[2026] IEHC 570

THE HIGH COURT

IN THE MATTER OF R.F.

AND IN THE MATTER OF THE INHERENT JURISDICTION OF THE HIGH COURT

[2026/131 MCA]

BETWEEN:

HEALTH SERVICE EXECUTIVE

APPLICANT

AND

R.F.

RESPONDENT

JUDGMENT of Mr. Justice Barry O'Donnell delivered on the 30th day of July, 2026

INTRODUCTION

1. This is the judgment of the court in respect of an application that was heard on the 8 July 2026. The court delivered a short ruling on the 9 July 2026 which set out the decision that the court had reached and a brief explanation of the reasons for that decision. I indicated at that instance that a more detailed judgment would be prepared in due course. The reason for adopting that course of action was that the purpose of the application brought by the Health Service Executive (the *HSE*) was to obtain permission for the carrying out of invasive medical

procedures where the evidence was that there was some real urgency to the matter. I considered that it was important that the parties were aware of and in a position to act on my decision as soon as possible, and also that the respondent should be aware in broad terms of the reasons for the decision for her own purposes and in the event that she wished to consider whether to appeal the decision.

REPORTING RESTRICTIONS

2. When the proceedings were commenced, the moving party sought an order that the proceedings be heard otherwise than in public. That is a more restrictive order than ordinarily is applied in proceedings under the inherent jurisdiction of the High Court, where the usual order is one made pursuant to s. 27 of the Civil Law (Miscellaneous Provisions) Act 2008. Such an order under the 2008 Act is made when the proceedings concern the medical circumstances of vulnerable persons. In this case, I agreed to the greater restriction proposed on the basis that (a) the particular combination of circumstances in this case meant that even if the case was anonymised it was considered that the respondent may be identifiable and that (b) separately, any reporting would likely lead to the respondent herself experiencing significant distress, where her conditions and these proceedings already are a source of extensive distress. Hence, in this judgment I have endeavoured to remove any references that may tend to identify the respondent, including the names of the medical practitioners who gave evidence and the identity of the hospital that sought the orders.

THE PARTIES

3. The moving party was the HSE, and it was acting to give effect to concerns raised by clinicians in a large hospital. The respondent is a woman in her thirties; she is intelligent, employed, and lives a fully independent life. The respondent was represented by a court appointed guardian *ad litem*, Niall McGrath. This arose where there was clinical evidence that the respondent lacked capacity to make the decisions that were the subject of the application. Throughout the proceedings the guardian *ad litem* ensured that the application was the subject of proper scrutiny by instructing experts to consider and comment on the evidence adduced by the HSE, ensuring a careful examination of the witnesses at the hearing, properly interrogating the manner in which the evidence interacted with the applicable legal principles, and making sure that the views and wishes of the respondent were ascertained and drawn to the attention of the court. This culminated in the respondent herself giving evidence to the court and clearly expressing her views about what was proposed.

THE APPLICATION

4. The application before the court was brought by the HSE for the relief sought in a notice of motion dated the 17 April 2026. The application was adjourned from time to time to allow for further attempts to engage with the respondent and also so that the guardian *ad litem* could identify and instruct appropriate medical experts to provide independent reports.

5. The application was triggered by a clinical view on the part of the treating clinicians that the respondent suffered from a serious eating disorder and required surgical treatment for the removal of a gastric band that had been in place for approximately 10 years. The proposal

had two elements. First, there was a need for laparoscopic surgery to remove the gastric band and some postoperative care. Second, there was a need for the respondent to be treated for a period following the operation as an inpatient in a specialised eating disorder unit so that she could be assisted in coming to terms with the absence of the band and engage in rehabilitation.

6. The clinical reasons for the application, were that (a) the continued presence of a gastric band was contraindicated where an eating disorder was present, but over and above that general concern, the evidence was that (b) the band itself was too tight with the result that very little nutrition was passing from the respondent's oesophagus to her stomach and thus causing malnutrition, and (c) the presence of the gastric band had caused damage to the respondent's oesophagus and stomach and risked causing further damage, including potentially fatal damage.

7. The proposal was that following the removal of the gastric band, the respondent would need some postoperative care and an inpatient admission to a specialised eating disorder unit so that nutritional rehabilitation could occur. That course of treatment, involved, essentially, clinical monitoring, treatment and assistance to allow the respondent to deal with the effects of the removal of the gastric band, which would likely involve a significant increase in hunger and the potential for some rapid weight gain, matters that were likely to be very distressing to the respondent.

8. There was unanimous clinical evidence, including independent expert evidence, to the effect that, as a result of her disorder, the respondent did not have the legal capacity to make decisions (a) as to whether the gastric band should be removed, or (b) to engage in the course

of postsurgical treatment. Despite that lack of capacity, the respondent was very clear that she did not wish to undergo the procedures.

9. Accordingly, the issues that the court had to address in order to determine the application were, first, the nature of the respondent's conditions and the rationale for the proposed treatment; second, whether the respondent lacked capacity to make the decisions relating to the treatment proposals; and third, whether the treatment proposals were proportionate and should be permitted to go ahead to avoid serious harm to the respondent's rights.

GASTRIC BAND SURGERY

10. Before addressing the evidence that was heard and the applicable legal principles it may be helpful to set out a general description of how a gastric band operates, which was taken from the evidence given by two consultant bariatric surgeons, Professor H. and Mr. R.

11. Prof. H. described gastric band surgery. The band generally is made from medical grade silicone rubber tubing. The end of the tubing is accessible by a subcutaneous metal port, through which fluid can be entered or withdrawn. The bands usually are inserted by keyhole surgery. The band is applied to the very top of the stomach, just a centimetre or two below where the oesophagus and the stomach meet. There are cushions in the inner part of the band, so that when fluid is added through the subcutaneous port it compresses further and tightens or further restricts intake from the oesophagus into the stomach. Similarly, the band can be loosened or 'de-filled' by removing fluid through the port. Prof. H. noted that even an unfilled band applies a significant restriction.

12. Where it is used properly, the typical weight loss brought about by a gastric band is about 15% to 20%. A properly or optimally filled band permits an appropriate amount of food to pass from the oesophagus to the stomach, which controls hunger but still allows nourishing food and a sufficient intake of macro and micronutrients to pass through to maintain good nutrition. When a band is overfilled there is too much fluid in the cushions and it blocks the top of the stomach. The best objective way to measure the extent of gastric band restriction and its position is a barium swallow test. This is an x-ray study where patients drink a contrast containing barium, and the presence of the barium permits the doctor to observe the material as it flows down from the oesophagus and into the stomach.

THE EVIDENCE

13. In advance of the hearing, the court was furnished with a booklet of materials, that included medical affidavits and reports from:

i. Dr. M., Consultant Psychiatrist at an eating disorder unit in a public hospital, who gave evidence for the HSE. Dr M. was the clinician who would take responsibility for the postoperative treatment at his eating disorder clinic.

ii. Dr. C., a Consultant Psychiatrist in a large hospital where he is the clinical lead for the eating disorder programme at that hospital. Dr. C. was retained by the guardian *ad litem*.

iii. Prof. H., who is a Consultant Bariatric Surgeon at the same hospital as Dr. M. and is a Professor of Surgery at a major university. Prof. H. was called by the HSE and was the head of the team that proposed carrying out the surgery.

iv. Mr R., a Consultant Bariatric Surgeon who works in a number of hospitals, and who was retained by the guardian *ad litem*.

Dr. M.

14. Dr. M. is a consultant psychiatrist with a speciality in treating eating disorders. Dr. M. had prepared a number of reports for the purpose of the proceedings, which he adopted as his evidence. In the course of his evidence, he described the diagnosis of the respondent. The diagnosis of "*Other Specific Feeding or Eating Disorder*" (*OSFED*) was described as a broad category of multiple different types of eating disorders which cause very high levels of distress and dysfunction. Dr. M. noted that he had first met the respondent in July 2025, and had then had in person and email communications with her up until December 2025. He summarised the respondent's presentation as involving a terror of weight gain to the point that she was jeopardising her long-term physical health and that it was impairing her functioning in life.

15. Dr. M. stated that the history given to him by the respondent was that she had problems with weight in her teenage years which caused distress. She sought a gastric band insertion under a consultant outside the State, and, very shortly after the insertion, she noticed that she was experiencing extreme regurgitation and that food which was of a thicker consistency would not pass through the band. She made adaptations to her diet, swapping out solid type foods for liquid type foods but developed nutritional deficiencies. Accordingly, her first encounter with the hospital resulted from her suffering anaemia. On the respondent's account she was consuming up to 16,000 calories a day, but Dr. M. estimated that approximately 90% of that intake was not being absorbed. He noted that that estimate was consistent with information obtained from a number of barium swallow tests that had been conducted.

16. Dr. M. accepted that the respondent did not want to have the surgery and treatment, but a point had been reached where that was largely unavoidable. Dr. M. reported that since July 2025 he had attempted to engage with the respondent by arranging meetings with dieticians, joint meetings with Prof. H., and meetings individually with the respondent in order to give her the opportunity to make the decision voluntarily. However, a point has been reached where it is clear that a more robust intervention was required. Dr. M. was satisfied that if the procedure was delayed any further it would increase the respondent's distress by having the issue hanging over her for an extended period.

17. Dr. M. described the proposed course of treatment post surgically. He described it as involving the respondent learning again how to eat regularly, how to respond appropriately to hunger cues, and how to manage the rebound effects of a band being removed. He noted that there was likely to be increased hunger and weight gain once the band was removed and, for that reason, he was proposing that the respondent use GLP-1 medication, which would need to be titrated over time. Dr. M. was of the view that de-filling the gastric band or loosening it was not an option: the band would still present a significant obstruction and would constitute a barrier to the respondent engaging properly in regular eating. Moreover, he was apprehensive that, because of her distress at potential weight gain following the de-filling, the respondent would likely engage in some sort of refilling process.

18. In relation to the question of capacity, Dr. M. was of the view that the respondent could not weigh up the information that was given to her. While she expressed a fear of missing work, he identified this as an illustration of the respondent's inability to accept what was being medically said to her and that she did not accept the truth of what was being proposed to her in terms of its consequences. He stated in his evidence that:

> "*her level of eating dysfunction and her level of beliefs around how little control she has itself as compared to how much control the gastric band itself has it is at a level she is not able to make that decision from her eating disorder warping her ability to weigh up those issues."*

19. The expectation was that once the respondent is engaged in treatment and the band is removed, it should be possible to maintain her weight at a threshold that she found satisfactory and that this would assist in addressing her concerns about the potential consequences of the removal of the band.

20. Dr. M. did not see any realistic alternative to inpatient treatment. This was on the basis that the respondent's level of eating dysfunction was so extreme that she will need significant support during what he described as the nutritional rehab period. This would involve very structured treatment involving acclimatising the respondent to being on a dose of GLP-1 medication and addressing eating behaviours, which will require considerable support.

21. Dr. M. was satisfied that his unit would be able to address the risks that arise where a person moves from being effectively malnourished to potentially overeating through an unrestricted oesophagus and the consequent risk of re-feeding syndrome. Dr. M. highlighted that while the respondent's weight was not yet at a dangerous level, because of the type of

nutrition she was taking on her micronutrients were likely extremely depleted and her diet was nutritionally unbalanced, and he highlighted the fact that she had been treated for nutritional related anaemia for some time.

22. Ultimately, the object of the proposed treatment plan was to eliminate the risks of death or having a sudden event related to the tension in the band, and also physically bringing the respondent to a healthier point in terms of her overall nutritional levels. This would lead to better health outcomes in later life, with a reduced likelihood of developing osteoporosis and a reduced likelihood of developing the consequences of long-term malnutrition.

23. Dr. M. highlighted that this was not a straightforward case and it was very difficult to make a clear assessment of potential success, but he was reasonably optimistic that the respondent would succeed in the treatment.

24. Dr. M. estimated that it would take 4 to 6 weeks of inpatient treatment to regularise the respondent's situation and after that matters could be addressed at outpatient clinics. He was satisfied that by interacting with her GP it should be possible to formulate a form of medical certificate that would achieve the objective of the respondent being certified as unfit for work for the relevant period while maintaining a degree of privacy for the respondent in respect of the treatment.

25. Under cross examination, Dr. M. was very clear that this was not a situation in which the respondent was making an unwise but capacitous decision. Instead, she was unable to accept the actual idea of treatment, and she was not accepting what was being told to her medically as likely to be true.

Dr. C.

26. Dr. C is a psychiatrist and head of the eating disorder clinic in a hospital (which is not the hospital at which the respondent was treated or was proposed to be treated). Dr. C. was retained by the guardian *ad litem* to provide an independent second opinion; and, by the time of the hearing his views were aligned with those expressed by Dr. M. Dr. C. placed considerable emphasis on a barium swallow study which had occurred early in the week before the hearing. This indicated a complete blockage at the point of the opening of the stomach, which suggested no possibility of food passing properly into the stomach and that there was a worsening dilation of the oesophagus. In those circumstances, Dr. C. was satisfied that there was an urgent need for the procedure to continue. That view was expressed in circumstances in which, at an earlier stage in the proceedings, Dr. C. had suggested that perhaps more time should be given to the respondent to see whether she was willing to engage in treatment on a voluntary basis.

27. In terms of capacity, Dr. C. expressed the view that, in the respondent's case, the issue related to an inability to weigh the information properly in the balance. This derived primarily from the extreme cognitive distortions caused by the eating disorder. He noted that the respondent had an extreme fear of weight gain and that that fear had primacy over any other aspects of her life, including her survival. He described this as an inability to weigh information in the balance because of cognitive distortions arising from the psychopathology of the eating disorder. In that sense, while the respondent, who is an intelligent person, can ostensibly accept and understand the information given to her, her understanding of the risks with not proceeding with the treatment simply cannot override the pathology of the eating disorder. The cognitive distortion prevents weighing those in the balance. He noted that this is a very common issue in the treatment of eating disorders.

Professor H.

28. Prof. H. had provided reports to the court prior to the hearing, and at the hearing provided some visual evidence in the form of slides with data from barium swallow tests. As noted above, Prof. H. began by providing a general description of gastric band surgery. Prof H.'s evidence – which was not contradicted – was that the best objective way to measure the extent of gastric band restriction and its position is a barium swallow test.

29. Ordinarily in a barium swallow test there should be immediate observable emptying from the oesophagus into the stomach unless there is an abnormality at the junction between the oesophagus and the stomach.

30. Where the band is too tight, this can be observed in a barium swallow test because no contrast will get through the band. This can lead to severe dilation of both a portion of the stomach pouch and, importantly, the oesophagus. In turn, this leads to a risk in the short to medium term of rupture of the gastric pouch or, in rarer instances, the oesophagus. The risk is heightened where there is forced vomiting.

31. In addition to the risks of rupture, there is also a risk that blood supply can be compromised by a tight band, which was a matter of concern in the respondent's case. With over-restriction and forced vomiting, sometimes the stomach can be forced to shift up through the band, become further compressed, and the blood supply to the stomach can be completely restricted leading to ischemia. In that scenario, the stomach may become unhealthy and, essentially, part of it dies. A further concern is that perforation or a hole can occur in that compromised part of the stomach. That is a life-threatening emergency, and in addition to

requiring the removal of the band, it usually requires at least part or sometimes all of the stomach to be removed.

32. Prof. H. showed visual images from the respondent's most recent barium swallow study which was done on the 6 July 2026. A number of matters were observed by Prof. H. First, in a normal situation contrast should have passed through the band almost instantly or within at least 2 to 3 minutes at most. In the respondent's case, at 11 minutes after the initiation of the swallow study, no contrast had passed through the gastric band. This was described as highly abnormal.

33. The second matter highlighted by Prof. H. was observable gross distension of the gastric pouch and the oesophagus. The oesophagus was measured by a radiologist at 7.8 cm. The normal diameter is usually approximately 2 cm, so it followed that the oesophagus was significantly dilated; this highlighted a risk of rupture particularly in the case of forced vomiting.

34. Prof. H. noted that her first contact with the respondent was in April 2021. At that point, the respondent's band had been in place for six years. The respondent unfortunately had received a diagnosis, unrelated to any of the current matters, and required a de-fill. After a de-fill at a private clinic, she gained weight very rapidly and there was a prospect of further weight gain. Prof. H. added 1 ml to an existing 4 ml fill at the time. When the respondent requested visits for further refills, these were refused by Prof. H. because she considered that this would over tighten the band.

35. Prof. H. saw the respondent again at an inpatient admission in June 2024, when she was admitted by a gastroenterologist due to severe malnutrition, anaemia and vomiting. A barium swallow test carried out in July 2024 showed complete obstruction, which apparently had been going on for approximately two years. At that time, the respondent refused permission to empty the band but was advised of the risks about perforation and compromise to the stomach and to her life.

36. The next meeting was when Dr. M. had asked her to see the respondent again. She went to an eating disorder clinic with the intention of fully emptying the band on the 24 September 2025 and there was a long multidisciplinary discussion with the respondent. The respondent required more time to prepare herself and refused a de-fill on that day. She attended a general surgery clinic in October and was listed for a full de-fill, but again the respondent only consented to the partial removal of 2.5 ml.

37. There was some conflict of evidence as between the respondent and the clinicians regarding the extent to which the band may have been refilled in the period between October 2025 and the current point in time. The respondent in her evidence was adamant that she had not had the band refilled, but Prof. H. considered that the evidence suggested that it was much tighter and certainly was not at the 4 ml level of fill that the respondent contended for. Prof. H. noted the progressive dilation of the oesophagus, suggesting a chronic problem of over restriction.

38. There was also a conflict of evidence insofar as the respondent denied forced purging or voluntary vomiting. Prof. H. noted that the degree of obstruction in the gastric band would

usually result in involuntary vomiting. Whether the vomiting was voluntary or involuntary, the effect would be the same in terms of the risk of damage to the oesophagus or the stomach.

39. Prof. H. also observed under cross examination that, based on the barium swallow, the gastric band was completely obstructed. That meant that nothing was getting through, whatever amount of fluid was actually in the band at the time. In terms of prognosis if the procedure was not carried out, Prof. H. observed from the barium swallow study that for approximately two years the bottom of the oesophagus was significantly dilated and now was almost four times what it should be. The natural rhythmic movement of the oesophagus was affected to the point that there was a risk that the patient may develop, or have developed already, a condition called pseudoachalasia. This is where there is a movement disorder of the oesophagus, and if it is present the oesophagus will never work properly and never carry food down appropriately. In turn, this greatly affects nourishment and quality-of-life. It can lead to difficulty swallowing, particularly solid or dry food, where the food cannot move down appropriately and would leave the respondent entirely dependent on a liquid or soft diet, which, in turn, affects quality-of-life and nutritional intake.

40. The next risk was a risk of gastric or oesophageal perforation due to the vomiting. Prof. H. noted that given the tightness of the band and the dilated gastric pouch and oesophagus, vomiting causes an increase in the intrinsic pressure within that small segment of the stomach and oesophagus and, at some point, it could rupture. Prof. H. was very careful to emphasise that this was a rare situation (the situation faced by the respondent) and that there was very little in the documentary evidence or literature to permit evidence-based appraisal of what was likely to occur. Prof H. was of the view, based on her experience and clinical judgement, that the estimated risk of gastric perforation was 3 to 5%. That is a risk that is 3 to 5 times that of

the general population. In the case of a perforation, if it occurs, the mortality rate is approximately 30%.

41. Prof. H. stated that she believed that her estimate was conservative, and that the mortality figures derive from evidence of gastric perforations of all natures and the timing at which they were treated. Hence, if there is a delay in presentation and treatment, the mortality rate can be much higher. In cases of oesophageal perforation, the mortality rate can be 100% if treatment is not initiated in the first 48 hours.

42. Prof. H. did not consider that there was any particular risk involved in the proposed surgery if it was conducted without the consent of the respondent. This was because the procedure will be carried out under general anaesthetic. However, she agreed with Mr. R. that it is ideal to have a compliant patient, particularly in relation to postoperative care where early mobilisation to prevent other surgical risks such as clots in the veins in the legs is important. Also, the patient needs to be able to eat and drink after surgery to be well nourished, which assists in recovery and reduces the risk of infections in the wounds. In addition, in the postoperative period it will be necessary for the clinicians to ensure that the respondent is treated postoperatively to address any potential vitamin B1 deficiency.

43. Prof. H. also agreed with the need for postoperative treatment with GLP-1 medications. That treatment is "off licence" or "off label" use. The need for the administration of the medication was identified because when people have gastric bands removed there is an inevitable increase in hunger and potentially sudden and distressing weight gain. In those premises, GLP-1 medication would be safe at a low dose and may mitigate the risks of a dramatic increase in hunger and weight.

44. Prof. H. also made very clear that it was not simply good enough in this case to fully empty the band and leave it in place. This was because of the degree of gastric pouch and oesophageal dilation, and also in relation to the risk that it would be refilled by the respondent outside of a medically approved or medically supervised clinic.

45. Under cross examination, Prof. H. clarified that, typically, the bands are either 8 ml capacity or 10 ml capacity. In the case of the respondent, Prof. H was not able to tell which size band was applied to the respondent. However, that did not alter her opinion that the degree of stomach and oesophageal dilation was a threat to life. In that sense, a full deflation, regardless of the capacity or current filling of the gastric band, would not resolve the question and the band needed to be removed.

46. Prof. H. also clarified that, aside from the risk of death that can result from perforation, her estimated figures were provided without reference to the presence of an eating disorder. As noted by Prof. H, the fact of the eating disorder itself poses an additional risk in terms of the risk of malnutrition which is a risk to life. In that regard, Prof. H. commented on the morbidity associated with the difficulty presented by the gastric band and the quality-of-life implications and long-term effects to the movement of the oesophagus and stomach if the band was not removed. Overall, Prof. H. was very clear that deflation was not sufficient, and removal was the only appropriate surgical treatment.

Mr. R.

47. The second bariatric surgeon who gave evidence was Mr. R., a consultant surgeon working in a number of hospitals. Mr. R.'s involvement came about when a second independent opinion was sought by the guardian *ad litem*. Mr. R. provided a very comprehensive and helpful

report, which he adopted as his evidence in chief. It was clear from his examination and cross-examination that in all material respects his view aligned with that of Prof. H. In particular, Mr. R. confirmed that in a normally functioning gastric band situation, a barium swallow image would show material passing almost immediately through the band into the stomach, and that 11 minutes was a very significant period in which to see nothing pass into the stomach. In addition, Mr. R. also agreed with the clinical estimate provided by Prof. H. in respect of the risks of gastric or oesophageal perforation. Like Prof. H., he highlighted the fact that there was very little literature on the topic and therefore it had to be a matter for clinical judgement. In light of the significant experience and qualifications of both Mr. R. and Prof. H., the court accepts their estimates in relation to the risk of perforation and the risk of mortality if that perforation occurred.

The respondent's evidence

48. The respondent herself gave evidence. In relation to the barium swallow issue, the respondent was adamant that eventually some food passed through the band and highlighted that her weight movements were not such as to reflect a situation where no nutrition was passing. The respondent denied that she had ever made herself deliberately sick or voluntarily sick but there were situations where food was regurgitated. The respondent appeared to distinguish between what she described as a form of regurgitation and a situation in which there was purging or making herself sick. In terms of the regurgitation, she said there have been occasions when there seems to be quite a lot of it. The respondent highlighted certain issues within her family which suggested that reports about her from certain members of her family were not reliable.

49. A significant issue from the point of view of the respondent was the effect of a prolonged admission in hospital on her financial situation. In that regard, the respondent highlighted that she had certain rent and household bills which had to be paid, and also that her current employment and work towards certain professional qualifications would be impacted. The respondent noted that her background involved a history of trauma. It is not necessary to go into the detail of the events that gave rise to the trauma, suffice it to say that all parties accepted that the respondent was a person who had experienced significant trauma in the not-too-distant past, and this was a matter that had to be borne in mind in approaching her situation. From the point of view of the respondent, it was stressed that her trauma history made her particularly protective of her own autonomy and bodily integrity.

50. The respondent accepted the *bona fides* of the various clinicians and accepted that they were working towards her protection. The respondent also accepted that she did not engage as much as she probably should have done with her treating clinicians, particularly in 2026. The respondent's preference was for a slower and less invasive way of approaching the difficulties.

51. While the court was very impressed with the genuine and heartfelt nature of the respondent's approach to her situation, the difficulty presented by the psychopathology of her eating disorder was illustrated by her approach to questions from counsel for the guardian *ad litem* regarding the potential to retain the band in place but to reduce its capacity. The respondent was suggesting very modest de-fills of the gastric band; and while she stated that she would agree to that taking place soon, when pressed she indicated her preference for a more gradual approach towards de-fills and deflation.

52. In terms of the procedure that was suggested by the clinicians, when asked to describe the impact of that for the respondent her focus was on practical matters such as work, her work towards professional qualifications and her ability to pay her rent. The benefits of the proposed treatment that she identified seem to be relating to the reduction in the amount of regurgitation that she would experience. In terms of the health risks, the respondent did not appear to completely take on board the medical evidence that she had heard and seemed to relate the health risks mainly to the question of purging or regurgitation.

53. The overall view of the respondent was also illustrated by a response to a question which asked for the court to be taken through her position at the moment. The respondent stated that she did not want the band entirely removed because it was a tool that had worked for her, and she did not think that it was dangerous. She stated that she had carried out her own research and considered that the real issue was that it was overfilled and over-tight, and if it was loosened it would reduce all of those risks. Likewise, the respondent did not accept that the support she required needed to be delivered on an inpatient basis and that she would cope much better being an outpatient.

RELEVANT LEGAL PRINCIPLES

54. The principles governing an application of this type are well established at this point. There was consensus as to those principles, with some debate as to whether the court should make a finding that the proposed intervention was proportionate having regard to the invasive nature of the proposal and the potential consequences for the respondent's employment and financial circumstances.

55. The test as to whether the respondent has capacity to make the necessary decisions has been set out in *In the matter of K.K.* [2023] IEHC 565 (*K.K. No 2*). This is the test identified by Laffoy J. in *Fitzpatrick v. F.K.* [2009] 2 I.R. 7, taking into account the approach to capacity set out in the Assisted Decision-Making (Capacity) Act 2015. The test is a functional test in that the assessment must consider the capacity at the given time of the affected person to make the specific decision that is under consideration. Here the decision is whether the respondent should undertake invasive surgery to remove her gastric band and undergo the postsurgical psychiatric treatment. Accordingly, the court must consider whether the respondent is able to:

i. understand the information relevant to the decision;

ii. retain that information long enough to make a voluntary choice;

iii. use or weigh that information as part of the process of making the decision;

iv. communicate the decision.

56. Here, it was clear that the respondent understood and retained the relevant clinical information and was able to communicate her preferences. The issue focussed on the question of whether the respondent could use or weigh the information as part of the decision-making process.

57. Even where a person lacks capacity, it does not follow automatically that the court should authorise the proposed treatment. Where the proposal involved an element of detention (and in this case: in addition to the medical treatment there is a necessary curtailment of liberty), Hyland J. in *K.K. No. 2* discussed the approach to deciding whether the intervention was necessary to defend and vindicate the constitutional rights of the affected person at para. 30, as follows:

> "*At its simplest, that requires an identification and analysis of (a) the type of restrictions on the liberty of the person proposed; (b) the constitutional rights negatively impacted by the proposed detention under threat; (c) the constitutional rights sought to be protected by the proposed detention; (d) the carrying out of a balancing exercise to identify what rights ought to prevail; and (e) a consideration of the proportionality of the measure proposed.*"

58. The court is also assisted by the approach adopted by Barniville P. in *In the matter of C.F.* [2024] 1 I.L.R.M. 30, where the court considered whether a medical intervention should be authorised for a person who lacked capacity. In approaching the issue, the court conducted an extensive and helpful analysis of the caselaw and distilled a series of fundamental principles. These were:

i. An adult with capacity was entitled to withhold consent to medical treatment, and capacity is presumed unless and until there is satisfactory evidence to rebut that presumption.

ii. The fact that a person lacks capacity does not mean that they have lost the benefit of their personal rights under the Constitution.

iii. There is a strong presumption in favour of maintaining life.

iv. Several constitutional rights are engaged in a case such as this; including the rights to privacy, bodily integrity, autonomy, equality and dignity in life and death. Although, it can be noted that the question of whether dignity properly is classified as a constitutional right is a matter for more detailed consideration, as explained by the Supreme Court in *Doe v Commissioner of An Garda Síochána* [2025] IESC 44.

v. Even where there is a lack of capacity, the clear and constantly expressed wishes or views of the affected person must be given considerable weight.

vi. Family views are important. However in this case I have chosen not to attach particular weight to the views attributed to the respondent's family members, for two reasons: (i) the views were not expressed to the court directly and therefore could not be questioned or queried in the same way as the other evidence, and (ii) there was a basis for considering that the relationship between the respondent and the family members in question was troubled and it would not have been safe to take their views at face value.

CONCLUSIONS ON THE EVIDENCE

59. The court is not qualified or equipped to carry out its own assessment of the respondent's capacity, that is a matter to be established by expert evidence. What was striking in this case was that the psychiatric evidence was unanimous that the respondent suffered from an eating disorder and the psychopathology of that disorder resulted in a position where the respondent simply could not weigh clinical evidence in the balance. By this I understand the evidence to be that the respondent's fear of weight gain means that any clinical information

supporting a need for an intervention which would result in potential weight gain simply cannot be taken on board or weighed by the respondent. The fear of weight gain amounts to an overwhelming factor that outweighs all other concerns. One could not avoid being impressed by the respondent, who has overcome significant difficulties in her life and is on track to achieving career and life goals. I am satisfied that her concerns about the potential impact of the treatment course on her career and ability to pay rent and bills are reasonable. However, in my view her evidence illustrated the concerns of the clinicians. It appeared to the court that the respondent's objective was to negotiate an outcome that avoided any imminent prospect of a course that involved weight gain. To my mind, this was not a situation in which an unwise decision was being made by a person with capacity to do so, but that the respondent was not able to make a capacitous decision in the first place.

60. I accept the psychiatric evidence, given as it was by very experienced clinicians, and therefore I accept that the respondent has a serious eating disorder that requires treatment but that the psychopathology of her disorder means that the respondent's capacity to make a lawful and effective decision to accept or refuse the treatment is absent. In the premises, I am satisfied that the psychiatric evidence should be accepted, and that the following findings can be made:

i. The respondent suffers from the eating disorder, "Other Specified Feeding Or Eating Disorder" or OSFED, a recognised mental disorder.

ii. The respondent requires to be treated to address her eating disorder.

iii. There have been extensive efforts to engage the respondent in the need for treatment on a voluntary basis.

iv. The respondent lacks capacity to make the medical decisions that needed to be made, thus the presumption of capacity has been rebutted.

v. The lack of capacity related to the ability of the respondent to use the medical advice or properly weigh it in the balance as part of the decision-making process. In all other respects the respondent is an intelligent articulate person who is fully capable of communicating her wishes and preferences.

vi. The respondent's ability to use or weigh the relevant medical information is compromised due to the psychopathology of her particular condition: she attaches disproportionate and overwhelming weight to the need to avoid any weight gain, and that objective cannot be dislodged by other factors or considerations, including the clear medical evidence that without the treatment her life and health is in jeopardy.

61. Similarly, I am entirely satisfied to accept the evidence given by Prof. H. and Mr R. Aside from the important fact that a gastric band is contraindicated for persons with eating disorders, there was compelling and uncontradicted evidence that the respondent was facing a substantial health risk by retaining the band in place. The evidence clearly established that the band was too tight and insufficient nutrition was passing from the oesophagus to the stomach, the oesophagus and gastric pouch were dilated, and there was a real risk of pseudoachalasia and a risk of perforation. The risks identified by Prof. H were appreciable and involved not only a risk of long-term damage to the respondent's health, but also a risk of death. I further accept the medical evidence that there is no clinically appropriate alternative to removing the gastric band.

62. In respect of matters raised by the respondent, first I understand the import of the evidence to be that any form of vomiting increases the risk of harm. Accordingly whether the

respondent engages in purging or forced vomiting, which she denies, or experiences involuntary regurgitation, it seems to me that the effect is the same and the risk of harm is present. Second, I consider it more likely than not that the respondent had the band refilled at some point after the 2.5ml was withdrawn in October 2025. It seems to me that this is the only reasonable explanation that can be identified for the fact that the most recent barium swallow test showed no material passing through the band.

63. Accordingly, I have been in a position to find as a fact that the removal procedure is clinically necessary and medically indicated where:

i. Recent investigations show that the band is dangerously obstructing the flow of food and fluid to her stomach.

ii. The band is causing notable dilation of her oesophagus, and may indeed already have caused damage.

iii. There is a significant risk of either or both gastric perforation or oesophageal perforation.

iv. The removal is a necessary step in the treatment of her eating disorder.

64. There are risks associated with the procedure which are exacerbated by the physical condition of the respondent, but I am satisfied that those risks are outweighed by the risks of not undertaking the surgery. The main identified risks of not undertaking the surgery are:

i. Progressive malnutrition due to the obstruction.

ii. The risk of gastric perforation and / or oesophageal perforation due to ongoing vomiting or regurgitation. This was demonstrated by the barium swallow.

iii. The risk of oesophageal dilation which may, if this has not already occurred, lead to permanent dilation resulting in pseudo achalasia.

iv. The risk of ischaemia of the gastric pouch above the band which could also lead to perforation.

v. The overall negative effect of the band on her current and future health.

65. I am satisfied that if any of those risks crystallised, the effect on the respondent, depending on the presenting circumstances, range from serious short and long-term ill effects on her health to a fatal outcome. In the premises, I am satisfied that the intervention is necessary and that the risks of not having the surgical intervention significantly outweigh the risks associated with the surgery. The surgery and postoperative treatment are necessary to defend and vindicate the respondent's constitutional rights.

66. The most significant issues are that the proposed intervention is strongly opposed by the respondent and the proportionality of the intervention when compared with less intrusive treatment options.

67. On balance, I am satisfied that although the respondent's wishes and objections were reasonable, heartfelt and presented clearly, these do not justify either postponing the surgery or seeking to address her medical situation in a less intrusive manner. I accept that the treatment course impacts on the rights to bodily integrity and autonomy of the respondent. Further, I accept that it may carry repercussions financially – those impacts are important but short term and transitory. These impacts, in terms of finance and autonomy, must be balanced against the impacts of not having the treatment. The evidence was clear that if the treatment was not permitted the respondent's life was at risk and, even if there is no fatal outcome, she will

nevertheless suffer long term medical consequences. Those consequences themselves would have a more appreciable impact on the respondent's bodily integrity, her professional life and ability to discharge her financial obligations than the impacts of having the surgery.

68. Hence, while there is no doubt that the medical plan overall involves a very substantial intervention that impinges on the respondent's constitutional rights, the intervention is proportionate when account is taken of the very serious risks associated with her current medical situation. This is particularly so in light of the accepted psychopathology of her condition and the evidence that the option of reducing the tension in the band will not resolve the existing negative physical impact in terms of damage to her oesophagus and stomach.

69. In those premises, I was fully satisfied that the orders sought should be granted. In granting the relief, I made clear that the more intrusive orders – particularly relating to removal of the respondent to the hospital and the use of restraint – should only be utilised as a last resort, and that every effort should be made to give effect to the orders in the least intrusive way consistent with proper medical practice and decision making. Every effort was to be made to seek to engage the cooperation of the respondent before the powers in the orders are utilised. It should be noted that my views above reflected the approach preferred by the treating clinicians.

70. I also made clear that I will maintain the proceedings under close review to ensure that they remain in place only for so long as the respondent lacks capacity and while they remain proportionate to the overall medical objectives.

71. I will hear from the parties on the next scheduled date in respect of any matters that may arise from this judgment, including any observations on the question of publication or a need for further redactions.