Review of current practice in the use of wardship for adults in Ireland

The National Safeguarding Committee

December 2017

National
Safeguarding
Committee

Promoting the rights of adults who may be vulnerable

Table of Contents

FOREWORD

"People with disabilities, both mental and physical, have the same human rights as the rest of the human race…The whole point about human rights is their universal character" Baroness Hale (P [2014] UKSC)

The National Safeguarding Committee was established in December 2015. It is a multiagency and inter-sectoral body in recognition of the fact that safeguarding vulnerable people from abuse is a matter that cannot be addressed by any one agency working in isolation, but rather involves a number of agencies and individuals working collaboratively with a common goal.

In November 2016, the Committee published its Strategic Plan 2017–2021 and identified a number of actions that it would undertake in the 5-year period. One of the key priorities was to: ***Develop a paper on current practices in the use of wardship within adult care services making recommendations to relevant stakeholders that promote and protect the rights of service users***.

The Assisted Decision-Making (Capacity) Act 2015 was enacted in December 2015 but is not yet fully commenced. This Act will replace the Wards of Court system and provides that the capacity of all existing wards be reviewed within a period of 3 years and discharged from wardship. Those wards who, on review, are found to lack the capacity to make decisions will transition to the new system.

Pending the full implementation of the 2015 Act, it is suggested that a more rigorous approach is required in respect of the capacities and therefore the human rights of Wards of Court, either when wardship is applied for or once a person has been admitted to wardship. Even though the Lunacy Regulations (Ireland) Act 1871 remains on the statute book, it is suggested that its statutory provisions need to be interpreted and applied in accordance with the provisions of:

- the European Convention for the Protection of Human Rights and Fundamental Freedoms as required under the European Convention on Human Rights Act 2003 and

- in line with the spirit of the UN Convention on the Rights of Persons with Disabilities, which is provided for in the Guiding Principles of the Assisted Decision-Making (Capacity) Act 2015.

This review highlights what are thought to be a number of gaps in the present system of wardship. It suggests some practical recommendations that might be implemented immediately, in order to respect the 'Voice of the Ward' and ensure that any interaction with a person who lacks capacity to make a decision complies with human rights standards and respects their inherent dignity, including their right to autonomy and self-determination.

The National Safeguarding Committee commissioned Kate Butler BL and Fionnuala McGee BL to carry out research on its behalf. They have carried out the task meticulously. We wish to thank them for the exceptional and sensitive manner in which they engaged with people on the subject of wardship proceedings, with members of the legal and medical professions and with staffs of relevant bodies on the important issues which arise in the context of wardship proceedings.

Patricia T Rickard-Clarke

Chairperson,
National Safeguarding Committee

December 2017

EXECUTIVE SUMMARY

A Ward of Court is an individual who has been deemed by the court to lack capacity to make decisions for himself or herself, and where the court steps in to act as agent[1] for the individual. This may arise due to dementia, intellectual disability, acquired brain injury or other reasons. Usually, a person is made a Ward following an application by a family member, the person's own solicitor or the Health Service Executive (HSE). In the vast majority of cases, at the time of writing, these applications are made in the "best interests" of the individual: to protect him or her and his or her assets. There are almost 3,000 wards, with total assets of over €1 billion.[2]

Our findings indicate that the procedures of the Ward of Court system in Ireland rely excessively on the integrity of families and professionals acting in the best interests of vulnerable adults. It also is heavily deferential to the professional integrity and competence of legal and medical practitioners. However, there are concerns that there are insufficient checks to ensure that the interests of a proposed Ward are independently considered and possible conflicts identified.

Key findings of the report:[3]

- The Voice of the Ward is not heard during an application for wardship, or subsequent to the individual being made a Ward. By 'Voice of the Ward', we mean the wishes and preferences of the individual on a range of matters should be ascertained and heard, including but not limited to: on being made a Ward; on consent to medical procedures; where he or she wishes to live; on how his or her property is to be disposed of.

- There is no automatic system of providing Respondents (prospective Wards in an application for wardship) with independent legal or non-legal advocacy. More

[1] Where the court receives the power to act on behalf of the Ward, binding the Ward as if he or she were himself or herself making the decisions.
[2] As of 30th September 2016, there were 2,850 Wards of Court (not including minors), with assets valued at €1.142 billion. The Office of the Accountant of the Courts of Justice, *Report and Financial Statements for the Year Ended 30th September 2016.*
[3] Recommendations are in Chapter 8.

frequently than not, a Respondent has no representation independent from the person making the application to have him or her made a Ward. This is in stark contrast to the position in many jurisdictions, particularly for example in the UK, where a person who is the subject of capacity proceedings is automatically appointed an advocate to help him or her articulate his or her wishes and preferences.

- The court procedures, to have someone made a Ward of Court, do not take account of the vulnerability of the Respondent: procedures which may be fair in a standard application may not be fair where the Respondent is vulnerable. These include the following:

    - The Applicant is obliged to give the court papers to the Respondent, but there is no requirement to ensure that the application is explained to the Respondent in a way that he or she can understand.
    - The medical reports which the Applicant rely on are not given to the Respondent, even though the Respondent is the subject of those medical reports.
    - The Respondent's ability to *object* to an application depends on whether he or she fully understands the nature of the application. If the application is not properly explained and if the Respondent does not receive the medical reports, it makes it more unlikely that he or she will object.

- When a person is made a Ward, he or she does not receive the order of the court. In one case, a Ward requested a copy of the order but the Office of Wards of Court declined to give it to them partly on the grounds that it would be difficult to understand.

- There is no system of review of Wards. There is no system of unannounced visits or otherwise, although we understand that there are plans to introduce this on a random basis. There is an excessive reliance by the Office of Wards of Court and the General Solicitor on information from the Ward's carers or Committee (the

person appointed by the Court to represent the Ward), without sufficient independent oversight.

- There is a review every six months of Wards who are the subject of detention orders. However, this system of review was introduced as late as 2014.

- Until 2000, all Wards were subject to a detention order. There are still some Wards who are subject to these historic detention orders. The review of these historic detention orders began as late as 2014 and is not fully completed.

- A person who could be involuntarily admitted to a psychiatric unit under the Mental Health Act 2001, but is instead made a Ward does not get the benefit of the safeguards available under the 2001 Act, for example, automatic legal representation.

- There is no system of review or appeal for Wards (and non-Wards) who are the subject of de facto detention: for example, voluntary patients of psychiatric units who are detained in the same circumstances as involuntary patients; older persons who are placed in nursing homes against their will; persons with intellectual disabilities who are placed in congregated settings and institutions against their will.

- There is no recognition by the court that a Ward may have capacity to make particular decisions himself or herself (apart from the exception of where the court may decide that the Ward has capacity to execute a will). There is a strong constitutional argument that the court should assess whether a Ward has the capacity to make particular decisions himself or herself, such as consent for medical procedures, and that this assessment should be done on a functional basis (whether the ward has the capacity to make a particular decision, at a particular time, in a particular context).

- There are no clear guidelines around conflict of interest in relation to the Applicant and also the person appointed to represent the Ward (known as the Committee).

- In making an individual a Ward, the court largely relies on the information in medical reports produced by medical practitioners. There may be up to three such reports put before the President in an application. However, a number of issues arise in relation to such reports:

    - There are no guidelines requiring a consistent standard of assessment. Legal practitioners described how, in some instances, reports with one line stating that the subject is of unsound mind and incapable of managing his or her affairs have been submitted by medical practitioners.
    - There is no requirement on the practitioner to comply with his or her duty to enhance and or maximise the capacity of the individual. A medical practitioner described how he has seen capacity assessments being carried out at 8am while the person was still in bed, even though there is research which shows that people are drowsier when lying in bed.
    - There is a conflict between the legal test required by the Ward of Court system, which the medical practitioner is required to satisfy, and the HSE guidelines in relation to consent.

- There are no independent social assessments carried out in relation to the Ward's circumstances. Medical assessments tend to focus on the capacity of the individual and do not consistently look at whether the Ward's lifestyle and living conditions are suitable.

- There is no clarity in relation to the legal test under the Lunacy Regulation (Ireland) Act 1871 for deciding if the individual is of unsound mind and incapable of managing his or her affairs. There is no definitive judicial definition of what "unsound mind" means.

- There is no transparent protocol of complaints to the Office of Wards of Court. If a complainant is unhappy with how the Office has dealt with his or her complaint, the only recourse is a potentially expensive application to the High Court, which can act as a deterrent.

- There is considerable confusion and lack of understanding around the Ward of Court system and what it means for individuals. We experienced such confusion amongst legal and medical practitioners, as well as amongst HSE staff.

- There is excessive reliance on the Ward of Court system — as the only system of protecting vulnerable adults — in situations where a less drastic intervention would be much more appropriate. For example, individuals are made Wards of Court in order to be able to access their funds for the Fair Deal nursing home scheme.

- The HSE has no transparent protocols about when and why it will instigate wardship proceedings and also has no centralised guidelines for legal practitioners and medical practitioners in protecting the rights of a Respondent in Ward of Court proceedings.

There are also concerns that the process is dehumanising and that the individual's human rights are negated in an overly protective system. There has been recognition of this for very many years, and consequently the system is due to be dismantled. The Assisted Decision-Making (Capacity) Act 2015 requires that all Wards be reviewed and discharged from wardship. However, the relevant sections in the 2015 Act (Part 6) have not yet been commenced at the time of writing. While the Office of the Decision Support Service has been set up, it will take some months before the Office is fully operational and hence individuals will continue to be taken into wardship.[4]

Pending commencement, we have made a number of findings and recommendations in relation to the Ward of Court procedures to ensure the human rights of the individuals at

[4] Áine Flynn, the Director of the Decision Support Service (DSS), commenced her post on 2nd October 2017. In Budget 2018, there was a commitment by the Government to resource the DSS with €3 million.

the heart of the proceedings are respected. Many of the recommendations could be implemented immediately with minimal cost and would dramatically improve the conditions of current Wards. They would also assist the court and the Office of Wards of Court in transitioning to the new system.

Some of the recommendations may involve some cost, particularly the critical recommendation that all prospective Wards should have independent legal or non-legal representation. This may require the provision of legal aid in some instances. Effecting this recommendation would resolve some of the key problems identified in the current system, but we believe this is a matter that should be addressed urgently.

INTRODUCTION

This paper is a contribution to an ongoing process of legal, practical and policy reform[1] in Ireland, the broad aim of which is to ensure respect for the rights of people who lack capacity.

The National Safeguarding Committee

In 2014, the Health Service Executive (HSE), in its *National Safeguarding Policy*,[2] recognised that there was a need for agencies to work together to protect vulnerable people — people with an intellectual or physical disability, older people or people with mental illness. As a result, the National Safeguarding Committee was established. The National Safeguarding Committee[3] is concerned with informing and influencing Government policy, raising public awareness and understanding, and supporting and promoting the protection of the rights of people who may be vulnerable.

Under the latter objective, a research subcommittee was set up to examine current practices in the use of wardship for adults and make recommendations that promote and protect the rights of service users. This paper is a presentation of its findings.

Purpose

In light of significant current legal and policy issues,[4] the paper examines the current wardship system from a number of perspectives:

- How a person is brought into wardship: procedural transparency of the wardship application and the legal test and medical reports therein.

[1] See generally Department of Justice *Roadmap to Ratification* http://www.justice.ie/en/JELR/Roadmap%20to%20Ratification%20of%20CRPD.pdf/Files/Roadmap%20to%20Ratification%20of%20CRPD.pdf on matters being addressed to allow ratification of the UN Convention on the Rights of Persons with Disabilities; http://hse.ie/eng/about/Who/QID/Other-Quality-Improvement-Programmes/assisteddecisionmaking/assisted-decision-making.html for preparatory work underway within the Health Service Executive (HSE) on the Assisted Decision-Making (Capacity) Act 2015; the establishment of the office of Decision Support Services under that Act, and the development of the Disability (Miscellaneous Provisions) Bill 2016.
[2] HSE, *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures Incorporating Services for Elder Abuse and for Persons with a Disability*, HSE Social Care Division, 2014.
[3] See www.safeguardingcommittee.ie for information on the work of the National Safeguarding Committee.
[4] See footnote 1 above.

- What happens once a person is in wardship: we look at review and monitoring of both the capacity and wellbeing of vulnerable people.
- Why a person is brought into wardship: care in the community and the discretion to institute Ward of Court proceedings.

Acknowledgments

We are indebted to the Honourable Mr. Justice Peter Kelly, President of the High Court,* for his time and engagement in this paper for the betterment of current and prospective wards. Thanks to Mr. James Finn, Registrar of the Wards of Court for his invaluable assistance. We would also like to thank Mr. Pat Treacy of the Office of the Wards of Court, and Messrs. Noel Rubotham and Noel Doherty of the Reform and Development Directorate, Courts Service, for their views and expertise.

We are also extremely grateful to all the other contributors, who spoke with us on an anonymised basis. They include a former Ward; the family members and representatives of former and current Wards; medical practitioners; legal practitioners; social workers; and HSE staff. They all shared their experiences with us openly and gave their time generously.

Any errors are the authors.

* In this report, Kelly J refers to his time as Judge Kelly; Kelly P refers to his current role as President of the High Court.

1. STRUCTURE AND METHODOLOGY

Contributors

Given that the topic of wardship is a highly sensitive matter, we spoke with contributors on an anonymised basis. Appendix 1 contains a record of the people we spoke with, a description of their role, and the month and year in which we spoke with them (in order to preserve anonymity). Where we have quoted or referred to any anonymous contributor in particular, we have given them a pseudonym, such as Former Ward of Court A or Consultant X.

Approach

We began our research in October 2016 and carried out the following work:

- observing the Ward of Court list of the High Court;
- interviewing key stakeholders;
- analysing legislation, case law and policy documents.

Chapter 2 gives an overview of the current wardship system in Ireland, changes due under legislation enacted but not yet fully commenced; and relevant international law.

Chapter 3 looks at how a person is brought into wardship, the legal procedure for doing so and issues of procedural transparency. It asks whether the procedures are always fair in the context of dealing with a vulnerable adult; whether they respect the rights of the person; and whether they give a voice to the Ward, which we felt was one of the most critically important omissions from the current system.

Chapter 4 addresses the functional test, which is established as the common law test in relation to assessing capacity. We look at the how use of the test in current assessments could assist the Office of Wards of Court and the President in preparing for the transition to the new regime under the Assisted Decision-Making (Capacity) Act 2015.

Chapter 5 focuses on assessments for the purposes of wardship proceedings. It contains feedback from medical and legal practitioners about the challenges they face in dealing

with the operation of two separate legal tests.
Chapter 6 examines issues facing Wards after they have been admitted to wardship. We consider, from a human rights perspective, review procedures and safeguards to prevent arbitrary detention of a person who is involuntarily detained under the Mental Health Act 2001, as against review procedures for those who lack decision-making capacity to access or protect their personal assets under the Lunacy Regulation (Ireland) Act 1871.

While review of detention orders is provided for under the Mental Health Act 2001,[1] the re-introduction by the current President of review of the living conditions of a Ward of Court under sections 56 and 57 of the 1871 Act,[2] and the pending introduction of reviews under the Assisted Decision-Making (Capacity) Act 2015, are to be welcomed.

Chapter 7 looks at some matters around the Nursing Homes Support Scheme (Fair Deal system) and the use of wardship as a means of moving people on from acute hospital settings. Finally, we summarise our recommendations.

Glossary of terms which may appear in this report

1871 Act	Lunacy Regulation (Ireland) Act 1871
2001 Act	Mental Health Act 2001
2015 Act	Assisted Decision-Making (Capacity) Act 2015
CRPD	United Nations Convention on the Rights of People with Disabilities
EPA	Enduring Power of Attorney
Fair Deal	The Nursing Homes Support Scheme Act 2009
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
MHC	Mental Health Commission
NHSS	The Nursing Homes Support Scheme Act 2009
the Office	Office of Wards of Court

[1] And section 283 of the Mental Treatment Act 1945.
[2] Having fallen into abeyance heretofore.

2. BACKGROUND

Over himself, over his own body and mind, the individual is sovereign.[1]

2.1. What is wardship?

When a person's capacity[2] is brought into question, whether through the onset of dementia, an acquired brain injury, intellectual or psychosocial disabilities, or something else, the Courts may intervene, and appoint a representative ("the Committee") to manage the person's property and personal decisions. The Committee is appointed by the Court to oversee the Ward's day-to-day affairs.[3]

The person is said to be brought into wardship, or made a "Ward of Court". Important legal and practical consequences follow. The person deemed to lack capacity becomes a person for whom others act, on the basis of an objective, though largely unmonitored, assessment of his or her best interests.[4]

The Supreme Court has found[5] that when a person is made a Ward of Court, the Court is vested with jurisdiction over all matters relating to the person and estate of the Ward, and in the exercise of such jurisdiction is subject only to the provisions of the Constitution and that in the exercise of its wardship jurisdiction, the Court's prime and paramount consideration must be the best interests of the Ward.

Therefore, while the Committee is involved in the management of the Ward's property and personal decisions, the Court has ultimately responsibility.

"Ward" is defined by Order 67, Rule 1 of the Rules of the Superior Court as "*a person who*

[1] JS Mill, *On Liberty*, 1869.

[2] For a discussion on the legal principles in relation to capacity, see Chapter 4.

[3] Order 67 Rule 57 states: "Where the Judge considers it expedient he may appoint two or more persons to be committees of the estate or of the person…." In cases where there is no suitable relative who is prepared to act, or where there is a conflict of interest or family disagreement, the General Solicitor for Minors and Wards of Court is appointed to act as Committee, which operates under the umbrella of the Courts Service. See Chapters 6 and 7 for further discussion.

[4] See generally, Donnelly, *A Legal Overview* in Foster, Herring and Doron, eds., *The Law and Ethics of Dementia*, Hart Publishing, Portland, Oregon, 2014.

[5] *In The Matter of A Ward of Court (Withholding Medical Treatment) (No.2)* [1996] 2 IR 79.

has been declared to be of unsound mind and incapable of managing his person or property and includes, where the context so admits, a person in respect of whom or whose property an order has been made under section 68 or section 70 of the Lunacy Regulation (Ireland) Act 1871."

People under 18 years of age are also admitted to wardship, usually where they have been awarded a substantial sum of money as compensation for an injury.[6]

In 2016, 311 declarations of wardship were made, of which 289 were adult declarations of wardship.[7] Of those, 234, or 81%, were admitted to wardship due to dementia and age-related illness.[8]

2.2. Change of regime

The 19th century legislation that governs wardship, the Lunacy Regulation (Ireland) Act 1871, does not allow for different degrees of incapacity, and it has been repeatedly criticised for being overly protective and unfairly discriminatory.

The Assisted Decision-Making (Capacity) Act 2015 is set to change this. When fully commenced, each Ward will be reviewed by the wardship Court (which can be either the High Court or Circuit Court). All Wards will be discharged from wardship. A discharged Ward who continues to have capacity needs will be offered the support option under the Assisted Decision-Making (Capacity) Act 2015 most appropriate to his or her needs.[9]

[6] Consideration of minors in wardship is beyond the scope of this paper.
[7] See Courts Service Annual Report page 57 http://courts.ie/Courts.ie/library3.nsf/(WebFiles)/300A3D2A10D824E880258168003 70ED2/$FILE/Courts%20Service%20Annual%20Report%202016.pdf.
[8] Ibid.
[9] See Chapter 4.4 of this paper.

2.3. Commencement of the Assisted Decision-Making (Capacity) Act 2015

On the 17th of October 2016, the Assisted Decision-Making (Capacity) Act 2015 was partly commenced.[10]

On full commencement of Part 1, a person's capacity to make a decision will, by law, be construed functionally — meaning that a person must understand, at the time and in the context that a decision is to be made, the nature and consequences of the decision to be made.

The partial commencement of Part 9 allows for the establishment of the Decision Support Service (DSS) and the appointment of the Director of the DSS.[11] The HSE and the National Disability Authority are preparing for commencement with significant work in the drafting of codes of practice underway at the time of writing.

2.4. Ratification of the UN Convention on the Rights of Persons with Disabilities

The commencement of some parts of the Assisted Decision-Making (Capacity) Act 2015 is a positive step to Ireland ratifying the UN Convention on the Rights of Persons with Disabilities (CRPD),[12] Article 12 of which states as a basic principle that: "persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."

The Convention on the Rights of Persons with Disabilities was adopted by the UN General Assembly in 2006 in an effort to ensure that persons with disabilities enjoy the same human rights as everyone else. Ireland signed the convention in 2007 but remains the only country in the EU yet to ratify it.[13]

---

[10] SI 515/2016 commenced

(a) Part 1, other than sections 3, 4 and 7

(b) Part 9, other than section 96, section 102 and Chapter 3;

SI 517/2016 commenced

(*a*) the definition of "Minister" in section 82;

(*b*) the definitions of "code of practice" and "working group" in section 91(1);

(c) Section 91(2).

[11] The Director Áine Flynn commenced on 2 October 2017.

[12] At the time of writing, Ireland is the only country in the EU yet to ratify the UN Convention on the Rights of Persons with Disabilities.

[13] The Assisted Decision-Making (Capacity) Act 2015 and the Disability (Miscellaneous Provisions) Bill 2016 are key to Ireland ratifying the UN Convention on the Rights of Persons with Disabilities.

Article 12, which is regarded as the 'beating heart' of the UN Convention on the Rights of Persons with Disabilities, provides for universal legal capacity:

> 1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
>
> 2. States Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
>
> 3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
>
> 4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
>
> 5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

In a General Comment,[14] the UN Committee on the Rights of Persons with Disabilities interpreted Article 12:

> "In most of the State party reports that the Committee has examined so far, the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed…."[15]

> "Legal capacity and mental capacity are distinct concepts. Legal capacity is the ability to hold rights and duties (legal standing) and to exercise these rights and duties (legal agency). It is the key to accessing meaningful participation in society. Mental capacity refers to the decision-making skills of a person, which naturally vary from one person to another and may be different for a given person depending on many factors, including environmental and social factors."[16]

Giving effect to the Convention on the Rights of Persons with Disabilities, the Guiding Principles set out in section 8 of the Assisted Decision-Making (Capacity) Act 2015 are:

(a) a person is presumed to have capacity in respect of the matter concerned unless the contrary is shown;
(b) a person shall not be considered as unable to make a decision unless all practicable steps have been taken to help him or her do so;
(c) a person shall not be considered as unable to make a decision merely because the decision made or likely to be made is an unwise decision;
(d) intervention should only take place on the basis of necessity and individual circumstances;
(e) intervention must be made in accordance with human rights, be proportionate and limited in duration;

[14] General Comment No. 1: Equal Recognition Before the Law (article 12) (Geneva: UN Committee on the Rights of Persons with Disabilities, 11 April 2014).
[15] Ibid, para 13.
[16] *Equal Recognition before the Law* General Comment No1 (2014) par 12.

(f) the intervenor must make maximum efforts to meet the wishes of that individual and take account of other specified requirements and interests.

There is a concern that while ratification is outstanding, the principles established in the United Nation's Convention on the Rights of Persons with Disabilities, which recognises the rights of persons with disabilities as fundamental human rights, are given no recognition in the current wardship system.

Our interviews with various stakeholders reveal that the current system does not meet basic human rights standards for those in the wardship system, which underlines the urgency of commencing the Assisted Decision-Making (Capacity) Act 2015 and ratifying the UN Convention on the Rights of Persons with Disabilities.

2.5. Optional Protocol to the Convention on the Rights of Persons with Disabilities (OP-CRPD)

The Optional Protocol to the Convention on the Rights of Persons with Disabilities (OP-CRPD) [17] provides for individual complaints to be submitted directly to the CRPD Committee[18] by individuals and groups of individuals, or by a third party on behalf of individuals and groups of individuals, alleging that their rights have been violated under the Convention.

While Ireland signed the OP-CRPD on 30 March 2007,[19] it also remains to be ratified at the time of writing. Ratification of the Optional Protocol by Ireland would allow the CRPD Committee to receive, consider and provide its views and recommendations in relation to alleged violations by Ireland of Convention rights as communicated by persons with disabilities or those acting on their behalf.[20] The Department of Justice and Equality has indicated that ratification of OP-CRPD is anticipated at the same time the United Nation's Convention on the Rights of Persons with Disabilities is ratified.[21]

[17] http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf.
[18] Article 34 of the OP-CRPD sets out the composition of the Committee and provides *inter alia* that it may have 12 experts, increasing to a maximum of 18 members, nominated by State Parties.
[19] https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en.
[20] Complaints may only be communicated against a State party that has ratified or acceded to the Optional Protocol and only upon the exhaustion of all available and effective domestic remedies.
[21] Roadmap to Ratification of the UNCRPD, Department of Justice

2.6. Support for the current system

Most people we spoke with in the course of the research expressed some concerns with the wardship system in its current incarnation. But we found strong support from one legal practitioner, who was of the view that as a system of protection for a vulnerable person, the current Wards of Court system is excellent.

Legal practitioner G[22] expressed grave concerns about the possibility of the transfer of general jurisdiction to the Circuit Court.[23] He believes that retaining the function centrally in the High Court wardship list ensures immediate access to orders, consistency in approach, specialisation and ultimately provides the very highest level of protection for vulnerable persons — a level that cannot be replicated in diverse circuit Courts throughout the country.[24]

The functional test, in the opinion of Legal Practitioner G, is overcomplicated, unworkable and will inevitably increase litigation for people who are least able to manage the pressures that flow from it. None of this, he states, is in the best interests of the persons that the new legislation — the Assisted Decision-Making (Capacity) Act 2015 — purports to protect.

Separately, his view is that the Office of the Wards of Court and current system protects the Ward's assets to a very high degree and he sees no reason to interfere with the current system.[25]

---

http://www.justice.ie/en/JELR/Roadmap%20to%20Ratification%20of%20CRPD.pdf/Files/Roadmap%20to%20Ratification%20of%20CRPD.pdf [accessed 13 April 2017].

[22] Appendix 1 — Interview February 2017.

[23] Notwithstanding that the legislation allows for certain wardship proceedings to take place in the Circuit Court, in practice most matters are currently dealt with in the High Court. Furthermore, that section 142 of the Assisted Decision-Making (Capacity) Act 2015 provides that matters under the act will be heard by specialist judges.

[24] Notwithstanding the position expressed by Kathleen Lynch, TD in Oireachtas debates in December 2016 on the positioning of the Decision Support Service within the Mental Health Commission: "People did not feel comfortable with the paternalistic approach taken to justice over the centuries by past governments. There is a perception that the court system is concerned with the imposition of penalty. This legislation is essentially about liberation and allowing people to make decisions for themselves. When we looked at the ideal decision support service we decided it must be stand-alone and independent." See http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/takes/dail2015121700015#N6.

[25] The authors note, however, that Article 12.5 of the UN Convention on the Rights of Persons with Disabilities specifically provides that persons with disabilities should not be deprived of their property.

3. PROCEDURAL TRANSPARENCY

3.1. Wardship proceedings

3.1.1. Section 15

Most wardship applications begin under section 15 of the Lunacy Regulation (Ireland) Act 1871, and are heard in the High Court. A section 15 petition may be brought by any person (the petitioner), supported by affidavits of two registered medical practitioners.[1] The Court will order an inquiry if satisfied that a prima facie case exists. The inquiry entails a "medical visitor"[2] visiting the Respondent (the prospective Ward) and furnishing a report as to his or her condition.

Once a prima facie case has been established and an inquiry ordered, Order 67, rule 18 of the Rules of the Superior Courts, says that the person on whom notice is served (that is, the prospective Ward) has seven days to object.[3] Responsibility for service on the Respondent falls to the petitioner, who is bringing the application.

The President of the High Court carefully reviews the medical reports and all evidence — including an affidavit by the petitioner setting out his or her relationship to the prospective Ward and his or her reasons for bringing the application — before him in chambers. It is clear that the vast majority of the work of examining the circumstances of the prospective Ward is done in the background, and a typical application for wardship runs very quickly through the public arena of open Court.

[1] See Chapter 5 of this paper for discussion of the medical affidavits and medical visitors.
[2] Ibid.
[3] Rule 18 provides as follows: *18. Where the respondent, without demanding a jury, wishes to object to any inquiry being had, or to any declaration being made that he is of unsound mind and incapable of managing his person or his property, he shall transmit to the Registrar, within seven days of the service upon him of the notice referred to in Rule 7, a notice in the Form No. 6.*

When admitting a person to wardship in a standard non-contentious application, the President declares that:

- he is satisfied on the basis of the medical evidence that the prospective Ward lacks capacity and requires the protection of the Court;
- the petitioner and committees are entitled to their costs when taxed or measured;
- consequential orders will be given in chambers.

In all, the public hearing part of a standard admission to wardship may take less than a minute.

A wardship order made under the standard section 15 procedure of the 1871 Act is of indefinite duration.

3.1.2. Section 12

Less frequently, under section 12, the President may direct the General Solicitor to bring wardship proceedings in respect of an individual where there is no willing and or suitable person to act as petitioner. This might arise, for example, where there is a need for a "Fair Deal" matter,[4] and there is no family member suitable or willing to sign the relevant documentation. The test is the same, but there may be some urgency attached under section 12 applications, as the person may be deemed to be in a vulnerable situation.

3.1.1. Section 103

Although a procedure for temporary wardship exists under section 103 of the 1871 Act, we understand it is rarely used in practice. We saw no cases of section 103 procedures in the course of our research.

3.1.2. Circuit Court

The powers of the Circuit Court to admit a person to wardship are set out in section 22(2) of the Courts (Supplemental Provisions) Act 1961 as amended, and the procedure is set out

[4] See sections 7.1 and 7.2 on the Nursing Homes Support Scheme (NHSS, Wardship and Delayed Discharges.

in Order 47 of the Circuit Court Rules 2001. Again, this is rarely used in practice.

3.2. Fair procedures and the standard section 15 application

In the case of *Fitzpatrick v FK*[5], Laffoy J relied on the common law principle that there is a presumption that all persons have capacity unless the contrary is proved. However, a unique situation arises in Ward of Court proceedings where a petition (application) will not be listed unless a prima facie case has been made out: in other words, where the petitioner has supplied two medical reports supporting his or her application, which both indicate that the Respondent is of unsound mind and incapable of managing his or her affairs.

Regardless of the prima facie case having been made out, however, the law is clear that an individual will not be deemed to lack capacity unless it has been proved: in other words, until the matter has been heard and the judge makes a determination that it is so.

In the case of *FD,*[6] Kelly J,[7] made it clear that even where a prima facie case has been established and an inquiry ordered, that the making of a wardship order is a judicial function which must be exercised in accordance with the Constitution of Ireland and with constitutional propriety, and is a discretionary jurisdiction.

In that case, FD was a minor who had been awarded a large sum of money in a personal injuries case. His parents did not want him made a Ward of Court. At one point prior to any inquiry being completed, they received a letter from the then Registrar of Wards of Court which included the words: "Once the plaintiff is taken into wardship…."[8] FD's parents took this to mean that a decision had already been made to take their son into wardship. The judgment, in quoting Denham J,[9] made it clear that fair procedures must apply in any wardship application:

> "Wardship proceedings must be fair and in accordance with constitutional justice.

[5] [2009] 2 IR 7; See Chapter 4 for further discussion.
[6] *FD (an infant) suing by his next friend BD v Registrar of Wards of Court* [2004] 3 IR 95; Also discussed at Chapters 4.2, 4.3 and 5.6.
[7] Currently the President of the High Court.
[8] Ibid, para 24.
[9] Currently the retired Chief Justice.

> The constitutional rights of all parties, the children and the parents, must be protected. Where rights are in conflict they must be balanced appropriately. Due process must be observed by the Court while exercising this unique jurisdiction. Consequently, if a legal right or a constitutional right is to be limited or taken away by a Court, this must be done with fair procedures. Fundamental principles such as those enunciated in *In re Haughey* [1971] I.R. 217 apply. There must be fair procedures."[10]

However, while the presumption of capacity must stand until the inquiry has been completed, the Office of the Wards of Court is also on notice that the Respondent is a vulnerable adult.

Prior to the matter being determined, the Respondent (prospective Ward) is not given the medical reports commissioned by the Petitioner and or the Court, which assess his or her capacity, unless the Respondent objects to the petition. There appears to be a concern that the medical reports may contain sensitive information about the Respondent which if disclosed to the Respondent may upset him or her.

By way of comparison, in personal injuries proceedings, where a plaintiff is examined by the defendant's medical practitioner, the medical report is disclosed to the plaintiff's legal team: not to do so would confer an unfair advantage to the defendant in litigation. While recognising that Ward of Court proceedings are not standard adversarial litigation, it is submitted that, in the interests of vindicating the right of the person to know their own personal sensitive information and the import of wardship proceedings for the person at their centre, every care should be taken to fully equip the Respondent with an understanding of the proceedings at each stage, and every effort should be made to ensure they are equipped to deal with the proceedings against him or her. The disclosure of medical reports is fundamental to this.

While the Respondent is not given medical reports about his or her capacity, on the basis

[10] Eastern Health Board v MK [1999] 2 IR 99, p. 111, as quoted by Kelly J in *FD (an infant) suing by his next friend BD v Registrar of Wards of Court* [2004] 3 IR 95, para 26.

that he or she is vulnerable, in respect of all the other procedures — service, right to object, hearing — the Respondent is frequently treated as a standard Respondent. It reveals a critical inconsistency in how the Ward of Court procedures treat the Respondent.

It is also precisely the inverse to how we would respectfully suggest that a Respondent should be treated in Ward of Court proceedings: that he or she has a right to have all material matters disclosed to him or her prior to the hearing, and that his or her vulnerability should be taken into account in respect of all procedures.

In light of this, we now examine aspects of the standard application:

- service of papers (3.2.1)
- objection (3.2.2)
- the hearing and advocacy at hearing (3.2.3)
- the legal test for capacity (Chapter 4)
- the medical affidavits supporting the petition (Chapter 5)
- the declaration order (3.2.4).

3.2.1. Service of papers

Once a prima facie case has been established and an inquiry ordered, Order 67, Rule 18 of the Rules of the Superior Courts, says that the person on whom notice is served (that is, the prospective Ward) has seven calendar days[11] to object.[12] Responsibility for service on the Respondent (the prospective Ward) falls to the petitioner, who is bringing the application.

The Office sends out a pro forma letter to the solicitor acting for the petitioner, with instructions in relation to service.[13] It includes the following instructions:

> "Please note that if the Respondent is blind or illiterate the Petition and Notice

[11] The Rules of the Superior Courts, Order 122 Rule 2 and Rule 9 give further guidance on the computation of time.
[12] See note 3 (page 26).
[13] See Appendix 2.1.

> must be read aloud to him/her in a clear and distinct manner and an effort should be made to explain the contents thereof to him/her insofar as his/her mental condition enables him/her to understand same. The manner of such service, i.e. that the Petition and Notice were read aloud and that an attempt was made at explanation of the contents thereof should be recited in the Affidavit of Service."[14]

Apart from these instructions, the question of the person receiving an understandable explanation of the meaning of the process they are facing is simply not addressed by any rule of Court, statutory obligation or otherwise.

The petitioner, who is bringing the application, is the person who notifies the Respondent that they may object to the petition. As stated, the petitioner must have produced two medical reports outlining that the Respondent is of unsound mind and incapable of managing his or her affairs, so it could at least be said that the Respondent is a vulnerable person. It is therefore surprising that normal Court procedure in relation to service applies in that situation, as if it were a standard application.

There is no recognition of the vulnerability of the Respondent, or that a petitioner may have a conflict of interest and therefore may not be best placed to ensure that the Respondent fully understands the implications of the petition, and his or her right to object to it. It is therefore unsurprising that there have been few objections to wardship raised in practice. Representation of the individual at the heart of the proceedings is unaddressed. There is no participation by the Respondent in Court, although the Respondent is served with the application, unless the Respondent objects.

There seems to be little recognition of the special circumstances of the Ward of Court system within the traditional legal framework. This is to be contrasted with the UK, where the Court of Protection Rules provide that if the protected party (that is the Respondent or vulnerable person) becomes a party to proceedings, all documents served on him or her

[14] Ibid.

must be served on his or her litigation friend[15] or other person duly authorised to conduct proceedings on his or her behalf.[16]

The Court of Protection Rules also demand that where the protected party is to be "notified" under that system, the person effecting notification must provide the protected party with information in a way that is appropriate to their circumstances (such as using simple language, visual aids, or any other appropriate means).[17] In addition, the person effecting notification must file a certificate describing the steps taken to enable the protected person to understand and the extent to which the protected person appears to have understood the information.[18]

3.2.2. Objection

The Respondent is entitled to object to the petition and has seven days from service in which to do so. There are no regulations in place in relation to what protocol the Office of the Wards of Court should follow should a Respondent object, although we understand that every objection is brought to the attention of the Court. The Office responds to all objections, including objections submitted outside of the seven-day rule and in any format. In other words, the Office will accept a written note from the Respondent as an objection. The Respondent will then be told to provide medical evidence and the matter will be listed before the President.

It has not always been so. In 2002, in the case of *Re Keogh,*[19] two days after the then President made an order to make the Respondent a Ward of Court, it came to his attention that the Respondent had written to the Office objecting to the petition: the Office had received it eight days prior to the inquiry. The President remedied this by having the inquiry heard by another High Court judge with a jury. While the current personnel in the Office appear to have a system of addressing this potential deficiency, it would be recommended that regulations should be in place to ensure that protocols are followed, regardless of what personnel are in place in the Office.

[15] Appointed by the court in the UK, a litigation friend may be a family member, friend, solicitor a professional advocate, a Court of Protection deputy, some with enduring power of attorney.
[16] Rule 33(1) The Court of Protection Rules 2007, as amended in 2015.
[17] Ibid Rule 46.
[18] Ibid Rule 48.
[19] [2002] Unreported, Finnegan P, 15th October 2002.

3.2.3. The Hearing and Advocacy at Hearing

As stated, a declaration admitting a person to wardship typically takes a very short time. While the proceedings are not meant to be adversarial, there is no room for the *legitimus contradictor*.[20]

There are two types of advocacy that would benefit a Respondent in Ward of Court proceedings: firstly, independent legal representation; secondly, non-legal advocacy.[21]

3.2.3.1. Independent legal representation

Independent legal representation for Respondents to petitions does happen in Ward of Court cases, but its occurrence is inconsistent and seems to largely depend on whether the petitioner views it as necessary. There are no guidelines from the Office of the Wards of Court for petitioners in relation to conflict of interest, and there is a complete reliance on the professional integrity of legal practitioners.

According to Legal Practitioner D, he has had instances where he has recommended independent legal representation:

> "I had a client with acquired brain injury, in his thirties. He settled the case for millions, on the undertaking that we would apply to have him made a Ward of Court. He was a high achiever with some executive function remaining. He had memory problems and risk of impulsivity. His wife was concerned the funds would be squandered. She had to serve Ward of Court proceedings on him. He was opposed to the application. The wife found herself in a conflict of interest situation. Both the man and his wife were our clients. We got him separate representation. I think that has to happen as a matter of form. We have done that on more than one occasion."[22]

[20] A *legitimus contradictor* is a person who puts an opposing point of view before the court. See Murdoch, Murdoch's Dictionary of Irish Law (4th ed Butterworths 2004) at 249 and 646-647.
[21] Both are provided for in the Assisted Decision-Making (Capacity) Act 2015 — Part 5.
[22] See Appendix 1 — interview March 2017.

While many Respondents in wardship applications have funds, not all of them are well off. There can also be an understandable tendency towards preservation of the Ward's money, which may result in forgoing the cost of independent legal advice. In those situations, however, there should be clear guidelines to ensure the rights of the individual are balanced with concerns of fund preservation.

While people who are involuntarily detained under the Mental Health Act 2001 are entitled to legal aid, and legal aid will be available under the Assisted Decision-Making (Capacity) Act 2015, when commenced,[23] at the time of writing it is not available to those in wardship, or those who are the subject of a petition to be brought into wardship.

The General Solicitor has recently acknowledged that separate representation in certain cases would be desirable, particularly where the Ward is detained. In one matter,[24] a Ward was detained in the Central Mental Hospital for many years, initially under the Mental Health Act 2001 and then, when a Mental Health Tribunal revoked her detention, subject to the inherent jurisdiction of the High Court. The woman's family approached Legal Practitioner F[25] and asked her to represent the woman, who was able to articulate what she wanted. The solicitor approached the General Solicitor who appointed Legal Practitioner F as a next friend[26] or Guardian Ad Litem.[27]

According to F, the President agreed with the General Solicitor's argument that the HSE, as the moving party, should bear the Ward's costs, having regard also to the fact that, if Part 10 of the Assisted Decision-Making (Capacity) Act 2015 had been commenced,[28] then the Ward would be detained subject to the Mental Health Act 2001 which operates a scheme of legal aid in all circumstances. In other words, the General Solicitor relied on

[23] Section 52.
[24] GG case, see Chapter 6.5.3 for further discussion.
[25] Appendix 1 — Interview December 2016.
[26] A next friend is a person who represents another person who is under disability or otherwise unable to maintain a suit on his or her own behalf and who does not have a legal guardian.
[27] A guardian ad litem is created by a court order only for the duration of a legal action. Courts appoint these special representatives for infants, minors, and people who lack capacity, all of whom generally need help protecting their rights in court.
[28] See Chapter 6.11 for further discussion.

the rights provided for in the Assisted Decision-Making (Capacity) Act 2015 in this instance, despite the fact that this Act is still not commenced.

3.2.3.2. Non-legal advocacy

Apart from independent legal representation, however, there is also a case to be made for non-legal advocacy being available to all Respondents in Ward of Court proceedings.

The UK has seen the development of non-legal assistance in Court, which has developed out of the idea that a litigant in person (or 'lay litigant') is entitled to assistance, whether a qualified legal professional or not. Distinct from the McKenzie friend,[29] the UK Court of Protection rules provide that if a party lacks litigation capacity then the Court of Protection appoints a 'litigation friend'[30] to carry on the proceedings on his or her behalf.

This rule applies in all civil proceedings.[31] In the context of access to justice, Lord Woolf commented:

> "In a climate where legal aid is virtually unobtainable and lawyers disproportionately expensive, the McKenzie friend and lay representatives make a significant contribution to access to justice. But reported cases tend to concentrate upon reasons why they should not be allowed rather than circumstances where they may be of assistance to a party and the Court. The judge has to identify those situations where such support is beneficial and distinguish circumstances where it should not be allowed."[32]

There is no provision for non-legal advocacy in relation to Wards. By contrast, the Assisted Decision-Making (Capacity) Act 2015, when fully commenced, makes provision for a non-legal representative — 'another person[33]' — in respect of whom the Court is satisfied that

[29] Professional or non-professional assistance to a lay litigant.
[30] See note 14.
[31] Rule 141, Court of Protection Rule 2007.
[32] Judicial College Equal Treatment Bench Book, *Litigants in Person* (2013), available online at https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/judicial-college/ETBB_all_chapters_final.pdf. At page 37, paragraph 63.
[33] This can be an independent advocate.

such person is suitable and willing and able to assist the person during the course of the hearing, or "Court friend" who may assist the person who lacks, or may lack capacity.[34]

In Ireland, *A Vision for Change*[35] recommended that advocacy should be available as a right to all service users in all mental health services in all parts of the country, and that advocacy training programmes should be encouraged and appropriately financed.[36]

HIQA's *National Standards for Residential Care Settings for Older People in Ireland* (2016)[37] makes reference to independent advocates; however, there is as yet no statutory framework for an independent advocate.

The President of the High Court has made it clear that a non-legal advocate does not have a right of audience before the Court.[38] *In the Matter of MB*[39] concerned an older person who was contesting her admission to wardship, and who had engaged with Sage (a support and advocacy service for older people) to make representations on her behalf. The advocate was an employee of Sage. The Court did not allow the advocate to make any submission but did allow Sage's in-house solicitor (a solicitor being an officer of the Court) to participate in the hearing on a de *bene esse* basis.[40] At the conclusion of his judgment, Kelly P stated:

> "What is not permissible is precisely what has happened in this case where [Sage's in-house solicitor] has appeared with Sage as her client working on instructions given to her by [Sage's nurse advocate] on behalf of MB. Accordingly, for the future, having heard argument on this issue, I will not permit Sage to appear on behalf of any other person as it has done on this application."[41]

[34] Section 36(8) Assisted Decision-Making (Capacity) Act 2015. The court friend may assist the relevant person where he or she has not instructed a legal representative. See below at 3.2.3.4 for further details.
[35] *A Vision for Change – Report of the Expert Group on Mental Health Policy*, Government of Ireland, 2006 — recommendation 3.2.
[36] Ibid recommendation 18.25.
[37] HIQA, *National Standards for Residential Care Settings for Older People in Ireland* (2016).
[38] There have been rare instances in the Irish courts where an unqualified advocate was allowed to represent a litigant: *Coffey v Tara Mines* [2007] IEHC 249.
[39] [2016] IEHC 214.
[40] In other words, provisionally.
[41] Ibid, paras 22 & 23.

Again, it is worth noting that under the Assisted Decision-Making (Capacity) Act 2015, "another person",[42] who may be an independent advocate, will have the right to make submissions to the Court.

3.2.3.3. A third way: guardian ad litem

In recent years, the High Court has used its inherent jurisdiction[43] to detain vulnerable individuals in exceptional circumstances. Because the Court is making detention orders outside of a statutory framework, the Court recognises that safeguards must be put in place.

In the case of *HSE v J O'B*,[44] for instance, Birmingham J, was asked to detain a young man with an intellectual disability and personality disorder. Recognising the serious interference with the right to liberty, Birmingham J provided for a Court review to take place every two months, which was to be readdressed once a routine was established for the young man. However, another safeguard that was available to the young man, under the inherent jurisdiction, was that he was appointed a guardian ad litem,[45] who had legal representation.

Appointing a guardian ad litem to an adult at risk of detention has also meant that when the Irish Courts come under the scrutiny of the UK Courts, this level of representation is acceptable. In a number of cases where the HSE has sought to have Irish patients transferred to British institutions, in order to do so, the Court of Protection must be satisfied, among other things, that the individual at the centre of the proceedings had an opportunity to have their voice heard in the Irish Courts. In a number of cases before the Court of Protection, the UK Court has allowed the applications in circumstances where the individual was appointed a guardian ad litem.[46]

Given the provision of legal aid under the Mental Health Act 2001 and the safeguards

[42] Section 36(8)(b).
[43] See Chapter 6.6 for further discussion.
[44] [2011] IEHC 73 (Unreported, Birmingham, 3rd March 2011).
[45] Appointed by the court to represent the interests of a minor or person who lacks capacity; see *A O'D v Judge Constantin G O'Leary* [2016] IEHC 555 for Baker J's judgment in relation to the issue of Guardians Ad Litem and legal representation in child care matters.
[46] See *Health Service Executive of Ireland v PA and another* [2015] EWCOP 38, [2015] EWCOP 48, [2015] All ER (D) 225 (Jul).

provided for within inherent jurisdiction orders — notably the appointment of a guardian ad litem — it seems a grave oversight that the same provisions, at the very least, are not available to individuals subject to a Ward of Court application.

3.2.3.4. Current statutory provisions for legal and non-legal advocacy in relation to vulnerable adults

- **Mental Health Act 2001**[47]

Where an individual is to be admitted on an involuntary basis to an approved centre, Section 16(b) provides for legal representation for the individual. This does not apply where an individual is admitted voluntarily.

- **Citizens Information Act 2007**

This Act provides for the establishment of a Personal Advocacy Service which has been deferred by successive governments. The National Advocacy Service for People with Disabilities (NAS) has been established by the Citizens Information Board on a non-statutory basis.

In total, the National Advocacy Service has 35 advocates and senior advocates. Its 2015 annual report recorded a waiting list of 154 (out of a client base of under 1,000). Therefore, proportionately, there is a high number of people waiting. Bearing in mind there are 600,000 persons with a disability in Ireland, the number of advocates is extremely low.[48]

The lack of statutory powers for advocates is also a problem. The service reports that it can have difficulty gaining access to services, information, and difficulty in overcoming the 'best interests' culture and as it describes: "Obfuscation in relation to delay in replying to correspondence and access to key decision-makers.[49]"

[47] See Chapter 6 for further discussion.
[48] National Advocacy Service, Annual Report, 2015.
[49] Ibid, page 13.

- **Sage**

The support and advocacy service for vulnerable adults and older persons was established in September 2014 on a non-statutory basis and is funded by the HSE and Atlantic Philanthropies. It has 20 staff (seven part-time) and 151 volunteers.[50]

- **Irish Human Rights And Equality Commission Act 2014 — Section 40**

Section 40 provides that a person may apply to the Irish Human Rights and Equality Commission for assistance to bring legal proceedings involving law or practice relating to the protection of human rights which a person has instituted or wishes to institute.[51]

The Commission may grant assistance in the form of legal advice,[52] legal representation,[53] or such other assistance the Commission deems appropriate in the circumstances.[54] Before granting such assistance, the Commission must consider whether assistance could be sought, under the Civil Legal Aid Act 1995,[55] or by any other means,[56] none of which are available at the time of writing to a person contesting wardship. This little-used but useful provision of the 2014 Act may assist a prospective Ward, or other interested parties under current wardship procedures.

- **Assisted Decision-Making (Capacity) Act 2015**

The Assisted Decision-Making (Capacity) Act makes provision for a relevant person[57] to instruct a legal representative. Section 52 amends the Civil Legal Aid Act 1995 to provide that a Respondent is entitled to legal aid.[58]

Section 36(8) of the Act provides that where the Respondent has not instructed a legal practitioner, he or she may be assisted in Court by a decision-making assistant, co-

[50] See detailed of activities in 2016 Annual Report at www.thirdageireland.is/sage.
[51] Irish Human Rights and Equality Commission Act 2014, Section 40(1)(a).
[52] Irish Human Rights and Equality Commission Act 2014, Section 40(10)(a).
[53] Irish Human Rights and Equality Commission Act 2014, Section 40(10)(b).
[54] Irish Human Rights and Equality Commission Act 2014, Section 40(10)(c).
[55] Irish Human Rights and Equality Commission Act 2014, Section 40(3)(a)(i).
[56] Irish Human Rights and Equality Commission Act 2014, Section 40(3)(a)(iii).
[57] Section 2; including a respondent in an application for a court's declaration in relation to his or her capacity.
[58] Section 52 amends the Civil Legal Act 1995 so that section 26(3) provides that a party to an application under Part 5 shall qualify for legal advice. Where a legal aid certificate has been granted to the relevant person, but they do not satisfy the financial criteria, the Civil Legal Aid Board may recover their costs (Section 33, 1995 Act).

decision-maker, decision-making representative, or designated healthcare representative. In circumstances where there is no such assistance available, then the Respondent may nominate 'another person', who the Court must be satisfied is suitable, willing and able, to assist the Respondent.[59] The Court is entitled to hear submissions from this person.[60]

Where no assistance is available to the Respondent from any of the above assistants, and where the Respondent has not instructed a legal practitioner, the Court may appoint a Court friend. Section 100 provides for a Court friend and 'another person', who does not have to be a legal professional, to advocate for a Respondent, in a Court setting. The role of the Court friend and 'another person' is to assist and represent the relevant person who wishes to make an application to the Courts. A panel of Court friends will be established by the Director of the Decision Support Service.

Section 139 provides for the right of the Respondent to be in Court during proceedings that he or she is a party to.

These sections are not yet commenced.

3.2.4. The declaration order

When a person is made the subject of a declaration order admitting them to wardship, he or she does not personally receive a copy of the order.[61] Former Ward A, who was a young woman in her early twenties diagnosed with a learning disability and living in a homeless shelter,[62] wrote to the Office of the Wards of Court some months after being made a Ward and asked for the legal documentation that admitted her to wardship. The Office of the General Solicitor for Minors and Wards of Court declined to give it to her on the basis that the order:

> "is a legal document which may be difficult to understand. Further, we would deem it inappropriate for you to be given a copy of same.[63]"

As a basic tenet of fair procedures, it is expected that an order bringing an individual into

[59] S. 36(8)(b).
[60] S.100 (12).
[61] A copy of the declaration order is sent to his/her legal representative and/or Committee.
[62] Appendix 1 — interview December 2016.
[63] Appendix 3.1 — letter.

wardship should be served on them. It is particularly troubling that a Ward could be refused access to the order, even on request, in relation to a matter which had such serious implications for her.

Any subsequent orders, such as in relation to the sale of the Ward's property, are also not served on the Ward.[64]

3.3. The voice of the Respondent

Notable by its absence is an obligation to articulate the will and preference of the individual who is the subject of the proceedings. This general omission of the voice of Respondents in the wardship process, both at the inquiry stage and once an order of admission to wardship has been made, is at odds with a body of international human rights legal jurisprudence and instruments, dating back at least to 1971.[65] These legal jurisprudence and instruments recognise that people who lack capacity, or who have diminished capacity, have the same rights as the rest of the population.[66]

It also goes against the Constitution of Ireland, where the Supreme Court has held[67] that a person who lacks capacity is entitled to the unenumerated rights[68] to bodily integrity,[69] privacy,[70] autonomy[71] and dignity[72] flowing from the constitutional guarantee of equality.

Although the Irish Courts are not yet bound by the UN Convention on the Rights of Persons with Disabilities,[73] there should be at least recognition of its principles that dovetail with the Constitution and international obligations.

[64] See Art 12.5 CRPD set out in Chapter 2.4.
[65] United Nations Declaration on the Rights of Mentally Retarded Persons, General Assembly Resolution 2856 of 20 December 1971.
[66] For further discussion, see Donnelly, *Legislating for Incapacity: Developing a Rights-Based Framework*, 2008 DULJ 30(1) 395.
[67] *In Re a Ward of Court* [1996] 2 IR 79.
68 Unenumerated rights are rights that, although not expressly provided for in the text of the Constitution, have been recognised by the courts.
[69] Ibid, para 124-125 per Hamilton CJ; 129-130, per O'Flaherty J; 163, per Denham J.
[70] Ibid, 124, per Hamilton CJ; 130-131, per O'Flaherty J; 163, per Denham J.
[71] Ibid, 126, per Hamilton CJ.
[72] Ibid, 163-164, per Denham J.
[73] See Chapter 2.4.

The UN Convention on the Rights of Persons with Disabilities sets out, in the Preamble, that "persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes including those directly affecting them."

In Article 5, one of the central components of the UN Convention on the Rights of Persons with Disabilities, the UN sets out that persons with disabilities have the right to recognition everywhere as persons before the law.[74] It also states that:

> "States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."[75]

The Assisted Decision-Making (Capacity) Act 2015, when commenced, shall provide that an intervener[76] must have regard to the person's autonomy, as set out in the Guiding Principles under section 8 of that Act. Guiding principle number 7 is particularly concerned with ensuring that the voice of the relevant person shall be heard. It says:

"(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

[74] Ibid, article 5(1).
[75] Ibid, article 5(3).
[76] "intervener", is defined in section 2 of the Assisted Decision-Making (Capacity) Act 2015, and refers to the person making an intervention in respect of a relevant person — the intervener may be a decision-making assistant, co-decision-maker, decision-making representative, attorney or designated healthcare representative, a special visitor or general visitor, a healthcare professional, the Director of Decision Support, the court or the High Court.

(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,

(d) unless the intervener reasonably considers that it is not appropriate or practicable to do so, consider the views of—

(i) any person named by the relevant person as a person to be consulted on the matter concerned or any similar matter, and

(ii) any decision-making assistant, co-decision-maker, decision-making representative or attorney for the relevant person,

(e) act at all times in good faith and for the benefit of the relevant person, and

(f) consider all other circumstances of which he or she is aware and which it would be reasonable to regard as relevant."

The Council of Europe Recommendation 99(4) on Principles concerning the Legal Protection of Incapable Adults 1999 Respect for Human Rights says:

> "The fundamental principle underlying all the other principles, is respect for the dignity of each person as a human being. The laws, procedures and practices relating to the protection of incapable adults shall be based on respect for their human rights and fundamental freedoms."

From the UK Court of Protection,[77] Judge Peter Jackson said:

> "….the European Convention make[s] clear, a conclusion that a person lacks decision-making capacity is not an 'offswitch' for his rights and freedoms. To state the obvious, the wishes and feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone else, and may even be more important."

[77] *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60, at paragraph 11.

The voice of the Ward in proceedings, and post-admission order, is necessary to give recognition and effect to his or her wishes or preferences, feelings, beliefs and values. There are many areas in the Ward of Court process and system where there is a negligible safeguarding of the rights of the individual to have their voice heard.

Notwithstanding that the Convention on the Rights of Persons with Disabilities and Optional Protocol to the Convention on the Rights of Persons with Disabilities (OP-CRPD) are yet to ratified, some recognition should be given by the Court to the spirit of the Convention and indeed to domestic constitutional rights.

4. THE LEGAL TEST FOR CAPACITY

4.1. Assessing legal capacity: Ireland's current regime

Legal capacity is the law's recognition of the validity of a person's decisions: it is the ability to hold rights and duties (legal standing) and to exercise these rights and duties (legal agency).[1] It is the key to accessing meaningful participation in society. It is distinct from mental capacity, which refers to a person's decision-making ability.[2]

At common law, any assessment of capacity relies on two fundamental principles: (a) adults are presumed to have legal capacity unless the contrary is proved,[3] and (b) the onus of proving that a person does not have legal capacity rests on the person asserting this.[4]

Prior to 2007, there was no indication — statutory or at common law — of how capacity should be assessed. Ms Justice Mary Laffoy's judgment of that year in *Fitzpatrick v FK*[5] is the authority for the common law test of capacity in this jurisdiction. Judge Laffoy adopted and clarified the common law presumption, "that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse medical treatment, but that presumption can be rebutted.[6]"

She went on to set out that the test "is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made.[7]"

This test is known as the functional test and is given statutory effect in section 3 of the

[1] This report is indebted to the Law Reform Commission's *Consultation Paper on Vulnerable Adults and the Law: Capacity* (L.R.C. C.P. 37-2005); O'Neill, Anne-Marie, *Irish Mental Health Law*, (2005) First Law; Donnelly, Mary, *Assessing Legal Capacity: Process and the Operation of the Functional Test* (2007) JSIJ 141; and to Donnelly, Mary, *Legislating for Incapacity: Developing a Rights-Based Framework*, (2008) DULJ 30(1) 395.
[2] The Assisted Decision-Making (Capacity) Act 2015 refers to decision-making capacity rather than mental capacity.
[3] *Masterman-Lister v Brutton & Co.* [2002] E.W.C.A. Civ. 1889.
[4] Ibid.
[5] [2009] 2 IR 7.
[6] Ibid, *para 84.*
[7] Ibid.

Assisted Decision-Making (Capacity) Act 2015.[8] It requires that a person's capacity must be assessed in relation to a particular decision, at a particular time, in a particular context.

The facts of *Fitzpatrick v FK* involved capacity to give or refuse consent for a medical procedure. *Fitzpatrick v FK* has been followed and adopted by a number of High Court judges, in a variety of cases. Many of the cases which adopt the test in *Fitzpatrick v FK* deal with medical procedures, most frequently in mental health cases.[9]

However, in two separate matters dealt with by Ms Justice Marie Baker in 2015, she applied the test in relation to assessing whether a man had capacity to execute an instrument creating an enduring power of attorney,[10] and also whether a man, who was conducting a hunger strike in prison, had capacity to refuse food.[11] In other words, there is an acceptance by the High Court that the test is applicable generally.

4.2. Legal test under the Lunacy Regulation (Ireland) Act, 1871

Under sections 15 and 16 of the 1871 Act, the Court is permitted to direct an inquiry as to whether the Respondent should be made a Ward. The legal test is whether the person is "of unsound mind and incapable of managing his person and property".[12]

There is no statutory or common law definition of "of unsound mind". An exploration of its meaning has arisen in just one case,[13] *In Re Francis Dolan*.[14] Kelly J[15] set out the following:

> "So it seems to me that the term 'person of unsound mind' in the context of this particular case means no more than that the plaintiff is incapable of managing his affairs, a fact which appears to have been accepted by his parents to date."[16]

However, this was in the context of a challenge to the test being applied in circumstances

[8] Section 3 is not yet commenced.
[9] *In the matter of B* [2016] IEHC 605 (unreported, Twomey J, 2nd November 2016*); In the matter of KW* [2015] IEHC 215; *HSE v VE* (A person of unsound mind not so found) (Unreported, Feeney J, 26th July 2012); *HSE v J O'B* (Unreported, Birmingham J, 3rd March 2011).
[10] *In Re SCR* [2015] IEHC 308.
[11] *Governor of X Prison v P Mc D* [2015] IEHC 259.
[12] *In Re Keogh*, Unreported, Finnegan P, 15th October 2002, pg 6016.
[13] It was not dealt with by Laffoy J in *Fitzpatrick v FK*.
[14] [2004] 3 IR 95; Also discussed at Chapters 3.2, 4.3 and 5.6.
[15] Currently the President of the High Court.
[16] Ibid, page 105.

where the plaintiff and his parents found the terminology of the test outdated and offensive. It would appear that the Court was addressing those concerns only. This is supported by the comments of Geoghegan J, in the Supreme Court appeal, where he approved Kelly J's statement.

The learned judge noted that this "special meaning" was given to the term in order to get around the legal difficulties arising from the terminology of the 1871 Act.[17] Indeed, it is surprising to note that there seems to have been no challenge before the Courts in relation to the validity of the test, constitutionally or otherwise, or simply in relation to its lack of clarity.[18]

Furthermore, two matters were not addressed in this discussion of the test's meaning: firstly, if "of unsound mind" was taken to mean "incapable of managing one's affairs", then why does the test of the 1871 Act repeat itself? In other words, the test "of unsound mind and incapable of managing his person and property" in this interpretation means "incapable of managing his affairs and incapable of managing his person and property".

Secondly, the issue of whether the test is two-part or not was not addressed by the High Court or the Supreme Court. In the case *In Re Keogh,*[19] the Respondent had been in a car accident and sustained a brain injury. She received an award of €590,000 and was made a Ward of Court. Two days after the order, it came to the President's attention that she had written to the Ward of Court office eight days prior to the inquiry. The president discharged his order and ordered that the matter be heard by a High Court judge and jury.

[17] This is discussed by Mary Donnelly in *Legislating for Incapacity: Developing a Rights-Based Framework*, (2008) DULJ 30(1) 395.
[18] The case of FD (also discussed at Chapters 3.2, 4.2 and 5.6) would go on to produce another two judgments, one by the High Court and then another by the Supreme Court. Raised as an issue was the constitutionality of wardship in circumstances where the Plaintiffs argued that their constitutional rights of family were being abrogated by what they claimed was the State's unwarranted interference in their family life. This matter was never fully ventilated in any of the judgments since the case became telescoped into a preliminary matter of whether the High Court has jurisdiction to set up a trust. Laffoy J in the Supreme Court ruled that the High Court has no jurisdiction to make a trust in *In the Matter of FD* [2015] IESC 83.
[19] Unreported, Finnegan P, 15th October 2002.

Two questions were put to the jury and were answered:

1. Whether the respondent was of unsound mind. Answer: No.

2. Whether the respondent was incapable of looking after her person and her property. Answer: Yes.[20]

When it came back before Finnegan P, he held the following in relation to how the test should be applied:

> "The very long established practice in relation to wards of Court has been to treat the word 'and' as conjunctive and to make orders only where both the requirements unsoundness of mind and incapacity of managing ones [sic] person or affairs are satisfied. It is inappropriate for this Court to review at this late stage the interpretation of the 1871 Act which it has for so long adopted."[21]

Since the jury had decided the Respondent's condition satisfied only one part of the test, the President dismissed the petition. However, he did not require the petitioner to pay the costs as it had been reasonable to bring the proceedings.

Despite this judgment, it is unclear whether the two-part distinction is applied in all matters under inquiry. Medical visitors are asked to comment in their report to the court on whether, in their opinion, "the Respondent is of unsound mind and incapable of managing their affairs."[22] Given that the test is a legal one, it is surprising that there are no rules of Court or regulations giving guidance to medical practitioners as to the appropriate criteria for the Court proceedings.

4.3. The functional test post-admission to wardship

While the Court is steadfast that the test under the 1871 Act applies in relation to admission of an individual to wardship,[23] there is considerable ambiguity about what test

[20] Ibid, pg 6015.
[21] Ibid, pg 6017.
[22] See Appendix 2.2 on page 133 for excerpt of pro forma letter sent from the Office of Ward of Court to medical visitors.
[23] Surprisingly, the ambiguity of this test in wardship proceedings has never been challenged, see above.

applies to individual decisions post-admission: for example, in relation to consent to medical care and treatment.

There is a strong constitutional argument to be made that where there is no explicit requirement in the 1871 Act to apply the statutory test in those instances that the functional test must apply. This is founded on the Supreme Court's recognition[24] that the unenumerated rights to bodily integrity,[25] privacy,[26] autonomy[27] and dignity,[28] flowing from the constitutional guarantee of equality, apply to a person who lacks capacity.

In 2007, Mary Donnelly wrote about the Irish legal regime in relation to capacity.[29] She raised the prospect of the Ward of Court system recognising and incorporating the functional test:

> "It is clear that, under the law as it presently stands, the requirement for a functional assessment of capacity is, to a degree, displaced where an individual has been made a ward of Court. However, the extent of the displacement is not entirely clear and it will be argued below that it is less extensive than has sometimes been presumed."[30]

Donnelly went on to note that the need for a functional test for testamentary capacity[31] has been held to continue even where the person making the will has been admitted to wardship.[32] She also pointed out that failure to apply a separate test for consent to medical treatment could result in an undermining of the Ward's right to autonomy and privacy arising under the Constitution and the European Convention on Human Rights.[33]

However, it does not seem that the functional test has ever been canvassed before the

[24] *In Re a Ward of Court* [1996] 2 IR 79.
[25] Ibid, pg 124-125 per Hamilton CJ; pg 129-130, per O'Flaherty J; pg 163, per Denham J.
[26] Ibid, pg 124, per Hamilton CJ; pg 130-131, per O'Flaherty J; pg 163, per Denham J.
[27] Ibid, pg 126, per Hamilton CJ.
[28] Ibid, pg 163-164, per Denham J.
[29] Donnelly, Mary, *Assessing Legal Capacity: Process and the Operation of the Functional Test* [2007] JSIJ 141.
[30] Ibid, pg 149.
[31] Whether one has the capacity to make a will.
[32] Ibid, pg 150.
[33] Ibid, pg 151.

High Court while exercising its Ward of Court jurisdiction. One of the key cases in recent years to challenge the jurisdiction of the High Court in Ward of Court matters, *In the Matter of FD,*[34] concerned a young man with cerebral palsy, who was in receipt of a large personal injuries award, but where the plaintiff and his parents — acknowledged by the Court to be exemplary carers — did not want him made a Ward of Court.

A number of issues were raised, including the constitutionality of the 1871 Act, but the assessment of capacity was not raised.[35] The case was dealt with on a preliminary issue, whether the High Court has the jurisdiction to create a trust instead of making a person a Ward. This matter was ultimately settled by the Supreme Court decision of Laffoy J in 2015,[36] where she held that the jurisdiction to create a trust does not exist where there is an express jurisdiction vested in the Court in wardship matters.

4.4. Assisted Decision-Making (Capacity) Act 2015

Capacity, in the Assisted Decision-Making (Capacity) Act 2015, is defined as "decision-making capacity".[37]

Section 3[38] of the Act sets out that the functional test applies in the assessment of capacity:

> "…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."

4.4.1 Part 6: Review of Wards

Part 6 of the Assisted Decision-Making (Capacity) Act 2015[39] requires that all existing Wards[40] be reviewed in terms of their capacity before being discharged from wardship, whether they have been deemed to lack capacity or not. This must be done within three

[34] FD (an infant) suing by his next friend BD v Registrar of Wards of Court [2004] 3 IR 95; In the Matter of FD [2011] 1 IR 75.
[35] This case is also discussed at Chapters 3.2, 4.2 and 5.6.
[36] In the Matter of FD [2015] IESC 83.
[37] S. 2.
[38] Not yet commenced.
[39] Not yet commenced. See the Law Society of Ireland's Submissions on Part 6 of the Assisted Decision-Making (Capacity) Act 2015 to the Department of Justice and Equality, Department of Health and Department of Social Protection, May 2017.
[40] In 2016, 2,626 wardship cases were heard, including petitions to have individuals made wards, but also including matters arising out of wardship.

years from the date of commencement and the Ward must have reached the age of 18 by that date, or else will reach the age of 18 within two years and six months of that date.[41] Where a Ward reaches the age of 18 after that period, then the Court must make a declaration within six months of the Ward reaching that age.[42]

A Ward is defined as a relevant person[43] in the wardship of a wardship Court; a wardship Court means the High Court or Circuit Court exercising its jurisdiction in wardship matters and is the Court which made the order by virtue of which the person is a Ward.[44]

Section 8,[45] which sets out the Guiding Principles, states that the principles "shall apply for the purposes of an intervention in respect of a relevant person, and the intervener shall give effect to those principles accordingly". An intervention is defined as including an action taken under the Act, orders given under the Act or directions given under the Act in respect of a relevant person by the Court or High Court.[46] In other words, any review of an existing Ward must be carried out in accordance with the Guiding Principles.

On review of each Ward, the wardship Court must make one of the following declarations:

- the Ward does not lack capacity[47] or
- lacks capacity without assistance[48] or
- lacks capacity even with assistance.[49]

If the Court finds that the Ward does not lack capacity, then the Ward shall be immediately discharged from wardship and his or her property returned to him or her.[50] The Court may only give directions, rather than orders, having regard both to the discharge and the circumstances of the former Ward.[51]

[41] s.54(2).
[42] Section 54(3).
[43] Section 2: Relevant person means (a) a person whose capacity is in question or may shortly be in question in respect of one or more than one matter; (b) a person who lacks capacity in respect of one or more than one matter, or (c) a person who falls within paragraphs (a) and (b) at the same time but in respect of different matters.
[44] Section 53.
[45] Not yet commenced.
[46] Section2.
[47] Section 55(1)(a).
[48] Section 55(1)(b)(i).
[49] Section 55(1)(b)(ii).
[50] In compliance with Article 12.4 of the CRPD.
[51] Section 55(2).

If the Court finds that the Ward lacks capacity without assistance, it shall discharge the Ward on registration of a co-decision-making agreement ("CDM agreement"), and shall order that the property of the former Ward be returned to him or her. Thereafter, the Court may only give directions, rather than orders, having regard both to the discharge and the circumstances of the former Ward.[52]

However, where there is no suitable person to act as co-decision-maker or where a co-decision-making agreement has not been registered within the required period (allowing for any extensions), then the Court shall act as though it had made a declaration that the Ward lacks capacity even with assistance and the powers under Part 5[53] come into play. In other words, the Court may make a decision-making order or a decision-making-representation order. The Court also must order that the Ward's property be returned to him or her.[54]

If the Court finds that the Ward lacks capacity even with assistance, the powers to make a declaration order under Part 5 also apply. The Ward must be discharged and the Court must return the Ward's property to him or her upon the appointment of a decision-making representative.[55]

With the time frame of three years provided, issues could arise where the Director[56] needs to carry out her functions in relation to Wards who have yet to be reviewed, perhaps as the Office of Wards of Court begins to phase out its responsibility for adults who lack decision-making capacity. Section 57 provides interim powers in that respect. In the case of a Ward — or class of Wards[57] who were Wards immediately before the commencement of section 57 — the wardship Court, after consultation with the Director, may direct the Director to exercise his or her functions as if the Ward were the subject of a declaration

[52] Ibid; section 55(3).
[53] Part 5 of the Assisted Decision-Making (Capacity) Act 2015 provides for applications to court in order to obtain a declaration in relation to a person's capacity. Where a person lacks capacity, even with assistance, the Court may make a declaration to that effect under s.37(1)(b) and appoint a decision-making representative in relation to that person.
[54] Ibid; section 55(4).
[55] Section 55(5).
[56] The Director of the Decision Support Service, a new government agency which will provide support, regulation and supervision in relation to persons who come within the Assisted Decision-Making (Capacity) Act 2015. See Chapter 2.3.
[57] Ibid note 39, para 3.6, where the LSI points out that legislation which provides for the exercise of functions in relation to a 'class of wards' is not in compliance with international human rights obligations.

under section 37(1)(b), that is that they lack capacity to make decisions even with assistance.

The Lunacy Regulation (Ireland) Act 1871 is repealed by section 7, but the validity of any order made by the wardship Court within its jurisdiction and which was in force immediately before the commencement of Part 6, shall not be affected by the repeal. Section 56(2) provides that pending a declaration on review, the jurisdiction of the wardship Court as set out in section 9 and 22(2) of the Courts (Supplemental Provisions) Act 1961 shall continue to apply.

Some difficulties with Part 6:

- Part 6 is silent as to whether the Ward, during the review of his or her capacity, is entitled to the same assistance in Court as a relevant person in a Part 5 application (that is a Respondent in an application to have a declaration in relation to capacity made about him or her). A relevant person in a Part 5 application is entitled to be assisted in Court by a suitable person or a Court friend,[58] who does not have to be a legal professional and may make submissions to the Court.
- Should the wardship Court find that the committee of the Ward is a person who may assist the Ward in any review of capacity, there is no corresponding provision to ensure that the committee meets the criteria as to suitability, eligibility and qualification[59] that are applied in relation to a decision-making representative.[60]
- There is no provision for legal aid for Wards who are being reviewed by the wardship Court.[61] This is in contrast with Part 5, which provides for legal aid for the relevant person in applications under that part.[62]
- The exercise of functions in relation to a 'class of wards', even on an interim basis, is not in compliance with international human rights obligations.[63] This also is in contravention of the Guiding Principles at Section 8 of Assisted Decision-Making (Capacity) Act 2015, which provide that any intervention in relation to a relevant

[58] See Chapter 3.2.3.4 for details on advocacy provided for in the Assisted Decision-Making (Capacity) Act 2015.
[59] Sections 38, 39 and 40.
[60] Ibid note 39, para 3.3 for further discussion.
[61] Ibid note 39, para 2.5.
[62] Section 52 Assisted Decision-Making (Capacity) Act 2015.
[63] Ibid note 60.

person must have regard to the wishes, preferences and values of the relevant person.[64]

- Section 139 of the Assisted Decision-Making (Capacity) Act 2015 provides that where there is an application to the Court under Part 5 (declaration as to capacity), Part 7 (Enduring Power of Attorney) and Part 8 (Advance Healthcare Directives), it must be heard in the presence of the relevant person or person concerned unless certain circumstances arise, including that it "would not cause an injustice" to the person. There is no corresponding provision in relation to the hearing of a review of the capacity of a Ward.[65]

The Law Society of Ireland has drafted submissions which include recommendations to amend the Act to address the above concerns.[66]

4.4.2 Future of Funds of Ward of Court

When a Ward is discharged under the Assisted Decision-Making (Capacity) Act 2015, the property of each Ward will be returned to him or her. It is therefore necessary that the information on each individual ward's property is clearly available. This information must include a detailed account of the amount of capital originally in the fund (to include current valuation) with details of income and expenditure incurred.

For those who require continuing assistance with decision-making, they will transition to the new regime and will be a 'relevant person' for the purposes of the Assisted Decision-Making (Capacity) Act 2015. For such persons, either the person will appoint a co-decision-maker in relation to his or her financial affairs, in which case the person will make decisions jointly with the co-decision-maker. Alternatively, the Court will appoint an appropriate decision-making representative and will authorise the decision-making representative to make decisions with regard to control, management and investment of the relevant person's property.

Co-decision-makers and decision-making representatives will have reporting obligations to

[64] Ibid note 39, para 3.8.
[65] Ibid note 39, para 3.10.
[66] Ibid note 39, part 4.

the Director of Decision Support Service[67] who will have a general supervisory role to ensure that the decision-making representative is performing his or her functions.

4.4.3 Commencement

Some limited parts of the Act have been commenced,[68] to allow the establishment of the Decision Support Service[69] and to allow work to begin on the drafting of codes of practice. In practical terms, the office of the Decision Support Service needs to be fully functioning before the review of Wards can begin.

There seems to be a general acceptance of the reality of the new Assisted Decision-Making (Capacity) Act 2015. However, there are varying estimates in terms of when it will be commenced and some concern about how it will work in practice; whether it will leave vulnerable adults open to abuse; and whether people, on an individual basis, will be able to manage the funds of a relevant person as effectively as the Office of the Wards of Court can, given its access to myriad experts.[70]

These concerns do not recognise the safeguards that are in place in the Assisted Decision-Making (Capacity) Act 2015, in relation to the oversight provided by the Director of the Decision Support Service, plus the work that is already underway in the drafting of Codes of Practice under the new regime and indeed the introduction of the Adult Safeguarding Bill 2017 in the Oireachtas in April 2017.

Despite the pending commencement of the Assisted Decision-Making (Capacity) Act, however, there seems to be little work being done in preparation for the review of Wards. While accepting that this may be partly due to a need for transitioning resources, it is respectfully submitted that the functional test under section 3 and the Guiding Principles under section 8 of the Act could be applied to existing Wards and prospective Wards, to

[67] See Chapter 2.3.
[68] SI No 515/2016 commences Part 1, other than sections 3, 4 and 7, and Part 9, other than sections 96, 102; SI No 517/2016 commences the definition of "Minister" in section 82, the definitions of "codes of practice" and "working group" in section 91(1) and section 91(2).
[69] See Chapter 2.3.
[70] See Chapter 2.6.

assist the Court in a number of ways.[71]

For instance, the Court could require that medical practitioners carry out a functional assessment, as well as applying the statutory test under the 1871 Act.[72] While satisfying the statutory requirement, it would also give the Court and the Office of the Wards of Court insight into what decisions the prospective Wards could potentially make themselves.

The implementation of the Guiding Principles would also very much assist the Court in ensuring the human rights of Wards are respected. Just as crucially, it would allow the Court and the Office to prepare for the Part 6 review of Wards, in that they would have a better idea of which Wards should be reviewed and discharged with the greatest urgency.

[71] It is noteworthy that in some circumstances, the court is prepared to recognise the application of the pending Assisted Decision-Making (Capacity) Act 2015: see the case of GG in Chapter 3.2.3.1.
[72] See comments of Consultants X and Y in Chapter 5, where they explain that they include functional assessments in their capacity assessments for the purposes of Ward of Court petitions.

5. MEDICAL REPORTS AND MEDICAL VISITORS

5.1. The role of medical reports in a Ward of Court petition

As stated,[1] in order to bring a petition to the High Court, a petitioner is required to submit two medical reports outlining that the Respondent is of unsound mind and incapable of managing his or her affairs. If the President directs that an inquiry should take place, he then instructs a court-appointed medical visitor to visit the Respondent and carry out an assessment.[2]

Therefore, in all cases, the decision of the Court in relation to a potential declaration of wardship is based on at least two reports, and often three separate reports, on the capacity of the Respondent. What is not clear, however, is the consistency of quality of each of those reports. There are no guidelines or regulations in place about how to execute a medical report for the purposes of a Ward of Court petition, whether commissioned by the petitioner or the President.

5.2. Assessing capacity: a medical test or a legal one?

A medical practitioner may need to make an assessment of a person's capacity to make decisions for various reasons, and may use various methodologies and tests to do so. However, where an assessment of a person's capacity to make decisions with legal consequences arises, this requires the application of a legal test.

This distinction can be seen most clearly in the judgment of Ms Justice Marie Baker in *In the Matter of SCR*,[3] where there was an objection to the registration of an enduring power of attorney,[4] on the grounds that the donor lacked capacity at the time he created the document which gave powers to the attorney. Although the donor's general practitioner

[1] See discussion in Chapter 3.1 Wardship proceedings.
[2] Ibid.
[3] [2015] IEHC 308.
[4] Where a person with capacity — the donor — gives authority to another person — the attorney — to act on his or her behalf should the donor subsequently lose capacity. This is set out in a document when the person has capacity and if he or she subsequently loses capacity, the document is registered with the Office of Wards of Court, at which point the attorney has the power to act on behalf of the donor.

(GP) was of the opinion that the donor had capacity at the time of execution, the judge declined to defer to that opinion and held that the test was a legal one, not a medical one:

> "I consider then that the question of cognitive capacity requires the Court to make a legal assessment of such capacity and that the Court ought not in the case of the execution of an instrument creating an EPA [enduring power of attorney] defer to a medical assessment, even one made following a contemporaneous or near-contemporaneous assessment."[5]

The judge then went to make the following conclusion on the test of capacity:

> "Thus I regard the question to be determined to be whether, on the balance of probabilities and taking the evidence as a whole, the donor had sufficient cognitive capacity as a matter of fact to understand the nature and effect of the instrument he actually purported to execute. The test is a legal one."[6]

Ms Justice Baker's position was that the Court must take all the evidence in relation to the individual's capacity in the round and not defer exclusively to medical evidence. She also held that the legal test for the Court to consider was one which focussed on a particular decision, in a particular context, at a particular time.

5.3 Professional guidelines

There are professional guidelines for medical practitioners in relation to capacity assessments. Firstly, the Medical Council's *Guide to Professional Conduct and Ethics* sets out guidelines in relation to capacity to consent to treatment.[7] These guidelines follow the functional test and provide safeguards for the rights of individuals.

The guidelines in relation to the assessment of capacity are as follows:

> "A lack of capacity may arise from a long-term or permanent condition or disability, or from short-term illness or infirmity. A person lacks capacity to make a

[5] Ibid, para 43.
[6] Ibid, para 49.
[7] Medical Council, *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*, 8th edition, 2016, page 15. Previous edition was published in 2009 post *Fitzpatrick v FK* [2009] 2 IR 7.

decision if they are unable to understand, retain, use or weigh up the information needed to make the decision, or if they are unable to communicate their decision, even if helped. In assessing patients' capacity, you should consider:

• their level of understanding and ability to retain the information they have been given;

• their ability to apply the information to themselves and come to a decision; and;

• their ability to communicate their decision, with help or support, where needed."[8]

Secondly, in 2014, the HSE published its National Consent Policy,[9] which includes guidelines in dealing with service users with capacity issues. The policy is very clear in its requirement for medical professionals to use the functional test:

> "Best practice favours a 'functional' or decision-specific approach to defining decision-making capacity: that capacity is to be judged in relation to a particular decision to be made, at the time it is to be made — in other words it should be issue specific and time specific — and depends upon the ability of an individual to comprehend, reason with and express a choice with regard to information about the specific decision. The 'functional' approach recognises that there is a hierarchy of complexity in decisions and also that cognitive deficits are only relevant if they actually impact on decision-making."[10]

The guidelines emphasise the duty to maximise capacity,[11] the presumption of capacity,[12] and that "even in the presence of incapacity, the expressed view of the service user carries great weight.[13]"

Despite these clear guidelines, there is no sense that they are being followed in relation to

[8] Ibid, page 15 and 16.
[9] Health Service Executive, *National Consent Policy*, 2014.
[10] Ibid, page 29.
[11] Ibid, page 29.
[12] Ibid, page 30.
[13] Ibid, page 33.

Ward of Court assessments. Indeed, given that the guidelines could be interpreted as requiring a practitioner to apply different tests and standards than those in the Ward of Court system, it might be expected that practitioners would raise this issue as a potential conflict in relation to how they carry out assessments.

5.4 Experience of professionals on the ground

Consultants interviewed for this report[14], and who carry out capacity assessments for the purposes of Ward of Court applications, state that they have endeavoured to apply the HSE and Medical Council guidelines.

Consultant X has been writing functional reports for some time but "it leads to endless problems, even if I am supporting the wardship application but am at pains to note that there are areas where the person is able to express themselves".[15]

Consultant X said that he was "reluctant to determine that someone is 'of unsound mind' where the only issue is in relation to finances, and where they are passing everything else [i.e. that the individual being assessed has capacity to make other decisions]. The formulation [of the test][16] grates, it is simply untrue [where someone has capacity to make some decisions, if not all]. It should be up to the President to make a decision in the round".[17]

Consultant X also confirmed that there is no uniformity in relation to the instructions from solicitors.[18] He informed us that some "solicitors are happy with a 7/8 line report".[19] Consultant Y,[20] who is "always working from the functional perspective", says that he may get instructions from solicitors which ask him to "comment on the mental capacity" of the individual, and which do not give any instructions that are decision-specific. In those

[14] Psychiatrists and geriatricians, see Appendix 1 for interview dates.
[15] Appendix 1 — Interview November 2016.
[16] The test being referred to is the MMSE medical test. See 5.5.
[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] Appendix 1 — Interview April 2017.

situations, Consultant Y goes back to the practitioner and asks them to set out what decision-making capacity needs to be assessed. "We do get push back, it's not always clear what they want or if they know what is required."[21]

Consultant Y says that he always does a detailed cognitive assessment first, which wouldn't necessarily be about capacity in relation to a specific decision. Then he does a functional assessment in relation to a specific decision. In order to do this, he obtains as much information as possible about the decision, which could be a complex financial matter with legal ramifications.[22]

He points out that getting accurate information can be tricky as there can be conflict between the patient and family members, while some family members might have agendas. He likes to meet the person on a number of occasions and also tries to get a sense of the person from the solicitor and family members.[23] He notes that the time required to carry out assessments in this way is not always available in a Ward of Court context.

Consultant Y is concerned about the lack of guidelines available to medical practitioners in relation to how to carry out an assessment. He says that he sees assessments executed at 8am in the morning, while the patient is lying in bed, even though there is research which shows that people are drowsier when lying in bed. He feels that it is essential that individuals are seen a number of times, at different times of the day.[24]

He also recommends that individuals be told why they are being assessed: "They should be asked if they are happy with that, if they want to have someone with them, if they need a hearing aid or glasses. These are often not addressed."[25]

[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Ibid.

Consultant Y emphasises the importance of enhancing the capacity of the individual:

> "Patients being assessed are often stressed and anxious. We find that if we spend time with an individual, over the course of a few days and at different times of the day, we often come to a different decision about their capacity then we had made at the outset.
>
> "We like to do the assessment in pairs, with one of us seeing the person in the morning and the other seeing them at a different time. We like to get as much information about the individual from as many sources as possible. We want to give the individual the opportunity to be at their best when we see them. There needs to be recognition of the complexity of the task and the seriousness of the process."[26]

He also stresses the importance of building a review process into the assessment, as well as treatment facilitation, including communication aides and memory aides, things that will minimise the disability and enhance capacity.

If carrying out an assessment for the purposes of a Ward of Court petition, Consultant Y says that he uses the general cognitive assessment to determine whether the individual is of unsound mind and incapable of managing their own affairs, while also including a functional assessment in relation to a specific decision. "The Court seems to be comfortable with this formulation. They are happy enough with a functional assessment as long as it meets the test."[27]

Meanwhile, legal practitioners[28] working in the Ward of Court list say that medical reports can range from two or three lines to four to five pages. Legal Practitioner E says that medical reports "may be as little as two lines from a GP".[29] She says that even where the reports don't contain a capacity assessment, but do contain the formulation "of unsound

[26] Ibid.
[27] Ibid.
[28] Including solicitors and barristers.
[29] Appendix 1 — interview February 2017.

mind and incapable of managing their affairs", these have been accepted.[30]

She says that she has sent medical reports back to the practitioner for more detail, even though she thought it would be accepted by the Court.[31]

Social workers[32] have different concerns. They raised the issue of how the system relies on medical reports from consultants, who have huge demands on their time, which can make the system very cumbersome.[33]

> "The process can take between 12 and 20 months. Getting the reports and getting them sworn can cause delays. These cases are not always a priority for solicitors. Then reports become out of date, so you have to start again."

5.5 Expert views on the Mini-Mental State Examination

The Mini–Mental State Examination (MMSE) or Folstein test is a 30-point questionnaire that is used in clinical and research settings to measure cognitive impairment. It is commonly used in medicine and allied health to screen for dementia (medical diagnosis), the idea being that a low score warrants further investigation. The test is frequently included in medical assessments of capacity which the High Court then relies on when making its assessment in Ward of Court petitions.

There is some controversy surrounding the MMSE: within the medical profession there is disagreement as to the usefulness of the MMSE in assessing an individual's capacity. There is a concern that the Court is deferring to assessments which use a controversial methodology of assessment (notwithstanding that the test is a legal test, not a medical test, as set out above).

Some of the criticisms are that the questions asked in the test are based on abstract

[30] Ibid.
[31] Ibid.
[32] Specialising in geriatric care in a major national hospital.
[33] Appendix 1 — Interview November 2016.

issues, are language-based and favour those with high educational attainment. For example, there is a concern that someone with low educational attainment will score low on the test and yet have capacity to make particular decisions.

Another concern would be where an individual has language difficulties — whether because English is not their native language, or due to an illness — and how to determine whether a low score is due to this or due to capacity issues. Furthermore, none of the questions are functional. In other words, the questions do not assess a person's ability to make a particular decision about a particular task.

The HSE's draft guidelines[34] in relation to the implementation of the Assisted Decision-Making (Capacity) Act 2015 have this to say about the Mini-Mental State Examination:

> 4.2.3 Cognitive tests, tests to assess intelligence and capacity determinations: Cognitive tests (such as the Mini-Mental State Examination (MMSE) or the Montreal Cognitive Assessment (MOCA)) and tests designed to assess intelligence (such as IQ tests) do not determine and should not be used for assessing a person's decision-making capacity. Their use is:
>
> • Inconsistent with the issue-specific nature of the functional approach to capacity. For example, the questions asked in some cognitive tests, such as the day of the week or copying a design bear no relationship to any particular decision and do not provide any useful information about the decision to be made or whether or not the person has capacity to make any decision.
>
> • Inconsistent with the presumption of capacity if a relevant person's results on such tests below a particular cut-off are interpreted in effect as reversing the presumption of capacity and result in the person being asked to demonstrate that they have capacity to make a decision.[35]

[34] Health Service Executive, *Assisted Decision-Making (Capacity) Act 2015, A Guide for Health and Social Care Professionals, Draft for Consultation*, March 2017.
[35] Ibid, page 47.

Consultant X described the issues as follows: "The MMSE is a quick screening test developed in the 1970s. There are 30 items, including whether the patient can draw intersecting pentagons. If they score less than 24 then it probably warrants further assessment. It is useful in epidemiology. However, its limitations are that it is educational, age and language dependent. I wouldn't regard it as a diagnostic tool and none of the questions are functional — for example, the intersecting pentagon question."[36]

Consultant Y[37] views the MMSE as a "useful quick clinical tool, but one which gives no useful information on mental capacity on a specific level". He said that he wouldn't use it when carrying out a mental assessment as it was a "basic screening test open to lots of errors", and he notes that the executive function is not tested by the MMSE. He speculated that some clinicians may be uncomfortable in making an assessment on a functional basis alone, and therefore use the MMSE as a quantifiable device. This may be why it appears to be so prevalent in the assessments generated for Ward of Court applications.[38]

However, he is concerned that the HSE guidelines, as set out above, may be going to another extreme in advising that there is no place for tools such as these, and he is concerned that "we may throw out the baby with the bathwater". He feels there is a place for these tools to allow clinicians to "build as rich a picture as possible in relation to an individual's cognitive ability".[39]

Consultant Y is also concerned that the HSE views such testing as being inconsistent with the legal presumption of capacity, in that a low score then appears to require people to prove that they have capacity. He disagrees with this and maintains that clinicians are using the test "to gather information".[40]

In the recent past, Psychologist Z, carried out research in Trinity College Dublin on the

[36] Ibid note 15.
[37] Ibid note 20.
[38] Ibid.
[39] Ibid.
[40] Ibid.

MMSE.[41] He looked at it in relation to investigating the cognitive abilities required for clients with Alzheimer's disease to have testamentary capacity. He posits that while the MMSE gives general information about an individual's decision-making capacity, it is possible to use that information in making assessments more specifically.

> "My research showed that a test like MMSE can give you information on the cognitive and neuropsychological substrates that are affected or might be affected, and from that you can infer what the person may have ability or competency for, beyond the specific function which may be being assessed e.g. ability to drive, or ability to manage one's finances."[42]

Psychologist Z had one important caveat in the use of the MMSE, however:

> "A critical aspect is related to the person interpreting the results. It's not necessarily a bad thing to be basing an assessment solely on the MMSE, but the practitioner must know what the results mean from a cognitive and neuropsychological perspective and understand its flaws. If they know that, they can take information from it that can be used effectively."[43]

While it may be arguable that the test may be useful in clinical circumstances, it is more difficult to see how it can assist in relation to the legal test as set out in the Assisted Decision-Making (Capacity) Act 2015. In other words, the MMSE test may give information in relation to an individual's decision-making capacity generally, but does not assist in the execution of the legal test: an assessment of an individual's decision-making capacity in relation to a particular decision, in a particular context, at a particular time.

[41] The research was part of an M.Sc. by Research, Trinity College Dublin.
[42] Ibid.
[43] Ibid.

5.6. Reports by medical visitors

The President has a panel of medical visitors to instruct in relation to Ward of Court petitions. There are no regulations in place to require a particular level of qualification or expertise, but medical practitioners who apply to the panel must supply their CV and information about areas of expertise and experience. It seems that most are at consultant level with clinical experience, often practising in psychiatry or geriatrics.

When instructing a medical visitor on behalf of the President, the Ward of Court Office sends out a pro forma letter[44] which asks that the medical visitor to include the following in his or her report:

1. The date and place of examination.

2. The name, nature and symptoms of the mental illness (if any).[45]

3. The suitability of the Respondent's residence and the manner in which the Respondent is being treated.

4. If in your opinion the Respondent is of unsound mind and incapable of managing their affairs.

The circumstances of *FD v Registrar of Wards of Court*[46] make the legal situation underpinning medical visitors very clear. The plaintiff and his parents objected to him being made a Ward. The President of the High Court made an order directing a medical visitor to visit the plaintiff for the purpose of an inquiry. The visit did not take place. Three months later, and after some correspondence, the President wrote to the plaintiffs indicating that if they did not allow a visit to take place, the assistance of the police would be invoked to ensure that the order was complied with.

[44] See Appendix 2.2 for copy of the pro forma letter sent from the Office of Ward of Court to medical visitors.
[45] Conflating mental illness with capacity is problematic.
[46] [2004] 3 IR 95; also discussed at Chapters 3.2, 4.2 and 4.3.

A medical visit then took place, but the visitor required a second medical examination before he could complete his report to the President. The plaintiffs objected to a second medical visit and instituted proceedings, seeking an injunction restraining further medical visits. Kelly J[47] declined the relief sought as the order made by the President — directing that the medical visit take place — affected the constitutional rights of the plaintiff and could not be the subject of an injunction. The only way of arresting such an order was by way of application to set the order aside or by appeal.

The then judge also held that the President, in exercising his wardship jurisdiction and deciding to take the plaintiff into wardship, must comply with constitutionally mandated norms. The wardship jurisdiction was "a beneficent one", to assist persons such as the plaintiff who labour under a legal disability in administering property.

Also, because the parents were not objecting to a medical examination but were objecting to what would follow — the making of a wardship order — the Court held that it was difficult to see what damage would be suffered by allowing it to take place. (This was in the context of an injunction, which requires the applicant to show that any damage caused by the complained-of event could not be compensated for in damages.)
The High Court's jurisdiction to order a medical visitor to visit a Respondent (that is the plaintiff in this case, the prospective ward) is a powerful one, predicated as it is on the Constitutional rights of the Respondent.

Where such power is exercisable, however, it seems clear that there must be unimpeachable safeguards and supervision in place in relation to how the medical visitors execute the order. Instead, there is only deferment to the clinical experience and expertise of the practitioner, and a complete reliance on his or her professional integrity.

The mother of former Ward B, who was discharged 11 years ago, said that when the medical visitor came to assess her daughter, who was then 18, she was surprised at the

[47] Currently President of the High Court

type of questions he asked her[48]. Former Ward B is non-verbal and her mother explained that one of B's favourite things was pop music. The medical visitor then asked B if she liked a particular Motown group from the 1960s. As her mother pointed out, it would have been much more appropriate to ask B which artists she liked, or at the very least, to have asked her about pop acts in the charts at that time.

"It seemed very strange that your future could depend on whether or not you knew [who this particular musical group was]," said B's mother.[49] Her daughter was discharged, so this question and B's response were not ultimately determinative of anything. However, it does raise concerns about some medical practitioner's ability to take into account an individual's personality, circumstances, wishes and preferences while making an assessment of their capacity.

Recently, an issue arose in the Ward of Court list before the President.[50] A woman in her eighties, C, had applied to the President to be discharged from wardship and he had sent out a medical visitor to assess her. The medical visitor found that she was of unsound mind and incapable of managing her own affairs. However, the woman had told the medical visitor that she had previously been in Court about the issue of wardship and had spoken to the judge herself. The medical visitor seemed to consider this to be a confabulation, basing his assessment in part on this. But the President knew that it was a true account as he was the judge she had spoken to. On that basis, he directed that another medical visitor be sent out to assess the woman.

That this situation arose raises concerns about whether medical visitors are speaking to those caring for, or supporting the Respondent or Ward, in order to find out about their personality, circumstances, wishes and preferences — particularly where it is difficult to ascertain from the person themselves. In the circumstances of this particular case, it would have been very simple to find out if the story was true or not, by speaking to the Ward's family members or carers. In circumstances where an account is so peculiar that it seems like a confabulation, and where a judgment is then being made in relation to that

[48] Appendix 1 — Interview February 2017.
[49] Ibid.
[50] 5th December 2016.

'confabulation', then there is an onus on the medical practitioner to ascertain whether it is or not a true account.

5.7. Recommendations

In 2007, Mary Donnelly made recommendations for "An Appropriate Procedural Framework".[51] Included in that was 'A Rigorous Approach to Expert Evidence'.[52]
In this paper, she cites Grisso,[53] a psychologist writing from an American perspective, about some of the problems with the quality of expert evidence in the context of capacity:

> "First, the medical expert may be ignorant of the law and consequently fail to provide relevant testimony. Grisso uses the example of the expert who gives evidence that the individual has a mental condition such as schizophrenia and then concludes on this basis that she is incapable rather than applying the legal test for capacity for the particular function at hand. Secondly, the expert may view her function not as facilitating the Court in making a decision but as persuading the Court to accept her view. Thirdly, experts may not take sufficient care in formulating the evidence they present. In Grisso's words:
>
> > Examiners sometimes may not obtain sufficient information about the examinee, in terms of quantity, type or reliability of the observations, in order to reach certain conclusions credibly. In other instances, adequate data regarding the examinee may be available, but the interpretative meanings of the data in relation to the information needs of the Court cannot be supported credibly by past research in psychiatry and psychology.
>
> The kinds of issues identified by Grisso may well arise in an Irish context."[54]

As outlined above, in the case of C who had previously spoken to the President, the third

[51] Donnelly, Mary, *Assessing Legal Capacity: Process and the Operation of the Functional Test*, [2007] JSIJ 142, page 161; see also recommendations in the Voice of the Ward in Chapter 1 of this paper.
[52] Ibid, page 163.
[53] Ibid, page 164.
[54] Ibid.

issue raised by Donnelly, via Grisso, *has* arisen in an Irish context. This was in circumstances where the President was able to catch the discrepancy. The concern is that the President is not always in a position to see behind the assessments made by the medical practitioners.

There is certainly an acute danger of the first and second issues raised by Donnelly/Grisso arising, given the lack of a definition and or guidelines, plus the paucity of instructions from legal practitioners and the Office of the Wards of Court, respectively, when commissioning a report from a medical practitioner.

At the time of Donnelly's article, the HSE's National Consent Guidelines had not yet been published. One way of addressing some of her concerns would be to require medical practitioners to follow these guidelines when carrying out an assessment for Ward of Court purposes.

Some additional suggested guidelines for medical practitioners could include:

- Presumption of capacity: individuals should be informed why they are being assessed.[55]
- Duty to enhance capacity:
    - individuals should be given the opportunity to have someone with them during the assessment;
    - any communication aids such as hearing aids and glasses should be available to them;
    - individuals should be assessed at different times on different days;
    - practitioners should seek to alleviate any stresses or anxieties that the individual has about the process.
- Collecting information: practitioners should seek to find out as much as possible about the person, and the person's wishes and preferences, from as many sources as possible.
- Care: practitioners should also make assessments about the nature of the care that the individual is receiving and whether it should be changed or improved in any way.

[55] Now a statutory presumption under the provisions of the Assisted Decision-Making (Capacity) Act 2015.

- Treatment facilitation: recommendations should be made in relation to treatments that will minimise the disability and enhance the capacity of the individual, such as communication aids and memory aids.
- Reviews process: if the practitioner is satisfied that the Respondent is of unsound mind and incapable of managing his or her affairs, he or she should make recommendations in relation to reviews.

The HSE has produced a draft document to assist healthcare and social care professionals in the implementation of the Assisted Decision-Making (Capacity) Act 2015. This also includes useful guidelines in how to carry out a capacity assessment.[56]

5.8. Medical reports and Part 6 of the Assisted Decision-Making (Capacity) Act 2015

When Part 6 of the Assisted Decision-Making Capacity Act 2015 is commenced, it will require the High Court[57] to review each Ward of Court. The review must be carried out in accordance with the guiding principles in the Act,[58] and the assessment of capacity will be pursuant to the functional test as codified by section 3.

As stated in Chapter 4.4 above, the reviews of the Wards must take place within 3 years of commencement. This is likely to place an extra burden on the office of President of the High Court,[59] albeit on an interim basis. As recommended in Chapter 4.4.3, if the Office of the Wards of Court required medical practitioners to carry out functional assessments now, in anticipation of commencement, it could ultimately assist and prepare the Court in this process.

[56] Ibid note 34, pages 49-51

57 Or the Circuit Court, in circumstances where a person was made a ward in that jurisdiction. For more detailed discussion on this, see Chapter 4.4.1

58 Section 8

59 There will also be some reviews in the Circuit Court, though the majority will be in the High Court.

6. AFTER ADMISSION TO WARDSHIP: VOICE OF THE WARD, DEPRIVATION OF LIBERTY, REVIEW AND SAFEGUARDS

6.1. Voice of the Ward: Will and Preferences

When a person becomes a Ward of Court, the Court is vested with jurisdiction over all matters relating to the person and estate of the Ward. In exercising this jurisdiction, the Court is subject only to the provisions of the Constitution; its prime and paramount consideration must be the best interests of the Ward.[1] In effect, the Ward loses his or her legal agency — the person may no longer exercise the right to make decisions about himself or herself. This ranges from decisions about what to buy or where to live, to decisions about medical treatment, travel and marriage.

Consultation with the Ward — meaningful efforts to ascertain their will and preferences on aspects of their care, property, living conditions or place of residence — is at the time of writing not provided for either in policy or legislation.

Meetings about a Ward's care and treatment often take place in the absence of the Ward. Where the Ward is present, it is not necessarily meaningful. For example, Former Ward A[2] told us that she was invited to attend a multidisciplinary meeting about her care, but the experience made her feel powerless and angry. She was invited to the meeting with a representative from the Office of Wards of Court and some social workers. When A arrived, she realised that the meeting was already underway: she says she was told they had a lot to discuss which is why they went ahead without her.

> "They were talking about me and making decisions about me before I came in and I was angry about this. I said to them, 'why are you talking about me, why wasn't I here at the beginning?' I felt I should have been there."[3]

1 *In The Matter of A Ward of Court (Withholding Medical Treatment)* (No.2) [1996] 2 IR 79
2 Appendix 1 — interview December 2016
3 Ibid

6.2. The Committees (Committee of the Person and Committee of the Estate)

The Committee[4] is the Court-appointed representative of the Ward and as such plays a crucial role in relaying the wishes and preferences of the Ward to the Office of Wards of Court and to the Court.

The Court appoints two[5] types of representative to a Ward: Committee of the Person and Committee of the Estate. One person can be both Committee of the Person and of the Estate.

Where there is no suitable person available to be Committee, the Court appoints the General Solicitor of Minors and Wards of Court to act as Committee of the Person and Estate.

The Committee of the Person has responsibility to see to the care, treatment and personal comfort of the Ward. To this end, he or she must visit the Ward from time to time and report to the Office on the Ward's needs. Where the Ward resides with the Committee, he or she is obliged to receive a medical visitor without prior notice.

Where the Committee forms the view that the Ward would benefit from a change of residence, he or she must obtain the leave of the Registrar. Where the Committee of the Person and the Registrar disagree about moving the Ward, there are particular procedures[6] to follow. These procedures are illustrative of a number of issues:

- Firstly, that it is envisaged that differences of opinion in relation to the care or residential circumstances of the Ward can arise between a Committee and the Registrar, and

[4] Order 67 Rule 57 states: "Where the Judge considers it expedient he may appoint two or more persons to be committees of the estate or of the person…."
[5] In cases where orders are made under section 68 or section 70, a Committee of the Estate alone is appointed.
[6] The Committee may submit an unsworn statement in application, but the Registrar may require the applicant to submit further evidence on affidavit. After consideration, the Registrar will either (i) submit the minutes of the order which he considers ought to be made and submit the application to the President in chambers for his order or directions or (ii) decline to do so and inform the applicant who may thereupon bring the application before the President by motion. O. 67, r.60 and O'Neill, *Wards of Court in Ireland*, First Law (2004), para 3.5.

- Secondly, that the procedures for dealing with such a disagreement are cumbersome and may ultimately lead to the matter being dealt with in an adversarial context, and
- Thirdly, the Committee is at risk of costs in taking such action.

These procedures could have the effect of deterring a Committee from taking action, even where he or she feels they are justified in the application. It also means that there is no means of moderating or mediating the relationship between the Committee and the Office, short of an escalation to a Court application.

Where medical treatment is concerned, the High Court has exclusive jurisdiction to grant or withhold consent to treatment for a Ward. The basis for this jurisdiction is not found in statute and the Courts have relied on the *parens patriae*[7] principle to ground it. It has been argued that this could result in an undermining of the Ward's right to autonomy and privacy arising under the Constitution and European Convention on Human Rights.[8]

A number of difficulties arise out of reliance by the Office and the Court on the Committee in relaying the wishes and preferences of the Ward:

- Firstly, in many cases, the person who is making the application to have a person made a Ward of Court is appointed the Committee. This is done without transparent criteria as to suitability or eligibility or indeed, if there is a conflict of interest.
- Secondly, there is the Office's reliance on the Committee — whether of the Person or the Estate, or both — to inform them about aspects of the Ward's care. Currently, there is no independent system of review for Wards, apart from Wards

[7] This translates as "parent of his or her country". It derives from an English sovereign prerogative defined in Eyre v. Countess of Shaftesbury England: (1722) 2 P. Wms. 103, 24 E.R. 659 as follows: *"[T]he King is bound of common right, and by the laws to defend his subjects, their goods and chattels, lands and tenements, and by the law of this realm, every loyal subject is taken to be within the King's protection, for which reason it is, that idiots and lunatics, who are incapable to take care of themselves, are provided for by the King as pater patriae; and there is the same reason to extend this case to infants. Infants as well as idiots and lunatics, are said to be under the care and protection of the Crown,as persons equally unable to take care of themselves."* See further discussion in Chapter Inherent jurisdiction.
[8] See Chapter 4.3 for further discussion.

who are subject to detention orders.[9]

- Thirdly, where the General Solicitor is the Committee of the Person and the Estate (which can happen in circumstances where there is no suitable person to take up the position, or if there is conflict in the family and an independent Committee is necessary), we understand that the General Solicitor gets information from a number of sources, such as an independent social worker, but may also get information from the carers of the Ward for information. Given that the carers may be nursing home operators and or employees of the HSE, this raises concerns about conflict of interest.

The Rules of the Superior Court specifically forbid that the proprietor of an institution where a Ward is resident (or their employee) may become Committee to a Ward.[10] However, there are exceptional instances where the President appoints HSE employees to act as Committee to Wards.[11] We would expect that these appointments are in keeping with the Rules, in that those acting as Committees must not own or be employed by the owner of the institution where the Ward resides. However, in such exceptional cases, there should be clear guidelines to ensure that no conflict of interest arises where the HSE is both the proprietor of an institution where a Ward resides, and, separately, the employer of a Ward's Committee.

Legal Practitioner E[12] raised concerns about the appointment of Committees, in that raising evidence against a proposed Committee can be problematic. There is nobody to independently verify the Ward's living and social conditions. Without any independent social report on the living conditions of the Ward, it can be difficult for the President to find out the reality of what is happening on the ground. While the medical visitor is the President's eyes and ears, the lack of guidelines in that respect mean there is no certainty that all medical visitors are consistently assiduous about assessing the living and social

[9] This is discussed further below in this chapter.
[10] Order 67, Rule 58.
[11] In a recent answer to a Parliamentary Question put to the Minister for Health by Fergus O'Dowd TD, it was disclosed that as of 12 May 2017 there were five HSE employees who were acting as Committees for Wards in exceptional circumstances. See Appendix 4.
[12] Appendix 1 — interview February 2017.

conditions of the Ward.[13] Also, given that there is no automatic periodic review of Wards[14] — both in relation to their care and their capacity — there is no independent verification of the Ward's care and condition.

6.3 Role and duties of Committee of the Estate

According to O'Neill,[15] the Committee of the Estate is entrusted with the responsibility of acting on behalf of the Ward in legal matters and the good management of the Ward's estate. His or her status is that of an officer of the Court.[16]

The Committee of the Estate must carry out its duties under the direction of the judge. He or she bears responsibility for applying for and receiving monies on behalf of the Ward, and (where authorised by the President), money applications for the Ward's maintenance and benefit, and the payment of outgoings on his or her estate.[17]

Where the Committee of the Estate is in receipt of money, he or she must lodge them on account of the Ward's estate to the credit of a separate bank account for the estate.[18] He or she must produce annual account of the affairs of the Ward and must submit an annual return to the Registrar setting out details of the Ward's property, deductions from same, the annual application of the net income of the Ward, the nature of the management of his property, details of provisions made for his maintenance and care and of persons continuing to have claims on him.[19]

There is no mention in the 1871 Act or the rules of Court that the Committee of the Estate is responsible for how the Ward's money is invested, or even has an input into that task. In a *pro forma* letter from the Office to Committees, it states: "The Committee can only do what the Court authorises him/her to do."[20] It would seem that this would only arise if the President of the High Court specifically provides for it in an order.

[13] See Chapter 5.
[14] See below.
[15] O'Neill, Anne-Marie, *Wards of Court in Ireland* (First Law, 2004), page 125.
[16] Ibid, para 3.42 and 3.48.
[17] Ibid, para 3.48.
[18] Ibid, para 3.49.
[19] Ibid, para 3.50.
[20] Appendix 2.3.

According to Committee of the Estate C, her understanding of her role is as follows:

> "We have always worked under the understanding that we were responsible for submitting a basis for funds based on needs — accounts of income and outgoings and projected outgoings year on year to provide for Ward. Also, areas like home maintenance, house insurance, health insurance and so on are left solely to us. The Office holds the Title Deeds of [the] Ward's home."[21]

6.3.1 What information does the Committee receive?

The position of the Office, based on data protection law, is that financial statements are not disclosed to persons — including family members — other than committees. However, even where a family member is Committee of the Person, he or she does not automatically receive any information about the Ward's funds. As the Committee of the Person makes decisions as to the day-to-day maintenance of the Ward, it is important that the financial implications of such decisions are available to them. Furthermore, in instances where funds may not be sufficient to cover the cost of care in the long term, or where funds are in depletion, this must be communicated in sufficient time to family members who will ultimately be responsible for the Ward's care once the funds run out.

6.3.2 Complaints

The Courts Service has a customer charter,[22] and a complaint form for general complaints, together with a Customer Service Action Plan dating from 2010.[23] There is no specific section directed to Wards and their particular needs. There are no specific guidelines for dealing with complaints pertaining to the needs of this vulnerable group.

We understand that under the current President, as a matter of practice, a Ward will receive an unannounced visit from a medical visitor within 24 hours when a matter concerning that Ward comes before the President. However, for those complaining to the

[21] Appendix 1 — Phone interview with Committee of the Estate C, April 2017. See Appendix 2.3 for Office of Wards of Court pro forma letter to Committees.
[22] Available online at http://www.courts.ie/Courts.ie/Library3.nsf/pagecurrent/EE250E12BE3CA1D880257FB8004BCCDF?opendocument&l=en.
[23] Courts Service 2nd Customer Service Action Plan available at http://www.courts.ie/Courts.ie/library3.nsf/(WebFiles)/9B2E3B00134A567080258057004B74E1/$FILE/Customer%20Service%20Action%20Plan.pdf.

Office of Wards of Court, there is no transparency in how the Office treats the complaint: whether they deem it to be meritorious or not, and whether that decision can be appealed.

According to the Registrar, the Office receives a number of complaints which are expressions of dissatisfaction with decisions made by the Office in response to applications from the committee or the Ward, for example in relation to proposed purchases.

Our many discussions with former Wards, representatives of Wards and family members, revealed a real frustration at the lack of a transparent process in making a complaint to the Office and how the Office chooses to act or not to act on that complaint. While the merits of their complaints are beyond the scope of this paper, it is clear that a transparent process for complaints-handling is needed. There also needs to be transparency of information in relation to the reason why in some situations it is not appropriate to speak to a person other than the Ward or his or her Committee.

Following a complaint, where the Office does not engage with the complainant in a way that the complainant is satisfied with, his or her recourse is to bring the matter before the President. This is a costly process and few have the resources to take this route. Further, few seem to be aware that they can take this route. This seems to be a fundamental issue of transparency about the process which should be addressed by the Office.

Since 2014, the Office of Wards of Court is under the purview of the Office of the Ombudsman. We understand that the Ombudsman has received no complaints about the Office of Wards of Court, though again we would raise concern about how well publicised this facility is. We recommend that when a complaint is made to the Office of Wards of Court, information about how its complaints system operates should be made readily available, including information about the right to refer the matter ultimately to the Ombudsman.

The Office of Wards of Court does not maintain a policy on complaints, nor is there a log of complaints that would provide for effective audit and accountability on complaints to

the Office. This in turn raises the question as to the information given to a complainant of the right to refer a matter to the Ombudsman. Under the new Assisted Decision-Making (Capacity) Act 2015 there will be a comprehensive system of complaints to the Director[24] and the discretion given to the Director to carry out an investigation.

6.4 Deprivation of Liberty, Review and Safeguards

Outside of the criminal justice system, there are a number of different circumstances in which an individual may find himself or herself detained in Ireland.

1. Pursuant to statute.

An individual may be detained statutorily and, in the case of wardship, in tandem with an order of the Court:

- The Lunacy Regulation (Ireland) Act 1871 ("the 1871 Act" or "wardship")
- The Mental Health Act 2001.

2. Pursuant to the inherent jurisdiction of the Court.

The operation of the inherent jurisdiction is the recognition that the Court is empowered to step in to protect an individual's personal rights under Article 40.3 of the Constitution. The Court may find that the personal rights of an individual are endangered, where, for example he or she requires therapeutic treatment, but does not have capacity to consent to it, necessitating the intervention of the Court.

3. *De facto* detention.

This arises where an individual is unable to leave a residential or institutional care setting, although there is no statutory detention or Court order of detention.

[24] See Chapter 2.3.

6.4.1 Unlawful detention for those lacking capacity

In principle, release from unlawful detention may be effected by habeas corpus[25] under Article 40 of the Constitution, which does not differentiate between types of detention. In relation to detention for people lacking capacity, Finlay CJ in *Re. D*[26] stated:

> "I feel I should express my view that, on my understanding of the provisions of Article 40, s. 4, sub-s. 2 of the Constitution, the High Court on the hearing of an application pursuant to that sub-article must reach a single decision, namely, whether the detention of the person concerned is or is not in accordance with law. If it is, then the application must be refused. If it is not, the person must be discharged from the custody in which he is. Such a procedure does not appear to me to admit of any supervision or monitoring of the interests of the person concerned, even allowing for a condition of mental retardation or other want of capacity."

Article 5 of the European Convention on Human Rights also guarantees the right to personal liberty and provides that no one should be deprived of liberty in an arbitrary fashion. It also carries an express procedural protection under Article 5(4):

> "4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a Court and his release ordered if the detention is not lawful."

6.5 The Mental Health Act 2001 and Wardship: contrasting approaches

The Mental Health Act 2001 and the Lunacy Regulation (Ireland) Act 1871 have very different purposes: the 2001 Act provides for the involuntary detention of a person with a mental disorder; the 1871 Act provides for arrangements for persons who lack decision-making capacity to have them and or their assets protected. Under the 1871 Act, detention of Wards may arise due to a court order, or in de facto detained circumstances.

[25] Persons who believe they are being detained or held unlawfully may apply to the High Court for an order of habeas corpus under the Habeas Corpus Act 1782. This requires the person or institution detaining them to either produce the body of the person detained before the court or release that person from such detention.
[26] [1987] 1 IR 449 at 457.

It is, therefore, useful to compare the two pieces of legislation from a human rights perspective in relation to the review procedures and safeguarding that are in place to prevent arbitrary detention.

The provisions of the Mental Health Act 2001 typically apply when a person is detained at an approved centre[27] following a recommendation for involuntary committal from a general practitioner (GP), the GP having acted on an application from a family member.

The Mental Health Act 2001 provides a statutory review system for persons detained under the Act. Despite the inherent value of this, the Mental Health Act 2001 is not a panacea for potential legislative or policy directions for protecting vulnerable people who are Wards or prospective Wards.

It was enacted[28] five years before the publication of *A Vision for Change*[29], and six years before Ireland signed the UN Convention on the Rights of People with Disabilities. Therefore, it does not reflect the policies contained in them, based on concepts of recovery and on individuals with mental health problems having autonomy to the greatest extent possible to make their own admission and treatment decisions. Nor does it contain a framework for the delivery of community-based, comprehensive and integrated mental health services, identified in successive mental health policies.[30]

The *Report of the Expert Group on the Review of the Mental Health Act 2001*[31] and *Interim Report of the Steering Group on the Review of the Mental Health Act 2001,*[32] usefully reviewed and recommended legislative changes, reflecting the cultural change away from paternalism and towards autonomy set out in the documents above. They also reflected the approach of other relevant policies such as *Time to Move on from Congregated Settings*.[33]

[27] Defined in the 2001 Act as a "*hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder*" and "*registered by the Mental Health Commission*.
[28] The 2001 Act was enacted in 2001, but was not commenced until November 2006, pursuant to S.I. 411/2006.
[29] *A Vision for Change — Report Of The Expert Group on Mental Health Policy*, Government of Ireland, 2006.
[30] Amnesty International. *Legislating for Change: accountability and reform of our mental health services: A discussion paper*. Amnesty International: 2010 https://archive.amnesty.ie/sites/default/files/Legislating%20for%20Change.pdf [Accessed 02 March 2017].
[31] Department of Health, *Report of the Expert Group Review of the Mental Health Act, 2001* (2015).
[32] Department of Health, *Interim Report of the Steering Group on the Review of the Mental Health Act, 2001* (2012).
[33] Health Service Executive, *Report of the Working Group on Congregated Settings*, June 2011.

Notwithstanding the above, what is to be emulated is the focus of the Mental Health Act 2001: the existence of detention-related safeguards. A brief overview of the safeguards for those involuntarily detained under the Mental Health Act 2001 is considered below, with a discussion of what corresponding safeguard is, or is not, provided for in wardship.

6.5.1 Avoidance of conflict of interest

Mental Health Act 2001

The Mental Health Act 2001 defines who may apply for an involuntary detention order,[34] and arguably more importantly, who may not apply.[35] Those prohibited from applying include a member of the governing body, or the staff, or the person in charge, of the approved centre concerned,[36] any person with an interest in the payments (if any) to be made in respect of the taking care of the person concerned in the approved centre concerned,[37] any registered medical practitioner who provides a regular medical service at the approved centre concerned[38] and anyone connected with the above.[39]

Wardship

Under wardship, the Rules of the Superior Courts[40] prohibit a person with an interest in the institution in which the Ward lives from acting as their Committee, but there is nothing to prevent a person who may have an interest in payments under the Fair Deal scheme, or who has an interest in discharging a person from an acute hospital bed, or otherwise, petitioning the Court to bring a person into Wardship.

[34] Section 9(1).
[35] Section 9(2).
[36] Section 9(2)(c).
[37] Section 9(2)(d).
[38] Section 9(2)(e).
[39] Section 9(2)(f).
[40] *Neither the proprietor nor the keeper nor the medical superintendent of the hospital or institution in which the ward shall, for the time being reside nor any person residing with or in the employment of any such proprietor, keeper or medical superintendent shall be appointed committee of the ward's person or estate either solely or jointly with any other person.*

6.5.2 Duty to inform the vulnerable person

Mental Health Act 2001

Under the Mental Health Act 2001, a person is detained in an approved centre under an admission order.[41] Within 24 hours of the admission order being made, the consultant psychiatrist who made the order must send a copy to the Mental Health Commission,[42] and give notice in writing to the person detained.[43] The person is given notice in writing telling them:

- which section of the Mental Health Act 2001 he or she is being detained under[44]
- that he or she is entitled to legal representation[45]
- a general description of his or her proposed treatment during his or her detention[46]
- that he or she is entitled to communicate with the Inspector of Mental Health Services[47]
- that he or she will have his or her detention reviewed[48]
- that he or she is entitled to a Circuit Court appeal[49]
- that he or she may be admitted as a voluntary patient if he or she indicates his or her wish to be so admitted.[50]

Wardship

Under wardship, no statutory scheme, rule of Court, or other obligation exists to ensure that every effort is made to communicate the meaning and circumstances of wardship to the person who is about to be made or has been made a Ward.

The Office of the Wards of Court instructs the solicitor serving a petition that "blind or

[41] Section 15 states that: "*An admission order shall authorise the reception, detention and treatment of the patient concerned and shall remain in force for a period of 21 days from the date of the making of the order and, subject to subsection (2) and section 18 (4), shall then expire.*"
[42] Section 16(1)(a).
[43] Section 16(1)(b).
[44] Section 16(2)(a).
[45] Section 16(2)(b).
[46] Section 16(2)(c).
[47] Section 16(2)(g).
[48] Section 16(2)(h); also see *Croke v. Smith* [1998] 1 IR 101.
[49] Section 16(2)(i).
[50] Section 16(2)(j).

illiterate" persons should have their petition "read aloud to him/her in a clear and distinct manner and an effort should be made to explain the contents thereof to him/her insofar as his/her mental condition enables him/her to understand same".[51] No instructions, guidelines or regulations exist for every prospective Ward or Respondent to seek to ensure his or her understanding of the petition being served on him or her.

6.5.3 Right to initial review, advocacy, and transparency of medical report

Mental Health Act 2001

The Mental Health Commission orders a review in the form of a Mental Health Tribunal[52] of each admission order[53] at which the person is entitled to his or her own legal representative.[54] The person is reviewed by a consultant psychiatrist in advance of the Mental Health Tribunal,[55] and matters to be examined are also laid out in statute.[56] The person's legal representative receives a copy of the consultant psychiatrist's report.[57] Prior to a tribunal convening, there is a constant obligation on the treating psychiatrists to revoke detention, should the consultant consider that the individual is no longer suffering from a mental disorder.[58]

Wardship

While there is no bar to a legal representative appearing on behalf of a prospective ward, a guardian ad litem, advocate or automatic legal representation such as that afforded by the Mental Health Act 2001 is not available in a standard application to bring a person into wardship. The Court is the agent of the Ward. In a recent case[59] concerning a person already the subject of wardship, the HSE funded a guardian ad litem for proceedings in which the Ward sought to move from the Central Mental Hospital to a designated centre.[60]

[51] See Appendix 2.1 for relevant excerpt of the pro-forma letter.
[52] Mental Health Tribunals are appointed by the Mental Health Commission under section 48 of the 2001 Act. Each tribunal has three members: a consultant psychiatrist, a legal member (who acts as Chairperson) and a lay member.
[53] Section 17.
[54] Section 17(1)(b).
[55] Section 17(2).
[56] Section 17(1)(c).
[57] Section 17(1)(c).
[58] Section 28(1).
[59] GG case – also see Chapter 3.2.3.1.
[60] Ibid.

While the provision of the guardian ad litem is welcome, the ad hoc nature of the funding of such an advocate is not.

The prospective Ward does not receive a copy of any of the medical reports relied on in the petition to make him or her a Ward, unless he or she objects to the petition.[61]

There is no review on admission of a Ward. See section 6.5.5 below in relation to reviews post admission.

6.5.4 Codes of practice

Mental Health Act 2001

A duty is placed on the Mental Health Commission to prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services,[62] ensuring current evidence-based practice is more likely to be in place.[63] Section 33 specifically provides that "*the principal functions of the Commission shall be to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act*".

Wardship

While the Office of Wards of Court has charge over the day-to-day running of affairs affecting wards, no similar oversight or mechanism as that in section 33 of the Mental Health Act 2001 exists that would allow current best practice to be discerned and shared.

[61] See Chapter 3.2 for further discussion.
[62] Section 33(3)(e).
[63] E.g. Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre See http://www.mhcirl.ie/for_H_Prof/codemha2001/ for list of codes published. [Accessed 24 April 2017].

6.5.5 Review and exit from detention

Mental Health Act 2001

Until the commencement of the Mental Health Act 2001, there was no statutory provision for independent judicial or quasi-judicial review of a decision to admit a person involuntarily for treatment. The only manner in which such a person could seek to review the decision was by way of a habeas corpus.[64] Now, in practice, statutory review of detention and treatment of patients with a mental disorder[65] under the Mental Health Act 2001 takes place.

Section 15(1) of the Mental Health Act 2001 authorises the making of an admission order for the reception, detention and treatment of a patient for a period of 21 days. The order may subsequently be extended for periods no longer than three months, then up to six

[64] Bulbia, The Mental Health Act 2001, *The Bar Review 2005, 10(1), 8-12.*

[65] Mental disorder as defined in Section 3 of the Mental Health Act 2001:

3.—(1) In this Act "mental disorder" means mental illness, severe dementia or significant intellectual disability where—

(*a*) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or

(*b*) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and

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

(2) In *subsection (1)*—

"mental illness" means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons;

"severe dementia" means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;

"significant intellectual disability" means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person.

months and thereafter periods of up to 12 months.[66] This means that where an individual is involuntarily detained under the Mental Health Act 2001, a Mental Health Tribunal is held, ensuring periodic statutory review of the detention of the person, at least every 12 months. Should a Mental Health Tribunal affirm an order made in respect of a person, he or she has a statutory right to appeal to the Circuit Court against that decision on the grounds that he or she is not suffering from a mental disorder.[67]

Pursuant to section 18 of the Mental Health Act 2001, the Mental Health Tribunal encompasses a review of whether the individual is suffering from a mental disorder and whether the statutory process has been complied with. There is a recognition of the importance of both the safeguarding procedures and the substantive rights of the individual: in the case of *WQ v Mental Health Commission,*[68] the Court held, among other things, that only minor procedural defects may be excused by a Mental Health Tribunal.

Since May 2017, however, the High Court has held that the Mental Health Act 2001 is incompatible with Article 5.4 of the European Convention on Human Rights, which provides for the right to a speedy review of detention. In the case of *A.B. v Governor of St Loman's Hospital & Ors,*[69] a Mental Health Tribunal made a decision on the 30th March 2016 to continue the detention of A.B., a significantly intellectually disabled man who was detained in a psychiatric unit. A.B. appealed the decision to the Circuit Court, which affirmed the order of the Tribunal on the 28th July 2016. This meant that A.B. had to wait 12 months from the date of the Tribunal decision (or eight months from the Circuit Court decision) until his detention would be reviewed again.

The High Court made a declaration that because Part 2 of the Mental Health Act 2001 did not provide for an entitlement for detained individuals to initiate a review of their detention after the exhaustion of their right to appeal to the Circuit Court, that this was incompatible with Article 5.4 of the European Convention on Human Rights.[70]

[66] The Expert Group on the Review of the Mental Health Act 2001believes that a period of 12 months for a renewal order is too long. It has recommended that this be reduced to a period not exceeding 6 months — Recommendation 67, Report of the Expert Group on the Review of the Mental Health Act 2001, http://www.mhcirl.ie/File/rpt_expgroupreview_mha2001.pdf.
[67] s.19.
[68] [2007] 3 IR 755.
[69] Unreported judgment of Binchy J, 3rd May 2017.
[70] Ibid, para 145.

Notwithstanding this issue, there are four situations where individuals do not benefit from the safeguards under the Mental Health Act 2001:

1. Where an individual with a mental disorder is admitted on a voluntary basis but where there are concerns over whether the individual has capacity to admit themselves voluntarily. These people are often kept in the same facilities and the same circumstances as those who are involuntarily detained, yet their admission is not subject to review.[71]
2. Where an individual with a mental health condition such that he or she poses a risk to himself or herself or to others, and thereby requires to be detained[72] but where the mental condition does not come within the definition of a mental disorder under the Mental Health Act 2001.[73] For example, a personality disorder is excluded by section 8(2) of the Act.[74] Where an application comes before the High Court in relation to these individuals, the High Court — where appropriate — detains the individual under the Wards of Court jurisdiction (see below), or to a lesser extent, the inherent jurisdiction (see below).
3. A person who is involuntarily detained but is also a Ward of Court due to lack of capacity.
4. Where an individual is placed in a care home, residential institution or nursing

[71] See below in De Facto detention for further discussion.
[72] It also arises where an individual requires medical or therapeutic intervention but who lacks capacity to consent to this.
[73] See note 65.
[74]

8.—(1) A person may be involuntarily admitted to an approved centre pursuant to an application under *section 9* or *12* and detained there on the grounds that he or she is suffering from a mental disorder.

(2) Nothing in *subsection (1)* shall be construed as authorising the involuntary admission of a person to an approved centre by reason only of the fact that the person—

(*a*) is suffering from a personality disorder,

(*b*) is socially deviant, or

(*c*) is addicted to drugs or intoxicants.

home, and is unable to leave of their own accord. This amounts to *de facto* detention.[75]

The question arises whether individuals who are admitted and or detained in those circumstances should be entitled to the same review procedures as those who are involuntarily detained under the Mental Health Act 2001.

Summary:

- The Mental Health Act 2001 provides for the review of individuals who are involuntarily detained under the Act.
- For those individuals, there is review on admission. For long-term detentions, there is review by a Mental Health Tribunal every 12 months. The interval of 12 months has recently been held by the High Court to be incompatible with Article 5 of the European Convention on Human Rights, which provides for the speedy review of detention.
- The review under the Mental Health Act 2001 is not available to individuals who are admitted voluntarily.
- The review under the Mental Health Act 2001 is not available to individuals who have a mental health condition that does not come within the definition of mental disorder of the Mental Health Act 2001, and so are detained as a Ward of Court (see below) or under the inherent jurisdiction (see below).
- The review under the Mental Health Act 2001 is not available to an individual who is involuntarily detained but is also a Ward of Court due to lack of capacity.
- A review of detention is not available to individuals who experience de facto detention.[76]

[75] See below in De Facto Detention for further discussion.
[76] Ibid note 10.

Wardship

The 1871 Act provides for the President of the High Court to direct a visitor to visit a person after they have been made a Ward of Court[77], but the practice of an automatic periodic review has fallen into abeyance for very many years.

Section 56 of the 1871 Act provides that there is a duty on medical visitors, under the direction of the Registrar of Wards of Court — who should decide the frequency and manner of the visit — to visit Wards and to inquire and investigate into their care, treatment, mental and bodily health, and the arrangements for their maintenance and comfort.

Section 57 provides for the review of Wards, in two particular circumstances:

(a) where a Ward is resident in a psychiatric hospital that is publicly funded. In those circumstances, the Ward must be visited at least once a year by a medical visitor. Where the Ward is compulsorily admitted, it is the duty of the medical visitor to see the Ward without notice to the persons detaining him or her.[78]

(b) Where a Ward is resident in a private hospital, she or he must be personally visited and seen by the medical visitor at least four times annually, and the intervals between successive visits must not exceed four months.[79]

Section 58 provides that after each visit, the medical visitor must report to the President on the state of mind and bodily health, general condition and also of the care and treatment of each person visited.

These sections provide for a general system of review of all Wards. The provisions require a review of the "state of mind" of the Ward, so it could be understood that a review

[77] Section 56.
[78] General Order, June 27, 1879.
[79] The distinction between private and public has been replaced by 'approved centre' as defined in the Mental Health Act, but unfortunately, the review process under the 1871 Act was not continued.

means a review of the Ward's capacity, as well as of his or her bodily health and the conditions that he or she lives in. As stated, such reviews have long fallen out of practice.

However, if a Ward is subject to a detention order, then the Ward's detention is subject to review. There are two groups of Wards who are subject to detention orders:

(1) Historically, it had been standard practice to subject every Ward to a detention order. This practice was stopped in 2000.[80] There remain some Wards in this group. We understand that it was not until 2014 that these historical detention orders began to be reviewed by the President and the Office of the Wards of Court. It is anticipated that most of these detention orders will be discharged by early 2018.

(2) Since 2000, detention orders were only applied to Wards in exceptional circumstances.[81] However, we understand that it was not until 2014 that a review process was initiated in relation to these Wards, whereby any Ward who is the subject of a detention order has that order reviewed at least every six months by the President in open Court. This seeks to replicate the review under the Mental Health Act 2001 and improves on that system of review in that the intervals are every six months rather than every 12 months (vindicated by the judgment of Binchy J in *A.B. v St Loman's Hospital*[82]).

Other safeguards, available to persons detained under the Mental Health Act 2001, are not available to detained Wards, notably independent legal representation. Another difference is that while a review by a Mental Health Tribunal takes place in the centre where the individual is detained, a review by the President takes place in the High Court.

The Office has not produced an outline of what safeguards are automatically available to a Ward who is detained. It seems, therefore, that (apart from the review every six months) the safeguards are put in place on an individual basis, by order of the Court and in that respect appear to be discretionary, in much the same way that the inherent jurisdiction is

[80] Following *Croke v Ireland* 33267/96 [2000] ECHR [European Convention on Human Rights] 680 wherein the applicant invoked Articles 5.1 and 5.1(e) and 5(4) of the Convention alleging that as a psychiatric detainee he had the right to have available to him reviews which comply with the requirements of Article 5 of the Convention, and that domestic law was deficient in this respect.
[81] In 2016, 33 detention orders were issued in respect of 16 people who are Wards of Court.
[82] Ibid note 47.

(see below). It is noteworthy that it took eight years after the commencement of the Mental Health Act 2001[83] before the Office of the Wards of Court implemented a system of review of detained Wards.

Should a Ward wish to be discharged from wardship, he or she must instigate the application and support it with two capacity assessments from the practitioners who assessed him or her for the purposes of the petition.[84]

We understand that the current President is initiating a pilot scheme whereby all Wards will be subject to unannounced visits from a panel of general practitioners (GPs), whereby the GP is asked to report on the mental state and physical condition (treatment and living conditions) of the Ward. Reviews will operate on a random basis.

Summary:

- There is statutory provision for the review of Wards, in relation to:
  - state of mind / mental health
  - bodily health
  - care and treatment.
- These provisions fell into abeyance. At the time of writing, there is no scheme of review of Wards generally; the only Wards that are subject to review are those who are subject to a detention order.
- The Office of the Wards of Court began the review of historical detention orders in 2014 and anticipates a discharge of these reviews by the start of 2018.
- Since 2000, detention orders are only applied to Wards in exceptional circumstances. Since 2014, these orders have been subject to review in open Court at six-month intervals, to correspond to (and improve) the Mental Health Act 2001's system of review at 12-month intervals. Detained Wards do not have the benefit of other safeguards under the Mental Health Act 2001, notably independent legal representation.

[83] The 2001 Act was commenced in 2006.
[84] O67, r. 93. O'Neill in *Wards of Court in Ireland*, First Law (2004) describes the process as informal, and that the Ward is required to provide just one medical report, without specifying that it needs to be by the practitioner who made the assessment which the petitioner relied on. However, Former Ward A's experience of discharge was that she was required to provide two medical reports, both by the practitioners who had assessed her for the purposes of the petition.

- The current President of the High Court is initiating a scheme of review where Wards will be visited by GPs on a random, unannounced basis. There will be reviews of the Ward's capacity, as well as his or her care and treatment.

6.6 Inherent jurisdiction

While the criteria for wardship are set out in the 1871 Act, and the procedure for bringing a person into wardship is set out in Order 67 of the Rules of the Superior Courts, the source of the jurisdiction is less clear.

Wardship originated as a Crown prerogative known as *parens patriae*, which was concerned with acting as guardian of the people and, by inference, especially of those unable to look after themselves.[85] Finlay C.J. in *In re D*[86] stated succinctly the position today, that "[t]he jurisdiction of the High Court in lunacy matters is provided for in s. 9 of the Courts (Supplemental Provisions) Act, 1961".[87]

The nature of the jurisdiction has been the subject of some discussion. Geoghegan J in the Supreme Court[88] said:

> "Given the nature of the new State, I am of opinion that that section must be given a broad interpretation and it must cover the jurisdiction exercised by the Lord Chancellor in relation to persons of unsound mind irrespective of whether the 1871 Act applied to the case in point or not."[89]

[85] Law Reform Commission Consultation Paper, *Law and the elderly*, LRC CP 23-2003, 2003, paragraph 4.04-4.13 discusses the origins and present day nature of the jurisdiction.
[86] *In Re D* [1987] I.R. 449.
[87] Section 9 states:
'(1) There shall be vested in the High Court the jurisdiction in lunacy and minor matters which -
(a) was formerly exercised by the Lord Chancellor of Ireland,
(b) was, at the passing of the Act of 1924, exercised by the Lord Chief Justice of Ireland, and
(c) was by virtue of subsection (1) of section 19 of the Act of 1924 and subsection (1) of section 9 of the Act of 1936, vested, immediately before the operative date in the existing High Court.
(2) The jurisdiction vested in the High Court by subsection (1) of this section shall be exercisable by the President of the High Court or, where the President of the High Court so directs, by an ordinary judge of the High Court for the time being assigned in that behalf by the President of the High Court.'
[88] *In the Matter of Wards of Court and In the Matter of Francis Dolan* [2007] IESC 26.
[89] Ibid.

In the same judgment,[90] Geoghegan J refers to a Law Reform Commission consultation paper:[91]

> "Even if the *parens patriae* jurisdiction did not survive past 1922, it can be argued that the legislation outlined in the passage quoted from Hamilton C.J. at paragraph 4.04 (this was in the Supreme Court appeal *In the Matter of a Ward of Court (Withholding Medical Treatment*) (No. 2) [1996] 2 I.R. 79) provided a statutory basis for a new, but similar, jurisdiction which is now vested in the President of the High Court. Alternatively, it may be that the President's authority in this field should be grounded in the inherent jurisdiction of the Court, whereby the Court is empowered to step in to protect an individual's personal rights under Article 40.3 of the Constitution." [92]

However, in commenting on the limits of the inherent jurisdiction, Laffoy J in *Re FD*[93] said:

> "Neither the nature of the High Court's judicial function nor its constitutional role in the administration of justice, in my view, permits the recognition of an inherent jurisdiction in the High Court to make provision for the protection of persons with mental incapacity outside the wardship process by, for example, sanctioning the establishment of a trust to protect the assets of a person believed to be incapable of managing his or her own property affairs."[94]

The inherent jurisdiction has been used in cases concerning people requiring medical or therapeutic interventions and who lacked capacity to consent to this. *HSE v KW* [95]and *HSE v JB,*[96] are two cases concerning minors who had been sent for treatment for personality disorder in the UK and who had now attained the age of majority and wished to return to Ireland.

[90] Ibid.
[91] Law Reform Commission Consultation Paper, *Law and the elderly*, LRC CP 23-2003, 2003, paragraph 4.04-4.10.
[92] Ibid note 66.
[93] [2015] IR 741.
[94] Ibid, at paragraph 32.
[95] *Health Service Executive v K.*W *(Respondent) and L.R. and J.T. (Notice Parties) and Raymond McEvoy Guardian ad litem on behalf of K.W.* [2015] IEHC 215; High Court, O'Hanlon J., 12 March 2015.
[96] [2015] IEHC 216.

In ordering the detention of *KW* in a psychiatric facility in this jurisdiction, to facilitate her to transition back to living in Ireland, O'Hanlon J held that:

- The criteria that the Court must consider in determining whether an individual has capacity are those set out in *Fitzpatrick v FK* [2009] 2 I.R.7.
- On an application of these criteria, the Respondent lacked capacity, which went to her failure to appreciate the seriousness of her condition. The Respondent lacked capacity to appreciate the benefit of others taking decisions on her behalf and lacked the capacity to express a decision that was the product of understanding relevant information, reasoning and appreciating the importance of the decision for her.
- As the Respondent lacked capacity, her best interests and personal rights under Article 40 of the Constitution were endangered such that necessitated the intervention of the Court. The Court had a duty to intervene to vindicate the Respondent's rights in a proportionate manner.
- The Respondent as a citizen of Ireland has a constitutional right to live in the State, which the Court had an obligation to vindicate.
- A proportionate response required the Respondent to be allowed return to this jurisdiction over a transitional period of three months and that the Respondent be detained, under the inherent jurisdiction of the Court, as an involuntary psychiatric patient in an appropriate adult psychiatric ward.

O'Hanlon J. reached a similar conclusion in *HSE v JB,*[97] again identifying the importance of the inherent jurisdiction in protecting JB's constitutional rights.

When an individual is detained under the inherent jurisdiction, his or her review is determined by the presiding judge. The application of this jurisdiction is entirely discretionary, and so is the application of any safeguards. In cases such as these, it is typical to see the Court assign a guardian ad litem[98] (who will usually have legal representation) to the individual at the centre of the proceedings. It is also typical to see

[97] [2015] IEHC 216; also discussed at Chapter 6.6.
[98] A guardian appointed by the court to protect the interests of a minor or person lacking capacity in a particular matter.

the Court retain control of the matter by putting in place a review schedule with intervals of one, three or six months. In the case of *HSE v J O'B*, for example, Birmingham J put in place a review schedule of every two months, which he said would be reconsidered once a routine for the Respondent had been established.[99]

Because of the discretionary nature of the jurisdiction, and consequently of the safeguards, in recent years, the High Court has relied on the inherent jurisdiction to a lesser extent, preferring to use the statutory provisions of the Ward of Court system instead (notwithstanding the difficulties with that as set out above).

There are some exceptional circumstances where the High Court will use the inherent jurisdiction. In a recent case,[100] the Court could not assess whether a woman had capacity with a view to making her a Ward of Court.

Kelly P. indicated that, in those circumstances, he could not make her a Ward of Court but would exercise the Court's inherent jurisdiction to try and mirror the wardship process as much as possible in relation to her care. He appointed the HSE's solicitor in a role akin to a wardship committee to assist the Court in making decisions on her welfare and managing her financial affairs. He also made permissive orders allowing the nursing home to treat the woman as a resident and arranging for hospital and medical treatment for her should she require that.

6.7 In the matter of A.M. - A proposed Ward of Court [2017] IEHC 184

The case of *AM - A Proposed Ward of Court*[101] is illustrative of how the rights of an individual can traverse the three jurisdictions of wardship, inherent jurisdiction and the Mental Health Act 2001.

In that case, A.M. had been detained in the high-security unit of the Central Mental

[99] [2011] IEHC 73 (Unreported, Birmingham, 3rd March 2011), page 12.
[100] HD, 30 January 2017.
[101] [2017] IEHC 184 Kelly P, 27th March 2017.

Hospital following convictions for manslaughter and serious assaults. At the conclusion of his sentence, the risk that his mental illness posed to the public and to himself meant he could not be released. On 10th November 2016, President Kelly made a temporary detention order in the context of an intended petition to have A.M. taken into wardship.

The HSE sought to have A.M. taken into wardship as it claimed that there was no other way of legally detaining A.M. in the Central Mental Hospital. The admission procedure under the Mental Health Act 2001 does not provide for direct admission to the Central Mental Hospital, which is a tertiary or referral hospital. The Mental Health Act 2001 provides, under Section 10, that where a registered medical practitioner is satisfied that a person is suffering from a mental disorder, that the person be involuntarily admitted to an approved centre (other than the Central Mental Hospital). Section 21 then provides for the director of an approved centre to refer a patient on to the Central Mental Hospital.

In the circumstances of A.M., the HSE contended that to be compliant with the Mental Health Act 2001, A.M. would have had to be transferred to an approved centre, temporarily, and then referred back to the Central Mental Hospital. Dr Henry G. Kennedy, the Director of the Central Mental Hospital swore an affidavit to say that no approved centre was willing to take A.M., even on a temporary basis, and even with extra safeguards in place. The route that the HSE therefore sought was to make A.M. a Ward of Court so that the President could detain him in the Central Mental Hospital under that jurisdiction.

Counsel for A.M. submitted that it was not necessary or appropriate to take A.M. into wardship, and that the application to do so would circumvent the provisions and safeguards of the Mental Health Act 2001. Counsel submitted that it would be possible to overcome the procedural problem of admittance by using the Court's inherent jurisdiction to detain A.M. in tandem with the Mental Health Act 2001's admittance procedures.[102] The President declined to do so on the basis that he had no jurisdiction to make such a free-standing order. He pointed out that the jurisdiction to detain A.M. under the order made on the 10th of November 2016 was in the context of an intended wardship application.

[102] It seems that neither side proposed making A.M. a temporary Ward to overcome the procedural problem, provided for under Section 103 of the Lunacy Regulation (Ireland) Act 1871.

The President felt that the requested order "would not have been legally justified".[103]

Counsel for A.M. also submitted that the safeguards of an individual such as A.M. in place in the Mental Health Act 2001 were superior to any as a Ward of Court. The President did not agree. In his judgment of 27th March 2017, he noted that:

> "First, the detention of a ward pursuant to s.9 has to be operated in a manner consistent with the Constitution and with the European Convention on Human Rights. This is achieved in part by a system of regular review. Certainly since I took up my present office I have made it clear that any orders made for the detention of a ward of Court must be subject to regular reviews at least every six months. In many cases a shorter period of review has been ordered. On such review there is an entitlement on the part of the ward to appear and or to be represented. Each review involves a report being presented to the Court by the treating consultant psychiatrist, the contents of which are made known to the committee of that ward. If necessary, the psychiatrist will be required to give oral evidence. If I have any doubts concerning the report presented it is open to me to order a Medical Visitor to conduct an examination and to make a separate and independent report to me on the condition of the Ward.
>
> In addition, detention orders made under the wardship jurisdiction are just that. They do not authorise the use of restraint unless such an order is specifically sought and then it is granted only on appropriate evidence as to its necessity being tendered.
>
> Furthermore, all detention orders are made with liberty to all interested parties to apply on very short notice. Certainly never more than 48 hours' notice is required in order to apply to Court. In practice it is often a much shorter notice period that is involved.
>
> Indeed, I believe it may be said, that in some respects the entitlements of a ward

[103] Ibid, note 101, paragraph 52.

> of Court subject to a detention order are superior to those of a person detained under the Act. A long-term detainee under the Act has his position reviewed every 12 months. The review period for a ward of Court is never more than six months. In addition, the ward of Court has immediate access to the High Court if any change in circumstances occurs whereas there is no such automatic entitlement to a patient detained under the Act."[104]

In discussing the jurisdiction of the Mental Health Act 2001 and that of wardship,[105] in *AM - A Proposed Ward of Court*[106] Kelly P stated as follows:

> "There is nothing contained in the [Mental Health] Act which interferes with the jurisdiction of this Court under s.9 (1) of the 1961 Act. Neither expressly nor by implication is the jurisdiction conferred under s.9 (1) of the 1961 Act fettered or diluted by the provisions of the Act. They are two separate jurisdictions albeit that they both deal with persons of unsound mind. The legislature has chosen to have these two separate jurisdictions exist in parallel and either may be used as appropriate. It is a question of which is the more appropriate or effective in a particular case. That will fall to be decided on a case-by-case basis." [107]

We understand that this judgment is subject to appeal. A number of issues arose both in relation to the judgment of 27th March 2017 and subsequent to the judgment:

- In the course of the hearing, submissions were made to the President by the Respondent in relation to safeguards that were provided in the Mental Health Act 2001, but which the President did not address in his judgment. For example, it was put to him that under section 4(2) of the Mental Health Act 2001, where there is a proposal to administer treatment to a person, there is an obligation to consult with the person and to get the person's view on the proposal, so far as is reasonably practicable. It would appear that for such a safeguard to apply in relation to a Ward, a specific, discretionary order would have to be made. However, it was not

[104] Ibid, note 101, paragraph 56-59.
[105] Jurisdiction derives from s.9 (1) of the 1961 Act.
[106] Ibid, note 101.
[107] Ibid, note 101.

addressed by the President in his judgment whether such discretionary orders are made in relation to detained Wards.

- Subsequent to the President's judgment, we understand that it was brought to his attention that the High Court (Moriarty J.) had made an order on the 6th May 2016, in a separate case where there were also difficulties in relation to the detention of an individual under the Mental Health Act 2001. The order of Moriarty J was in the terms that were being sought by the Respondent in A.M.: in other words, Moriarty J used the inherent jurisdiction in tandem with the Mental Health Act 2001 to detain the individual.
- Subsequent to the President's judgment, we understand that on 7th April 2017 the HSE applied for ancillary orders in relation to the Respondent. The orders sought, among other things, that the Central Mental Hospital should treat the Respondent as if he had been detained under the Mental Health Act 2001. This appears to be recognition by the HSE of the value of the statutory safeguards of the Mental Health Act 2001.

These issues highlight the complexity of detaining Wards where there are statutory safeguards potentially available to them in the Mental Health Act 2001. Ultimately, the HSE appears to have sought to overcome these difficulties by incorporating the safeguards of the Mental Health Act 2001 into the wardship system by order. However, it is unclear which jurisdiction has priority, for instance in relation to review: should the Mental Health Tribunal conduct reviews, or the High Court? It remains problematic and unclear.

Furthermore, once the 1871 Act is repealed, in the Assisted Decision-Making (Capacity) Act 2015, Part 10 requires that the procedures in the Mental Health Act 2001 must be followed in any situation before the Court where a relevant person may be detained (see below at 6.11). This seems another persuasive argument for detaining under the Mental Health Act 2001 rather than wardship, even where the inherent jurisdiction is required to overcome procedural problems with the Mental Health Act 2001. The guiding principles of the Assisted Decision-Making (Capacity) Act 2015[108] provide for the least restrictive intervention into a person's rights.

[108] See section 8(6) for the guiding principles of the Assisted Decision-Making (Capacity) Act 2015.

6.8 De facto detention

De facto detention arises where people are detained as a matter of fact, as opposed to under a legal or statutory order or regime.

People who are the subject of detention orders are not the only people to experience deprivation of liberty. In the UK, a system of Deprivation of Liberty Safeguards operates, and the test which governs whether an individual is entitled to those safeguards is:

> (a) whether the person is subject to continuous supervision;
> (b) whether the person is free to leave.[109]

Despite Article 40 of the Constitution of Ireland and Article 5 of the European Convention on Human Rights, Ireland — at the time of writing — has no such consideration in law of the realities of detention for people in psychiatric units, nursing homes and congregated settings. [110] Where a decision is made that a vulnerable adult will reside in a psychiatric unit, nursing home or congregated setting, there is no means to appeal that decision. There is no system of review of that decision.

Voluntary patients in psychiatric units

According to an article in *The Irish Times,*[111] written by Mary Donnelly in 2012, each year there are about 20,000 admissions to Irish psychiatric hospitals and units, and of those approximately 90 per cent are voluntary admissions. Unlike involuntary detentions, these voluntary admissions are not subject to any review:[112]

> "We do not know how many of these patients lack the mental capacity to consent

[109] *P v Cheshire West and Chester Council and another and P and Q v Surrey County Council* [2014] UKSC 19.
[110] The Department of Health opened a public consultation in December 2017 on Deprivation of Liberty: Safeguard Proposals and Draft Heads of Bill of Part 13 of the Assisted Decision-Making (Capacity) Act 2015, http://health.gov.ie/wp-content/uploads/2017/12/Public-Consultation-paper-on-draft-deprivation-of-liberty-proposals.pdf [accessed December 2017].
[111] 'Voluntary' psychiatric patients need protection, 9th February 2012.
[112] See above at 6.3 for further discussion.

> to admission. Nor do we know how many patients who have capacity have genuinely chosen to be admitted and how many have agreed to be admitted voluntarily to avoid the stigma of involuntary admission."[113]

Donnelly's article was written in the context of *PL v St. Patrick's University Hospital,*[114] where the High Court held that a voluntary patient in a psychiatric hospital was not held unlawfully despite having made several attempts to leave the locked unit. This decision is under appeal at the time of writing.

In Irish law, there is no recognition that voluntary patients are often kept in the exact same circumstances, and with the exact same restrictions on their liberty, as involuntary patients. Furthermore, there seems to be little recognition within the medico-legal system of the complexities of whether a voluntary patient has capacity to give a valid consent to treatment.

Nursing homes

It is generally accepted that most people do not want to move into a nursing home, or live in an institution. A survey by the National Council on Ageing and Older People[115] showed that 87% of people said they wanted to continue to live in their own homes. In a 2012 NCPOP survey[116] on staff-resident interactions and conflicts in nursing homes, one of the most frequently reported conflicts was that of preventing an older person from leaving the home in which they were receiving care.[117] In 2016, an 86-year-old nursing home resident called RTÉ's *Liveline* radio programme[118] stating her wish to return to her own home, but, as she perceived it, she "needed one of her family to sign her out".

At the recent Citizen's Assembly,[119] two people gave testimony about their experiences of

[113] Ibid note 111.
[114] [2014] 4 IR 385.
[115] Garavan et al, *The Health and Social Services for Older People*, 2001 ("The HeSSOP report").
[116] Drennan et al, *Older People in Residential Care Settings: Results of a National Survey of Staff-Resident Interactions and Conflicts*, National Centre for Protection of Older People, 2012 http://www.ncpop.ie/userfiles/file/Older%20People%20in%20Residential%20Care%20Settings_Final%20Proof_28Nov2012.pdf.
[117] The other most frequently reported conflict was dealing with a resident who was unwilling to dress.
[118] Liveline — 3 November 2016: http://www.rte.ie/radio1/liveline/podcasts/.
[119] *How We Best Respond to the Challenges and Opportunities of an Ageing Population*, 10th June 2017.

nursing homes. The first, an 86-year-old women, described how she entered a nursing home in Dublin on a temporary basis, as she had a pain in her hip, and she believed her children wanted her to stay there on a longer-term basis. “Another month ended up into 10 months,” she maintained.

The woman said she made two attempts to go home but was stopped. She spoke to a Sage advocate who advised her that the nursing home had no authority to stop her from leaving. “My case was packed for a whole month or six weeks, before they let me go.” The woman said she got a taxi to her home in the south of Ireland, which cost her €320. She maintained that her children “weren’t very pleased..... They thought I was taking things too much in my own hands. But now they see that I’m happy”.

The second person, a 95-year-old man, entered into a nursing home of his own volition. “This was a factual situation where I couldn’t live at home because I didn’t have the medical support you get in a nursing home,” he said. The man spoke positively of his experience of the nursing home system and had a practical outlook: “You are in a community of 40 to 60 people, who may not be the people you would select to associate with every day of your life. You are here 24/7 with those people. You have to learn to adjust, if you can. There are different degrees of illness and you must recognise that. You will find people who are not mentally capable and they are relying on staff and management to look after them and make decisions for them.”

De facto detention in nursing homes whereby people are unaware of their right to leave of their own accord, or where the doors are locked to prevent “wanderers” from absconding, appears to exist in some cases, notwithstanding that the standard of care within the centre might be excellent. The adage that “a gilded cage is still a cage” appears apt.

The prominence of temporary (agency) staff in nursing homes leads to a lack of continuity of care, so that people working in the home do not get to know the individual, their routines, wishes or preferences.

A person in charge of the nursing home (or designated centre[120]) may exercise such control over the residents that they are, to all intents and purposes, a place of detention as well as care. The culture may be one of control and best interests because the will and preferences of individuals is either too difficult or impossible to establish. There is little recognition by service providers that a decision to prevent an individual from absconding may amount to de facto detention. There is no system of review or appeal in relation to these decisions.

Congregated settings

In 2015, over 3,000 people with disabilities were living in congregated settings, and for 93% of those, intellectual disability is their main disability.[121] A congregated setting is where 10 or more people with a disability are housed in a single living unit, or placed in accommodation that is based in a campus or institution.

In 2011, the HSE published a report, *Time to Move on from Congregated Settings*,[122] which found that many people with a disability living in congregated settings live isolated lives, segregated from the community and family. Many experience institutional living conditions where they lack basic privacy and dignity.

The TILDA Institute at Trinity College Dublin, which carries out The Longitudinal Study on Ageing, has found that people living in institutional settings were more likely to feel excluded than those living in independent or family residences.[123] It also found that the most critical social partners in the lives of older people with an intellectual disability are paid staff (75.4%), friends with whom people live with (53.4%) and family members (32%).[124] A further finding is that older people with intellectual disabilities are three times more likely than the general population to be on five or more medications.[125]

[120] "Designated centre" is defined in section 2 of the Health Act 2007. This Act, together with associated regulations, is the main governing legislation for nursing homes and residential services for people with disabilities.
[121] Inclusion Ireland, Congregated Settings Fact Sheet, 2015.
[122] Report of the Working Group on Congregated Settings.
[123] Advancing Years, Different Challenges: Wave 2 IDS-TILDA, Findings on the ageing of people with an Intellectual Disability, page 3.
[124] Ibid.
[125] Growing Older with an Intellectual Disability in Ireland 2011, IDS-TILDA, page 93.

A *Prime Time Investigates* report in December 2014, entitled "Inside Bungalow 3", exposed physical and verbal abuse happening in the congregated setting of Áras Attracta, Swinford, Co Mayo. In 2015, some 20 congregated settings were facing the prospect of closure after HIQA issued them with proposals to cancel or refuse their applications for registration, due to failings in compliance with standards.[126]

The HSE's Time to Move On report recommended a new model of accommodation and support in the community, where individuals are enabled to live in a home of his or her choice and have individualised supports to enable his or her integration into the community. A seven-year time frame was planned for the full implementation of the recommendations. At the time of the report, in 2011, there were 4,000 people living in a congregated setting. The figure is now down to 2,500 at the time of writing. There are a number of issues with this, as follows:

1. The recommendations of the report are unlikely to be delivered within the seven-year time frame, which runs out next year.
2. The reduction in residents in congregated settings is not all down to people moving to community settings. Many people have died and many have moved into nursing homes.
3. The report recommended that a maximum of four residents who *choose* to share accommodation should live together in community settings. Despite this, 59%[127] of people who have moved to community settings have moved into accommodation for at least five people. It is not clear whether each individual chose that setting, and if there is a procedure to determine and record how that choice was made.[128]
4. Despite the strong recommendation in the report that there should be no new admissions into congregated settings, between 2012–2014, there were 55 new admissions, while in 2015, a total of 41 admissions were made.[129] Some of these were new admissions while some were re-admissions.

[126] *The Irish Times*, "Inspectors find failings in every HSE disability care home", 13th August 2015.
[127] Between January 2012 and March 2014. Maloney, S., *Presentation to the Moving Ahead Seminar*, November 2014.
[128] Ibid note 122, at page 9: "Most individuals with ID reported not participating in choosing the new location to live and that they were not part of the decision to move."
[129] HSE, Performance Report Oct–Dec 2016; HSE, Progress report on the implementation of Time to Move on from Congregated a strategy for community inclusion, Annual Report for 2015, 2017.

5. The 2016 Programme for Partnership Government[130] includes a new de-congregation target: it aims to reduce the number of people living in a congregated setting by one third by the year 2021. This is an admission of the failure of the policy as set out in the 2011 report, and a deferment of the rights of individuals to live self-directed lives.

Where an admission is made to a congregated setting, or a decision that an individual should remain in a congregated setting, there is no system of review or appeals of that decision.

As well as the institutionalisation of those who lack capacity, issues of deprivation of liberty may arise within any of the above settings in a number of forms: sedation, physical restraint, monitoring, and restricted opportunities for access to fresh air.

The importance of an appropriate legal framework is clear in light of the potential for abuse and the vulnerability of the Ward and also non-Wards in these facilities.

6.9 Deprivation of Liberty Safeguards in the UK

The UK case of *HL v United Kingdom*[131] ("the Bournewood decision") initiated legislative change under the Mental Capacity Act 2005 in what ultimately became known as the Deprivation of Liberty Safeguards ("DoLS"). These provide that a care setting[132] applies to a local authority for a DoLs authorisation for a deprivation of liberty.

The Deprivation of Liberty Safeguards have been criticised for being overly technical and legalistic. The UK Law Commission[133] has recently recommended an overhaul of that system and proposes to introduce Liberty Protection Safeguards in their stead. One major change to the final scheme from the Commission's initial proposals is a shift from a system of automatic Court review to realise the Article 5(4) rights of detained persons. This would be a system whereby advocates or appropriate persons are appointed to assist the person

[130] May 2016, Page 72.
[131] (2005) 40 EHRR 32 (App no. 45508/99).
[132] The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.
[133] *Mental Capacity and Deprivation of Liberty* Law Com No 372, 2017, www.gov.uk/government/publications.

in exercising their rights of appeal, and must support them to do so if they wish to challenge their detention, regardless of their prospects of success.

6.10 New legislation

The UN High Commissioner for Human Rights has taken the view that article 14 of the UN Convention on the Rights of Persons with Disabilities[134] requires the repeal of any legislation that authorises the institutionalisation of people with disabilities on the grounds of their disability without their free and informed consent.[135]

Article 14 of the Convention states that:

> 1. State Parties shall ensure that persons with disabilities, on an equal basis with others:
> (a) Enjoy the right to liberty and security of person;
> (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
> 2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

The Committee on the Rights of Persons with Disabilities, in its draft General Comment on Article 14[136] and the right to independent living, has provided a useful definition of institutionalisation:

> "Institutionalization is not about living in a particular setting, it is, first and foremost, about losing control as a result of the imposition of a certain living arrangement.

[134] United Nations Convention on the Rights of Persons with Disabilities.
[135] UN High Commissioner for Human Rights, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities (OHCHR Legal Measures Study)*, UN Doc A/HRC/10/48, 26 January 2009 at paragraphs 48 and 49. http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf [Accessed 05 April 2017].
[136] 2017.

> Therefore, neither large scale institutions with more than a hundred residents nor smaller group homes with five to eight individuals can be called independent living or community living arrangements. Although institutionalized settings can differ in size, name and setup, there are certain defining elements, such as: isolation and segregation from community life, lack of control over day-to-day decisions, lack of choice over whom to live with, rigidity of routine irrespective of personal will and preferences, identical activities in the same place for a group of persons under a certain authority, a paternalistic approach in service provision, supervision of living arrangements and usually also a disproportion in the number of persons with disabilities living in the same environment. Institutional settings may offer persons with disabilities a certain degree of choice and control, however, these choices are limited to specific areas of life and do not change the segregating character of institutions."

Progress to ratification of the UN Convention on the Rights of Persons with Disabilities in Ireland has been painstakingly slow to date,[137] notwithstanding the enactment of the Assisted Decision-Making (Capacity) Act 2015. Ireland is now the only country in the EU that has not ratified the Convention.

One of the key pieces of legislation that the Irish Government has stated needs to be enacted prior to ratification is one that deals with detention in residential care facilities. As set out above, there is no statutory review or appeals framework for where a decision has been made that a patient should not leave residential care facilities for health and safety reasons. It is intended that this be addressed by the introduction of a new part to the Assisted Decision-Making (Capacity) Act 2015.[138]

[137] See Department of Justice *Roadmap to Ratification* http://www.justice.ie/en/JELR/Roadmap%20to%20Ratification%20of%20CRPD.pdf/Files/Roadmap%20to%20Ratification%20of%20CRPD.pdf [accessed 25 April 2017].
[138] See Department of Health, *Deprivation of Liberty: Safeguard Proposals* consultation Paper and Draft Heads of Bill of Part 13 of the Assisted Decision-Making (Capacity) Act 2015, December 2017 http://health.gov.ie/wp-content/uploads/2017/12/Public-Consultation-paper-on-draft-deprivation-of-liberty-proposals.pdf [accessed December 2017].

6.11 Detention-related safeguards under the Assisted Decision-Making (Capacity) Act 2015

The yet-to-be-commenced Assisted Decision-Making (Capacity) Act 2015 refers to the Mental Health Act 2001 in its sections on detention (Part 10, sections 104–108) and replicates its detention-related safeguards.

On commencement, each person whose capacity is in question, regardless of whether a person is involuntarily detained under the Mental Health Act 2001 or is a Ward of Court, or otherwise, will be assessed under the provisions of the Assisted Decision-Making (Capacity) Act 2015. Decisions as to treatment and detention for those coming within the provisions of Part 4 of the Mental Health Act 2001 are matters that come within the remit of the Act.

The Assisted Decision-Making (Capacity) Act 2015 deals with two aspects of detention:

1. Where an application is being made under the Assisted Decision-Making (Capacity) Act 2015, and an issue arises as to whether the person who lacks capacity is suffering from a mental disorder and there is a proposal to detain the person, then the Court must follow the procedures provided for under the Mental Health Act 2001.[139]
2. Where a wardship Court ordered the detention of a person immediately before the commencement of the Act, and the person continues to be detained, then that order must be reviewed by the wardship Court.[140]

When reviewing a detention under Part 10 of the Assisted Decision-Making (Capacity) Act 2015, the Court is required to hear evidence from the consultant psychiatrist responsible for the care and treatment of the person concerned, and also from an independent consultant psychiatrist selected by the Court.[141] This is notable in that the legislation does not require the Court to do so under Part 5 (which provides for the Court to make declarations as to capacity) and Part 6 (which provides for the review of the capacity of all wards).

[139] Section 106.
[140] Sections 107(1), 108(1).
[141] Sections 107(5), 108(5).

It is open to the Court, following review, to order the continuation of the detention for a further three months, at which point a further review shall take place. Following the subsequent review, the Court may order the continuation of the detention for a further six months.[142] A further review is then required and if following that, the Court is satisfied that the person concerned is suffering from a mental disorder, it may direct that the detention continue.[143] The Court determines the period for any subsequent reviews, though not to exceed 6 months.

[142] Sections 107(2), 108(2).
[143] Sections 107(3), 108(3).

7 ALTERNATIVES TO WARDSHIP

-"Where do human rights begin?"
-"In small places, close to home."[1]

7.1 The Nursing Homes Support Scheme

Approximately 20% of older people living at home have one or more disabilities and need help and support.[2] A further 4% of the older adult population live in long-stay residential care.[3] As of 31 December 2016, there were 580 nursing homes (or "designated centres" as they are defined in the Health Act 2007) providing 30,396 registered beds.[4]

The Nursing Homes Support Scheme Act 2009 ("the NHSS" or "Fair Deal" as it is also known) allows for a care representative[5] to be appointed where a person seeking a nursing home place lacks capacity to make an application for nursing home support. This arises when the person has not appointed an attorney under the Enduring Power of Attorney Act 1996 and neither the person themselves, nor a trusted other, can complete the "financial assessment" that is required as part of the NHSS.[6]

A care representative is appointed solely for the purposes of applying for NHSS loans, in that it facilitates another person to make an application for ancillary State support, and, if the vulnerable person has title of ownership of property or land, the care representative can consent to creating a charge over an interest in land.[7] The care representative has no legal authority to access the money or assets: the role is concerned only with the application for ancillary State support.[8]

[1] Eleanor Roosevelt, at the adoption of the Universal Declaration of Human Rights.
[2] Professor Eamon O'Shea — Paper delivered to the Citizens Assembly on 11 June 2017 https://www.citizensassembly.ie/en/Meetings/Prof-Eamon-O-Shea.pdf.
[3] Ibid.
[4] Health Information and Quality Authority Annual Report 2016, paragraph 4.1.1 https://www.hiqa.ie/sites/default/files/2017-05/HIQAs-2016-Annual-Report.pdf.
[5] Section 21.
[6] A financial application can be made without care representative where a loan is not required.
7 Note that the care representative has no authority of access to money: their only remit is to make the application for State support.
[8] The Law Society has recommended the repeal of Sections 21 and 22 of the Nursing Homes Support Scheme Act 2009 on the commencement of Parts 3, 4 and 5 of the Assisted Decision-Making (Capacity) Act 2015. This would obviate the need for a care representative, and instead the provisions of the Assisted Decision-Making (Capacity) Act 2015 would apply.

7.2 NHSS, Wardship and Delayed Discharges

Social Worker H[9] described wardship as a "blunt instrument",[10] often initiated when an older person is admitted to hospital and, having been treated medically, it comes to light that they may lack capacity and are seen as being unable or unsuitable to return home. The concern of the hospital is twofold: the safe discharge of the patient and that acute hospital beds are made available to those who most need them. The only option available appears to be moving the person concerned to a nursing home,[11] and this transfer requires the completion of the Nursing Homes Support Scheme form. Where a patient lacks capacity to manage their financial affairs, cannot live independently and no one has authority to act on their behalf to apply for the Nursing Homes Support Scheme or access funds, then wardship may be the only option to limiting the hospital stay.

The following response which we received from Survey I,[12] and which is reflective of other interviews, highlights the hospital's viewpoint of the difficulties with the wardship system:

> "Ward of Court inpatients are commonly stuck in a legal vacuum and delayed in hospital until the legal authority of Wardship is appointed to a Committee. We regularly encounter the primary issue of no person being in a position to access the WOC [Ward of Court] applicant's financial resources until Wardship is finalised. This delays their transfer to nursing home care."

From the hospital's perspective, the summer months are particularly difficult because of delays in discharge when the Courts are in recess. A standard wardship application that takes place over this time will result in the patient remaining in an acute hospital rather than transferring to more suitable long-term care setting. Pressures to release the bed and an overtly paternalistic approach to the safety of the vulnerable person result in the person themselves left in an unsuitable position by a system in which the goal is to access

[9] Appendix 1
[10] Ibid.
[11] Or designated centre as defined in section 2 of the Health Act 2007.
[12] Ibid, note 8.

their money. We understand that the HSE is moving to address this issue through the provision of step-down beds as an intermediate step between hospital and long-stay care. Nevertheless, this incurs a further move and inherent disruption for the vulnerable person at a particularly vulnerable time in his or her life.

We were told[13] of one nursing home resident, a man in his 40s with epilepsy and low IQ, residing in a nursing home, who wanted to return home. According to the advocate, the HSE position was that the cost of emergency interventions was excessive and that if he insisted on going home, he would be made a Ward of Court.

7.3 Discretion to institute proceedings

The HSE plays a critical role in identifying persons they perceive as requiring the protection of the wardship system and also in instituting the incumbent legal proceedings. Following a series of staff workshops held by the HSE, the HSE itself identified[14] that a fundamental misunderstanding as to the meaning and implications of wardship exists.

The impression of some front-line professionals was that wardship meant bringing the person into the public health system, not recognising that the Ward pays for his or her care from his or her own estate, or that his or her ability to make fundamental decisions about his or her life is removed from him or her and placed within the ultimate supervision of the Courts. It is disquieting to acknowledge this disconnect and the decision-making that may flow from a flawed understanding of the system. Recognition of the issue by the HSE is positive, but the need to correct this flawed understanding is imperative.

[13] Ibid note 6.
[14] Appendix 1 — HSE Quality Improvement Division.

7.3.1 Where the HSE decides to institute wardship proceedings

Given the import for the vulnerable person of a decision by the HSE to petition the Court to admit the vulnerable person to wardship, a clear, robust and transparent decision-making process might reasonably be expected. It would seem there is none.

Under the Assisted Decision-Making (Capacity) Act 2015, the HSE has indicated that the *Guide for Health and Social Care Professionals* (for consultation at time of writing) may introduce procedures for identifying a person to be brought under the Assisted Decision-Making (Capacity) Act 2015. The HSE anticipates that specific guidance will be developed in collaboration with HSE Legal Services on this matter.

7.3.2 Where the HSE decides not to bring proceedings

In the case of "Grace", a woman with an intellectual disability who was abused as a child while in the care of a foster home approved by the HSE,[15] it recently emerged in Conal Devine's report on the case[16] that an internal HSE committee — Vulnerable Adults Committee (VAC) — discussed the option of making Grace a Ward of Court. However, this option was never followed up, despite clear safeguarding concerns.[17] Devine's report makes the finding that "the VAC did not function as the accountable forum to deal with the emerging issues… Specifically, in relation to SU1 the Inquiry Team is of the view that the VAC failed in its stated duty to monitor an investigation into the immediate concerns relating to SU1's care".[18]

There is an absence of guidelines and structures about when and why the HSE should apply for wardship. In an area where there is potential for conflict of interest, this is something where strict protocols should apply.

[15] *The Irish Times'* report of 27th April 2017, "*Judge awards 'Grace' €6.3m over 'scandal' of her treatment.*"
[16] Conal Devine & Associates, *Inquiry into Protected Disclosures, SU1*, HSE, February 2017; following publication of this report, the Government set up the Farrelly Commission to inquire into the circumstances of the case. The Commission began in April 2017 and was due to deliver a report within 12 months from that date.
[17] Ibid, at 6.3, Role of the Vulnerable Adult Committee in respect of SU1.
[18] Ibid at 6.3.10.

7.4 Enduring power of attorney

Although beyond the scope of this paper, it would be remiss to exclude mention of the enduring power of attorney (EPA) system,[19] which provides for the management of a person's affairs in the event of his or her future lack of decision-making capacity. An EPA is an instrument signed by or by direction of a person (the donor), giving the donee (the attorney) the power to act on behalf of the donor, once the donor lacks capacity. In order to crystalise this power to act, the attorney must be able to show that the donor lacks capacity, and thus have the instrument registered by the Registrar of Wards of Court. Once this is done, the attorney can make decisions on behalf of the donor in a manner prescribed by the donor. Following registration, however, there is no requirement on the attorney to report to any supervising body.

An EPA may not be created where a person has never had capacity, as it will be necessary to understand the implications of creating an EPA which may include giving another person authority to manage a person's affairs. EPAs created under the Assisted Decision-Making (Capacity) Act 2015 (on its commencement) will have reporting requirements to the Decision Support Service,[20] which will also be able to review and investigate complaints.

7.5 Think Ahead

The Irish Hospice Foundation has produced a form called *Think Ahead,*[21] which is for general information purposes, and is not a legal document. It encourages people to think about future decisions they or their relatives may need to make, and seeks to ensure that their right to make decisions for themselves is honoured. On commencement of the Assisted Decision-Making(Capacity) Act 2015, statutory force will be given to Advanced Healthcare Directives to ensure that the will and preference of the person is protected in treatment choices.

[19] Governed by Enduring Powers of Attorney Act 1996, subject to amendments on the commencement of Part 7 of the Assisted Decision-Making (Capacity) Act 2015.
[20] The Director of the Decision Support Service, Áine Flynn, commenced on 2nd October 2017.
[21] http://hospicefoundation.ie/programmes/public-awareness/think-ahead/fill-in-think-ahead-form/the-think-ahead-form-2/.

8 RECOMMENDATIONS

The Voice of the Ward

1. The Ward should be served with all Court orders in relation to his or her wardship.
2. The Ward should be permitted, encouraged and facilitated to participate in decision-making.
3. The Ward's current and past wishes and preferences, in so far as they are reasonably ascertainable, should be given effect, in so far as is practicable.
4. The Ward should be included in multidisciplinary meetings about his or her care and treatment.
5. The Ward should be consulted on important personal matters including the sale of his or her home or any property.
6. A code of practice should be introduced to ensure that there is no conflict of interest arising between the Ward and his or her Committee.
7. Instructions to legal practitioners should be produced to advise and alert them to potential conflicts of interest between the Ward and his or her Committee.
8. The Office should ensure that the information it receives about the care and treatment of the Ward is independent and reflects the will and preferences of the Ward.
9. The Office should review its reliance on the Committee of the Person and or Committee of the Estate for information about the care and treatment of the Ward.
10. Where the General Solicitor is Committee of the Estate and Person, that the General Solicitor reviews its reliance on the carers of Wards for his or her information about the care and treatment of the Ward.
11. That independent social work reports on the living conditions of Wards should take place in all instances.

Inquiry

12. The Office should issue a practice direction about the need to uphold the legal presumption of capacity until the point at which an inquiry finds that a prospective Ward lacks decision-making capacity.

13. A necessary initial requirement, before the process of wardship commences, is to give to the person who is to be the subject of any application, details of her or her rights and information as to what the process entails in an easily understandable format.
14. Fair procedures should be a fundamental requirement in relation to any application to have a person made a Ward of Court. These procedures should be documented and given to the person who is the subject of the inquiry. The inquiry should give due recognition to the vulnerable condition of the Respondent; procedures which may be fair in a standard application may not be fair where the Respondent is vulnerable. Procedures must take into account the vulnerable circumstances of a prospective Ward.
    14.1. When a Respondent is being served, the person effecting notification should provide the vulnerable person with information in a way that is appropriate to their circumstances, such as using plain language or visual aids.
    14.2. When a Respondent is being served, all documents should be served on his or her legal representative, advocate or other person duly authorised to conduct proceedings on his or her behalf.
15. The Office should establish a protocol for the receipt and handling of objections from Respondents.
16. Medical reports should be made available to the Respondent, unless there are serious reasons not to do so.
17. The Office should produce guidelines about conflicts of interest arising particularly in relation to the Petitioner who is making the application and also in relation to the proposed Committee. Such guidelines should provide that where conflict arises, independent legal representation should be in place.
18. A Respondent to wardship proceedings should be entitled to legal aid.
19. A Respondent who has no independent legal representation should be entitled to a non-legal advocate or lay representative or a guardian ad litem.

<u>Legal test</u>

20. There is need for an unambiguous definition and clear direction on operation of the legal test.
21. To comply with human rights obligations, consideration should be given to applying the functional test to individual decisions post-admission.

22. In order to assist in transitioning on the commencement of the Assisted Decision-Making (Capacity) Act 2015, it is recommended that the functional test apply as well as the current statutory test in medical assessments.

Complaints

23. The Office of Wards of Court should formulate clear practice directions governing the receipt and handling of complaints by the Office of the Wards of Court.
24. A customer charter should be established specifically for dealing with representatives of Wards.
25. A transparent process is required in making a complaint to the Office with an obligation to inform the complainant of the steps the Office chooses to take or not take.

26. Complainants should be informed of their right to refer the matter to the Ombudsman, and contact details of the Office of the Ombudsman should be given.
27. Where complainants are dissatisfied with how the Office has dealt with their complaint, there should be a means of appealing that outside of the costly process of going to the High Court.
28. The Office of Wards of Court should maintain a log of complaints to provide for effective audit and accountability.

Medical Reports

29. Medical practitioners executing assessments for the purposes of a wardship application should be required to follow the Health Service Executive's (HSE's) consent guidelines and the Medical Council's guide.
30. Legal practitioners who are instructed by the HSE should be given centralised guidelines in relation to commissioning a medical assessment (see recommendation 34 below), to include:
    30.1. Duty to enhance capacity:
        - individuals should be given the opportunity to have someone with them during the assessment;

- any communication aids including hearing aids and glasses should be available to them;
- individuals should be assessed at different times on different days;
- practitioners should seek to alleviate any stresses or anxieties that the individual has about the process.

30.2. Collecting information: practitioners should seek to find out as much as possible about the person, and the person's wishes and preferences, and as appropriate from sources other than the person themselves.

30.3. Care: practitioners should also make assessments about the nature of the care that the individual is receiving and whether it should be changed or improved in any way.

30.4. Treatment facilitation: recommendations should be made in relation to treatments that will minimise the disability and enhance the capacity of the individual, such as communication aids and memory aids.

30.5. Reviews process: if the practitioner is satisfied that the Respondent is of unsound mind and incapable of managing his or her affairs, he or she should make recommendations in relation to reviews.

Health Service Executive (HSE)

31. The HSE in tendering for legal services in relation to Ward of Court proceedings should ensure that legal practitioners have appropriate expertise in relation to the law on decision-making capacity and human rights obligations.
32. The HSE needs to ensure compliance with its own consent policy guidelines by HSE personnel and lawyers instructed by the HSE.
33. The HSE should produce centralised guidelines for legal practitioners in protecting the rights of a prospective Ward in proceedings.
34. The HSE should produce centralised guidelines for legal practitioners commissioning medical practitioners to carry out assessments for Ward of Court proceedings.

Vulnerable people in the community

35. The HSE should establish and maintain national protocols about when and why they will instigate wardship proceedings in respect of a vulnerable person.

36. The HSE and hospitals should review the practice of using wardship as a means of accessing a person's funds for payment for nursing home care.

37. On commencement of the Assisted Decision-Making (Capacity) Act 2015, the care representative provided for in section 21 of the Nursing Homes Support Scheme Act 2009 should be abolished; the co-decision maker or other intervener under the Assisted Decision-Making (Capacity) Act 2015 should exercise the role currently undertaken by the legal representative.
38. A new part of the Assisted Decision-Making (Capacity) Act 2015 containing Deprivation of Liberty Safeguards was open for public consultation at time of writing. Enactment of these provisions would ensure that a person’s right to decide where they wish to live is obtained before any decision is taken as to where their care will be provided.

Appendix 1 Contributors to review

Pseudonym	Description	Date of interview
	Advocate	November 2016
	Advocate	November 2016
	Advocate	November 2016
Consultant X	Consultant geriatrician	November 2016
Consultant Y	Consultant neuropsychiatrist	April 2017
	Consultant psychiatrist	March 2017
Former Ward A	Former Ward of Court	December 2016
	HSE Quality Improvement Division	October 2016
	HSE Quality Improvement Division	October 2016
Legal Practitioner D	Legal practitioner	March 2017
Legal Practitioner E	Legal practitioner	February 2017
Legal practitioner F	Legal practitioner	December 2016
Legal Practitioner G	Legal practitioner	February 2017
	Legal practitioner	December 2016
	Legal practitioner	February 2017
	Legal practitioner	February 2017
	Legal practitioner	January 1999
	Legal practitioner	January 1999
	Legal practitioner	December 2016

Pseudonym	Description	Date of interview
	Legal practitioner	January 2017
	Medical social worker at major national hospital	November 2016
	Medical social worker at major national hospital	November 2016
	Medical social worker, specialising in wardship at a major national hospital	November 2016
Mother of Former Ward B	Mother of Former Ward B	February 2017
	Policy officer at NGO	October 2016
Psychologist Z	Psychologist	March 2017
Committee of the Estate C	Representative of a Ward	February 2017; April 2017
	Senior Policy and Public Affairs Adviser, State body	October 2016
Social worker H	Social worker specialising in safeguarding and protection	October 2016
Survey I	Survey given to HSE personnel working in wardship	December 2016

Appendix 2 Pro-forma letters from the Office

2.1 Excerpt from Standard Letter to Solicitors

(1) The Notice should now be dated and signed by either the Petitioner or the Solicitor for the Petitioner.

(2) Once the Notice has been dated and signed as aforesaid a photocopy of the attested copy Petition with the said Notice and Endorsement attached thereto should be made.

(3) Service on the Respondent should take place by showing him/her the attested copy Petition with the said signed Notice endorsed thereon and by leaving with him/her the photocopy of same, i.e. the attested copy Petition with Notice endorsed thereon is retained by the server.

(4) After service has taken place the server should endorse service on the Notice by filling in the place, time and date of service, etc. at Number 1 and by signing and dating Numbers 2 and 3.

(5) The server should then swear an Affidavit of Service - see precedent in Appendix K, Form 15(A) of the Rules of the Superior Courts - exhibiting the said attested copy Petition and Notice therein and sign and complete the Notice at Numbers 4 and 5. The details at Number 5-7 should correspond directly with those in the jurat[1] of the Affidavit of Service. The same Commissioner for Oaths that signs the Affidavit of Service should sign the Notice at Number 7. The said attested copy Petition with Notice endorsed thereon together with the Affidavit of Service should then be filed in this Office.

Please note that if the Respondent is blind or illiterate the Petition and Notice must be read aloud to him/her in a clear and distinct manner and an effort should be made to explain the contents thereof to him/her insofar as his/her mental condition enables him/her to understand same. The manner of such service, i.e. that the Petition and Notice were read aloud and that an attempt was made at explanation of the contents thereof should be recited in the Affidavit of Service.

[1] The jurat is a clause at the foot of an affidavit showing when, where, and before whom it was sworn.

2.2 Excerpt from Standard Letter to Letter to Medical Visitors

I should be grateful if you could visit the above named Respondent at NAME AND ADDRESS OF RESPONDENTS CURRENT RESIDENCE and furnish a medical report on their mental condition for submission to the President of the High Court.

Your Report as Medical Visitor is confidential to the Court and you should not, therefore, reveal the contents of your Report to any other party, even if requested to do so by a Solicitor acting in the matter.

The Respondent's date of birth is the XXXXXXX and he/she previously resided at XXXXXXXX.

In cases where the Respondent is resident in a hospital, hostel, nursing home, etc. it would be advisable to contact the appropriate authorities of such institution before you visit, in order to make arrangements for same.

For assistance in arranging the visit you can contact XXXXX Solicitors on 0123456789. If the Respondent is residing at home you will need to contact the solicitor for the name and contact number of a family member that the MV can contact.

Your dated report should contain the following information:

1. The date and place of examination.

2. The name, nature and symptoms of the mental illness (if any).

3. The suitability of the Respondent's residence and the manner in which the Respondent is being treated.

4. If in your opinion the Respondent is of unsound mind and incapable of managing their affairs.

2.3 Excerpt from Standard Letter to Committee

Role and Duties of Committee

A Committee in wardship means one or more persons to whom the welfare or affairs of a Ward are "committed". The persons appointed by the Court as Committees are usually but not necessarily family members. The Committee can only do what the Court authorises him/her to do; a Committee has no inherent authority or power. It is generally the case that the Committee is appointed to -

- oversee the personal care of the Ward (i.e. Committee of the Person); and / or
- assist the Wards of Court Office in managing the financial affairs of the Ward (i.e. Committee of the Estate).

A case officer in the Office of Wards of Court will be appointed when a new ward is declared. The Committee (and solicitor) can then liaise with that case officer in relation to relevant matters.

Generally, a Committee is required to attend on a regular basis to the day to day affairs of the Ward which often includes the following –

- ensuring the Ward's personal needs are met;
- administering pensions and other income on behalf of a Ward;
- operation of a Committee bank account
- discharging nursing home fees and other expenses on behalf of a Ward;

- managing a Ward's property including payment of utility bills, property insurance etc.;

- providing instructions to the solicitor acting in the Wardship so as to enable the solicitor submit proposals to the Wards of Court Office in relation to matters relevant to the Ward (e.g. the sale or letting of a Ward's property etc.).

A Committee is accountable to the Wards of Court Office for all monies received and payments made on a Ward's behalf.

While a Committee is not paid a fee or salary, s/he is entitled to be reimbursed in respect of out of pocket expenses. Requests for payment can be addressed to the relevant Case Officer together with supporting documentation.

At any stage a Committee may apply in writing to be permitted to retire as Committee. If you wish, you or your solicitor may make a recommendation for the appointment of another suitable person to act as the substituted Committee. Your recommendation should be accompanied with a letter from that person stating that he/she is willing to be appointed.

The Court may decide to replace the Committee in certain circumstances where the Court deems the appointed Committee to be no longer suitable to act in the best interest of the Ward.

Appendix 3 Letter to Ward

3.1 Letter to Former Ward A

OIFIG AN ARD-ATURNAE UM MIONADEISIGH AGUS COIMIRCITHE CÚIRTE
An tSeirbhís Chúirteanna
15-24 Sráid an Phiarsaigh Thuaidh Margadh na Feirme
Baile Átha Cliath 7
Teileafón: 01 8886731
Facsuimhir: 01 8723661
Ríomhphost: gmaol@courts.ie
Láithreán Gréasáin: www.courts.ie

An tSeirbhís Chúirteanna
Courts Service

OFFICE OF THE GENERAL SOLICITOR FOR MINORS AND WARDS OF COURT
Courts Service
15-24 Phoenix Street North
Smithfield
Dublin 7
Telephone: 01 8886731
Fax: 01 8723661
E-mail: gmaol@courts.ie
Website: http://www.courts.ie

Our Ref: [redacted] Your Ref: Date: [redacted]

[redacted]

Dear [redacted]

I note you requested a copy of the High Court Order bringing you into Wardship and as I explained this is a legal document which may be difficult to understand. Further we would deem it inappropriate for you to be given a copy of same.

However I can explain that you were assessed by the President of the High Court's Medical Visitor on the [redacted] and it would appear that you did not demand an Inquiry. The President of the High Court declared that you were deemed to be incapable of managing your own person/property and ordered that [redacted] be appointed as your Committee.

As you are aware, the General Solicitor oversees your personal care and your financial arrangements.

I hope this explains how you were declared a Ward of Court and that the General Solicitor was appointed as your Committee. I am the case officer assigned to your case.

Yours sincerely,

[redacted]
Solicitor

[redacted]

Appendix 4 Letter from HSE on number of HSE staff acting or who has acted as a committee for a Ward

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Oifig an Cheannaire Oibríochtaí,
Na Seirbhísí Míchumais/An Rannán Cúram Sóisialta,
31-33 Sráid Chaitríona, Luimneach.

Office of the Head of Operations,
Disability Services/Social Care Division,
31-33 Catherine Street, Limerick.

T: 00353 (0) 61 483369
Suíomh Gréasáin/Website: http://www.hse.ie

12th May 2017

Deputy Fergus O'Dowd,
DailEireann,
Leinster House,
Kildare Street,
Dublin 2.
e-mail: fergus.odowd@oireachtas.ie

Dear Deputy O'Dowd,

The Health Service Executive has been requested to reply directly to you in the context of the following parliamentary question, which was submitted to this department for response.

PQ 19991/17

To ask the Minister for Health the number of cases in which a HSE staff member is acting or has acted as a committee for a ward either in a residential setting or in the community setting in the years 2015 and 2016 respectively; and if he will make a statement on the matter.

HSE Response

The HSE doesn't collect the information sought by the Deputy, so the Office of Wards of Court was requested to provide the relevant information.

There are currently over 2,000 wards of court. HSE employees are appointed as committee only in exceptional cases, for example if there is no family member suitable or available to act. As the Wards of Court case tracking system does not always record the occupation of a committee, it was not possible to provide the answer with absolute certainty. However, the following information was extracted by the Registrar from records held by the Office of Wards of Court:

In 2015 there were 11 HSE employees acting as committee.

In 2016 there were 8 HSE employees acting as committee.

Currently there are 5 HSE employees acting as committee.

Yours sincerely,

Dr. Cathal Morgan,
Head of Operations,
Disability Services, Social Care Division

Building a Better Health Service
CARE COMPASSION TRUST LEARNING

Email: info@safeguardingcommittee.ie

Website: www.safeguardingcommittee.ie