[2024] IEHC 643

THE HIGH COURT

[2024/1651 SS]

IN THE MATTER OF AN APPLICATION FOR AN INQUIRY PURSUANT TO ARTICLE 40.4 OF THE CONSTITUTION

BETWEEN:

B.G.

APPLICANT

AND

THE CLINICAL DIRECTOR, DEPARTMENT OF PSYCHIATRY, MIDLAND REGIONAL HOSPITAL AND THE HEALTH SERVICE EXECUTIVE

RESPONDENTS

JUDGMENT of Mr. Justice Barry O'Donnell delivered on the 8th day of November, 2024

INTRODUCTION AND BACKGROUND

1. This is the judgment of the court in relation to an inquiry into the detention of the applicant pursuant to article 40.4.2 of the Constitution. The applicant – whose name has been anonymised – currently is detained at the respondent hospital pursuant to the provisions of sections 14 and 15 of the Mental Health Act 2001 as amended (*the 2001 Act*). The respondent hospital is an approved centre for the purposes of the 2001 Act.

2. The proceedings were commenced by an *ex parte* application on Tuesday the 5 November 2024, and the substantive hearing took place over the course of Wednesday the 6 November 2024. The basis for this inquiry is set out in a short affidavit of Finbarr Phelan which was sworn on the 4 November 2024. Mr Phelan is a solicitor acting for the applicant. By letter dated the 29 October 2024, he was appointed by the Mental Health Commission (*the Commission*) to act as legal representative for the applicant for the purposes of a hearing scheduled to occur before a Mental Health Tribunal on the 13 November 2024.

3. The detention of the applicant was certified by the acting clinical director of the approved centre on the 6 November 2024. The acting clinical director certifies that the applicant is being detained at the approved centre pursuant to an admission order dated the 26 October 2024 made pursuant to section 14(1) and section 15(1) of the 2001 Act.

4. Save for the certificate and Mr Phelan's affidavit, the inquiry proceeded on the basis of the statutory forms that were completed as part of the admission process under the 2001 Act, and which were exhibited by Mr Phelan. No further evidence was offered by either party.

5. Mr Phelan sets out that the applicant was detained in the respondent hospital on foot of an application, recommendation and admission order pursuant to sections 9, 10 and 14 of the 2001 Act. The overall process commenced on the morning of the 25 October and the admission order was made at 1 pm on the 26 October 2024. From paragraph 6 of his affidavit onwards, Mr Phelan makes the legal argument that the admission order must make clear how the applicant satisfies the criteria in section 3 of the 2001 Act. He asserts that this must include not only the clinical diagnosis but also the extent to which the patient's judgment is impaired and why it is said that that there would likely be a serious deterioration in his condition without an

involuntary admission, or alternatively that the administration of appropriate treatment would be prevented without an involuntary admission. That argument is made by reference to the decision of the High Court (Simons J) in *A.A. v Clinical Director of the Aishlin Centre* [2024] IEHC 408. In that regard, Mr Phelan explains his belief that the admission order in this case does not adequately set out the reasons why the admission order was made.

GENERAL PRINCIPLES

6. The fact that the detention under inquiry has been certified is not determinative. The following apposite observations were made by Hogan J. in the Court of Appeal in A.B. v. Clinical Director of St Loman's Hospital [2018] 3 I.R. 710:

> *"[98] It is accordingly clear that the High Court could direct the release of an involuntary patient by way of an Article 40.4.2 application not only where the order in question was good on its face, but also where there had been a fundamental breach of constitutional rights or the existence of some other material defect in the process leading to the making of the detention order in question. But even no matter how brightly the beacon of liberty has heretofore shined to vindicate the constitutional rights of Article 40.4.2 applicants, an adjudication upon the purely medical merits of the detention of an involuntary patient under the 2001 Act seems to lie just outside the arc of that spotlight of review."*

7. Hence, for the purposes of this inquiry the court is not permitted to interrogate the clinical views or clinical judgment that underpin the admission order.

8. *Prima facie*, to comply with the legislative provisions, there is a necessity to adhere to certain formal requirements. There must be a clinical examination that allows for the formation of the necessary clinical opinion. That examination must occur within the prescribed period. If there is to be an involuntary admission, an admission order must be made in the specified form.

9. The necessity to comply with the specified process is a function not merely of the language of the statute, but because the effect of the order is to authorise the reception, detention and treatment of an adult, who otherwise is fully entitled to their liberty and to choose not to receive medical treatment. These all are matters that may be subject of inquiry or challenge in an appropriate case.

10. However, substantively the 2001 Act also requires the consultant psychiatrist to be satisfied that the person concerned "*is suffering from a mental disorder*". The respondents argue that this is purely an exercise of clinical judgment and, as noted by Hogan J. in *A.B.*, the court is not entitled to interrogate clinical judgments. I do not agree that this construction is correct, or at least fully correct.

11. A determination that a person is suffering from a mental disorder is a determination conducted by reference to a legal test that carries serious consequences. There is no doubt that there is a core clinical element which requires the exercise of clinical judgment, however there are other elements to the test. Section 3 of the 2001 Act has been the subject of extensive consideration by the courts, and it provides:

> "*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."

12. The diagnosis of mental illness, severe dementia or significant intellectual disability all are matters that call for the exercise of clinical judgment. However, even in that situation, there is a necessity identified in subsection (2) that the actual mental illness dementia or disability reach a particular threshold of seriousness. Hence, the clinical judgment must be exercised by reference to clear statutory criteria.

13. Likewise, with subsection (1)(a), there is a need to identify (i) a likelihood that reaches the standard of seriousness, and (ii) that the likelihood is of the person causing "*immediate and serious harm*". Again, there is a strong element of clinical judgment throughout the subsection, but the clinician is not at large, and there must be some identified basis for finding that the harm anticipated is serious, immediate, and likely to occur.

14. Accordingly, while there is a need for the exercise of clinical judgment, its location within a clear legal test means that at the very least the clinical decisions must be capable of being understood. I understand this requirement to mean not that there is a free-standing administrative need for reasons of the type that arise where administrative or quasi-judicial decisions are made that impact on a person's rights or entitlements, but rather that the decisions or judgments involved in the process for admission under the 2001 Act should be capable of being shown to have been compliant with the relevant statutory criteria.

15. In that regard, it has been noted in numerous cases that the Oireachtas has framed the overall structure of the 2001 Act (which must be considered in seeking to interpret individual provisions) in a way that gives rise to a coherent and interlocking network of checks and balances that seek to accommodate the rights of individuals to autonomy, dignity and privacy, with the public interest in ensuring that medical care is available to potentially highly vulnerable and unwell persons, who because of the effects of their particular presenting illness are unable to access medical treatment voluntarily.

THE PROCESS LEADING TO THE ADMISSION ORDER

16. At this point it may be helpful to consider the actual steps taken that led to the involuntary admission in this case. It was common case that the admission order was made following the sequence set out in the 2001 Act, and that the matters complained of went to the reasons set out in the Form 6 document provided by the Commission for the making of admission orders.

17. The operation of the 2001 Act has been the subject of extensive consideration by the courts since its full commencement in 2006. Accordingly, I intend only to address the issue of the sequencing of events provided for in the 2001 Act and the matters that the Oireachtas require to be addressed in the course of that process, as these are the central issues raised on behalf of the applicant. In can be noted that throughout the process, the Oireachtas has made provision for certain steps to be documented in forms specified by the Commission. Those forms are made available by the Commission and are subject to amendment from time to time. In this case, the relevant forms to be utilised were updated by the Commission towards the end of July 2024, after the judgment in *A.A*.

18. At 10.35 am on the 25 October 2024, a Clinical Nurse Manager completed a document known as Form 4 and headed "*APPLICATION TO A REGISTERED MEDICAL PRACTITIONER BY ANY OTHER PERSON FOR A RECOMMENDATION FOR INVOLUNTARY ADMISSION OF AN ADULT TO AN APPROVED CENTRE."*

19. Form 4 is a template form produced by the Commission for the purposes of section 9 of the 2001 Act. Section 9 permits specified categories of persons that are identified in subsection (1)(a) to (c) to apply to a registered medical practitioner for a recommendation that a person should be involuntarily admitted to an approved centre. It constitutes one of the primary mechanisms to commence a process of involuntary admission. Subject to certain restrictions that are not relevant to this inquiry, an application also may be made by "*any other person*", (s.9(1)(d)). All applications must be made "*in a form specified by the Commission*", (s.9(3)). Where the recommendation is sought under s.9(1)(d), the application is required to contain a statement of the reasons why it is so made, of the connection of the applicant to the person in question and the circumstances in which the application is made (s.9(5)).

20. In this case, the Form 4 was completed by an identified person – who under the terms of the form itself - is not one of the persons specified in s.9(1)(a) to (c). That person identified themself as a "*CNM1 – no connection*". There was relative consensus that this referred to a clinical nurse manager. Form 4 contains a box for text headed "*State reason for making an application*". The CNM wrote the following:

> "*PATIENT IS REFUSING MEDICAL TREATMENT AND NURSING INTERVENTION IN HOSPITAL.*
>
> - *INABILITY TO CARRY OUT HIS OWN ADLS.*
> - *PARANOID TOWARDS STAFF.*
> - *REFUSING TO TAKE MEDICATIONS.*
> - *PT IS DOCUMENTED TO HAVE MENTAL ILLNESS*"

21. In the text box headed "*Circumstances in which the application is made*" the CNM wrote:

> "*PATIENT NEEDS PSYCHIATRIC MANAGEMENT AND ADMISSION. DOCUMENTED TO HAVE MENTAL ILLNESS*"

22. The next document in the sequence is a Form 5, "*RECOMMENDATION (BY A REGISTERED MEDICAL PRACTITIONER) FOR INVOLUNTARY ADMISSION OF AN ADULT (TO AN APPROVED CENTRE)".*

23. Again, Form 5 is a document produced by the Commission. It is required to be used when a recommendation is made for the involuntary admission of a patient to an approved centre pursuant to s.10 of the 2001 Act. That section provides:

> *"10.-(1) where a registered medical practitioner is satisfied following an examination of the person the subject of the application that the person is suffering from a mental disorder, he or she shall make a recommendation (in this Act referred to as "a recommendation") in a form specified by the Commission that the person be involuntarily admitted to an approved centre (other than the Central Mental Hospital) specified by him or her in the recommendation."*

24. Section 10(4) of the 2001 Act mandates that the recommendation is sent to the clinical director of the identified approved centre, and "*a copy of the recommendation shall be given to the applicant concerned*". While there was a suggestion that this subsection meant that the patient was to be given a copy of the recommendation and therefore arguably entitled to be provided with the reasons for the recommendation, this seems incorrect. Section 2 sets out the definitions of terms used in the 2001 Act, and it is clear that an "*applicant*" means the person who made the application under section 9, and not the person that was the subject of the application.

25. Hence in providing for the interlocking framework of applications and protections concerning the involuntary admissions of persons to approved centres, the Oireachtas made no express provision that those persons are to be provided with what are now described as Forms 4 and 5.

26. In this case the Form 5 was completed by a registered medical practitioner whose name is not legible but who provided their registration number with the Medical Council. No issue was taken with the illegibility. The form notes that the relevant examination took place at a

hospital (that was not the ultimate approved centre) at 14.00 pm on the 25 October 2024. The Form contains a text box headed "*Criteria for Mental Disorder*" in which there is a pre-printed text beside which there are boxes to be ticked, each of which refer to the criteria for "*mental disorder*" provided for in section 3 of the 2001 Act. As those criteria represent the only criteria that can give rise to a lawful involuntary admission, and the form is for use where a decision has been made to make a recommendation it appears that in reality this is not a pro forma box ticking exercise but instead a necessary indication of whether a clinical view has been formed as to whether the criteria have been met. In this case the medical practitioner stated that the criteria set out in section 3(1)(b) were met.

27. At section 12 of the Form 5 there is a text box headed "*Description of the person's mental disorder*" and begins with the pre-printed words "*My opinion above that the person has a mental disorder is based on the following grounds:*", after which there is space for the medical practitioner to set out the specified information. In this case the following was set out:

> "*I HAVE DISCUSSED THIS WITH DR CARMEN. PATIENT WAS REFERRED TO HOSPITAL WITH PURPORTED CONFUSION. PATIENT HAD NORMAL CT BRAIN, NORMAL INFLAMMATORY MARKERS, NORMAL BILIRUBIN(3) ALBUMIN (47) INR (1.0), TOX SCREEN NEG. PREVIOUS HISTORY C2H5OH MISUSE* [which I understand to be a reference to ethanol or ethyl alcohol]. *SUBSEQUENT ADMISSION PATIENT REFUSES ALL TESTS, IMAGING, VITAL SIGNS MONITORING, TREATMENTS, MEDICATIONS. PATIENT WILL NOT ENGAGE BEYOND ACCUSING TEAM OF "FLAYING HIS SKIN WITH A KNIFE", "DRAINING HIS BLOOD" "PROVIDING CORROSIVE SOAP". IN MY VIEW ORGANIC CAUSE (DELIRIUM) HIGHLY UNLIKELY. MY CONCLUSION IS FIRST EPISODE OF PARANOID*

PSYCHOSIS. CANT EFFECT FURTHER INVESTIGATIONS DUE TO COOPERATIVITY."

28. Hence at the point when the recommendation was made, the information that was transmitted to the approved centre was that there was a medical view that the applicant suffered from a mental disorder. This was grounded in attempts to rule out other causes; and a situation in which the patient was confused, refusing medical care and exhibiting troubling symptoms. All of this led the recommending doctor to express a clinical view that the applicant was experiencing an episode of paranoid psychosis. Without expressing at this point a view on the extent of the necessity for reasons in the context of an admission, it cannot really be disputed that the Form 5 in this case clearly explained the reason why the recommendation was being made.

29. The next step in the process involved section 14 of the 2001 Act. Under that provision, once the recommendation is received by the clinical director of the approved centre, the person concerned may be taken in charge at the centre for a maximum of 24 hours. During that period, a consultant psychiatrist at the centre must carry out an examination of the person. Having carried out the examination the psychiatrist has only two options. If he or she is not satisfied that the person suffers from a mental disorder the admission order must be refused. If he or she is so satisfied, the psychiatrist must make an admission order. Again, the admission order must be "*in a form specified by the Commission*". The Commission has prepared a Form 6 document which sets out what must be addressed in an admission order.

30. Here, the relevant consultant psychiatrist completed a Form 6 at 13.00 pm on the 26 October 2024. The only issue that has been taken on behalf of the applicant with the admission process is the record of why the psychiatrist decided that the applicant had a mental disorder.

31. Following the structure of Form 6, at the operative parts, in section 7 the psychiatrist stated that in his opinion the applicant had a mental disorder of the type identified at s.3(1)(b) of the 2001 Act. This was done by the psychiatrist ticking a box beside preprinted text that set out the various elements in the section 3 criteria. Below that section, one finds section 8, which is headed "*Description of the person's mental disorder*". There is an empty text box above which are the preprinted words, "*My opinion above that the person has a mental disorder is based on the following grounds*". Below that, the psychiatrist wrote:

> *"LOOKS OLDER THAN STATED AGE*
>
> *HE IS VERY GUARDED & SUSPICIOUS*
>
> *HAS VERY BIZARRE THOUGHTS*
>
> *THAT HE HAS NO BLOOD*
>
> *THAT HIS LEGS ARE BURNT BECAUSE OF WALKING & THAT HE HAS NO SKIN COVERING HIS SOLES.*
>
> *THAT HE WOULDN'T SHAVE FOR FEAR OF GETTING BURNT BECAUSE OF AN INCIDENT THAT HAPPENED YEARS AGO-*
>
> *HE HAS LACK OF INSIGHT*
>
> *POOR JUDGEMENT*
>
> *IMPAIRMENT IN REASONING*
>
> *COMPROMISED DECISION MAKING"*

32. Following the completion of the admission order, the psychiatrist prepared a patient notification form, as required by section 16(2) of the 2001 Act, in which the patient was provided with the information that is prescribed in that provision. No issue was raised in relation to that part of the process. The admission was notified to the Commission and a hearing is scheduled to occur before a Mental Health Tribunal on the 13 November 2024.

THE ARGUMENTS

33. The applicant argues that the Form 6 document does not identify a mental illness and does not explain why the matters set out in the form lead to a conclusion that a failure to admit the applicant to an approved centre either would result in a serious deterioration in his condition or would prevent the administration of appropriate treatment that could only be given by such an admission, and that the reception detention and treatment of the applicant would be likely to benefit or alleviate his condition to a material extent. That argument was based on matters set out in the judgment of Simons J. in *A.A.* referred to above. That judgment was given on an *ex tempore* basis in an inquiry pursuant to Article 40.4.2 of the Constitution.

34. The respondents considered that *A.A*. could be distinguished from the present case. However, they were clear that if the court was not satisfied that the cases could be distinguished, then this court should reach a different view on the legal issues to that reached in *A.A.*

35. The applicant, in response, was adamant not only that the case was not capable of being so distinguished but that there was no basis for differing with the views in *A.A.* In that regard, the applicant referred the court to the relatively recent Supreme Court judgment in *A. v.*

Minister for Justice and Equality, the Attorney General and Ireland [2021] 3 IR 140. That judgment contains an extensive discussion and extremely helpful guidance on the circumstances in which a High Court judge can come to a different view to a colleague on the same legal issue. The guidance drew on the existing jurisprudence explained in cases such as *Re Worldport Ireland Limited (in liquidation)* [2005] IEHC 189 and *Kadri v. Governor of Wheatfield Prison* [2012] IESC 27.

36. The court found that adherence to precedence did not bind judges to follow earlier decisions and they were entitled to consider developments in the law and arrive at a different conclusion. However, the Supreme Court gave very clear guidance that where that situation arose there was a real risk of introducing uncertainty, in the sense that it would then be difficult for parties and their advisors to predict the likely legal consequences of adopting a particular course of action. In those premises, and hopefully without doing an injustice to the careful explanations in the judgment, the Supreme Court made clear that if a court was to adopt a different view to an earlier judgment this should be explained properly. The Court noted some situations that may arise, such as where it was apparent that relevant case law had not been drawn to the attention of the judge dealing with the earlier case or where the earlier judgment was of some antiquity and required to be updated to take account of legal developments. In any case there is a need to give reasons, and my understanding of the thrust of the case law is that strong reasons are required where there is a considered and reasonably recent earlier judgment, and where it cannot be said that the court was deciding matters without having had relevant caselaw drawn to his or her attention.

37. I have some concerns as to whether the judgment in *A.A.* perhaps goes further than required by the legislation, but ultimately, I have concluded that it is not appropriate or

necessary to express a contrary view to those expressed by Simons J. in *A.A*. Primarily, this is because I agree that the factual situation in the current case is sufficiently different to the facts of *A.A.* to warrant a distinction. I am also taking into account that the *A.A.* judgment is the subject of an appeal to the Court of Appeal. I was informed that it is under active management in that Court. In those premises, there is likely to be a determinative judgment from that Court within a reasonably short period. I consider that if I was to make a different finding on the legal issues to that taken by Simons J. it would introduce an unhelpful degree of uncertainty in circumstances where clarity is both required and is imminent.

38. In *A.A.*, the admission order was documented in an earlier version of Form 6, the relevant form required an identification of the "*clinical description*" of the persons mental disorder, whereas the current version only requires a "*description*" of the mental disorder. I have to say that I am not convinced that the difference in wording between the two versions of Form 6 is really a proper basis for distinction.

39. Of far more significance, it seems to me, is that in *A.A*., the basis for the psychiatrist's opinion was extremely terse: "*Grandiose & paranoid delusional beliefs, lacks insight into need for treatment*."

40. In deciding on the question of the need to give reasons in these type of cases, Simons J. placed reliance on the Court of Appeal decision in *F.C. v. Mental Health Tribunal* [2022] IECA 290. There the Court in effect upheld a complaint that a decision of the Mental Health Tribunal failed to provide adequate reasons. This was because the judgment of the Tribunal did not engage at all with the evidence that was given by the patient at the hearing before the Tribunal in which he explained why he believed the order ought to be revoked. Simons J.

highlighted that the Court of Appeal had referred to an observation by Hardiman J. in *M.D. v Clinical Director of St Brendan's Hospital* [2008] 1 IR 632, which Simons J. considered was to the effect that the provision of reasons in the context of involuntary hospitalisation or detention, quoting Hardiman J., was an "*absolutely essential part"* of the Mental Health Tribunal's functions.

41. Simons J. was clear that the requirement for reasons in a Tribunal decision was not a requirement that could be "*read across*" to a duty to give reasons at an earlier stage in the process. This was a result of the different contexts in which decisions are made at various stages in the process. The court was clear that there was a need for real care in any process that has such profound effects for an individual. Fundamentally, and what I understand to the core of the decision, was a holding that a court or tribunal considering the admission order must be able to understand the basis on which it had been reached. In *A.A.*, Simons J. therefore held that there needed to be some indication that the decision maker had properly considered the statutory criteria in reaching the relevant opinion. In that regard he noted the consultant psychiatrist should provide even a preliminary diagnosis and should indicate which of the criteria within section 3(1)(b) of the 2001 Act had been considered applicable and some indication why that was the case.

42. I do wish to express some tentative, respectful concern that, taken on their own, some of the matters adverted to by Simons J. may be interpreted as extending the way that reasons should be expressed beyond what is required. It may be the case that when the admission order under question is considered, particularly in light of the recommendation, those identified matters can be understood by implication even if they are not set out in express terms.

43. I am in complete agreement that in a statutory process that could lead to the detention of an individual there is a need for stringent vigilance to ensure that the process is adhered to fully, and that the rights of the individual are respected. That need is all the stronger where the statutory process affects the rights of potentially very vulnerable persons who, because of the effects of their illness, temporarily may be unable to take steps to protect their own interests.

44. The framework established by the Oireachtas for the recording and transmission of decisions at various stages in the admission process must be seen as operating in a coherent manner. In that regard it is possible to understand the relevant forms – whose format the Oireachtas has expressly delegated to the expertise of the Commission – as constituting primary and important evidence of how the processes have been carried out. I am not persuaded that the completion of the forms amounts to a box ticking exercise as that term is used colloquially. The forms are solemn mandatory elements within the protective framework of the legislation which must be signed by the relevant person. In the case of medical practitioners, Forms 5 and 6 require the practitioner to express a very specific clinical view. The fact that this is expressed by choosing a box to tick does not detract from the fact that this involves the exercise and expression of a clinical judgment. While clearly the subsequent part of the forms that record the basis for the clinical judgment must be completed, I am not convinced that there is a need for an extensive discussion. This is because the legislation does not require the forms to be furnished to the patient himself or herself, but instead to, among others, the Commission, Tribunal, Independent Psychiatrist and specially trained legal representatives. Hence some element of brevity or medical shorthand could be permissible, so long as it is capable of being understood by the persons who will have to consider the forms as part of the overall process.

45. Finally in this regard, it bears noting that the processes introduced by the 2001 Act in some respects reflect elements already present in medical practice. For instance, the recommendation process involves a medical practitioner sending a referral to a consultant psychiatrist setting out a preliminary view on a patient. It seems to me that in a similar way to the operation of such referrals outside the context of the 2001 Act, the consultant doctor who receives that recommendation or referral will have regard to what the other medical practitioner has set out in the referral. In that way I consider that the contents of the recommendation could legitimately shed light on the contents of the admission order, as they form part of the same overall process.

FINDINGS ON THIS INQUIRY

46. It can be noted that the evidence in this case was not that the applicant did not understand why he was admitted – the applicant did not swear an affidavit and this contention was not made on his behalf. Similarly, Mr Phelan did not suggest that he was unable to understand the reasons for the admission. Instead, the case was presented solely on the basis that the information in the Forms was insufficient to establish the basis for the admission in the sense of how the criteria in section 3 of the 2001 Act were met.

47. In this case, the relevant consultant psychiatrist found that the applicant was suffering from a mental disorder within the meaning of section 3(1)(b) of the 2001 Act. The reasons that were given were expressed far more extensively than the very terse reasons in *A.A.*

48. As noted above, I consider that it is permissible to consider the Form 6 document in the context of the Form 5 recommendation that was made by the referring medical practitioner.

The recommendation made in this case describes an individual presenting as confused and expressing what can be understood as delusional beliefs, such as that hospital staff were flaying his skin with a knife. The registered medical practitioner tentatively ruled out organic causes for the behaviour and considered that the applicant was experiencing an episode of paranoid psychosis, a mental illness. In addition, it was clear from the Form 5 that the applicant was refusing treatment. Hence there is a clear indication of a mental illness, and reasons why a view could be taken that without an admission the person will deteriorate or would not receive treatment.

49. The Form 6 admission order also describes bizarre thoughts that gave rise to a reasonable concern that the applicant was suffering from delusions, e.g., that he had no blood and that he had no skin on the soles of his feet. The reference by the consultant psychiatrist to lack of insight, poor judgment, impaired reasoning and compromised decision-making clearly can be understood by necessary implication as a reason for his finding that, without an admission, the applicant would have deteriorated or would not receive treatment.

50. In the premises and even within the parameters of my understanding of the core findings in *A.A*., I am satisfied that what has occurred in connection with the admission of the applicant was lawful and that the Form 6 complied with the legislative requirements. I am satisfied that the persons to whom the Form 6 is required to be sent would be in a position to understand the reasons for the admission and how those reasons relate to the relevant criteria in section 3 of the 2001 Act.