal*", and the directive-maker is required to tick the box beside the relevant statement. Ms. M ticked the first box, i.e., that she wished her refusal to apply even if her life is at risk because of the refusal.

22. Section 2 of the form contains three copies of the questions just referred to (presumably to give the directive-maker an opportunity to express their wishes in relation to different forms of treatment). In the first field of the second copy of the questions, Ms. M stated:

> "I don't even want medical professionals to suggest that I take psychiatric medication. I know about psychiatric medication and I know that it is an option...I want this to apply in all circumstances unless I change my mind at some point."

She repeated the answers she had given in fields two and three of the earlier copy of section 2.

23. Section 3 of the form is headed "*Specific Treatment I Would Like to Receive*". The first field asks for details of "*Specific treatment* ***I would like to receive***" [emphasis in the original]. Ms. M stated:

> "Please leave me to myself as much as possible. Obviously unless I am causing harm to somebody, just let me off. I am completely prepared to experience whatever happens to me. It is nobody else's place to decide what is or isn't "too much" for me to cope with."

24. The next field asks for the circumstances in which the directive-maker wishes for this request to apply and Ms. M stated:

> "If I am hospitalised as a result of my experiencing an "altered state of consciousness" or "manic episode", depending on your perspective".

<u>Relief sought</u>

25. Against that background, the HSE seeks, inter alia, the following reliefs:

1. A declaration that Ms. M lacks capacity at the time of the hearing to make decisions concerning her immediate psychiatric treatment and related matters;

2. A declaration that the advance healthcare directive made by Ms. M is not valid;

3. In the event that the court finds the advance healthcare directive to be valid:

(a) directions or declarations as to its applicability to the treatment of Ms. M's physical health conditions; and

(b) directions or declarations regarding Ms. M's continued detention in the hospital and as to the treatment, if any, that may be administered to her there.

4. Further and/or in the alternative:

1. A declaration that Ms. M is in present need of an appropriate and continuous regime of clinical, medical, nursing and ancillary treatment in the hospital for the protection of her constitutional rights, including her right to bodily integrity and to life;

2. An order permitting the medical and nursing staff of the hospital to carry out such medical, psychiatric and nursing and ancillary treatment of Ms. M as they consider in the exercise of their clinical judgment to be necessary and appropriate in the best health and welfare interests of Ms. M, including but not limited to:

(a) Such medical treatment to Ms. M as may be in her treating doctor or psychiatrist's opinion necessary for the purpose of securing her best medical treatment and welfare interests, including but not limited to:-

i. the administration of medication, including anti-psychotic medication;

ii. the extraction of blood for testing, including for determining and monitoring glucose levels;

iii. diagnostic testing; and,

iv. any ancillary or associated treatment that Ms. M's treating doctors consider clinically appropriate.

(b) Reasonable force and/or restraint to be used in the course of the said care and medical procedures to the extent to which it may reasonably be necessary and in the best interests of the Respondent, which said force and/or restraint is to be conducted by appropriate personnel trained in therapeutic management of aggression and violence.

(c) The use of minimum necessary amount of sedation, if required, in the course of such care and medical procedures which said sedation is to be administered by appropriately trained professionals as in their medical and/or clinical opinion they deem necessary in the best interests of Ms. M in accordance with the requisite protocols, procedures and guidelines that apply."

Issues arising

26. Counsel for the HSE in their written submissions identified a number of issues which required to be determined. This provided a very helpful framework and I gratefully adopt it, subject to what I say in paragraphs 29-32 below.

27. That framework is as follows:

(i) the court must determine whether it has jurisdiction to consider the application in respect of the validity and applicability of the AHD in accordance with section 89(2) of the 2015 Act. This arises because the Circuit Court has exclusive jurisdiction unless the application "*involves*

considerations relating to life-sustaining treatment". Thus, the first question is whether the application involves considerations relating to life-sustaining treatment;

(ii) if the court has jurisdiction, a determination will have to be made whether the AHD is valid. The basis upon which it is claimed that the AHD is invalid is that Ms. M lacked capacity to make it on the day on which she did so;

(iii) if the AHD is valid, it will then be necessary to determine whether it is applicable having regard to section 85 of the 2015 Act. This will require a consideration of the terms of the AHD itself and the circumstances pertaining at the time when treatment was proposed. The HSE also identified that the implications that Ms. M's status as a patient detained under the Mental Health Act 2001 has for the applicability of the AHD, if any, will have to be considered;

(iv) separate from the question of administration of psychiatric medication and the AHD, the Court must determine whether the HSE has authority to provide treatment for Ms. M's physical health conditions under the Mental Health Act 2001 and, if not, whether the court should exercise its inherent jurisdiction to direct or permit such treatment. This largely turns on the interpretation of sections 2, 22 and 57 of the 2001 Act and an assessment of Ms. M's current capacity at the time of the hearing;

(v) if the Court determines that the AHD is valid and that it is applicable to preclude the administration of psychiatric treatment, the question then arises whether Ms. M's involuntary admission under the 2001 Act is permitted where she can not be treated with psychiatric medication to benefit and/or alleviate her condition. This arises in circumstances where she is currently detained on the basis of a mental disorder within the meaning of section 3(1)(b) of the 2001 Act.

28. There was no real disagreement by the other parties that these were the relevant issues, though they did identify some other issues within those identified by the HSE. It was also submitted on behalf of the Guardian ad Litem that it would be more appropriate to determine the question of applicability before the question of

validity. Furthermore, both the Guardian ad Litem and the Mental Health Commission submitted that it was not necessary to determine the fifth point at this stage and that, if necessary, a separate hearing should be held on that issue.

Post-hearing

29. Some weeks after I had heard the matter, I was informed that Ms. M had been discharged from hospital. All of the parties urged that I should nonetheless give judgment. This was on the basis that the proceedings either were not moot or, even if they were technically moot, they fall within the narrow range of cases in which the court has a discretion to give judgment.

30. I am satisfied that it is appropriate that I should do so in respect of issues (i) and (ii), for the following reasons. Firstly, Ms. M wishes me to do so. That is not a sufficient reason in itself but it is a factor to be taken into account. Certainly if Ms. M did not wish me to give judgment, that would lean heavily against giving judgment on any of the issues. Secondly, Ms. M could execute a new AHD, although the original AHD is still in existence and, therefore, the question of its validity is still technically a live question. Again, that would not be a sufficient reason in itself for me to give judgment, but it is important to have regard to the following. If the AHD's validity is not determined at this point, it may come back before the court in similarly urgent circumstances at another point in the future. If, for example, Ms. M discontinues the medication and suffers a relapse and has to be admitted to hospital, the question of the validity of the AHD would have to be fully heard again and determined within a very short time period. I do not see how that could be in anyone's interests. Furthermore, there is a real possibility that in those circumstances if the medication was given on an interim basis pursuant to section 89(3), Ms. M would be discharged from hospital again before judgment was given. The effect of that would be either that there would never be a determination on the validity of the AHD or, if there was such a determination and the AHD were held to be valid, Ms. M's stated will and preference would have been repeatedly frustrated by the administration of the medication on an interim basis. Importantly, the question of the AHD's validity is to be determined on the basis of the circumstances in November 2025. Those circumstances are not going to change. Thus, the court is in as good a position now to determine that point as it will be in the future. Different considerations apply to the question of the applicability of the AHD. That is dependent on the particular circumstances pertaining when the

decision as to treatment has to be made. The third reason I am satisfied I should give judgment is that, as mentioned above, other than *Governor of a Prison v XY*, these provisions have not been considered before and there is a broader public interest in there being guidance in relation to the operation of the provisions. This is particularly so in relation to the question of the meaning of "*life-sustaining treatment*" because this goes to the questions of jurisdiction, of the court in which an application should be brought, and of whether treatment can be administered pending a decision from the court.

31. I do not believe that I should determine issue (iii) because, as just touched upon, the question of whether an AHD is applicable is specific to the facts which pertain when the question of whether it is applicable has to be determined. Where Ms. M has been discharged no such determination has to be made and therefore any judgment on the issue as it stood at the date of hearing would be purely advisory and has no broader public interest. Furthermore, I have decided that the AHD is not valid and in those circumstances it is not necessary to determine its applicability.

32. I do not propose to determine issue (iv) in circumstances where strictly speaking it is no longer a live issue. More importantly, while some submissions were made on the issue, particularly by the HSE, it was by no means the focus of the proceedings or of the argument. It turns on the meaning of "*treatment*" in the Mental Health Act 2001 and it seems to me to be more appropriate to await full argument. I do, however, make some comments on this issue in circumstances where I permitted the administration of "*treatment*" for Ms. M's physical conditions on an interlocutory basis.

33. It is not necessary to determine issue (v) in circumstances where Ms. M is no longer subject to detention under the Mental Health Act.

APPLICABLE STATUTORY PROVISIONS

34. Section 8 of the 2015 Act sets out a series of guiding principles which are to "*apply for the purposes of an intervention in respect of a relevant person, and the intervener shall give effect to those principles accordingly.*" I return to these principles in the discussion later in this judgment. It is not necessary to set them out at this stage.

35. Advance healthcare directives are provided for in Part 8 of the 2015 Act. They are part of the mechanisms whereby effect might be given to an individual's will and preferences. Section 83 identifies this as a purpose of Part 8. It provides:

> "83. (1) The purpose of this Part is to-
>
> (a) enable persons to be treated according to their will and preferences, and
>
> (b) provide healthcare professionals with information about persons in relation to their treatment choices.
>
> (2) A relevant person who has attained the age of 18 years and who has capacity is entitled to refuse treatment for any reason (including a reason based on his or her religious beliefs) notwithstanding that the refusal-
>
> (a) appears to be an unwise decision,
>
> (b) appears not to be based on sound medical principles, or
>
> (c) may result in his or her death."

36. Section 82 of the 2015 Act defines "*advance healthcare directive*". It provides:

> ""advance healthcare directive" –
>
> (a) in relation to a person who has capacity, means an advance expression made by the person, in accordance with *section 84*, of his or her will and preferences concerning treatment decisions that may arise in respect of him or her if he or she subsequently lacks capacity, and
>
> (b) ...,
>
> which has not been revoked pursuant to *section 84(7)*;"

37. Section 84 of the Act sets out the formal requirements which must be satisfied for an advance healthcare directive. I return to some of these later. Section 84 provides at subsection 1 and 2, that:

> "(1) A person who has attained the age of 18 years and who has capacity may make and advance healthcare directive.

(2) A refusal of treatment set out in an advance healthcare directive shall be complied with if the following three conditions are met:

(a) at the time in question the directive-maker lacks capacity to give consent to the treatment;

(b) the treatment to be refused is clearly identified in the directive;

(c) the circumstances in which the refusal of treatment is intended to apply are clearly identified in the directive."

38. Section 85 provides, inter alia:

"85. (1) An advance healthcare directive is not valid if the directive-maker—

(a) did not make the directive voluntarily, or

(b) while he or she had capacity to do so, has done anything clearly inconsistent with the relevant decisions outlined in the directive.

(2) An advance healthcare directive is not applicable if—

(a) at the time in question the directive-maker still has capacity to give or refuse consent to the treatment in question,

(b) the treatment in question is not materially the same as the specific treatment set out in the directive that is requested or refused, or

(c) at the time in question the circumstances set out in the directive as to when the specific treatment is to be requested or refused, as the case may be, are absent or not materially the same."

39. Importantly, section 85(3) goes on to provide:

"An advance healthcare directive is not applicable to life-sustaining treatment unless this is substantiated by a statement in the directive by the directive-maker to the effect that the directive is to apply to that treatment even if his or her life is at risk."

40. Section 86(1) provides:

"86. (1) A specific refusal of treatment set out in an advance healthcare directive is as effective as if made contemporaneously by the directive-maker when he or she had capacity to make that decision."

41. The Act also makes provision for challenges to the validity and/or applicability of an AHD. Section 4(1)(f) of the Act confers exclusive jurisdiction on the Circuit Court in respect of such challenges save in specific circumstances, which are set out in section 89(2).

42. Section 89(1) provides:

"89. (1) On an application (being an application that does not involve considerations relating to life-sustaining treatment) made to it by any interested party, the court may make a declaration as to whether-

(a) an advance healthcare directive is valid,

(b) an advance healthcare directive is applicable, or

(c) a designated healthcare representative is acting in accordance with the relevant powers. "

The 'court' that is referred to is the Circuit Court.

43. Section 89(2) provides for the circumstances in which the High Court shall have jurisdiction in respect of such challenges:

"(2) On an application (being an application that involves considerations relating to life-sustaining treatment) made to it by any interested party, the High Court may make a declaration as to whether-

(a) an advance healthcare directive is valid,

(b) an advance healthcare directive is applicable, or

(c) a designated healthcare representative is acting in accordance with the relevant powers."

44. Thus, the Circuit Court has exclusive jurisdiction in respect of challenges to the validity or applicability of AHDs which do not involve considerations relating to life-sustaining treatment. The High Court has jurisdiction in cases which do involve such considerations.

45. It was correctly pointed out by Senior Counsel for the HSE that section 89 goes beyond the question of which court has jurisdiction to determine the validity and/or applicability of an advance healthcare directive. Section 89(3) provides that the terms of an AHD do not preclude the administration of medication or treatment whilst a determination of the directive's validity or applicability is awaited from the High Court. This only applies where a determination is awaited from the High Court. Therefore, due to the interaction between section 89(2) and (3), it only applies where the application is one that involves considerations relating to life-sustaining treatment. Section 89(3) provides:

> "(3) Whilst awaiting a decision of the High Court relating to an application under *subsection (2)*, nothing in the advance healthcare directive concerned shall be construed to prevent a person from-
>
> (a) providing life-sustaining treatment to the directive-maker, or
>
> (b) doing any act which he or she reasonably believes to be necessary to prevent-
>
> (i) a serious deterioration in the health of the directive-maker, or
>
> (ii) if the directive-maker is a pregnant woman, a deleterious effect on her pregnancy. "

JURISDICTION

46. The question of whether the court has jurisdiction under section 89 turns on whether the application involves considerations relating to life-sustaining treatment. Unfortunately, the Act does not contain any definition of "*life-sustaining treatment*". On the one hand this is surprising given its importance in the legislative scheme, but on the other, that omission probably reflects a point which I return to, that whether or not treatment is "*life-sustaining*" will depend on the context and circumstances of a particular case.

What is life-sustaining treatment?

47. In circumstances where the Oireachtas has decided not to define "*life-sustaining treatment*" and where whether or not a particular treatment is "*life-sustaining*" will depend entirely on the facts, it is not possible to give an exhaustive definition. Rather, it is more appropriate to set out the principles or approach by which

the task of determining whether or not treatment in a particular case is *"life-sustaining*" should be carried out.

The parties' positions on the meaning of "life-sustaining treatment"

48. The HSE submitted that whether or not a particular treatment is life-sustaining is dependent on the prevailing context and circumstances. They gave the example of treatment with antibiotics which may not be life-sustaining treatment in the case of a routine infection that may resolve without treatment, but which will be life-sustaining treatment in the case of a person with sepsis who will be at risk of death if they do not receive intensive medical treatment.

49. However, the HSE also went on to submit that in any case in which the directive-maker confirms that the refusal in the AHD is to apply even if it puts his or her life at risk the AHD is one which involves considerations relating to life-sustaining treatment. They submitted that "*Where a declaration is sought as to the validity or applicability of an advance healthcare directive in which the directive-maker positively indicates that a decision to refuse a particular treatment is to apply even if their life is at risk, such an application necessarily involves considerations relating to life-sustaining treatment. It is submitted that this must be so because the resulting declaration will apply to the validity and applicability of the directive itself in all eventualities*." They also returned to the example of antibiotics in relation to this submission, saying "*An application for a declaration as to the validity of an advance healthcare directive in which the directive-maker decides they do not wish to receive antibiotics in any circumstances, even if their life is at risk, will be an application that involves considerations of life-sustaining treatment even if no treatment is proposed at the time of the application or if the treatment proposed would not be life-sustaining in the existing circumstances.*"

50. The Guardian ad Litem emphasised the need to interpret the phrase in the overall context of the Act. It was submitted on his behalf that the test for whether treatment is life-sustaining treatment must be a high one because of the overall context of the Act (including the guiding principles in section 8, the presumption of capacity and the presumption of validity, and the limited circumstances in which it is permissible to treat a directive-maker while the High Court is considering an application in relation to the validity or applicability of an AHD).

51. The Guardian ad Litem also submitted that when one examines other cases in which treatment has been referred to as "*life sustaining treatment*", it is clear that the instant case is fundamentally different. He cited a number of cases, including *In the matter of JJ [2022] 3 IR 1* which involved "*CPR and other invasive and aggressive treatments"; Re a Ward of Court (withholding of medical treatment) (No. 2) [1996] 2 IR 79* in which artificial nutrition was characterised as life-sustaining treatment; *Re SR [2012] 1 IR 305* which concerned intubation and invasive ventilation; *HSE v JM [2018] 1 IR 688* which involved an increase in ventilation support, vasopressor support, cardiopulmonary resuscitation cardioversion, defibrillation and the insertion of arterial or central venous lines for monitoring of cardiovascular variables; and *In the matter of SM [2025] IEHC 717* which concerned use of a ventilator, nasogastric feeding, and cardiovascular supports. The Guardian ad Litem correctly pointed out that the courts in those cases did not consider the meaning of "*life-sustaining treatment*" but rather proceeded on the basis those interventions were life-sustaining, but he submitted that the type of treatment which is at issue in this case is fundamentally different.

52. The Mental Health Commission submitted in their written submissions that any proper interpretation of "*life-sustaining treatment*" must be guided by the following considerations:

(i) Whether or not a particular treatment is life-sustaining is dependent on the prevailing context and circumstances of each case;

(ii) "*Life-sustaining*" must be read in its ordinary meaning as treatment that is given to sustain the life of the patient;

(iii) The risk to life without such treatment must be to some degree temporal to the finding that the court is being asked to make;

(iv) Life-sustaining must require some degree of certainty or imminence of fatal consequences resulting from failure to provide or withdrawal of life-sustaining treatment;

(v) The risk to the patient without such treatment cannot be so vague or unlikely that there is no evidence to suggest that it is in any way imminent;

(vi) The Court must have evidence as to the degree and proximity of the risk involved pertinent to the particular treatment which is under consideration.

(vii) "*Life-sustaining treatment"* should be interpreted as something akin to medical intervention (whether that involves medical procedures, the use of medical technology, or medication etc) that is administered to preserve a person's life, where failure to provide it would result in a significant risk of death.

Discussion

53. It seems to me that the approach suggested by the Mental Health Commission is broadly correct, though with some important adjustments.

54. The principles applicable to statutory interpretation are well-established at this stage and are set out in *Heather Hill Management Company CLG v An Bord Pleanála [2022] IESC 43* and in *A, B and C v Minister for Foreign Affairs and Trade [2023] IESC 10*. In the latter case, Murray J said at paragraph 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 CLG 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 construction, 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."

55. Adopting this approach, there are a number of factors which give guidance as to what constitutes "*life-sustaining treatment*".

56. As noted above, it was submitted on behalf of the Guardian ad Litem that the overall context of the Act requires the term to be construed narrowly, or for a high test to be applied as to whether treatment in a particular case constitutes "*life-sustaining treatment*".

57. In my view, it is not necessary or appropriate to adopt either a particularly narrow or broad approach to the construction of the term. I am of this view as there are aspects of the Act which support the adoption of a narrow approach to the question of whether treatment is or is not life-sustaining, but there are also parts which lean against such an approach.

58. The factors in the Act that suggest that "*life-sustaining treatment*" should be construed narrowly are as follows.

59. The objectives of maximising autonomous decision-making and ensuring that effect should be given to a person's will and preference are central planks of the Act. For example, the long title to the Act states that the Act is to, inter alia, "*provide for the making of advance healthcare directives by persons of their will and preferences concerning medical treatment decisions should such a person subsequently lack capacity...*". Indeed, section 83(1) specifically states that a purpose of Part 8 is to "*enable persons to be treated according to their will and preferences.*"

60. It is also clear from the guiding principles in section 8 of the Act that autonomous decision-making is at the heart of the Act. Sub-section (5), for example, provides that there "*shall be no intervention in respect of a relevant person unless it is necessary to do so having regard to the individual circumstances of the relevant person*", and sub-section (6) provides:

> "(6) An intervention in respect of a relevant person shall—
>
> (a) be made in a manner that minimises—
>
> (i) the restriction of the relevant person's rights, and
>
> (ii) the restriction of the relevant person's freedom of action,

(b) have due regard to the need to respect the right of the relevant person to dignity, bodily integrity, privacy, autonomy and control over his or her financial affairs and property,

(c) be proportionate to the significance and urgency of the matter the subject of the intervention, and

(d) be as limited in duration in so far as is practicable after taking into account the particular circumstances of the matter the subject of the intervention."

Sub-section (7) provides, inter alia:

"(7) The intervener, in making an intervention in respect of a relevant person, shall—

(a) permit, encourage and facilitate, in so far as is practicable, the relevant person to participate, or to improve his or her ability to participate, as fully as possible, in the intervention,

(b) give effect, in so far as is practicable, to the past and present will and preferences of the relevant person, in so far as that will and those preferences are reasonably ascertainable,

(c) take into account—

(i) the beliefs and values of the relevant person (in particular those expressed in writing), in so far as those beliefs and values are reasonably ascertainable, and

(ii) any other factors which the relevant person would be likely to consider if he or she were able to do so, in so far as those other factors are reasonably ascertainable,..."

61. Under section 89(3), the effect of a challenge to the validity or applicability of an AHD which is claimed to involve life-sustaining treatment is that the treatment may be administered notwithstanding the apparently clear expression of the person's will and preference not to receive that treatment. If "*life-sustaining treatment*" is construed too broadly, those objectives of maximising personal autonomy and giving effect to the individual's will and preference would be undermined because the effect would be that in many such challenges the very treatment which is refused by the directive-maker could be administered.

62. It is also relevant that the default position is that exclusive jurisdiction is vested in the Circuit Court and that the jurisdiction of the High Court in challenges to the validity or applicability of an AHD is an exception to the default position. Therefore it follows that, the category of cases in which treatment that is refused in the AHD may be given should be the exception rather than the default.

63. However, these have to be balanced with the use by the Oireachtas of the term "*life-sustaining*" rather than "*life-saving*". There are obvious overlaps between these terms but there are also important subtle differences. "*Life-saving*" means something that is essential to avoid certain imminent death. "*Life-sustaining*" on the other hand connotes treatment which is, or may be, necessary to continue life but does not necessarily involve certain imminent death. This is reinforced by the contents of a code of practice published by the Director of the Decision Support Service, which I return to, which acknowledges that death does not have to be a certain result of the failure to give the treatment in order for the treatment to be life-sustaining treatment.

64. Furthermore, the Act must also be read in its constitutional context and in the context of the obligation to vindicate the individual's rights, including his or her right to life. It seems to me that if the term is construed too narrowly or the bar is set too high there would be a real risk that the right to life would not be adequately vindicated because it would mean that in some cases where there is a serious issue about the validity or applicability of the AHD, the individual would not receive necessary treatment while the decision of the court is awaited. The failure to provide that treatment in that period may lead to death or a serious deterioration in the person's health and yet it may ultimately be decided that the AHD was not valid (or applicable). In other words, the individual's death would have been brought about by an invalid directive; one, for example, that was only given under duress.

65. I am also satisfied that there is ample guidance in the Act to assist in interpreting "*life-sustaining treatment*".

66. Thus, it seems to me that no particular general interpretative approach is warranted by the overall scheme, context, or the other provisions of the Act. The correct approach is to apply the principles discussed below with caution so as not to conclude too readily that "*treatment*" is "*life-sustaining treatment*".

67. "*Treatment*" is defined by section 2 of the Act as "*in relation to a person, ... an intervention that is or may be done for a therapeutic, preventative, diagnostic, palliative or other purpose related to the physical or mental health of the person, and includes life sustaining treatment.*" Thus, life-sustaining treatment is "*treatment*" but not all treatment is "*life-sustaining treatment*". There must be some qualitative difference between "*treatment*" and treatment that is "*life-sustaining*", otherwise express reference to "*life-sustaining treatment*" in the definition of "*treatment*" is unnecessary and redundant. This is reinforced by the fact that section 89 makes separate provision for cases involving treatment which is not life-sustaining (s.89(1)) and cases involving treatment which is life-sustaining (s.89(2)).

68. The starting point is that "*life-sustaining treatment*" must be read in its ordinary meaning in the context of the Act as a whole. The simple ordinary meaning, when section 2 is taken on its own, is '*treatment that is given to sustain the life of the patient*'. The problem with this is, of course, that it is circular and therefore does not advance the interpretative process very far. Thus, while taking the ordinary meaning of the words in section 2 is the appropriate starting point, it is not sufficient and we have to look elsewhere in the Act to assist in the construction of the section's true meaning.

69. It follows from the absence of a specific definition in the Act and from the nature of illness and of medical treatment that whether or not treatment is life-sustaining will depend on the context and circumstances of each case. In many cases, it will be clear that treatment could not be construed as life-sustaining. For example, it is difficult to see how physiotherapy for an injured leg muscle could ever be construed as life-sustaining treatment. However, there will be other cases in which it will be more difficult to identify whether treatment is life-sustaining treatment or not. That question will, it seems to me, depend on the context and circumstances of the case. To borrow the example given on behalf of the HSE: the administration of antibiotics for the treatment of a wound to an otherwise healthy adult may not be life-sustaining treatment in that context and circumstances because there is no real possibility of death if the antibiotics are not given at that time; but antibiotics to treat the same infection in either a severely immuno-suppressed person, or where the infection has progressed to sepsis in the otherwise healthy adult, may well amount to life-sustaining treatment. The relevant context and circumstances will include, in particular (though not necessarily exhaustively), the purpose for which the treatment is to be administered, the relationship between the treatment and the possibility of death if it

is not given, the extent of that possibility, and the proximity between the possibility of death and the non-provision of the treatment at that point in time.

70. There is clearly an overlap between these factors. Nonetheless, they can be separated out for the purpose of discussion and, while acknowledging the overlap, I propose to take them in turn.

71. It seems to me that there can be no controversy that in order for "*treatment*" to be construed as "*life-sustaining*" at least one of its purposes must be to sustain the life of the relevant person.

72. I propose to discuss the other factors within the framework of guidance given by the Director of the Decision Support Service in a "*Code of Practice on Advance Healthcare Directives for Healthcare Professionals*".

73. The Act provides that account must be taken of any such code of practice. Section 91(3) of the 2015 Act provides for the publication of such codes of practice by the Director, and section 91(14) requires the court to take account of any relevant provision of such code. It provides:

> "Where it appears to a court, tribunal, or body concerned, conducting any proceedings that –
>
> (a) a provision of a code of practice published under subsection (3), or
> (b) a failure to comply with a code of practice published under subsection (3),
>
> is relevant to a question arising in the proceedings, the provision or failure, as the case may be, shall be taken into account in deciding the question."

74. The terms of the code of practice can not, of course, bind the court in its interpretation of the Act, but account must be taken of them, and the code therefore presents a useful framework to discuss the relevant provisions of the Act.

75. Paragraph 2.5.4 of this Code of Practice states, inter alia:

> "Treatment can be regarded as life-sustaining where failure to provide that treatment at that time would result in a significant risk of death. This may include any clinically appropriate medical treatment, technology, procedure, or medication

that is administered to preserve life, for example mechanical ventilation, artificial hydration and nutrition and chemotherapy.

If the directive-maker intends the advance healthcare directive to apply to life-sustaining treatment, it must include a statement that the directive-maker understands that their life is at risk as a result of refusing that treatment."

76. There are a number of elements of relevance in this guidance.

77. The first element is whether or not, on its proper construction, the Act requires death to be a certain result of the treatment not being given in order for the treatment to be life-sustaining treatment. The guidance in the code of practice does not require such a certainty. It simply requires that there would be a "*significant risk of death*" if the treatment is not given. In my view, the absence of a requirement for certainty in the code of practice is correct and reinforces my interpretation of the Act. The only reference in Part 8 to the possibility of death resulting from the treatment not being given is in section 85(3). It states, "*An advance healthcare directive is not applicable to life-sustaining treatment unless this is substantiated by a statement in the directive by the directive-maker to the effect that the directive is to apply to that treatment even if his or her life is at risk.*" It refers to the directive-maker's life being at risk and not that he or she *will* die if the treatment is not given.

78. In their written submissions, the Mental Health Commission submitted that there had to be a degree of certainty of fatal consequences. It was later accepted on behalf of the Commission at the hearing that this may be too strong, and that the proper formulation might be that there must be a likelihood of fatal consequences. In my view, this was a correct and appropriate acknowledgement by the Commission. However, this is still too high a bar and is not supported by the terms of the Act itself (or by the terms of the code of practice).

79. This is also relevant to the second element of the code of practice, i.e. the extent of the risk of death. The code of practice refers to the "*failure to provide the treatment [resulting] in a significant risk of death*". However, this must be approached with some caution because the adjective "*significant*" does not feature in the Act itself. As noted above, the only reference to the possibility, or risk, of death in Part 8 is in section 85(3). It simply refers to a "*risk*" to the directive-maker's life. There is an important difference between "*significant risk*" and "*risk*". In my view, the language of the Act is clear and it is not open to the court to import words into the Act. If the

Act required the risk to be "*significant*", section 85(3) would have required the directive-maker to substantiate by a statement in the AHD that the directive is to apply to that treatment even if his or her life is at "*significant risk*". Similarly, if the Act was intended to require that there be a likelihood of fatal consequences, section 85(3) would have employed that language.

80. Of course, the risk of death must be real and not simply a risk that is vague, notional or general. Risk of death is part of the human condition. There must be something more. If this were not the case, very many forms of medical treatment could be characterised as "*life-sustaining*". This can not have been what was intended by the Act because to construe "*life-sustaining treatment*" as including treatment to mitigate such general or notional risk would effectively set at nought the distinctions drawn in sections 2 and 89 of the Act between "*treatment*" and "*life-sustaining treatment*".

81. The third element in the code of practice is the use of the phrase "*at that time*", i.e., "*where failure to provide that treatment at that time would result in a significant risk of death.*" This suggests that there must be some degree of proximity, immediacy, or short-term link between the failure to give the treatment and the resulting risk of death. The requirement that there be such a temporal link arises from section 89(3). If there did not have to be such a link, then it would be unnecessary to make provision for the administration of the declined treatment on an interim/interlocutory basis. The example already given may illustrate the point: an antibiotic to treat a common chest infection is not life-sustaining treatment at that point in time because at that stage the failure to give the treatment would not result in a real risk of death. However, if the infection deteriorates significantly and appears likely to deteriorate into sepsis, the antibiotics may well become life-sustaining treatment because without them there would be a real and short-term risk of sepsis and therefore a risk of death.

82. It is also important to note that as a matter of language the temporal link must be between the non-provision of the treatment and a resulting risk of death, rather than the death itself. This follows from the language of the Act but also follows from the fact that the Act does not require death to be certain if the treatment is not given.

83. As noted above, the HSE submitted that an AHD, in which the directive-maker states that the AHD is to apply to treatment even if their life is at risk, automatically involves considerations relating to life-sustaining treatment. I do not accept that this

is correct. The effect of this would be, to return to the earlier example, that a challenge to the validity of an AHD could be brought in the High Court rather than the Circuit Court where a person had a common chest infection and had directed that he did not wish to be given antibiotics. The effect of that, in turn, would be that antibiotics could be administered to the person pending a decision of this court, even though there was no short-term risk of death (and possibly no risk of death at all). This would effectively undermine the AHD and the objectives of the Act. It would deprive the directive-maker of the opportunity to refuse treatment because in the event of an application to the High Court the provision of the treatment would be allowed even where life was not put at risk by the medication not being given, and that would stymie the AHD. The effect of such an interpretation in any case where there was a challenge to the validity or applicability of a directive would be that once the directive-maker had ticked that box, irrespective of whether or not there was a current risk to their life or whether or not such a risk would arise very shortly, the challenge could be brought in the High Court and the effect of subsection (3) would be that the treatment could be provided on an interlocutory basis. That would, it seems to me, be inconsistent with the overall objective of the Act. It would also be inconsistent with the exclusive jurisdiction that is conferred on the Circuit Court and the non-availability of interim/interlocutory measures.

84. I do not accept that the cases referred to on behalf of the Guardian ad Litem are determinative of or limit the meaning of "*life-sustaining treatment*" in the Act to the interventions which were the subject of those cases. The courts in those cases did not have to consider the meaning of "*life-sustaining treatment*" but rather simply proceeded on the basis that the interventions were life-sustaining interventions. I accept that the principles outlined above could lead to interventions which are fundamentally different from the interventions in those authorities being found to be "*life-sustaining*" but the mere fact that they are different does not preclude such a finding.

85. In all of those circumstances, it seems to me that "life-sustaining treatment" is to be construed as follows:

(a) There is no exhaustive definition of "*life-sustaining treatment*". Whether or not particular treatment constitutes "*life-sustaining treatment*" will depend on the context and all of the circumstances of the particular

case. The context and circumstances may vary but will include the following;

(b) The "*treatment*" must be proposed for the purpose of sustaining life in order to constitute "*life sustaining treatment*";

(c) The non-provision of treatment must result in a risk of death which is not notional, vague or general. This must include that if there is already a risk, the non-provision of the treatment will continue or increase that risk;

(d) The risk must result from the non-provision of the treatment at that time and not at some point in the future;

(e) The risk must be one which will result immediately, proximately, or within a very short time of the failure to give the treatment;

(f) The assessment of the nature of the treatment by reference to these criteria should be approached cautiously to reflect the position that the default position is that the Circuit Court has exclusive jurisdiction and section 89(2) and (3) constitute carve-outs or exceptions to that default position.

Is the psychiatric medication life-sustaining treatment in this case?

86. The evidence in respect of the nature of the treatment was primarily given by Dr. D. Before dealing with the substance of the evidence, it is necessary to deal with a point made on behalf of the Mental Health Commission in relation to how that evidence should be treated. This point was made in the context of how the court should approach the medical evidence in relation to capacity, but it applies equally to the evidence dealing with the nature of the treatment.

87. The Commission referred to the judgment of Stack J in *C.D and B.B [2023] IEHC 204*, in which she considered the "*Principles material to consideration of expert evidence.*" There were a number of issues in that case that are not relevant to this case. Stack J stated at paragraphs 72 – 76.

"72. Before setting out the nature of that evidence, it is appropriate to note some comments of the Court of Appeal in a very recent case, Duffy v. McGee [2022] IECA 254, as to the correct approach to expert evidence…

73. …the application was advanced on the basis that there was uncontroverted medical opinion in this case as to lack of capacity. Collins J. at para. 18 reiterated that the Supreme Court had made it clear in Donegal Investment Group Ltd. v. Danbywiske [2017] IESC 14, [2019] 1 I.R. 150 that even uncontroverted expert opinion does not have to be accepted by a court.

74. In this case, there was also, as set out above, a long delay before the body of the principal report on which the application was founded was disclosed to me by way of exhibit. At para. 19 of Duffy v. McGee, Collins J. states: "To properly perform its function, the court must be able to understand and engage with the evidence, which in turn requires that experts should sufficiently explain their opinions and the basis for them."

75. He also quoted with approval the following dictum of Charleton J. in Flynn v. Bus Éireann [2012] IEHC 398, at para. 9, that the entitlement of experts to give their opinions: "is predicated upon also informing the court of the factors which make up their opinion and supplying to the court the elements of knowledge which their long study and experience has furnished to them whereby they have formed that opinion so that, in those circumstances, the court may be enabled to take a different view."

76. The furnishing of a conclusion to a lengthy report, which advances an opinion on the ultimate issue I have to decide, could never therefore have legitimately persuaded me to find that the applicant lacks capacity. It was always imperative that I would see the body of the report in order to identify the basis on which the opinion was offered and, if necessary, to differ from it. A report asserting lack of capacity to continue proceedings requires detailed consideration for the reasons identified by Charleton J. in Flynn v. Bus Éireann."

88. This led the Commission to submit that the following applied to the court's approach to the medical evidence in this case:

(i) Even uncontroverted expert opinion does not have to be accepted by a court;

(ii) The court should approach speculative opinions as to capacity with caution;

(iii) Mere statements of conclusion in terms of capacity are not sufficient. Capacity has a singular meaning throughout the 2015 Act. It must be assessed in accordance with section 3 of that Act and having regard to the guiding principles in section 8, including the presumption of capacity and the fact that an unwise decision is not determinative of incapacity;

(iv) The court must be able to understand and engage with the evidence, which in turn requires that experts should sufficiently explain their opinions and the basis for them;

(v) The court must be informed of the factors which make up the clinician's opinion;

(vi) The court must be provided with the elements of knowledge which the clinician's long study and experience has furnished to them whereby they have formed that opinion so that, in those circumstances, the court may be enabled to take a different view;

(vii) The court must be able to identify the basis on which the opinion was offered and, if necessary, to differ from it.

89. Obviously, (ii) and (iii) do not apply to the evidence relating to the nature of the treatment. They do apply to my later consideration of the evidence in relation to capacity.

90. There was no disagreement between the parties in relation to these general principles. The need for such an approach is in fact heightened in this case where the evidence in respect of the nature of the treatment was given by Dr. D, who is the treating consultant, rather than by an independent consultant. I have therefore approached the evidence in accordance with those principles.

91. As I said earlier, Dr. D gave evidence in person and by affidavit. She also exhibited reports prepared by her and she adopted those reports in evidence. It is important to note at this stage that no party suggested that the evidence was deficient

when measured against the above principles. That, of course, does not mean that I must accept the opinion.

92. At the substantive hearing, Dr. D confirmed that she would describe the psychiatric medication as "*life-sustaining treatment*". She did so by reference to her earlier report of the 5th February 2026 in which she wrote:

> "19. [Ms. M] continues to require life-sustaining treatment for both her mental and physical health. Untreated mania in bipolar disorder significantly elevates the risk of cardiovascular disease and premature death. Untreated mania is associated with an increased incidence of major adverse cardiac events, including heart attacks and stroke. The excessive cardiovascular mortality is strongly linked to the burden of manic symptoms. In addition, [Ms. M] has major underlying physical illnesses which place an additional burden on her risk for physical complications such as from a cardiovascular standpoint, namely a history of diabetes, high blood pressure and raised cholesterol. Furthermore, [Ms. M] has a significant maternal history of heart disease with her maternal grandmother dying at age 66 years of heart failure and [Ms. M's] mother having required a stent due to arterial blockage, and having double heart bypass surgery in August 2024."

93. Dr. D used the phrase the "*burden of manic symptoms*" and explained that it means "*[E]ssentially, when somebody is in a manic or high, elevated state...it puts increased stress or strain on one's heart and as a result it can affect...the beating of one's heart, it can cause an irregular heartbeat or it can cause other compromise to the heart in terms of say heart attack, strokes, etc. It is very important to properly treat mania in order to essentially reduce the risk of cardiovascular events in individuals.*" Dr. D went on to say "*... Essentially untreated mania in itself puts someone at risk of cardiovascular events in isolation. If you couple that with underlying physical illnesses like, for example, in this case we have diabetes, we have high blood pressure, we have raised cholesterol, it puts an individual at even greater risk, so to speak, of a cardiovascular event, so it steps up the risk if you want to think of it that way, elevates the risk. It's very important not only to treat the mania but to treat the underlying physical illnesses such as the diabetes, the blood pressure, the lip raised cholesterol in order to have the risk as low as possible.*" She also referred to Ms. M's family history and said "*You've got three, so to speak, three major risk categories, if you would like to put it that way. I mean you've got the psychiatric illness, the untreated mania, or partially treated mania, if you would like to think of it that way, increasing the cardiovascular risk, number one. Number two going a step*

up the ladder, you've got her underlying physical illnesses, the diabetes, blood pressure, raised cholesterol which are increasing the risk further. A third step up the ladder you've got the family history which again, as I said, is placing even greater risk."

94. Under cross-examination by Senior Counsel for the Guardian ad Litem, Dr. D agreed that the physical ailments suffered by Ms. M, i.e., high blood pressure, cholesterol and diabetes are essentially chronic conditions but ones which can lead to acute conditions or crises. She also agreed that it would not be fatal not to take the medication for one of these conditions on a particular day. However, she emphasised that this was not the scenario in this case. Rather, Ms. M had been off medications for diabetes and blood pressure for a number of weeks. Dr. D was also asked whether there was any specific evidence of the manic episode putting a strain on Ms. M's heart. She said that the blood pressure readings before Ms. M was recommenced on medication were quite raised and concerning. She confirmed that an ECG undergone by Ms. M did not show an abnormality, but she also emphasised that while an ECG will show a heart attack occurring at that point in time it will not necessarily show that a heart attack will or will not happen in the near future.

95. At the interlocutory hearing on the 23rd January 2026, Dr. D said that Ms. M had a fasting sample done that morning in respect of diabetes and that the level that was recorded was significantly higher than the desired threshold for diabetes. She described this as "*very concerning for her physical health, certainly high blood pressure can cause serious problems if it remains high.*" She went on to say that Ms. M "*needs prompt treatment for her physical health, in addition to her mental health, of her diabetes and high blood pressure and associated risks which can result from high blood sugars.*" She confirmed the physical risks as "*heart disease, heart failure, stroke, kidney failure, blindness and nerve damage*" and that "*if somebody's blood sugar remains high over time it leaves them open to a whole range of risks, cardiovascular and so forth. So I mean, you know, it is really a quite concerning situation.*" She described the consequence for Ms. M's health of untreated mania as "*her mental state will deteriorate further over time. The more that is untreated...as the days have passed, she's become more and more mentally unwell and it leaves her open to a far worse prognosis eventually the more days that pass with this untreated mental state. And in conjunction with that, it certainly puts her physical health...at increased risk because she's declining, as I mentioned her medications for her physical health, in conjunction to this altered mental state that she has.*" She was also asked

to explain why she describes the treatment she required as "*life-sustaining*". Dr. D said that the impact on Ms. M's health means "*that her...mania is escalating, she's becoming more intrusive, chaotic, disorganised. She's not sleeping on the ward. She's up all night. She's pacing the corridors. This is certainly very unhealthy from a medical—sorry, from a mental and physical perspective for somebody not to be sleeping for a prolonged amount of time. It's continuing to play its toll on her both mentally and physically...I mean certainly she's not sleeping, or getting very minimal sleep, sleeping for maybe an hour or two. So, you know, I mean certainly lack of sleep is going to cause a further deterioration in her mental state as the days go on. It's going to cause physical exhaustion for her. I mean she's going to have a big crash, you know, if she doesn't get sleep, which certainly if she was medicated quite urgently she would get the required sleep which, as I say, which would significantly alleviate the toll on her mental health and physical health...Certainly, if you take it in conjunction, if you take a number of factors together, I mean this is a lady with mania, who's elated, who's not sleeping, who's overactive on the ward, who, as I say, is not sleeping. So, I mean it can play, you know, certainly it puts her at risk for a cardiovascular complications. So I mean, you know, it really, it's quite a concerning situation that we're in.*"

96. Ms. M participated in that interlocutory hearing remotely so I had the opportunity to observe her. Certainly, her presentation on that day accords with the above descriptions. She was constantly moving and changing position, at times sitting on a large boardroom table and at other times lying flat on the table. Her hands and arms were very active. Her movement could be described as frenetic.

97. During her evidence at the interlocutory hearing (i.e. prior to the order being made), Dr. D explained that Ms. M had agreed to a blood sugar measure that day for the first time and that on the basis of that measure it was likely that Ms. M may need a transfer to an acute hospital in the next 24 to 48 hours. Under questioning from the court, Dr. D said that it is difficult to put an exact timeframe on it and that if her blood glucose level was to rise slightly higher, it would put her at risk of diabetic ketoacidosis, which is a potentially life-threatening situation.

98. Dr. D also gave evidence (at the hearings, on affidavit, and in her reports) that Ms. M was invading the space of other patients, being verbally hostile, and had physically assaulted staff and other patients. She gave an example of Ms. M targeting a very vulnerable patient and on one occasion trying to force a spoon down his throat.

She expressed a concern that Ms. M was at risk of retaliation from other patients against her "*chaotic and intrusive presentation*" which includes the incident just referred to and Ms. M pacing the corridors and playing music loudly at night and entering the bedrooms of other patients. Dr. D described the psychiatric treatment that Ms. M requires as life-sustaining "*to stop her causing serious harm to herself or to another individual*".

99. I am satisfied that the psychiatric medication is life-sustaining treatment in the very particular context and circumstances of this case. Dr. D's evidence is clear that "*untreated mania in bipolar disorder significantly elevates the risk of cardiovascular disease and premature death*" and is "*associated with an increased incidence of major adverse cardiac events, including heart attacks and stroke*." To that must be added Ms. M's particular physical conditions. The evidence is that her high blood pressure, diabetes, and raised cholesterol place "*an additional burden on her risk for physical complication from a cardiovascular standpoint*." Dr. D also emphasised Ms. M's significant maternal history of heart disease. Dr. D's evidence was that Ms. M had three major risk categories: the psychiatric illness which increases the cardiovascular risk, the underlying physical condition, and the family history. One difficulty is that it is not possible to predict when a cardiovascular event might occur, or indeed, if one would occur. However, Dr. D's evidence when taken in its entirety is clear that Ms. M's particular profile meant that unless she was immediately given psychiatric medication to treat the mania and therefore alleviate the burden of manic symptoms, she was at real risk of a cardiovascular event and therefore at risk of death.

100. I have also considered whether the psychiatric medication would constitute life-sustaining treatment if Ms. M took or was given her medication for her physical conditions and had monitoring for her diabetes. This is important because it is only the psychiatric medications that are subject of the AHD.

101. It follows from the evidence that if Ms. M took her other medication and allowed diabetes monitoring, the risk of cardiovascular event from the mania and the underlying physical illness would be somewhat reduced. However, it does not follow that there is not still a real risk from "*the burden of the manic symptoms*" for the psychiatric medication to constitute life-sustaining treatment in the particular facts of this case. Ms. M would still face the risk from untreated mania against a background of a very significant family history and with risk from her underlying physical

conditions (even if they as a risk factor are somewhat reduced by her having treatment for those conditions).

102. I am therefore satisfied that this court has jurisdiction to deal with the challenge to the validity and/or applicability of the AHD under section 89(2) on the basis that the psychiatric medication is "*life-sustaining treatment*".

103. For completeness, I should say that I am not satisfied that the risk of harm from retaliation by other patients if Ms. M's mania continues to cause her to bother or harm other patients is the type of risk required by the Act.

INTERLOCUTORY ORDERS

104. As discussed above, the HSE applied for interlocutory orders permitting the administration of medication, including psychiatric medication, i.e. the medication that Ms. M had refused in her AHD. It is necessary to say a few words about the court's jurisdiction to make such orders.

105. Firstly, it seems to me that it is not strictly necessary for such orders to be made in order for treatment to be administered whilst a decision of this court is awaited. Section 89(3) is self-operating. It provides that whilst a decision of the High Court is awaited on the validity or applicability of an AHD "*nothing in the advance healthcare directive concerned shall be construed to prevent a person from - (a) providing life-sustaining treatment to the directive-maker or (b) doing any act which he or she reasonably believes to be necessary to prevent (i) a serious deterioration in the health of the directive-maker...*" Thus, whilst a decision is awaited from the High Court, the clinicians are not precluded from administering life-sustaining treatment or doing any other act which they reasonably believe is necessary to prevent a serious deterioration in the person's health. A court order is not required.

106. However, as this case shows, there may be uncertainty or a dispute as to whether or not the particular treatment is life-sustaining treatment or not and therefore whether section 89(3) applies. Thus, save in very clear cases, it can be anticipated that clinicians will sometimes seek interlocutory orders.

107. The question that arises is what test must be applied by the court at the interlocutory stage. This arises because on its face section 89(3) only applies in cases

that actually involve life-sustaining treatment rather than cases where a claim is made that it involves such treatment, but, of course, one of the issues might well be whether the treatment is in fact life-sustaining or not. That can only be determined after the substantive hearing, but that may be too late.

108. It seems to me that the appropriate test where such orders are sought at the interim or interlocutory stage must be analogous to the test for a mandatory interlocutory injunction. The applicant must establish that it has a strong case that it will succeed at trial in establishing that the treatment is life-sustaining treatment and that the AHD is invalid and/or inapplicable. A lower test would be inappropriate and would not properly vindicate the individual's rights under the Constitution and the 2015 Act, or indeed, the objectives of the Act. The effect of section 89(3) is that an AHD is rendered ineffective for a period of time; this means that the person will be administered treatment which he or she has stated they do not want to receive. It seems to me that a low bar, such as, for example, one which might apply to an application for a prohibitory injunction would not be sufficient in those circumstances. However, in addition to the obligation to vindicate those rights and the directive-maker's rights to autonomy and bodily integrity, the court must also vindicate the directive-maker's right to life. If the bar is set too high, there would be a risk of death occurring prior to the substantive case being heard and determined. The test for a mandatory injunction strikes the correct balance.

VALIDITY AND APPLICABILITY OF THE ADVANCE HEALTHCARE DIRECTIVE

Whether applicability should be decided

109. As noted above, it was submitted on behalf of the Guardian ad Litem that I should deal with whether the AHD was applicable and should only deal with its validity if necessary.

110. The question of applicability arises due to the evidence that Ms. M was harming other patients and the following statement in Ms. M's AHD: "*Please leave me to myself as much as possible.* ***Obviously unless I am causing harm to somebody, just let me off.*** *I am completely prepared to experience whatever happens to me. It is nobody else's place to decide what is or isn't "too much" for me to cope with.*" [emphasis added] The statement was in response to the heading "*Specific treatment I would like to receive*". Ms. M's response obviously has to be read in the context of the AHD as a

whole and in particular her statement that the refusal of psychiatric medication is "*to apply in all circumstances unless I change my mind at some point*." Ms. M also stated at the hearing that she did not intend to indicate that psychiatric medication could be given in those circumstances but was referring to other forms of intervention such as restraint. Thus, it is not entirely clear whether Ms. M was indicating in her AHD that psychiatric medication could be given in the event that she was harming someone else. It is, however, at least open to that interpretation.

111. The Guardian ad Litem submitted that I should deal with this question first because the court, in dealing with an application under section 89, is carrying out an intervention within the meaning of the Act and is required to give effect to the guiding principles in section 8 of the Act. In summary, these require any intervention to be necessary in the particular circumstances, to be made in a manner that minimises the restriction of the person's rights, to have due regard to the need to respect the person's right to dignity, bodily integrity, autonomy and control over his or her financial affairs and property, to be proportionate, and to give effect, in so far as is practicable, to the will and preferences of the person. The Guardian ad Litem submitted that a determination on the question of applicability before determining the question of validity would be more consistent with those principles.

112. However, in light of Ms. M's discharge, it is no longer necessary or appropriate to determine the question of applicability at all. As noted above, the question of whether the refusal of psychiatric medication is applicable arises because Ms. M stated that she was to be left alone unless she was harming someone else and the evidence clearly established that she was causing harm to other people. It seems to me that the question of applicability is entirely fact specific and relates to a particular point in time. In circumstances where those facts have fundamentally changed, in that Ms. M is no longer in hospital, any judgment would not be addressing a live controversy and would not be addressing a broader public interest. I therefore do not propose to determine the applicability question and will move directly to the question of whether or not the AHD is valid.

Invalidity on grounds of lack of capacity

113. The basis upon which it is suggested that the AHD is not valid is that Ms. M did not have capacity to make it at the particular time.

114. An issue which first has to be dealt with is whether a lack of capacity is a basis upon which an AHD can be declared to be invalid under section 89.

115. This arises because section 82 provides that in Part 8 of the Act "*valid*" in relation to an AHD shall be construed in accordance with section 85. Section 85(1) provides that:

> "An advance healthcare directive is not valid if the directive-maker –
>
> "(a) did not make the directive voluntarily, or
>
> (b) while he or she had capacity to do so, has done anything clearly inconsistent with the relevant decisions outlined in the directive."

116. Thus, section 85(1) does not expressly provide that an AHD is not valid if the directive-maker did not have capacity to make an AHD at the time of doing so. Does this mean that a court can not make a declaration under section 89 that an AHD is invalid on the basis that the directive-maker did not have capacity to make the AHD? On one reading of section 85(1), this is the case.

117. However, in my view, this is not the correct construction when the sections are read in their overall context.

118. If this interpretation is correct, it gives rise to a fundamental issue about the operation of the Act and section 89 in general, and sub-sections (2) and (3) in particular. It means that neither the Circuit Court nor the High Court could make a declaration under section 89 that an AHD is not valid on the ground of the directive-maker's lack of capacity. Indeed, on the same basis, neither court could make a declaration under section 89 that an AHD is not valid because it was made when the directive-maker was not yet eighteen years of age. This would mean that section 89(3) would not apply even if the AHD involved life-sustaining treatment. That in turn means that there is no statutory provision whereby a directive-maker could be given life-sustaining (including life-saving) treatment, which was purportedly refused in the AHD, while the decision of the court is awaited on a challenge to the AHD on the grounds that the directive-maker lacked capacity to make the AHD at all, or on the ground that he or she was a child at the time of making the AHD. On the other hand, such treatment could be given to a directive-maker who had capacity to make the

AHD but is claimed to have been acting under duress or undue influence, or who is alleged to have done something which is allegedly clearly inconsistent with the AHD. That can not be the proper construction of the Act as it would mean that it provides no protection to the person who lacked capacity or the child but does to the second category of person. There is no reason why the Act would afford protection to the latter category of person and not to the former. It means that if an application is made for a declaration that an AHD in which the directive-maker refused a blood transfusion, for example, is invalid on the grounds that the directive-maker had no capacity at all when he made the AHD, section 89(3) would not operate to permit a transfusion to be given even in emergency circumstances pending a decision by this Court.

119. It was submitted at the hearing that section 85(1)(a) ("*did not make the directive voluntarily*") could be interpreted as including a situation where a person did not have capacity on the basis that a person could not be said to have made the AHD voluntarily if he did not have capacity to do so. Unfortunately, "*voluntarily*" is not defined in the Act. I was referred to Murdoch & Hunt's "*Dictionary of Irish Law*" (6th Ed) and Stroud's "*Judicial Dictionary of Words and Phrases*" (10th Ed.). In the former, "*voluntary*" is defined as "*Free exercise of will involving an act of choice*". Stroud refers to *DPP for Northern Ireland v Lynch [1975] AC 653 at 689F*, where it was stated "*The concept of 'voluntariness' is extremely elusive. Its core meaning would seem to be that a physical movement (or a failure to move out of a particular situation when circumstances required such movement) cannot be said to have been voluntary if the subject did not (or even, probably, could not) direct his will to the movement or lack of movement in question.*" The second of these was obviously dealing with a very different context. There is some basis in these for suggesting that "*voluntarily*" could include the notion of capacity on the basis that inherent in the concept of "*voluntariness*" is that the person is acting according to their own free will and inherent in that is that the person must have the capacity to form a will and preference.

120. However, in my view, this is not the correct way of reading section 85(1)(a). I am of this view for two reasons. Firstly, while that would mean that a lack of capacity is a ground for a declaration under section 89 and therefore for the availability of the protection in section 89(3), it would also mean that the fact that the directive-maker was a minor is still not a ground for a declaration under section 89. It would be stretching language beyond any normal meaning to read "*voluntarily*" as encompassing a requirement that the directive-maker is eighteen or older. It is

important to remember that capacity and age are both dealt with in the same section (section 84(1)). It would be absurd if a lack of capacity were to be a ground of challenge under section 89 and therefore one that attracts the protection under section 89(3) but the fact that the directive-maker was a child at the time of making the AHD was not. Secondly, a difficulty with this interpretation is that the Act repeatedly uses the word "*capacity*". In my view, the concept of "*voluntariness*", which is used for the first time in section 85(1)(a), must be intended to mean something different than a lack of functional capacity.

121. In my view, section 82 and section 85(1) are properly understood as providing for two circumstances in which an AHD will be invalid, but they are not to the exclusion of other circumstances also contained in Part 8. The circumstances that are enumerated in section 85(1), i.e. that the directive-maker did not make the AHD voluntarily, or that he or she has done anything clearly inconsistent with the relevant decisions outlined in the AHD, are not provided for elsewhere. Without section 85(1)(b), for example, a subsequent inconsistent action by the directive-maker would not necessarily mean that the AHD is invalid. However, section 84(1) already provides that only a person who has attained the age of eighteen and who has capacity may make an AHD. Thus, an instrument purporting to be an AHD which is made by a person of sixteen or by an adult who did not have capacity is not valid as an AHD. That is provided for so clearly in section 84(1) and is such a fundamental proposition that it was simply not necessary for it to be expressly stated in section 82(1) or 85(1) as one of the bases upon which an AHD is not valid. In my view, if section 82(1) and 85(1) were intended to limit the bases upon which an AHD may be found to be invalid and to therefore exclude lack of capacity and age rather than to supplement those other bases, very clear language indeed would be required.

122. In my view, section 89 includes applications for declarations that an AHD is not valid on the basis that the directive-maker did not have capacity to make the AHD or had still not reached eighteen years of age.

123. If I am wrong on this, then I am satisfied that there is a lacuna in the legislation which permits the court to use its inherent jurisdiction. Of course, the court's inherent jurisdiction should only be used sparingly and where there is a legislative lacuna. If I am wrong in my interpretation of the Act then it follows that there is no statutory mechanism by which an AHD made by a person who lacked capacity or by a minor can be challenged on either of those two grounds or, more importantly, by which the

court can give protection to a person while that challenge is being determined. This means that the Act provides no statutory means by which the individual's right to life may be vindicated pending a decision by the court. It is undoubtedly the case that a challenge may be brought in respect of a purported AHD on the ground that it was made by a person who lacked capacity, but if I am wrong on the interpretation point then such a challenge would not be one in which the court could make a declaration under section 89. The effect of this is that there is no statutory provision permitting the administration of life-sustaining or life-saving treatment while the court makes its decision. Thus, there is no statutory mechanism by which the directive-maker's rights may be vindicated pending the decision of the court. That is a statutory lacuna. It is, of course, not a lacuna if it was intended that treatment may not be provided on an interlocutory basis in such cases. The argument can certainly be made that as the Oireachtas made provision in section 89(3) in respect of certain cases then the non-availability in other cases is not a lacuna but a deliberate choice. I do not accept this. It would mean that the Act was intended to leave minors or persons who made an AHD without capacity with no protection during the period whilst the court's judgment was awaited. In my view, in those circumstances, the court may exercise its inherent jurisdiction to permit the administration of treatment on an interlocutory basis.

124. Thus, I am satisfied that the question of Ms. M's capacity at the time she made the AHD must be determined.

Assessment of Capacity

125. The fundamental starting point is that a person is presumed to have capacity. Section 8(2) of the 2015 Act provides "*It shall be presumed that a relevant person who falls within paragraph (a) of the definition of "relevant person" in section 2(1) has capacity in respect of the matter concerned unless the contrary is shown in accordance with the provisions of this Act."* The Act sets out how a person's capacity is to be assessed. Section 3 provides that a person's capacity is to be construed functionally. Section 3(1) provides that "*a person's capacity shall be assessed on the basis of his or her ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time.*" Subsection (2) then provides:

"A person lacks the capacity to make a decision if he or she is unable—

(a) to understand the information relevant to the decision,

(b) to retain that information long enough to make a voluntary choice,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his or her decision (whether by talking, writing, using sign language, assistive technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party."

126. The subsequent subsections go on to set out a number of matters relating to the assessment of capacity, but it is not necessary to set these out in the circumstances of this case. The important point is that Ms. M must be presumed to have had capacity at the time she made the AHD unless the contrary is shown in accordance with the provisions of the Act. The burden of proof lies on the HSE in this case.

127. In *Fitzpatrick v FK [2009] 2 IR 7*, Laffoy J held:

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

128. In *Governor of X Prison v PMcD [2015] IEHC 259*, Baker J held (at paragraph 33):

"…the test of whether a person has capacity to make a decision must of course depend on the nature of the decision, and the gravity and complexity of the consequence of such a decision. Birmingham J. in *X.Y., A Minor v. H.S.E.* [2013] 1 I.L.R.M. 305 made a distinction, which I adopt, between a decision to consent to recommended treatment and the decision to refuse such treatment. The latter type of decision involves a high degree of understanding and a clearly stated wish, and

for the court to assess the quality of the decision it is required that oral evidence be heard and tested as necessary."

129. Both of these judgments predate the coming into operation of the 2015 Act and therefore have to an extent been overtaken by the statutory presumption of capacity. Nonetheless, it seems to me that the general principle that the assessment of capacity, and the assessment of whether that presumption has been rebutted, must have regard to the gravity of the particular decision and that a decision to refuse life-sustaining treatment involves a high degree of understanding still applies. In light of the presumption of capacity, it is not for Ms. M to show that she had a high degree of understanding but rather for the HSE to establish that the evidence is sufficient to rebut the presumption, having regard to the need for a high degree of understanding on the part of Ms. M.

130. The evidence in relation to the question of capacity is contained in a joint statement by Ms. M's parents (they both swore affidavits exhibiting their statement), the Guardian ad Litem's attendances on two friends of Ms. M who witnessed her signing the AHD, the evidence of Dr. D, and a report of Dr. Aoife Hunt, the independent consultant psychiatrist engaged by the Guardian ad Litem. The parties were agreed that the Guardian ad Litem's attendances on Ms. M's friends and Dr Hunt's report could be admitted as evidence without those individuals being called, and that it was not necessary that Ms. M's parents be called to give oral evidence.

131. I set out the statement given by Ms. M's parents and the attendances on the friends/witnesses in full even though they are quite long. I think it is appropriate to do so given that Ms. M's parents are very familiar with her history and had interactions with her in the relevant period, and that her friends were with her at the time that she completed the AHD. Perhaps more importantly, Dr. D's and Dr. Hunt's views are informed by the contents of the statements/attendances.

132. In the statement made by Ms. M's parents they referred to a number of placenames and to the names of individuals. In the interests of anonymising the judgment I have replaced the names given with different names. These changes do not impact the substance of the statement. Ms. M's parents said:

"Our daughter has a significant history of mental illness. She can remain well whilst she is taking medication and adhering to clinical advice. She went to [Greece] in

January 2025 for the whole month to write a book about her life experiences. After that she was in [Brussels] in February 2025 and her friend contacted [Ms. M's mother] to express her concern that she going high. She was working in [Waterford] but was attending various events, festivals and gatherings. We had to go to [Mayo] in the early hours of the 10th May 2025 to collect her from a festival and a festival steward commented to us that there appeared to be a want in [Ms. M]. We noticed ourselves that [Ms. M] was living life at breakneck speed, she was coming and going and did appear more "high" than usual to us in July 2025. She was travelling to multiple friends and family members all of whom felt that she was not at her baseline. We are aware for example of her visiting her friend in [England] in August and also our son in [Norway] in July and both expressed concerns to us about [Ms. M]. They saw that [Ms. M] had increased energy, was much more talkative and was talking a lot about [Peter], a man who she had previously worked with while teaching in Vietnam...,but never had a relationship with. She tends to become infatuated with [Peter] when she is unwell.

[Ms. M] made us aware that she had made a decision to reduce taking her medication as prescribed. We let her know we thought she should be following her doctor's advice. She did assure us that she wouldn't cease her medication until Spring 2026.

We would have had weekly contact with [Ms. M] and prior to her admission to hospital she would have come to visit us about every month. The visits in 2025 tended to be short in duration and we felt in late Summer/Autum 2025 that she was high although she spent little real time with us as she would often arrive late and leave shortly after getting up.

She went to [an artists' retreat] for a month in October 2025 to finish the book she had been writing in [Greece]. She in fact only remained in this retreat for 13 days, she then went to [Tralee] for three nights, she then went to visit [Ms. M's mother]'s brother in [Killarney], then went to stay in [Listowel] and came back to us in [Enfield]. That was in the last week of October 2025 and she then left her car at our house in [Enfield]. Her car is still outside our house.

Having seen her in late October/early November we definitely felt that she was higher than usual. Any attempt to discuss with her about medication was met with increased agitation. She had excess energy, she was more grandiose in manner and not agreeable to listen to any advice about the advance healthcare directive that she was planning on signing. We pointed out to her that we had concerns that she was not making the right decision in signing that but she was not prepared to

listen to us or even discuss it. In relation to the advance healthcare directive she advised us that she would not be medicated with psychiatric medication even if it was to save her life and she was prepared to ride out whatever would happen if she was not medicated. We don't believe in late October/early November 2025 she fully understood the full implications for her health by not following the clinical advice and taking the medication. She fully believed at that stage she could survive without her medication. In fact she told us that coming off her medication would only have the same effect on her as taking ecstasy.

We are also very concerned that [Ms. M] appears not to have been compliant with the medication for her blood pressure and diabetes. There is a very significant maternal history of serious heart disease as [her maternal grandmother] died of heart failure in 1976 at age 66 and [Ms. M's mother] collapsed in November 2003, had to be resuscitated and was subsequently was [sic] diagnosed with 85% arterial blockage and required a stent. [Ms. M's mother] had a double bypass in August 2024.

We observed that she brought cannabis into our home. We are not aware of how often she used cannabis but we are aware that she drank alcohol as well.

Many of [Ms. M's] friends have contacted us expressing their concerns about [Ms. M] and how unwell she was.

On 21st December 2025 [an employee from Ms M's workplace] contacted us that [Ms. M] was very unwell. We offered to go to [Waterford] immediately but [the employee] advised us that they would bring [Ms. M] to Heuston on the 23rd and we would collect her there. When we met [Ms. M] at the station she was talking gibberish and we were told it had been a difficult journey from [Waterford] as she had invaded the space of other passengers. When were [sic] got home to [Enfield] we realised just how unwell she was and that she needed a psychiatric assessment. We tried to get her to go voluntarily to [Drogheda] but she refused. We then had no option but to call the Gardai and she was removed by the Gardai and an ambulance from our home and involuntarily admitted to hospital on the 24th December 2025.

We are both very concerned for [Ms. M's] health. We do not believe that she understood the effects coming off medication would have on her and the significant deterioration of her mental health that would occur as a result of not taking the medication prescribed."

133. Two of Ms. M's friends witnessed her signature on the AHD. They were subsequently interviewed by the Guardian ad Litem.

134. One of the witnesses, Ms. V, is noted by the Guardian ad Litem as saying:

> "I have been friends with the Respondent for five years. I am not one of her closest friends but a good friend. She asked us ([Ms. A] and myself) to be a witness for her filling out a health form and watch her sign it. I did not do a whole lot of research into it as she asked that we are just witnesses to confirm it was her filling out the form and signing it. [Ms. A] and I did it together and [Ms. M] insisted that we followed the correct procedures for the form. She had her notes written out in a notebook and was copying them to the form that day. [Ms. M] was a bit erratic that day but was fine. I did not see any big issue then. She told us her Psychiatrist and Doctors and parents are in the loop of her plans. As a friend I was happy to help her act as a witness for her to sign the form. She told us everyone knew. She was not her full bubbly self that day. She was scatty. She was a small bit heightened but not lacking capacity.
>
> [Ms. A] did ring me after to see if I though [sic] [Ms. M] was alright and felt she might be slightly out of character. She was alright in my view but there was an intense energy from her that day and she adamant [sic] on completing the form. The Respondent's behaviour hadn't changed previously. She said everyone was aware of her plans and it was literally just a witness signature that she needed from us. I was not sure why I was asked to sign. She did seem alright. She did say that she was coming down off her meds. I was not aware that she had come off her meds fully. I had never experienced anything like this before so all this process was new to me, and I just thought I was helping a friend out. I did not envisage or foresee her mental health deteriorate so rapidly."

135. The other witness, Ms. A, is recorded as saying:

> "[Ms. A] confirms she is a friend of the Respondent. She works as a [public servant]. She confirms she is the witness to the Respondent's Advanced Healthcare Directive.
>
> [Ms. A] advised that the Respondent said she was coming off her meds and in case things "went down hill" like in the past, the Respondent was clear she did not want medication. [Ms. A] indicated she does not want the Respondent to know we are having conversations about this. [Ms. A] describes the Respondent as very vulnerable but does not want her to believe her friends are betraying her.

> With regard to the context of the Respondent signing the Directive she was asked by the Respondent to be a witness and [Ms. A] agreed. [Ms. A] expressed that she was concerned at the time and did not want to be drawn into the situation. The respondent assured [Ms. A] that she would not. [Ms. A] read the paperwork regarding her obligations as a witness and reviewed the Respondent's information also. [Ms. A] confirmed that the Respondent sat with her and [Ms. V]. [Ms. A] is of the view that the Respondent was fully aware of what she was doing. [Ms. A] described the Respondent's behaviour as a little high. [Ms. A] confirmed that the Respondent had indicated that she has a lot of issues with her medication including that it gives her high cholesterol and that there is weight gain.
>
> The Respondent also indicated that she was concerned about the side effects for other health issues.
>
> [Ms. A] confirmed that she asked the Respondent not to go cold turkey. The Respondent indicated that her doctor was aware. [Ms. A] confirms that she witnessed the document to support her friend. [Ms. A] confirms that the Respondent felt that she did not need her medication as she was doing so well. [Ms. A] was of the view that the Respondent was doing fine until she dropped her medication to 2.5 milligrams and there was a change in behaviour insofar as she was more, since the change in medication, more highly strung. [Ms. A] confirmed that the Respondent did know what she was doing when she signed the documents."

136. Dr. D's initial evidence (in her grounding affidavit) was based on conversations with Ms. M's mother, Ms. M's brother, and her paternal uncle and his wife. The account given by Dr. D of her conversation with Ms. M's mother largely reflects the contents of the parents' statement quoted above. Dr. D stated that Ms. M's uncle and his wife and Ms. M's brother corroborated the account that Ms. M's mental health had deteriorated over the previous number of months. This led Dr. D to say at paragraphs 23-25 of her grounding affidavit:

> "23. As appears from my report dated 19 January 2026, on that date I obtained a collateral history from the Respondent's mother in relation to her mental state over the past number of months. In that regard, [Ms. M's mother] informed me that she has almost daily contact with the Respondent by phone and she also sees her in person almost every month. [Ms. M's mother] informed me that the Respondent became mentally unwell from July 2025, and that when she made the AHD she was "high" and not at her baseline state. In particular she noted that the Respondent

had increased energy, was more grandiose in manner and not agreeable to listening to any advice. [Ms. M's mother] also confirmed that the Respondent remained unwell from a mental health perspective, and she considers that the Respondent did not make the right decision in making an AHD.

24. As appears from my report dated 21 January 2026, the Respondent's brother [Mr. C] and her paternal uncle and his wife, [Mr. T and Ms. B], have all corroborated the account given by [Ms. M's mother] that the Respondent's mental health has deteriorated over the past number of months. The Respondent's family also advised that they do not know the persons who witnessed the AHD on 6 November 2025.

25. In light of the corroborated account of the Respondent's presentation as "high", excessively energetic and having grandiose delusions, I believe that the Respondent has been suffering from a relapse of her bipolar disorder since July 2025 secondary to reduced/non-compliance with her prescribed medication. The description provided to me of the Respondent's mental condition since July 2025 is also consistent with her current presentation. I therefore believe that when making the AHD on 6 November 2025, approximately seven weeks prior to her admission to [Hospital B], the Respondent in all likelihood did not have the ability to understand or use and weigh information relevant to the decision in making an advance healthcare directive having profound consequences for the provision of psychiatric treatment to her and that she therefore lacked capacity to do so."

137. In the report of the 19th January 2026, exhibited to Dr. D's affidavit, she explained that Ms. M had attended for a new patient assessment on the 6th January 2023 and gave some of the background and history, including Ms. M's history from 2006-2009. She then said at paragraphs 5 and 6:

"[Ms. M] has been reviewed in the psychiatry outpatient clinic at regular intervals since her new patient assessment. [Ms. M] has stated at these outpatient reviews that she had reduced her prescribed psychiatric medication since her last appointment. [Ms. M] has therefore been reducing her own psychiatric medication over time, against medical advice. She has been advised against reducing her medication on many occasions, advising her of the risk of relapse of her major mental illness.

[Ms. M] was most recently reviewed in the psychiatry outpatient clinic on 16th May 2025. [Ms. M] again stated at that review that she had further reduced her psychiatric medication. [Ms. M] was again advised to continue her medication as

prescribed due to her being at increased risk of relapse and for deterioration in her mental state. [Ms. M's] mental state was documented as stable at that review. "

138. Dr. D said in evidence at the substantive hearing:

> "…Well obviously I wasn't there personally on 6th November to speak to her at that time but certainly going by – we have had a number of reports at this stage. We have had the reports of the two friends of [Ms. M] who witnessed her signing the Advance Healthcare Directive, we have had the report of her parents and we have had the report of the independent consultant psychiatrist who was called by the Guardian, Dr. Hunt. I mean the evidence from these various parties is that [Ms. M] was, her mental health was not optimal at that point in time and that her capacity was impaired. Certainly from what she has told me, which I've mentioned, I will go to the current report, sorry to go back and forth, the current report, 18th March of this year, if I go to paragraph 12A, just the top of page three, with this various unwise, so to speak, spending that was going on around the time of this Advance Healthcare Directive. It certainly points to somebody who lacks capacity, whose judgment is impaired. So I mean putting all the various pieces together it does seem that her judgment was impaired, that she lacked capacity at the time of 6th November when this Advance Healthcare Directive was taken out."

139. The reference to 'unwise spending' is a reference to Ms. M spending a significant sum of money on buying products for a project which she believed would be attractive to schools but which drew no interest at all.

140. Dr. D was asked about the parents' statement that "*We don't believe in late October/early November 2025 she fully understood the full implications for her health by not following the clinical advice and taking the medication. She fully believed at that stage she could survive without her medication. In fact she told us that coming off her medication would only have the same effect on her as taking ecstasy*". Dr. D was asked how she would see that in the context of a capacity assessment. She explained that she would say that the person making that comparison has impaired judgment and lacked capacity and would "*certainly see her as not understanding the information, sorry not understanding or believing the relevance of medication and the implications of coming off medication, I mean likening it to taking ecstasy is certainly a somewhat questionable comparison that one would make. I would see her as lacking the various components to the capacity test."*

141. Dr. Aoife Hunt, the independent psychiatrist engaged by the Guardian ad Litem, addressed the question of capacity. She stated in her report that:

> "I believe she did not have mental capacity in November 2025, since she described serious concern from her family, sitting on the floor, not being able to sleep, and eventually herself calling the Gardaí, which would be an unusual way to conclude a family discussion, and which was not consistent with her delightful and partially insightful presentation when I met her."

142. This is based on the history given by Ms. M (see paragraph 12 of Dr. Hunt's report) but unfortunately it is inaccurate. It is common case that the incident described in that passage happened on the 24th December 2025, not in November. However, Dr. Hunt went on in her report to state:

> "I believe because her current manic episode seems to have begun when she stopped taking her medication in mid-2025 ["I had been taking Abilify 5mg from the previous December 2024 and I halved that"] that she probably did not have mental capacity at the time of writing the advance healthcare directive in late 2025"

143. One issue which arose during Dr. D's evidence is the question of precisely when Ms. M stopped taking the psychiatric medication. Dr. D said at paragraph 6 of her grounding affidavit:

> "After a lengthy period during which the Respondent reported her mental health was stable, she presented on 6 January 2023 for an assessment following which she was reviewed at regular intervals. During these reviews, the Respondent stated that she had reduced her prescription medication since the last appointment despite medical advice to not do so having regard to the risk of relapse of her major mental illness. During her most recent review on 16 May 2025, the Respondent reported a further reduction of her medication. The Respondent's mental state was noted to be stable and she was again advised to continue with her medication as prescribed. "

144. In her evidence, Dr. D said:

> "I mean to be completely honest I have had this conversation with [Ms. M] on a number of occasions. She is an absolutely delightful lady, don't get me wrong, but she can be a very inconsistent historian in terms of a timeline for events. I have

got different answers from her at various points in time. I don't know. I don't want to give a categorical answer. She has been clear to me that she was reducing the medication over time, say over the course of 2025, for example, she was reducing the medication. She has told me that she stopped the medication roughly about two weeks prior to the admission to Connolly Hospital on 24th December 2025. As I say she is's [sic] not a completely consistent historian. That's what she has told me on a few occasions, that it was roughly about two weeks prior to that admission. I don't know is the honest answer. I couldn't hang my hat on the exact date, I am sorry."

145. Ms. M informed the court in response to Dr. D's evidence that:

> "Well it was more I wanted to clarify the date that I stopped taking the medication because there seems to be some confusion there. Basically I had been taking just 5mg of Abilify starting in December 2024 and then I changed that and started splitting the tablets in two, so I went down to 2.5mg of Abilify, but not until I think it would have been the last Monday in October, because it was the [music event] in [Waterford], when the [music event] was over, and I had been travelling, I was away travelling so I came back and then on the Monday that is when I started splitting the tablets in two. Until that point I had been stable at 5mg since December 2024. I just wanted to make that clear because I think there was confusion about that. That is all. "

146. Thus, on Ms. M's own account, she reduced the psychiatric medication further by a half approximately a week before making the AHD. I proceed on that basis.

147. The Guardian ad Litem also consulted with Ms. M's mother and his account of what he was told by her is largely the same as Dr. D's account.

148. I am satisfied on the evidence that Ms. M did not have capacity to make the AHD on the 6th November 2025. The real question is, of course, whether the presumption of capacity has been rebutted. I am satisfied that it has been.

149. The assessment of whether a person had capacity to make a particular decision at a point in the past is not at all straightforward. This is particularly so in this case.

150. On their face, the Guardian ad Litem's attendances on the witnesses to the AHD, Ms. M's friends, support the conclusion that Ms. M did have capacity at the time

of making the AHD. Considerable weight must be placed on their evidence as they were clearly familiar with Ms. M and are the only persons who had direct knowledge of Ms. M's presentation when she was actually signing the AHD.

151. Ms. V told the Guardian ad Litem that Ms. M did not lack capacity at the time. She also stated that Ms. M's behaviour had not changed previously and that "*she did seem alright*". Ms. A told the Guardian ad Litem that she was of the view that Ms. M was fully aware of what she was doing. She also confirmed that Ms. M knew what she was doing when she signed the AHD. In addition to these statements, it is important to note that Ms. M appears, from what the witnesses said, to have been well-prepared. For example, Ms. V told the Guardian ad Litem that Ms. M insisted that they follow the correct procedures and that she "*had her notes written out in a notebook and was copying them to the form that day.*" Ms. A also told the Guardian ad Litem that Ms. M explained to them that she was coming off her medication and wanted to sign the AHD because she did not want medication if things "*went down hill*" like in the past.

152. However, even the witnesses' accounts are not straightforward. They also gave other information about Ms. M's presentation. Ms. V, for example, said "*She was not her full bubbly self that day. She was scatty. She was a small bit heightened but not lacking capacity.*" She also said that Ms. A phoned her later to inquire whether she felt that Ms. M was alright and that Ms. A felt that she might be slightly out of character. Ms. V stated that "*She was alright in my view but there was an intense energy from her that day and she adamant [sic] on completing the form.*" Ms. A described Ms. M's behaviour to the Guardian ad Litem as "*a little high*". She also said that Ms. M was of the view that she did not need her medication as she "*was doing so well.*" Importantly, Ms. A was of the view that Ms. M was doing fine until she dropped her medication to 2.5mg "*and there was a change in behaviour insofar as she was more, since the change in medication, more highly strung.*"

153. Ms. M's parents did not have any direct interaction with Ms. M when she was signing the AHD. However, they gave information about Ms. M's presentation in the months, weeks and days leading up to that date. This includes that in February 2025 a friend contacted them to express her concern that Ms. M was "*going high*", and that in May 2025, they had to collect her from a festival and a steward expressed concern about her. They also state that Ms. M "*was living at breakneck speed*" and appeared more "*high*" than usual in July 2025. They report that friends and relatives expressed concerns that she was not at her baseline. The significance of this period is that Ms.

M had reduced her medication to 5mg in December 2024. The parents felt that in late Summer/Autumn 2025 Ms. M was high, but they emphasised that she spent little real time with them in that period because she would often arrive late and leave shortly after getting up. They say in their statement that Ms. M was frequently moving from place to place around the country in October 2025. They said that having seen her in late October/early November they felt that she was higher than usual. They said "*Any attempt to discuss with her about medication was met with increased agitation. She had excess energy, she was more grandiose in manner and not agreeable to listen to any advice about the advance healthcare directive that she was planning on signing. We pointed out to her that we had concerns that she was not making the right decision in signing that but she was not prepared to listen to us or even discuss it.*" They went on to say "*We don't believe in late October/early November 2025 she fully understood the full implications for her health by not following the clinical advice and taking the medication. She fully believed at that stage she could survive without her medication.*"

154. However, it is important to note that they also stated that "*In relation to the advance healthcare directive she advised us that she would not be medicated with psychiatric medication even if it was to save her life and she was prepared to ride out whatever would happen if she was not medicated.*"

155. It is, of course, the case that a person shall not be considered as lacking capacity to make a particular decision merely by reason of making, having made, or being likely to make an unwise decision (section 8(4)). Thus, the mere fact that Ms. M clearly told her parents that she would not take the medication even if it was to save her life can not determine that Ms. M lacked capacity. However, the evidence from the parents must be taken in its entirety. It is not merely the fact that she decided not to take the medication even to save her life but rather that she was not willing to listen to advice or to even discuss her decision that is important. She also told her parents that "*coming off her medication would only have the same effect on her as taking ecstasy.*"

156. This evidence from the two witnesses to the AHD and from Ms. M's parents is important. It is important in its own right because it is the court's function to assess whether the evidence is sufficient to rebut the presumption of capacity, but it is also important because it informed Dr. D's and Dr. Hunt's opinions.

157. As noted already, the medical evidence was given by Dr. D and Dr. Aoife Hunt. I accept the point made on behalf of the Mental Health Commission that in circumstances where that evidence is not based on direct personal knowledge it must be approached with caution.

158. Dr. D expressed the opinion in paragraph 25 of her grounding affidavit (quoted above) that in light of the descriptions of Ms. M's presentation she was satisfied that Ms. M was suffering from a relapse of her bipolar disorder since July 2025 secondary to reduced compliance or non-compliance with her prescribed medication and that she in all likelihood did not have capacity to make the AHD on the 6th November 2025. She said in her oral evidence at the substantive hearing that "*putting all the various pieces together it does seem that her judgment was impaired, that she lacked capacity at the time of 6th November when this Advance Healthcare Directive was taken out.*" In relation to Ms. M describing coming off her psychiatric medication as being the same as taking ecstasy, she expressed the view that this indicated a lack of understanding or believing the relevance of medication and the implications of coming off medication.

159. I do have a concern about Dr. D expressing the view that Ms. M's 'unwise spending' around the time that she made the AHD points to a person who lacks capacity. As discussed a moment ago, section 8(4) provides that a person shall not be considered to lack capacity to make a particular decision merely by reason of making an unwise decision. However, it is clear that Dr. D's opinion is based on all of the circumstances and information provided by the family and not "*merely*" on the basis of this unwise spending.

160. I have placed limited weight on Dr. Hunt's opinion for two reasons. Firstly, as noted above, her opinion as to capacity is based partly on the narrative that the event when the Gardaí were called and Ms. M was brought to hospital occurred around the time that Ms. M made the AHD. However, this is incorrect. Secondly, there is no real reasoning given for the conclusion that she did not have capacity when making the AHD in November other than that the manic episode seems to have begun in mid-2025.

161. Ms. V and Ms. A express the view that Ms. M had capacity at the time she made the AHD. However, they also acknowledge a number of issues in Ms. M's presentation. These go to the question of capacity. Furthermore, they, understandably, give no

explanation as to how they assessed her capacity, particularly having regard to the test of capacity set out in the Act. It must also, of course, be borne in mind that they are lay people.

162. Ms. M's parents are, on the other hand, very clear in their view that Ms. M did lack capacity. However, their views are subject to the same caveats as I have just noted in relation to Ms. V and Ms. A. Furthermore, there are parts of their statement which on one reading suggest that Ms. M did appreciate the significance of what she was deciding in that she seemed to accept that that there might be adverse consequences and was "*prepared to ride out whatever would happen if she was not medicated",* though this must be balanced with her belief that she could survive without her medication.

163. On balance, I am satisfied that the presumption of capacity has been rebutted and that Ms. M did not have capacity to enter the AHD. The witnesses to the AHD were satisfied that Ms. M had capacity and those opinions are important. However, they also gave evidence of features of Ms. M's presentation which suggest that she may not have had capacity. I accept the view of Dr. D. She had the benefit of all of the information contained in Mr. McCoy's attendances on Ms. V and Ms. and in the statements given by Ms. M's parents. She also had the benefit of taking collateral information from the parents and other relatives. The doctor gave her evidence as a person with expertise in psychiatry. She also expressly refers to the functional capacity test in the Act in stating her conclusion. She said *"...the Respondent in all likelihood did not have the ability to understand or use and weigh information relevant to the decision in making an advance healthcare directive having profound consequences for the provision of psychiatric treatment to her and that she therefore lacked capacity to do so."* She also, importantly in light of the principles set down by Collins J in *Duffy v McGee [2022] IECA 254* and Stack J in *C.D v B.B. [2023] IEHC 204*, set out her reasoning for her opinion.

164. It is also relevant that Dr. Hunt's opinion accords with that of Dr. D, although for the reasons set out above, I am not placing significant weight on Dr. Hunt's report.

TREATMENT FOR PHYSICAL HEALTH CONDITIONS

165. The HSE seeks orders under the Court's inherent jurisdiction permitting the delivery of treatment for Ms. M's physical conditions. The treatment in question is

medication for hypertension, diabetes, and regular blood sugar monitoring for her diabetes. The availability of the Court's inherent jurisdiction depends on whether those treatments may be provided to Ms. M under the provisions of the Mental Health Act 2001 as an involuntary patient under that Act. Thus, the first issue is whether those treatments may be provided under the 2001 Act without the consent of Ms. M.

166. The HSE submitted that the authorities seem to suggest that the treatment provisions in the 2001 Act do not authorise the delivery of treatments which are not related to the patient's mental disorder. It was not suggested by any party that these treatments were related to Ms. M's mental disorder. On that basis it was submitted that it may not be possible for the treatments to be provided under the 2001 Act.

167. As explained above, I do not propose to determine these issues, but I should say that it seems to me that this position is far from clear.

168. The relevant statutory provisions are as follows.

169. Section 2 of the 2001 Act provides that:

> ""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."

A person who is detained under the Act is known as a "*patient*" (sections 2 and 14 of the Act).

170. Section 57 of the 2001 Act 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."

171. Sections 58, 59 and 60 are not relevant to the particular issues in this case.

172. Section 22 of the Act provides:

> "22.—(1) A clinical director of an approved centre may arrange for the transfer of a patient detained in that centre for treatment to a hospital or other place and for his or her detention there for that purpose.
>
> (2) A patient removed under this section to a hospital or other place may be kept there so long as is necessary for the purpose of his or her treatment and shall then be taken back to the approved centre from which he or she was transferred.
>
> (3) The detention of a patient in a hospital or other place under this section shall be deemed for the purposes of this Act to be detention in the centre from which he or she was transferred."

173. These provisions were considered in *HSE v MX [2012] 1 IR 81* (MacMenamin J) and *HSE v VF [2014] 3 IR 305* (McDermott J). Section 57 was the focus of *HSE v MX* and section 22 was the focus of *HSE v VF*.

174. In *HSE v MX*, MacMenamin J stated at paragraph 67 that "[*C]learly "treatment" could not include measures or procedures which are entirely unrelated to a patient's mental illness*". This appears to be the origin of the view that only interventions which are related to the patient's mental disorder can constitute "*treatment*" within the meaning of the 2001 Act.

175. However, this statement must be taken in the context of the actual issues in that case. 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. A complication of some of the medication was an adverse reaction 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 the occurrence of this adverse reaction. Thus, the clinicians were of the clinical view that the medication was necessary to treat the defendant's mental disorder 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.

176. The HSE applied to the court in order to be able to administer the drug regime including taking the blood samples. There was no dispute that the medication itself constituted "*treatment*" as it was intended to ameliorate the defendant's mental disorder. The dispute was about whether the ancillary drawing of blood was "*treatment*".

177. It was submitted on behalf of the defendant in that case 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.

178. MacMenamin J held that "*treatment*" in section 2 of the Act was ambiguous and capable of being interpreted broadly or narrowly. He went on to hold that it should be given a purposive or broad interpretation because the Act was designed for the protection of vulnerable people, and 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. He held, therefore, that 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.

179. At paragraph 53 of his judgment, MacMenamin J said:

> "[53] The first striking feature of the definition of "treatment" is that it is not intended to be all encompassing. The words used are illustrative: the definition "treatment" includes the identified measures which *may* be "physical, psychological *or other*" (emphasis added). There may also be other remedies not

enumerated or identified in the Act. One test of the intent of the legislature is whether a definition is intended to exclude as well as include; is there an identification by way of limitation? Here the answer is "no". These are not words of delimitation but illustration. The intent of the legislature is evident by virtue of the fact that the term "treatment" is not exclusively defined, but rather contains a number of illustrations as to forms which such treatment may take for the purposes of ameliorating a mental disorder. There may be "other" remedies. One cannot read this definition as reflecting an intent to preclude other forms of treatment not enumerated in the section. The consequence of the interpretation urged on behalf of the defendant in this case would be, in fact, to preclude the possibility of the form of remedial treatment envisaged here used as an ancillary to the regime of "medicine" because of the risks inherent in having one without the other."

180. At paragraph 55, he said:

> [55] The evidence before the court is that the "treatment" is necessary to restore the patient's health and to alleviate her condition. It is to relieve her suffering. Surely it would be an absurd and certainly unintended interpretation, that those treating the defendant to restore her health would be precluded from taking such measures as were necessary in order to safeguard the *life* of the patient in so doing?; see s.5 of the Interpretation Act 2005."

181. Importantly in the context of this case, MacMenamin J said at paragraph 67:

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

182. In *HSE v VF*, McDermott J was concerned with section 22 of the 2001 Act and with an application for the transfer of the defendant, who was an involuntary patient under the 2001 Act, from an approved centre to an unapproved centre. The application was in fact made under the court's inherent jurisdiction, but the Guardian ad Litem resisted the use of the inherent jurisdiction on the basis that the transfer could be effected under section 22(1) of the Act. McDermott J therefore had to consider section 22. He rejected the Guardian ad Litem's position that section 22 was available. In the course of his consideration of the 2001 Act he said:

> "28. Section 22 provides that a clinical director of an approved centre may arrange for the transfer of a patient 'for treatment to a hospital or other place and for his or her detention there for that purpose'. The duration of the detention in the 'hospital or other place' may only be for 'so long as is necessary for the purposes of his or her treatment' and the patient must then be taken back to the approved centre from which he or she is transferred. This period of detention is deemed to be detention in the centre from which he or she was transferred. As quoted above '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'. While this section clearly covers the transfer of a patient to a general hospital for medical or surgical treatment and the patient's return to the approved centre following that treatment, the definition of 'treatment' under s. 2 also embraces the temporary removal to a 'hospital or other place' for the administration of remedies in relation to the care and rehabilitation of the patient under medical supervision which is intended to ameliorate 'a mental disorder'. The period spent in that 'hospital or other place' is also deemed to be detention in the approved centre from which the person was transferred."

183. McDermott J distinguishes between medical or surgical treatment in a hospital and treatment in a hospital in relation to the care and rehabilitation of a patient which is intended to ameliorate the mental disorder. He therefore appears to allow of the possibility that "*treatment*" in section 22 includes treatment that is not related to the individual's mental disorder. This, of course, is contrary to the statement by MacMenamin J in *HSE v MX*.

184. Both of these cases must be approached with caution as providing any sort of definitive statement as to the meaning or scope of "*treatment*" in the 2001 Act.

185. In *HSE v MX*, MacMenamin J clearly concluded that the blood tests were closely related to the medication and there was no dispute that the medication constituted "*treatment*". Thus, he did not have to determine whether "*treatment*" must be limited to interventions which are related to ameliorating the mental disorder. In those circumstances, it appears that the statement is obiter.

186. MacMenamin J did not consider whether the use of "*including*" in the definition of "*treatment*" means that "*treatment*" encompasses interventions other than interventions related to the mental disorder. Certainly, it seems that this would be

more consistent with section 57(1). This is likely because it was not necessary for MacMenamin J to do so in light of his finding that the blood testing was related to the treatment for the mental disorder. (MacMenamin J did consider whether the definition in section 2 was exhaustive but that was from the point of view of whether the list of the forms of treatment for a mental disorder listed in the section was exhaustive.)

187. Nor did MacMenamin J have to consider the effect of an interpretation of "*treatment*" which limits it to interventions relating to the mental disorder on the ability of an approved centre to provide care for a patient who will not consent to treatment for anything. This would appear to have the effect that an involuntary patient could not be treated with paracetamol for the symptoms of a flu virus or antibiotics for a common chest infection without an application having to be made to court.

188. In *HSE v HH [2024] IEHC 564,* I also proceeded on the basis that "*treatment*" means interventions related to the amelioration of the mental disorder. However, in that case, I was also satisfied that the proposed intervention (naso-gastric feeding in the context of an eating disorder) was treatment to ameliorate the mental disorder and was related to the disorder. I therefore did not have to consider whether "*treatment*" was limited to remedies intended for the purposes of ameliorating a mental disorder.

189. McDermott J, for his part, was concerned with the issue of whether an effectively permanent transfer from an approved centre to an unapproved centre for treatment of the mental disorder was permissible under section 22 of the Act. He was not concerned with whether section 2 or section 22 was limited to treatment related to the mental disorder. In those circumstances, his comment that "*While this section clearly covers the transfer of a patient to a general hospital for medical or surgical treatment and the patient's return to the approved centre following that treatment, the definition of 'treatment' under s. 2 also embraces the temporary removal to a 'hospital or other place' for the administration of remedies in relation to the care and rehabilitation of the patient under medical supervision which is intended to ameliorate 'a mental disorder'"* must either be understood as meaning that the treatment in a hospital must be limited to treatment related to the mental disorder and must be temporary or, to the extent that he means that it is not limited, his statement is obiter. Furthermore, McDermott J does not appear to have been asked to consider *HSE v MX*.

190. I refer to these issues to highlight that it can not be taken as having been conclusively determined that only interventions which are directed at ameliorating a mental disorder, or which are related to same, constitute "*treatment*" in the 2001 Act.

191. They will obviously have to be the subject of full argument in an appropriate case. In the meantime, it seemed to me at the interlocutory stage that where an individual such as Ms. M requires medical treatment for physical conditions that put her health and life at risk the court's inherent jurisdiction was available for the court to consider authorising the delivery of such treatment.

CONCLUSION

192. For the reasons set out I am satisfied of the following:

(i) In the particular circumstances of this case when it came before me, the psychiatric medication was "*life-sustaining treatment*";

(ii) This court therefore had jurisdiction to hear and determine the application pursuant to section 89(2) of the 2015 Act for a declaration that the AHD was not valid and/or was not applicable;

(iii) Lack of capacity to make an AHD on the part of a directive-maker is a ground upon which an AHD may be found to be invalid and upon which a declaration may be made pursuant to section 89;

(iv) Ms. M did not have capacity to make the AHD at the time that she did so.

193. In those circumstances, I will make a declaration pursuant to section 89(2) that the AHD, made on the 6th November 2025, is not valid.