THE HIGH COURT

[2026] IEHC 291

Record No. HMCA 2025/497

IN THE MATTER OF PJ

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

BETWEEN:

HEALTH SERVICE EXECUTIVE

APPLICANT

AND

PJ

RESPONDENT

***Ex Tempore* Judgment of Ms Justice Emily Egan delivered on the 6th day of May, 2026**

Introduction

1. This is a difficult and sensitive case in which an application was brought by the Health Service Executive under the inherent jurisdiction of the High Court in respect of PJ, a seventy-eight-year-old man who is currently detained in an approved centre. As will become apparent, this judgment is being delivered in circumstances of considerable urgency.

2. The Court is asked to determine whether the respondent has capacity to make decisions concerning his medical treatment and his accommodation and care needs. Specifically, the Court is asked to

determine whether it is lawful for the respondent's treating clinicians to apply a ceiling of care excluding coercive feeding, coercive medical treatment, and cardiopulmonary resuscitation. The Court is also asked to determine whether non-coercive palliative care may be provided in defined circumstances and whether the respondent's continued detention in the approved centre is necessary and proportionate.

3. It is important to be clear at the outset as to what this application is, and what it is not. This is not an application to withdraw existing life-sustaining treatment. It is not an application to authorise any positive act intended to hasten death. Nor is it an application to deny the respondent care. Rather, it is an application seeking legal clarity that clinicians may lawfully refrain from instituting invasive and coercive interventions which they regard, in good faith and in accordance with professional ethics, as futile, harmful, and disproportionate. If this court grants the relief sought, it remains the intention of the respondent's treating physicians to continue to offer him all appropriate treatment and care.

4. On the other hand, it is unfortunately clear that the proposed ceiling of care will likely result in the respondent's premature death. The application therefore engages the respondent's constitutional rights at a fundamental level, including his right to life, bodily integrity, dignity, autonomy, and liberty.

5. This case's complexity, as the Guardian *ad litem* points out, derives in large part from the respondent's refusal to engage in any meaningful way with his treating clinicians or with the Guardian *ad litem*, notwithstanding their concerned and sustained efforts to do so. The tragedy is that for a long period of time now, the respondent has both literally and indeed in common parlance, turned his face to the wall. The respondent refuses all engagement with clinicians and refuses all medical treatment or interventions of any kind. I am satisfied that there is unfortunately no reasonable prospect whatsoever that this will change or that the respondent will consent to or engage with the medical treatments advised, which are necessary to improve and preserve his health, his well-being and even his life.

6. For reasons that I now set out, I am satisfied as to the following:

a. First, the presumption of capacity has been rebutted in this case. Therefore, even though the respondent has clearly expressed his refusal of all medical interventions, because he lacks functional capacity to make such decisions, it is reasonable for the HSE to seek a declaration of lawfulness in relation to non-intervention, substitute consent in relation to palliative care and orders in respect of detention at the approved centre.

b. Second, in the particular circumstances of the respondent's case, the ceiling of care is lawful and necessary.

c. Third that, balancing of the constitutional rights engaged, it is necessary and proportionate to grant substitute consent for any palliative measures to which the respondent consents (but not to those which he resists).

d. Fourth that, balancing of the constitutional rights engaged, it is necessary and proportionate that the respondent would remain in the approved centre.

Framing the reliefs sought:

7. In so far as concerns future medical treatment (and non-treatment), the HSE seeks two separate suites of orders. It seeks firstly, an order permitting non-treatment by way of a ceiling of care and secondly orders permitting palliative care in certain circumstances. It is important to analyse the legal basis for these two suites of reliefs separately.

8. Although, as drafted, the motion frames the ceiling of care relief as an order of the court, such relief is not available by an order. Rather, it should be sought by way of a declaration that it is lawful not to deliver the measures which it is proposed to withhold (coercive feeding, coercive treatment, and CPR).

9. This reflects the Supreme Court's rejection of the United Kingdom Supreme Court's substitute-consent-based analysis regarding withholding treatment, as analysed in *In the Matter of JJ* [2022] 3 IR 1:–

> *[157] In circumstances involving the withholding of treatment … the legal issue is not whether the patient … consents to the course proposed by the doctors, but rather whether it is lawful for the doctors to do so; i.e., whether the judgement is one to which they can properly come. For those reasons, we would, and with respect, not agree with the portion of the judgment of Baroness Hale of Richmond in Aintree University Hospital…*

10. By contrast, seeking permission for treatment and palliative care engages the Court's power to grant substitute consent to the treatment sought.

Procedural History and Evidence

11. The proceedings were commenced in October 2025. Adrian Lennon was appointed Guardian *ad Litem* by order of the Court. I wish to record that the Guardian *ad Litem* has discharged his role with care and independence, both by seeking to advance the respondent's voice insofar as possible and by rigorously testing the evidential and legal foundations of the relief sought.

12. The Court heard oral evidence from the respondent's treating psychiatrist, Dr James McLoughlin, Consultant Psychiatrist of Later Life who has had prolonged and repeated engagement with him over a significant period, including an assessment on the morning of the hearing.

13. The Court also heard evidence from Dr Hisham Idris, Consultant Psychiatrist of Old Age, instructed independently by the Guardian *ad Litem* for the purpose of providing an independent expert opinion.

14. I found both witnesses careful, measured, and objective. The convergence of their professional opinions, notwithstanding their different roles, is significant.

Clinical Background

15. The respondent has a history of severe depressive illness with psychotic features. Over the past two years he has become profoundly frail, has sustained multiple serious fractures, and has experienced marked weight loss. The respondent is minimally ambulant and spends the vast majority of each day in bed.

16. During a prolonged admission in an acute mental health unit between late 2024 and mid-2025, the respondent persistently refused psychiatric medication and medical treatment. He underwent a course of involuntary electroconvulsive therapy between 2 December 2024 and 10 January 2025. This ECT, which was authorised under the Mental Health Act 2001, resulted in only brief and limited improvement in mood, engagement, and nutritional intake, which was not sustained.

17. Dr Sinead Costello carried out a clinical review some days after the ECT treatment and noted some improvement. Notwithstanding this, the respondent continued to refuse medical treatment, citing longstanding personal beliefs and distrust of the pharmaceutical industry rather than psychotic reasoning. He expressed a consistent view that his quality of life was poor, that he did not wish to reside in a nursing home, and that death was inevitable, while not accepting that he was depressed.

18. On 6 February 2025, after discussions with the respondent Dr McLoughlin placed a "ceiling of Care" letter on his chart. In Dr McLoughlin's view this was necessary to prevent distressing or harmful interventions by on-call clinicians.

19. This Letter records the respondent's wish that medical treatment will be offered but not forced and that there should be no coercive feeding, no coercive treatment, and no CPR. Although the respondent verbally agreed that these were his wishes, he declined to sign the document. In any event, Dr McLoughlin's view is that the respondent lacked capacity at that time to make these decisions independently. This is not therefore a valid advance care directive. This discussion does however provide a clear statement of the respondent's will and preference, which I am satisfied he had long held and continues to hold, that there should be no coercive measures.

20. Following transfer to the approved centre, the respondent has continued to refuse most meals offered, declined investigations and medication, and refused engagement with physiotherapy, occupational therapy, and other supportive interventions. He has consistently expressed opposition to invasive and coercive medical intervention, including force-feeding, intravenous treatment, and cardiopulmonary resuscitation.

The Presumption of Capacity

21. The Guardian *ad Litem* correctly emphasised that the respondent benefits from a presumption of capacity. As Laffoy J stated in *Fitzpatrick v FK* [2009] 2 IR 7:

"There is a presumption that an adult patient has the capacity… to make a decision to refuse medical treatment, but that presumption can be rebutted."

22. It is common case that given the gravity of decisions which may result in serious harm or death, the standard of proof is exacting. As Laffoy J further observed, the Court *"should not draw its conclusions lightly".*

23. Capacity is both issue-specific and time-specific, a principle long recognised at common law and now reflected in the Assisted Decision-Making (Capacity) Act 2015.

24. In addition, of course, capacity is, as the Guardian *ad litem* points out, the jurisdictional gateway to the relief sought. If the court determines that the presumption of capacity has not been displaced, then the question of granting relief does not arise.

Evidence on Capacity and on the respondent's refusal to accept medical treatment

Evidence of Dr McLoughlin

25. Dr McLoughlin reported as follows in October 2025:

> *"Assessment of Capacity: [The respondent] has not allowed for any accurate assessment of his cognitive function, though he demonstrated no overt difficulties at the time when he would speak with me.*
>
> *At the time that [the respondent] was still speaking with me, he demonstrated a clear lack of capacity around his desire to go home, stating that 'I managed before, I can manage now,' unable to account for the significant change in his circumstances (frailty, weight loss, multiple fractures, lack of family support) which have occurred since August 2023. He could provide no reasonable understanding of how he would manage in [a] mobile home without power or water in his impaired state.*
>
> *Regarding his future care wishes, [the respondent] demonstrates clear ability to retain relevant information, consider it and communicate his decision. However, he significantly minimises the likelihood of the potential outcomes, stating 'that's what you think, I think you exaggerate,' showing an impairment of his ability to appropriately judge the information and thus his capacity is compromised."*

26. This opinion relates to assessments several months ago. However, Dr McLoughlin also assessed the respondent's capacity on the morning of the hearing. Although once more, the respondent's engagement was limited, Dr McLoughlin's opinion remains the same.

27. Thus, Dr McLoughlin's view is that the respondent can understand information, retain it, and communicate a choice. However, he was clear that the respondent cannot *use or weigh* that information in a meaningful evaluative way. Thus, Dr McLoughlin described repeated interactions in which the respondent minimised risk and dismissed professional advice as exaggeration.

28. Dr McLoughlin also emphasised that treatment is and will continue to be continually offered, stating:

> *"[The respondent] would be offered treatments as clinically indicated but that should he refuse to have those treatments; they won't be forced upon him."*

29. He explained further:

"He is offered medications; he declines. He is offered that his vital signs are monitored; he…declines."

30. There is no suggestion that this pattern of behaviour is expected to change.

Evidence of Dr Idris (Independent Expert)

31. Dr Idris attempted to assess the respondent on two occasions. The respondent declined to engage on both occasions.

32. Dr Idris reported as follows:–

"The respondent demonstrates capacity to express a choice, as evidenced by his consistent and selective refusals. However, he shows significant impairment in his ability to weigh relevant information, particularly in relation to his care needs, treatment options, and the consequences of refusal."

33. Dr Idris further stated :

"The respondent's refusal to engage in assessment, combined with entrenched rigidity, hostility, and neurological vulnerability, substantially limits his ability to participate in a balanced decision-making process."

34. Dr Idris concluded:

"Accordingly, it is my opinion that [the respondent] lacks decision-making capacity in respect of complex decisions relating to his care and treatment."

Please kindly note that this opinion is formed on the balance of probabilities and is consistent with my direct observations, collateral information, and the broader clinical context."

35. Dr Idris's verbal evidence to the Court was to similar effect.

Findings on Capacity

36. The starting point for an application such as this is the presumption of capacity, now enacted in s.8(2) of the Assisted Decision-Making (Capacity) Act 2015, but also at common law, *Fitzpatrick v FK* [2009] 2 IR 7:–

"(1) There is a 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."

37. At p.43, Laffoy J went on to address the standard of proof:–

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

38. Baker J adopted this analysis in a hunger-strike case, *Governor of X Prison v. PMcD* [2015] IEHC 259, [2016] 1 ILRM 116, at para 57. The "clear and convincing proof" standard is of course derived from Hamilton CJ's judgment in *In re a Ward of Court (No. 2)* [1996] 2 IR 79, affirming an approach that "*...required clear and convincing proof of all relevant matters before reaching what must be regarded as an awesome decision...*".

39. There does not appear to be any Irish caselaw on the effect of a person's refusal to engage with a capacity assessment such as to frustrate it. In principle, one can see that in many cases, such an approach may well result in the non-rebuttal of the presumption of capacity.

40. This issue has been judicially considered in England. In *QJ v A Local Authority* [2020] EWCOP 7, Hayden J considered the position of an elderly man with dementia, presenting with food refusal, who also refused to engage in a capacity assessment. There, the Court focused on the question of whether the Respondent was unable, or simply unwilling, to engage in the capacity assessment:–

....[23] I am highly conscious that the presumption of capacity is a fundamental safeguard of human autonomy. It requires cogent, clear and carefully analysed information before it can be rebutted.

[24] It is important to emphasise that lack of capacity cannot be established merely by reference to a person's condition or an aspect of his behaviour which might lead others to make unjustified assumptions about capacity (s.2(3) MCA). An aspect of QJ's behaviour included his reluctance to answer certain questions. It should not be construed from this that he is unable to. There is a good deal of evidence which suggests that this is a choice.

[25] All parties in this case agree that evaluating capacity on this specific issue is finely and delicately balanced. But ultimately, I have to be satisfied, on the balance of probabilities (s. 2(4) MCA), that the presumption has been rebutted. I am unable to reach that conclusion.

41. I have to be conscious, as the Guardian *ad litem* points out, not to interpret a refusal to engage with a capacity assessment as evidence of lack of capacity. The respondent has a right to refuse to engage with his medical attendants and with the Guardian *ad litem*. I must determine whether, aside entirely from this non-engagement, the respondent's decision to decline all medical treatment is capacitous or whether, on the other hand, the presumption of capacity has been rebutted.

42. Having considered the evidence of both psychiatrists, I am satisfied that the presumption of capacity has been rebutted to the requisite standard. Essentially, the oral evidence of both experts is that the respondent does not accept or believe the advice that he is given concerning the likely impact of his choices on his health and indeed his life.

43. In such circumstances I accept that the respondent is unable to properly weigh the information given as regards his decision to refuse feeding or any form of medical treatment which might improve or, indeed imperil, his physical or mental state or his life. I am satisfied that the respondent's longstanding and trenchant refusals of treatment do not represent capacitous, evaluative decision-making, but rather decisions made in the absence of an ability to weigh the consequences thereof. I am also satisfied that the respondent also lacks capacity to consent to palliative medical treatment and to make decisions in relation to his accommodation.

Lawfulness of ceiling of care and *JJ*

44. This aspect of the case is governed by the decision of the Supreme Court in *JJ* [2022] 3 IR 1 ("*JJ*").

45. *JJ* concerned a child who had suffered a catastrophic injury and was made a ward of court. The hospital sought declaratory relief as to whether it could lawfully withhold aggressive life-sustaining treatment in the event of further deterioration.

46. The Supreme Court reaffirmed that, in such circumstances, the presence or absence of consent—whether from the patient, family or court—does not alter the legal position if withholding treatment

is otherwise lawful. The central question is whether the proposed course is lawful in all the circumstances.

47. As the Supreme Court stated:

> *"In circumstances involving the withholding of treatment… the legal issue is not whether the patient or family consents to the course proposed by the doctors, but rather whether it is lawful for the doctors to do so."*

48. The Court further recognised that, while court approval is not legally required, it may be prudent to seek confirmation where it is not possible to bring the patient or family to the same position so that they could be said to "consent" to the course of treatment.

49. While cases involving patients who lack capacity and where treatment is already in place require a substitute-consent analysis, *JJ* makes clear that this approach is not universal.

50. Therefore, where the case concerns a prospective decision not to commence treatment which clinicians consider to be clinically inappropriate or unethical, the correct focus is on the lawfulness of that decision. In short, the Court is not engaged in a substitute-consent or best-interests analysis, but in determining whether it is lawful for clinicians to act as proposed.

51. This distinction was examined in *A v. Hickey* [2021] IEHC 318, where the Court emphasised that the declaratory route identified in *JJ* is confined to circumstances in which clinicians themselves rely upon their entitlement not to provide treatment they consider to be unethical. The Court distinguished that case on the basis that it involved the withdrawal of an established treatment regime which no treating clinician had described as unethical.

52. Against this backdrop, it is significant that the present case concerns a prospective decision not to commence invasive and coercive treatment which, on the uncontroverted evidence, would be distressing, harmful, and unlikely to confer any meaningful benefit. The question for this Court is whether the proposed clinical decision not to institute coercive feeding or involuntary treatment is one which the respondent's treating clinicians may lawfully adopt, having regard to their clinical judgment and ethical obligations.

Clinicians cannot be compelled to act against clinical judgment

53. In considering the legal issues arising as regards such prospective decisions not to institute life-sustaining treatment in *JJ* the Supreme Court referred to what was then the current edition of the Medical Council's *Guide to Professional Conduct and Ethics* (8th ed., 2016). The Court endorsed the position that doctors are not obliged to start or continue treatment which, in their clinical judgment, is likely to cause more harm than benefit or to result in pain or distress outweighing any benefit.

54. This reflects the principle that clinicians cannot be compelled to provide treatment contrary to their *bona fide* clinical and ethical judgment.

55. The current 2024 edition of the Medical Council's *Guide to Professional Conduct and Ethics* (9th ed., 2024), provides that treatment, including resuscitation or medical nutrition and hydration, should not be started or continued where it is unlikely to work, may cause more harm than benefit, or is likely to cause pain or distress outweighing any benefit.

56. These principles were referred to by Barniville P. in *SM (A Ward of Court*) [2025] IEHC 717 in a decision granting substitute consent to the withdrawal of life-sustaining treatment and active supportive care in the case of a ward of court. At para 7, the President stated:

> *"When considering the legal and ethical issues engaged here, it is relevant that the continued provision of the current interventions (she is on a ventilator, has had nasogastric feeding, cardiovascular and other supports) are all very active and invasive interventions. There is certainly an ethical issue from the clinicians' perspective in continuing these active interventions where they have no prospect of achieving a positive outcome. Stemming from the ethical code under which the doctors are operating (the Guide to Professional Conduct and Ethics for Registered Medical practitioners (9th Edition, 2024) issued by the Medical Council (the "Guide")), there are issues from their perspective in continuing to provide those forms of very active and invasive intervention when they are not going to lead to any positive result or benefit for Ms SM and where they are, potentially, and actually, denying her a dignified death. Under paragraph 46.4 of the Guide, a doctor should not start or continue treatment, including resuscitation, or provide nutrition and hydration by medical intervention if the doctor considers the treatment is "unlikely to work", "might cause the patient more harm than benefit" or is "likely to cause the patient pain, discomfort or distress that will outweigh the benefits" (Guide, page 64)."*

57. To similar effect are the observation of Kearns J in *In the Matter of S.R.* [2012] 1 IR 305 that it was difficult to conceive of circumstances in which a court could properly require a medical practitioner to administer treatment which, in the practitioner's judgment, conflicted with the duty to act in the patient's best interests.

58. Similar principles were affirmed in *An Irish Hospital v R.F.* [2015] IEHC 608 and in the English decision of *Re J (A Minor)(child in care: medical treatment)* [1993] Fam 15, where the courts made

clear that it would be an abuse of power to require a doctor to act contrary to their professional judgment.

59. These authorities consistently confirm that the Court's function is not to direct clinical care, but to determine whether the course proposed by clinicians is legally permissible.

X Assessment of lawfulness of ceiling of care

60. The ceiling of care engages the respondent's constitutional rights at a fundamental level, including the right to life, bodily integrity, dignity, autonomy, and liberty.

61. The Guardian *ad Litem* correctly emphasised the special place of the right to life. In *In re a Ward of Court (No. 2)*, Hamilton CJ described such decisions as an *"awesome decision"*. However, the right to life does not exist in isolation from other constitutional rights and the presumption in favour of life-saving treatment can be rebutted..

62. Undoubtedly, an adult of full capacity has a constitutional right to refuse medical treatment, even where refusal may result in death. This has been the respondent's long standing expressed will and preference. Although the respondent lacks capacity to make that decision, his will and preference are still to be afforded considerable weight by the Court.

63. Where, as here, an adult lacking capacity takes such an approach, the Court must undertake a proportional balancing exercise to determine whether to authorise non-intervention.

64. The relief sought engages the right to life insofar as non-intervention may foreseeably shorten life. However, it does not authorise any positive step to terminate life. As O'Malley J stated in *An Irish Hospital v RF*:

"The courts will never authorise positive steps to terminate life. However… authorisation may be given to steps not being taken to prolong life.

65. This, in my judgment, is an appropriate case in which to provide such authorisation. Such authorisation respects the respondent's longstanding will and preference to refuse medical treatment, even if his life is in jeopardy and, to that extent, reflects his longstanding values. Previous involuntary ECT caused the respondent significant levels of distress and was ultimately of no perceptible benefit to him.

66. I accept that cardiopulmonary resuscitation would equally not be of benefit to the respondent. Dr McLoughlin explained:

"He would… require ventilation… he would… pull out those tubes… you would want to restrain him… and I don't think it is a wise decision to allow that happen."

67. Dr McLoughlin's opinion is that cardiopulmonary resuscitation in isolation will not necessarily be "lifesaving". In order for it to be lifesaving, the patient has to then be treated and recover in a high dependency unit, which would involve further intensive management, which the respondent would as a matter of high probability resist. I accept Dr McLoughlin's evidence that, in the particular circumstances of the respondent, CPR would initiate a cycle of invasive and highly distressing treatment and restraint with no realistic prospect of meaningful benefit.

68. I also accept Dr McLoughlin's evidence that given his frailty and fragile bones, there is a significant chance of causing injury to the respondent if he were restrained for the purposes of administering involuntary treatment or nutrition.

69. Overall therefore, I accept that this application falls directly within the *JJ* analysis and within the Medical Council's Guidelines cited at para 55 above. Involuntary treatment and coercive feeding will not as a matter of probability have any lasting benefit. Such interventions are therefore "unlikely to work". Moreover, such interventions will destroy any remaining therapeutic relationship and are "likely to cause the patient pain, discomfort or distress that will outweigh the benefits". In truth they will "cause the patient more harm than benefit".

70. Applying the *JJ* analysis and indeed the proportionality framework, I am satisfied that compelling such treatment would be disproportionate.

XI Palliative Care and detention

71. Substitute consent is sought to palliative care to which the respondent consents (or does not actively resist), i.e. non-coercive palliation, principally when he enters the active stage of dying.

72. Dr McLoughlin explained that it would be ethically unacceptable to permit a patient in the active stage of dying to suffer unmanaged pain or distress. Rather, the respondent should be offered medication to alleviate pain and if unconscious or unresponsive, should be managed in such a way as to ensure that he was as comfortable as possible.

73. I entirely accept that such non coercive palliative treatment is a necessary and proportionate intervention which respects the respondent's wishes and preferences but also protects and vindicates

his right to equal access to healthcare and to dignity in life and in death. It is appropriate to grant substitute consent in these circumstances.

74. Finally, I accept that the respondent's detention at the placement undoubtedly restricts his liberty. However, given his lack of capacity, extreme frailty, and inability to appreciate risk, I am satisfied that this is necessary and proportionate to protect his right to bodily integrity

XII Conclusion

75. Having considered the evidence, the submissions of the HSE and the Guardian *ad litem*, I am satisfied that:

- the respondent lacks capacity to make decisions concerning accommodation and treatment;
- the proposed ceiling of care is lawful;
- all appropriate care will continue to be offered;
- it is lawful to refrain from coercive feeding, treatment, and CPR;
- non-coercive palliative care may be provided where appropriate; and
- continued detention in the approved centre is necessary and proportionate.

76. Accordingly, the declaration of lawfulness to the ceiling of care and the other orders sought are granted.