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The Rights of Older People in Residential Care
An Examination of the Law and Practice

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This Thesis was submitted to the National University of Ireland, Galway for the Degree of Ph.D. in the School of Law

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Abstract

“The only stable state is the one in which all men are equal before the law.”  Aristotle (384 BC - 322 BC)

Since the foundation of the State older people in residential care settings have been largely ‘invisible’ to the State. Their personhood has been diminished or indeed negated where the older persons’ will and preference has largely been ignored and decisions made in their, or perhaps more accurately, the State’s or the residential care centres’, best interest. This position arose perhaps out of disinterest and inertia but certainly this research demonstrates a major contributing factor were the large deficits with regard to law, policy and practice concerning older people and safeguarding their fundamental rights. Legislative craters still exist for many frail and/or vulnerable older people. Concomitant with this are the lacunae in policy and practice.

International and regional human rights treaties which incorporate dignity of the individual as a core value provide clear direction for advancing human rights for older people in residential care settings in Ireland. The Convention on the Rights of Persons with Disabilities (CRPD) heralds a new departure for safeguarding fundamental rights. It is visionary in its concept and design. While the CRPD may not provide any new rights both the CRPD and the European Convention on Human Rights, itself a living instrument, when applied to older people, challenges us to make a difference by engaging with older people in residential care to provide robust protections to empower and protect their rights.

Since Ireland is a dualist state, ratification of the CRPD is essential to enable implementation of the monitoring mechanism. While international human rights treaties do not have domestic legal effect they provide a very clear roadmap to enable reform of legislation and policy in the context of older people and residential care. Legal capacity reform is crucial as is reform of mental health legislation. The following steps need to be taken: elimination of wardship, reform of enduring power of attorney legislation especially capacity assessment and enactment of legislation with regard to advance care directives and advocacy.

Variability in practice impacts on outcomes and expenditure in care which may have a detrimental effect on older people in residential care. Professional self-regulation should be abolished to prevent the possibility of exploitative and abusive behaviour by a worker. The potential for human rights’ abuse increases with escalating dependency since the need for more intimate care is required.

Multidisciplinary involvement is essential to addressing the complex care needs of older people in residential care. Legislative reform and policy development will have little impact unless they translate into practical and effective measures where best practice informs each workers relationship with the older person. Information, instruction, training and supervision of all workers are pivotal in securing fundamental rights for older people in residential care. The twelve hour working day should be reduced to a maximum of eight hours for all residential care workers. Independent inspection is critically important to ensure that the standards set are implemented and maintained.
Dedication

In memory of my father for helping to show me the true values in life and to the kindness and care of the many unlauded workers in residential care centres who did make a difference especially Aileen and LaLa.
Acknowledgments

My deep gratitude to my supervisor Dr. Mary Keys for her commitment and generosity in sharing her wisdom and extensive knowledge.

My sincere thanks go to the following people Laurent Pech, Donncha O’Connell, Conor Hanly, Anne Egan, Ciara Smyth, Tom O’Malley, Tommy Mc Donagh and Marie McGonagle for their time, helpful suggestions and encouragement.

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My grateful thanks and appreciation to my mother for her encouragement, advice and constant prayer and to her friend St. Martin for his help. To Sr. Cecelia, Pat, John, Dáire, and Eoin a special thank you.

To those I have not mentioned by name my deep thanks.
Chapter 1   Introduction

“A thing, once seen, cannot be unseen; and when you have seen a great moral wrong, to remain silent is as much a political act as to speak against it.”

The concept of human dignity may be considered the grounding principle for human rights. Dignity recognises the intrinsic and equal worth of all human beings, their right to respect by others and protection from ill-treatment or abuse. Dignity is the core value in international and regional human rights instruments and in the Irish Constitution and it has been acknowledged by the Irish Courts.

In his discussion on loneliness Jean Vanier provides a harrowing account of a visit to a psychiatric hospital “where hundreds of children with severe disabilities were lying neglected…” He describes the “deadly silence. Not one of them was crying. When they realize nobody cares, that nobody will answer them, children no longer cry. It takes too much energy.” Such ill-treatment and neglect is a denial of human dignity, a denigration of their human rights and a move towards effacement of their personhood. Vanier’s description has resonance for older people in some residential care settings in Ireland. Life takes on its own mantle where older people are sequestered around a room and the only sound is the noise from the television that nobody is watching. “We cry out only when there is hope that someone may hear us.” Hope on the other hand opens up all kinds of possibilities; it enables us to become fully human. Of fundamental importance is respect for autonomy and consent where the will and preference of the older person in residential care is upheld.

Historically there are large deficits with regard to law, policy and practice concerning older people and protection of their fundamental rights. Whereas scholarship has flourished in other areas of the law there is no tradition of scholarship in Ireland with regard to the older person in residential care. In terms of the State older people in residential care were largely

3 The right to dignity is not expressly stated in the European Convention on Human Rights. It is located in Article 26 of the Revised European Social Charter in the context of workers.
4 See, for example, McGee v Attorney General [1974] IR 284 and In re Ward of Court (withholding medical treatment) (No. 2) [1996] 2 IR 79, p. 163.
6 Ibid.
forgotten. Much of the provision of care, including access to and quality of care, was unregulated and if regulated was generally vague and unprescriptive and therefore open to subjective interpretation. As Mangan points out “[l]egislation, in itself, is not a guarantee that policies will be implemented, even if that legislation actually reflects policy. However, it is a prerequisite for the provision of certain services and, without specific legislation, it is difficult for individuals to establish or vindicate their rights.”

Older people do not form a homogenous group. The term ‘older people’ merely indicates a group of people aged 65 years of age and older. As Marks observes “[o]lder people as a group are as heterogeneous and varied as the rest of the population” and are equally entitled to robust safeguards to protect their human rights. Increased longevity is to be welcomed especially if their lives can be lived to the optimum of their capabilities; in the words of Doll and Peto we should aim to “die young as late as possible.” While such admirable thoughts may be a desirable and legitimate aspiration, for some of our older people it is a lost dream given their current reality.

Ireland’s ageing population is giving rise to concern for service providers with the demographic transformation and increasing numbers seeking care and social services. There has been an increase from 467,926 to 535, 393 people aged 65 years or over living in Ireland today, with a projected rise to 741,000 by 2021. There are more older females (292,080) than males (243,314), evidence of women’s longer life expectancy. Layte predicts by 2021 “[t]hose aged 65+ will increase from 11% to 15.4% of the population, with the those aged 85+ increasing from 1.1% to 2.1% which represents on absolute increase of

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13 CSO, 2007 (n 11).
14 CSO, 2012 (n 11).
16 CSO 2012 (n 11) p. 37i.
17 See Appendix 1 in this work.
42, 900 individuals.” It is considered that the numbers of older people using long-term residential care will rise by 12, 270 by 2021.

The majority of older people live out their lives in their own homes but for some who incur some loss of function to live independently, residential long term care may be their only choice. O’Neill points out that “[a]geing is a complex process where complex care, support and rehabilitation may be required. Nearly five per cent of older people live in one of the 607 residential units/homes in Ireland, of these 120 are public and 489 are private. Approximately two thirds of the patients are female. The main reasons for admission to long term residential care are chronic physical illness and dementia. The absence of quality community health and social care services to enable older people to continue to live in their own home may also be a factor in seeking residential care. When an individual or a neighbour has been subjected to burglary or robbery the older person may feel unsettled and vulnerable. Fear may propel the older person to seek alternative accommodation. The individual and/or the person’s family have an expectation that the

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19 Cardi Future demand for long-term care in Ireland 25th October 2012. Available at http://www.cardi.ie/userfiles/Long%20Term%20Care%20(Website)%20(2).pdf. Last accessed 28th October 2012. See also Appendix 2 and 3 of this work for Long Stay Activity Statistics 2002-2010, the category of residential care and age profile of residents.

20 Ibid. Appendix 2 and 3.


22 Pillinger, J., National Advocacy Programme for Older People in Residential Care Evaluation Commissioned by the HSE / NAPA January 2011, p. 7. Available at http://www.hse.ie/eng/services/Publications/Your_Service_Your_Say_Consumer_Affairs/AdvocacyResidentialEvaluation.pdf. Last accessed 28th July 2012. During the census 2011 94% of older people were in private households “with the remainder, 31, 054 persons, in communal establishments.” This includes religious communities. For further discussion see generally CSO, 2011 (n 11).


24 Ibid. p. 18. The National Institute for Health and Clinical Excellence and Social Care Institute for Excellence, “Dementia: Supporting people with dementia and their carers’ in health and social care” Nice clinical guideline 42 (London, National Centre for Mental Health, 2006) at p. 4 state: “Dementia is a progressive and largely irreversible clinical syndrome that is characterised by a widespread impairment of mental function. Although many people with dementia retain positive personality traits and personal attributes, as their condition progresses they can experience some or all of the following: memory loss, language impairment, disorientation, changes in personality, difficulties with activities of daily living, self-neglect, psychiatric symptoms (for example apathy, depression or psychosis) and out-of-character behaviour (for example, aggression, sleep disturbance or disinhibited sexual behaviour, although the latter is not typically the presenting feature of dementia”).

25 Jones, R., Mental Capacity Act Manual 2nd ed. (London, Sweet and Maxwell, 2007) p. 58 para. 82 has provided a description of a vulnerable adult: “Someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind or dumb or who is substantially handicapped by illness, injury or congenital deformity.”
older person is going to a better place where more expansive care tailored to the person’s specific needs can be provided. Some residential care settings may provide the quality care and security sought and therefore may be empowering. However where the residential care setting denies or denigrates human rights’ values such as dignity, autonomy or equality older people becomes disempowered. Their personhood is diminished.

Ageism has been considered “as great an affront to the supposed values of our society as is sexism or racism.” Emanating from a negative belief and attitude about older people it can manifest itself in direct and indirect discrimination. Age discrimination commonly arises in the context of health and social services for example polypharmacy and inappropriate medical referrals. Another commentator has said that “ageism … is a way of pigeonholing people and not allowing them to be individuals with unique ways of living their lives.” A similar view is offered by Comfort “[a]geism is the notion that people cease to be people, cease to be the same people or become people of a distinct and inferior kind, by virtue of having lived a specified number of years.” Potential ageism is abated where there is multidisciplinary involvement in health and social services that centres on the needs of the older person.

Older people in residential care are largely an invisible group. Critical issues for research include whether the law protects the rights of older people in residential care in Ireland. Key elements will include how legal instruments can translate into tangible benefits for the older person in terms of their quality of life. While theory is of little benefit to the older person who has soiled their clothing because their call bell was not answered in time, it is essential to inform the development of law, policy and practice. Given the example of the call bell the benefits to the older person will be the timely response to a call bell by the residential care worker. Essentially this may mean the avoidance of an accident that may be humiliating for the older person. A pivotal issue concerns the competency of care providers in terms of education, experience and training. Of vital importance is the role that professional bodies play in upholding or denying an older person’s fundamental rights. Advocacy is core to advancing rights for older people to voice values on their behalf where

27 See generally, McGlone, E. and Fitzgerald, F., Report no. 85 Perceptions of Ageism in Health and Social Services in Ireland Dublin, (Dublin, National Council of Ageing and Older People, 2005). See also discussion in Ch. 6 of this work on inappropriate prescribing.
necessary. Wardship on the other hand is an abomination and the proposed Scheme of Mental Capacity Bill 2008 with its guardianship provision does not auger well for any of us.

Taking account of the key research question which addresses whether the law in Ireland advances or meets the needs of older people in residential care settings, Chapter two examines international and regional human rights instruments and draws attention to the most relevant in the context of the older person in residential care. The focus shifts in Chapter three to domestic legislative provisions where constitutional rights are explored and the trajectory of legal provisions in Ireland is traced from the inception of the State to the present date in the context of older people and, in particular, those in residential care. The law’s attempt to enhance the capacity of older people in residential care will be contrasted with the traditional, more paternalistic approach taken by the State towards such residents. The increased numbers of older people in residential care settings points to the State’s inadequate strategies for maintaining interdependent living. It could be considered that residential care by its very nature weakens the older residents’ capacity to make their own decisions. It could also be argued that even highly regarded bodies like the Health Information and Quality Authority (HIQA) may weaken personal autonomy when, for example, HIQA requires a residential care setting to close but the older person may wish to continue residing in the particular care setting.30

The evolution of the theoretical perspectives in autonomy, its emanation in the law in the form of consent and the concept of capacity are considered in Chapter 4. Governance in most residential care settings resulted in partial or full loss of autonomy for many older people and placed them “not on a pedestal but in a cage.”31 In contrast autonomy as empowerment may be viewed as a wellspring of rights where the older person is centre-stage, an actress in her own life. Legal institutions including wardship, enduring power of attorney, advance directives and advocacy are detailed in Chapter 5. This discussion highlights the present position in Ireland emphasising shortcomings and advancing opportunities for change in line with international best practice. A critical issue is supported decision-making where necessary to enable older persons exercise their legal capacity.

Of fundamental importance to the older person in residential care is the therapeutic and personal relationship the older person has with all workers within the residential care setting. Chapter 6 addresses current regulatory provisions with regard to education, experience and

30 Annual Report 2011 p. 21 HIQA 24th May 2012. Available at http://www.hiqa.ie/publications, last accessed 1st June 2012. See also Watts v United Kingdom (Admissibility) (Application no. 53586/09) 2010 ECHR 793. For further discussion please see Ch.3 of this work para. titled Coroners Act, 1962 as amended.

31 This phrase was stated in a different context by Brennan, J in Frontiero v Richardson, 411 US 677 (1973) but has equal applicability here.
training of kindred professional and non-professional workers and makes recommendations for addressing legislative weaknesses.

The penultimate Chapter discusses [t]he Commission of Investigation (Leas Cross Nursing Home) Final Report.\textsuperscript{32} The appalling conditions that prevailed for many older residents in Leas Cross Nursing Home appear to have accelerated their morbidity and mortality.\textsuperscript{33} In terms of pressure sores O’Neill reported “[p]ressure sore care is (a) key indicator of quality of care for vulnerable older people in residential care….The care in Leas Cross raised grave concerns in the case notes reviewed. Pressure sores were documented at one stage or other in 33 of 100 available notes…” With regard to the use of restraints O’Neill comments that “[a]n alarming number of residents were being noted as being nursed in Buxton chairs, and although there was a written policy on restraints, there is only evidence of one relatively cursory attempt at surveying restraints and consent.”\textsuperscript{34} The resulting public furore from the television programme acted as a catalyst for legislative change, policy and practice. The concluding Chapter synthesises the findings of the earlier chapters and makes recommendations for bridging the legislative gaps that currently exist for safeguarding the rights of older people in residential care in Ireland.

Summary of Findings

Legislative deficits for the older person in residential care in Ireland have existed from the foundation of the state to date and the harrowing conditions continue to prevail for some in the absence of robust legislative safeguards, policy and practice. The publication of the Health Act 2007\textsuperscript{35}, its attendant regulations\textsuperscript{36}, the commencement of inspections by HIQA in July 2009 and the development of National Quality Standards for Residential Care Settings\textsuperscript{37} reflect a move from a more paternalistic approach by the State to one respecting personhood. A similar shift is taking place in the mental health sector with the publication of the Mental


\textsuperscript{33} O’Neill, D., A Review of the Deaths at Leas Cross Nursing Home 2002-2005 (Dublin, Health Service Executive, 2006) p. 16. O’Neill reports “[i]n Leas Cross, the median time to death of those who died was 221.5 (7.3 months) days from all hospitals, but only 77 days (2.5 months) for the St. Ita’s patients. This was a particular cause of concern…” Available at http://hse.ie/eng/services/Publications/services/olderpeople/Leas_Cross_Report_.pdf Last accessed 23\textsuperscript{rd} August 2012.

\textsuperscript{34} Ibid. p. 25.

\textsuperscript{35} Please see Ch. 3 of this work for further discussion.

\textsuperscript{36} Ibid.

\textsuperscript{37} Health Information Quality Authority National Quality Standards for Residential Care Settings for Older People in Ireland HIQA, 19\textsuperscript{th} February 2009. Available at http://www.hiqa.ie/standards/social/older-people. Last accessed 29\textsuperscript{th} August 2012.
Health Act 2001 (Approved Centres) Regulations 2006 and the five codes of practice. However gaps remain.

International and regional instruments provide a road map for addressing the legislative short falls in, for example, capacity legislation, enduring power of attorney, advance care directives and advocacy. Amending regulation is also required to address professional self-regulation. The twelve hour working day needs to be reduced to eight hours for those working in residential care centres to avoid negative consequences. The provision of core competencies for all workers which embraces a re-orientation in thinking that enables each worker to reflect on their practice is essential if practice is to change.

38 Please see Ch. 3 of this work for further discussion on mental health legislation and codes of practice.
Chapter 2  Human Rights

The views of Daw Aung San Suu Kyi in a different context have equal applicability in this discourse on human rights and the older person, when she invokes us to “please use your liberty to promote ours.” Such an appeal can be expanded to ask each of us to embrace the concept of personhood grounded in respecting the rights of older people in residential care. Flowing from this premise—the person as ‘subject’ rather than ‘object’ where the residential care setting, in the words of Gerard Quinn, “anchors itself on a sense of the centrality of the person” facilitates honouring the rights of the individual. As human beings we are relational and accordingly our human rights exist in the context of each of us as relational beings. As Donati observes, our human rights “are not conceived as rights to an object or to a functional performance, but rather as rights to certain human relations of the proper quality.”

This Chapter examines international and regional human rights instruments in the context of the older person in residential care in Ireland. The legal status of the instruments varies, while some may have binding legal effect, all contain a moral imperative to safeguard the rights of vulnerable older people in residential care. Respect for human dignity is germane to all major human rights instruments. These instruments set minimum standards and impose negative and positive obligations on states to protect individuals from human rights abuse such as inhuman and degrading treatment and to take positive actions to promote respect for fundamental human rights.

The human rights framework provides a clear roadmap for implementation of domestic legislation, policy and practice and when followed will ultimately provide positive outcomes for those it seeks to support and protect. In other words the tangible benefits of complying with international and regional human rights obligations are respecting and honouring the rights of older people in residential care in a practical and effective way.

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39 Words delivered by her husband at an address to the American University in Washington January 1997.
40 See amicus brief to the European Court of Human Rights of the European Group of National Human Rights Institutions in D.D. v Lithuania (Application no. 13469/06) Judgment 22 April 2008 for further discussion.
41 Quinn, G., “Rethinking Personhood: New Directions in Legal Capacity Law and Policy or How to Put the ‘Shift’ back into ‘Paradigm Shift’” paper presented at the University of British Columbia 29th April 2011 available at www.nuigalway.ie/cdlp
43 Ibid. 160.
44 (n 2).
Chapter 2 Human Rights

Chapter 2 forms the backdrop for Chapter 3 which examines constitutional rights in the context of older people and traces the history of legal provisions in Ireland from the inception of the state to date as applied to older people, in particular, those in residential care.45

INTERNATIONAL INSTRUMENTS

There are a series of nine46 core overlapping and intersecting international human rights treaties that formally protect human rights.47 A committee of experts has been formed by each of the treaties to monitor implementation of the treaty provisions by State Parties.48 Protocols may supplement some of the treaties, for example, the Optional Protocol to the Convention on the Right of Persons with Disabilities.49 In addition to the core human rights treaties other pertinent universal human rights instruments will be included in this discourse. The date of publication has been included to indicate the developmental nature of the rights. Some of the international instruments are more relevant than others to this discussion on the rights of older people in residential care and accordingly are included. The obvious starting point, therefore, is the Universal Declaration of Human Rights.

Universal Declaration of Human Rights (UDHR) 1948

The UDHR was adopted by the General Assembly of the United Nations in 1948.50 It set out standards of human rights for all countries to achieve and the mechanisms for the universal protection of these rights. It locates respect for human dignity as a central entity of all human beings.51 The core rights from which many other rights emanate are contained in Article 3 which provides that “[e]veryone has the right to life, liberty, and security of person.” For example, Article 5 requires that “[n]o one shall be subjected to torture or to

45 In this context the specific domestic human rights instrument, the European Convention on Human Rights Act 2003 No. 20 of 2003 cannot be divorced from other Irish legal provisions and is included in Ch. 3.
48 Ibid.
49 Ibid.
50 The UN was established in 1945 and the Charter (constitution of the UN) was published in the same year; 26th June 1945, 59 stat. 1031, T.S. 993, 3 Bevens 1153. While the Charter refers to human rights its prime purpose is international peace.
51 Preamble: “Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world....” and in Article 1 “[a]ll human beings are born free and equal in dignity and rights....”
cruel, inhuman or degrading treatment…” while a right to “medical care and necessary social services, and the right to security in the event of ... sickness, disability and old age....” is provided by Article 25. Although not legally binding, since its adoption the Universal Declaration has been used as a source and model for virtually every international human rights instrument and it continues to provide a moral, political, and legal influence in an ever changing world.54

**The International Covenant on Civil and Political Rights (ICCPR) 1966**

The Covenant codifies the rights and freedoms as set out in Articles 1-21 of the Universal Declaration. Article 2 affirms the rights contained in the Covenant are available to all without discrimination. It recognises that legislative provisions may need to be instituted to give effect to these rights and where there is a violation of the rights that the affected party has a right to an “effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity.”56

Protection from cruel, inhuman or degrading treatment is contained in Article 7.57 This critical provision has relevance for older people in residential care. In this regard relevant legislative safeguards to help protect older residents from potential abuse include, for example, the Mental Health Act, 2001 which prohibits the participation of an involuntary patient in clinical trials. Another example concerns the conduct of clinical trials on medicinal products for human use in Ireland that is now regulated by the European Communities (Clinical Trials on Medical Products for Human Use Regulations, 2004 (as amended)).59

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52 My inclusion in Italics.
56 Article 3(a) ICCPR.
57 Article 7 ICCPR provides, “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.”
58 S. 70 which commenced on 1st November 2006.
59 S.I. No. 190 of 2004; these Regulations which transposed the European Communities Clinical Trials Directive 2001/20/EC into Irish Law have been amended by EC (Clinical Trials on Medicinal Products for Human Use) (Amendment) Regulations 2004 S.I. No. 878 of 2004; the EC (Clinical Trials on Medicinal Products for Human Use (Amendment No. 2) Regulations 2006 S.I. No. 374 of 2006 and the EC (Clinical Trials on Medicinal Products for Human Use) (Amendment) Regulations 2009 S.I. No. 1 of 2009.
Chapter 2

Human Rights

With regard to liberty the most valuable provisions in this context are detailed in Article 9 (1) which provides that “[n]o one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.” In this regard, for example, review of detention under mental health legislation is addressed in paragraphs 188 – 194 of the Third Report by Ireland on the Measures Adopted to Give Effect to the Provisions of the Covenant.

The International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966

The Covenant pertains in the main to the rights and freedoms expressed in Articles 22-27 of the Universal Declaration. It restates in the preamble the role of dignity as set down in the Charter of the United Nations. The right to optimum health is recognised in Article 12 that provides that “[t]he State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” The measures to be taken by State Parties to secure this standard are detailed in Article 12.2. Of particular relevance here is Article 12.2.(d) that requires “[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness.” The treaty was ratified by Ireland in 1990. The ratification indicates Ireland’s willingness to implement progressively the rights contained in the Covenant and to specify the steps taken to advance these rights in periodic reports prepared and sent to the Committee on Economic, Social and Cultural Rights of the Economic and Social Council.

A new protocol opened for signature in September 2009 to allow individuals or groups representing them to request UN assistance should their rights under the covenant be

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60 With regard to mental health legislation see discussion on the Mental Health Act, 2001 No. 25 of 2001 and the Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No. 551 of 2006 in Ch. 3 of this work.
63 Article 2(1).
64 Ireland’s 3rd periodic draft report to the ICESCR is available at http://www.dfa.ie/uploads/documents/Political%20Division/Human%20Rights/ireland's%20third%20periodic%20report%20to%20the%20un.pdf. Accessed 4th April 2012; No. 270 of the Report provides, for example: “From 1 January 2007, people in residential care became eligible for full Disability Allowance as a matter of right, subject only to the same conditions as apply to others. This ensures that all persons with disability in residential care have an entitlement to an income maintenance payment and are treated in the same way as other social welfare recipients.” At No. 399 the Report states: “Closure plans are currently being developed for large psychiatric hospitals and this will include arrangements for the transfer of individuals with an intellectual disability to appropriate community residential facilities. Records maintained for planning purposes show a group of 188 individuals who were living in psychiatric hospitals in 2008 have been identified as needing to transfer from these locations to more appropriate accommodation. Achievements to date show a 68% reduction in the number of people with intellectual disability accommodated in psychiatric hospitals in the period 2000-2005.”
violated. However to date Ireland has not signed the new protocol;\textsuperscript{65} such assistance is already in place with regard to an individual’s civil or political rights.

While there is no express reference to the rights of older people in the Covenant its provisions apply equally to all individuals. Equality was first ascribed to women in Article 15 of United Nations Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) 1979.\textsuperscript{66} Legal capacity, a key element of human rights, was first mentioned in CEDAW.\textsuperscript{67}

In addition to Article 12 of the ICESCR the right to health is captured in Article 5(e)(iv) of the Convention on the Elimination of all Forms of Racial Discrimination (CERD) 1965 and the right to health protection and equal access to health care is enshrined in Articles 11.1(f) and 12 respectively of the CEDAW.

**Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984\textsuperscript{68}**

The prohibition of torture, cruel, inhuman or degrading treatment or punishment carried out (in the absence of lawful sanctions) by a public official or carried out with their knowledge is clearly outlined in Article 1 of the Convention that defines torture as,

\begin{quote}
any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.
\end{quote}

\textsuperscript{65} See www.dfa.ie/home/index.aspx?id=318. Last accessed 15\textsuperscript{th} April 2012.


\textsuperscript{67} Ibid. Article 15.2.

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As Buergenthal states, “the Convention is designed to prevent and punish” the offender.\footnote{Buergenthal, T., *International Human Rights in a Nutshell* 2nd ed. (St. Paul, MN., West Publishing Company, 1995) p.73.} Article 2 requires that adequate arrangements including legislation\footnote{The following is included for completeness but has little relevance for older people in residential care. The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment became effective on the 11th May 2002, available at http://www.dfa.ie/home/index.aspx?id=25058, last accessed 9th April 2012. This was enabled by the Criminal Justice (United Nations Convention against Torture) Act 2000 No. 11 of 2000. S. 11 was brought into operation on the 11th May 2002 by the Criminal Justice (United Nations Convention Against Torture) Act, 2000 (Commencement) Order, 2002 S.I. No. 166 of 2002; the purpose of the Act is to give effect to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment adopted by GA Res 39/46 (1984) U. N. The Criminal Justice (United Nations Convention against Torture) Act 2000 was amended by s. 186 of the Criminal Justice Act, 2006 No. 26 of 2006; s. 186 came into operation on the 1st August 2006 with the promulgation of the Criminal Justice Act 2006 (Commencement) Order 2006 S.I. No. 390 of 2006.} administrative, judicial or other remedies are in place to protect the individual from torture. Ireland is a signatory to the Optional Protocol to the Convention.\footnote{It was signed on the 2nd October 2007; the aim of the optional protocol is to provide further measures to protect persons from torture and other cruel, inhuman and degrading treatment or punishment and to increase the safeguards for those deprived of their liberty against such conditions.}

In addition to the legislative provisions\footnote{(n 70).} implementation of the Covenant is via the reporting system to the Committee against Torture (CAT) and through the interstate (Article 21) and individual (Article 22) complaint mechanisms. On the 11th April 2002 Ireland brought into force the complaints procedure pertaining to Articles 21 and 22. With regard to Article 21 Ireland “recognizes the competence of the Committee against Torture to receive and consider communications to the effect that a State Party claims that another State Party is not fulfilling its obligations under this Convention.” With reference to Article 22 Ireland “recognizes the competence of the Committee against Torture to receive and consider communications from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State Party of the provisions of the Convention.”

Ireland’s sole examination to date by CAT did refer to the treatment of persons with mental disabilities.\footnote{Cat/C/IRL/CO/1 22/23 May 2011. Available at http://www2.ohchr.org/english/bodies/cat/docs/co/CAT_C_IRL_CO_1.pdf The second periodic report is due 3rd June 2015.} The Committee recommended that:

> the State party review its Mental Health Act of 2001 in order to ensure that it complies with international standards. The Committee, therefore, recommends that the State party report on the specific measures taken to bring its legislation into line with internationally accepted standards in its second periodic report.\footnote{Ibid. para. 28.}
The Vienna International Plan of Action on Ageing 1983
The Vienna International Plan of Action on Ageing (the Vienna Plan) adopted by the United Nations General Assembly in 1982 can be heralded as the first international instrument on ageing.\textsuperscript{75} It contains 62 recommendations for action with regard to the protection of human rights for older people. This immensely important document provides a road map for governments, non-government organisations, policy makers, older people and those that may eventually provide services and care for older people. The recommendations take a holistic view of the individual and affirm ways of enabling an older person maximise their independence and wellness. For example, Recommendation 2 stresses the need to take “into account the interdependence of the physical, mental, social, spiritual and environmental factors” with regard to the care of the older person. It emphasises the desire of older people to live independent lives (but supported where necessary) in the community. Recommendation 1 pertains to individualised care plans “to alleviate the handicaps, re-educate remaining functions, relieve pain, maintain the lucidity, comfort and dignity of the affected” older person and “help them to re-orient their hopes and plans.” Significantly the requirement for early intervention with regard to mental illness is recognised.\textsuperscript{76} The need for geriatric assessment and a personalised treatment plan supported by a multidisciplinary team to optimise the health outcomes for the individual is appreciated.\textsuperscript{77}

In the context of spiralling health and social care costs the Assembly recognises that “those who give most direct care to the elderly are often the least trained, or have insufficient training for their purpose.”\textsuperscript{78} It acknowledges that a more co-ordinated approach is required between the parties involved in the delivery of care. Accordingly, a new skill set is recommended for the older person, their family, health workers and social welfare workers in the local communities to promote and maintain the health of the older person in the community.\textsuperscript{79}

I believe that information, instruction and training and supervision are pivotal in securing fundamental rights for older people in residential care. The Vienna Plan specifies that:

(a) the general population should have the necessary information to deal with an older person who requires care,

(b) the older person should receive education in self-care,

\textsuperscript{75} (U. N., New York, 1983).
\textsuperscript{76} Ibid. Recommendation 4.
\textsuperscript{77} Ibid. Recommendation 5.
\textsuperscript{78} Ibid. p. 25, para. 60.
\textsuperscript{79} Ibid. Recommendation 6.
(c) those who work in residential care settings should have the requisite training to enable them to carry out their work in conjunction with the older person and their family and with other workers within the work setting and,

(d) health care professionals, including students, should have the necessary training and skills with regard to “gerontology, geriatrics, psychogeriatrics and geriatric nursing.”

The plan recognises the importance of choice in terms of selection of service or care and that the optimal decision maker is the older person to whom the care or service relates. The plan, however, is silent with regard to information, instruction, training and supervision in terms of capacity building or property rights including, for example, enduring power of attorney.

While the Vienna Plan quite correctly highlighted the importance of training needs for both professional and non-professional workers, this did not translate into practice for those working in residential care settings for the elderly in Ireland. Until recently Ireland’s response to the Vienna Plan with regard to older people in residential care can best be described as sluggish in the extreme as the plan was largely ignored.

**United Nations Principles for Older Persons 1991**

In 1991 the UN General Assembly adopted the United Nations Principles for Older People and encouraged governments to incorporate them into national programmes where possible. Five main distinct yet interrelated areas were identified including independence, participation, care, self-fulfilment and dignity. The areas were amplified to incorporate the individual principles. Examples of the most relevant principles are adapted below to take account of older people in residential care settings:

(1) Independence

An older person in residential care should to be able to reside in a safe environment that is adaptable to a person’s circumstances in terms of their own preferences and altering capabilities.

Building on the Vienna Plan, the need for a safe environment is incorporated into the principles that take account of a person’s changing circumstances and wishes. While Principle 1 addresses independence it is silent on the notion of interdependence as

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80 Ibid. Recommendation 7.
81 Ibid. Recommendation 7-8.
82 See, for example, HIQA National Quality Standards for Residential Care Settings for Older People in Ireland (n 37).
83 A/Res/46/91.
84 Ibid. No. 5.
envisioned by Article 19 of the Convention on the Rights of Persons with Disabilities (CRPD)\textsuperscript{85} which is considered as “an articulation of equality and inclusion, and a declaration of independence and interdependence.”\textsuperscript{86}

(II) Participation

An older person in residential care according to their ability should be able to actively participate in policy development and implementation with regard to their own well-being and not be excluded from society.\textsuperscript{87}

The CRPD\textsuperscript{88} seems to reflect and augment the rights of the individual in terms of participation.\textsuperscript{89} For the older person in residential care in Ireland little account was taken of their need for independence or their inclusion in society.\textsuperscript{90}

(III) Care

Older people should:

i. have the care and protection consistent with society’s cultural value system,\textsuperscript{91}

ii. have access to preventative health care to enable them to prevent/delay ill-health and should ill-health arise the appropriate treatment to enable them to maintain/recapture their well-being.\textsuperscript{92}

iii. be able to make contact with legal or social services should they so desire, to enable them to augment their autonomy, care and protection\textsuperscript{93} and

iv. have suitable residential care services available that address the needs of the individual and respect each resident’s human rights and fundamental freedoms including the resident’s “dignity, beliefs, needs, privacy” and their “right to make decisions about their health care and quality of their lives.”\textsuperscript{94}

(IV) Self-fulfilment

\begin{enumerate}
\item A/Res/61/106.
\item CommDH/IssuePaper(2012)3. The right of people with disabilities to live independently and be included in the community p. 19, last accessed November 2012; for further discussion on autonomy and support see, for example, CommDH/IssuePaper(2012)2 Right to legal capacity for persons with intellectual and psychosocial disabilities. Last accessed November 2012.
\item (n 83) No. 7.
\item (n 85).
\item The CRPD does not contain any new rights.
\item See, for example, paras. titled the Health (Nursing Homes) Act, 1990 No. 23 of 1990 and the Finance Act 1998 No. 3 of 1998 in Ch. 3 of this work; changes have occurred more recently. See also HIQA, 2009, (n 37).
\item (n 833) No. 10.
\item Ibid. No. 11.
\item Ibid. No. 12; the proposed capacity legislation is still awaited.
\item Ibid. Nos. 13-14.
\end{enumerate}
An older person in residential care should be able to maximise their full potential and have “access to educational, cultural, spiritual and recreational resources.”

(V) Dignity

The older person in residential care “should be able to live in dignity and security and be free of exploitation and physical and mental abuse” and should be treated fairly irrespective of their circumstances.

Similar to the Vienna Plan the United Nations Principles for Older People had little impact for the older person in residential care in Ireland.

**United Nations Principles for the Protection of Persons with Mental Illness 1991**

The 25 principles provide a framework for protecting individuals with a mental health illness and improving their care. The first principle addresses basic rights and fundamental freedoms and includes, for example, the provision of optimum care, respect for dignity, protection from “economic, sexual and other forms of exploitations, physical or other abuse or degrading treatment” and a personal representative where the person lacks capacity.

Respect for information regarding a person with mental illness is enshrined in Principle 6. Principle 8 details the protection afforded to standards of care. Treatment is to be based on the individual needs of the patient, any such treatment is to be reviewed regularly and revised where the person’s condition requires. The treatment and any revisions to the treatment are to be discussed with the patient and provided by “qualified professional staff.” The preservation and respect for personal autonomy, one of the most fundamental rights is captured in Principle 9 sub-section 4.

Reference to the proper administration of medication is contained in both Principle 8 and 10. For example a person with a mental illness is to be protected from unjustified medication and where medication is justified it is only to be given as required and never given as either “a punishment or for the convenience of others.” Reflecting the ramifications of consent to treatment Principle 11 incorporates provisions where a person has capacity to give consent to treatment and where the person lacks this capacity.

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95 Ibid. Nos. 15-16.
96 Ibid. Nos. 17-18.
98 Ibid. Principle 1.3.
100 Ibid. Principle 9.
102 Ibid. Principle 10.
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Among other things arrangements for both voluntary and involuntary admissions\(^{103}\) are addressed in the principles as are notice of rights\(^{104}\), personal rights and conditions in mental health facilities\(^{105}\) and procedural safeguards.\(^{106}\)

For the majority of older people who were in residential care the safeguards contained in these principles were never realised. For others the impact of Ireland’s pattern of response to these principles has been slow in the extreme\(^{107}\) and for some others they continue to be a mere aspiration, for example older people that are wards of court. While I accept in principle Pound’s “slow and orderly approach to change of the law through the courts and other established legal institutions”\(^{108}\) the pace of change in this context is shameful as it denigrates the rights of these older people.


CRPD embraces those “who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”\(^{110}\) The intention of the Convention is to “promote, protect and ensure that ... human rights and fundamental freedoms” of “all persons with disabilities” can be enjoyed fully and equally and that their dignity is respected.\(^{111}\) Article 3 contains the Convention’s core values. Amongst the most relevant in this context are:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices and independence of persons;

(b) Non-discrimination;

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\(^{103}\) Ibid. Principle 15 and 16.

\(^{104}\) Ibid. Principle 12.

\(^{105}\) Ibid. Principle 13.


\(^{107}\) See, for example, the Mental Treatment Act 1945 No.19 of 1945 much of which remained in existence until 1st November 2006; ss. 1-5, 7 and 31-55 of the Mental Health Act 2001 No. 25 of 2001 became effective on the 5th April 2002 by the Mental Health Act 2001 (Commencement Order) S.I. No. 90 of 2002. The remaining sections of the Mental Health Act 2001 came into effect on the 1st November 2006 by the Mental Health Act 2001 (Commencement Order) 2006 S.I. No. 411 of 2006; the Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No. 551 of 2006 came into operation on this date also.


\(^{109}\) (n 85). The Convention was adopted by the UN General Assembly on the 13th December 2006.

\(^{110}\) Ibid. Article 1.

\(^{111}\) Ibid.
(c) Full and effective participation and inclusion in society;

(d) Respect for difference and accepting of persons with disabilities as part of human
diversity and humanity;

(e) Equality of opportunity;

(f) Accessibility;

(g) Equality between men and women.

Article 12 concerns equal recognition before the law. It has particular significance in that it
emphasises the right of persons with disabilities to make their own decisions on an equal
basis with others, that they may need support to make their decisions but that right should
explains, “Article 12 of the Convention is central. It both reflects and expresses the core
philosophy of the Convention...”\footnote{Quinn, G., “Statement to the Oireachtas Joint Committee on Justice, Defence and Equality, Re: Hearing on the Mental Capacity Bill” 29th February 2012 p.4 available at www.nuigalway.ie/cdlp Last accessed 21st April 2012.} The essence of the philosophy is a move from a
reductionist view of the person as object that somebody needs to look after to a more holistic
view of the person as subject taking charge of their own lives having equal protection
before the law.\footnote{Ibid. McKay, D., as cited by Quinn, G., p. 4; see also D.D. v Lithuania (n 40) for further discussion.}

Article 12 specifies that State Parties are required to 1. “reaffirm that persons with
disabilities have the right to recognition everywhere as persons before the law.” This right
Quinn explains:

Primarily ... means a decisive shift away from a deficits-oriented philosophy – one
that first seeks out decision-making frailty on account of disability and which then
finds safe ways of substituting for the decisions of the person by placing decision-
making authority in the hands of suitably circumscribed third parties. It means a
decisive shift towards an assumption of legal capacity – one that does not turn exclusively on cognitive ability.\textsuperscript{115}

The enjoyment of legal capacity on an equal basis with others is captured in Article 12.2 which provides that “State Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.” Bach and Kerzner note, that the term ‘legal capacity’ in both CEDAW and CPRD “is generally understood as referring to people’s capacity to have rights, and to have the capacity to act on those rights on an equal basis with others without discrimination on the basis of gender or disability. Legal capacity in this sense is a recognized status.”\textsuperscript{116}

Access to support tailored to the needs of the person is contained in Article 12.3 which provides that the State “shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.”\textsuperscript{117} The changing circumstances of an older person’s life means that such supports evolve as the person evolves. For example an older person with increasing dementia may require increasing support to augment their legal capacity.

Article 12.4 is reproduced in full here given its significance:

State 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.

\textsuperscript{115} Ibid. p. 5.
\textsuperscript{116} Bach and Kerzner, 2010, (n 112) p. 16.
\textsuperscript{117} See the UN CRPD handbook that states, “[s]upported decision-making can take many forms. Those assisting a person may communicate the individual’s intentions to others or help him/her understand the choices at hand. They may help others to realize that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity.” Available at http://www.un.org/disabilities/default.asp?id=242. Last accessed 1\textsuperscript{st} May 2012.
State Parties are charged with a duty to take robust measures to enable an older person to control their own financial affairs and ensure that they are “not arbitrarily deprived of their property.”

Liberty and security of the person are addressed in Article 14. Legitimately a person with a disability cannot be unlawfully or arbitrarily deprived of their liberty. Where a person with a disability is lawfully deprived of their liberty it must be on an equal basis with others and they must be afforded the same safeguards.

Articles 12 and 14 were deemed relevant by the Strasbourg Court in the case of Stanev v Bulgaria. The Court considered that the measures in place in the social care home “entailed significant restrictions on personal freedom giving rise to a deprivation of liberty with no regard for the applicant’s will or wishes.” This case can be contrasted with the recent Irish High Court case that held that a voluntary patient was not detained unlawfully even though they had requested on several occasions to leave the locked unit. As Donnelly points out this case “serves as a reminder of the unacceptable position of such patients under Irish Mental Health Law.”

Article 15 deals with freedom from torture or cruel, inhuman or degrading treatment. The Article also contains an express prohibition on medical or scientific experimentation in the absence of the person’s consent. Freedom from exploitation, violence and abuse is addressed in Article 16. State Parties are required, among other things, to take all appropriate means to protect persons from exploitation, violence and abuse, in the first instance by ensuring that appropriate legislative, administrative and social arrangements are in place, that gender and age-sensitive help and support are in place (for the person with a disability and their family) and that facilities and programmes are monitored by competent independent persons. Also, where exploitation, violence and abuse against a person with a disability may arise, the State Party is required to ensure that both legislation and policies are in place to investigate and, where the circumstances warrant, prosecute the offender.

The critical issue of protection of the integrity of the person finds expression in Article 17. Physical and mental integrity are directly related to the right of the older person in

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118 CRPD, Article 12.5.
119 Ibid. Article 14.2 provides: “State 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.”
120 (Application no. 36760/06 Judgment) 17th January 2012 para. 72.
121 Ibid. para. 149.
122 Donnelly, M., “Voluntary psychiatric patients need protection” Irish Times 9th February 2012.
123 Ibid.
residential care to respect for privacy and family life. This takes into consideration the internal and outer world of the individual—the right to be able to establish and maintain relationships, for example, through private correspondence and the facility to be able to make a private telephone call.\footnote{For further discussion see this Ch. para. titled Article 8: Right to Respect for Privacy and Family Life.}

Choice\footnote{Article 19 a. provides: “Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement.”} equal access to services\footnote{Article 19 b. provides: “Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.”} and individualised support\footnote{Article 19 c. provides: “Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.”} are core elements of Article 19 that addresses “living independently and being included in the community.”

Article 20 deals explicitly with personal mobility. This is to be welcomed. The Article provides that “[s]tate parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities.” This includes enabling the disabled person to choose the manner and time of when they themselves want to move, the availability of optimal mobility aids and the provision of training in mobility skills to both the disabled person and to the person working with them. Basic human needs such as toileting and bathing for the older disabled person are of particular import in this context.

Article 21 addresses “freedom of expression and opinion, and access to information.” The information must be in a form that is comprehensible to the recipient. Irrespective of where a person lives, be it in a public or private residential care setting, their privacy must be protected and not interfered with in an arbitrary or unlawful manner.\footnote{CRPD Article 22 Respect for privacy.}

Older people are specifically mentioned in Article 25. Health services must be tailored to the needs of the person with disabilities, following early identification and appropriate intervention, and incorporate services that are aimed at limiting and preventing further disability. State Parties are required to ensure that the same quality of care is provided to all persons, “including on the basis of free and informed consent.” This is to be achieved by increasing awareness of human rights among health care professionals though training and dissemination of “ethical standards” to include but not limited to public and private residential care settings for older people. Human rights embrace the concepts of “dignity, autonomy and needs of persons with disabilities.” Article 25.d. does not compel State Parties to raise awareness of human rights among non-health care professionals.
With regard to training requirements detailed in Article 26.2 the duty on State Parties is less onerous, in that they merely have to “promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.” Furthermore no reference is made to the standard, content or duration of such training.

The Optional Protocol to the Convention provides two procedures to augment the implementation and monitoring of the Convention. The first allows individuals to bring complaints where there is infraction of their human rights to the Committee while the second procedure enables the Committee to inquire into serious infringements of the Convention. While Ireland was a signatory to the Convention it has not signed the optional protocol nor ratified the Convention.129

The World Health Organisation (WHO)

WHO, an agency of the United Nations has particular interest in public health. The WHO constitution provides that its objective is the attainment by all people of the highest possible level of health.130 The right to health is both “complex and extensive.”131 Hunt highlights the need for the “[r]ight to health accountability that is much neglected.”132 In his statement he says among other things, “[t]he right to health demands accountability – not with a view to blame and punishment, but with a view to identifying what works (so it can be repeated) and what does not (so it can be revised).”133 Other relevant comments in this context are the urgent need for palliative care134 and that “it is imperative that more health workers engage with human rights.”135

Of interest in this context is the definition of an ‘institution’ that has been provided by the WHO:

Any place in which persons with disabilities and older people … live together away from their families.136 Implicitly, a place in which people do not exercise full

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129 There were 88 ratifications to the Convention with 54 ratifications of the Protocol on 17th July 2010.
131 Hunt, P., Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (“right to health” or ‘right to the highest attainable standard of health’). Statement made on the 11th March 2008, UN Human Rights Council.
132 Ibid. p. 1; my inclusion in italics. See also Ch. 7 of this work on Leas Cross Nursing Home.
133 Ibid Hunt, P.; for further discussion see Potts, H., “Participation and the right to the highest attainable standard of health.” Available at http://www.essex.ac.uk/human_rights_centre/research/rth/projects.aspx Accessed 12th February 2012.
134 Ibid. Hunt, P.
136 My inclusion in italics.
control over their lives and day-to-day activities. An institution is not defined merely by its size.\textsuperscript{137}

**Proposed UN Convention on the Rights of Older Persons**

A Resolution has been adopted\textsuperscript{138} to advance and secure fundamental rights for older people.\textsuperscript{139} How this will impact on the residents in residential care settings remains to be seen. Empowering older people, promoting their rights, raising awareness of ageing issues,\textsuperscript{140} the need for relevant information, instruction and training in the family, the wider community and the residential care setting can only yield positive benefits if the relevant law and policy is in place and enforced to translate into tangible benefits for the older person in residential care.

**REGIONAL**

**The European Convention on Human Rights 1950**\textsuperscript{141}

The Convention for the Protection of Human Rights and Fundamental Freedoms\textsuperscript{142} was drafted in 1950 by the newly formed Council of Ministers.\textsuperscript{143} The ECHR was developed against the background of the Second World War and the threat to individual liberty from communism and fascism with the aim of creating greater unity among the signature countries to the Convention by protecting in the main\textsuperscript{144} civil and political rights.\textsuperscript{145} The


\textsuperscript{140} Ibid.

\textsuperscript{141} ETS 5. The Convention came into force on the 3rd September 1953.

\textsuperscript{142} It is more generally known as the European Convention on Human Rights (ECHR).

\textsuperscript{143} The Council of Europe’s executive body (foreign ministers of all member states, or their permanent representatives in Strasbourg); the Committee of Ministers of one of the two statutory organs of the Council of Europe, the second is the Parliamentary Assembly representing the political forces in its member states. For a more extensive exposé see www.coe.int/cm and www.assembly.coe.int

\textsuperscript{144} The rule is limited by Article 1 of the First Protocol that provides for the protection of property and Article 2 of the First Protocol that provides for the right to education.

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Convention also established a Commission and later a Court of Human Rights. These were merged into a single court by Protocol 11.146

Since its development, the rights protected by the Convention have been extended and procedures have been improved. As a living instrument, the Convention is interpreted in the context of present day conditions.147 Given the evolving nature of the Convention a number of articles have particular relevance for safeguarding the rights of older people in residential care.

**Article 1**

Article 1 provides that, “[t]he High Contracting Parties shall secure to everyone within their jurisdiction the rights and freedoms defined in Section 1 of this Convention.” Section 1 merely provides a list of rights.148 However Article 1 animates the list by transforming rights into obligations for Contracting Parties that have ratified the Convention.149 The use of the Convention is governed by the principles of solidarity and subsidiarity.150 In the first instance Contracting Parties are obliged to give effect to the Convention by putting the arrangements in place to secure the Convention rights for their citizens, secondly by ensuring that a remedy is put in place in the event of a violation of a person’s Convention rights151 and thirdly by providing that all national remedies are exhausted before an individual seeks a remedy for violation of Convention rights from the European Court of Human Rights (ECtHR).152 The ECtHR recognises the principle of proportionality, that rights may be restricted in a democratic society but such a reservation must be ‘proportionate’ to the legitimate aim pursued.153

The judgments of the ECtHR are transmitted to the Committee of Ministers. On foot of a judgment a State has six months to implement its action plan and communicate this action plan to the Committee of Ministers. The role of the Committee of Ministers is to supervise the State’s implementation of judgments.


148 S.1 consists of Articles 2-18 of the Convention.

149 White and Ovey, 2010, (n 145) p. 84.

150 Ibid. p. 85, fn. 1.

151 Article 13.

152 Article 35; White and Ovey, 2010, (n 145) p. 84.

153 *Soering v U.K.*, A 161 (1989), 11 EHRR 439 para. 89. This case concerned the proposed extradition of a German to the United States on foot of a capital murder charge. It is included here given the impact of anticipated punishment now comes within the definition of torture. In a residential care setting, for example, is there a possibility that an older resident becomes compliant and silent by virtue of excessive fear that they will be punished-secured in a chair, left unchanged with the risk of developing untreatable pressure sores or medicated against their wishes?
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Article 2: Right to Life

The right to life is the most basic and fundamental of all rights. It cannot be derogated from under Article 15. The Court has observed that “its provisions must be strictly construed.”154 The Court has stated that in addition to refraining from the intentional and unlawful taking of life a State must also take appropriate steps to protect the lives of those within its jurisdiction.155 Such safeguards must be applied by a State “in a practical and effective”156 manner ... “in the context of any activity, whether public or not, in which the right to life may be at stake.”157 These positive obligations extend to the area of public health requiring states to put systems in place to protect the lives of residents in public or private residential care settings.158

The investigation of unlawful death may be considered as an implicit requirement of Article 2 when read in conjunction with the State Party’s duty under Article 1 of the Convention to “secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention.”159 The Court stated that “[t]he essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility.”160 This procedural obligation the Court said “is not an obligation of result, but of means.”161 It considered that the inquiry’s absence of power to compel witnesses and the private nature of the proceedings compromised the fatal accident investigation.162

The Court in the case of Calvelli and Ciglio v Italy163 referring to earlier cases was of the view that States are required to ensure that “an effective independent judicial system is set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable.”165 Inefficiency by a State Party with regard to investigation of the death of the applicant’s son due to alleged medical negligence was at issue in the Case of Šilih v Slovenia,166 the Court

156 Öner yields v Turkey (Application no. 48939/99) Judgment 30th November 2004 para. 69.
157 Ibid. para. 71.
158 Calvelli and Ciglio v Italy (Application no. 32967/96) Judgment 17th January 2002 para. 49.
160 Ibid. para. 69.
161 Ibid. para. 71.
162 Ibid. para. 87.
163 Calvelli and Ciglio v Italy (n 158).
164 My inclusion in italics.
165 Calvelli and Ciglio v Italy (n 158); my inclusion in italics.
166 (Application no. 71463/01) Judgment 9th April 2009.
stating that the State Party’s response to the applicant’s claim lacked the “level of diligence” that Article 2 required.\footnote{Ibid. para. 211.}

The case of \textit{Dodov v Bulgaria}\footnote{(Application no. 59548/00) Judgment 17\textsuperscript{th} January 2008.} arose as a result of alleged negligence by nursing home staff where an older woman with Alzheimer’s disappeared from the residential care setting when she was left alone in the yard with the gate unlocked.\footnote{Ibid. para. 23.} The Court considered that the “chains of events that were triggered by a negligent act and led to loss of life”\footnote{Ibid. para. 20.} may be examined under Article 2 since the events come within the ambit of “safeguarding the right to life”\footnote{Ibid. para. 21.} enshrined in Article 2. The Court recognised the duties of non-professional staff towards older vulnerable persons in residential care and said that “there is no reason why the requirement to regulate the activities of public health institutions and afford remedies in cases of negligence should not encompass such staff, in so far as their acts may ... put the life of patients at risk, the more so where patients’ capacity to look after themselves is limited...”\footnote{Ibid. para. 80.} This statement has particular relevance for Ireland where non-professional staff play a crucial role in the lives of older people in residential care. Greater regulatory emphasis is required in terms of their competence, delivery of care and sanctions in the absence of adherence to standards of care.

A salutary caution is offered by the Court with regard to medical negligence and compensation. Where medical negligence results in the death of a person the Court restated the principle that “where a relative of a deceased person accepts compensation in settlement of a civil claim based on medical negligence he or she is in principle no longer able to claim to be a victim.”\footnote{Ibid. para. 71.}

The ‘right to die’ was considered by the European Court in \textit{Pretty v United the Kingdom}\footnote{Pretty v United Kingdom (Application no. 2346/02) Judgment 29\textsuperscript{th} April 2002.} Mrs Pretty who was suffering from motor neuron disease sought freedom from prosecution for her husband should he assist her suicide. The Court held that the right to life does not mean ‘a right to die.’\footnote{Ibid. para. 40.}
Within the scope of the application of Article 2 the Strasbourg Court has considered the impact of pain relief. The Court considered that the treatment to relieve the pain of a severely disabled child was not administered with the intention of shortening life.\footnote{Glass v U. K., (Application no. 61827/00) Judgment 9th March 2004 para. 22.}


**Article 3: Prohibition of Torture**

The concept of human dignity permeates all of the ECHR; however it finds particular expression in Article 3 that states: “No one shall be subject to torture or to inhuman or degrading treatment or punishment.” As the Court has said “one of the main purposes of Article 3 is to protect, namely a person’s dignity and physical integrity.”\footnote{My inclusion in italics.} There is no derogation with regard to the provisions of Article 3.

The ECtHR has distinguished between the degrees of ill-treatment for all within the scope of Article 3. The threshold level is dependent on the individual set of circumstances under examination “such as the duration of the treatment, its physical and mental effects and in some cases, the sex, age and state of health of the victim, etc.”\footnote{Tyrer v U. K., (n 147) para. 33; my italics added.} Ill-treatment “must attain a minimum level of severity” if it is to come within the reach of Article 3.\footnote{Ireland v U.K., A, 25, para. 162 (1978); see Campbell and Cosans v U. K., A, 48 para. 30 (1982) with regard to the sensitivity of the applicant and the threat of degrading punishment.}

In Z v United Kingdom\footnote{ Moldovan and others v Romania Judgment No. 2 (Application nos. 41138/98 and 64320/01), Judgment 12th July 2005, para. 100.} the Court re-stated that:

> Article 3 enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment. The obligation on High Contracting Parties under Article 1 of the Convention to secure to everyone within the jurisdiction the rights and freedoms

\footnote{176 Glass v U. K., (Application no. 61827/00) Judgment 9th March 2004 para. 22.}
defined in the Convention, taken together with Article 3, requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment, including such ill-treatment administered by private individuals. These measures should provide effective protection in particular, of children and other vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge.\footnote{Ibid. p. 131 para. 73.}

The Strasbourg Court has repeatedly reminded States of their duties with regard to protecting vulnerable people from ill-treatment at the hands of private individuals.\footnote{Moldovan and others v Romania Judgment No. 2 (n 184) para. 98; in Leas Cross Nursing Home the authorities had knowledge of the standards of care and the conditions of the residents. See Ch. 7 of this work for a more extensive discussion.} In \textit{A v The United Kingdom}\footnote{Ibid. para. 22.} the Court stressed that “vulnerable individuals are entitled to State protection, in the form of effective deterrence, against such breaches of personal integrity.”\footnote{Ibid. para. 24.} In that case A, a child who had been beaten by his stepfather argued successfully that the State was responsible for a violation of his rights under Article 3 since the UK legal system had not sufficiently protected him against inhuman and degrading treatment. While the Court recognised that the State was not directly responsible for the beatings meted out by the stepfather, the State was duty bound to protect an individual from such punishment.\footnote{Soering v UK, (n 153).}

The \textit{Soering} case expanded the definition of inhuman or degrading treatment or punishment to include the severe effects of anticipated punishment.\footnote{See also Ireland v UK A 25 (1978) and Tyer v U.K., (n 147).}

Where medical intervention is carried out in the absence of consent because of therapeutic necessity it will not violate Article 3 “where the medial necessity has been convincingly shown to exist”.\footnote{Herczegfalvy v Austria (Application no. 10533/83) Judgment 10 July 2001 para. 82.} Given the evolving nature of the Convention, in \textit{Tanko v Finland}\footnote{Ibid.} the Commission recognised that it “does not exclude that a lack of proper medical care in a case where someone is suffering from a serious illness could in certain circumstances amount to treatment contrary to Article 3.”\footnote{Ibid. para. 22.} Such circumstances arose in \textit{Pilčić v Croatia}.\footnote{Ibid. para. 24.} The absence of surgical treatment for the removal of kidney stones that caused “the applicant to
suffer considerable occasional pain for a prolonged period of time”197 was deemed to be a violation of Article 3 of the Convention.198

The Court recognises that vulnerable people may not have the ability to make complaints about their treatment. In assessing whether the treatment or punishment received comes within the ambit of Article 3, the Court has taken into consideration the vulnerability and the person’s ability to make a comprehensible complaint or indeed if they are able to communicate the impact of any treatment they may have received.199

Treatment or punishment of an individual may be considered degrading “if it grossly humiliates him before others or drives him to act against his will or conscience.”200 However as White and Ovey point out the “Strasbourg Court has stated on several occasions that gross humiliation, as the purpose of the acts in issue, is not always a necessary ingredient of degrading treatment.”201

The inhuman treatment need not be intentional.202 In Price v United Kingdom203 the Court considered whether the purpose of the treatment Ms Price received while in custody was to humiliate or debase her. The Court said “one of the factors which the Court will take into account is the question whether its object was to humiliate and debase the person concerned, although the absence of any such purpose cannot conclusively rule out a finding of violation of Article 3.”204 While the Court found that while there was no intention to humiliate or debase the applicant, … to detain a severely disabled person in conditions where she is dangerously cold, risks developing sores because her bed is too hard or unreachable, and is unable to go the toilet or keep clean without the greatest of difficulty, constitutes degrading treatment contrary to Article 3 of the Convention.205

In the case of Hurtado v Switzerland206 the Commission considered that there was degrading treatment when the applicant who had soiled himself was unable to change his clothing until the following day. Conditions of detention, force-feeding, punishment and poor medical

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197 Ibid. para. 42.
198 Ibid. para. 43.
200 Denmark, Norway, Sweden and the Netherlands v Greece (1969) 12YB 1 at 186.
202 Labita v Italy (Application no. 26772/95), 6th April 2000 [GC], (2008) 46 EHRR 1228, ECHR 2000-IV para. 120.
204 Ibid. p. 1292 para. 24.
205 Ibid. para. 30.
treatment were at issue in Nevmerzhitsky v Ukraine.\textsuperscript{207} The Court held “that the applicant was held in unacceptable conditions”\textsuperscript{208} and accordingly this amounted to degrading treatment contrary to Article 3 of the Convention. In addition the court viewed the disciplinary punishment meted out in the isolation cell as “totally unacceptable”\textsuperscript{209} and the absence of adequate medical treatment was considered degrading treatment.\textsuperscript{210} Furthermore it held that force-feeding in the absence of “medical necessity” together with the equipment used characterised torture and therefore violated Article 3.\textsuperscript{211}

The same points were emphasised by the Court in Ciorap v Moldova.\textsuperscript{212} The Court held that there was a violation of Article 3 of the Convention citing the inhuman conditions of his detention namely “the extreme overcrowding, unsanitary conditions ... the low quantity and quality of food” together with the extensive period of detention.\textsuperscript{213} Furthermore the intermittent force feeding in the absence of medical necessity carried out with the intention of forcing the applicant to cease his protest and undertaken in a manner that caused immense “physical pain and humiliation” was deemed to constitute torture and therefore a violation of Article 3.\textsuperscript{214}

In the case of Selimouni v France\textsuperscript{215} the Court considered the “pain or suffering inflicted on Mr Selimouni”. The Court considered that “severe” in the context of Article 1 of the U.N. Convention had a meaning similar to that of “minimum severity” that was required to uphold an application under Article 3 of the European Convention on Human Rights.\textsuperscript{216} Torture has also been identified in the case of rape where the perpetrator was an unidentified state agent.\textsuperscript{217}

\textsuperscript{207} (Application no. 54825/00) Judgment 5\textsuperscript{th} April 2005. This case relates to a prisoner charged under the criminal code and is included here since some older people in residential care have or continue to experience one or other of these conditions, for example, the voluntary incapacitated patient. See Ch. 4 of this work para titled A Lacuna in the Law for discussion on the voluntary incapacitated patient. See Ch. 7 of this work for discussion on Leas Cross Nursing Home.

\textsuperscript{208} Ibid. para. 86; the Court viewed the detention conditions as a whole and included overcrowding in the cell and the “lack of proper hygiene, ventilation, sunlight, daily walks, appropriate clean bedding or clothes...”

\textsuperscript{209} Ibid. para. 86.

\textsuperscript{210} Ibid. para. 106.

\textsuperscript{211} Ibid. paras. 98 and 99.

\textsuperscript{212} (Application no. 12066/02) Judgment 19\textsuperscript{th} June 2007. This case relates to a prisoner charged under the criminal code and is included here since some older people in residential care have or continue to experience one or other of these conditions, for example, the voluntary incapacitated patient. See Ch. 4 of this work para titled A Lacuna in the Law for discussion on the voluntary incapacitated patient. See Ch. 7 of this work for discussion on Leas Cross Nursing Home.

\textsuperscript{213} Ibid. paras. 70 and 71.

\textsuperscript{214} Ibid. para. 88.

\textsuperscript{215} (Application no. 25803/94) Judgment 28\textsuperscript{th} July 1999, 29 EHRR 403 paras. 92-106.

\textsuperscript{216} Ibid. para. 100; see definition of torture at paragraph titled Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984 in this Chapter.

\textsuperscript{217} Aydin v Turkey (Application no. 23178/94) Judgment 25\textsuperscript{th} September 1997 para. 86.
Given the range of the applications of Article 3 it could conceivably be used in the context of an older person in a residential care setting where a violation of Article 3 could potentially arise where a vulnerable older person is subjected to inhuman or degrading treatment if local remedies have been exhausted. This has been affirmed in the recent case of *Stanev v Bulgaria*\(^{218}\) where the Court emphasised:

That the prohibition of ill-treatment in Article 3 applies equally to all forms of deprivation of liberty, and in particular makes no distinction according to the purpose of the measure in issue; it is immaterial whether the measure entails detention ordered in the context of criminal proceedings or admission to an institution with the aim of protecting the life or health of the person concerned.\(^ {219}\)

Prevention of inhuman or degrading treatment is fundamental by ensuring robust safeguards are in place. Any reports of ill-treatment must be investigated thoroughly to prevent re-occurrence. As Hammarberg affirms “we cannot accept impunity for violations of the rights of the most vulnerable.”\(^ {220}\)

**Article 5: Right to Liberty and Security**

Article 5.1 reads: “Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.” This right is subject to six exceptions. For the purpose of this discussion the most relevant exception is (e) that provides for: “The lawful ... detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.” Article 5.4 provides that “[e]veryone 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.”

Article 5 imposes negative and positive obligations on State Parties. Negative obligations require the state to ensure that it does not remove a person’s liberty without lawful cause. Positive obligations impose duties on the State to ensure that private parties within its jurisdiction do not relieve individuals of their liberty unlawfully or arbitrarily.\(^ {221}\)

\(^{218}\) (n ).

\(^{219}\) Ibid. para. 206.


\(^{221}\) *De facto* detention was at issue in *H.L. v UK* (Application no. 45508/99) 5\(^{th}\) January 2005. For discussion see Ch. 4 of this work.
One of the earliest cases that addressed unlawful detention (involuntary committal) in a psychiatric hospital was Winterwerp v the Netherlands.222 In this case the Court set out minimum conditions (except in emergency cases) to be satisfied for lawful detention of a person with mental ill health namely (i) the person must be deemed to be of unsound mind by a competent authority using objective medical expertise, (ii) the nature or extent of the condition must justify compulsory confinement and (iii) the continuity of the confinement must be based on the persistence of the condition. A fourth condition was later added, the Court223 observing that “there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention.”224

In ascertaining whether someone is deprived of his liberty the ECtHR has stated that “the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of measure in question.”225 This has been restated.226 The Court in H.M. v Switzerland227 accepted that the correct measures were put in place given the serious deterioration of HM’s home living conditions.228

“Deprivation of liberty ... must be necessary in the circumstances.”229 Where lesser sanctions exist and they are sufficient to protect the individual or public interest such measures should be first considered.230 For a person suffering with mental ill-health a place of lawful detention is considered “a hospital, clinic or other appropriate institution.”231 In the case of Mr. Shtukarturov232 the Court considered that the applicant’s hospitalisation was unlawful and therefore fell foul of Article 5.1(e) of the Convention.233 The Court stated that “it had not been ‘reliably shown’ by the Government that the applicant’s mental condition necessitated his confinement.”234 Significant restriction on personal freedom was also at issue in Stanev.235 The applicant’s indefinite placement in a social care home by the

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222 (Application no. 6301/73) Judgment 24th October 1979 para. 61.
224 Ibid. para. 46.
226 See, inter alia H.M. v Switzerland (Application no. 39187/98) Judgment 26th February 2002 para. 42; Storck v Germany (Application no. 61603/00) Judgment 16th June 2005 para. 71; Stanev v Bulgaria (n 120).
227 Ibid. (Application no. 39187/98).
228 Ibid. paras. 42 and 44.
229 Litwa v Poland (Application no. 26629/95) Judgment 4 April 2000 para. 78.
230 Ibid. paras. 79-80.
231 Aerts v Belgium (n 223) para. 46.
233 Ibid. para. 116.
234 Ibid. para. 115.
235 Staney v Bulgaria (n 120).
authorities without his consent that required a special permission to leave while the home’s management retained his papers was deemed to amount to a breach of Article 5.1.\textsuperscript{236}

Positive State obligations were identified in \textit{Storck v Germany}.\textsuperscript{237} The Court citing previous court opinion stated that it

has consistently held that the responsibility of a State is engaged if a violation of one of the rights and freedoms defined in the Convention is the result of non-observance by that State of its obligation under Article 1 to secure those rights and freedoms in its domestic law to everyone within its jurisdiction.\textsuperscript{238}

Accordingly, the Court held that the first sentence of Article 5 is to be interpreted as having a positive obligation on each State to protect their citizens’ liberty.\textsuperscript{239} The lawfulness and length of the applicant’s detention were among the issues in \textit{Nevmerzhitsky v Ukraine}.\textsuperscript{240} The Court found that the applicant’s detention was unlawful and in contravention of Article 5.1(c).\textsuperscript{241} Given the length of time the applicant was held in pre-trial detention in the absence of judicial supervision the Court held that these circumstances amounted to a breach of Article 5.3 of the Convention.\textsuperscript{242} The Court stated that the “reasons relied on by the authorities to justify the applicant’s continued detention ... although possibly relevant and sufficient initially, lost these qualities as time passed.”\textsuperscript{243}

Where a person has been detained their detention must be reviewed regularly to ensure that the continued detention is valid.\textsuperscript{244} In \textit{Stanev}\textsuperscript{245} there was no periodic review of the applicant’s detention and no facility for the applicant to challenge the lawfulness of his detention in the social care home.\textsuperscript{246} In considering that there was a breach of Article 5.4\textsuperscript{247} the Court stated “the remedies ... were either inaccessible to the applicant or were not judicial in nature. Furthermore, none of them can give rise to a direct review of the

\textsuperscript{236} Ibid. para. 160.
\textsuperscript{237} (n 226).
\textsuperscript{238} Ibid. para. 101.
\textsuperscript{239} Ibid. para. 102.
\textsuperscript{240} (n 212) paras. 122-138.
\textsuperscript{241} Ibid. para. 121.
\textsuperscript{242} Ibid. para. 129.
\textsuperscript{243} Ibid. para. 138.
\textsuperscript{244} E v Norway (1994) 17 EHRR 30.
\textsuperscript{245} (n 120).
\textsuperscript{246} Similar circumstances arose in the case of \textit{Kędzior v Poland} (Application no. 45026/07) Judgment 16 October 2012.
\textsuperscript{247} \textit{Stanev v Bulgaria} (n 120) para. 178.
lawfulness of the applicant’s placement in the ... social care home in terms of domestic law and the Convention.”

**Article 6: Right to a Fair Trial**

In brief Article 6 1 provides “[i]n the determination of his civil rights and obligations ... everyone is entitled to a fair ... hearing ... by [a] ... tribunal....” It is considered a pivotal right. In the case of *Stanev v Bulgaria* the Court re-affirmed that the

Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective. This is particularly true for the guarantees enshrined in Article 6, in view of the prominent place held in a democratic society by the right to a fair trial with all the guarantees under that Article.

According to Harris et al, Article 6 has a place of “pre-eminence in the Convention” because of the right itself and the large number of applications and jurisprudence it has given rise to. As Bartlett et al point out this Article does not normally impact decisions with regard to detention in psychiatric residential settings since deprivation of liberty falls more readily under Article 5. However in the context of older people and residential care its application is germane to areas such as retention of legal capacity, guardianship and consent to medical treatment.

The failure to examine a complaint of force-feeding was considered in the case of *Ciorap v Moldova*. There was a violation of Article 6 since the applicant did not have recourse to a tribunal. The same principles applied in *Shtukaturov v Russia* where the applicant was denied access to the domestic court resulting in deprivation of his legal capacity. The Court “confirmed that a person of unsound mind must be allowed to be heard either in person or, where necessary, through some form of representation.” In view of the fact that the applicant was a relatively autonomous person the Court considered that he should have been afforded the opportunity to present his own case and the judge should have had sight of the

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248 Ibid. para. 177.
249 Ibid.
250 Ibid. para. 231.
251 Harris, O’Boyle and others 2009 (n 145) p. 201.
252 Much of the jurisprudence emanates from criminal charges.
254 Ibid.
255 (n 212).
256 Ibid. para. 96.
257 (n 232).
258 Ibid. para. 71.
applicant and been given the opportunity to pose questions. Accordingly the Court considered that the Judge’s opinion based solely on documentary evidence “was unreasonable and in breach of ... Article 6 1.”

More recently the Court in Stanev recognised “the growing importance which international instruments for the protection of people with mental disorders are now attaching to granting them as much legal autonomy as possible” and “the trends emerging in national legislation” for persons with diminished capacity to access their national courts. Accordingly “the Strasbourg Court considers that Article 6.1 of the Convention must be interpreted as guaranteeing in principle that anyone who has been declared partially incapable ... has direct access to a court to seek restoration of his or her legal capacity.”

**Article 8: Right to Respect for Privacy and Family Life**

Article 8 provides for a right to respect for a person’s “private and family life, his home and correspondence” subject to an interference in accordance with the law. In essence the Article imposes positive and negative obligations on the State to respect and protect aspects of an individual’s personal life. The Article protects the individual against arbitrary interference. States have a margin of appreciation when considering what is the content of the duty ‘to respect’ one of the interests in Article 8 1. It is up to the Strasbourg Court to ascertain if the state has exceeded its power of appreciation.

Private life in the context of Article 8 has been difficult to define. Two elements to privacy were recognised by the Court in Niemietz v Germany. The first is the idea of “an ‘inner circle’ in which the individual may live his own personal life as he chooses” and the second is “the right to establish and develop relationships with other human beings.” In considering Niemietz, the Court in Botta v Italy said:

> Private life, in the Court’s view, includes a person’s physical and psychological integrity; the guarantee afforded by Article 8 of the Convention is primarily intended

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259 Ibid. para. 73.
260 Ibid.
261 Stanev v Bulgaria (n 120).
262 Ibid. para. 244.
263 Ibid. para. 245.
264 Ibid.
265 See Harris, O’Boyle and others 2009 (n 145) p. 350 fn 69.
266 (1992) 16 EHRR 97.
267 Ibid. p. 111 para. 29.
268 Ibid.
269 Ibid.
to ensure the development, without outside interference, of the personality of each individual in his relations with other human beings. 271

Mental health and its preservation have been clearly recognised by the Court as being an essential part of private life. In the case of Bensaid v United Kingdom 272 the Court stated:

Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development and the right to establish and develop relationships with other human beings and the outside world. The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the right to respect for private life. 273

While Article 8 places duties on the State to refrain from inappropriate interference in family life, it may also create positive duties to prevent or stop another person from interfering with an individual’s private life. As the Court said in Botta, 274

While the essential object of Article 8 is to protect the individual against arbitrary interference by the public authorities, it does not merely compel the State to abstain from such interference: in addition to this negative undertaking, there may be positive obligations inherent in effective respect for private or family life. These obligations may involve the adoption of measures designed to secure respect for private life even in the sphere of the relations of individuals between themselves ... In order to determine whether such obligations exist, regard must be had to the fair balance that has to be struck between the general interest and the interests of the individual. 275

The Court re-stated these general principles in Shtukaturov v Russia 276 saying

that any interference with an individual’s right to respect for his private life will constitute a breach of Article 8 unless it was ‘in accordance with the law’, pursued a legitimate aim or aims under paragraph 2, and was ‘necessary in a democratic society’ in the sense that it was proportionate to the aims sought. 277

271 Ibid. p. 257 para. 32.
272 (2001) 33 EHRR 205.
273 Ibid. para. 47.
274 (n 270).
275 Ibid. p. 257 para. 33.
276 (n 232).
277 Ibid. para. 85.
The Shtukaturov case concerned an applicant who suffered from a mental health disorder who was deemed to be fully incapacitated without assessment, such incapacitation ensuing for an indefinite period. A review of the incapacitation could not be undertaken without a guardian’s permission and the permission required was denied to the applicant in this case. The applicant did not attend the District Court and was not seen by the judge nor was he able to appeal the District Court’s ruling. Therefore he was not involved in the decision-making process. Furthermore the Russian Court only recognised whether the person had or did not have capacity.

Involvement in the decision-making process was also at issue in Elsholz v Germany and in Sahin v Germany. In the former, the ECtHR held that in denying the applicant access to his child there was a breach of Article 8. The national court had failed to obtain a psychology expert to help it assess the child’s statement and the father did not have sufficient involvement in the decision-making process. Similarly in the latter case the national court’s denial of a father’s right of access to his child gave rise to a violation of Article 8 of the Convention. The ECtHR placed particular significance on the absence of “[c]orrect and complete information on the child’s relationship to the applicant as the parent seeking access to the child is an indispensable prerequisite to establishing a child’s true wishes and thereby striking a fair balance between the interests at stake.”

In the absence of consent, a medical intervention even one of a minor nature has been considered as an interference with the person’s right to privacy by the European Commission on human rights. A blood test for paternity was deemed lawful. Similarly the Commission found that the obligation to undergo a urine drugs test is a compulsory medical intervention and is therefore an interference with the right to respect for private life but that the interference was “in accordance with the law” and therefore fell within the meaning of Article 8.2 of the Convention.

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278 Ibid.
279 Ibid. para. 95.
280 (Application no. 25735/94) Judgment 13th July 2000. While this case relates to parental access to a child similar issues may arise in a different context for an older person in a residential care setting. Establishing the true wishes of the older person is key to securing his or her fundamental rights. Supported decision making where required further enables the older person secure their true wishes.
281 (Application no. 30943/96) Judgment 8th July 2003. This case relates to parental access to a child and the reason for inclusion in this work is similar to above.
282 (n 273) para. 53.
283 (n 274) paras. 48 and 49.
284 X v Austria (1979) 18 D.R.154 at 156 (E. Comm. H.R.); 8278/78 Commission decision of 13th December 1979.
285 Ibid.
“Physical and moral integrity of the person” has also come within the scope of private life. In *X and Y v The Netherlands* the Court said that “fundamental values and essential aspects of private life are at stake. Effective deterrence is indispensable in this area and it can be achieved only by criminal law provisions.” The case concerned a sexual assault on a person with intellectual disability in a residential care setting. In *Y. F. v Turkey* the Court referring to *X and Y v the Netherlands* affirmed that private life embraced both the physical and psychological integrity of the person and an enforced gynaecological examination of the applicant’s wife was interference not in “accordance with the law.”

In terms of positive obligations the Court in *Storck* considered “that on account of its obligations to secure to its citizens their right to physical and moral integrity, the State remained under a duty to exercise supervision and control over private psychiatric institutions.” This ruling is particularly significant in that State obligations now extend to private places, for example, private nursing homes.

Correspondence and arrangements for meeting visitors has come within the scope of Article 8. A violation of Article 8 of the Convention occurred on two accounts in the case of *Ciorap v Moldova*, the first resulting from a breach of the applicant’s right to privacy with correspondence since “some of the applicant’s correspondence had been opened by the prison administration” and the second violation of Article 8 resulted from inadequate conditions to meet with his visitors. An over-zealous guardian’s intrusion into the applicant’s private sphere was one of the issues for consideration by the Strasbourg Court in the case of *Herczegfalvy v Austria*. The applicant’s letters (with the exception of those sent to his lawyer, advisor and the guardianship court) were sent with the approval of hospital management to Mr Herczegfalvy’s guardian for the guardian to forward at his discretion. Also when the applicant left the hospital six folders with the originals of his letters and approximately fifty unsent closed letters were returned to him demonstrating that

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287 *X and Y v Netherlands* Application no. 8978/80 Judgment 26th March 1985 para. 22.
288 Ibid.
290 Ibid. para. 33; *X and Y v Netherlands* (n 287) para. 22.
291 Ibid. *Y. F. v Turkey*, para. 43.
292 *Storck v Germany* (n 226).
293 Ibid. para. 150.
294 Ibid.
295 (n 212).
296 Ibid. paras. 101 and 104.
297 Ibid. paras. 118 and 119.
298 (n 193).
299 Ibid. para. 35.
the latter had never in fact been posted.\textsuperscript{300} The interference in the applicant’s correspondence was considered to be a violation of Article 8.\textsuperscript{301}

All of these issues are central to life in residential care. Health records were also deemed to be a vital component of private life in the case of \textit{I v Finland}.\textsuperscript{302} The Court said, “[r]especting the confidentiality of health data ... is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.” The Finnish hospital failed to protect a nurse’s health record. The Court found that the record system that was in place in the hospital was not in accordance with Finnish legislative requirements.\textsuperscript{304} Accordingly the Court held that the State were in breach of its positive obligations under Article 8.1 of the Convention.\textsuperscript{305}

**Article 13**

The right to an effective domestic remedy for Convention violations is enshrined in Article 13 which reads: “Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority not withstanding that the violation has been committed by persons acting in an official capacity.”

The Court affords the domestic authorities some discretion with regard to the manner in which they address their obligations under Article 13. The Court in \textit{Stanev v Bulgaria\textsuperscript{306}} recognises that “[t]he scope of the obligation under Article 13 varies depending on the nature of the applicant’s complaint under the Convention” but equally recognises that the remedy under this provision “must be ‘effective’ in practice as well as in law.”\textsuperscript{307}

**Article 14**

The non-discrimination provision is located in Article 14. The rights that accrue under this Article do not exist independently and must be supported by another provision of the Convention or Protocols to become operational.\textsuperscript{308} Other specific weaknesses, such as those that have a limiting or restrictive effect on this Article, have been identified.\textsuperscript{309} To close the gap that allows governments to discriminate, for example, by failing to provide equitable

\textsuperscript{300} Ibid. para. 36.
\textsuperscript{301} Ibid. para. 91.
\textsuperscript{302} (Application no. 20511/03) Judgment 17\textsuperscript{th} July 2008.
\textsuperscript{303} Ibid. para. 38.
\textsuperscript{304} Ibid. para. 44.
\textsuperscript{305} Ibid. paras. 48-49.
\textsuperscript{306} \textit{Stanev v Bulgaria} (n 120).
\textsuperscript{307} Ibid. para. 217.
\textsuperscript{309} Ibid. pp. 366, 369.
opportunities on the grounds of age, disability, sex or race, the Council of Europe Committee of Ministers agreed to Protocol No. 12, Article 1. Protocol 12 Article 1 has a strong conception of equality. While Wintemute agrees with the contents of Protocol No. 12 he is concerned with the tardiness of member states to ratify the Protocol. Ireland has signed the Protocol but disappointingly has failed to ratify it to date.\footnote{Status as of October 2012.} Clearly “non choice” grounds such as age and disability remain vulnerable until Protocol 12 is adopted.\footnote{Wintemute, 2004, (n 308) pp. 366, 372.} The gradual closing of some public long-stay beds in Ireland is especially worrying for older people and their families.\footnote{Rationalisation of community nursing homes was “inevitable” according to Minster of Health Dr. O’Reilly, Irish Times 25\textsuperscript{th} November 2011.} To avoid discrimination in the absence of Protocol 12 a transparent system on the allocation of beds in long-stay units needs to be available for all to see. While the ECtHR has advanced the concept of reasonable accommodation\footnote{Thlimmenos v Greece (Application no. 34369/97) Judgment 6\textsuperscript{th} April 2000; Glor v Switzerland (Application no. 13444/04) Judgment 30\textsuperscript{th} April 2009.} the CRPD is buttressed by the equality provision (Article 2 of CRPD) that supports all of the Convention.\footnote{CommDH/IssuePaper(2012)2 (n 86) p. 13.}

**European Social Charter 1961\footnote{CETS No. 035; entered into force 1965.} (revised 1996)\footnote{CETS No. 163; entered into force 1\textsuperscript{st} July 1999; in Ireland entered into force 1/1/2001.}**

The Council of Europe’s Social Charter as revised guarantees fundamental social and economic rights for everybody. It is enforced by the European Social Committee of Social Rights. The Charter recognises the right to health protection\footnote{Article 11.} and anyone without adequate resources has the right to social and medical assistance.\footnote{Article 13.} Article 11.3 includes the prevention “as far as possible [of] epidemic, endemic and other diseases, as well as accidents.” For example in this context influenza, clostridium difficile and fall prevention have relevance for vulnerable older people in residential care. The right of older people to social protection is enshrined in Article 23, part of which refers specifically to residential care. It guarantees elderly persons living in residential care “appropriate support, while respecting their privacy, and in participation in decisions concerning living conditions in the institution.” Van Bueren considers that Article 23 “represents significant progress” in that it “is the first binding human rights treaty provision to specifically protect the general rights of
older people. While this may indeed be the case, in Ireland however in the context of older people in residential care Article 23 seems largely to have gone unnoticed.

*Autism-Europe v France* the first 'collective complaint' sought successfully to defend the rights of persons with disabilities. A window of opportunity therefore exists for older people in residential care through the collective complaints mechanism where a breach of the Charter arises. In contrast to the applicant seeking redress under the ECHR the collective complaint applicant to the European Committee of Social Rights is not required to have exhausted all domestic remedies and if the application is deemed admissible the applicant party may envisage a decision within eighteen months. This is significant given the position in the life cycle of older people in residential care.

**Committee of Ministers of the Council of Europe**

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) was established under Article 1 of the 1987 Council of Europe Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment to assess during either a periodic or ad hoc visit the treatment of individuals deprived of their liberty and where required to augment the provisions for safeguarding those individuals from torture and from inhuman or degrading treatment. The CPT standards are the “substantive” sections of the CPT’s General Reports that provide guidelines with regard to care and living conditions and treatment for people in residential care. This includes residential care settings for older people.

In the context of care and living conditions the CPT has drawn attention to basic physical requirements such as food, hygiene, heat and clothing. With regard to the latter the CPT referred to “substantial stocks of clothing provided by donors … which” was markedly

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324 CETS No. 126.

325 CPT/Inf (98) 12 section c.

326 My inclusion in italics.
depersonalised and interchangeable among residents....” Another report refers to residents in a psychiatric geriatric unit and an admissions unit wearing “hospital pyjamas/track suits ...” stating that such clothing “is not conducive to strengthening their personal identities and self-esteem....” The CPT recommendation was “that all non-bedridden patients be allowed and, if necessary, encouraged to wear their own clothes during the day or be provided with appropriate non-uniform garments.”

The CPT visits may take place in any residential care setting “where persons are deprived of their liberty by a public authority”, for example, where de facto detained or where there is appearance of detention or involuntary placement in psychiatric or other residential care settings for older people. The CPT has paid tribute to the care patients have received from most staff members in psychiatric establishments. They also recognised that ill-treatment of patients does take place on occasion, reporting that auxiliary rather than professional health care workers are more likely to ill-treat a patient. Accordingly the CPT has recognised the importance of careful selection, training and supervision of workers to prevent the ill-treatment of vulnerable people in their care. The CPT has also drawn attention to the importance of proper management systems to reduce the risk of ill-treatment.

Another notable area addressed by the CPT in advancing protection for adult psychiatric patients is the means of restraint. To avoid or minimise the use of restraints requires management commitment, involvement and support, a comprehensive restraint policy that is implemented and supervised and the correct training and leadership to enable the worker to respond to the needs of an agitated and/or potentially violent patient in a respectful manner without harming themselves.

Voluntary patients who are truly voluntary in psychiatric institutions are outside the remit of the CPT. However the CPT’s delegation (among the issues it has addressed) has

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329 CPT/Inf (2011) 3 para. 151.
332 CPT/Inf/ (98) 12, (n 325) para. 27.
333 Ibid. para. 28.
334 Ibid. para. 31.
337 CPT is concerned with involuntary patients deprived of their liberty.
recognised that current Irish legislation does not safeguard the rights of those voluntary inpatients.\textsuperscript{338} It has observed that many so-called “voluntary” patients were in reality deprived of their liberty; they were accommodated in closed units from which they were not allowed to leave and, in at least certain cases, were returned to the hospital if they left without permission. Further, if staff considered it necessary, these patients could also be subjected to seclusion and could be administered medication for prolonged periods against their wish.\textsuperscript{339}

Potential violence remains an issue for both patients and staff in Irish residential care settings. The particularly severe nature of violence by a small number of patients on staff and other residents in a given unit has been cited.\textsuperscript{340} The delegation considered that the violence in one unit was also associated with other matters, for example, the poor condition of the unit, lack of privacy and inadequate staff training and experience.\textsuperscript{341} Another contributing factor is the mix of patients, long stay and those recently admitted together with a varied age range.\textsuperscript{342} The age of the patients in one unit visited ranged from 19 to 80 years.\textsuperscript{343}

In another unit three patients with limited mobility were unable to go outside because the assistance they needed was not available “apparently due to staff shortages.”\textsuperscript{344} The matter was raised with management who undertook to address the situation immediately.\textsuperscript{345} Patients with limited mobility have been highlighted in an earlier CPT Report.\textsuperscript{346} The CPT delegation observed at that time that “[p]hysically disabled residents should also, to the extent possible, be provided with appropriate assistance so that they can fully benefit from access to outdoor facilities.”\textsuperscript{347} The need for physiotherapy for residents with diminished mobility and speech therapy for elderly residents was also raised.\textsuperscript{348}

The CPT Reports have the potential to act as a catalyst for change. The CPT welcomed sections of the Mental Health Act 2001 that provided for “automatic and regular review of non-voluntary placements by Mental Health Tribunals, the rules on seclusion and bodily

\textsuperscript{338} CPT/Inf (2011) 3 (n 329) para. 117.
\textsuperscript{339} Ibid.
\textsuperscript{340} Ibid. paras 118-119.
\textsuperscript{341} Ibid.
\textsuperscript{342} Ibid.
\textsuperscript{343} Ibid. para. 119-120; similar findings were reported in St. Raphael’s at an earlier date- CPT/Inf (2003) (n 330) 36.
\textsuperscript{344} Ibid. para. 121.
\textsuperscript{345} Ibid.
\textsuperscript{346} CPT/Inf (2003) 36.
\textsuperscript{347} Ibid. para. 103
\textsuperscript{348} Ibid.
restraint, provisions on consent to treatment ... and the Mental Health Board... HIQA inspections of residential care settings for persons with intellectual disabilities are planned to commence in early 2013. However many of the action items identified in the Reports remain outstanding.

Recommendation No. R. (99) 4 of the Committee of Ministers of the Council of Europe on principles concerning the legal protection of incapable adults

Given its relevance in this context the pertinent part of this Recommendation is included:

**Principle 2 - Flexibility in legal response**

1. The measure of protection and other legal arrangements available for the protection of the personal and economic interests of incapable adults should be sufficient, in scope or flexibility, to enable suitable legal response to be made to different degrees of incapacity and various situations.

2. The range of measures of protection should include, in appropriate cases, those which do not restrict the legal capacity of the person concerned.

**Principle 3 – Maximum preservation of capacity**

1. The legislative framework should, so far as possible, recognise that different degrees of incapacity may exist and that incapacity may vary from time to time. Accordingly, a measure of protection should not result automatically in a complete removal of legal capacity. However, a restriction of legal capacity should be possible where it is shown to be necessary for the protection of the person concerned.

2. In particular, a measure of protection should not automatically deprive the person concerned of the right to vote, or make a will, or to consent or refuse consent to any intervention in the health field, or to make other decisions of a personal character at any time when his or her capacity permits him or her to do so.

A conflict arises here with Article 12 CRPD that provides full and equal capacity for everyone with the right to support to exercise one’s legal capacity.
Chapter 2  Human Rights

Principle 6 Proportionality

1. Where a measure of protection is necessary it should be proportional to the degree of capacity of the person concerned and tailored to the individual circumstances and needs of the person concerned.
2. The measure of protection should interfere with the legal capacity, rights and freedoms of the person concerned to the minimum extent which is consistent with achieving the purpose of the intervention…

Principle 13 – Right to be heard in person

The person concerned should have the right to be heard in person in any proceedings which could affect his or her legal capacity.

Principle 14 – Duration review and appeal

1. Measures of protection should, whenever possible and appropriate, be of limited duration. Consideration should be given to the institution of periodical reviews.
2. There should be adequate rights of appeal.

The significance of the Recommendation with regard to residential care settings has been affirmed. For example, the CPT delegation to Ireland has recommended that the proposed capacity legislation should take account of the 27 principles listed in these Recommendations.353 Another example is provided in Stanev v Bulgaria,354 where the ECtHR cited with authority Principles 2, 3, 6, 13 and 14.355 In terms of the CRPD this case also demonstrates that the ECtHR has not fully embraced the “revolution in thinking about legal capacity and it underlying basis, legal personhood”356 as the Court continues “to recognise mental disorder as a possible justification for limiting legal capacity.”357

Convention on Human Rights and Biomedicine (the Oviedo Convention 1997)358

The Convention seeks to protect the dignity and integrity of persons with regard to biological and medical developments. The right to health is contained in Article 3, “taking into account health needs and available resources ... [provide] equitable access to health care of appropriate quality.” The provision is limited with the caveat that the provision is

353 CPT/Inf (2011) 3 (n 329) para. 148.
354 (n 120).
355 Ibid. para. 73.
357 Ibid. para. 4.2.1.
358 Convention for the protection of Human Rights and dignity of the human being with regard to the application of biology and medicine: The Oviedo Convention 1997, CETS No: 164.
dependent upon resources available. Article 5 provides that a health related intervention may only be provided where the recipient of the intervention has “given free and informed consent” having first received the relevant information about the proposed treatment and its outcomes and that the recipient may “withdraw consent at any time.” Where a person is unable to give consent, subject to Articles 17 and 20, an intervention must be for the “direct benefit” of the recipient and only given when authorised. The authorisation may cease at any time in the best interests of the recipient.  

An intervention may be given to a person suffering from a serious mental illness without the person’s consent only where serious harm would occur to the person’s health, in the absence of the intervention, in an emergency situation or in response to “previously expressed wishes.” In contrast Article 17 of the CRPD affirms the right of people with disabilities to respect for their physical and mental integrity on an equal basis with others.

To date Ireland has not ratified the Oviedo Convention. Hamilton recognises that in the absence of ratification “many areas of scientific research remain unregulated with the exception of the area of clinical trials.” He advocates the implementation of the Convention tempering it with reservation or declarations to enable its advancement. While it has not been ratified by the UK, in Glass v United Kingdom the ECtHR said “that it does not consider that the regulatory framework in place in the United Kingdom is in any

359 Article 6.
360 Article 7.
361 Article 8.
362 Article 9.
363 The Human Rights Unit (HRU) was established in the Political Division of the Department of Foreign Affairs in 1996. Among its functions, the HRU has responsibility for facilitating the ratification of international human rights instruments. See http://www.dfa.ie/home/index.aspx?id=313 for further details on the HRU. Last accessed 7th April 2011.
364 November 2009; reasons for non-ratification were offered by Mr. Ivor Callely T.D. the then Minister of State at the Department Health and Children speaking in the Seanad on 4th December 2002 when he said that “there are difficulties with a number of articles that have implications for the destruction of human embryos.” While he did not reference the specific articles he continued: “I am deeply concerned about the absence of statutory controls in regard to a range of interventions in the sphere of assisted human reproduction, including that of human cloning. While medical practice in the area of reproductive medicine is governed by Medical Council guidelines, these only apply in the case of any service provided by other persons.” 107 Seanad Debates Col 1528 available at http://historical-debates.oireachtas.ie/S/0170/S.0170.2002120400008.html Accessed 15th April 2012.
366 Given the work completed by the Irish Commission on Assisted Human Reproduction and advise from the Irish Council for Bioethics.
367 Ibid.
368 (n 176).
way inconsistent with the standards laid down in the Council of Europe’s Convention on Human Rights and Biomedicine in the area of consent ...

**Recommendation Rec (2004)10 of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorder**

The purpose of these guidelines is to provide additional safeguards to protect the dignity, human rights and fundamental freedoms of individuals with a mental disorder especially those subject to involuntary placement or treatment. Article 7, for example, requires that arrangements are put in place to protect, in particular, vulnerable individuals who do not have capacity to consent or those who may be unable to prevent violation of their own human rights. Training and qualification of workers in mental health facilities is addressed in Article 11 that provides:

1. Professional staff involved in mental health services should have appropriate qualifications and training to enable them to perform their role within the services according to professional obligations and standards.
2. In particular, staff should receive appropriate training on:
   i. protecting the dignity, human rights and fundamental freedoms of persons with mental disorder;
   ii. understanding, prevention and control of violence;
   iii. measures to avoid the use of restraint or seclusion;
   iv. the limited circumstances in which different methods of restraint or seclusion may be justified, taking into account the benefits and risks entailed, and the correct applications of such measures.

**Recommendation Rec (2006)5 of the Committee of Ministers to member States on the Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015**

The Action Plan sets out a broad plan for ameliorating the lives of persons with disabilities. The plan emphasises fifteen key action areas including health care, legal protection and

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369 Ibid. para. 75.
371 Adopted by the Committee of Ministers on 5 April 2006; available at https://wcd.coe.int/wcd/ViewDoc.jsp?id=986865, last accessed 14th May 2011.
372 Ibid. para 3. 9.
Chapter 2 Human Rights

protection against abuse and violence. With regard to health care, the plan emphasises the importance of informed health care decision-making. It affirms the need for new health care policies and strategies in the context of the older person with disabilities.

The plan emphasises the provision of equal access to adequate health care that is respectful of the person’s rights provided by health care professionals trained on the social model of disability. This re-orientation from a solely medical approach to disability by health care professionals (medical approach has a tendency to view the person as ‘object’ to be cared for) to one that encompasses a focus on the social and human rights model of disability that views the patient/client/service user as subject is welcomed. It acknowledges the individual’s human rights.

In terms of legal protection the plan re-states that persons with disabilities are recognised as persons before the law. The plan recognises that some individuals may need assistance to exercise their legal capacity and accordingly safeguards may need to be implemented. The need for training on human rights and disability is highlighted “for enforcement personnel, public officials, judiciary and medical staff.” Disappointingly reference is not made to such training for health care workers.

The requirement to protect the most vulnerable in our society against abuse and violence is emphasised in the plan. One of the objectives requires that “systems are in place for the protection against abuse of persons with disabilities in psychiatric facilities, social care homes and ... other institutional settings.” The plan again draws attention to the need for information and training for relevant people. It specifies the need for training of staff; “for police and judicial authorities so that they can receive testimony from disabled people

373 Ibid. para. 3. 12.
374 Ibid. para. 3. 13.
375 Ibid. para. 3. 9.1.
376 Ibid. para. 1.3.
377 This has particular relevance in the context of capacity; see D.D. v Lithuania (n 40) for further discussion.
378 Older person may be referred to as a patient in a hospital or nursing home, as a client or patient in the mental health sector and a service user in the area of intellectual disability.
381 Ibid. para. 3.12.3.iii.
382 Ibid. para. 3.13.3.vii.
383 Ibid. para. 3.13.2.viii.
and treat instances of abuse seriously,\textsuperscript{384} and information for people with disabilities on how to “avoid ... recognise ... and report” incidences of violence and abuse.\textsuperscript{385}

**Recommendation CM/Rec(2009)6 of the Committee of Ministers to member states on ageing and disability in the 21\textsuperscript{st} century: sustainable frameworks to enable greater quality of life in an inclusive society\textsuperscript{386}**

This Recommendation seeks member states governments to “contribute to the creation of sustainable frameworks\textsuperscript{387} to enhance the lives of older persons ageing with a disability (people with a disability for the greater part of their lives who have grown old) and older people with disabilities (older people where the disability has arisen in their later years)\textsuperscript{388} by following these recommendations when putting the Council of Europe Disability Action Plan 2006-2015 into practice.\textsuperscript{389}

The recommendations include, for example, the promotion of autonomy,\textsuperscript{390} augmenting the quality of services\textsuperscript{391} by the provision of among other things information, relevant training and support for carers\textsuperscript{392} and improving equal access to services, for example, legal protection.\textsuperscript{393} Of significant import among the recommendations for enhancing the quality of services pertains to service providers. The Recommendation provides:

> The right to good quality of services provided by all service providers should be defined and guaranteed in legislation, with means of redress clearly specified. Areas to be covered include: training and qualifications of staff, quality standards in specific services, systems for monitoring and inspection, and complaints systems.\textsuperscript{394}

Such provisions are crucial for augmenting the quality of services for older people in residential care.

**European Union Law and Fundamental Rights**

In the European Union (EU) the evolving nature of human rights protection is evidenced in more recent EU legal provisions together with the entry into force of the Charter of

\textsuperscript{384} Ibid. para 3.13.2.ix.
\textsuperscript{385} Ibid. para 3.13.2.x.
\textsuperscript{386} Adopted by the Committee of Ministers on the 8th July 2009.
\textsuperscript{387} Ibid. p. 1.
\textsuperscript{388} Ibid. Appendix to Recommendation CM/Rec(2009)6.
\textsuperscript{389} Ibid. General Considerations.
\textsuperscript{390} Ibid. no. 1.
\textsuperscript{391} Ibid. no. 2.
\textsuperscript{392} Ibid. no. 2.7.
\textsuperscript{393} Ibid. no. 3.
\textsuperscript{394} Ibid. no. 2.9.
Fundamental Rights, 395 the establishment of a human rights agency, the European Union Agency for Fundamental Rights 396 and the forthcoming accession of the EU to the European Convention on Human Rights 397.

The origins of the EU can be traced to the ideas of Robert Schuman with the publication of the Schuman Declaration on the 7th May 1950 and the signing of the ECSC Treaty in Paris the following year. The objectives of the early Treaties 398 were mostly 399 economic and they did not contain any comprehensive provisions for the protection of human rights 400. The EU treaties can be considered as the EU’s constitutional charter and the primary source of EU law. In most cases, EU legislation must be jointly adopted by the Council and the European Parliament.

Legislative Acts may be either in the form of Regulations that are directly applicable and Directives that must be transposed into national law. 401 As is well known, EU law is said to prevail over conflicting provisions of national law 402 and most provisions of EU Law are capable of being directly effective. 403

Relevant provisions of EU law in the Context of the Older Person in Residential Care

European Law comprising of the Treaties, the law and judgments of the European Court of Justice (ECJ) have evolved to take account of fundamental rights. One of the earliest references to fundamental rights by the ECJ was in the Stauder 404 case, the Court stating that “the provision at issue contains nothing capable of prejudicing the fundamental rights enshrined in the general principles of Community law and protected by the Court.” 405

Affirming that fundamental rights were an integral part of European Economic Community

398 The European Coal and Steel Community (Treaty of Paris), the European Atomic Energy Community (Treaty of Rome) and the European Economic Community (Treaty of Rome).
404 Stauder v City of Ulm (Case 29/69) [1969] ECR 419.
405 Ibid. para. 7.
law the ECJ said that the “protection of such rights ... must be ensured within the framework of the structure and objectives of the Community.”  

Fundamental rights first secured treaty status with Article F (2) of the Treaty of the European Union (TEU) that provided:

The Union shall respect fundamental rights, as guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms signed in Rome on 4 November 1950 and as they result from the constitutional traditions common to the Member States, as general principles of Community Law.  

The Treaty of Amsterdam, 1997 clarified Article F (2) with the inclusion: “The Union is founded on the principles of liberty, democracy, respect for human rights and fundamental freedoms, and the rule of law, principles which are common to Member States.” However there was a lack of a cohesive response to give effect to the principles. Article 7 enabled the Council to use sanctions for persistent breach of fundamental rights by a member state.  

Article 168 of the Functioning of the European Union (TFEU) makes provision for the European Union’s participation in matters pertaining to public health—primarily health promotion (prevention, protection and education):

The community shall contribute toward ensuring a high level of human health protection by encouraging co-operation between Member States, and if necessary, lending support to their action. Action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission as well as health information and education.

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407 Art. 6 (2) EU Treaty; von Bogdandy, A. and von Bernstorff, J. “The EU Fundamental Rights Agency within the European and International Human Rights Architecture: The Legal Framework and some Unsettled Issues in a New Field of Administrative Law” (2009) 46 Common Market Law Review 1035 (fn) 16 comment that, “[t]he fundamental freedoms of Art. 6 (2) EU are not the internal market freedoms under the EC Treaty but are derived from fundamental rights traditions of the Member States and from international conventions...”
408 Article 6 (2) ex Article F. 2.
409 Signed 2nd October 1997 and came into effect on 1st May 1999.
412 Article 7 was amended and expanded by the Nice Treaty.
413 ex Article 152 of the Treaty of the European Union (TEU) (129).
414 Ibid.
European Union Law has no specific application with regard to older people in residential care. A majority of EU Member States (excluding Ireland) have ratified the CRPD and it has been technically confirmed by the EU. It may be envisaged that duties to persons with disabilities may arise in the context of Article 4.3 TEFU that enshrines the duty of ‘loyal cooperation’ between Member States themselves and the EU. Such co-operation is envisaged when implementing legislation relevant to CRPD. Article 32.1 of Council Decision 2010/48/EC with regard to international cooperation provides, for example, that State Parties may co-operate in “facilitating and supporting capacity-building, including through the exchange and sharing of information, experiences, training programmes and best practices” to secure the aims and objective of the CRPD. The EU may advance structural funds to subsidise the requirements of Article 19 CRPD.

The Charter of Fundamental Rights of the European Union

Article 6 TEU inserted by the Lisbon Treaty provided the Charter with legal effect equal to the Treaties. The Charter contains within a single EU document rights that are enshrined in a number of legal instruments. It includes lists of economic, social and cultural, civil and political rights of the citizens and residents of the EU that are divided into six thematic chapters. These include dignity, freedoms, equality, solidarity, citizen’s rights and justice. The Charter applies to European institutions (taking account of the principle

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415 In terms of older workers Article 13 of the Amsterdam Treaty grants the EU the power to “take appropriate action to combat discrimination based on sex, racial or ethnic origin, relation or belief, disability, age or sexual orientation.”


418 Article 32.2 2010/48/EC provides that “[t]he provisions of this Article are without prejudice to the obligations of each State Party to fulfil its obligations under the present Convention.”

419 Article 32.1(b) Council Decision 2010/48/EC.


421 For example, those of the United Nations, National and EU laws.

422 For example: Article 1 Human dignity; Article 2 Right to life; Article 3 Right to integrity of the person and Article 4 Prohibition of torture and inhuman or degrading treatment or punishment.

423 Relevant examples include: Article 6 Right to liberty and security; Article 7 Respect for private and family life; Article 8 Protection of personal data and Article 17 Right to property.

424 For example Article 21 provides for cultural, religious and linguistic diversity.

425 For example Article 35 pertains to health care.

426 Article 40 includes the right to vote.

of subsidiarity) and to the Member States when they implement EU law. 428 The more salient in this discussion on older people in residential care are referred to below.

Chapter 1 of the Charter pertains to Dignity. Article 1 states “Human dignity is inviolable. It must be respected and protected.” In doing so it reaffirms 429 the respect afforded to human dignity. Prior to the Lisbon Treaty coming into effect the ECJ confirmed the right to dignity in Netherlands v Parliament and Council. 430 The Charter recognises the “right to the integrity of the person.” 431 In particular (in this context) Article 3 provides that “everyone has the right to respect for his or her physical and mental integrity” and in the area of medicine and biology respect must be given to “the free and informed consent of the person concerned, according to the procedures laid down by law.” 432 Article 4 aims to protect persons from “torture or inhuman or degrading treatment or punishment.”

 Freedoms are addressed in the second chapter. The right to privacy is recognised in Article 7 that states: “Everyone has the right to respect for his or her private and family life, home and communications.” Article 8 provides protection for an individual’s personal data.

 Equality before the law given its significance is afforded its own chapter. Equality before the law is recognised in Article 20 and Article 21 which provides: “Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.”

 A right to health care and the rights of persons with disabilities are located in chapter 4. Article 25 refers to the rights of older people. It acknowledges that “[t]he Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life.” 433 The rights of persons with disabilities are recognised and respected by Article 26 that provides “measures designed to ensure their independence, social ... integration and participation in the life of the community.” Everyone has a right of access to preventative health care and to medical treatment according to national arrangements as provided by Article 35.

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428 Article 51.
429 The Universal Declaration of Human Rights 1948 states that: “All human beings are born free and equal in dignity and rights and are entitled to life, liberty and security of the person.”
431 Article 3.2.
432 Ibid.
433 Article 25.
It is recognised from a legal viewpoint that two difficulties prevail in EU law in the event of multiple discrimination when seeking access to healthcare.\textsuperscript{434} Firstly EU law has a limited sphere of protection in terms of discrimination and access to healthcare. While discrimination on grounds of sex and racial or ethnic origin are included, disability, age, sexual orientation and religion are notable by virtue of their exclusion. Secondly any suggestion of bringing a claim or making a complaint is limited since multiple discriminations are largely outside the remit of those who develop policies on equal access to health care.\textsuperscript{435}

\textbf{European Union Agency for Fundamental Rights (FRA)}

The FRA was established in 2007 as an advisory and a data gathering body of the European Union.\textsuperscript{436} The purpose of the FRA is to

> provide the relevant institutions, bodies, offices and agencies of the Community and its Member States when implementing Community law with assistance and expertise relating to fundamental rights in order to support them when they take measures or formulate courses of action within their respective spheres of competence to fully respect fundamental rights.\textsuperscript{437}

The work of the FRA is confined to the scope of application of EU law.\textsuperscript{438} They are one of four bodies (the others being European Parliament’s Petitions Committee, the European Ombudsman and the European Commission) identified by the European Commission to work with people with disability and their representative organisations in the implementation of the CRPD. In this regard the FRA in its role as a data gathering body will “collect and analyse data … and in cooperation with the Commission … develop indicators and benchmarks to support the monitoring process.”\textsuperscript{439} It is considered likely that the FRA will be appointed as the EU’s internal monitoring body under the CRPD (Article 33).\textsuperscript{440}
Further Commentary

To advance co-operation between the EU and the Council of Europe a memorandum of understanding was signed in May 2007. This was followed by the signing of an agreement between the Commission and the Council of Europe containing the Council’s agreement on cooperation with the FRA. Formal talks were initiated between the EU and the Council of Europe towards accession to the European Convention on Human Rights resulting in the publication of the draft agreement on the Accession of the EU to the European Convention on Human Rights. Accession is enabled by Article 6 of the Lisbon Treaty and envisaged by Article 59 of the ECHR as amended by Article 17 of Protocol 14. Currently the ECHR does not apply to EU Acts even though member states are obliged to take account of its requirements when applying or implementing EU law. As Groussot, Lock and Pech explain, EU accession to the ECHR would enable the ECtHR to check the compatibility of any provision of the EU Treaties and legislation with the rights set out in the ECHR.

As a corollary of accession the EU would be treated the same as member states and (once all pertinent EU remedies have been exhausted) could therefore be brought before the Strasbourg Court to respond to any accusations of breach of the ECHR that have been levied against it.

The road map for respecting and honouring the rights of older people in residential care has been provided by international and regional human rights instruments but Ireland has been slow to follow it. The moral imperative contained in the international and regional instruments has been largely ignored. The impact of the European Court of Human Rights and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment can be viewed as vehicles of limited positive change to date in terms of the vast majority of older people in residential care settings.

Greer considers the most pressing problem for the ECtHR is that of the ever-expanding case load. He considers that “[t]he most pervasive problem is a lack of commitment to the delivery of constitutional justice”. Only a small number of applicants are heard by the

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443 14th October 2011.
445 See generally Groussot, Lock and Pech 2011 (n 397).
ECtHR since it rejects “about 90 in every 100” applications “after a full examination” by the ECtHR. Costa acknowledges that “the waiting time for cases to be decided is often unreasonable...” The waiting time in respect of some cases following EU accession is likely to be even greater given the prior involvement of the ECJ in certain cases.

Among the limitations of the Convention system in Strasbourg Greer has identified are the inadequate information and expertise to give directions to resolve human rights violations and that the Court does not provide a vehicle for individual justice given the volume of applicants and limited number of annual judgments.

The ECtHR is free to applicants. However, it has limited jurisdiction. It can make a decision with regard to the presence or absence of a violation of the Convention but it cannot provide a prescriptive response with regard to a remedy, nor can it rescind legislation and the level of compensation is paltry. In the case of a potential older applicant seeking redress the person is likely to be dead before the final legal judgement. That presupposes, of course, that it will be heard given the numbers of rejected cases.

In general, international and regional human rights instruments and ECtHR’s rulings have had persuasive impact on Irish laws and practices. However, in the context of older people and residential care it has been shown to have limited impact. In terms of EU accession it is reasonable to envisage that accession will augment the protection of human rights. While the Charter of Fundamental Rights of the European Union might be considered to offer a wider array of rights than the ECHR the EU rights have less legal

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447 Speech by Jean-Paul Costa President of the Court, Solemn hearing of the Court of Human Rights on the occasion of the opening of the judicial year, 29 January 2010, 6
448 Ibid.
451 Ibid. 319.
452 Greer, 2008 (n 446) p. 684.
454 Hanahoe v Hussey [1998] 3 IR 69 at 102. The Court viewed the ECHR as persuasive authority stating “in cases of doubt or where jurisprudence is not settled, the courts should have regard to the Convention for the Protection of Human Rights”; Airey v Ireland (1979) 2 EHRR 305 eventually gave rise to free legal aid, more recently the Supreme Court in the case of Magee v Farrell [2009] IESC 60, the Court stated unanimously that “[a] right to legal representation does not carry with it a right to State funded legal aid. Where, however, the liberty of the individual is in issue before the Criminal Courts there is an entitlement to State funded legal aid.” Norris v Ireland (1991) 13 EHRR 831 eventually gave rise to legislative change decriminalising homosexuality; Croke v Ireland (Application no. 3326/94) and X v United Kingdom (1991) 4 EHRR 188 strongly influenced the promulgation of the Mental Health Act 2001.
455 Most older people are outside the scope of the protection afforded to involuntary patients under mental health legislation.
definition.\textsuperscript{456} It is not yet clear how the benefits will materialise. Indeed it would be premature to comment on the likely impact accession may have on older people in residential care. In a more general context O’Connell, reflecting on the benefits that may accrue to individuals, considers that while EU accession “may end up as yet another symbolic gesture, but such gestures can yield unanticipated and even unintended promise.”\textsuperscript{457}

A new orientation is required that recognises the merits of both international and regional human rights instruments and that most older people are more than capable of managing their own lives notwithstanding that most of those in residential care may need varying degrees of support to manage and that facilitated decision-making is a last option where the will or the preferences of the individual cannot be ascertained.

The CRPD is visionary in its concept and content. Relevant legal frameworks and monitoring mechanisms for residential care settings, while crucial, may be little more than paper exercises in the absence of active participation by the older person, enforcement of the legislative provisions, sanctions that take account of all service providers, and the absence of competent (by virtue of their qualifications, experience and training) professional and non-professional workers in the residential care setting. The adoption of a new UN Convention on the Rights of Older People may offer possibilities for strengthening rights for older people in residential care settings depending on its content, if ratified and incorporated into Irish law.


\textsuperscript{457} Ibid. O’Connell, 2010.
Chapter 3 Irish Legal Provisions

Introduction
A thorough examination of Irish legal provisions in the context of the older person in residential care has not been carried out previously. This chapter traces the trajectory of legal provisions in Ireland thematically from the inception of the state to date in the context of older people and in particular, those in residential care in order to demonstrate the incremental but sluggish pace of progress until recently.

The purpose is to examine what arrangements have been put in place for protecting older people, to highlight weaknesses and to make recommendations for bridging the legislative gaps that may still exist. Ultimately the purpose is to advance rights for older people in residential care so that their rights are upheld in practice as well as in law.

Given the volume of material the chapter is set out under the following headings, the Irish Constitution, statutory provisions, funding, statutory based bodies and additional criminal offence provisions. The statutory provisions are subdivided to include state structure/system, rights, health services, mental treatment law, nursing home/institutional development including residents’ legal capacity, care, conditions and safeguards.

The Irish Constitution
The dignity of the individual in its universal meaning has been embraced by many constitutional drafters in the 20th Century. Ireland is one of the front runners in this regard and this idea of dignity together with freedom has been considered as a “foundational and ordering ethico-legal concept” in our society. Abuse by its very nature disregards the inherent dignity and freedom of a human being. In the Preamble the inseparable values of justice, prudence and charity are interlinked with dignity and freedom. As O’Dowd demonstrates the dignity of the human being finds clearer expression as a constitutional value in the Irish text of the Constitution. The preamble is referred to by O’Byrne J. when he said “[t]hese most laudable objects [expressed in the Preamble] seem to us to inform the various Articles of the Constitution, and we are of opinion that, so far as possible, the

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458 Legal provisions with regard to wardship, enduring power of attorney and advocacy are included in Ch. 5 of this work. Regulation in the context of education, experience and training is addressed in Ch. 6 of this work.
459 Some statutory bodies fit more readily in Ch. 6 by virtue of their association and accordingly are included there.
461 Inglesias, 2000a (n 2) 9; see also Inglesias, 2000b (n 2) 19.
Constitution should be so construed as to give them life and reality." A more subtle view is espoused by Lavery J. when he said that the Preamble “may add little to more precise terms of the relevant Articles” but may assist “in determining the meaning of and the effect to be given to particular provisions.”

In *McGee v Attorney General* Walsh J. affirmed that one of the aims of the people in enacting the Constitution was to ensure “dignity and freedom” prevailed for every human being. He stated:

> Both Aristotle and the Christian philosophers have regarded justice as the highest human virtue. The virtue of prudence was also esteemed by Aristotle as by the philosophers of the Christian world. But the great additional virtue introduced by Christianity was that of charity: not the charity which of giving to the deserving, for that is justice, but the charity which is also called mercy. According to the Preamble, the people gave themselves the Constitution to promote the common good with due observation of prudence, justice and charity so the dignity and freedom of the individual might be assured.

The common good was afforded prominence in an earlier case when the Supreme Court permitted the Gardaí to take a person suffering from mental ill-health into a psychiatric institution. More recently, in *McKinley v Minister for Defence* Hederman J. stated that Articles 40 and 41 should not be read in isolation but in the reading to take due regard of the Preamble of the Constitution so “the dignity and freedom of the individual might be assured.

The constitutional protection of dignity prevails throughout life’s journey irrespective of whether the individual has full or diminished capacity. Denham J. said: “An unspecified right under the Constitution to all persons as human persons is dignity – to be treated with dignity. Such right is not lost by illness or accident. As long as a person is alive they have this right.”

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465 Ibid.
466 (n 4).
467 Ibid. p. 319.
468 *In Re Philip Clarke* [1950] IR 235.
470 Ibid. p. 349.
471 *In re Ward of Court (withholding medical treatment) (No. 2)* (n 4) p. 163.
Personal Rights in the Constitution

It has been said that “[t]he constitutional ideal of a state based upon freedom, human dignity, and equality seeks to empower all members of society.” However, the question that arises at this juncture is how can constitutional personal rights be exercised to protect the older person in a residential setting from abuse of his/her human rights? Remedies for breach of constitutional rights depending on the circumstances include: challenge to the constitutionality of a statute, freedom from detention (because of anomaly in law or procedure), damages for unlawful interference with a person’s constitutional rights and injunction. Constitutional rights may be enforced against the State and or private individuals. In *Meskell v CIE,* Walsh J. stated, “if a person has suffered damage by virtue of a breach of a constitutional right or the infringement of a constitutional right, that person is entitled to seek redress against the person or persons who have infringed that right.”

Equality Provision

The Constitution of the Irish Free State 1922 did not contain an equality clause. It had its genesis in the 1937 Constitution with the inclusion of Article 40.1 that provides:

> All citizens shall, as human persons, be held equal before the law. This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function.

Doyle suggests that the inclusion of the equality guarantee in the 1937 Constitution was “motivated by an egalitarian ideal.” He credits Hearne and de Valera as the chief protagonists of this ideal. He further suggests that the equality guarantee envisaged by the framers was one that principally concerned protection of civil equality. While civil and political equality were envisaged under the aegis of the second sentence of Article 40.1 social equality, while absent, was not ruled out.

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473 For example, *Meskell v CIE* [1973] IR 121 breach of right to dissociate and *Conway v INTO* 1991 Case 39 breach of right to free primary education.
475 [1973] IR 121.
476 Ibid. p. 133.
479 Ibid. p. 56.
480 Ibid. p. 65.
The historical record shows that the equality doctrine, in the main, found little favour with the judiciary and consequently it remains “undeveloped.” According to Doyle the courts have selected substantive constitutional provisions in place of Article 40.1 when deciding cases and even in these circumstances where they discounted Article 40.1 it necessitated “enumeration of a new constitutional right” to enable a result. Hogan has expressed concern at the lack of certainty and unevenness of constitutional development. A somewhat similar view is espoused by Forde who suggests that there seems to be “either confusion or a lack of consensus among the Irish judiciary” with benchmarking the law against the Irish Constitution. In Redmond v Minister for the Environment, Herbert J. said, “a law which has the effect ... of discriminating between human persons on the basis of money is an attack upon the dignity of those persons ... who do not have money.” This “is exactly the type of discrimination targeted by Article 40.1.”

The nature of the guarantee in Article 40.1 of the Constitution was clarified by Walsh J. in Quinn’s Supermarket v. Attorney General and cited with approval in re Article 26 and the Employment Equality Bill, 1996 as follows:

The provisions of Articles 40 s. 1, of the Constitution were discussed in the decision of this Court in the State (Nicolaou v An Bord Uchtála) [1996] IR 567. As was there decided, this provision is not a guarantee of absolute equality for all citizens in all circumstances but it is a guarantee of equality as human persons and (as the Irish text of the Constitution makes quite clear) is a guarantee related to their dignity as human persons and a guarantee against any in equalities grounded upon an assumption, or indeed a relief, that some individuals or individual or classes of individuals, by reason of their human attributes or their ethnic or racial, social or religious background, are to be treated as the inferior or superior of other individuals in the community.

Legislative regulation of age discrimination was upheld in re Article 26 and the Employment Equality Bill, 1996. Treating all persons equally Hamilton C.J. explained would, for

485 Redmond v Minister for the Environment [2001] 4 IR 64.
486 Ibid p. 80.
487 Ibid.
488 [1972] IR 1. This case concerned the trading times of kosher butchers shops (the late opening enabled Jews to buy meat in advance of the Sabbath.)
490 This the first case that the Supreme Court gave extensive consideration to arguments based on Article 40.1.
491 [1972] IR 1 p. 13 as cited in (n 489) at p. 342.
492 Ibid (n 489). ( 
example, effectively limit the State making “special provision in the social welfare code for the elderly.”

The Supreme Court\textsuperscript{494} held:

That Article 40 sub-s 1 did not require the State to treat all citizens equally in all circumstances, but rather allowed for the provision of measures which places individuals in different categories for the purposes of relevant legislation. Classifications based on age could not of themselves be regarded as being constitutionally invalid; nevertheless, they must be related to a legitimate objective and not arbitrary or irrational….The age limits chosen [in the equality Bill] of 18 and 65 years respectively, reflected the thresholds at which a significant number of the population enter of leave the working place, and could not, therefore, be plausibly characterised as irrational or arbitrary.\textsuperscript{495}

In its consideration of the equality provision the Supreme Court\textsuperscript{496} first focused on the essential attributes of the human person and not on the context of the discrimination. The effect of the human personality doctrine\textsuperscript{497} has resulted in a narrow interpretation of the equality provisions given that the courts have viewed the person as an entity in themselves\textsuperscript{498} separate to his or her business or employment.\textsuperscript{499} The Report of the Constitutional Review Group 1996 has recommended that the words as ‘human persons’ should be deleted.\textsuperscript{500}

Second Hamilton C.J. affirmed the classifications based on age set out by Barrington J. in \emph{Brennan & Others v Attorney General}\textsuperscript{501} who stated that “the classification must be for a legitimate legislative purpose … it must be relevant to that purpose, and that each class must be treated fairly.”\textsuperscript{502} It would appear that the Court has increased the scope of application of Article 40.1. given its assessment of the statutory provisions and that they were neither “irrational or arbitrary.”\textsuperscript{503}

Of further relevance with regard to disability discrimination is the Supreme Court’s finding that the “reasonable accommodation” provisions in the Employment Equality Bill 1996\textsuperscript{504}

\begin{itemize}
\item \textsuperscript{493} Ibid. p. 346.
\item \textsuperscript{494} Ibid.
\item \textsuperscript{495} Ibid. p. 322.
\item \textsuperscript{496} Ibid.
\item \textsuperscript{498} (n. 488).
\item \textsuperscript{499} \textit{Murtagh Properties v Cleary} [1972] IR 330.
\item \textsuperscript{501} [1983 ILRM 449].
\item \textsuperscript{502} Ibid. p. 480 as cited in (n 489) p. 346.
\item \textsuperscript{503} (n. 488) p. 322; for further discussion see Hogan and Whyte, (n 477) page 1347.
\item \textsuperscript{504} Section 16 (3). 
\end{itemize}
were repugnant to the Constitution on property grounds as the accommodation required would be too onerous on employers.\textsuperscript{505}

Whether the status quo continues remains to be seen. More recently legislative changes have taken place both within Europe\textsuperscript{506} and at home.\textsuperscript{507} The Employment Equality Act 1998 and the Equal Status Act 2000\textsuperscript{508} (as amended by the Equality Act 2004) have amplified the meagre specific legislative provisions that were in place before regarding the protection from unjustified discrimination in respect of the nine separate grounds that include age and disability.\textsuperscript{509} It is acknowledged that this legislation as amended has gaps and that “significant forms of discrimination remain fully legal in Irish Law.”\textsuperscript{510}

This prompts the question: do older people incur a lower standard of service from health and social service providers? A preliminary but incomplete response is that they do. Age classification has been upheld as cited above by the Supreme Court.\textsuperscript{511} However, as Doyle and Whyte noted, the Supreme Court has hinted that legislative age discrimination “might require greater justification than legislative discrimination in general.”\textsuperscript{512} Ageism in health care has recently been examined with regard to cancer screening. It is reported that the upper age limit for breast cancer screening is 64 while the most prevalent age group for development of breast cancer is between 55 and 75 years of age.\textsuperscript{513} Another example of discrimination pertains to aged disabled persons. Older people are not included on the national disability database. A disabled person reaching the age of sixty five is therefore effectively removed from the disability services with the consequent risk of inadequate planning for health and social care needs, this include long stay residential care.\textsuperscript{514} This anomaly has been addressed in new legislative provisions that require individual needs

\textsuperscript{505} [n. p. 368.}
\textsuperscript{506} Article 19 TFEU grants the EU the power to “take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.”
\textsuperscript{508} Further commentary on the Equal Status Act 2000 is provided later in this Ch.
\textsuperscript{509} The other seven independent grounds are race, gender, religion, marital status, member of the travelling community, sexual orientation and family status.
\textsuperscript{511} [1997] 2 IR 322.
\textsuperscript{512} Whyte, G. and Doyle, O., “The Separation of Powers and Constitutional Egalitarianism after the Health (Amendment) (No. 2) Bill Reference” in O’Dell (n 7) p. 415.
\textsuperscript{513} Irish Times June 21\textsuperscript{st} 2006 report by Carl O’Brien on the Fianna Fáil policy document compiled by Senator Mary White that was circulated to the Parliamentary on 20\textsuperscript{th} June 2006.
\textsuperscript{514} National Disability Authority (NDA), Response to Human Rights Commission Consultation Document on Older People in Long Stay Care (Dublin, NDA, 2003).
assessments and tailored programmes to meet the needs of those in designated care settings.\textsuperscript{515}

\textbf{Unenumerated Personal Rights}

Many of the rights provided by the Constitution are subject to limiting factors or qualifying words. Article 40.3.1 states that “[t]he State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.” Article 40.3.2 provides that “[t]he State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen.”

“As best it may” limits the duty of the state to protect personal rights and the Courts have provided varying opinions on the differences between subsections 1 and 2.\textsuperscript{516} In this context where an older person in residential care sought protection from the State to protect their constitutional personal rights, the duty would fall on the older person in the first instance to prove that an injustice had befallen them.\textsuperscript{517}

The right to life may also be understood as the right to die by natural means. In \textit{Re Ward of Court (withholding medical treatment) (No 2)}\textsuperscript{518} Hamilton C.J. in the Supreme Court said,

\begin{quote}
[a]s the process of dying is part, and an ultimate inevitable consequence, of life, the right to life necessarily implies the right to have nature take its course and to die a natural death and, unless the individual concerned so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means, which have no curative effect and which is intended merely to prolong life.\textsuperscript{519}
\end{quote}

In addition to the rights contained in Article 40.3 the Courts have recognised unspecified fundamental rights, for example, the right to bodily integrity\textsuperscript{520}, the right not to be tortured or ill-treated\textsuperscript{521}, the right to marital privacy\textsuperscript{522} and the right to individual privacy.\textsuperscript{523}

In \textit{Ryan v Attorney General}\textsuperscript{524} Kenny J. stated: “Firstly...[i]t follows, ... that the general guarantee ... must extend to rights not specified in Article 40. Secondly, there are many

\textsuperscript{515} Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 S.I. No. 236 of 2009.


\textsuperscript{517} Ibid. Hogan and Whyte, 2003 (n 477) p 1392, fn 18.

\textsuperscript{518} (n 4).

\textsuperscript{519} Ibid. p. 124.

\textsuperscript{520} Ryan v Attorney General [1965] IR 294.

\textsuperscript{521} The State (C) v Frawley [1976] IR 365.

\textsuperscript{522} McGee v Attorney General (n 4).

personal rights of the citizen which follow from the Christian and democratic nature of the State which are not mentioned in Article 40 at all…"525 The right to bodily integrity he considered was an un-enumerated right given that personal rights were not limited to those specified in Article 40. He said,

no mutilation of the body or any of its members may be carried out on any citizen under authority of the law except for the good of the whole body and that no process which is or may, as a matter of probability, be dangerous or harmful to the life or health of the citizens or any of them may be imposed (in the sense of being made compulsory) by an Act of the Oireachtas.526

The Supreme Court527 agreeing with Kenny J. stated

that the ‘personal rights’ mentioned in section 3.1° are not exhausted by the enumeration of ‘life, person, good name, and property rights’ in section 3.2° as shown by the words ‘in particular’; nor by the more detached treatment of specific rights in the subsequent sections of the Article. To attempt to make a list of all the rights which may properly fall within the category of ‘personal rights’ would be difficult and, fortunately, is unnecessary in this present case.528

The right to health was considered by the High Court in *The State (Richardson) v Governor of Mountjoy Prison*529 (the arrangements for slopping out were a danger to her health.) An individual’s health could not be endangered by the State.530 As Ó’Dalaigh stated in an earlier case “'[t]he State has the duty of protecting the citizens from dangers to health in a manner not incompatible or inconsistent with the rights of citizens as human persons.'"531 However a right to healthcare has not been recognised by the Courts other than in a negative way as in *Ryan*.532

Whyte considers that socio-economic rights may be located within the body of implied rights.533 He bases his argument on the affirmation of social solidarity and social inclusion values within the Constitution.534 He suggests “that these values can inform our reading of

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524 (n 520).
525 Ibid. p. 313.
526 Ibid. p. 313-314.
527 Ibid. p. 332.
528 Ibid. p. 344-345.
529 [1980] ILRM 82.
530 Ibid. p. 92-93.
531 Ryan v Attorney General (n 520) p. 348.
532 Ibid.
533 Whyte, G., *Social Inclusion and the Legal System Public Interest Law in Ireland* (Dublin, Institute of Public Administration, 2001) 43. He draws attention in the first instance to the two specific socio-economic rights as envisaged in Articles 41 and 42.
534 Ibid. p.45.
Article 40.3.

Protection of socio-economic rights is primarily the role of both the legislature and the executive. However Whyte suggests that in exceptional circumstances there is an argument for court direction to the executive by way of a mandatory order.

The judicial reasoning by the majority in *Sinnott v Minister for Education* varied mainly between the historical/present tense and the literal/contextual. Murray J’s historical approach is significant since primary education did not exist for persons with intellectual disability in 1937. The Keane C.J. judgment alone held that there is a right to free primary education as “[n]o principled basis exists either in law or in the evidence for the contention advanced by the defendants that a person in his position ceases to be in need of primary education...” His focus on need rather than age is significant when applied to older people in residential care.

The doctrine of the separation of powers was at issue in *T.D. v Minister for Education*. The Supreme Court held that:

The order of the High Court involved the court in determining the policy the executive should follow in dealing with a particular social problem. The courts were concerned with communicative and not distributive justice and had no function in making assessments on the validity of competing claims on national resources.

The judiciary found little support for the suggestion of implied socio-economic rights. Murray J. said,

[w]ith the exception of Article 42 of the Constitution, under heading “Education”, there are no express provisions therein cognisable by the courts which impose an express obligation on the State to provide accommodation, medical treatment welfare or any other form of socio economic benefit for any of its citizens however needy or deserving.

Keane C.J. referring to *Ryan v The Attorney General* questioned the doctrine of implied rights first “the criteria by which the unenumerated rights are to be identified .... Secondly there was no discussion in the judgment of this court to whether the duty of declaring the unenumerated rights assuming them to exist, should be the function of the courts rather than the Oireachtas.” Consequently he said, “I would have the gravest doubts as to whether the courts at any stage should assume the function of declaring what are today frequently described as ‘socio-economic rights’ to be unenumerated rights guaranteed by Article 40.”
It does not look hopeful based on such comments that socio-economic rights will yield tangible benefits for older people in residential care settings. There is little consensus on the explicit inclusion in the Constitution of guarantees of socio-economic rights. It is considered that the preponderance of a classical liberal democratic political vision limits the inclusion.

In *in re Article 26 and the Health (Amendment) (No. 2) Bill 2004* there is a tentative claim for an older person to be maintained by the state.

In a discrete case in particular circumstances an issue may well arise as to the extent to which the normal discretion of the Oireachtas in the distribution or spending of public monies could be constrained by a constitutional obligation to provide shelter and maintenance for those with exceptional needs.

The doctrine of the separation of powers, involving as it does respect for the powers of the various organs of State and specifically the power of the Oireachtas to make decisions on the allocation of resources, cannot in itself be a justification for the failure of the State to protect or vindicate a constitutional right.

This case concerned the constitutionality of charges imposed retrospectively on older people in residential care. The Supreme Court held that “the retrospective provisions of the Bill … are repugnant to the Constitution and in particular Articles 43 and 40.3.2.”

Referring to Article 43.2.1, the Supreme Court in considering the principles of social justice acknowledged the property of persons of modest means deserved particular protection. The case also recognised the Court’s, albeit limited, role in protecting socio-economic rights. Doyle and Whyte recognise that the Supreme Court implicitly can but did “not explicitly engage in egalitarian group analysis.” However after this case they consider that it will be more difficult for the Court to avoid such an examination. Unpacking the constitutional guarantee of equality in Article 40.1 has the potential of questioning the constitutionality of legislative classifications that discriminate against older people.
Personal Liberty

The Constitution guarantees that no citizen shall be deprived of their liberty save in accordance with law.558 The indefinite holding of a patient with a mental illness permitted under the Mental Treatment Act 1945 was upheld by the Supreme Court in In re Philip Clarke where Byrne J said:

The impugned legislation of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and well-being of the public generally ... We do not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger to themselves or others.559

The potential denial of an older person’s liberty still prevails in Ireland under the Mental Health Act 2001. The protections now afforded to involuntary patients set out in the Mental Health Act 2001 are largely absent for voluntary patients.560 As Quirke highlights “the 2001 Act has an overall paucity of safeguards for voluntary patients.”561

Family Rights

The family enjoys a particular protection by the State562 under the terms of both Articles 41.1.1˚ and 41.1.2˚ that provide respectively, “[t]he State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law” and “[t]he State, therefore, guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.”

As Kenny J. explained the words, “‘[i]nalienable’ means that which cannot be transferred or given away while ‘impresscriptible’ means that which cannot be lost by the passage of time or abandoned by non-exercise.”563 The special place that the family occupies in the Constitution was acknowledged by Keane C.J. when he said “the family … is endowed with

558 Article 40.4.1.
559 (n 468) p. 248.
560 These are discussed more fully later in this chapter.
561 Quirk, T., “Older People in Irish Mental Health Law” in O’Dell, 2006 (n 7) 274; the proposed Scheme of Mental Capacity Bill 2008 is long awaited.
562 This is not dissimilar from other countries. See Walsh, B. in “Foreword to the First Edition” in Forde, M., Constitutional Law 2nd ed. (First Law Ltd., Dublin, 2004) ix.
563 Ryan v Attorney General (n 520) p. 308; a similar explanation is located in Fajjonu v Minister for Justice [1990] 2 IR 151, [1990] ILRM 234.
an authority which the Constitution recognises as being superior even to the authority of the
State itself….the Constitution firmly outlaws any attempt by the State … to usurp the
exclusive and privileged role of the family in the social order.”

The Courts have considered that the rights contained in Article 41.1.1’ and 41.1.2’ accrue to
the family unit protecting them from external forces rather than offering protection to
individual family members. However the Constitution discourages but does not prohibit
intervention in family life in exceptional circumstances. In The People (Director of
Public Prosecution) v T the protection afforded to the family by the Constitution was
recognised by the Court of Criminal Appeal when the court found against family members
guilty of causing harm to other family members. The guarantee relating to family rights
therefore might be applied in the case of an older vulnerable person sexually abused by a
family member.

In its submission to the All-Party Oireachtas Committee on the Constitution the Irish Human
Rights Commission recommended

that the proposal to amend Article 41.2 of the Constitution should recognise the
equal role and responsibility of men and women for carrying out the caring function
in society. In addition, the constitutional amendment should recognise the
significant contribution made to society by those who engage in caring work and
should contain a state guarantee to support such persons.

The Irish Senior Citizens Parliament proposed that the definition of family should be altered
to include the role of grandparents. They stated that:

Grandparents’ love and affection when reciprocated by the grandchildren can play a
very important part not only in the development of the grandchild but also in the
quality of life of the grandparent, and we believe that this needs to be recognised as
part of the modern family.

However in its conclusion the Committee reported that an amendment to alter the definition
of the family would be too divisive for society and was unlikely to be accepted by the
majority of the electorate. Accordingly it proposed to address the problems included in the
submissions by “other constitutional changes and legislative proposals...”

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564 North Western Health Board v H.W and C.W. [2001] 3 IR 622, 687.
566 Article 42.5.
570 Ibid. p. A137 para. 6.
571 Ibid. p. 122.
Private Property

The Constitution recognises the right to own private property; however this right may be limited by the State. Article 43 provides:

1.1 "The state acknowledges that man, in virtue of his rational being, has the natural right, antecedent to positive law, to the private ownership of external goods.

1.2 "The State accordingly guarantees to pass no law attempting to abolish the right of private ownership or the general right to transfer, bequeath, and inherit property.

2.1 "The State recognises, however, that the exercise of the rights mentioned in the foregoing provisions of this Article ought, in civil society, to be regulated by the principles of social justice.

2.2 "The State, accordingly, may as occasion requires delimit by law the exercise of the said rights with a view to reconciling their exercise with the exigencies of the common good.

In addition to land ownership and rights accruing from that ownership, the definition of property pertains to moveable property, money and intangible rights.\textsuperscript{572}

The recent Criminal Law (Defence and Dwelling) Act 2011\textsuperscript{573} may provide some comfort for older people (and other lawful occupants) in the community knowing that justifiable use of force may be used to protect themselves and their home. This legislation may act in some small way as a deterrent to potential offenders and if relevant supports are provided in the community setting for older people (should they need and wish to use such supports) it may obviate the need for residential care as a result of fear. Living out one’s days as independently as possible by one’s own fire, sleeping in one’s own bed, with the person/people or pets they love nearby is a desire of many older people. As Harris comments: “All of us who wish to go on living have something that each of us values equally, although for each it is different in character....The thing is of course ‘the rest of our lives.’ So long as we do not know the date of our deaths then for each of us the ‘rest of our lives’ is of indefinite duration.”\textsuperscript{574}

\textsuperscript{572} Hogan and Whyte, 2003, (n 477) p. 1971 para. 7.7.06.
\textsuperscript{573} S. 2. No. 35 of 2011 came into effect on the 13\textsuperscript{th} January 2012 with the publication of Criminal Law (Defence and the Dwelling) Act 2011 (Commencement) Order 2012 S.I. No. 2 of 2012.
\textsuperscript{574} Harris, J., \textit{The Value of Life} (London, Routledge, 1985) 89.
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Article 45

The Directive Principles of Social Policy may offer “directions for the guidance of the Oireachtas.”575 While they may serve to support arguments to advance rights their strength is weakened in that while legally binding they are not justicable.

Article 45.1 provides that “[t]he State shall strive to promote the welfare of the whole people by securing and protecting as effectively as it may a social order in which justice and charity shall inform all the institutions of the national life.”

Article 45.4.1˚ provides particular reference to the rights of older people stating that “[t]he State pledges itself to safeguard with especial care the economic interests of the weaker section of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged.”

The State cannot dissociate itself from the actions of its servant undertaken wrongfully while engaged working. In Byrne v Ireland576 the Supreme Court held that the State as a juristic person is vicariously liable for wrongful actions of its servants that are carried out in the course of work related activities. This case may have relevance for an older person on foot of an injury arising as a result of a tortious act of a public servant. The rights of individual citizens was affirmed in Mc Gee v The Attorney General577 when the Supreme Court speaking through Justice Walsh said with regard to fundamental rights that “the legislature is not free to ... neglect the common good or the protection or enforcement of the rights of individual citizens.”578 The legislature failed to protect rights of older people in Leas Cross Nursing Home given “[t]he deeply deficient Nursing Home Legislation.”579

Rights and Duties

The freedom to implement a right may be governed by others respecting that right. The liberty of vulnerable persons in residential care to exercise their rights is often dependent on the enablement of others, for example, care workers. O’Dálaigh C.J. in the Education Co. Of Ireland v Fitzpatrick580 recognised that “[l]iberty to exercise a right, it seems to me, prima facie implies a correlative duty on others to abstain from interfering with the exercise of such a right.”581

575 Hogan and Whyte, 2003, (n 477) p. 2080 para. 7.9.05.
577 [1974] IR 284
578 Ibid. 310.
581 Ibid. p. 343.
International Human Rights Law in an Irish Context

Article 29.3 of the Constitution provides that, “Ireland accepts the generally recognised principles of international law as its rule of conduct in its relations with other States”. The UNCRPD and the ECHR have particular relevance in this examination of legal safeguards for older people in residential care. Under the “dualist system” Ireland does not automatically incorporate or transpose international law into domestic law. As Article 29.6 of the Constitution states, “[n]o international agreement shall be part of the domestic law of the State save as may be determined by the Oireachtas.”

Similarly in the case of Kavanagh v Governor of Mountjoy the Supreme Court said that “[t]he Constitution establishes an unmistakable distinction between domestic and international law…” The Court considered that the State’s ratification of the UNCCPR did amount to a “legitimate expectation that the [State’s] agencies will respect its [the Covenants] terms. However, it could not accept such an obligation so as to affect either the provisions of a statute or a judgment of a court without coming into conflict with the Constitution.”

Statutory Provisions

This section provides a comprehensive thematic overview of statutory provisions as they relate to older people in residential care from the foundation of the state to date. The overview has not been done before. Public bodies that are core to the rights of older people have also been included in this examination.

The Chapter also makes reference to ancillary statutory provisions in this context that do not directly relate to residential care but do have applicability by virtue of the rights they bestow although the benefits that may accrue may be somewhat tenuous.

The evolution of legislative provisions will help demonstrate what actual legislative arrangements and protections existed or were absent for older people in residential care. Attention will be focused on the elements of the provisions that generate benefits.

582 [2002] 3 IR 97.
583 Ibid. p. 129.
584 Ibid.
585 “Statute” and “Statutory Instruments” are defined in the Statutory Instruments Act, 1947 No. 44 of 1947 s.1. This Act came into operation on the 1st January 1948. Secondary legislation was provided in the form of Statutory Rules and Orders between 1922 and 1947.
586 For a broader discussion on the development of the Irish health service see, for example, Barrington, R., Health Medicine and Politics in Ireland 1900-1970 (Dublin, Institute of Public Administration, 1987); Hensey, B. The Health Services of Ireland 3rd ed. (Dublin, Institute of Public Administration, 1979); Barry, J., et al Inequalities in Health in Ireland - Hard Facts Report (Dublin, Department of Community Health and General Practice TCD, 2001); Burke, S., Irish Apartheid Health Care Inequality in Ireland (Dublin, New Island, 2009).
Weaknesses will be identified. Discussions on some of the provisions by virtue of their limited applicability will be brief.

Extensive new legislative provisions have been published. Comprehensive commentary will be made on their content. However it is premature to comment on their impact. None the less the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 is especially welcome. It is acknowledged that legislation of itself will not safeguard human rights. However it does provide the standards or benchmarking from which the quality of services can be measured and failings more easily identified and remedied.

Up until recently legislative provisions addressed in the main the provision of accommodation for older people in residential care. The arrangements for the provision of care were addressed in a superficial manner. Standards and quality of care received little attention. Greater emphasis seems to have been placed on financial arrangements and tax incentives rather than on the needs of the individual resident. The law did not protect older people in residential care.

In the earlier years of the State much of the care was unregulated and provided by voluntary bodies, church authorities and family.\textsuperscript{587} Where regulated older people were not seen as a separate cohort with particular needs and more tellingly they had “invaded” different types of institutions.\textsuperscript{588} The \textit{White Paper}\textsuperscript{589} provides the following descriptive account of the types of regulated residential care settings in use at that time:

> With a few exceptions, provision has not yet been made for specialised hospital treatment of older people; they have not, in fact, been recognised generally as a separate medical class with the result that they … occupy all sorts of institutions not primarily intended for them or suited to their needs. They are found in large numbers in County Homes, to an extent which has gone a long way to alter the nature and purpose of these institutions; they may also be found in various District and in some County Hospitals.\textsuperscript{590}

\textsuperscript{587} With regard to numbers in voluntary institutions for older people the Department of Health, \textit{White Paper on Reconstruction and Improvement of County Homes} (Dublin, Government Stationary Office, 1951) p. 11 stated that many of the institutions “house more than a hundred persons.” The \textit{White Paper} is a summary report of the unpublished \textit{Report of the Interdepartmental Committee Appointed to Examine the Question of the Reconstruction and Replacement of County Home}.

\textsuperscript{588} Ibid.

\textsuperscript{589} Ibid.

\textsuperscript{590} Ibid.
State Structure/System
The following section sets out the early structural arrangements in particular for the establishment of county homes and for the administration and maintenance of all public residential care settings for older people, including the appointment of staff and procedures for admission to these institutions.

Local Government (Temporary Provisions) Act, 1923

This temporary legislation relating to relief of the poor, provided for the closure of workhouses and transfer of residents (inmates) to county homes in named counties. In practice in most counties one workhouse was selected as the newly designated county home and inmates from other workhouses within the county were transferred to the county home. The following description portrays a view of those who were transferred to the county homes. The county homes became repositories for all types and conditions of poor persons the majority of whom were aged and infirm, but who also included considerable numbers of mental defectives, unmarried mothers, children (legitimate and illegitimate), persons suffering from various long-term illnesses and some able bodied destitute.

The Poor Relief Commission of 1927 provided a description of a typical workhouse:

The majority of the buildings were commenced in the years 1839-1840, and finished within three or four years. They were built much on the same plan. The walls were unplastered and the rooms unceiled. In their construction and fitting up a rigid economy was observed. One side of the house was allotted to males and the other to females. The classification on each side was roughly as follows:

(1) The Admission Ward, which in later years became the casuals’ or night lodgers’ ward,
(2) The Able-bodied,

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591 No. 9 of 1923
592 Long title of Local Government (Temporary Provisions) Act, 1923 provided “until a comprehensive reorganization of the whole law of Local Government in Saorstát Eireann can be prepared and submitted to the Oireachtas it is necessary that temporary provision should be made to remedy the more serious defects in the law and in particular that legal authority should be given to the said Schemes of poor relief which have been put into operation…..”
593 In the mid-1800s, there were 158 workhouses in the country according to Dr. Sean Lucey on the Myles Dungan History Show RTE Radio 1 on the 20th March 2011. Historically there was local resistance to the closure of workhouses. Local trades people supplied goods and services and with the closure and amalgamation to larger county homes business was lost to the local community.
594 The word inmate was still in use in 1942 in the Public Assistance (General Regulations) Order, 1942 S.I. No. 83 of 1942
595 White Paper, 1951, (n 587).
596 Ibid. p. 10; the first four decades of the State brought little change to these conditions.
(3) The Infirm,
(4) The School and Children Ward,
(5) The Infirmary,
(6) The Lunatic Ward.

In addition, there was on the female side a nursery and maternity ward. In some of the larger workhouses there were wards known as the male and female separation wards. The standard of comfort in the body of the house was, in many instances, very poor, and the closet and bathing accommodation bad.  

Sch. 1 of the Local Government (Temporary Provisions) Act, 1923 provided details of existing schemes for the administration of relief measures in named counties. Stringent conditions had to be met prior to admission. For example, the County Clare Scheme states:

_The Central Home—Admission_ on a certificate signed by three “recognised” persons, and containing a solemn declaration to the effect that the aged or infirm person (a) is unable to take care of himself (b) has no home, and no responsible relative able to care for him and (c) has no friend, distant relative, or other person in the parish who will give him a home in consideration of a grant.

Where, prior to admission the older person was in receipt of a pension or other allowance he was obliged to

(a) Sign an agreement handing over the pension or grant, or pay 10s per week or according to pension to the Committee of Management of the Central Home.
(b) Sign an order authorising the Clerk of the Home to draw the pension or grant on his behalf.

[No person to be admitted until it is proved conclusively that he cannot be maintained in his own parish].

Prior transfer conditions were detailed in the Leitrim County Scheme in terms of structural improvements required for Leitrim County Home namely “(a) Extension of electric light to

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597 Ibid. as cited p. 6.
598 Recognised persons include “Clergymen, Medical Practitioners, Brehons, County Councillors, and Rural and Urban Councillors, the three signatures being of different classes.”
599 My inclusion in italics.
600 My inclusion in italics.
602 Ibid. No. 20.
603 Ibid. First sch. Leitrim County Scheme, at “[d]etails For Bringing Scheme Into Operation And Mode Of Procedure In This Connection, No. 2.”
all buildings, (b) New lavatories and baths in body of house\textsuperscript{604} and “(c) The preparation of wards in the body of the house, which should be made bright and airy.”\textsuperscript{605}

An outline of the varied staff required was provided.\textsuperscript{606} These included, “(i) Medical Officer and Surgeon, (ii) A Matron who must be a trained nurse, (iii) A requisite number of nurses and attendants, (iv) A Secretary to the Committee of Management whose duties will be defined by that Committee and\textsuperscript{607} (v) Porter, ambulance driver, etc.”\textsuperscript{608}

County schemes for the relief of poor in the county were made (where no schemes existed) or altered by virtue of s. 3 or s. 5 respectively of the Local Government Act (Temporary Provisions) Act, 1923.\textsuperscript{609} For example, the Mayo County Scheme Order\textsuperscript{610}, that came into effect on the 1\textsuperscript{st} of July 1923 provided that the Board of Health (subject to the provisions of the scheme and ministerial direction) provide and maintain: “(a) [a] County Home at Castlebar for the aged and infirm persons …. and (f) [w]ith the approval of the Minister, such other institutions as they may deem desirable for the relief of the poor in their county.”\textsuperscript{611}

Residents effectively signed over their autonomy to the Board and its representatives and they followed whatever directions were given. While it could be argued that they now had a roof over their heads their rights while they remained in the home were effectively extinguished.

The legacy of the former county homes with its resonance of poverty and shame prevailed up to the 1980’s–some older people opting to choose private care instead of public as many of the public residential institutions were located in the same buildings or grounds of former county homes.

**County Boards of Health (General Regulations) Order 1924**

The order permitted the Minister for Local Government to make and prescribe rules and regulations with regard to among other things governance of county institutions and the

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\textsuperscript{604} Ibid.
\textsuperscript{605} Ibid.
\textsuperscript{606} Ibid. 4(c).
\textsuperscript{607} My inclusion in italics.
\textsuperscript{608} First sch., Leitrim County Scheme, at “[d]etails For Bringing Scheme Into Operation And Mode Of Procedure In This Connection” No. 4c.
\textsuperscript{609} County Scheme Order, Carlow No. 2, 1924; County Scheme Order, Cork No. 1, 1924; County Scheme Order, Kerry No. 2, 1924; County Scheme Order, Kerry No. 2, 1924; County Scheme Order, Louth No. 1, 1924; County Scheme Order, Mayo No. 1, 1923; County Scheme Order, Offaly (Amendment), 1924; County Scheme Order, Tipperary (N.R.) No. 1, 1924; County Scheme Order, Tipperary (S.R.) No. 1, 1924.
\textsuperscript{610} County Scheme Order, Mayo No. 1, 1923.
\textsuperscript{611} Ibid. s. 15.
appointment and contractual obligations of its officers. For example Article 34 required that nobody could be appointed as a Matron of a County Home or County Hospital unless they were 30 years of age and a trained nurse. The Article as amended\textsuperscript{612} enabled the appointment of a permanent officer of the Board to the position of Matron with the consent of the Minister.

**Ministers and Secretaries Act, 1924\textsuperscript{613}**

Under the terms of this legislation new state departments were set up. Health came within the ambit of the Department of Local Government and Public Health. Section 1. (iv) of the Act provided that

\begin{quote}
[t]he Department of Local Government and Public Health ... shall comprise the administration and business generally of public services in connection with ... public health, relief of the poor, care of the insane (including insane criminals), health insurance ... and to include in particular the business, powers, duties and functions of the branches and officers of the public service specified in the Third Part of the Schedule to this Act...
\end{quote}

Included in the public service were:

- The Local Government Board for Ireland, including appeals under the Old Age Pensions Acts
- The Inspectors of Lunatic Asylums in Ireland\textsuperscript{614}
- National Health Insurance Commission
- General Nursing Council.

**The County Schemes (Officers of District Hospitals) Order, 1927\textsuperscript{615}**

This legislation dealt with the appointment, qualification and duties of district hospital officers namely the medical officer, head nurse and nurse. Article 9 outlined the prescribed

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\textsuperscript{612} The County Boards of Health (General Regulations) (Amendment) Order, 1925 (unnumbered).  
\textsuperscript{613} No. 16 of 1924; s. 3 repealed by the Ministers and Secretaries (Amendment) Act, 1946 No. 38 of 1946.  
\textsuperscript{614} S. 79 of the Local Government Act 1925 No. 5 of 1925 heralded the change of the name from “lunatic asylum” to “mental hospital.” Such a change in nomenclature however was not indicative of any alteration in the provision of the service. Also the terminology was retained elsewhere see, for example, the Lunacy Regulation (Ireland) Act 1871 with regard to wardship that is discussed more extensively in Ch. 5 of this work.  
\textsuperscript{615} No. 100 of 1927; Article 1 states that: “this order may be cited as the County Schemes (Officers of District Hospitals) Order, 1927, and shall be read and construed as one with the County Boards of Health (General Regulations) Order, 1924.”
\end{flushright}
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duties of the medical officer\textsuperscript{616} including being on the premises not later that 10am daily and more frequently if required by the head nurse or nurse in the event of sudden illness, accident or emergency and at “all such other times as the state of the patients may render necessary.”\textsuperscript{617} Among other things the medical officer was required to document any direction with regard to a patient’s dietary requirements\textsuperscript{618} and “[t]o report in writing to the board of assistance\textsuperscript{619} any defect in the diet, drainage, ventilation, warmth, or other arrangements of the district hospital.”\textsuperscript{620}

The Order required that every head nurse must be a trained nurse and be thirty years of age or over\textsuperscript{621} and every nurse must be a qualified nurse. The duties of the head nurse and nurse were set out in accordance with Article 57 and 55 respectively of the County Boards of Health (General Regulations) Order 1924.

Public Hospitals Act, 1933\textsuperscript{622}

The main purpose of the Act was to provide for funding for hospitals and to make provision for the management and improvement of hospitals.\textsuperscript{623} The Act provided an extensive definition of hospital and included “infirmaries provided by local authorities (whether as parts of county homes or otherwise) for the care and treatment of aged and infirm persons and infirmaries not so provided but to which such persons are sent by any local authority....”\textsuperscript{624} While the legislation provided for the establishment of Hospitals Commission whose members were empowered to inspect and examine an institution’s fittings and fixtures and be provided with full information with regard to the management and financial status of the premises, no reference is made to standards of care. It did however refer to “the needs of the people for such facilities” and the requirement for “the adjustment of such facilities to such needs.”\textsuperscript{625}

\textsuperscript{616} Ibid. Article 6 required that every district hospital medical officer is a registered medical practitioner.
\textsuperscript{617} Ibid. Article 9 (1).
\textsuperscript{618} Ibid. Article 9 (5).
\textsuperscript{619} The boards of assistance under certain county schemes provided and maintained district or cottage hospitals.
\textsuperscript{620} No. 100 of 1927 (n 615) Article 9 (6)
\textsuperscript{621} Ibid. Article 7. The Nurses Registration (Ireland) Act, 1919 Chapter 96 s. 3(2)(c) enabled an existing nurse (within two years of the publication of the Council rules) to become registered if they satisfied the criteria (with regard to training and experience) laid down by the General Nursing Council for Ireland. A qualified nurse satisfied the standard of training and examination for admission to the register.
\textsuperscript{622} No. 18 of 1933; s.14 (except subsection (6)), ss. 15-19, s. 24 (3) and 24 (4) were repealed by the Health Act, 1970 No. 1 of 1970.
\textsuperscript{623} Long title Public Hospitals Act, 1933; the Act repealed the Public Charitable Hospital Acts, 1930-32 and provided transitory provisions.
\textsuperscript{624} Ibid. s. 1.
\textsuperscript{625} Ibid. s. 17 (c).
The progressive nature of the first ten years of the Irish state health service provisions has been acknowledged. However it had little impact on the older people in residential care.

**Hospitals Act, 1939**

This legislation enabled the Minister for Local Government and Public Health to make orders with regard to management, control and finance of voluntary hospitals. Sections 1(a) and (b) of the Act set out the requirements to be satisfied prior to approval of the institution as a “voluntary hospital”. Section 1(a) set out the types of service(s) that must be provided to the public. These included one or more of the following, for example, (i) services for the “prevention, treatment or cure of disease, injury or deformity”, (ii) “medical, surgical or dental treatment” or (iii) the provision of “asylum to blind, deaf, dumb or mentally defective persons.” Section 1(b) precluded a state department or a local authority or one of its committees being a governing body. No criteria were set for the standards of care to be provided within the voluntary hospitals. An establishment order may have included provisions other than funding, for example, for the inspection of the premises by officers of the Minister and local authority personnel.

**Public Assistance Act 1939** and **County Management Act, 1940**

The Report of The Irish Poor Law Commission recommended among other things “the abolition of boards of health” and the transfer of their functions to the local authorities. This recommendation was enacted some 15 years later with the commencement of the Public Assistance Act 1939 and the County Management Act, 1940 that altered the administration of health services in the country. By way of example the County Scheme

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626 Barrington, 1987, (n 586) p. 112.
627 Hensey, 1979 (n 586) p. 22.
628 No. 4 of 1939; the Public Assistance Act 1939 and the County Management Act 1940 provided for the administration of health services—for discussion see Barrington, 1987, (n 586) pp. 132-134.
629 Hospitals Act 1939, No. 17 of the sch.
630 No. 27 of 1939; the application of the Act was restricted by s. 69 of the Health Act, 1953—that provided for the cessation of both “(a) medical assistance … and (b) general assistance … given by way of admission to an institution.”
631 No. 12 of 1940.
633 Ibid. p. 28.
634 Commenced on the 26th August 1942 by the Public Assistance Act, 1939 (Date of Commencement) Order, 1942 S. I. No. 413 of 1942.
635 Commenced on the 26th August 1942 by the County Management Act, 1940 (Date of Commencement) Order, 1942 S.I. No. 365 of 1942. Subsections (1), (2), (6) and (7) of s. 4; ss. 15, 22, 23, 24, 25, 28 and 29 were repealed by the City And County Management (Amendment) Act, 1955 No. 12 of 1955 that was commenced by City and Management (Amendment) Act, 1955 (Date of Commencement) Order, 1955 S.I. No. 130 of 1955 on 1st July 1955.
Authority was abolished and its function transferred to the Public Assistance Authority (County or Borough Council). The Boards of Health were dissolved and their functions were transferred to the County Councils. Each public assistance authority was charged with providing and maintaining homes, hospitals and other institutions within their area of responsibility. The County Councils were also charged with maintaining and administering district mental hospitals including the appointment of visiting committees.

Public Assistance (General Regulations) Order, 1942

The governance of county hospitals, district hospitals and county homes was located in these comprehensive orders. A county hospital was deemed to be “any district institution maintained by public assistance authority as a central hospital.” A district hospital was considered “a district institution being a hospital other than a county hospital.” Matters such as admission and treatment of patients/inmates, the appointment and duties of officers (surgeon, physician, medical officers, matron, nurse, porter, chaplain, superintendent assistance officer and assistance officer) and treatment of inmates were included.

Procedures for admission to a district hospital were detailed in Article 23. An inmate could discharge themselves from a county home having given notice to the matron.

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636 The Public Assistance Act 1939 s. 13; Public Assistance Authorities are defined in s. 8. These include, for example, borough and county councils.
637 Ibid. s. 14.
638 The County Management Act, 1940 s. 36.
639 S. 31 Public Assistance Act 1939.
640 Ibid. s. 34. Eason, 1928 (n 632) states “[t]he number of mental defectives in public institutions at the end of 1925 was 18,376, of whom 1,872 were in Poor Law institutions.” p. 23.
641 No. 83 of 1942 came into operation on the 26th August 1942. These Orders were made under the Public Assistance Act, 1939.
642 There were twenty four county hospitals with 70-170 beds in each according to the Department of Health, Health Progress 1947-1953 (Dublin, Government Publications, 1953) p. 6.
643 Ibid; there were 56 district hospitals with approx. 27 beds in each hospital.
644 Public Assistance (General Regulations) Order, 1942, Article 1.
645 Ibid. Article 2.
646 Ibid. Article 23.
647 Ibid. Article 43.
648 Ibid. Article 48.
649 Ibid. Article 49.
650 Ibid. Articles 50-52.
651 Ibid. Articles 53-54.
652 Ibid. Article 55.
653 Ibid. Article 56.
654 Ibid. Article 57.
655 Ibid. Article 58.
656 Ibid. Article 59.
657 Ibid. Article 27.
658 Ibid; where a person is admitted in a different mode their admission must upheld by the public assistance authority as provided by Article 25.
Discharge from a hospital was dependant on the approval of the medical officer that the patient was either fit for discharge or the patient would not benefit from further treatment.\textsuperscript{660} The medical officer could also transfer the patient to another hospital.\textsuperscript{661} On foot of detention of a patient in a hospital for more than two months (and monthly thereafter) the medical officer was required to notify the public assistance authority outlining the reason for the detention.\textsuperscript{662} The public assistance authority was required to notify the minister\textsuperscript{663} of each report.\textsuperscript{664} Such detention did amount to loss of liberty.

Inmates in an institution other than a hospital were to be given where it could be provided “suitable” work without remuneration.\textsuperscript{665} The matron of a county home was required among other things “[t]o provide for and enforce the employment of adult inmates in suitable duties.”\textsuperscript{666} It was the duty of the public assistance authority to maintain the premises.\textsuperscript{667}

**Ministers and Secretaries (Amendment) Act, 1946**\textsuperscript{668}

Section 2 of the Act provided for the setting up of the Department of Health.\textsuperscript{669} The functions transferred to the Minister of Health from the Minister for Local Government are detailed in sch. 1\textsuperscript{670} of the Health (Transfer of Departmental Administration and Ministerial Functions) Order, 1947.\textsuperscript{671} The most relevant in this context include the Public Hospitals Acts 1933 to 1940, the Hospitals Act 1939, the Nurses Registration (Ireland) Act, 1919 and the Medical Practitioners Act, 1927.\textsuperscript{672} The main health services were operated by the local health authorities under the control of the Minister for Health. The most relevant in this context included the Public Assistance Service (Public Assistance Authorities’ Hospitals (the district and county hospitals) and the County Homes) and the Mental Health Service. Food hygiene, its availability and quality in institutions also came with the ambit of the Public Assistance Service. Public Assistance Authorities could also obtain services from an

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\textsuperscript{659} Ibid. Article 35.  
\textsuperscript{660} Ibid. Article 36.  
\textsuperscript{661} Ibid.  
\textsuperscript{662} Ibid. Article 34.  
\textsuperscript{663} Ibid. Minister for Local Government and Public Health.  
\textsuperscript{664} Ibid. Article 34.  
\textsuperscript{665} Ibid. Article 38.  
\textsuperscript{666} Ibid. Article 54. (7).  
\textsuperscript{667} Ibid. Article 41.  
\textsuperscript{668} No. 38 of 1946.  
\textsuperscript{669} For discussion on the functions of the Department of Health see, for example, Department of Health, *White Paper: Outline of proposals for the Improvement of the Health Services*, (Dublin, Stationary Office, 1947).  
\textsuperscript{670} Sch. one comprises of forty-six complete enactments and sections of fourteen other acts.  
\textsuperscript{671} S.I. No. 58 of 1947; effective 18\textsuperscript{th} March 1947.  
\textsuperscript{672} No. 27 of 1927.
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extern service provider, for example, “voluntary hospital and homes for persons requiring special treatment.”

Conclusion

Minimal structures were established and older people were sequestered in institutions that were not fit for purpose where their lives were highly regulated.

Health Services

The provision of health services expanded both within the community and in the hospital settings over the next twenty years. However these developments had little impact on those older people residing in residential care settings within this period.

Health Act, 1947

This extensive piece of legislation was made up of 109 sections and two schedules. Its purpose was to attempt to streamline and enhance the provision of health services and to make provision for making regulations to enable certain charges to be made. A more expansive definition of health care premises was provided by s. 2 of the Act where “Institution” was defined to include a hospital, sanatorium ... convalescent home ... or other similar institution maintained by a health authority subject to s.10 of the Act that pertained to the provision and maintenance of these institutions. The Act provided for the making of rules for the conduct and management of such an institution. While a more expansive definition of institution was provided, the definition did not include premises not provided by the local authority but where persons were sent by the local authority as was provided by the Public Hospitals Act, 1933.

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674 No. 28 of 1947. Ss. 1 to 3 inclusive, part s. 4, ss. 5 to 9, ss. 16 and 20, Parts V, VI, V111, IX and X were commenced by the Health Act, 1947 (Date of Commencement) Order, 1947 No. 342 of 1947 on the 1st November, 1947; ss. 29 and 44 were commenced by the Health Act, 1947 (Date of Commencement) (No. 1) Order, 1948 S.I. No. 19 of 1948; Health Act, 1947 (Date of Commencement) (No. 2) Order, 1948 S.I. No. 98 of 1948 commenced part of s. 4, ss. 10 to 15 inclusive, ss. 17 to 19 inclusive, ss. 21 to 24 inclusive, s. 28, ss. 30 to 43 inclusive, ss. 45 to 52 inclusive, and Part VII of the Act; s. 4 was commenced by Health Act, 1947 (Date of Commencement) Order, 1951 S.I. No. 14 of 1951. Part 11 Institutions, Part V11 Officers of Health Authorities and ss. 99, 102 and 104 that pertain to health promotion, home nursing and ambulances respectively were repealed by the Health Act 1970.
675 For a more extensive discussion see Seanad Éireann Debate 1947 Vol. 34 No. 3.
676 S. 2 of the Health Act, 1947 defines “health authority” as a borough or county council. The meaning of the words “health authority” were amended by s. 9 of the Health Authorities Act, 1960 No. 9 of 1960 to “(a) include a health authority established by this Act, and (b) not include the council of a county or corporation of a county borough who appoint members of a health authority established by this Act.”
677 Health Act 1947, s. 18; repealed by the Health Act, 1953 No. 26 of 1953.
678 See, for example, Kilcommins, S., O’Donnell, I., O’Sullivan E. and Vaughan B., Crime, Punishment and the Search for Order in Ireland (Dublin, Institute of Public Administration, 2004) for
Reference to patient records was included for the first time in the Act with the requirement that they were to be treated in a confidential manner.\footnote{Reference to patient records was included for the first time in the Act with the requirement that they were to be treated in a confidential manner.}

The notion of compensation is not a new phenomenon. The Act provided for compensation for damage to property caused by a health authority save for activities pertaining to Part VIII of the Act.\footnote{The notion of compensation is not a new phenomenon. The Act provided for compensation for damage to property caused by a health authority save for activities pertaining to Part VIII of the Act.} Similarly where personal injury has resulted from negligence on the part of an authority or one of its agents the injured party may claim compensation.\footnote{Similarly where personal injury has resulted from negligence on the part of an authority or one of its agents the injured party may claim compensation. Where the negligence resulted in a fatal injury coming within the ambit of the Fatal Accidents Acts, 1846 to 1908 the deceased’s personal representative could seek damages from a health authority.}

Section 29 entitled the Minister for Health by regulation to specify the diseases that are infectious diseases.\footnote{Section 29 entitled the Minister for Health by regulation to specify the diseases that are infectious diseases.} More recently a revised list of notifiable diseases was provided by an amendment to the Infectious Diseases Regulations 1981\footnote{More recently a revised list of notifiable diseases was provided by an amendment to the Infectious Diseases Regulations 1981.} by the Infectious Diseases (Amendment) (No. 3) Regulations 2003\footnote{by the Infectious Diseases (Amendment) (No. 3) Regulations 2003} that also required laboratory directors to report infectious diseases. This duty prior to the legislative amendment rested solely with the medical practitioner to report a case of or a suspected case to a Medical Officer of Health.

\textbf{Health Act 1953}\footnote{This legislation among other things amended and extended the Health Act 1947. The meaning of institution was redefined to include “county home” and “home for persons suffering from physical or mental disability.”}  

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Respect for religious beliefs and facilities for religious services were to the fore in legislative provisions for institutional settings. For example, s. 4. (2) states that “[a]ny person who avails himself of any service provided under this Act shall not be under any obligation to provide such service in a manner inconsistent with his religious belief.”

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\end{footnotes}
submit himself or any person for whom he is responsible to a health examination or treatment which is contrary to the teaching of his religion” and s. 12. (1) provides that “[a] health authority shall make arrangements with the appropriate authorities for the due performance of religious services in each hospital, sanatorium, county home, home for persons suffering from physical or mental disability ... convalescent home ... maintained by them.”

Governance was addressed in s. 8 in terms of conduct, management and admissions to the institutions. Institutional and specialist services were made available for those of limited means or those who would suffer undue hardship in their endeavours to attain such services. Dental, ophthalmic and aural services were included for the middle income group.

Institutional assistance (“shelter and maintenance in a county home or similar institution”690) was made available by the local authority where a person was unable to provide for shelter or maintenance for either himself or his family. The provision of sanctions against residents who misbehave is detailed in s. 54. (5):

Every person maintained by a health authority in a county home or similar institution who behaves in a disorderly manner in such home or institution, or causes unreasonable disturbance to other persons maintained in such home or institution or to persons employed therein, shall be guilty of an offence under this subsection and shall be liable on summary conviction thereof to imprisonment for a term not exceeding twenty-one days.

**Health (Corporate Bodies) Act, 1961**691

The Health (Corporate Bodies) Act, 1961 as amended by s. 22 of the Health (Amendment) (No. 3) Act, 1996692 provided a definition of health service. It stated “health service’ includes any service relating to the protection, promotion or improvement of the health or welfare of people.”693 The Act made provision for the establishment of bodies to advise on health policy and provide health services.

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688 S. 15 of the Health Act, 1953.
689 Ibid. s. 21.
690 Ibid. s. 54. (1).
691 No. 27 of 1961.
692 No. 32 of 1996.
693 Ibid.
Health Act 1970\(^{694}\)

This legislation provided for the establishment of health boards\(^{695}\) that could provide and maintain hospitals and related premises as required by the Health Acts, 1947 to 1970. Section 26, for example, deals with the contracting out of services to a private service provider. The legislation did not address standards of care in either a public or private facility.\(^{696}\)

The functions of the health boards were set out in s. 6 (1). Eight regional health boards were established under that Department of Health for the management of health services that were previously managed by the local authority system.

Similar to previous legislation consideration was given to provision of religious services. Section 39 (1) required a health board to make arrangements with the appropriate bodies for the provision of religious services in each of its hospitals, sanatoriums and homes. Provision of religious services is one of the constants throughout the legislation.

The legislation made provision for free\(^{697}\) in-patient services (“in a hospital, convalescent home or home for persons suffering from physical or mental disability or in accommodation ancillary thereto”)\(^{698}\) for persons with full or limited eligibility. Full or limited eligibility was dependent on means. The legislation allowed a patient to make alternative arrangements in terms of the service provider. While the 1970 Act provided general statutory duties it was difficult for individuals to secure particular entitlements.

Health (Amendment) (No. 3) Act, 1996\(^{699}\)

The long title to this legislation includes three objectives.\(^{700}\) The clarification of responsibilities with regard to the Health Boards and the executive are detailed in ss. 3 and 4


\(^{695}\) Ibid. s. 4 (1).

\(^{696}\) Ibid. s. 38 (1) and (2).

\(^{697}\) Charges may be made of person of limited eligibility by virtue of s. 53 (2).

\(^{698}\) Ibid. s. 51.

\(^{699}\) No. 32 of 1996; ss. 1, 2(1), 2(3), 3, 4(3), 5, 6(1) to 6(3), 6(6), 7(1) to 7(5), 8(1), 8(2), 9(1), 10, 11(1) to 11(4), 13, 14, 15(1), 15(2), 15(4), 15(5), 16, 17(a) to 17(d), 18(a), 18(c), 19, 23, 24 and 25(3) repealed by the Health Act, 2004.
respectively. Section 3 limits the duties of the health boards to “reserved functions.” The chief executive officer has responsibility (with minor exceptions) for all other non-reserved functions.

Ministerial sanctions are provided in s. 12 with regard to the Health Board. A board’s functions may be transferred to another person on foot of a report detailing the board has failed to carry out one or more of its functions or a direction of the Minister. With the consent of the Minister the chief executive officer may be removed from office in accordance with their service contract.

Section 20 of the 1996 Act closed a loophole in the law. While the Health (Nursing Homes) Act, 1990 provided for the imposition of sanctions on conviction of offences, it did not include what constituted an offence. Accordingly a person in charge of or carrying on an unregistered nursing home is deemed to have committed an offence under s. 3 (5) of the Health (Nursing Homes) Act, 1990 as amended by s. 20 of the 1996 Act. Similarly someone purporting that a non-registered nursing home is registered is guilty of an offence.

Health Act 2004

The primary function of the Health Act 2004 was to establish the Health Service Executive (HSE) and transfer administrative functions previously undertaken by several bodies (the Eastern Regional Health Authority, the Northern Area Health Board, the East Coast Area Health Board, the South Western Area Health Board and the Health Boards set up under the 1970 Health Act) to one body, the HSE.

A person may make a complaint against any action taken or omitted by the executive or a service provider where that action is not commensurate with fair and proper administrative

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700 “An Act to make further provision in relation to the income, expenditure and indebtedness of Health Boards, to apportion responsibilities between Health Boards and their Chief Executive Officers, to amend the Heath Acts, 1947 to 1996, the Health (Corporate Bodies) Act 1961, and the Nurses Act, 1985, and to provide for related matters.”

701 Reserved functions are set out in sch. 1 of No. 32 of 1996 and deal with matters such as land acquisition and disposal and the removal of the chief executive officer.

702 Ibid. s. 14 (3).


704 No. 42 of 2004. The Act was enacted on the 17th December 2004 and the HSE was established on the 1st January 2005 by the Health Act 2004 (Establishment Day) Order 2004 S. I. No. 885 of 2004. This legislation was introduced on foot of the publication of Prospectus and Watson Wyatt, Audit of the Structure and Functions in the Health System (Dublin, Government Publications, 2003) http://www.healthreform.ie/pdf/prospectus.pdf. Last accessed 28th June 2012. As stated in the Report p. 23, “[t]he overall purpose of the reforms proposed is not simply to reduce the number of agencies or to deal with any single issue in isolation. Fundamentally, it is about reducing overall fragmentation of effort, thereby creating real opportunities to release the potential of healthcare workers to deliver enhanced quality services to consumers and value for money to taxpayers.”

705 Ibid. s. 6 of the Health Act 2004.
practice and impacts the person adversely. Where a person is unable to make the complaint themselves by virtue of their age, illness or disability, it can be made on their behalf by a near relative or the person’s carer, their legal representative, by someone who has the care of the person’s affairs, any person who has been permitted to do so by the complainant or any person where consented by law. However the enabling legislation did not come into effect until the 1st January 2007.

Conclusion

Great advances were made in the provision of health services in Ireland since the late 1940s with the use of penicillin and streptomycin and developments in medicine and surgery. However older people in residential care continued to live highly regulated lives.

Rights

This section addresses the arrangements for the protection of individual’s personal data, the release of information from public bodies, safe guards to prevent unjust discrimination and the protection of human rights.

Data Protection Act, 1988

This legislation is intended to protect the privacy of individuals’ personal data that is processed by means of “performing automatically logical or arithmetical operations on the data....” The current definition of ‘personal data’ is “data relating to a living individual who is or can be identified either from the data or from the data in conjunction with other information that is in, or is likely to come into, the possession of the data controller.”

706 Ibid. Part 9.
707 Ibid. ss. 46. (1) and (2).
708 Ibid. s. 9 came into operation on the 1st January 2007 with the Health Act 2004 (Commencement) Order 2006 S.I. No. 651 of 2006; the regulations governing the making of complaints, carrying out investigation and review are provided by The Health Act 2004 (Complaints) Regulations 2006 S.I. No. 652 of 2006 that came into operation on the 1st January 2007.
709 No. 25 of 1988; this Act gives effect to Ireland’s obligations under the Convention for the Protection of Individuals with Regard to Automatic Processing of Personal Data completed at Strasbourg on 28 January 1981.
710 Data Protection Act, 1988 s. 1(1).
711 S. 2 (a) (iv) of the Data Protection (Amendment) Act 2003 No. 6 of 2003 that amends s. 1 of the Data Protection Act, 1988. No. 6 of 2003 was enacted to comply with the requirements of EU Data Protection Directive 95/46/EC; all sections of the Act are in force, with the exception of s. 4(13); further information is available at, for example, Data Commissioner web-site at http://www.dataprotection.ie/viewdoc.asp?DocID=796. See also IHRC Submission to the Department of Justice and Equality on the European Commission’s proposal for a new Data Protection Regulation May 2012 available at http://www.ihrc.ie/download/pdf/ihrc_submission_to_the_dept_of_justice_on_proposal_for_a_new_data_protection_regulation_directive.pdf. Last accessed 25th May 2012. See also Regulation (EC) No 1049/2001 of the European Parliament and of the Council regarding public access to documents (30 May 2001). The purpose of this Regulation is to define the principles, conditions and limits on
Personal data may include patient records. \textsuperscript{712} Section 4 of the Act provides right of access to such information. The information must be given in a form that is comprehensible to the average person. Where terms used are not readily understandable the information must be accompanied by an explanation. Information may be restricted where its provision would be a likely cause of a serious adverse effect on an individual’s physical or mental well-being.

**Data Protection (Access Modification) (Health) Regulations, 1989**\textsuperscript{713}

These regulations limit a patient’s right of access to their physical or mental health data where the release would have a severe deleterious impact to their physical or mental well-being.\textsuperscript{714}

Health data that would not have an adverse impact on the patient may be given as requested.\textsuperscript{715} The legislation also makes provision for the communication of this health data to the patient.\textsuperscript{716}

**Data Protection (Access Modification) (Social Work) Regulations, 1989**\textsuperscript{717}

These regulations prohibit the supply of social work data to the subject client where the release of this information would have an adverse impact on the client to such an extent that it would cause them serious physical or mental harm.\textsuperscript{718} This prohibition does not extend to information that would not cause such a degree of harm.\textsuperscript{719}

**The Data Protection (Amendment) Act 2003**\textsuperscript{720}

In addition to the requirements of data protection legislation, draft procedures for non-service providers to enable the making of protected disclosures and for carrying out investigations with regard to protected disclosures must be forwarded by such bodies

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\textsuperscript{712} In *S and Marper v UK* 30562/04 [2008] ECHR 1581 personal data also included finger prints, biological samples and DNA.

\textsuperscript{713} S.I. No. 82 of 1989.

\textsuperscript{714} Ibid. Regulation 4(1).

\textsuperscript{715} Ibid. Regulation 4(2).

\textsuperscript{716} Ibid. Regulations 5 and 6.

\textsuperscript{717} S.I. No. 83 of 1989.

\textsuperscript{718} Ibid. Regulation 4(2).

\textsuperscript{719} Ibid. Regulation 4(2).

\textsuperscript{720} No. 6 of 2003. Enacted to comply with the requirements of EU Data Protection Directive 95/46/EC; all sections of the Act are in force, with the exception of s.4.(13); see also Regulation (EC) No 1049/2001 of the European Parliament and of the Council regarding public access to documents (30 May 2001). The purpose of this Regulation is to define the principles, conditions and limits on grounds of public or private interest governing the right of access to European Parliament, Council and Commission documents and to promote good administrative practice with regard to access to these documents.
(established under the Health (Corporate Bodies) Act 1961\textsuperscript{721}) to the Data Protection Commissioner for their opinion to ensure that the draft procedures would not contravene the data protection legislation.\textsuperscript{722} Relevant bodies, for example, service providers, have a duty to have procedures for persons making protected disclosures and carrying out investigations with regard to the subject of such disclosures.\textsuperscript{723}

**Freedom of Information Act, 1997\textsuperscript{724} as amended by the Freedom of Information (Amendment) Act, 2003,\textsuperscript{725} the Safety, Health and Welfare at Work Act, 2005\textsuperscript{726} and the Health Act 2007\textsuperscript{727}**

The purpose of this legislation among other things is to enable members of the public to access information that public bodies may have in their possession. Such bodies would include but not be limited to the Department of Health or Health Service Executive (formerly the Health Boards) and the Office of the Ombudsman.\textsuperscript{728} An application for information may be refused on several grounds,\textsuperscript{729} for example, where release of the information sought is considered detrimental to the health of the individual.\textsuperscript{730}

The Freedom of Information Act, 1997 (Section 28 (6)) Regulations, 2009\textsuperscript{731} permits access to another’s record of personal information including those of a deceased individual, in prescribed circumstances.\textsuperscript{732}

**Equal Status Act 2000\textsuperscript{733}**

The purpose of the Act is to prohibit unjust discrimination and harassment in the provision of goods and services, the disposal of property, provision of accommodation and other

\textsuperscript{721} No. 27 of 1961.
\textsuperscript{722} 55H. (2) of the Health Act 2004 as inserted by s. 103 of the Health Act 2007 No. 23 of 2007.
\textsuperscript{723} Ibid. 55H (1).
\textsuperscript{724} No. 13 of 1997.
\textsuperscript{725} No. 9 of 2003.
\textsuperscript{726} No. 10 of 2005.
\textsuperscript{727} No. 23 of 2007.
\textsuperscript{728} The first schedule of the 1997 Act provides a list of public bodies. S. 46. (1) of the Freedom of Information (FOI) Act 1997 was amended by s. 74 of the Safety Health and Welfare at Work Act 2005 exempting enforcement and investigation records of the Health and Safety Authority from FOI.\textsuperscript{729} For example, Part 111 details exempt records.
\textsuperscript{731} S.I. No. 387 of 2009; for further discussion see, for example, Costello, C. and Barry E., (eds.) *Equality in Diversity* (Dublin, Irish Centre for European Law, 2003) and O’Cinnéide, C., “Age Discrimination and Irish Equality Law” in O’Dell, 2006 (n 7) p. 293.
\textsuperscript{732} See, for example, Donnelly, M. and McDonagh, M., “Access to Health Information in Respect of Deceased Persons: The Law in Ireland” 2010 (16) 1 MLJI pp. 7-15.
\textsuperscript{733} No. 8 of 2000.
matters on any one of nine grounds including age, gender, sexual orientation, and disability.\textsuperscript{734}

Nursing homes may provide single sex accommodation. Discrimination does not occur where accommodation is limited to one gender where embarrassment or infringement of privacy is likely to prevail where a person of another gender is present.\textsuperscript{735} In this regard subsection (5) specifically refers to a nursing home.\textsuperscript{736}

The proposed eviction of a tenant, aged 74, was among the issues that gave rise to the case in \textit{Desmond McGreal v Cluid Housing}.\textsuperscript{737} A complaint on the grounds of age discrimination was upheld by the Equality Tribunal.\textsuperscript{738} This case is included as it deals with discrimination of an older person with regard to accommodation albeit in the community. At the time of writing there were no cases that addressed age discrimination and residential care.

**European Convention on Human Rights (ECHR) Act 2003\textsuperscript{739}**

The ECHR Act came into force on the 31\textsuperscript{st} December 2003.\textsuperscript{740} This gives effect to the European Convention on Human Rights in Irish Law.\textsuperscript{741} Rights under the Convention therefore may be pleaded directly before the Irish courts and tribunals obviating the necessity to have cases heard before the European Court of Human Rights in Strasbourg. These rights can be sought by either relying on one or more sections of the Act. For example s. 3 of the Act obligates every organ of the State\textsuperscript{742} (subject to any other statutory provision or rule of law) to comply with the requirements of this legislation; a remedy of damages may be available in certain circumstances.\textsuperscript{743} A declaration of incompatibility may be obtained under s. 5 where the courts are of the opinion that a statutory provision is

\hspace{1cm}\textsuperscript{734}Ibid. s. 3.2.
\textsuperscript{735}Ibid. s. 6. (2)(e).
\textsuperscript{736}Ibid. s. 6. (5) provides: “Where any premises or accommodation are reserved for the use of persons in a particular category of persons for a religious purpose or as a refuge, nursing home, retirement home, home for persons with a disability or hostel for homeless persons or for a similar purpose, a refusal to dispose of the premises or provide the accommodation to a person who is not in that category does not, for that reason alone, constitute the discrimination.”
\textsuperscript{737}Dec-S2011-004
\textsuperscript{738}Ibid. para. 5.2.
\textsuperscript{739}No. 20 of 2003.
\textsuperscript{742}“Organ of State” has been defined by s. 1 of the Act and includes a tribunal or any other body (other than the President or the Oireachtas or either House of the Oireachtas or a Committee of either such House or a Joint Committee of both such Houses or a court) which is established by law or through which any of the legislative, executive or judicial powers of the State are exercised.
\textsuperscript{743}Ss. 3 (2) and 3 (3) of the European Convention on Human Rights Act 2003.
incompatible with the States requirements under the Convention conditions. An *ex gratia* compensation may be made to the party seeking redress.\(^\text{744}\)

It may be premature to consider the benefits that may accrue under the Act in terms of the older person in residential care. However in terms of duty holders the Commission on Patient Safety and Quality Assurance drew attention to the disciplinary functions of professional regulatory bodies, while recognising that the prime purpose of Fitness to Practice inquiries is to protect the public interest they also had a responsibility to ensure that their registered members under investigation received “a fair and public hearing by an independent and impartial tribunal” in keeping with the requirements of the 2003 Act.\(^\text{745}\)

**Disability Act 2005**\(^\text{746}\)

This legislation establishes a statutory basis for an individual independent needs assessment\(^\text{747}\), a service assessment and redress for a person with a disability.\(^\text{748}\) Furthermore, among other things it provides for access to services and the development of a sectoral plan for all Government Departments detailing the arrangements in place to secure services.\(^\text{749}\)

A person is considered to have a disability if they incur a substantial restriction where the restriction “(a) is permanent or likely to be permanent, results in a significant difficulty in communication, learning or mobility or in significantly disordered processes, and (b) gives rise to the need for services to be provided continually to the person...”\(^\text{750}\)

Any person with a disability or their representative\(^\text{751}\) may make an application for an assessment if they meet the eligibility criteria sent out in the Health Acts 1947-2004. Such an assessment is carried out without regard to the cost or the capacity to provide services identified outlined in the assessment.\(^\text{752}\) A report is prepared on foot of the assessment setting out the results of the assessment and will include where the assessor is of the opinion

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\(^{744}\) Ibid. s. 5.

\(^{745}\) Commission on Patient Safety and Quality Assurance Building a Culture of Patient Safety *Report of the Commission on Patient Safety and Quality Assurance* (Dublin, Department of Health and Children, 2008) 8. For a detailed discussion on professional regulatory bodies see Ch. 6 of this work.

\(^{746}\) No. 14 of 2005.

\(^{747}\) In practice there are tight deadlines. Needs assessment only activated for those in the 0-4 age range.

\(^{748}\) Disability Act 2005, Part 2.

\(^{749}\) Ibid. Part 3.

\(^{750}\) Ibid. s. 7. (2).

\(^{751}\) Ibid. s. 9. (2) that considered representative to include, a spouse, ... a relative of the person for whom the assessment is sought, a guardian, a legal representative or a personal advocate designated by Comhairle to act on behalf of the person with a disability.

\(^{752}\) Ibid. s. 8. (5).
that the person under assessment has a disability, an ideal timescale for implementation of remedial measures.\footnote{Ibid. s. 8. (7).}

A service had been defined by s. 2 of the Act as

a service or facility of any kind provided by a public body which is available to or accessible by the public generally or a section of the public and, without prejudice to the generality of the foregoing, includes-

(a) the uses of any place or amenity owned, managed or controlled by a public body,

(b) the provisions of information or an information resource or a scheme or an allowance or other benefit administered by a public body,

(c) any cultural or heritage services provided by such a body, and

(d) any service provided by a court or tribunal.

The assessment report is sent to the HSE. On foot of receipt of an assessment report that includes a determination for the appropriate health services for the applicant, arrangements are made with a liaison officer to prepare a service statement.\footnote{Ibid. s. 11.} The service statement details the services that will be provided by the HSE to the applicant.\footnote{Ibid.} Complaints with regard to assessments or service statements may be made to the HSE by the applicant or their representative.\footnote{Ibid. s. 14. (1).}

The Act makes provision for offences committed by a body corporate, for duty holders of such a body and for members (when the body corporate is managed by them), where “the offence is proved to have been committed with the consent, connivance or approval of, or to have been attributable to any neglect” by that person.\footnote{Disability Act, 2005 (n 746) s. 54.}

Sections 26, 27, and 28 of the Act makes provision with limitations for access to services, access to purchased goods or services and access to information. The Disability Act 2005 (Code of Practice) (Declaration) Order 2006\footnote{S.I. No. 163 of 2006.} provides clarification for public bodies including the HSE with regard to access and delivery of information and services to people with disabilities.
Chapter 3  Irish Legal Provisions

The national quality care standards for disabled persons in residential care were launched on the 11th May 2009 by HIQA but due to budgetary restraints will not be implemented on a statutory basis until 2013.\textsuperscript{759}

\textbf{Conclusion}

The forgoing legislative provisions have had little impact on the lives of older people in residential care to date in Ireland. However MacMenamin J. in the High Court in \textit{HSE v X}\textsuperscript{760} referring to s. 4 of the ECHR Act 2003 stated: “In interpreting the law, in applying a Convention provision, the court must take due account of the principles laid down in such judgements or declarations.”\textsuperscript{761} The ECHR Act 2003 may, perhaps, offer some possibilities for safeguarding the rights of older people in residential care.

\textbf{Mental Health}

\textit{Bird’s Nest Soup}\textsuperscript{762} details the harrowing account by one individual captured by the provisions of the Mental Treatment Act 1945. Chargeable patient reception orders had a profound effect on an individual detained under this system where the individual’s rights were largely extinguished. The Mental Health Act 2001 brought a shift in legislative provision however a narrow paternalistic response is still evidenced by recent court decisions.\textsuperscript{763} This section examines the mental health legislative provisions in the context of older people and draws attention to current legislative lacunae in this area. For older people in residential care these legislative gaps may involve a serious curtailment of their rights.

\textbf{The Mental Treatment Act 1945}\textsuperscript{764}

The purpose of the legislation was to provide for the prevention and treatment of mental disorders and to provide arrangements for the care of those affected. The legislation introduced three categories of admissions, one voluntary\textsuperscript{765} and two compulsory categories of detained patients, the temporary patient and the person of unsound mind. A further

\textsuperscript{759} O’Brien, C., “State has no funds for disabled standards: regulations for disabled in care will not be implemented” Irish Times May 12\textsuperscript{th} 2009 p. 6. HIQA recently published, for public consultation, draft national standards for residential care services for adults and children with disabilities on the 17\textsuperscript{th} October 2012.

\textsuperscript{760} [2011] IEHC 326.

\textsuperscript{761} Ibid. para. 52.

\textsuperscript{762} Greally, H., (Dublin, A. Figgis, 1971).


\textsuperscript{764} No. 19 of 1945; commenced 1\textsuperscript{st} January 1947 by the Mental Treatment Act, 1945 (Date of Commencement) Order, 1946 S.I. No. 329 of 1946; repealed with saving (other than Part V111 and ss. 241, 276, 283 and 284) by Mental Health Act 2001 No. 25 of 2001; see, for example, Kelly, B., “The Mental Treatment Act 1945 in Ireland: an historical enquiry” (2008 ) 19 1 \textit{History of Psychiatry} pp. 47-67 for a discussion on the development of mental treatment in Ireland.

\textsuperscript{765} Ibid. No. 19 of 1945, part XV.
distinction was made in the legislation between public and private types of admissions.\textsuperscript{766} In addition, an application for recommendation for reception and detention of a person of unsound mind (known as a P.U.M.) could be made by relatives, gardaí and the community welfare officers to the authorised doctor.\textsuperscript{767}

There was no time limit to the detention under the chargeable reception order.\textsuperscript{768} It is likely that older people currently within the mental health institution or recently transferred from mental health institutions to private nursing home were originally admitted to mental health institutions under chargeable patient reception orders.

A mental health institution had extensive powers for charging a patient, for the repayment of charges where payment was outstanding and for the appropriation of the patient’s property for the cost of his care.\textsuperscript{769}

The powers and duties of the Inspector of Mental Health Hospitals were extensive.\textsuperscript{770} For example, the Inspector was required to\textsuperscript{771}

- inquire where any system of coercion, restraint, or seclusion is in operation and if so-
  - (i) the particulars of the system,
  - (ii) the means by which it is practised,
  - (iii) whether it is by medical treatment or otherwise,
  - (iv) its results.

In addition, the Inspector had a duty to see each patient admitted since the previous inspection and to examine the admitting documents.\textsuperscript{772} The Inspector was required to

\textsuperscript{766} Ibid; see ss. 184. (2) and 185. (2) that distinguished the requirements for the application and making of temporary chargeable and private reception orders respectively. Persons that may seek chargeable patient reception orders for patients of unsound mind are provided by ss. 162. (2), 162. (3), 165 and 166. Applicants seeking private patient reception orders (s. 177. (3), (4) and (5)) fall into the same category as those seeking temporary private reception orders. Private patient reception orders require the signature of two doctors (s. 178(1)). Where the patient is not private only one doctor’s signature is required by s. 163.

\textsuperscript{767} Ibid. ss. 162(2), 165 and 166.

\textsuperscript{768} Ibid. s. 172.

\textsuperscript{769} Ibid. ss. 232, 233 and 234; repealed and amended by s. 71 of the Health Act, 1953 No. 26 of 1953.

\textsuperscript{770} Ibid. Part XV111.

\textsuperscript{771} Ibid. s. 237. (f).

\textsuperscript{772} Ibid. s. 237. (l).
prepare an annual report that was furnished to the Minister, a copy of which was laid before the Dáil and the Seanad and a copy sent to the President of the High Court.\textsuperscript{773}

The first mention in the Acts of the Oireachtas of ill-treatment or neglect with regard to any patient was provided by s. 253 which stated:

Where the person in charge of a mental institution or a person employed therein ill-treats or wilfully neglects a patient in the institution, or a person having charge, whether by reason of any contract or of any tie of relationship, marriage, or otherwise, of a person of unsound mind ill-treats or wilfully neglects such a person of unsound mind he shall be guilty of an offence...

The legislation made provision for an increase in a custodial sentence where a worker was convicted of a sexual offence or attempted sexual offence against a women patient\textsuperscript{774} ("who was considered to be an idiot, imbecile, or feebleminded")\textsuperscript{775} in a mental health institution.\textsuperscript{776} The prosecution had to be held within 12 months of the offence being committed. While the majority of women patients were less than 65 years of age some may have been considered older people.

The application of bodily restraint was governed by ss. 263 and 264. Near insurmountable barriers existed in the form of s. 260 for former in-patients\textsuperscript{777} seeking redress through the courts for actions carried out by function holders under the Act. Section 260 provided:

No civil proceedings shall be instituted in respect of an act purporting to have been done in pursuance of this Act save by leave of the High Court and such leave shall not be granted unless the High Court is satisfied that there are substantial grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care.

Section 260 has been considered by Henchy J. as that which "re-enacts a bar to litigation which existed in the law of lunacy in England since the Lunacy Act, 1890."\textsuperscript{778} In \textit{Murphy v Green}\textsuperscript{779} the plaintiff successfully secured leave from the High Court to initiate a civil action for neglect, false imprisonment and libel. On appeal to the Supreme Court the leave was denied, O’Flaherty J. said:

\textsuperscript{773} Ibid. s. 247.
\textsuperscript{774} Ibid. s. 254.
\textsuperscript{775} Criminal Law Amendment Act, 1935 No. 6 of 1935, s. 4.
\textsuperscript{776} Ibid. s. 4. 2.
\textsuperscript{777} Two successful cases: Bailey and Gallagher [1996] 2 ILRM 433 and Melly v Moran and North Western Health Board [1997] IEHC 101 unreported SC.
\textsuperscript{778} O’Dowd v North-Western Health Board [1983] ILRM 186, p. 196.
\textsuperscript{779} [1990] 2 IR 566.
The Court has to hear both sides at this stage of the proceedings. Or, more accurately, it must hear both sides before the proceedings can be launched. Because of the nature of the legislation the court will of necessity look at the individual seeking to sue. Is he a crank? Is he paranoid? Has he a case of any description? These are the first questions that must be asked and, it may be very often, the only questions that need to be answered.\footnote{Ibid. p. 582.}

More recently in \textit{Blehein v Minister for Health and Children}\footnote{[2008] 2 ILRM 401.} the Supreme Court upheld the decision of Carroll J. in the High Court who considered that s. 260 was unconstitutional. The case arose initially as a result of the plaintiff’s involuntary admissions to hospital on three occasions.

Carroll J. said:

\begin{quote}
In my opinion the limitation of access to the courts on two specified grounds constitutes an impermissible interference by the legislature in the judicial domain contrary to Article 6 of the Constitution providing for the separation of powers and Article 34 providing for the administration of justice in the courts….Since the relief sought by the plaintiff basically consists of seeking a declaration setting out his arguments, it seems to me the appropriate order is a declaration that s. 260 of the Mental Treatment Act, 1945 (as amended) is unconstitutional having regard to Article 6 and Article 34 of the Constitution.\footnote{Ibid. para 10.}
\end{quote}

Anecdotally it is reported that older people that did not have a mental health problem and had mild to moderate dementia were admitted to mental health hospitals. They were accepted for admittance more readily in the local mental health hospital rather than in the county home.

\textbf{Mental Health Act, 2001}\footnote{No. 25 of 2001; the Mental Health Act, 2001 was fully implemented on November 1\textsuperscript{st} 2006 by the provision of the Mental Health Act (Commencement) Order 2006 S.I. No. 411 of 2006 that brought ss. 6, 8-30 and 56-75 inclusive of the Act into operation.}

A re-orientation in mental health legislation from a medical discretion model\footnote{Mental Health Acts, 1945 to 2001 (these include the Mental Treatment Act, 1945 No. 19 of 1945, the Mental Treatment Act, 1961 No. 7 of 1961 and the Mental Health Act, 2001 No. 25 of 2001. In the absence of a commencement order the Health (Mental Services) Act 1981, reforming legislation that appears on the statute books was not implemented) and the Mental Health Act 2008 No. 19 of 2008.} to a more rights based person centred approach was introduced with the Mental Health, Act 2001.\footnote{Ibid. para 10.}
However “there are growing concerns that this ethos is diluted by an emerging paternalistic approach that has been adopted by the judiciary in the interpretation of the Act.”

The Act sets out the criteria for admission to an approved centre of involuntary patients suffering from a mental disorder, the establishment of a Mental Health Commission (MHC), a Mental Health Tribunal and an Inspector of Mental Health Services. The main focus of the Act is on an involuntary patient rather than a voluntary patient. A voluntary patient is considered as a “person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order.” Virtual exclusion of the voluntary patient from the Act is problematic. This legislative omission gives rise to grave concern for patients with diminished capacity since they are de facto detained outside the protective zone of the Mental Health Act, 2001.

The Act was long awaited. The Health (Mental Services) Act 1981 was not implemented in the absence of the commencement order and The Mental Treatment (Amendment) Bill 1992 was defeated. The White Paper on Mental Health was published in 1995 that outlined proposed changes to mental health legislation that included the establishment of an independent Mental Health Review Board which could direct the discharge of a patient. The White Paper is informed by the UN Principles for the Protection of Persons with Mental Illness 1991 and the ECHR. It states, for example:

The UN Principles recommend that the review body be judicial or other independent and impartial body established by domestic law and envisages a review of every decision to detain. Under the European Convention, the review body must have power to discharge a person if it considers that the criteria and procedures for detention have not been met in any particular case and its decisions cannot be overruled by an executive body.

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785 For an extensive discussion on the Mental Health Act 2001 see Keys, M., Mental Health Act 2001 (Dublin, Round Hall Sweet and Maxwell, 2002).


787 As detailed in s. 63 of the Act an approved centre is one that is registered and the person carrying on a centre must be the registered proprietor.

788 Detention of a patient under an admission order or renewal order requires the patient to be referred to a Mental Health Tribunal. At variance to the requirements of the ECHR there is no provision for review of detention or treatment in the legislation for voluntary patients. See, for example, PL v The Clinical Director of Saint Patrick’s Hospital and Anor [2012] IEHC 15.

789 Mental Health Act, 2001. (n 783) s. 2.

790 Patients with diminished capacity come within the ambit of the common law or wardship. See Ch. 5 of this work for further discussion on wardship.


792 Ibid. p. 52.
In *O’Reilly v Ireland* the ECtHR deemed admissible “the applicant’s complaints relating to the nature of her examination by a doctor leading to her involuntary committal to a psychiatric institution.” The initial case arose out of failure to obtain leave to take a civil action. Mrs O’Reilly was admitted to hospital on foot of a signed medical certificate under s.184 of the Mental Treatment Act 1945. There was no legal requirement for the hospital to examine a patient on admission. She was released three days later. She subsequently made an application to the High Court seeking leave to institute proceedings under s. 260 of the Mental Treatment Act 1945. The High Court considered the medical examination adequate and Mrs O’Reilly appealed to the Supreme Court against the refusal to grant her leave to sue her doctor. The Supreme Court held that the “observation” of the doctor from a distance (he was about twelve to fifteen yards away) could be deemed an examination. The dissenting judgement of Blayney J. is of interest in that he viewed s. 260 of the Mental Treatment Act 1945 breached her constitutional right of access to the courts.

However *Croke v Ireland* was influential in law reform. The case, also deemed admissible before the ECtHR, resulted in a friendly settlement and may be considered the catalyst for moving the 1999 Bill to the Mental Health Act, 2001. The initial case arose following transfer of a patient from a general hospital to the Central Mental Hospital on foot of a person of unsound mind order. The Supreme Court held that he was detained according to the law, that s. 172 of the Mental Treatment Act 1945 was constitutional. The applicant’s complaint to the ECtHR concerned the absence of an automatic and independent review of his varying periods of detention under the Mental Treatment Act 1945. The ECtHR stated that the applicant was “in a class of persons (involuntary psychiatric detainees) directly affected by the absence of appropriate legislation [and the application raised] serious issues under Article 5.1 and 5.4 of the Convention which require determination on the merits.”

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793 (Application No. 24196/94).
794 Ibid.
795 *O’Reilly v Moroney and the Mid Western Health Board* [1992] 2 IR 145.
796 Ibid.
797 Ibid. SC unreported 16 November 1993.
798 Ibid.
800 (Application No. 3326/96).
801 *Croke v Smith* (No 2) [1988] 1 IR 101.
802 *Croke v Ireland* (Application No. 3326/96).
803 Ibid. p. 15.
The definition of mental disorder including severe dementia has given rise to considerable concern. The consequences could be involuntary admission for an older person with severe dementia and behavioural symptoms or an older person with a significant intellectual disability. In her commentary Quirke observes that “the ability of a mental hospital to provide appropriate care for a person suffering from dementia or Alzheimer’s disease, who does not concurrently have psychiatric symptoms, is questionable.” More specifically such provision would be at variance with the requirements of Article 25 CRPD that provides that “persons with disabilities have the right to the enjoyment of the highest attainable standard of health…”

Section 4 of the Mental Health Act, 2001 provides that decisions made under the Act are to be in the best interests of the person. Where reasonably practicable, where an involuntary admission, recommendation or treatment is proposed the affected person is notified and provided with an opportunity to respond prior to admission and due regard is to be given to any such representation.

The need to respect the rights of the individual with regard to their dignity, bodily integrity, privacy and autonomy is affirmed in s. 4 (3) that provides: “In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.”

Section 22 provides for the transfer of a patient to hospital or other place and for the detention of the person in that place and such detention “shall be deemed for the purposes of this Act to be detention in the centre from which he or she was transferred.” The Mental Health Act, 2001 can therefore apply to persons in residential care settings for older people who have been transferred from approved centres if a detention order is in place. The

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804 The Mental Health Act, 2001 (n 783) s. 3 defines mental disorder as “mental illness, severe dementia or significant intellectual disability where....” Mental illness is a state of mind affecting a person’s thinking, perception, emotion or judgment and affects the person’s mental functioning to such an extent that care or medical treatment is required. Severe dementia is considered as a deterioration of the brain which significantly impairs an individual’s intellectual function thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression. Significant intellectual disability is defined as “a state of arrested or incomplete development of mind of a person.”


806 See (n 32) p. 227; in 2001 nearly 40% of the residents in psychiatric hospitals were older residents which was the same as it had been in 1984.

807 Quirke (n 7) p. 279.

808 A narrow paternalistic approach has been adopted by the Courts in the context of best interests. See, for example, M.R. v Flynn and Byrne (n 786) p. 211, J. H. v Lawlor (n 786) p. 225 and EH v St. Vincent’s Hospital (n 786) p. 46.

809 Mental Health Act 2001, (n 783) s. 4 (2).
Inspector of Mental Health Services\textsuperscript{810} has no inspection rights if the mental health patient is not in an approved mental health centre i.e. if in a non-psychiatric residential care setting.

The MHC is an independent statutory body with obligations under the Mental Health Act 2001.\textsuperscript{811} The MHC is required to promote, encourage and foster high standards and good practice in the delivery of mental health services and to take all reasonable steps to protect the interests of anyone detained under the Act.\textsuperscript{812} The MHC ensures that quality management systems are implemented and maintained in the first instance by ensuring the approved centres are registered.\textsuperscript{813} The Act makes provision for the making of rules by the MHC for governing electro-convulsive therapy\textsuperscript{814} and the use of seclusion and mechanical means of bodily restraint.\textsuperscript{815} The MHC prepares and reviews codes of practice (COP).\textsuperscript{816} Five COPs\textsuperscript{817} have been prepared for the guidance of persons working in adult mental health services.

Of critical importance is the requirement for individual care plans that are completed for each resident in an approved mental health centre. The care plan is completed in consultation with the resident as far as practicable. The plan is holistic in design and incorporates among other things appropriate goals for the individual.\textsuperscript{818}

Consent to treatment is enshrined in Part 4 of the Act. Consent is not required where the consultant psychiatrist in whose care the patient is believes that the patient requires lifesaving treatment or treatment to restore health, improve the condition or relieve suffering where the patient because of their mental ill-health is unable to give the consent required.\textsuperscript{819}

\begin{thebibliography}{9}
\bibitem{810} Ibid. the MHC was established by s. 32 of the Mental Health Act, 2001.
\bibitem{811} Ibid. s. 33.
\bibitem{812} For a discussion on quality standards see http://www.mhcirl.ie/Standards_Quality_Assurance/Quality_Framework.pdf, Last accessed 16\textsuperscript{th} September 2012.
\bibitem{813} Ibid. Mental Health Act, 2001 (n 783) s. 64.
\bibitem{814} Ibid. s. 59 (2).
\bibitem{815} Ibid. s. 69 (2); a patient coming within the ambit of s. 69 includes a person to whom an admission order (section 14) or a renewal order (section 15) relates and a voluntary person; MHC Rules Reference Number: R-S69(2)/02/2006.
\bibitem{816} Ibid. s. 33 (3) (e).
\bibitem{817} MHC, \textit{COP on the Use of Electro-Convulsive Therapy for Voluntary Patients} 1\textsuperscript{st} Version 2008, 2\textsuperscript{nd} Version October 2009 effective on 1/1/2010; MHC, \textit{COP on the Use of Physical Restraint in Approved Centres} 1\textsuperscript{st} Version November 2006, 2\textsuperscript{nd} Version October 2009 commencement date 1/1/2010; MHC, \textit{COP Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities} September 2009, came into effect on 1/1/2010; MHC, \textit{COP for Mental Health Services on Notification of Deaths and Incident Reporting} January 2008; MHC, \textit{COP on Admission, Transfer and Discharge to and from an Approved Centre} September 2009, came into effect on 1/1/2010 and see also the MHC, \textit{The Quality Framework for Mental Health Services} (2007) that is relevant.
\bibitem{818} Ibid. s. 33 (3) (e).
\bibitem{819} Mental Health Act, 2001 (n 783) s. 66 (2) (g).
\end{thebibliography}
In *Re a Ward*\(^{820}\) the Supreme Court affirmed the constitutional equality guarantee in Article 40.1\(^{821}\) for an incapacitated person stating that “[t]he loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution ... including self-determination, and the right to refuse ... treatment.”\(^{822}\) However the paternalistic power of the Supreme Court to determine the medical treatment displaced family authority in this case\(^{823}\) when the personal rights of the ward trumped the institutional rights of the family.\(^{824}\) As Hamilton C.J. explained “[t]he views of the committee and family of the ward, although they should be heeded and careful consideration given thereto, cannot and should not prevail over the court’s view of the ward’s best interest.”\(^{825}\) Of further significance is that the court authorised a course of action that lead to the death of the patient.

The issue of interpretation of the Mental Health Act 2001 with regard to treatment arose in the case of *HSE v X*.\(^{826}\) This case concerned the proposed “treatment” of Ms X an involuntary civil patient in the central mental hospital.\(^{827}\) MacMenamin J. in the High Court took a purposive approach to interpretation allowing the taking of blood for full blood counts against the patient’s wishes stating “the obtaining of fbc’s (full blood counts) as part of, and ancillary to the treatment and medicine regimes in this case is lawful, in the patient’s best interest, and in accordance with the Act.”\(^{828}\)

Complaints (with regard to s. 57) have been made to the CPT delegation who have sought comment from the Irish authorities first with regard to the extent of the consultant psychiatrist’s power in the “absence of a clear test of ‘incapability’”\(^{829}\) and second the power of the court in the absence of the relevant expertise to ascertain whether individuals administered medication without consent were incapable of giving the consent necessary.\(^{830}\)

\(^{820}\) (n 4).
\(^{821}\) “All citizens shall, as human persons, be held equal before the law. This shall not be held to mean that the State shall not in its enactments have due regard to differences to capacity, physical and moral, and of social function.”
\(^{822}\) Hamilton CJ, *In re a Ward of Court (withholding medical treatment) (No. 2)* (n 4), 123.
\(^{823}\) (n 4).
\(^{824}\) Hogan and Whyte (n 477) p. 1863.
\(^{825}\) (n 4) p. 28.
\(^{826}\) [2011] IEHC 326
\(^{827}\) Ibid. para 10.
\(^{828}\) Ibid. para 68.
\(^{829}\) CPT/Inf (2011) 3 para 124.
\(^{830}\) Ibid.
Inconsistencies in the Act with regard to treatment are worrying. Donnelly recognises that the lack of an independent second opinion is “pretty flawed” in respect of “electro convulsive therapy and on-going treatment.”

**Mental Health Act 2001 (Approved Centres) Regulations 2006**

These Regulations set out the minimum standards that must be provided in approved centres for mental health. The Regulations specify the manner in which general care and welfare is provided for residents, the specific care of residents that is detailed in each resident’s care plan, the standards for the premises, staffing arrangements, the records required and other provisions that address such matters as the Mental Health Tribunals, complaints procedures, risk management procedures, insurance and the certificate of registration. The MHC is charged with enforcing the Regulations. Regulation 35 (2) reads as follows: “The Commission shall satisfy itself as to the compliance of an approved centre with these Regulations, having regard to any reports of the Inspector and any reports requested from the approved centre concerned.”

An approved centre is required to furnish another approved centre, hospital or other place, for example, a private nursing home with relevant information concerning a resident if he/she is transferred. A policy and procedure on resident transfer is required. However the law is silent on the requirement for the registered proprietor to comply with the written policy and procedure.

The registered proprietor is required to notify the MHC of a planned closure of an approved centre and to make arrangements for the transfer of voluntary patients and their records to another approved centre, such a centre being capable of accommodating the patients and

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831 Mental Health Act, 2001 (n 783) ss. 57, 59 and 60.
832 Donnelly M., “Falling through the Gaps?: Formulating Reform in a Dual-Model System” paper presented the Mental Health Law Reform: New Perspectives and Challenges Conference at the National University of Ireland Galway on the 23rd June 2012, p. 4.
834 Ibid. Part 2.
835 Ibid. Part 3.
836 Regulation 15; Regulation 3 defines an individual care plan as “a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident....The individual care plan shall be recorded in the one composite set of documentation.”
838 Ibid. Part 5.
839 Ibid. Part 6.
840 Ibid. Part 7.
841 Ibid. Regulation 35 (1).
842 Ibid. Regulation 18.
their specific needs as detailed in their individual care plan. The approved centre must continue to provide the necessary care and treatment for a period of three months unless a shorter time finds acceptance with the MHC; such an agreement must be in writing.

**Criminal Law (Insanity) Act 2006**

The legislation primarily deals with mental health patients coming before the courts. The Act provides for the establishment of an independent body, the Mental Health (Criminal Law) Review Board for those detained in the Central Mental Hospital. The impetus for the innovation arose from the ECtHR’s rulings with regard to the detention of persons of unsound mind to determine the lawfulness of the detention. The CPT has recommended that the “Irish Authorities introduce legally binding safeguards, including as regards consent to treatment and use of means of restraint and seclusion, for patients detained under this Act.”

**Conclusion**

Amending legislation is urgently needed to protect vulnerable older people subject to the provisions of the mental health legislation. Safeguards, such as, the inclusion of voluntary patient with diminished capacity, review of the definition of mental disorder, inclusion of a definition of treatment and provision for review of treatment are required. In *HSE v X* the High Court recognised that the Mental Treatment Act 2001 “is silent on any review of ‘treatment.’” In terms of legal capacity Dhanda suggests that “[t]he altered construction of legal capacity in the CRPD should guide mental health law reform.” She invites us to “imagine a mental health law for all that will heal but not harm.”

**Nursing Homes/Institutional Development and Safeguards**

The closure of the workhouses, the opening of county homes and provision of other types of public institutional care did little to enhance the lives of its residents. In fact it can be argued that the State through much of its history abandoned older people in residential care. Given the arrangements within these institutional settings it could also be argued that in the
regimented living conditions when the will and preferences of the residents were not entertained their capacity became diminished and individualism effaced. In 1923 the Local Government (Temporary Provisions) Act 1923 provided for institutional accommodation for, among others, the aged and infirm, persons with intellectual disability and persons with mental illness with little safeguards. Over the years it could be said that conditions improved for some residents. However the harrowing conditions for older people that prevailed in Leas Cross Nursing Home in 2005 points to a serious failure by the State.

This section details the fragmented legislative provisions that were in place prior to the investigation of Leas Cross Nursing Home and the legislative changes implemented of foot of the findings.

**County Homes**

The *White Paper on the Reconstitution and Improvement of County Homes*\(^{851}\) provided a damning report into the appalling prevailing conditions for residents of County Homes in Ireland in the 1950’s. Few improvements had occurred since the inception of the state.

The wards are large and commonly have unplastered walls, no ceilings rough floor, poor beds and bedding, very few chairs or lockers and no dressing tables or mirrors. A number of the wards still have the original central valley or depression which served as a gangway when the inmates slept on straw spread on the raised portion of the floor at either side.

The narrow, steep stone stairways, which the elderly and ailing people find difficulty in using still survive in many Homes. In a number of Homes, however, efforts have been made to improve the staircases by covering them in wood. No County Home has a lift. Windows are generally too small and often have the original workhouse diamond panes and in general they are ineffective either for the provision of ventilation or light.

Sanitary and bathing facilities are insufficient and are generally rather crude. Baths are the ordinary deep reclining type into and out which helpless patients must be lifted, often with great difficulty. Supplies of running water, especially running hot water are frequently insufficient....the standard of heating resulting from the single open fire in a large ward or room is usually quite inadequate. Quite often, too, the fire smokes, thus adding to the prevailing gloom.\(^{852}\)

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\(^{851}\) White Paper, 1951, (n 587).

\(^{852}\) Ibid. p. 10.
The Health Progress Report does acknowledge that in some County Homes the workers and the Public Assistance Authority “have contrived to overcome the disabilities inherent in the buildings [however they] remained institutions affording little more than rough care”\(^\text{853}\) for the residents. Even with such a damning report implementation of changes progressed very slowly.\(^\text{854}\)

**Courts (Supplemental Provisions) Act, 1961\(^\text{855}\)**

The jurisdiction of the High Court in lunacy and minor matters\(^\text{856}\) originated in the Lunacy Regulation (Ireland) Act, 1871. Jurisdiction in this area was originally vested in the Lord Chancellor of Ireland from where it passed to the Lord Chief Justice of Ireland and thereafter to the High Court. The jurisdiction vested in the High Court was exercised in *Re a Ward of Court*.\(^\text{857}\) Diminution of personhood by virtue of the austere nature of wardship has been well documented and is best avoided.\(^\text{858}\)

**Coroners Act, 1962\(^\text{859}\) as amended.**

Once a coroner is informed of the presence of a body of a deceased person within his or her district s. 17 of the Act requires the coroner to hold an inquest where the coroner is of the opinion that “the death may have occurred in a violent or unnatural manner, or suddenly and from unknown causes or in a place or in (such) circumstances” that require an inquest to be carried out. The coroner has optional powers to carry out an inquest where a medical certificate cannot be procured.\(^\text{860}\) Section 18 (4) requires every person in charge of any institution or premises where a deceased person was living at the time of their death to report the matter to the coroner when they are of the opinion that the death occurred directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he had been seen and treated by a registered medical practitioner within one month before his death or in any other circumstances as may require investigation...\(^\text{861}\)

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853 Department of Health, 1953 (n 642) p. 8.
854 See, for example, Dáil Éireann - Volume 193 - 14 February, 1962; Dáil Éireann - Volume 167 - 23 April, 1958.
856 Ibid. s. 9. (1).
857 (n 4) 79.
858 For extensive discussion see Ch. 5 of this work.
859 No. 9 of 1962 and the Coroners (Amendment) Act 2005 No. 33 of 2005; see also Ch. 2 of this work with regard to Article 2 ECHR and revision of the Coroners Act.
860 S. 18 (1) of the Coroners Act 1962.
861 Ibid. s. 18 (4).
In addition to the coroner’s inquest a review of the deaths at one Irish nursing home from 2002-2005 was carried out. Since 2004 the coroners have recommended that deaths in nursing homes should be notified to the Coroner’s office. O’Neill recognises that this recommendation “while not legally binding, represents not only best practice but also a strong moral imperative.” As well as the risk of increased morbidity and mortality arising from poor standards of care, the risk of increased mortality of residents as a result of ill planned relocation from one residential care centre to another has been acknowledged in the UK. More recently the ECHR considered the involuntary transfer of an older resident from one residential care setting to another. The Court said, “a badly managed transfer of elderly residents of a care home could well have a negative impact on their life expectancy as a result of the general fraility and resistance to change of older people” giving rise to a potential breach of Article 2 of the ECHR.

**Health (Homes for Incapacitated Persons) Act, 1964**

The Health (Homes for Incapacitated Persons) Act, 1964 provided the first legislative provisions that directly addressed private profit homes for incapacitated persons. It enabled the making of regulations with regard to standard setting for private homes where a person of “(a) old age (b) physical infirmity or a physical injury, defect or disease, or (c) mental infirmity or a mental handicap” is maintained for profit. In particular it made possible the making of regulations with regard to the requirements for the care of incapacitated persons, the number and qualification of workers, “the design, maintenance, repair, ventilation, heating and lighting ... and space,” accommodation including bathroom and toilet facilities, food, cleanliness of the facility, “description of homes in written...”

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862 O’Neill, D., 2006, (n 33). See Ch. 7 of this work for a more detailed discussion.
863 Ibid. p. 18.
864 See, for example, Jolly, D., *A Report to The High Court of Justice Queen’s Bench Division Administrative Court in the Matters of Ref: Co/2278/2002 Lancashire Care Association and Others (Claimants) and Lancashire County Council (Defendants) and Ref: Co/5147/2002 Jesse Jackson and Others (Claimants) and Lancashire County Council (Defendants) February 2003.* http://www.ragenational.com/pdfs/jolley.pdf. Last accessed 25th June 2012.
865 Watts v United Kingdom (n 30).
866 Ibid. para. 88.
867 No. 8 of 1964; repealed by s. 15 of the Health (Nursing Homes) Act, 1990 No. 23 of 1990.
868 The word home has been defined in s. 1(1) of the Health (Homes For Incapacitated Persons) Act, 1964 to include “any premises in which incapacitated persons are maintained, excluding (a) premises in which no incapacitated person is maintained for private profit” (b) where only one incapacitated is maintained, (c) premises where persons are receiving acute care under the control of medical or surgical doctors, (d) maternity care, (e) a mental institution as defined in Mental Treatment Acts, 1945-1960 and to include a number of other exclusions.
869 Ibid.
870 Ibid. s. 2 (2) (a).
871 Ibid. s. 2 (2) (b).
872 Ibid. s. 2 (2) (c).
873 Ibid. s. 2 (2) (d).
communication and the display in homes of notices specified in the regulation," the need to provide privacy for interview of persons (including) workers where a health authority is concerned about the adequacy of care and for the inspection and enforcement of the regulations by health authorities and their officers.

The person in charge of the nursing home had a duty to notify the health authority in writing at least one month in advance of opening the nursing home. The legislation provided that a fine not exceeding £25 could be levied on a person in charge of the nursing home for failing to notify the health authority.

Prior to the publication of the Homes for Incapacitated Persons Regulations, 1966, an Inter-Departmental Committee was established in 1965 to ascertain what services were in place for older people and to make recommendations for the development of services to meet the future needs of older people. During this period the average number of individuals per day that were afforded accommodation by the local authorities in either county homes or similar type accommodation was 9,736. The findings of the Inter-Departmental Committee were reported in 1968. The Report was the first that considered the needs of an ageing population. It recommended the provision of four main types of care settings for those that required residential care based on the older person’s individual needs assessment. These included general hospitals, geriatric assessment units, long-stay hospitals and welfare homes. Another notable recommendation was that older people should remain in their own home where possible.

Homes for Incapacitated Persons Regulations, 1966

Unfortunately the possibilities of the Health (Homes for Incapacitated Persons) Act 1964 were not realised in the drafting of the Homes for Incapacitated Persons Regulations, 1966

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874 Ibid. s. 2 (2) (e); s. 6 of Health (Homes for Incapacitated Persons) Act, 1964 amended s. 64 of the Health Act 1947 that pertain to food kept in certain establishments to incorporate the word ‘home’ after convalescent home within the meaning of this Act.

875 Ibid. s. 2 (2) (f).

876 Ibid. s. 2 (2) (g).

877 Ibid. s. 2 (2) (h).

878 Ibid. s. 2 (2) (i).

879 Ibid. ss. 3 (1) and (2).

880 Ibid. s. 3 (3).

881 Dáil Éireann - Volume 221 - 08 March, 1966.


884 *The Inter-Departmental Committee on the Care of the Aged Report* (Dublin, Stationary Office, 1968).

885 Ibid.

886 Ibid; for further discussion see, for example, Hensey, 1979 (n 586) pp. 148-149.

887 S.I. No. 44 of 1966.

888 No. 8 of 1964, s. 2.
since it did not translate into robust legislative requirements. The provisions contained in
the Regulations were of a general nature. The statutory instrument was laden with vague
prescriptive terms such as "competent", "suitable and sufficient", "properly prepared" and "in a proper state". No definitions were provided for these terms. Inconsistency in the standards of care could prevail in the absence of specific requirements. Also by virtue of the lack of precision in the terminology, consistency in terms of enforcement by a health authority (county or borough council) was a mere aspiration. Furthermore an offence under the provision is not surprisingly omitted given the uncertainty of the requirements.

In 1970 Noel Brown said,

no matter who tries to do anything with … many of these old institutions such as county homes and mental hospitals, he cannot hope to succeed. No laws we pass here, even with the best will in the world on the part of the personnel involved, would change those dreadful places to anything other than what they were intended to be, punitive, soul-destroying, demoralising institutions intended to humiliate and degrade anybody going into them.

Fire Services Act 1981

Fire safety was one of the areas the State took very seriously in relation to residential care for older people. The person in control of a premise providing treatment and care is required to take all reasonable measures to prevent an outbreak of fire at the residential care setting and to ensure so far as is reasonably practicable the safety of any person therein.

This legislation is crucial to prevent potential mortality and morbidity of older people due to smoke inhalation, burning or falling trying to escape a fire. A minor fire can give rise to severe anxiety to a person with reduced mobility. Of special concern are those with high or maximum dependency levels who are likely to be in need of assistance to evacuate a section

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889 Regulation 4(2)(f)
890 For example, each sub s. of Regulation 4(1) and (2) is prefaced by the term 'suitable and sufficient'.
891 Regulation 4(1)(c).
892 Regulation 6.
893 Enforced by officers of the Health Authority as provided by Part IX of the Health Act, 1947 No. 28 of 1947.
894 Dáil Debates Vol. 247 No. 1, 26th May 1970.
895 No. 30 of 1981.
896 Ibid. s. 18 (1)(b).
897 S. 18 (2).
of or the building itself. Of key importance is prevention and if necessary control of a fire, as evacuation is a last resort.

**Homes for Incapacitated Persons Regulations 1985**

Elements of these Regulations are noteworthy. A patients’ register for the home, a case record for each patient and a fire and an equipment record were required. Other clear requirements existed, for example,

(c) over bed lamps at each bed and permanent night lighting with dimming facilities;

(d) minimum heating of 65 degrees F (18 degrees C) in bedroom areas and 70 degrees F (21 degrees C) in day areas;

(f) a separate kitchen with suitable and sufficient and sufficient cooking facilities, kitchen equipment and tableware.

(d) a visitors reception area...

(e) an office for staff and general use.

Overcrowding was prohibited by limiting resident numbers to that approved by the health board. Regulation 11 (1) (d), (f) and (g) requires the person carrying on a home or any person concerned in its management to among other things:

(d) ensure that materials contained in bedding and the internal furnishings of the home have adequate fire retardancy properties and where possible have low levels of toxicity when on fire;

(f) ensure that emergency lighting is provided in the home and that emergency call facilities are provided at each bed;

(g) ensure that handrails are provided in circulation areas and that grab-rails are provided in bath and shower areas and in w.c.s…

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898 An assessment of an older person’s care needs is carried out under s. 7 of the Nursing Home Support Scheme Act 2009 No. 15 of 2009.
900 Home has the same meaning as provided in s. 1 (1) of No. 8 of 1964.
901 S.I. No. 317 of 1985 Regulation 10. (1) (c), (d) and (f).
902 Ibid. Regulation 10 (2) (d) and (e).
903 Ibid. Regulation 10 (3).
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The legislation made provision for the availability of a medical practitioner to attend patients and to be on-call in the event of emergency and that “the person in charge in a home at any given time is a nurse...”

Minimal attention was given to quality of life issues. Of particular import in this regard was the failure to define competency and ratios of staff members with regard to the dependency levels of residents.

The requirement for inspection of private nursing homes at least once in every six months was detailed in Regulation 8. The duty on persons in charge of a nursing home to notify the health authority was precise. It is difficult to see how offences under s. 2. (5) of the Health (Homes for Incapacitated Persons) Act, 1964 Act could arise given the vague and imprecise requirements of most of these regulations. At a more immediate level for the residents the ill-defined legislative requirements gave rise to further problems in that whatever aspirational standards the regulations intended to introduce largely remained illusory due to what could only amount to as the subjective nature of enforcement. O’Neill recognises the importance of “nursing home inspection teams … with relevant expertise to be able to detect poor practice patterns, and vigorously supported by the HSE in their recommendations.”

Safety, Health and Welfare at Work Act, 1989

The main purpose of the Safety, Health and Welfare at Work Act, 1989 was to make further provision for securing the safety health and welfare of workers at a place of work and others who may be affected by work activities. The Act had limited applicability in this context. However the benefits that did accrue to the older person in residential care should not be overlooked. Section 7 placed duties on employers and the self-employed to persons other than their employees. Such employers were required to conduct their undertaking in such a manner as to ensure so far as is reasonably practicable that persons not in his employment were not exposed to health and safety risks and to provide relevant information where a risk existed.

904 Ibid. Regulation 12 (1) (a) and (b).
905 Ibid. for example, Regulations 6 (a), 9, 10(1), 10(2) and 10(4), 11, 12(c) and 13(a) are not sufficiently precise to be of benefit to the residents.
906 Ibid. Regulation 12(1) requires that “[i]n every home the person carrying on the home and any person concerned in the management thereof shall ensure that-(c) a sufficient number of competent staff, including nursing staff, are on duty at all times having regard to the number of patients maintained therein and the nature and extent of their incapacity.”
907 S. 1 (1) of No. 8 of 1964.
908 Ibid. s. 3.
911 “Place of work” includes premises such as residential care settings.
The term ‘reasonably practicable’ is considered a balancing of risk in terms of time, money and trouble. In the oft quoted explanation of the term, Asquith L.J. in the English Courts in Edwards v National Coal Board\textsuperscript{912} stated:

‘Reasonably practicable’ is a narrower term than ‘physically possible’, and seem to me to imply that a computation must be made by the owner in which the quantum of risk is placed on one scale and the sacrifice involved in the measures necessary for averting the risk (whether in money, time or trouble) is placed in the other, and that, if it be shown that there is a gross disproportion between them—the risk being insignificant in relation to the sacrifice—the defendants discharge the onus on them. Moreover, this computation falls to be made by the owner at a point of time anterior to the accident.\textsuperscript{913}

Therefore older persons in residential care should not have been exposed to risks to their health and safety as a result of failure by an employer to conduct his undertaking in a safe manner. Where a risk existed they should have been provided with the prescribed information about such aspect of the way he conducted his undertaking that might have affected their safety and health.

General duties were imposed on persons concerned with places of work to persons other than their employees. For example a contractor engaged by the residential care centre to paint the centre had a duty to the residential care workers and others to use a ladder and equipment safely and without risk to health.\textsuperscript{914} Where a tenancy or contract existed in respect of a place of work the person in control of the workplace had duties to maintain and repair the workplace, to provide safe access or egress and to ensure the workplace was safe with regard to any article of substance.\textsuperscript{915} The residential user did not come directly within the ambit of s. 8; however the resident as a downstream user of the workplace may have accrued benefit from the duty holder’s compliance with the Act.

Anecdotally it has been suggested however that health and safety legislation may have the opposite effect on older people in residential care. A narrow interpretation of the law may enable the smoother running of residential care setting by enabling older people to become more dependent when generic written risk assessments and control measures are

\textsuperscript{912} [1949] 1 All ER 743. The employer’s duty under the 1989 Act can be distinguished with the employer’s duty under the Safety, Health and Welfare at Work (General Application) Regulations 1993 S.I. No. 44 of 1993. In Everitt v Thorsman (Ireland) Limited [2000] 1 IR 256 the court held that the duties impose “virtually an absolute duty on employers.”
\textsuperscript{913} Ibid. Edwards v National Coal Board p. 747.
\textsuperscript{914} S. 8 of No. 7 of 1989.
\textsuperscript{915} Ibid. s. 8 (3).
implemented that adversely impact on autonomy and personal freedoms. In this context holistic patient risk assessments overcome this anomaly.

**Health (Nursing Homes) Act, 1990**

The (Nursing Homes) Act, 1990 was in the main a re-enactment (with particular amendments), of the Health (Homes for Incapacitated Persons) Act 1964. Its main purpose was to provide a formal system of registration for private nursing homes and to provide arrangements for boarding out of persons, to make provision for the care of older persons and for other related matters including, for example, the payment of nursing home subventions.

A “dependent person” was defined under s. 1 of the Act as “a person who requires assistance with the activities of daily living such as dressing, eating, walking, washing and bathing by reason of-(a) physical infirmity or a physical injury, defect or disease, or (b) mental infirmity.” A nursing home was considered an “institution for the care and maintenance of more than two dependent persons.”

A major anomaly of these legal provisions was the exclusion of many residential care settings. The legislation only applied to private nursing homes. The Act also excluded residential care settings for intellectually disabled people which were operated on a non-profit making basis but were grant aided and for persons with a disability where the majority did not receive full time nursing care.

The health board/HSE had to maintain a register of nursing homes. In order to carry on a nursing home the applicant had to seek approval from the relevant health board/HSE that he/she was a suitable person. An application was granted once the person had not committed an offence “such as to render the person unfit to carry on a nursing home.” Therefore once the applicant had satisfied this criterion he was deemed to be a fit person to

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916 It should be noted that generic written risk assessments may not be in compliance with the requirements of the 1989 Act given that specific risks are likely to be omitted in generic risk assessments.
918 No. 8 of 1964; this Act was repealed by s. 15 of No. 23 of 1990.
919 No. 23 of 1990, s. 2.
920 Ibid. s. 10; s. 209 of the Mental Treatment Act 1945 (n 764) made provision for the boarding out of persons in a private dwelling.
921 Ibid. No. 23 of 1990 (n 917) s. 7.
922 Ibid. s. 2 (1).
923 Ibid.
924 Ibid. s. 4 (4)(a).
carry on a nursing home. The legislation did not include any provisions for appealing such decisions.

A health board/HSE could refuse to register a nursing home or remove a nursing home from the register if:

(i) the premises ... do not comply with the regulations

(ii) the carrying on of the nursing home is not or will not be in compliance with the regulations

(iii) the applicant or the registered proprietor … is not fit. 925

The requirements of the Act 1990 were disappointingly vague and non-specific with regard to standards of care. Largely similar to s. 2. (1) of the 1964 Act, s. 6. (1) of the 1990 Act provided:

The Minister shall, for the purpose of ensuring proper standards in relation to nursing homes, including adequate and suitable accommodation, food and care for dependent persons while being maintained in nursing homes, and the proper conduct of nursing homes, make such regulations as he thinks appropriate in relation to nursing homes.

The main difference was that in the earlier legislative provision the minister had discretion to make regulations in relation to nursing homes and in the latter the minister was obliged to make regulations in relation to standards in nursing homes. However, in s. 6. (2) of the 1990 Act it stated, “[w]ithout prejudice to the generality of subsection 1, regulations under this section may prescribe requirement as to ... care....”

Again s. 6. (2) of the 1990 Act was quite similar to s. 2. (2) of the 1964 Act in providing a number of new inclusions that may be prescribed, for example, to insure against injury to one of the residents,926 arrangements to enable the examination of a resident where the relevant health board is of the opinion that the resident is not in receipt of “proper maintenance or care or medical or other treatment”927 and the provision by the health board of training programmes to the nursing home staff.928 Another innovation on the 1964 Act is that the minister may provide for the investigation by the health boards of written complaints

925 Ibid. s. 4 (6).
926 Ibid. s. 6 (2)(h).
927 Ibid. s. 6. (2)(i).
928 Ibid. s. 6. (2)(k).
made pertaining to the nursing home itself or issues regarding standards of care for the residents.929

A marked difference with the 1964 Act is that s. 9 of the 1990 Act allowed a health board to take charge and manage the nursing home when it was of the opinion that the nursing home had breached the requirements of s. 6. However the legislation was silent on the Health Boards’ (HSE’s) power to close a nursing home.

A further weakness of this legislation is that the prohibition on unregistered nursing homes did not specify what constituted an offence.930

**Boarding Out Regulations, 1993**931

The *White Paper on Reconstruction and Improvement of County Homes* recommended that local authorities should investigate the possibilities of finding homes for older people with families in their local communities.932 Such an initiative was to be supported financially by the local authority with the older person contributing a portion of their pension. The Report drew attention to the absence of occupational therapy and other activities for older people and it attributed the increasing morbidity on admission to the County Homes to “the sudden transition from a life of comparative activity to a seemingly purposeless existence.”933 The Government accepted the committee’s recommendations.934 However, it took more than twenty years for the Boarding Out Regulations, 1993 to be published.935

A householder may enter into arrangements with a health board to board out up to six adults. The householder must satisfy the requirements of these regulations in terms of, for example, maintenance, care, welfare and privacy of the resident.936 There is a requirement for inspection by the health boards at least once within every six month period937 but there are no reports detailing these inspections.

While the boarding out arrangements continue for those already in place the scheme is being phased out and no new people are being accepted into the scheme. Where there is HSE involvement all new admissions for long term care are being addressed under the Nursing Home Support Scheme. These arrangements seem to be at variance with Article 19 of the

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929 Ibid. s. 6. (2)(m).
930 Ibid. s. 3.
931 S. I. No. 225 of 1993. See also (n 764).
933 Ibid.
935 They came into effect on the 1st September 1993.
936 Regulations 4-14 of Boarding Out Regulations, 1993.
937 Ibid. Regulation 15.
CRPD that states “persons with disabilities … are not obliged to live in a particular living arrangement.”\footnote{938} The case of \textit{Stanev}\footnote{939} is relevant. Mr Stanev’s powerlessness in his placement in the social care home was evidenced, for example, by his lack of consent to the placement, the distance of the social care home from his own home, and the retention of his identity papers by the management of the home.\footnote{940} Currently there is no requirement in Irish law to engage with a person’s wishes. In line with Article 19, an older person who wishes to remain in their local community be that in their own home or other setting including with another family (boarding out scheme) must have the supports necessary to enable them to do so for as long as possible. Of course residential care may be the only option when dependency levels are of a high or maximum dependency level.\footnote{941}

\textbf{Nursing Homes (Care and Welfare) Regulations, 1993}\footnote{942}

At first reading these Regulations appeared to have set standards for the delivery of care and nursing standards to nursing home residents. Regulation 5 pertained to welfare and well-being. It required the registered proprietor and the person in charge\footnote{943} to provide the resident with among other things, “(a) suitable and sufficient care to maintain the person’s welfare and well-being, having regard to the nature and extent of the person’s dependency; (b) a high standard of nursing care;” and Regulation 10.5 (c) required that “a nurse\footnote{944} is on duty at all times.”

However the Regulations were weakened for several reasons: -no definition of “suitable and sufficient” was provided under the Health (Nursing Home) Act, 1990 or these regulations. It is difficult to understand how one nurse could provide a high standard of care to a large number of residents, especially where dependency needs were high. It has been reported that in one residential setting one nurse had care responsibilities for 40 older residents.\footnote{945} In

\begin{footnotesize}
\item[938] Article 19 a. CRPD (n 125).
\item[939] \textit{Stanev v Bulgaria} (n 120).
\item[940] Ibid. paras. 122, 126, 130.
\item[941] Regulation 12 of the Nursing Homes (Subvention) (Amendment) Regulations, 2006 S.I. No. 642 of 2006.
\item[943] Regulation 10.3 provides that “the registered proprietor may be the person in charge, provided that at all times there is a nurse on duty in the home.”
\item[944] Regulation 4 considers nurse to mean someone who is registered in the register of nurses set up under the Nurses Act 1985 No. 18 of 1985.
\item[945] Spiers, M., “For the safety of our older patients” January 2005 available at \url{http://www.ino.ie}; Murphy, K., O’Shea, E., Cooney, A., Shiel, A. and Hodgins, M., \textit{Improving Quality of Life for Older People in long-Stay Care Settings in Ireland} Report No. 93 (Dublin, National Council on Ageing and Older People, 2006), 123.
\end{footnotesize}
another a letter reference is made to one nurse “looking after perhaps 40 or 50 patients.”

The quality of care in such circumstances can only be a remote aspiration. According to Mangan, “high quality care ... requires that the ethos or philosophy of care be respectful of rights and have due regard to values such as dignity and equality.”

Where the person in charge was a nurse, they must satisfy the requirements of Regulation 10.2 that required the nurse to have a “minimum of three years appropriate post registration experience within the previous six years.” “Appropriate” was not defined in the legislation. Successful completion of one of four initial professional nurse training courses enabled the qualified nurse’s name to be entered on the register of nurses. The four disciplines included: (i) general nurse, (ii) mental handicap nurse, (iii) psychiatric nurse or (iv) children’s nurse. Furthermore there was no legislative requirement to have a post graduate qualification in gerontological nursing. In addition, no consideration was given in the legislation to the requirement for previous supervisory or management qualifications or experience. It could perhaps be suggested that little has changed since 1927 in terms of the absence of explicit legislative requirements regarding qualifications, experience and training. Indeed, it could be inferred that every head nurse appointed to a cottage or district hospital was likely to have had more nursing post qualification experience given that they could not obtain the position until they were at least thirty years of age.

Both the registered proprietor and the person in charge had a duty to ensure that a medical practitioner the resident had nominated or was acceptable to the resident was available to provide medical care. The legislation is silent with regard to requirements for post graduate training for medical doctors who provide care to the elderly in a residential care setting. Furthermore this legislation made no provision for assessment by a geriatrician at any time during the person’s residency in such a setting.

The legislation provided that “a sufficient number of competent staff” were required to be “on duty at all times having regard to the number of persons maintained therein and the

946 In the context of Leas Cross Nursing Home, letter dated 7th October 2004 to Medical Superintendent, St. Ita’s Hospital, Portrane, Co. Dublin from Consultants A and B as cited by O’Neill, D., 2006, (n 33) p. 46; see also reference to memo and issues discussed with the Director of Nursing of Leas Cross following visit in July 2004 that refers to one nurse and 9 care staff for sixty five residents at p. 45.
947 Mangan, I., Older People in Long Stay Care (Dublin, Irish Human Rights Commission, 2002), 38.
948 More recently the name has changed to Intellectual Disability Nursing.
949 At that time midwifery was a post-graduate qualification similar to nurse tutor and public health nurse.
950 The County Schemes (Officers of District Hospitals) Order, 1927 (n 615).
951 Medical practitioner is defined by Regulation 4 as someone “registered in the general register of medical practitioners established under [s]ection 26 of the Medical Practitioners Act, 1978 (No. 4 of 1978).”
952 Regulation 5(c) of the Nursing Homes (Care and Welfare) Regulations, 1993 (n 942).
nature and extent of their dependency.\cite{953} However the sole definition of a competent person was “a chartered engineer with experience in fire safety engineering and fire safety management.”\cite{954} Regulation 27(e) and (f) quite rightly required such a competent person within the context of fire precautions. By contrast no definition was provided in terms of qualifications, experience and training with regard to care workers. No specific legislative requirement was made with regard to ratios of older persons with varying dependency levels to care workers. These anomalies were major legislative omissions. It is hard to understand how those deficiencies can be reconciled with the requirements to deliver “suitable and sufficient care.” The National Council on Ageing and Older People (NCAOP) has expressed “particular concern” regarding the “formal training for care workers.”\cite{955}

Vague terminology prevailed throughout the legislative provision with the use of non-defined expressions such as “adequate”, suitable, and sufficient.” For example Regulation 8(b) required that residents were given “adequate space … for a reasonable number of personal possessions.” Often there was little obvious evidence of personal possessions on view, for example, family photographs or other personal memorabilia. Most people put great store by having their own things around them. Tobin recognises that cherished possessions and photographs are older individuals’ “bequests to themselves.”\cite{956} The ECtHR has recognised the right to personal identity.\cite{957}

Additionally often arrangements had (and still have) to be made to secure another home for pets such as cats or dogs as few residential settings have any provisions for boarding animals. This can be extremely distressing for many older people. Loss of one’s home can be indeed harrowing without the added loss of a loved companion.

Regulations 15(e) required the adequate provision of “disposable sheets and incontinence pads” and Regulation 15(f) required that they “are changed as frequently as may be required for the comfort and well-being of the person. The NCAOP’s discussion on the “maintenance of independent dignity” of the older person in residential accommodation was especially concerned with the inadequate “supply of incontinence pads.”\cite{958}

\begin{footnotes}
\item[953] Ibid. Regulation 10.5(d).
\item[954] Ibid. Regulation 4; amended by Regulation 2 of the Nursing Homes (Care and Welfare) (Amendment) Regulations, 1993 S.I. No. 379 of 1993 to include “a properly and suitably qualified architect.”
\item[955] NCAOP, A Framework for Quality in Long-Term Residential Care for Older People in Ireland Report No. 62 (Dublin, NCAOP, 2002).
\end{footnotes}
The over reliance by staff on incontinence wear is equally dehumanising and detrimental to the dignity and well-being of the older person where their use has resulted from the failure of the service provider to assist with toileting. Bregman acknowledges that “dignity is the essence of Canadian equality,” and asks with regard to accommodation for the elderly, “is accommodation made in terms of reduced mobility and toileting?” This question is especially pertinent given that some older persons require assistance with toileting. Where reduced mobility is the issue and there is inadequate staffing or they are not trained in continence management, the elderly resident may incur temporary loss of bladder control resulting in the unnecessary use of incontinence wear. The elderly person may lose confidence and begin to rely on the incontinence wear within a short period. Complaints about the inappropriate use of incontinence pads were one of the issues raised by Consultant A with the Director of Nursing in Leas Cross Nursing Home and also with the Director of Nursing in St. Ita’s.

With regard to Regulation 16.1 there was no requirement for a trained person in the kitchen to provide what is deemed to be “suitable, sufficient and varied” food. If the nursing home was notified in advance of a visit from the HSE how can quality standards be implemented with uniformity? This points to the importance of un-announced inspections.

Regulation 26 pertained to the making of complaints, who can make a complaint, who it should be addressed to and the actions the health board (more recently HSE) may take on foot of receipt of a complaint. Regulation 26.1 provided: “[a] dependent person being maintained in a nursing home or a person acting on his or her behalf may make a complaint to the chief officer or a designated officer of the health board.” Designated officer is defined by Regulation 4 to mean “officers of health boards authorised by the chief executive officer or the deputy chief executive officer of a health board to carry our functions under the Act and these Regulations.”

The provisions of Regulation 26.1 were unclear and they created unnecessary barriers to an ordinary person wishing to make a complaint. Ambiguity arose with the term “on behalf”. It is unclear who exactly could make a complaint—did the complainant if other than the resident need to have the resident’s permission to make a complaint? The making of the complaint had to be made to the chief executive officer or a designated officer of the health board. The ordinary person was unlikely to have known that such limitations exist. Also, if

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959 Bregman, P., *Disability Rights in Canada-Evolving Towards Equality* paper presented at the Galway Disability Conference, National University of Ireland Galway, 13/6/06.

960 Ibid.

961 See O’Neill D., 2006, (n 33) p. 45. See also Ch. 7 of this work.

962 Healthy Catering Guidelines for staff and visitors in healthcare facilities have been developed by the Department of Health and Children in February 2005.
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a person made a complaint to another health board employee the complainant had no way of knowing the complaint reached the relevant person(s). Anecdotally, it is well known that often when an older person is transferred from another hospital or admitted directly from home to a nursing home the person or persons caring for the older person up to that point are often worn out and exhausted from caring at home or making hospital visits. For most people in such circumstances making a complaint is a last resort and where complaints are made and go unheeded they are a source of great anxiety and trauma for the persons concerned. When a complainant made a complaint, which was neither vexatious nor frivolous, whether the complaint was made in writing or verbally, the complainant needed to be assured that a transparent investigation process would take place and a response would be made in a timely manner notwithstanding the fact that fair procedure was afforded to all concerned.\textsuperscript{963} Fear of reverberation after a complaint was a deterrent to making a complaint.

One of the functions of the health boards was to enforce these regulations.\textsuperscript{964} As Mangan quite rightly argued “\[i\]t is difficult to see how the public provider could properly regulate the private providers in any circumstances but the task is close to impossible when the public provider is itself dependent on the private sector to enable it to carry out its statutory functions.”\textsuperscript{965}

**Nursing Homes (Care and Welfare) (Amendment) Regulations, 1993**\textsuperscript{966}

These Regulations made minor changes to the 1993 nursing home care and welfare legislation. Firstly, it created changes to the definitions of competent person with the inclusion of architect and clarified what constitutes a medical record. The Nursing Homes (Care and Welfare) Amendment) Regulations, 1994\textsuperscript{967} altered the requirements with regard to fire safety in the registration of the nursing home.

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\textsuperscript{963} Complaint procedures are now addressed in Part 12 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.

\textsuperscript{964} Regulation 35.

\textsuperscript{965} Mangan, I., “Deficiencies of the Law Relating to Care for Older People” in O’Dell, 2006, (n 7) p. 366.

\textsuperscript{966} S.I. No. 379 of 1993. They came into operation on the 1\textsuperscript{st} of September 1993 and were revoked by S. I. No. 236 of 2009.

\textsuperscript{967} S.I. No. 147 of 1994. They were revoked by S. I. No. 236 of 2009.
Medicinal Products (Prescription and Control of Supply) Regulations, 1996\(^{968}\) and 2003\(^{969}\)

These Regulations give authority to hospitals\(^{970}\) to use medication protocols for the supply and administration of medication by the clinic, nursing home or similar institution to facilitate the needs of patients/service users with regard to medication management without an individual prescription.

European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations, 2004 (as amended)\(^{971}\)

These regulations govern the conduct of human clinical trials on medicinal products. Of particular import in this context are the protections afforded in Part 5 to persons who are incapacitated adults and are therefore unable to consent. Part 5 pharmacovigilance requires, among other things, notification of adverse events by the investigator\(^{972}\), notification by the sponsor of suspected serious unexpected adverse reactions to “(i) the Board, (ii) the competent authorities of all EEA States, other than the State, in which the trial is being conducted and (iii) the relevant ethics committee”\(^{973}\) and for the preparation of an annual list of suspected serious adverse reactions and a report on the safety of the subjects of those trials.\(^{974}\) The annual list and the report are prepared by the sponsor and furnished to the Board and the relevant ethics committee.

Safety, Health and Welfare at Work Act 2005\(^{975}\)

The 2005 Act repealed the Safety, Health and Welfare at Work Act 1989. Similar to the 1989 Act, failure to comply with the duties may attract sanctions including criminal prosecution. Breach of statutory duty may also lead to civil liability.\(^{976}\) While the main purpose of the Act is to secure the safety, health and welfare of workers, older people in residential care may come within the ambit of health and safety legislation.

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\(^{968}\) S.I. No. 256 of 1996.
\(^{969}\) S.I. No. 540 of 2003.
\(^{970}\) Regulation 4 (1) provides the term hospital as including a clinic, nursing home or similar institution.
\(^{971}\) S.I. No. 190 of 2004.
\(^{972}\) Ibid. Regulation 29.
\(^{973}\) Ibid. Regulation 30.
\(^{974}\) Ibid. Regulation 32.
\(^{975}\) No. 10 of 2005.
\(^{976}\) Ibid. not all of the duties under the 1989 Act could be used in civil claims.
Duties of the self-employed, general duties of employers to persons other than their employees, to employees, to persons in control of a place of work and to designers, manufacturers, importers and suppliers of articles and substances are provided in the Act. Section 20(4) requires the employer to bring to the attention of any person who may be affected by any specific task taking place at the workplace that pose a risk to their safety, health and welfare, such information to include the nature of the risk and the arrangements in place for securing their health and safety.

Under the terms of s. 80 directors, managers or officers of undertakings (includes both public and private sectors entities) may attract criminal liability where an offence under any of the relevant statutory provisions has been committed with their authorization, consent, connivance or neglect.

No person may intentionally, recklessly or without reasonable cause risk the safety, health and welfare of any person in connection with work activities. The manual handling regulations requires an employer to take organisational measures or use the appropriate means such as mechanical equipment to avoid the need for manual handling and where it cannot be avoided to assess the risk taking account of the risk factors specified in sch. 3 (the characteristics of the load, the physical effort involved, the characteristics of the working environment).

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977 Ibid. s. 1 (6) provides clarity with regard to the term ‘reasonably practicable’ regarding duties of an employer—“the employer has exercised all due care by putting in place the necessary protective and preventative measures, having identified the hazards and assessed the risks to safety and health likely to result in accidents or injury to health at the place of work concerned and where the putting in place of any further measures is grossly disproportionate having regard to the unusual, unforeseeable and exceptional nature of any circumstances or occurrences that may result in an accident at work or injury to health at that place of work.”

978 Ibid. s. 7.
979 Ibid. ss. 8-11.
980 Ibid. s. 12.
981 Ibid. ss. 13-14.
982 Ibid. s. 15.
983 Ibid. s. 16.
984 Ibid.
985 Ibid.
986 Ibid. s. 16; s. 2. (1) of the Act defines “Article” as “(a) any plant, machine, machinery, appliance, apparatus, tool or any other work equipment for use or operation (whether exclusively or not) by persons at work, (b) any article designed for use as a component in, part of or to control any such plant, machine, machinery, appliance, apparatus, work equipment, tool or any other work equipment, and (c) any other product used by persons at work.”
987 Ibid. s. 16 and s. 2 “substance” is considered as “any natural or artificial substance, preparation or agent in solid or liquid form or in the form of a gas or vapour or as a micro-organism.”
988 Ibid. s. 2. (1) “undertaking” is defined as “a person being an individual, a body corporate or an unincorporated body of persons engaged in the production, supply or distribution of goods or the provision of a service (whether carried on by him or her for profit or not).
989 Ibid. s. 14 (b).
990 Regulation 68 and 69 of the Safety, Health and Welfare at Work (General Application) Regulations 2007 S.I. No. 299 of 2007; see also Regulation 31. (4)(f) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 S.I. 239 of 2009 which requires that “staff are trained in the moving and handling of residents.”
environment, the requirements of the activity and individual risk factors) to reduce the risk.

Such measures may include the use of hi lo beds, three sided access to a shower, bath chairs and manual handling training for workers. Adequate staffing levels are crucial for the implementation of these regulations. A breach of the manual handling regulations therefore may have direct impact not only on the worker but also on the older person in residential care.

Another measure that may positively impact an older person with loss of mobility in residential care includes the requirement of Regulation 52(3) of the Safety Health and Welfare at Work (General Application) Regulations 2007\textsuperscript{991} that requires six monthly testing of patients’ hoists and passenger lifts as part of a thorough examination of the lifting equipment since failure of such equipment could adversely impact both the worker and the person being hoisted or using a passenger lift.

\textbf{Interim Health Information and Quality Authority (Establishment) Order, 2005}\textsuperscript{992}

The order established the Interim Health Information and Quality Authority (HIQA) whose function was to prepare a plan for the establishment of the HIQA with a view to promoting “standards, quality improvement and assurance programmes, accreditation within the health service, carry out health information functions assigned in the National Health Information Strategy and develop capacity to undertake health technology assessment.”\textsuperscript{993}

The interim HIQA was required to take account of “relevant considerations and recommendations in the following reports.”\textsuperscript{994}

\begin{itemize}
  \item [(a)] \textit{Quality and Fairness: A Health System for You}...\textsuperscript{995}
  \item [(b)] \textit{Audit of Structure and Functions in the Health System}...\textsuperscript{996}
  \item [(c)] \textit{The Commission on Financial Management and Control Systems in the Health Service}...\textsuperscript{997}
  \item [(d)] \textit{Health Information-A National Strategy}...\textsuperscript{998}
\end{itemize}

Safeguards for the statutory functions of the named bodies were provided.\textsuperscript{999}

\begin{itemize}
  \item \textsuperscript{991} Ibid. S.I. No. 299 of 2007 Part B of sch. 1.
  \item \textsuperscript{992} S.I. No. 132 of 2005. The Order was revoked by s. 104 of the Health Act, 2007.
  \item \textsuperscript{993} Ibid. “Long title”.
  \item \textsuperscript{994} Regulation 6 of S.I. No. 132 of 2005.
  \item \textsuperscript{995} (Dublin, Government Stationary Office, 2001).
  \item \textsuperscript{996} Ibid. 2003.
  \item \textsuperscript{997} Ibid.
  \item \textsuperscript{998} Ibid. 2004.
  \item \textsuperscript{999} Regulation 7 of S.I. No. 132 of 2005; the bodies included “(a) the Medical Council, (b) the Dental Council, (c) An Bord Altranais, (d) the Mental Health Commission (e) the Inspector of Mental Health
\end{itemize}
Health Act 2007\textsuperscript{1000}

The Health Act 2007 is a significant piece of legislation.\textsuperscript{1001} Its purpose is to provide among other things a “scheme of registration and inspection of residential services for older people.”\textsuperscript{1002} In March 2005 HIQA was established on an interim basis.\textsuperscript{1003} It was placed on a statutory footing under s. 6 of the 2007 Act. The commencement date for registration and inspection of the designated centres for older people was 1\textsuperscript{st} July 2009.\textsuperscript{1004}

Its main functions are to set safety and quality standards,\textsuperscript{1005} to determine compliance with the standards,\textsuperscript{1006} and to carry out investigations.\textsuperscript{1007} Thirty two standards have been created.\textsuperscript{1008} More recently eighteen written and operational policies are required.\textsuperscript{1009} In carrying out its functions HIQA is dependent on the “resources available to the Executive.”\textsuperscript{1010} Even so, the 2007 Act amplifies the meagre legislative provisions that existed before for protecting older persons in residential care settings by providing a framework for securing the safety, health and wellbeing of older people in these environments.

A further critical safeguard to the safety, health and well-being of residents is contained in s.50 that provides criteria for the granting or refusal of registration of a nursing home. This provision augments earlier provisions, for example, Regulation 4 of the Health (Nursing Homes) Act, 1990. Of particular import in this regard is that the Chief Inspector must be

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\textsuperscript{1000} No 23 of 2007. With the establishment of the Health Act 2007, the Health Acts 1947 to 2006, the Health Act 2007 and the Health (Nursing Homes)(Amendments) Act 2007 may be read as one—the Health Acts 1947 to 2007 as provided by s. 1.(2) of the Health Act 2007. It was signed into law on the 21\textsuperscript{st} April 2007.

\textsuperscript{1001} It contains 105 sections and 2 schedules.

\textsuperscript{1002} Ibid. Long Title.

\textsuperscript{1003} S.I. No. 132 of 2005.

\textsuperscript{1004} Health Act 2007 (Commencement) (No. 2) Order 2009 S.I. No. 237 of 2009.

\textsuperscript{1005} Health Act 2007 (n 1000) s. 8 (1)(b)(i) provides for the setting of standards with regards to (1) the Health Acts 1947 to 2007 (except for services under the Mental Health Acts 1945 to 2001) that, under the Health Act 2004 are provided by the HSE ... and (2) services provided by a nursing home as defined in s. 2 of the Health (Nursing Homes) Act 1990.

\textsuperscript{1006} Ibid. ss. 8. (1)(c), 41. (1)(a)(ii), 41. (1)(b), 41. (1)(c)(i), 45. (b) and 73. (1)(a) in respect of s. 8. (1)(b).

\textsuperscript{1007} Ibid. s. 8. (1)(d).

\textsuperscript{1008} HIQA, 2009 (n 37).

\textsuperscript{1009} For further discussion see this Ch. para titled Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.

\textsuperscript{1010} Health Act, 2007 (n 1000) s. 8 (2)(c).
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satisfied that the registered provider or person seeking such registration and each person who acts in the management of the nursing home

(a) is a fit person to be the registered provider ... and to participate in its (the nursing home’s) management, and

(b) if the application is for registration, will comply with, or, if for renewal, is in compliance with-

(i) standards set by the Authority under section 8(1)(b),

(ii) regulations under section 101, and

(iii) any other enactment which appears to the chief inspector to be relevant, and is cited to the applicant in writing by the chief inspector,

[the chief inspector] shall grant the application and if not satisfied shall refuse it.

This legislation also heralds a new departure in the monitoring of residential care settings for older people in that monitoring of public nursing homes now comes within the ambit of the legislation. An investigation may be carried out by HIQA where there is a serious risk to the health or welfare of a resident resulting from an act, omission or negligence of “the Executive, a service provider, the registered provider ... of a residential care setting for older people, or the person ... responsible for the residential care setting if other than the registered provider.”

The legislation creates positive obligations on duty holders. The HIQA standards may be used in court proceedings to give guidance to the legislative provisions, under the Act itself and under regulations in the context of standards set by the Authority.

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1011 Ibid. s. 2 provides “Registered Provider … in relation to a designated centre means the person whose name is entered in a register as the person carrying on the business of the designated centre.”
1013 My inclusion in brackets.
1014 Health Act, 2007 (n 1000) s. 50 (1).
1015 Ibid. see ss. 41 and 73.
1016 My inclusion in italics.
1017 My inclusion in Italics.
1018 Health Act 2007 (n 1000) s. 9 (1).
1019 Ibid. s. 11.
The legislation provides for the making of regulations\textsuperscript{1020} with regard to among other things, the care and well-being of older people in residential care and the residential care setting itself, including:\textsuperscript{1021}

(a) the maintenance, care, welfare and well-being of persons resident ...

(b) the numbers, qualifications and availability of persons employed ...

(c) the design, maintenance, repair, cleaning and cleanliness, ventilation, heating and lighting …

(d) the accommodation (including the amount of space in bedrooms and wards, the washing facilities and the sanitary conveniences) provided ...

(e) the food provided ...

(f) the records to be kept ...

(g) the effecting by registered providers of designated centres of contracts of insurance against injury to persons resident in them;

(h) the management and control of the operations ...

(i) the notification of incidents occurring ...

(j) the giving of notice by the registered provider of periods during which-

   (i) the registered provider, or

   (ii) the manager, if the registered provider is not the manager ...

proposes to be absent … and specifying the information to be supplied in the notice;

(k) adequate arrangements for the running of the residential care setting\textsuperscript{1022} during the period when a manager is absent from it.\textsuperscript{1023}

and for other related matters.\textsuperscript{1024}

The legislation makes provision for the establishment of the Office of Chief Inspector of Social Services\textsuperscript{1025} whose function among other things is:

\textsuperscript{1020} Ibid. Part 13 came into operation on the 25\textsuperscript{th} of June 2009 under the provisions of the Health Act 2007 (Commencement) (No. 2) Order 2009 S.I. No. 237 of 2009.
\textsuperscript{1021} Ibid. s. 101.
\textsuperscript{1022} My inclusion in italics.
\textsuperscript{1023} Health Act 2007 (n 1000) s. 101.
\textsuperscript{1024} Ibid.
To carry out inspection of the H.S.E.’s performance in respect of boarding out of persons in private dwellings\textsuperscript{1026}

To establish and maintain a register of nursing homes\textsuperscript{1027}

To register and inspect such nursing homes and to ascertain if the registered provider complies with the regulations and standards set by the Authority.\textsuperscript{1028}

Required or prohibited conduct with regard to residential care settings is set out in s. 56. For example s. 56. (4) (a) and (b) provides that the registered provider is not to provide a service or do anything else that would contravene the registration conditions of the residential care centre for older people.

The Chief Inspector may make an application for an \textit{ex parte} interim order for cancellation or variation of registration where there “is a risk to the life, or a serious risk to the health or welfare”\textsuperscript{1029} of the residents. Where the cancellation of the registration of a residential care setting for older people arises (closure of the nursing home), the chief inspector is required to notify the HSE.\textsuperscript{1030} If the HSE were the registered provider prior to the cancellation of registration the HSE may continue as if it were the registered provider while alternative arrangements are put in place.\textsuperscript{1031} If the HSE were not the registered provider (private nursing home) just before cancellation of the registration pending alternative arrangements, the HSE may either with the consent of the registered provider who was in place prior to the cancellation of registration or by order of the District Court take charge of the residential care setting as the registered provider.\textsuperscript{1032} On foot of inspection and enforcement action by HIQA six designated centres for older people were closed in 2011 where HIQA had reasonable grounds for forming the opinion of the serious risk to residents’ wellbeing.\textsuperscript{1033} The care of residents following closure of a nursing home has been addressed by the ECtHR.\textsuperscript{1034} In \textit{Watts v United Kingdom}\textsuperscript{1035} the Court acknowledged that a state has positive

\textsuperscript{1025} Ibid. s. 40.
\textsuperscript{1026} Ibid. s. 41 with regard to s. 10 of the Health (Nursing Homes) Act 1990.
\textsuperscript{1027} Nursing home as defined by s. 2 of the Health (Nursing Homes) Act 1990.
\textsuperscript{1028} Health Act 2007 (n 1000) s. 41; paragraphs (b) and (c) of subsection (1) of s. 41 as it relates to residential services for older people, subsection 2 of s. 41 (2) and s. 42 came into effect on the 1\textsuperscript{st} July 2009 as provided by the Health Act 2007 (Commencement) (No. 2) Order 2009.
\textsuperscript{1029} Ibid. ss. 59 and 60 of the Health Act 2007.
\textsuperscript{1030} Ibid. s. 64. (1).
\textsuperscript{1031} Ibid. s. 64. (2) and (3).
\textsuperscript{1032} Ibid. s. 64. (2) and (4).
\textsuperscript{1033} Ibid. s. 64. (2) and (4).
\textsuperscript{1034} Annual Report 2011 (n 30) p. 21. More recently the Circuit Court sitting in Galway on the 31st July 2012 confirmed the Order of the District Court made on the 4\textsuperscript{th} July 2012 that cancelled the registration of Owenrif Nursing Home.
\textsuperscript{1035} Ibid.
obligations under Article 2 in transferring elderly patients.\textsuperscript{1036} In terms of Article 8(1) the Court said “that the applicant’s private life is engaged and that the proposed transfer constitutes an interference within the meaning of art. 8(1).”\textsuperscript{1037}

Part 9 of the Health Act 2004 has been expanded by s.103 of the Health Act 2007\textsuperscript{1038} that provides for the protection of disclosed information and the investigation of matters pertaining to the protected disclosure. This safeguard will hopefully encourage any concerned employee to report to an authorised person matters as specified in the legislation most especially where a resident is at risk.

**Health Act 2007 (Section 103) (Commencement) Order 2009\textsuperscript{1039}**

Section 103 came into effect on the 1\textsuperscript{st} March 2009. The making of complaints on reasonable grounds and in good faith by health services employees to an authorised person is a protected disclosure. Sometimes referred to as whistleblowing, disclosures may also be made by individuals to a professional regulatory body\textsuperscript{1040} and in certain circumstances to HIQA or the Inspector of Mental Health Services. The statutory provision provides statutory protection (for the individual making the disclosure) against penalisation in their employment and against civil liability.

**Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009\textsuperscript{1041}**

These important regulations came into effect on the 1\textsuperscript{st} July 2009 revoking the Nursing Homes (Care and Welfare) Regulations 1993\textsuperscript{1042} and the Nursing Homes (Care and Welfare) (Amendment) Regulations 1993\textsuperscript{1043} and 1994.\textsuperscript{1044} They provide requirements with regard to the maintenance, care, welfare and well-being of older people in designated residential care settings,\textsuperscript{1045} the numbers, qualifications and availability of workers,\textsuperscript{1046} the design, maintenance, repair, cleaning and cleanliness, ventilation, heating and lighting of and the

\textsuperscript{1036} Ibid. para. 88. See also Ch. 2 of this work for discussion on Article 2 ECHR.
\textsuperscript{1037} Ibid. para. 97. See also Ch. 2 of this work for further discussion on Article 8 ECHR.
\textsuperscript{1038} With the insertion of Part 9A.
\textsuperscript{1039} The Health Act 2007 (Section 103) (Commencement) Order 2009 S.I. No. 27 of 2009 commenced most provisions of s. 103 from the 1\textsuperscript{st} March 2009. The Health Act 2007 (Commencement) (No. 3) Order 2009 S.I. No. 268 of 2009 brought into operation from the 1\textsuperscript{st} August 2009 provisions in s. 103 not already in operation.
\textsuperscript{1040} See Ch. 6 of this work for a discussion on professional regulatory bodies.
\textsuperscript{1041} S.I. No 236 of 2009, part 2.
\textsuperscript{1042} S.I. No. 226 of 1993.
\textsuperscript{1043} S.I. No. 379 of 1993.
\textsuperscript{1044} S.I. No. 147 of 1994.
\textsuperscript{1045} S.I. No. 236 of 2009, part 2.
\textsuperscript{1046} Ibid. part 3.
accommodation provided in such settings, the food provided for residents, record keeping, the contracts of insurance to be implemented and maintained, the management and control of the activities within the designated care setting, notifications including incidents, periods when the person in charge is absent from the premises, the procedures and arrangement in place to be effected when the person in charge is absent and the arrangement for dealing with complaints made by or on behalf of prospective residents, residents or former residents and the promulgation of these arrangements.

The registered provider is charged with among other things the general welfare and protection of older persons resident in a designated centre. They are required to take all reasonable measures to protect residents from any form of abuse and ensure that “there is a policy on and procedures in place for the prevention, detection and response to abuse.” Regulation 6(2) requires the person in charge to ensure that all arrangements are in place to prevent residents being harmed or abused or being put at risk of either harm or abuse; and to record any such event and respond in a proper manner.

The registered provider is required to provide residents with:

(a) Suitable and sufficient care to maintain the resident’s welfare and well-being, having regard to the nature and extent of the resident’s dependency and needs as set out in their care plan;
(b) a high standard of evidence based nursing practice;
(c) appropriate medical care by a medical practitioner of the resident’s choice or acceptable to the person; and
(d) opportunities to participate in activities appropriate to his or her interest and capacities.

Individual care plans identifying a resident’s needs must be developed by the person in charge and agreed with each resident. The person in charge is required to facilitate the

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1047 Ibid. part 4.
1048 Ibid. part 5.
1049 Ibid. part 6.
1050 Ibid. part 7.
1051 Ibid. part 8.
1052 Ibid. part 9.
1053 Ibid. part 10.
1054 Ibid. part 11.
1055 Ibid. part 12.
1056 Ibid. Regulation 6 (1).
1057 Ibid. Regulation 6 (3).
residents accessing their care plan, to formally review the care plan according to the changing needs of the resident and at least once in a three month period and to amend the care plan following consultation with the resident (where the resident is capable of engaging in such a consultation) and to notify the resident of the review.\textsuperscript{1059}

The registered provider is charged with ensuring that each resident is provided with optimal health care. It is up to the person in charge to facilitate the delivery of medical treatment once it has been agreed by the resident. Other health related services such as chiropody, occupational therapy or physiotherapy may be facilitated by the registered provider or by the HSE.\textsuperscript{1060} Regulation 9 (c) recognises a resident’s right to refuse treatment. Such a refusal must be respected, documented and brought to the attention of the resident’s medical practitioner.\textsuperscript{1061}

The legislation makes provision for the HSE to supply services at the request of the registered provider subject to the ‘terms, charges and conditions’ prescribed by the HSE consequent to a discussion with the registered provider.\textsuperscript{1062} The registered provider is duty bound to ensure that records are kept of all referral and follow-up appointments.\textsuperscript{1063}

Matters pertaining to the residents’ rights, dignity and consultation that must be provided by the registered provider are addressed in Regulation 10 that covers arrangements for: the provision of occupational and recreational facilities for residents, freedom to exercise choice and privacy subject to the rights of other residents and a resident’s own ability to carry out personal activities independently and information regarding current affairs, local happenings, voluntary groups and community activities.\textsuperscript{1064} In addition as part of the management the registered provider must, take account of the ‘sex, religious persuasion, racial origin, cultural and linguistic background, and any disability of residents’,\textsuperscript{1065} to put arrangements in place so far as reasonably practicable to enable residents, exercise their ‘civil, political and religious rights’\textsuperscript{1066} and be consulted and participate in the organisation of the residential care setting.\textsuperscript{1067}

\textsuperscript{1058} Individual care plans are also required under s. 66 (2)(g) of the Mental Health Act, 2001.
\textsuperscript{1059} S.I. No. 236 of 2009 Regulation 8 (2).
\textsuperscript{1060} Ibid. Regulation 9.
\textsuperscript{1061} See Ch. 3 of this work for discussion on consent.
\textsuperscript{1062} S.I. No. 236 of 2009 Regulation 9 (3).
\textsuperscript{1063} Ibid. Regulation 9 (4).
\textsuperscript{1064} Ibid. Regulation 10 (a)-(d).
\textsuperscript{1065} Ibid. Regulation 10 (e).
\textsuperscript{1066} Ibid. Regulation 10 (f).
\textsuperscript{1067} Ibid. Regulation 10 (g).
Regulation 15 requires that there is a named person in charge of a residential care setting. The appointed person is responsible for the governance, operational management and administration of the residential care setting(s). The person in charge may be either a registered provider where there is a nurse on duty at all times or a full time nurse with a minimum of three years geriatric experience within the previous six years.

The legislation requires that the ‘person in charge’ is required to ensure that there is a staff and skill mix appropriate to the residents’ care needs assessment. Regulation 16 (2) requires one “appropriately qualified registered general nurse on duty and in charge at all times.” Before this Regulation 10 (5)(c) of the Nursing Homes (Care and Welfare) Regulations 1993 applied. This change in legislation regarding the specificity of the qualification is welcome. However it does not define the term ‘appropriately qualified’. Clarity is now required in terms of the meaning of ‘appropriately qualified’. The legislation still requires only one nurse on duty. Failure to augment this legislation in this regard is disappointing given that most of the residents in residential care settings are of moderate to high dependency. Furthermore a private nursing home is a for profit organisation and there is likely to be a budgetary restraint on the ‘person in charge’ who is more often an employee rather than the registered provider being the ‘person in charge’. Regulation 16 (1) should be amended to transfer the duty regarding staff and skill mix to the registered provider. The function could be delegated to the person in charge with ultimate responsibility held by the registered provider.

Regulation 17 addresses training and staff development. The person in charge is merely required to ensure that workers have “access to education and training” so that they would be able to provide optimum care. The provision is ambiguous. “Access to” implies voluntary attendance. Training is not mandatory since there is no requirement that workers attend such training. The person in charge is required to bring to workers’ awareness “provisions of the Act and all the Regulations and rules made [there under], commensurate with their role, the statement of purpose and with any policies and procedures dealing with the general welfare and protection of residents.” This provision is equally ambiguous. There is no requirement that such information is brought to the workers’ attention verbally in a language that is likely to be understood. The legislation is silent on the

1068 See the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010 S.I. No. 36 of 2010 that removes the word “general”.
1069 The statement of purpose required by S.I. No. 236 of 2009 Regulation 5 (1) consists of: “(a) a statement of the aims, objectives and ethos of the designated centre; (b) a statement as to the facilities and services which are to be provided by the registered provider for residents; and (c) a statement as to the matters listed in Schedule 1.” See Appendix 4 in this work.
1070 Ibid. S.I. No. 236 of 2009 Regulation 17 (3).
The frequency of communication. Such information should be communicated on recruitment and annually or more frequently where changes may arise in a language that will be understood by the worker. Of course more specific information, for example, changes in a resident’s mobility requires more immediate communication. In addition, a mechanism should be in place to satisfy the person in charge that workers have understood the communication. Disappointingly, the legislation for the most part is silent on the type or duration of training for care workers who are the main providers of care in private residential care settings for older people. This is another missed opportunity to standardise training requirements for all care workers.

In addition to written policies and procedures with regard to recruitment, a registered provider is restricted from employing a person in a residential care setting unless they satisfy the requirements of Regulation 18 (2) namely:

(a) the person is fit to work at the designated centre;

(b) the registered provider has obtained in respect of that person the information and documents specified in Schedule 2; and

(c) s/he is satisfied on reasonable grounds as to the authenticity of the references referred to in Schedule 2 in respect of that person.

Regulation 18 (3) provides that a person is unfit to work in a residential care setting unless:

(a) s/he is of integrity and good character;

(b) s/he has qualifications suitable to the work to be performed, and the skills and experience necessary for such work;

(c) s/he is physically and mentally fit for the purposes of the work to be performed at the designated centre; and

(d) full and satisfactory information is available to him/her in respect of the matters set out under Schedule 2.

The new legislative provision with regard to supervision is welcomed. The person in charge is required to provide in so far as reasonably practicable facilities for a resident who would like to wash and iron their own clothes. This is a bit of a nonsense. Where reasonable the person in charge can certainly facilitate such wishes but this duty should rest with the registered provider as the owner or occupier of the building.

Regulation 19 prohibits the registered provider from using premises that would interfere with the delivery of the stated aim and objectives of the statement of purpose. It also

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1071 Ibid. Regulation 6 (2) identifies a specific training requirement.
1072 See Appendix 5 in this work.
1073 S.I. No. 236 of 2009 Regulation 17 (2).
1074 Ibid Regulation 13.
prohibits the use of premises where the location is not appropriate to the needs of the residents. These innovative provisions are to be welcomed. It will be interesting to see the level of enforcement of these provisions given the provisions of the Finance Acts 1988-2007 that provided capital allowances in respect of expenditure in nursing homes however remote the location. The Finance Acts were silent in terms of location. Consequently it was considerably cheaper to locate residential care setting in remote areas and benefit fully from the allowances.

The registered provider is also required to comply with the requirements of the Planning and Development Acts 2000-2006 and current building bye-laws. Regulation 19 (3) provides that the registered provider must take account of the number and needs of the residents with regard to the premises:

(a) the physical design and layout ... meets the needs of each resident;
(b) the premises are of sound construction and kept in a good state of repair internally and externally;
(c) equipment provided ... is maintained in good working order;
(d) centre is kept clean and suitably decorated;
(e) adequate private and communal accommodation is provided for residents;
(f) the size and layout of rooms … are suitable for [residents] needs;
(g) there is adequate sitting, recreational and dining space provided separately from the resident’s private accommodation;
(h) the communal space provided for residents is suitable for the provision of social, cultural and religious activities appropriate to the circumstances of residents;
(i) suitable facilities are provided for residents to meet visitors in communal accommodation and, in as far as is practicable, a suitable private area which is separate from the resident’s own private rooms;
(j) there are provided at appropriate places in the premises sufficient number of lavatories, and of wash basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection;
(k) necessary sluicing facilities are provided…

Heating is addressed in Regulation 19 (3)(p) that requires it to be suitable for residents. No reference is made to minimum temperature either day time or night time. There is no

1075 Location was an issue that was raised in Stanev v Bulgaria (n 120) para. 125.
1076 See this Ch. sub-section titled ‘Funding’ for further discussion.
1077 S.I. No. 236 of 2009 Regulation 19 (2).
requirement to have a gauge to indicate oil levels to ensure that it is ordered in a timely manner so that the heating can be maintained at least at minimum levels. With regard to sanitary facilities the legislation\textsuperscript{1078} requires among other things the provision of wash-hand basins\textsuperscript{1079} (thermostatically controlled to prevent scalding) in each bedroom and the provision of assisted baths and showers to facilitate the dependency level of the residents.\textsuperscript{1080}

The term “adequate arrangements” contained in Regulation 19 (7)(g) with regard to disposal of biological agents is vague. Safe disposal of biological agents are governed by the requirements of Safety, Health and Welfare at Work (Biological Agents) Regulations, 1994 as amended in 1998\textsuperscript{1081} and the European Communities (Carriage of Dangerous Goods by Road and Use of Transportable Pressure Equipment) Regulations 2011.\textsuperscript{1082}

A resident’s guide must be furnished to each resident by the person in charge.\textsuperscript{1083} The guide compiled by the registered provider\textsuperscript{1084} must contain a summary of the centre’s statement of purpose,\textsuperscript{1085} details of the terms and conditions with regard to resident’s accommodation\textsuperscript{1086} together with a “form of contract for the provision of services and facilities”,\textsuperscript{1087} a copy of the last inspection report,\textsuperscript{1088} a précis of the complaints procedure\textsuperscript{1089} and contact details for the Chief Inspector of Social Services.\textsuperscript{1090}

Records,\textsuperscript{1091} including medical records are to be kept by the registered provider for a minimum of seven years after the resident to whom the records concern ceases to be a resident in the centre.\textsuperscript{1092} The content of the medical records include the patient’s state of health on admission\textsuperscript{1093}, daily nursing record\textsuperscript{1094}, details of any investigations, diagnoses and treatment provided, record of any medication prescribed, signed and dated by a medical

\begin{flushleft}
\textsuperscript{1078} Ibid. Regulation 19 (7).
\textsuperscript{1079} Ibid. Regulation 19 (7)(a).
\textsuperscript{1080} Ibid. Regulation 19 (7)(d).
\textsuperscript{1082} S.I. No. 349 of 2001.
\textsuperscript{1083} S.I. No. 236 of 2009 Regulation 21 (2).
\textsuperscript{1084} Ibid. Regulation 21 (1).
\textsuperscript{1085} Ibid. Regulation 21 (1)(a).
\textsuperscript{1086} Ibid. Regulation 21 (1)(b).
\textsuperscript{1087} Ibid. Regulation 21 (1)(c); the contract to be agreed with the resident within one month following admission as required by Regulation 28 (1).
\textsuperscript{1088} Ibid. Regulation 21 (1)(d).
\textsuperscript{1089} Ibid. Regulation 21 (1)(e).
\textsuperscript{1090} Ibid. Regulation 21 (1)(f).
\textsuperscript{1091} Ibid. as listed under schs. 3 and 4. See Appendix 6 and 7 in this work.
\textsuperscript{1092} Ibid. Regulation 22 (3) and 25 (2).
\textsuperscript{1093} Ibid. Regulation 25 (1)(a).
\textsuperscript{1094} Ibid. Regulation 25 (1)(b).
\end{flushleft}
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doctor\textsuperscript{1095} and its administration in accordance with the order and professional guidelines.\textsuperscript{1096} Medical records also include recording the use, nature and duration of any restraint\textsuperscript{1097}, refusal of any treatment\textsuperscript{1098} and of any medication errors or adverse reaction.\textsuperscript{1099}

Regulation 27 requires the registered provider to ensure that written and operational policies are in place with regard to eighteen listed items.\textsuperscript{1100} For example, in addition to a policy on and procedures in place for “the prevention, detection and response to abuse”\textsuperscript{1101} the registered provider must ensure that there are written operational policies and procedures with regard to “residents personal property and possessions”\textsuperscript{1102}; communication\textsuperscript{1103}; for end of life care\textsuperscript{1104}; recruitment, selection and vetting of staff\textsuperscript{1105}; provision of information to residents\textsuperscript{1106}; and for the “creation of, access to, retention of and destruction of records.”\textsuperscript{1107}

A comprehensive risk management policy is to include risk assessments and control measures for the centre and to include the arrangements in place to minimise risk in the following particular areas, namely, unexplained absence of a resident, assault, unintentional injury to a resident or staff member, aggression and violence and self-harm.\textsuperscript{1108} These policies and procedures are to be reviewed as advised by the Chief Inspector and at least once every three years and amended to take account of any recommendations made by the Chief Inspector.\textsuperscript{1109}

The person in charge is required to ensure that all relevant information is transferred with a resident when they are being temporarily treated in another care setting and similarly when the resident is returning to the centre that all relevant information is transferred back with them.\textsuperscript{1110}

\textsuperscript{1095} Ibid. Regulation 25 (1)(c).
\textsuperscript{1096} Ibid. Regulation 25 (1)(d).
\textsuperscript{1097} Ibid. Regulation 25 (1)(e). See (n 817) COP on restraint that the MHC oversees.
\textsuperscript{1098} Ibid. Regulation 25 (1)(f).
\textsuperscript{1099} Ibid. Regulation 25 (1)(g).
\textsuperscript{1100} Ibid. as listed in sch. 5. See Appendix 8 in this work.
\textsuperscript{1101} Ibid. sch. 5. 1.
\textsuperscript{1102} Ibid. Regulation 7.
\textsuperscript{1103} Ibid. Regulation 11.
\textsuperscript{1104} Ibid. Regulation 14 (1).
\textsuperscript{1105} Ibid. Regulation 18.
\textsuperscript{1106} Ibid. Regulation 21 (4).
\textsuperscript{1107} Ibid. Regulation 22 (2).
\textsuperscript{1108} Ibid. Regulation 31 (2)(c).
\textsuperscript{1109} Ibid. Regulation 27 (2).
\textsuperscript{1110} Ibid. Regulation 29 (1)(2).
All residential centres are required to have a system for the review and improvement of quality and safety of care and quality of life of residents. The review incorporates consultation with residents and their representatives. The registered provider is required to make a copy of any such review available to the residents and to the Chief Inspector where requested.\footnote{111}

Except in the case of an emergency the Chief Inspector must be notified in writing one month in advance where the person in charge intends to absent continuously for twenty eight days or more.\footnote{1112} Such notification is to include the length or anticipated length of absence, the date of commencement of the leave and likely return date together with the arrangements made for running the centre during the person’s absence.\footnote{1113} Where the person’s in charge absence arises as a result of an emergency the Chief Inspector must be notified within 3 working days by the registered provider of the absence. In this context the Regulation does not require the notice to specify the proposed duration of absence or the likely return date.\footnote{1114}

Part 12 of the legislation provides the arrangements for dealing with complaints made by or on behalf of older persons seeking or in receipt of ‘services’ in this context-residential accommodation. Records in respect of such complaints must be retained for at least seven years.\footnote{1115}

**Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009**\footnote{1116}

Designated centres for older people include institutions where residential services are provided for older dependent persons, in relation to their dependencies.\footnote{1117} These Regulations came into effect on the 1st July 2009. The Chief Inspector of Social Services is charged with establishing and maintaining a register of each category of designated centre for older people.\footnote{1118} Regulation 3 expands the requirements of s. 49(1) of the Health Act

\footnote{111} Ibid. Regulation 35.
\footnote{1112} Ibid. Regulation 37.
\footnote{1113} Ibid. Regulations 37 (2) and 38.
\footnote{1114} Ibid. Regulation 37 (3); sub-article (3) was amended by Regulation 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People)(Amendment) Regulations 2010 S.I. No. 36 of 2010.
\footnote{1116} S.I. No. 245 of 2009.
\footnote{1117} S. 2 of the Health Act 2007.
\footnote{1118} Regulation 3 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009.
2007 in respect of registers. For example the maximum number of residents that can be accommodated in the centre during the period of registration must be included in the register. A registration or renewal registration fee of €500 is payable on submission of the application form and an annual fee of €190 in respect of each resident in the residential care setting is payable by the registered provider in three equal instalments. Other application requirements include, for example, (i) written confirmation that the designated centre complies with legislative fire safety and building control requirements, completed by a competent person, (ii) documentary evidence of any relevant qualifications or accredited training records in respect of the registered providers or intended registered provider or those in management roles and (iii) details of current registration status with a professional regulatory body. A weakness of this legislation is that it does not require details of qualifications or accredited training records for non-management staff. Non-management workers are likely to be the care providers.

**Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010**

These Regulations came into effect on the 15th February 2010 and amend the following: Article 16 is amended by removal of the word “general”, the change, resulting in a return to the non-specificity of qualification of a registered nurse. Regulation 37 is amended with regard to an emergency absence of the person in charge-the notice details to the Chief Inspector to include the same information as that in a planned absence. Schedule 4 is amended to remove the requirement for an employee to provide a copy of their passport and birth certificate. A copy of the substituted sch. 3 as amended by Regulation 5 of this Regulation is attached in Appendix 9.

**Food Safety**

For completeness sake a brief mention is made of Regulation (EC) No 852/2004 as amended that was brought in to effect in Ireland by European Communities (Hygiene and

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1119 Ibid. Regulation 4 and 6. ‘Professional regulatory body’ means (a) An Bord Altranais, (b) the Dental Council, (c) the Health and Social Care Professional Council, (d) the Medical Council, or (e) the Pharmaceutical Society of Ireland as provided by the Health Act 2004 as amended by s. 103 of the Health Act 2007. For discussion see Ch. 6 of this work.
1120 S.I. No. 36 of 2010.
1121 Regulation 4 of S.I. No. 36 of 2010.
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Foodstuffs) Regulations 2006 as amended. The regulations are enforced in the residential care centres by the HSE. Of particular import are the hazard analysis and critical control point (HACCP) principles, personal hygiene and training to control food safety.

**Scheme of Mental Capacity Bill 2008**

Capacity is considered as having the requisite knowledge to understand the nature, choices and consequence of a decision at the time of decision-making. All adults are presumed to have capacity unless proved otherwise. Where a person lacks capacity decisions may be made in their best interests having first considered all the relevant circumstances. At present the old system of wardship co-exists with the new system on nursing homes which adopts a functional assessment of capacity. The proposed capacity legislation will reform capacity legislation in Ireland and reform wardship legislation to bring it in line with the ECHR and Article 12 of the CRPD providing a global approach to older people. The proposed legislation makes provision for the appointment of a personal guardian where a person lacks capacity to make decisions with regard to their personal welfare, property and other related matters. Disappointingly advocacy is not included in the new legislative provision.

**Conclusion**

*The Inter-Departmental Committee on the Care of the Aged Report* was the first Report that took account of the needs of an ageing population. The Report recommended among other things that older people should be able to remain in their own homes where possible. While the focus of this work has been on residential care it is readily recognised that most older people would like to stay in their own home and would not seek residential care if they had the supports where necessary to enable them to remain at home should they so wish. The tension between the State’s role in enhancing capacity of people to keep them out of institutions and its protective role which tends to legitimate institutions can be evidenced in the mental health and intellectual disability sectors with the closure of institutions and the transfer of residents to independent and interdependent living accommodation. However

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1125 See Ch. 4 of this work for a more extensive discussion on capacity.
1126 Article 12 of the CRPD requires a move away from best interests to ensuring that the will and preferences of the individual are respected.
1127 See, for example, *Shukauturov v Russia* (n 232) and *Stanev v Bulgaria* (n 120). See also Ch. 5 of this work for discussion on wardship.
1128 See Ch. 5 of this work for a more extensive discussion on the proposed bill.
1129 (n 884).
such tension is not so obvious when addressing residential care for older people. A possible public policy of phasing out public residential care settings for older people in the absence of strengthening community provisions to enable them to live in their own homes would be a State failure to address the needs of older people. For some older people residential care may be their only option. Among other things of particular significance in protecting and advancing rights for older people in residential care settings are implemented individual care plans and competent workers.

**Funding**

During the 1920’s in Ireland state finances were an immediate source of concern for the new government.\(^{1130}\) This is not unlike the current situation. *The Report of the Irish Poor Law Commission*\(^ {1131}\) recognised the dominance of finance with regard to implementation of the report’s recommendations that included, for example, “1. The removal of the defects in hospitals and county homes. 3. Establishment of auxiliary homes for mental defectives. 4. Establishment of auxiliary homes for aged and infirm. 5. Supply of ambulances to county hospitals and homes.”\(^ {1132}\) In the context of older people in residential care the following legislative provisions outline funding and charging arrangements for residential care from the inception of the State to date.

**Public Charitable Hospitals (Temporary Provisions) Act, 1930**\(^ {1133}\)

This legislation makes provision for securing funds for institutions through sweepstakes.\(^ {1134}\) This innovative provision, among other things, helped partially fund Irish institutions for many years.\(^ {1135}\)

**Public Hospitals Act, 1933**\(^ {1136}\)

The main purpose of the Act was to provide for funding for hospitals and to make provision for the management and improvement of hospitals.\(^ {1137}\)

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\(^{1130}\) The Irish Free State was created following the Anglo-Irish Treaty signed in December 1921.

\(^{1131}\) Eason, 1928 (n 632).

\(^{1132}\) Ibid p. 28.

\(^{1133}\) No. 12 of 1930; this legislation was amended and extended by the Public Charitable Hospitals (Amendment) Act, 1931 No. 24 of 1931 and extended by the Public Charitable Hospitals (Amendment) Act, 1932 No. 8 of 1932.

\(^{1134}\) Ibid. long title.

\(^{1135}\) For further discussion see Barrington, 1987 (n 586) pp. 108-110.

\(^{1136}\) No. 18 of 1933; s. 14 (except subsection (6)), ss. 15-19, s. 24 (3), and 24 (4) were repealed by Health Act, 1970 No. 1 of 1970.

\(^{1137}\) Long title Public Hospitals Act, 1933; the Act repealed the Public Charitable Hospital Acts, 1930-32 and provided transitory provisions.
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Hospitals Act, 1939\(^\text{1138}\)

This legislation enabled the Minister for Local Government and Public Health to make orders among other things for financing of voluntary hospitals. The voluntary hospital establishment orders enabled (with the consent of the Minister for Finance) the Minister for Local Government and Public Health to lend the hospital board(s) public monies as provided by the Local Loans Fund Act, 1935.\(^\text{1139}\)

Public Assistance Act, 1939\(^\text{1140}\)

Among other duties the Superintendent Assistance Officer was charged with reviewing the means of mental hospital patients and sourcing any liable relatives in terms of costs.\(^\text{1141}\)

Health Services (Financial Provisions) Act, 1947\(^\text{1142}\)

Local authorities were grant aided up to fifty per cent toward their costs on health services.\(^\text{1143}\) This legislation enabled the local authorities to undertake repair and maintenance of county homes without drawing on local funding.\(^\text{1144}\)

Health Act, 1953\(^\text{1145}\)

Section 54 provides for shelter and maintenance in county homes where the person is unable to provide such arrangements for himself or his dependents. Section 54(4) provides for the possibility of payment stating that a person is required “to contribute in specified cases towards the cost of providing them with institutional assistance”. A brief mention is made of s. 65 of the Act that made provision for funding to voluntary organisations for health and allied purposes.\(^\text{1146}\)

Institutional Assistance Regulations, 1954\(^\text{1147}\)

Institutional assistance as provided by s. 54 of the Health Act, 1953 may be given by a Health Authority. This legislation sets out the admission procedure to county homes or similar institutions and includes such matters as clothing, food and accommodation, medical

\(^{1138}\) No. 4 of 1939; the Public Assistance Act, 1939 and the County Management Act, 1940 provided for the administration of health services; for discussion see Barrington, 1987 (n 586) pp. 132-134.

\(^{1139}\) S. 5 (g) of the Hospitals Act, 1939.

\(^{1140}\) No. 27 of 1939.


\(^{1142}\) No. 47 of 1947.

\(^{1143}\) Ibid. s. 4.

\(^{1144}\) Department of Health, 1953 (n 642) p. 8.

\(^{1145}\) (n 685).

\(^{1146}\) S. 65 grants as they were known became s. 39 grants under the Health Act, 2004.

\(^{1147}\) S.I. No. 103 of 1954
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examination and treatment and visiting. A person in receipt of institutional assistance may be required to make a financial contribution to the health authority, an amount as deemed appropriate by the health authority where their income was in excess of 10s a week.\textsuperscript{1148}

In a case involving challenge to payment for nursing home care Finlay J. \textit{In the Matter of Maud Mchnerney, a Ward of Court}\textsuperscript{1149}, considered that s. 51 of the Health Act 1970 was more relevant to the circumstances of the ward than s. 54 of the Health Act 1953. Therefore no charges could be levied on the ward for in-patient services as she was in receipt of more than shelter and maintenance as she was receiving a “form of medical care.”\textsuperscript{1150} The Eastern Health Board appealed the ruling to the Supreme Court. In dismissing the appeal the Supreme Court affirmed the judgment of Finlay J. stating that the ward “gets the nursing care requisite for a patient of her age and state of health in a geriatric institution ... In other words, what she is getting is ‘in-patient services’ which she requires as a geriatric patient.”\textsuperscript{1151}

State abuse in the form of illegal charging of older people has been acknowledged. It has been the subject of several reports.\textsuperscript{1152}

\textbf{Institutional Assistance Regulations, 1965}\textsuperscript{1153}

This legislation amended article 12\textsuperscript{1154} of the Institutional Assistance Regulations, 1954.\textsuperscript{1155} The Heath Authority could seek contributions for institutional assistance. In doing so the Health Authority gave recognition to the £1 allowable income and any property or trade charges as detailed in Regulation 3.12(ii).

\textbf{Health Act 1970}\textsuperscript{1156}

Eligibility for services is addressed in part IV of the Act.\textsuperscript{1157} Section 45(1) entitles adult persons or their dependents to attend a general medical practitioner or obtain surgical services who would not be able in ordinary circumstances be able to obtain same without

\textsuperscript{1148} Ibid. Article 12; the Institutional Assistance Regulation 1965 also refers to Article 12.
\textsuperscript{1150} Ibid. p. 333.
\textsuperscript{1151} Ibid. Henchy J. p. 234.
\textsuperscript{1152} See, for example, the Houses of the Oireachtas Joint Committee on Health & Children \textit{Interim Report on the Report on Certain Issues of Management and Administration in the Department of Health and Children associated with the Practice of Charges for Persons in Long-Stay Care in Health Board Institutions and Related Matters March 2005} also known as the \textit{Travers Report}. \url{http://www.oireachtas.ie/documents/committees29thdail/committeereports2005/document3.pdf}
\textsuperscript{1153} S.I. No. 177 of 1965.
\textsuperscript{1154} As cited in the Institutional Regulations, 1954.
\textsuperscript{1155} S.I. No. 103 of 1954.
\textsuperscript{1156} (n 694).
\textsuperscript{1157} Ibid. Chapter 1.
due hardship. The system more commonly known as the medical card system (the General Medical Scheme or GMS) also provided those with full eligibility drugs, medicines and appliances free of charge. The Act details other services provided, for example, dental, ophthalmic and aural services. Other categories of persons may be entitled to limited eligibility and the criteria to satisfy the requirements for such benefit are set out in s.46.

The definition of “In-patient services” includes institutional services for those requiring in-patient treatment in a hospital, convalescent home or home for persons incurring a physical or mental disability “or in accommodation ancillary thereto.” As outlined by Henchy J. in *In the Matter of Maud McInerney, a Ward of Court* “the services provided for the ward are institutional in character” and therefore come within the definition of “in-patient services” as provided by s. 51 of the Health Act 1970. Section 52 requires the health boards (HSE) to provide in-patient services for those with either full or limited eligibility. In practice therefore this implies that any older person requiring residential care should be able to obtain it through the health board/HSE. To date this requirement has not been realised.

Most older people seeking residential care have no chance of securing a public nursing home place.

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1158 Ibid. s. 45 was amended by s. 2 the Health (Amendment) Act, 1991 No. 15 of 1991 and as amended, amended by s. 1 of the Health (Amendment) Act 2005 No. 3 of 2005.
1159 Ibid. Part IV, Chapter 111.
1160 Ibid. Part IV, Chapter V.
1161 Ibid. s. 51.
1162 (n 1149) 233-234.
1163 For further discussion see Office of the Ombudsman *Who Cares? – An Investigation into the Right to Nursing Home Care in Ireland* A Report to the Dáil and Seanad in accordance with section 6(7) of the Ombudsman Act 1980 (Dublin, Office of the Ombudsman, November 2010); Office of the Ombudsman *Nursing Home Subventions: An Investigation by the Ombudsman of Complaints Regarding Payment of Nursing Home Subventions By Health Boards*, A Report to the Dáil and Seanad in accordance with s. 6(7) of the Ombudsman Act, 1980 (Dublin, Office of the Ombudsman, 2001). At p. 14 fn (1) it provides “in commenting on a draft of this report, the Department [of Health and Children] disputed the view that the Health Acts confer a legally enforceable entitlement to hospital in-patient services. The Department argues that the Health Act, 1970 distinguishes between the terms “eligibility” and “entitlement” and that the former, in the context of the Health Act, provides for eligible people to avail of services. However, as the Health Act does not define the manner in which, or the extent to which, in-patient services should be provided, the Department argues that the extent of any health board’s legal obligation in this regard is unclear. The Ombudsman does not accept that there is any doubt as to the obligation on health boards to provide in-patient services for eligible people. This is clearly established by [S]ection 52(1) of the Health Act, 1970. The Ombudsman is not aware that the issue of entitlement to in-patient services has been considered by the Courts. However, the issue of entitlement to services under [S]ection 62 of the Health Act, 1970 – which provides for medical and midwifery care for mothers – has been considered by the Supreme Court in *Spruyt and Wates v Southern Health Board* (1988). The structure of [S]ection 62 is virtually identical with [S]ection 52. What was at issue in *Spruyt* was whether the Southern Health Board should provide domiciliary midwifery services through a general practitioner or through a midwife. That there was a statutory obligation under [S]ection 62 to provide the service was not in dispute and this obligation was restated by the Court. See also … the Travers Report, March 2005. Section 52 of
Importantly s. 53\textsuperscript{1164} dealt with charges for in-patient services and stated at s. 53(1) that “charges shall not be made for in-patient services made under s. 52.” However over a period of 30 years an anomaly existed where unlawful charges were levied on many medical card holders for in-patient services.\textsuperscript{1165}

Section 53 (2) did make provision to enable the Minister with the consent of the Minister for Finance to make regulations-

(a) providing for the imposition of charges for in-patient services in specified circumstances on persons who are not persons with full eligibility or on specified classes of such persons, and

(b) specifying the amounts of the charges or the limits to the amounts of the charges to be so made.

The selection of in-patient services by a patient who came within the ambit of s. 52 was addressed in s. 54. Such a patient could opt for private services in an approved hospital or home similar to those that were available to them in the public system with the prescribed payment paid by a health board.\textsuperscript{1166} The prescribed payment would not however defray the full cost of the residential care in an approved private nursing home. Despite coming within eligibility a patient could opt to pay in private accommodation.

Section 55 allowed a health board to make available in-patient services for persons not covered by s. 52; such accommodation could be make available in either private or semi-private accommodation.

**Health (Charges For In-Patient Services) Regulations 1976\textsuperscript{1167} and Health (Charges for In-Patient Services)(Amendment) Regulations 1987\textsuperscript{1168}**

The Health (Charges For In-Patient Services) Regulations, 1976 deals with charges (as provided by s. 52 of the Health Act, 1970) towards the cost of in-patient services that were levied on persons who did not have full eligibility for in-patients services and had no dependants where the person was in receipt of services for ninety days either consecutively

\textsuperscript{1164} S. 53 (as amended by s. 4 of the Health (Amendment) Act 2005) was amended by s. 34 (2) and (3) of the Nursing Home Support Scheme Act 2009 (n 898).

\textsuperscript{1165} Ombudsman, *Who Cares?* 2010, (n 1163) and the *Travers Report* (n 1152); see also *In the Matter of Maud McInerney, a Ward of Court* (n 1149) 229.

\textsuperscript{1166} S. 54 of the Health Act, 1970 was repealed by s. 15 of the Health (Nursing Homes) Act, 1990.

\textsuperscript{1167} S.I. No. 180 of 1976.

\textsuperscript{1168} S.I. No. 300 of 1987.
or within the previous twelve months. The charge could not exceed the person’s income, less a total of £2.50 a week or less such larger sum as determined by the relevant health board chief executive officer taking the person’s circumstances into consideration.\textsuperscript{1169}

Health (Charges for In-Patient Services)(Amendment) Regulations 1987 amended the Health (Charges For In-Patient Services) Regulations, 1976 by reducing the 90 days to 30 days where it occurred either consecutively or within a twelve month period.

**Health (Nursing Homes) Act, 1990\textsuperscript{1170}**

The Act allowed health boards to make subventions where the resident did not have sufficient means to meet the costs “where a person enters or is in a nursing home.”\textsuperscript{1171} A significant change brought about by this legislation was the repealing of s. 54 of the Health Act, 1970 that allowed a subvention to be paid where a person choose an approved private institution instead of availing of services in a public institution.

**Nursing Home (Subvention) Regulations 1993\textsuperscript{1172}**

These Regulations set out the criteria and procedures to be followed for obtaining a subvention\textsuperscript{1173} towards nursing home care costs where the person had not the means to pay the whole or part of the costs. The health boards were charged with assessing a person’s financial eligibility\textsuperscript{1174} and their circumstances\textsuperscript{1175} for the subvention and the dependency level was ascertained by a health professional who may have been a designated officer of a health board.\textsuperscript{1176}

When a person satisfied the financial criteria, the subvention amount awarded was dependant on the degree of dependency as outlined in the First Schedule to these Regulations. It is notable that this is the first legislative differentiation of dependency.\textsuperscript{1177}

\textsuperscript{1169} S.I. No. 180 of 1976 (n 1167) Regulation 3.
\textsuperscript{1171} S. 7 of the Health (Nursing Homes) Act 1990; Regulation 38 of the Nursing Homes Support Scheme Act 2009 (n 898) amended s. 7A (inserted by s. 3 of the Health (Nursing Homes) (Amendment) Act 2007) of the Health (Nursing Homes) Act 1990.
\textsuperscript{1173} “Subvention is defined as “a payment payable for a health board under s. 7 of the Health (Nursing Homes) Act, 1990 No. 23 of 1990 and these Regulations”.
\textsuperscript{1174} Regulation 8 of S.I. No. 227 of 1993.
\textsuperscript{1175} Ibid. Regulation 9.
\textsuperscript{1176} Ibid. Regulation 7.
\textsuperscript{1177} Ibid. sch. 1 No. 17 as it pertains to Regulation 7.
Accordingly dependency\textsuperscript{1178} was distinguished by virtue of its level (a) medium, (b) high or (c) maximum impairments.

(a) A person with medium dependency is considered as someone

whose independence is impaired to the extent that he or she requires nursing home care because the appropriate support and nursing care required by the person cannot be provided in the community. His or her mobility would be impaired to the extent that he or she would require supervision or a walking aid.\textsuperscript{1179}

(b) High dependency refers to a person whose

independence is impaired to the extent that he or she needs nursing home care but is not bed bound. The person may have a combination of physical and mental disabilities, may be confused at times and be incontinent. He or she may require a walking aid and physical assistance to walk.\textsuperscript{1180}

(c) Maximum dependent person is someone who is deemed “to require constant nursing care. The person is likely to have very restricted mobility, require assistance with all aspects of physical care or be confused, disturbed and incontinent.”\textsuperscript{1181}

Problems accrued with the restrictive definitions of dependency in terms of obtaining a subvention since admission to a nursing home required the person being admitted to be sufficiently dependent to warrant maintenance in a nursing home irrespective if their needs were of a medium, high or maximum dependency. While it was appropriate to distinguish care needs according to the needs of the individual differentiating subventions according to dependency levels often aggravated financial pressures for both the individual and/or their families. Reference to all dependency levels in terms of subvention was abolished by the Nursing Homes (Subvention) (Amendment) Regulations, 2006.\textsuperscript{1182}

\textsuperscript{1178} Ibid. Regulation 3 defined dependency as the “level of physical or mental dependency of a person applying for a subvention, in accordance with the meaning given to “dependent person” in s. 1(1) of the Health (Nursing Homes) Act 1990. This definition was amended by the Nursing Homes (Subvention) (Amendment) Regulations, 2006 S.I. No. 642 of 2006 by the deletion of the words “level of”.

\textsuperscript{1179} Ibid. sch. 1 para. 17.

\textsuperscript{1180} Ibid.

\textsuperscript{1181} Ibid.

\textsuperscript{1182} S.I. No. 642 of 2006. Regulation 12 provided an amendment to sch. 1 para. 17: “dependency describes a person whose independence is impaired to the extent that he or she requires nursing home care because the appropriate support and nursing care required by the person cannot be provided by the community.”

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The legislation required that an application for a subvention was to be made before the person was admitted to the nursing home.\textsuperscript{1183} This was at variance with s. 7 (1) (a) of the Health (Nursing Homes) Act, 1990 that allowed an application to be made for a subvention when the applicant was resident in the residential care setting. After the 1\textsuperscript{st} of September 1993 when a person was admitted to a nursing home and they had not secured a subvention in advance of admission they had to wait two years from the date of admission before applying for a subvention unless the chief executive officer of a health board made a determination in their favour\textsuperscript{1184} or where the person was admitted in an emergency.\textsuperscript{1185} The delay wielded further harsh sanctions against the older person and/or their family by virtue of denial of a subvention. The tension between the State’s role in enhancing the capacity of older people through strategies to keep them out of institutions and its protective role which tends to immerse older people in highly regulated lives and undermine their residual capacity did not arise as the issue was solely one of finance.

In assessing means\textsuperscript{1186} a health board took account of assets and income.\textsuperscript{1187} For example the first £6,000 of any asset or assets that the applicant owned was not taken into account when making the assessment.\textsuperscript{1188} A transfer of an asset(s) within the five years prior to the application could be included. A stipend amounting to one fifth of the weekly rate of the old age contributory pension could be retained by the older person. This sum was not included in the means assessment for the subvention.\textsuperscript{1189}

“Circumstances” was defined as “the capacity of a son and/or daughter, aged twenty one years and over residing in the jurisdiction, of a person who has qualified for a subvention to contribute towards the cost of nursing home care of his or her parent.”\textsuperscript{1190} The regulations allowed for the assessment of the capacity of a son and/or a daughter aged twenty one years and over who lived in the jurisdiction to contribute towards the cost of nursing home care of his/her parent(s).\textsuperscript{1191} Equally disturbing was the power granted to the health board when

\textsuperscript{1183} Regulation 4 of S.I. No. 227 of 1993.
\textsuperscript{1184} Ibid. Regulation 4.3.
\textsuperscript{1185} Ibid.
\textsuperscript{1186} Ibid. Regulation 3 defined means as “the income and the imputed value of assets of a person in respect of whom a subvention is being sought and the income and imputed income of his or her spouse.”
\textsuperscript{1187} Ibid. Regulation 8.
\textsuperscript{1188} Ibid. sch. 2. 9. This was increased to €11,000 by the Nursing Homes (Subvention) (Amendment) Regulations, 2005 S.I. No. 814 of 2005. These regulations also increased the asset threshold above which the subvention could have been refused, increased the threshold of the value of a person’s principle residence above which subvention could have been refused and increased the income threshold of a spouse/dependent relative resident in the principle residence. Rates were further amended with the Nursing Homes (Subvention) Amendment) Regulations, 2006 S.I. No. 642 of 2006
\textsuperscript{1189} Ibid. S.I. No. 227 of 1993, Regulation 8.2.
\textsuperscript{1190} Ibid. Regulation 3.
\textsuperscript{1191} Ibid. Regulation 9.
calculating the rate and amount of subvention to take account of the monies already paid to a
nursing home by or on behalf of a person seeking a nursing home subvention when assessing
means and circumstances.\textsuperscript{1192} Such consideration was in addition to those specified in sch. 3
relating to the requirements of Regulation 9 concerning the assessment of circumstances.

Personal allowances were increased for adult sons and daughters of an applicant for
subvention under the Nursing Homes (Subvention) Amendment) Regulations, 1996.\textsuperscript{1193} The
provisions regarding “circumstances” remained in place from the first of September 1993
until the first of January 1999 when revoked.\textsuperscript{1194}

Payment of nursing home subventions gave rise to many complaints. In the \textit{Nursing Home
Subventions: An Investigation by the Ombudsman of Complaints Regarding Payment of
Nursing Home Subventions By Health Boards}\textsuperscript{1195} report on this issue the Ombudsman was
“neutral” on whether a person’s offspring should financially contribute towards the cost of
nursing home care. He recognised that there were certain “disquieting features” with regard
to the conditions attached to application for a subvention and the assessment of capacity.\textsuperscript{1196}
He mentioned however that the legislation was implemented largely in the absence of debate
in either the Dáil or the Seanad. In his opinion this was a matter of public policy and should
therefore have been addressed by the houses of the Oireachtas.\textsuperscript{1197} The level of intrusion
into family life was not welcomed. One commentator viewed the powers of the health
boards as more onerous than the tax man.\textsuperscript{1198}

In terms of implementation of the legislation the Ombudsman was highly critical of the
manner in which older people were treated in relation to the subventions and he asserted that
“significant maladministration” occurred within Department of Health and in the health
boards.\textsuperscript{1199} Aligned to the maladministration were the defective relationships between or
within the Oireachtas, the Executive and the operating agencies.\textsuperscript{1200} The Ombudsman
considered that separation of powers between the organs of state would ultimately have to be
reviewed to address the anomalies that occurred. He clearly affirmed that human rights

\textsuperscript{1192} Ibid. Regulation 10.5.
\textsuperscript{1193} S. I. No. 225 of 1996.
\textsuperscript{1194} Nursing Homes (Subvention) (Amendment) Regulations, 1998 S.I. No. 498 of 1998.
\textsuperscript{1195} Ombudsman, 2001 (n 1163).
\textsuperscript{1196} Ibid. p. 15.
\textsuperscript{1197} Ibid. p. 6-7.
\textsuperscript{1198} Boland J., Irish Press on 19th September 1993 as cited in Ombudsman 2001 (n 1163). p. 17.
\textsuperscript{1199} Ibid. p. 73.
\textsuperscript{1200} Ibid. p. 6.
should be an integral part of the process of any future considerations of related matters addressed by the Oireachtas and the Executive.\textsuperscript{1201}

**Nursing Homes (Fees) Regulations, 1993\textsuperscript{1202}**

These Regulations set out the requirements for the payment of fees to be paid by the applicant for declaring and registering a nursing home and for seeking an application for a declaration that the applicant is a fit person to carry on a nursing home as required by s. 4 of the Health (Nursing Homes) Act, 1990.

**Health (In-Patient Services) Regulations 1993\textsuperscript{1203}**

These Regulations amend s. 52 of the Health Act, 1970 regarding the provision of services for residents in residential care settings that are registered under the Health (Nursing Homes) Act, 1990; such services are to be provided in accordance with the Health (Nursing Homes) Act 1990 and Regulations made under it. This legislation allowed health boards to place public patients in private nursing homes. Mangan\textsuperscript{1204} argued that these Regulations delimited a Health Board’s/HSE obligation to provide public long term residential care and she questions the legal validity for such change given that the amendment is provided in secondary rather than primary legislation.\textsuperscript{1205} A similar view was opined by Cousins who said that the Health (In-Patient Services) Regulations 1993 is “almost unconstitutional” and conveys “an attempt by the Minister to amend primary legislation contrary to Article 15.2.1. of the Constitution.”\textsuperscript{1206} The now much cited test on the issue was provided by O’Higgins C.J in *Cityview Press v An Chomhairle Oiliúna*\textsuperscript{1207}:

In the view of this Court, the test is whether that which is challenged as an unauthorised delegation of parliamentary power is more than a mere giving effect to principles and policies which are contained in the statute itself. If it be, then is not authorised; for such would constitute a purported exercise of legislative power by an authority which is not permitted to do so under the Constitution. On the other hand,

\textsuperscript{1201} Ibid. p. 73.
\textsuperscript{1202} S. I. No. 223 of 1993.
\textsuperscript{1203} S. I. No. 224 of 1993. These regulations amended s. 52 of the Health Act, 1970 and were revoked by the Health (Nursing Homes)(Amendment) Act 2007. Ss 52 (as amended) and 53 of the Health Act, 1970 were amended by s. 34 of the Nursing Homes Support Scheme Act 2009 (n 898); s. 53 of the Health Act, 1970 was further amended by the Health (Miscellaneous Provisions Act 2009 No. 25 of 2009.
\textsuperscript{1204} Mangan, I, “Deficiencies of the Law Relating to Care for Older People” in O’Dell, 2006 (n 7) p. 365.
\textsuperscript{1205} Ibid. In this regard she cites at fn 41 (n 1163) and O’Shea, *Review of the Nursing Home Subvention Scheme* (Dublin, Stationary Office, 2002).
\textsuperscript{1206} Cousins, M., as cited in Ombudsman 2001 (n 1163) p. 57.
\textsuperscript{1207} [1980] IR 381.
if it be within permitted limits – if the law is laid down in statute and details only are filled in or completed by the designated Minister or subordinate body – there is not unauthorised delegation of legislative power.\textsuperscript{1208}

The impact of the Health (In-Patient Services) Regulations 1993 in terms of nursing home charges can be viewed more expansively when read in conjunction with the Health Nursing Home, Act 1990 and regulations made under it. They effectively created a dual approach to charging distinguishing between public patients by virtue of their means and circumstances. Also, before this, all patients could make a choice in the selection of a nursing home. This responsibility was transferred to the health board and they were charged with securing a bed in a residential care setting.

\textbf{Social Welfare (Consolidation) Act, 1993}\textsuperscript{1209}

Section 221 of the Social Welfare (Consolidation) Act, 1993 enabled the Minister when controlling and investigating entitlement of benefits to obtain details on residents from nursing homes.\textsuperscript{1210}

\textbf{Boarding Out Regulations, 1993}\textsuperscript{1211}

The Health Boards made arrangement for boarding out of older persons partly or fully funded by the Health Boards/HSE.

\textbf{Nursing Homes (Subvention) Amendment) Regulations, 1996}\textsuperscript{1212}

The expansion of the Nursing Homes (Subvention) Regulations, 1993\textsuperscript{1213} as amended by these Regulations\textsuperscript{1214} with the insertions of Article 22.3 and 22.4 allowed a health board

\textsuperscript{1208} Ibid. p. 399; the Supreme Court restated this test in \textit{in re Article 26 and the Health (Amendment) (No. 2) Bill 2004} [2005] IESC 7 p. 16 and considered that the prospective provisions in the Bill complied with the constitution. The Court said “the imposition of charge by the Minister pursuant to the section in question would be no more than the implementation of the principles and policies contained in the Act and the power delegated to him to make the regulations is compatible with the Constitution.”
\textsuperscript{1209} No. 27 of 1993.
\textsuperscript{1210} Ibid. s. 221 provides: “For the purposes of controlling and investigating entitlement to any benefit, under this Act or under schemes administered by or on behalf of the Minister, the Minister may require such persons as may be prescribed to provide him with such information in relation to such persons or classes of persons as the Minister may determine and any person so prescribed shall be required to provide such information as may be required.” This section was amended by s. 22 of the Social Welfare Act, 1998 No. 6 of 1998; now s. 260 of the Social Welfare (Consolidation) Act 2005 No. 26 of 2005. It allows the Minister to prescribe persons that will be required by law to provide information. Non-compliance will attract a criminal offence and possible fine on summary conviction.
\textsuperscript{1211} S. I. No. 225 of 1993. See also (n 931).
\textsuperscript{1212} S. I. No. 225 of 1996.
\textsuperscript{1213} S. I. No. 227 of 1993 (n 1172).
\textsuperscript{1214} Nursing Homes (Subvention) (Amendment) Regulations, 1993.
where a person has qualified for a subvention to offer alternative care in a health board home instead of paying the subvention. In addition a health board can make arrangements to provide in-patient services in a registered nursing home (contract beds).\textsuperscript{1215} In doing so, a health board can exceed the maximum subvention rates. An amendment to paragraph 6 of the Third Schedule increased the personal allowances of adult sons and daughters of an applicant for a subvention. While the latter amendment was welcomed it did allow for the continuance of assessment of family members that was already considered to be legally flawed.\textsuperscript{1216}

**Taxes Consolidation Act 1997**\textsuperscript{1217}

Section 469 provided tax relief for particular “health expenses” including nursing home fees for a dependent relative.\textsuperscript{1218}

**Nursing Home (Subvention) (Amendment) Regulations, 1998**\textsuperscript{1219}

The provision requiring the assessment of the capacity of adult children to contribute to nursing home care costs for their parent(s) was revoked. A further amendment was the deletion and substitution of “Article 8.2”\textsuperscript{1220} of the Nursing Homes (Subvention) Regulations, 1993\textsuperscript{1221} that required health boards to disregard income equivalent to one fifth of a person’s old age non-contributory pension in assessing their means. The Ombudsman argued that this is a mere restatement, that the earlier legislation was eminently clear but was obfuscated in its interpretation.\textsuperscript{1222}

**Finance Act 1998**\textsuperscript{1223}

Part 9 of the Taxes Consolidation Act, 1997\textsuperscript{1224} as amended by s. 22 of the Finance Act 1998 allowed for capital allowances in respect of expenditure incurred on or after the 3\textsuperscript{rd} of December 1997 for construction or refurbishment of buildings used as private registered

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\textsuperscript{1215} The Northern Area Health Board purchased ‘contract beds’ in Leas Cross Nursing Home in 2003. High dependency patients were transferred from St. Ita’s Hospital. Beaumont Hospital was allocated two ‘contract beds’. See O’Donovan, 2009 (n 32) pp. 59 and 269; see also Ch. 7 of this work.

\textsuperscript{1216} Ombudsman 2001 (n 1163) p. 32.

\textsuperscript{1217} No. 39 of 1997; amended by s. 48 of the Nursing Homes Support Scheme Act 2009 (n 898) that provided exemption in respect of payments of State support i.e. care services.

\textsuperscript{1218} S. 466 of the Act deals with dependent persons.

\textsuperscript{1219} S.I. No. 498 of 1998. The Regulations came into operation on the 1\textsuperscript{st} January 1999.

\textsuperscript{1220} As cited in the Regulations.

\textsuperscript{1221} S.I. No. 227 of 1993.

\textsuperscript{1222} Ombudsman 2001 (n 1163) p. 41.

\textsuperscript{1223} No. 3 of 1998.

\textsuperscript{1224} No. 39 of 1997.
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nursing homes. Section 22 of the Finance Act 1998 provides a tax shelter for investors of 15 per cent per annum for six years and 10 per cent per annum in year seven. Investors may have been attracted by the investment potential that allows capital allowances which an individual can offset against all sources of income rather than motivated by the need to provide quality care for older people in community settings. Legislators ignored the recommendations of the Vienna International Plan of Action on Ageing 1983 that recognised, “[i]n the case of institutional care alienation through isolation of the aged from society should be avoided inter alia by further encouraging the involvement of family members and volunteers.” For many older people who are unable or no longer fit to drive or where public transport is not available to the residential care setting, they are effectively prevented from visiting a loved one in residential care. For some of the more fortunate a family member or neighbour may be able to bring them at the week-end. The remote location of these nursing homes has been identified as worrying by An Bord Pleanála where planning appeals for such developments have come before the board. In particular the chairman stated that “the locations of some are singularly inappropriate in planning terms and even in terms of future occupiers, operators and employees.” He further states that “a number of large scale nursing homes have been proposed in isolated green-field sites remote from towns or villages, shops or services of any description” and that “invariably, these have been refused by the Board.”

Such a principled and pragmatic approach is to be welcomed. Disappointingly however some local authorities do not apply the same criteria in their decision-making. Unfortunately some approved new developments and change of use of older premises have not been referred to An Bord Pleanála and residents are now sequestered in remote locations that are not accessible to their family, friends, shops, hair dressers or other services providers. In addition a further financial burden is placed on many older people and their families where an older person has to travel by taxi for a hospital or other appointment for example a chiropodist given the remote location of the residential care centre. Frequently a care assistant accompanies the resident which will place an added charge on most residents.

1225 To qualify for the allowances the nursing home must come within the meaning of the Health (Nursing Homes) Act, 1990.
1227 Limits may apply in certain circumstances, for example, a ceiling applies to a passive investor (person who has no active involvement in the trade of the nursing home) against non-rental income however there is no ceiling on the capital allowances that can be offset against rental income.
1228 Para. 62. See Ch. 2 of this work for discussion on the Vienna Plan.
1230 Ibid.
1231 Ibid.
An Bord Pleanála has rightly recognised that the optimum locations for residential care homes for older people is one that is accessible to people and services while affirming the importance of sufficient outdoor space at the nursing home.\textsuperscript{1232} This ties in with the requirements Article 19 of the CRPD to live independently and be included in the community.\textsuperscript{1233}

**Finance Act 2000\textsuperscript{1234}**

Convalescent homes are to be treated as nursing homes. Section 36 (i) of the Finance Act 2000\textsuperscript{1235} amends s. 268(1) of the Taxes Consolidation Act, 1997\textsuperscript{1236} that pertains to capital allowances for expenditure on private convalescent facilities. As a result of the amendment convalescent homes are brought within the ambit of the Health (Nursing Homes) Act, 1990 and subsequent regulations made under s. 6 of that Act. Another consequence of this amendment is that guidelines for convalescent homes required under s. 48 of the Finance Act 1999 will no longer be required.

**Finance Act, 2002\textsuperscript{1237}, 2004\textsuperscript{1238} and 2007\textsuperscript{1239}**

Further investment could be secured by investors under the capital allowance scheme for associated housing units for older people with the amendment of s. 268 of the Taxes Consolidation Act 1997 by s. 33 of the Finance Act, 2002. The tax relief is the same as the existing relief for nursing homes. The main conditions of the scheme is that the ‘qualifying residential unit’ is on the site of or a site immediately beside a registered nursing home, that the units are designed to meet the specific needs of the resident and that there is back up nursing and medical care available if required by the residents. The requirement by s. 33 of the Finance Act 2002 for a minimum of 20 units on the site was reduced to 10 by amendment of s. 268(3A) of the Taxes Consolidation Act 1997 by s. 23 of the Finance Act

\textsuperscript{1232} Ibid.  
\textsuperscript{1233} (n 125, n 126, n 127).  
\textsuperscript{1234} No. 3 of 2000.  
\textsuperscript{1235} S. 36(i) provides: “for the purposes of a trade which consists of the operation or management of a convalescent home for the provision of medical and nursing care for persons recovering from treatment in a hospital, being a hospital that provides treatment for acutely ill patients, and in respect of which convalescent home that health board in whose functional area the convalescent home is situated, is satisfied that the convalescent home satisfies the requirements of ss. 4 and 6 of the Health (Nursing Homes) Act, 1990, and any regulations made under s. 6 of that Act as if it were a nursing home within the meaning of section 2 of that Act.”  
\textsuperscript{1236} No. 39 of 1997.  
\textsuperscript{1237} No. 5 of 2002.  
\textsuperscript{1238} No. 8 of 2004.  
\textsuperscript{1239} No. 11 of 2007.
2004. Section 268(3A) as amended also provided for the change from “a house comprised in a two storey building to one” to “one or more storeys” once it had a fire certificate.\footnote{1240}{Building Control Regulations 1997 S.I. No 496 of 1997 Part 111. No. 14 of 2001. Amended The Tobacco (Health Promotion and Protection) Act, 1988 No. 24 of 1988. These provisions apply to community settings. Regulation 14 provides for the “laying of regulations in draft before Houses of the Oireachtas.” As amended, s. 6 (7) of the Health (Nursing Homes) Act, 1990. S. 3 (b) of the Health (Miscellaneous Provisions) Act, 2001. S.I. No. 179 of 2004; amended by Nursing Homes Support Scheme Act 2009 (n 898) s.41. See Dáil Debate Vol. 555 No. 5, para. 320. (n 898) s. 41 (1) (b)(ii). Ibid. s. 40.} Section 28 of the Finance Act, 2007 allows for capital allowances for qualifying residential units associated with registered nursing homes having first supplied the requisite data to the HSE.

**Health (Miscellaneous Provisions) Act, 2001**\footnote{1241}{No. 14 of 2001. Amended The Tobacco (Health Promotion and Protection) Act, 1988 No. 24 of 1988. These provisions apply to community settings. Regulation 14 provides for the “laying of regulations in draft before Houses of the Oireachtas.”} Section 1 of the Health (Miscellaneous Provisions) Act, 2001 amended ss. 45 and 59\footnote{1242}{Amended The Tobacco (Health Promotion and Protection) Act, 1988 No. 24 of 1988. These provisions apply to community settings. Regulation 14 provides for the “laying of regulations in draft before Houses of the Oireachtas.”} of the Health Act, 1970. The amendment to s. 45 provided all persons over aged 70 years and over with full eligibility for medical services. Section 59 augmented the provision of pharmacological preparations and surgical and medical appliances.\footnote{1243}{As amended, s. 6 (7) of the Health (Nursing Homes) Act, 1990.} Section 3 of 2001 Act amended ss. 6, 7 and 14\footnote{1244}{As amended, s. 6 (7) of the Health (Nursing Homes) Act, 1990.} of the Health (Nursing Homes) Act, 1990 by empowering the Minister to (a) “make different provisions for different classes of nursing homes, and (b) prescribe different requirements for different classes of nursing homes,”\footnote{1245}{As amended, s. 6 (7) of the Health (Nursing Homes) Act, 1990.} and to alter the arrangements in place with regard to subvention payments.\footnote{1246}{As amended, s. 6 (7) of the Health (Nursing Homes) Act, 1990.} Even though these legislative provisions enabled the Minister to make regulations with regards to standards in private nursing homes this facility was never availed of.

**National Treatment Purchase Fund Board (Establishment) Order, 2004**\footnote{1247}{S.I. No. 179 of 2004; amended by Nursing Homes Support Scheme Act 2009 (n 898) s.41. See Dáil Debate Vol. 555 No. 5, para. 320. (n 898) s. 41 (1) (b)(ii). Ibid. s. 40.} The National Treatment Purchase Fund (NTPF) was established in April 2002 to provide private care to public patients who were the longest on in-patient waiting lists.\footnote{1248}{See Dáil Debate Vol. 555 No. 5, para. 320. (n 898) s. 41 (1) (b)(ii). Ibid. s. 40.} Financial support for the provision of long term residential care in a nursing home is dependent on the nursing home being approved.\footnote{1249}{See Dáil Debate Vol. 555 No. 5, para. 320. (n 898) s. 41 (1) (b)(ii). Ibid. s. 40.} The NTPF Board is the authorised body\footnote{1250}{Ibid. s. 40.} to negotiate with proprietors of registered private and voluntary nursing homes the maximum prices of long term care under the Nursing Homes Support Scheme Act 2009. The NTPF Board may examine records and accounts of an approved nursing home or those of a nursing home

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seeking approval as a nursing home under the 2009 Act.\textsuperscript{1251} There is a recommendation for the abolishment of the NTPF with prospective funding returned to the HSE.\textsuperscript{1252}

**Health (Amendment) (No. 2) Bill 2004**

By amending s. 53 of the Health Act 1970 the Bill sought to (a) validate charges retrospectively, made on and paid by many medical card holders for in-patient services that they should have received free\textsuperscript{1253} and (b) to impose such charges prospectively on future in-patient services. The Bill was struck down by the Supreme Court,\textsuperscript{1254} the Court stating that “the retrospective provisions of the Bill ... are repugnant to the Constitution and in particular Articles 43 and 40.3.2.”\textsuperscript{1255} In the matter of the prospective payment not exceeding 80 per cent of the maximum weekly rate of the old age (non-contributory) pension within the meaning of the Social Welfare Acts the Court was of the opinion that such a payment was not considered an infringement of rights leading to undue hardship or restriction in access to services given that such charges could be removed or reduced should undue hardship result from making the payment.\textsuperscript{1256}

**Health (Amendment) Act 2005**\textsuperscript{1257}

In determining full eligibility\textsuperscript{1258} for health services s. 45 of the Health Act 1970 (as amended)\textsuperscript{1259} provided for account to be taken of a person’s reasonable expenditure with regard to himself or herself and his or her dependents.

Section 53 of the Health Act 1970 was amended by s. 4 of the Health (Amendment) Act 2005 that includes arrangements for charges to be made for in-patient services for person(s) who do not have full eligibility. Such weekly charges are not to exceed 80 per cent of the maximum of the weekly rate of the non-contributory old age pension within the meaning of

\textsuperscript{1251} Ibid. s. 41 (1) (b)(iii).
\textsuperscript{1253} Health Act 1970, (n 694) s. 53.
\textsuperscript{1255} Ibid. p. 44.
\textsuperscript{1256} Ibid. p. 13.
\textsuperscript{1257} No. 3 of 2005.
\textsuperscript{1258} Those eligible for a medical card.
\textsuperscript{1259} Health (Amendment) Act 1991 No. 15 of 1991 s. 2 amended by Health (Amendment) Act 2005 s. 1.
the Social Welfare Acts and where such payment would not cause undue financial hardship to that person.\textsuperscript{1260}

\textbf{Health (Repayment Scheme) Act 2006}\textsuperscript{1261}

This legislation sets out the arrangement for repayment of recoverable health charges to the relevant person or a person connected to them\textsuperscript{1262} and regulates patients’ private property.

\textbf{Health (Nursing Homes) Amendment Act 2007}\textsuperscript{1263}

In order to secure a nursing home subvention an applicant must satisfy the needs and financial assessment requirements. A nursing home needs assessment of an applicant seeking a nursing home subvention is carried out by a competent person as prescribed by s. 7B (1) and is

made on the basis of (a) the applicant’s ability to carry out the activities of daily living, including the applicant’s-(i) degree of mobility, (ii) ability to dress unaided, (iii) ability to feed unaided, (iv) ability to communicate, (v) extent of orientation, (vi) cognitive ability, (vii) ability to bathe unaided, and (viii) degree of continence, (ix) the family and community support available to the applicant, (x) the medical services the applicant is receiving, and (xi) any other matter which affects the applicant’s ability to care for himself or herself.\textsuperscript{1264}

The detailed requirements in terms of the financial assessment\textsuperscript{1265} are located in the appendix.\textsuperscript{1266}

\textbf{Health Act 2008}\textsuperscript{1267}

Section 3 of the Health Act 2008 amended s. 45 of the Health Act 1970\textsuperscript{1268} as amended by s.1 of the Health Act (Miscellaneous) Provisions 2001\textsuperscript{1269} with the introduction of means testing for persons aged 70 years and over to qualify for full eligibility of services.

\begin{itemize}
  \item \textsuperscript{1260}Ibid. s. 4 of Health (Amendment) Act 2005.
  \item \textsuperscript{1261}No. 17 of 2006, see also Health (Repayment Scheme) (Further Functions of Connected Persons) Regulations S.I. No. 212 of 2008.
  \item \textsuperscript{1262}Ibid. s. 5 of No. 17 of 2006.
  \item \textsuperscript{1263}No. 1 of 2007.
  \item \textsuperscript{1264}Ibid. s. 7B (2) of the Health (Nursing Homes) (Amendment) Act 2007.
  \item \textsuperscript{1265}Ibid. s. 7B (3) subject to subsection (4).
  \item \textsuperscript{1266}See Appendix 10 in this work.
  \item \textsuperscript{1267}No. 21 of 2008. Effective from 1\textsuperscript{st} January 2009.
  \item \textsuperscript{1268}No. 1 of 1970 (n 694).
  \item \textsuperscript{1269}No. 14 of 2001.
\end{itemize}
Health (Repayment Scheme) (Further Functions of Connected Persons) Regulations 2008

These Regulations made under s. 20 of the Health (Repayment Scheme) Act 2006 enable a connected person or a further connected person to continue with an application for repayment or appeal a decision made under s. 16 of the Act without the need to renew the application where the initiator of the application (relevant person or a connected person) has become unwilling or unable to continue with the application.

Nursing Homes Support Scheme Act 2009

This Act deals with the establishment of the Nursing Home Support Scheme that may provide financial support to those who need long term residential care in public, voluntary and approved private nursing homes where the person seeking support has had their care needs assessed and a determination made on whether the person needs or does not need care services. The findings of the care needs assessment does not imply that the HSE will arrange or provide the identified care services. It merely indicates the most appropriate care needs of a person.

In making a determination the HSE will also have regard for the applicant’s financial assessment. The financial assessment will determine the amount the applicant contributes towards their residential care. According to the terms of the Scheme a resident will contribute 80% of their income, up to 15 per cent of their prime residence (consisting of 5 per cent per year capped at 3 years) and 5 per cent of any other assets each year towards the cost of care.

A major short-coming of the scheme for non-medical card holders is that the charge does not include physiotherapy, chiropody, specialised wheelchairs, incontinence wear.

In order to become approved for the purposes of the scheme a private nursing home must satisfy the following criteria: the nursing home must be registered and subject to inspection by HIQA, the proprietor of the nursing home must have agreed a price for the scheme with the National Treatment Purchase Fund and the registered proprietor must hold a valid tax

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1271 No. 15 of 2009; the scheme commenced on the 27th October 2009.
1272 Ibid. ss. 7 and 7(8).
1273 The scheme was closed to applicants for a period of time in 2011.
1274 No. 15 of 2009 (n 1271) s. 7 (11).
1275 Ibid. s. 10(2).
1276 The first €36k (€72k for a couple) of a person’s/couples assets are not included in the financial assessment.
clearance certificate in accordance with s. 1095 (as substituted by s. 127(b) of the Finance Act 2002) of the Taxes Consolidation Act 1997. 1277

In evaluating an applicant’s care needs, the assessor includes the following:

(a) the person’s ability to carry out the activities of daily living, including the cognitive ability, the extent of orientation, the degree of mobility, the ability to dress unaided, the ability to feed unaided, the ability to communicate, the ability to bathe unaided, and the degree of continence, of the person,

(b) the family and community support that is available to the person,

(c) the medical, health and personal social services being provided to or available to the person both at the time of the carrying out of the assessment and generally,

(d) any other matter that affects the person’s ability to care for himself or herself, and

(e) the likelihood of a material alteration in the circumstances referred to in paragraph (a) to (d) during the lifetime of the person. 1278

There is a presumption that any contract for care services is valid when such services under s. 7 have been identified by the HSE as appropriate for the health and welfare of the person whether such a person had capacity to sanction their approval of the contract or the care services were secured on their behalf. 1279

A court may appoint one or more persons to be an older person’s care representatives where the older person does not have full capacity (as confirmed by at least two medical practitioners who examined the older person) 1281 and where the older person is not excluded by virtue of the following: 1282

(i) is a ward of court,

(ii) has appointed an enduring power of attorney, where

(a) if registered, such registration has not been cancelled and

(b) the attorney is not precluded by the term of the appointment from carrying out functions under this section namely,

(a) the making of an application for ancillary State support,

1279 Ibid. s. 7(6).
1280 Ibid. s. 43.
1281 Ibid. s. 21(6); the Nursing Homes Support Scheme Act 2009 (Commencement) Care Representatives and Regulations) Order 2009 S.I. No. 381 of 2009 commended parts of s. 3 that were not already in operation together with ss. 21, 22 and 36. See also discussion in this Ch. on the Nursing Homes Support Scheme (Assessment of Capacity Report) Regulations 2009 S.I. No. 409 of 2009.
1282 Ibid. s. 21 (18)(a).
1283 Ibid. s. 21 (3).
(b) consenting to the creation of a charge in relation to an interest in land situated within the State,
(c) taking necessary actions in connection with the application for ancillary State support, the making of an order under section 17(2) or the registration of such order in the Land Registry or the registry of Deeds (including the perfection of the title of the person to whom the application relates)\(^{1283}\)

(iii) where a person is permitted by law to act on their behalf.\(^{1284}\)

In terms of care representatives, a person is deemed not to have capacity to make a decision where they are unable

(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his or her decision (whether by talking, using sign language or any other means) or, if the decision requires the act of a third party to be implemented, to communicate by any means with that third party.\(^{1285}\)

A care representative must act in the best interests of the older person they are representing, to maintain records of their actions and to give assistance to the HSE with regard to registration of an order for ancillary support.\(^{1286}\) Sections 21 and 22 of the Act that enabled the appointment of care representatives became operational on the 5\(^{th}\) October 2009 with the commencement of the Nursing Home Support Scheme Act 2009 (Commencement) (Care Representatives and Regulations) Order 2009.\(^{1287}\)

Charges may be levied by the HSE for care services.\(^{1288}\) Section 44 enables the HSE to specify forms required under the scheme. This section was commenced on the 28\(^{th}\) September 2009 with the Nursing Homes Support Scheme Act 2009 (Commencement) (Specified Forms) Order 2009.\(^{1289}\)

This legislation is commonly known as the fair deal scheme but this is a misnomer given that essential services that may be required, for example, to maximise/preserve mobility in the form of essential physiotherapy and speech therapy following a stroke may not be

\(^{1283}\) Ibid. s. 21 (1).
\(^{1284}\) Ibid. s. 21 (3).
\(^{1285}\) Ibid. s. 21 (43).
\(^{1286}\) “Ancillary State Support”, is a money loan advanced by the HSE under Part 3 of the Act.
\(^{1287}\) S.I. No. 381 of 2009.
\(^{1288}\) S. 33 of the Nursing Homes Support Act 2009 (n 898).
\(^{1289}\) S.I. No. 394 of 2009.
included in the scheme. From a psychological perspective the hair-dresser can provide enormous benefit in terms of well-being. Disappointingly such service is not included in the scheme. Recent criticism of the scheme highlights charges that may be levied on the older person or their family with regard to transport to clinics, toiletries, incontinence pads and laundry services as such charges may fall outside the scheme.

**Nursing Homes Support Scheme Act 2009 (Commencement) (Certain Provisions) Order 2009**

This Order commenced ss. 40 and 41 of the Nursing Homes Support Scheme Act 2009 to facilitate the NTPF to negotiate and agree prices with owners of private nursing homes with regard to the Nursing Homes Support Scheme (fair deal scheme). The Order also commenced the definitions of “approved nursing home” and “long-term residential care services” in terms of ss. 40 and 41.

**Nursing Homes Support Scheme (Making and Discharge of Orders) Regulations 2009**

These Regulations prescribe the format of Charging Orders made under the Nursing Homes Support Scheme Act 2009 with regard to an application for ancillary State support and they prescribe the format of applications and receipts for the release or discharge of these Charging Orders.

**Nursing Homes Support Scheme (Assessment of Capacity Report) Regulations 2009**

These Regulations came into effect on the 5th October 2009. They are concerned with the appointment of care representatives in the case of a person not having full capacity to make a decision with regard to “(a) making an application for Ancillary State support (the “Nursing Home Loan”), (b) consenting to the creation of a (“Charging Order”) in relation to the asset

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1290 A national survey of 60 nursing homes in Ireland indicated that 1 in 6 older people in residential care have suffered a stroke and “a wide range of disabilities.” Functional and cognitive problems experienced by post-stroke residents include communication difficulty, swallow difficulty, cognitive impairment, positioning needs, limited independence, risk of falls, decreased independence in transfers (bed to chair and back), decreased balance, poor mobility/mobility needs and residual weakness after stroke. For further discussion see Cowman, S., Royston, M., Hickey, A., Horgan, F., McGee, H., O’Neill, D. “Stroke and Nursing Home care: a national survey of nursing homes” 2010 10 4 BMC Geriatrics. Available at [http://www.biomedcentral.com/1471-2318/10/4](http://www.biomedcentral.com/1471-2318/10/4). Last accessed 5th October 2012.

1291 Irish Independent 24th September 2012. A review of the scheme has recently being undertaken by the DOHC. The closing date for submissions was the 16th July 2012. At the time of writing the report of the review has not been published.

1292 S.I. No. 256 of 2009.


concerned” and related matters. The Regulations prescribe the format of reports for submission to the Circuit Court by medical practitioners in keeping with the provisions of s.21 of the Nursing Homes Support Scheme Act 2009. Importantly it includes a capacity assessment.

**Nursing Homes Support Scheme Act 2009 (Commencement) (Remaining Provisions) Order 2009**

This order signed on the 22th October 2009, commenced any outstanding provisions of the Nursing Homes Support Scheme Act 2009.

**Nursing Homes Support Scheme (Collection and Recovery of Repayable Amounts) Regulations 2009**

These Regulations came into effect on the 2nd of November 2009. They make provision for the collection and recovery of any repayable amount of monies advanced by way of ancillary State support by the Revenue Commissioners, acting as agents for the HSE on foot of the provisions of the Nursing Homes Support Scheme Act 2009. The Regulations set timeframes for the repayment of monies advanced by way of ancillary State support by the relevant accountable person. Failure to pay may attract the following consequences; firstly, a written notice from the Revenue Commissioners demanding payment together with any interest accruing within seven days from receipt of the notice and secondly, where payment does not result the Revenue Commissioners may commence recovery procedures. The rules of the court applicable to civil proceedings apply in this context.

**Conclusion**

A re-orientation in thinking is required to enable older people to remain in their own homes for as long as possible. Support tailored to the needs of individuals may be required. Tax incentives for the development of residential accommodation in isolated areas should be

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1295 Ibid. sch. 1 s. 2. 1.
1296 Ibid. s. 2. 1(c).
1297 Ibid. Regulation 3.
1298 S.I. No. 423 of 2009.
1300 Ibid. Regulation 5.
1301 Ibid. Regulation 3(1) and (2); s. 26 (16) of the Nursing Homes Support Scheme Act 2009 (n 898) defines “relevant accountable person” as “(a) a person who as respects a particular relevant or deferred relevant event is primarily accountable, and (b) a person who is accountable by reason of subsection 14, for the payment of repayable amount to the Revenue Commissioners”; subsection 14 provides: “[a] person who becomes entitled to an interest in the asset against which the repayable amount is secured shall also be accountable for payment of the repayable amount to the Revenue Commissioners.”
1302 Ibid. Regulations 3(3), 4, 5(1)-5(5).
1303 Ibid. Regulation 5(6).
discontinued. The Nursing Homes Support Scheme Act 2009 needs to be amended to include essential services that may be required such as physiotherapy and speech therapy following a stroke.

**Statutory Based Bodies**

**The National Council for Ageing and Older People, the National Disability Authority, the Ombudsman, the Human Rights Commission, the Equality Authority and the Equality Tribunal**

**The National Council on Ageing and Older People (Establishment) Order 1997**

The National Council on Ageing and Older People (NCAOP) was established on the 19th March 2007 by the National Council on Ageing and Older People (Establishment) Order 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The main function of the NCAOP was to inform the Minister of Health on all matters with regard to ageing and welfare of older people. Such information was to be given on request by the Minister or self-initiated by the Council, especially information pertaining to older people, and to include means to promote health, means to encourage social inclusion, advice on implementing recommendations contained in policy reports undertaken at the behest of the Minister, co-ordination between public bodies at national and local level in the planning and delivery of services, facilitation of a greater working relationship between statutory and voluntary bodies in providing services, means to

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1304 S.I. No. 120 of 1997; the Order established under the Health (Corporate Bodies) Act 1961 No. 27 of 1961 as amended by s. 22 of the Health (Amendment) Act, No. 3 1996, the National Council on Ageing and Older People.


1306 A national council for older people was first proposed in the Inter-departmental Committee on the Care of the Aged Report 1968 at p. 112. The National Council for the Elderly and the National Council for the Aged were both administered by the National Social Services Board. See Dáil Debates Vol. 347, 25th January 1984.

1307 Ibid. 4 (1) (a).

1308 Ibid. 4 (1) (b).

1309 Ibid. 4 (1) (a).

1310 Ibid. 4 (1) (a).

1311 Ibid. 4 (1) (d).

1312 Ibid. 4 (1) (e).
address the needs of the most vulnerable\textsuperscript{1313}, promotion of positive ageing\textsuperscript{1314}, enabling greater participation\textsuperscript{1315} and to develop and plan services based on research.\textsuperscript{1316}

In addition the Council was charged with assisting in the creation of national and regional policies and strategies to augment social and health gain for older people\textsuperscript{1317} by conducting research on the needs and lifestyle of older people\textsuperscript{1318}, defining and promoting models of care and service delivery to older people\textsuperscript{1319}, to ensure that those involved in the development of policies and/or implementation of policies and services were furnished with relevant research based findings\textsuperscript{1320} and liaising with relevant statutory, voluntary and professional bodies who have a responsibility for creating and/or implementing policies for health or social gain on either a national or regional basis.\textsuperscript{1321}

The Council could if requested provide advice on ageing and older people to other Ministers.\textsuperscript{1322} Furthermore the Council was responsible for advancing understanding of ageing and older people\textsuperscript{1323}, supporting measures with regard to health, welfare and autonomy\textsuperscript{1324} and networking with like-minded bodies in other jurisdictions.\textsuperscript{1325}

**Health (Miscellaneous Provisions) Act 2009\textsuperscript{1326}**

As part of the rationalisation of public sector agencies, the Act enabled the advancement of arrangements for the creation of the Office of Older People within the Department of Health and Children. The NCAOP was dissolved by s. 5 of the Act\textsuperscript{1327} and the order was brought into operation on the 1\textsuperscript{st} September 2009 by the Health (Miscellaneous Provisions) Act 2009 (Commencement) Order 2009.\textsuperscript{1328}

\textsuperscript{1313} Ibid. 4 (1) (f).
\textsuperscript{1314} Ibid. 4 (1) (g).
\textsuperscript{1315} Ibid. 4 (1) (h).
\textsuperscript{1316} Ibid. 4 (1) (i).
\textsuperscript{1317} Ibid. 4 (2).
\textsuperscript{1318} Ibid. 4 (2) (a).
\textsuperscript{1319} Ibid. 4 (2) (b).
\textsuperscript{1320} Ibid. 4 (2) (c).
\textsuperscript{1321} Ibid. 4 (2) (d).
\textsuperscript{1322} Ibid. 4 (5).
\textsuperscript{1323} Ibid. 4 (4).
\textsuperscript{1324} Ibid. 4 (3).
\textsuperscript{1325} Ibid. 4 (5).
\textsuperscript{1326} No. 25 of 2009.
\textsuperscript{1327} S. 14 revoked The National Council on Ageing and Older People (Establishment) Order 1997 S.I. No. 120 of 1997. See also Prospectus Report, 2003 (n 704) recommendation 4.1.
\textsuperscript{1328} S.I. No. 288 of 2009.
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National Disability Authority Act, 1999\textsuperscript{1329}

The Commission on the Status of People with Disabilities (the Commission) published its extensive report in 1996 that brought about a change in the mind set in the state with regard to persons with disabilities.\textsuperscript{1330} The Commission’s equality strategy took account of legislative solutions, new policy and new structures for the delivery of a rights based service keeping the person with a disability centre-stage.\textsuperscript{1331} The National Disability Authority (NDA) was established as an independent statutory authority in June 2000 under the National Disability Authority Act, 1999. The functions of the NDA are set out in s. 6 of the Act. One of its functions is to “assist in the development of statistical information appropriate for the planning, delivery and monitoring of programmes and services for persons with disabilities.” Older people however, are not included on the national disability database. The impact of this exclusion was that a disabled person reaching the age of sixty five was effectively removed from the disability services with the consequent risk of inadequate planning for health and social care needs, including long stay residential care.\textsuperscript{1332}

Ombudsman Act 1980\textsuperscript{1333}

This legislation allows for investigation of actions of public bodies including administrative functions of the Department of Health and of the HSE\textsuperscript{1334} by the Ombudsman where it appears to her having first carried out a preliminary examination,

(a) that the action has or may have adversely affected a person ... and (b) that the action was or may have been (i) taken without proper authority, (ii) taken on irrelevant grounds, (iii) the result of negligence or carelessness, (iv) based on erroneous or incomplete information, (v) improperly discriminatory, (vi) based on an undesirable administrative practice, or (vii) otherwise contrary to fair or sound administration.\textsuperscript{1335}

\textsuperscript{1329} No. 14 of 1999; the NDA was established on the 12\textsuperscript{th} June 2000 by the National Disability Authority Act, 1999 (Establishment Day) Order, 2000 S. I. No. 162 of 2000. The National Rehabilitation Board established by the National Rehabilitation Board (Establishment Order) 1967 S.I. No. 300 of 1967 was dissolved and revoked on the 12\textsuperscript{th} June 2000 by the National Rehabilitation Board (Dissolution and Revocation) Order, 2000 S.I. No. 171 of 2000.
\textsuperscript{1331} Ibid. Flood, J., Forward.
\textsuperscript{1332} NDA, \textit{Response to Human Rights Commission Consultation Document on Older People in Long Stay Care} (Dublin, NDA, 2002).
\textsuperscript{1333} No. 26 of 1980; amended by s. 40 of the Disability Act 2005.
\textsuperscript{1334} Ombudsman Act (First Schedule) (Amendment) Order, 1984 S.I. No. 332 of 1984. S. 4 (a) and (b) of the Ombudsman Act 1980.
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The Ombudsman may not investigate a person(s) acting on behalf of the HSE or those (in the opinion of the Ombudsman) acting solely in the exercise of clinical judgement when diagnosing, treating or caring for a patient “whether formed by the person taking the action or any other person.”\(^{1336}\) Nor may she investigate the HSE when they act on the advice of such a person(s) where the HSE actions in the opinion of the Ombudsman resulted solely on that advice.\(^{1337}\)

Having carried out a preliminary examination of the issue the Ombudsman may not decide to carry out an investigation under the Act if the complaint is trivial or vexatious or she is of the opinion that the complainant does not have sufficient interest in the issue or has not taken reasonable steps to seek redress in respect of the issue or if he has taken such steps has not been refused.\(^{1338}\)

Complaints must be brought to the Ombudsman’s attention within 12 months or when the complainant first become aware of the matter whatever is the later.\(^{1339}\) An extensive investigation was carried out by the Ombudsman into complaints on behalf of older people who were unable to access long-term residential care from their respective health boards (HSE).\(^{1340}\)

The Ombudsman is precluded from investigating a complaint where the affected person has initiated civil proceedings\(^{1341}\) or “the person affected has a right conferred by or under statute, of appeal, reference or review to or before a court in the State”\(^{1342}\) or where such a person “has a right of appeal, reference or review to or before a person other than the Department of Health” or the HSE.

Section 7 (3) provides: “A person shall not by act or omission obstruct or hinder the Ombudsman in the performance of his functions or do any other thing which would, if the Ombudsman were a court having power to commit for contempt of court, be contempt of such court.”

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\(^{1336}\) Regulation 2 (b)(a) of the Ombudsman Act (First Schedule) (Amendment) Order, 1984.

\(^{1337}\) Ibid. 2 (b)(b).

\(^{1338}\) S. 4 (5) of the Ombudsman Act 1980.

\(^{1339}\) Ibid. s. 5 (1)(f).

\(^{1340}\) Ombudsman, 2010 (n 1163).


\(^{1342}\) Ibid. s. 5 (1)(a)(ii).
Ombudsman (Amendment bill) 2010

The proposed Ombudsman (Amendment) Bill extends the remit of Ombudsman to include bodies such as HIQA and the National Treatment Purchase Fund.


The purpose of the 2000 Act was to set up the Human Rights Commission and define its functions that would provide greater protection for human rights. Section 8(a) permits the Commission to “keep under review the adequacy and effectiveness” of legislative provisions and their implementation that concern the protection of human rights. “Human rights” have been defined by s. 2 as,

(a) the rights, liberties or freedoms conferred on, or guaranteed to, persons by the Constitution, and

(b) the rights, liberties or freedoms conferred on, or guaranteed to, persons by any agreement, treaty or convention to which the State is a party.

Under s. 8(H) of the 2000 Act the Commission may apply to the High Court or the Supreme Court for permission to appear as amicus curiae (‘friend of court’) in any proceedings pertaining to the rights of any person. Legal representation and legal assistance may be provided by the Commission in some situations. Criticism has been levied at the inadequate resourcing of the Commission that impedes its ability to adequately carry out one of its statutory functions as a litigator. O’Connell and others further recognise that the Commission is ideally placed if properly resourced to support ‘organs of state’ carrying out their functions under s. 3 of the ECHR Act.

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1343 The (Ombudsman (Amendment) Act 2012 passed its final stage in the Dáil on the 23rd October 2012.
1346 See also the definition as provided by s. 11 of Human Rights Commission Act 2000.
1349 Ibid. p. 121.
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The Irish Human Rights Commission (IHRC) has identified seven reasons for offering Human Rights Training\textsuperscript{1350} to civil and public servants:

1. to augment ‘business performance’ and advance ‘productivity and efficiency,’
2. to retain ‘highly professional’ staff through increased ‘employee satisfaction,’
3. to enhance staff skills to enable them to ‘deliver people-centred public service,’ and
4. to foster staff skills to aid ‘policy formation,’
5. increased customer satisfaction due to increased effectiveness,
6. benefits may accrue to the staff themselves in terms of securing ‘their own rights and those of others,’
7. the inclusion of human rights training for staff may ‘help to avoid litigation.’\textsuperscript{1351}

The Working Group on the Irish Human Rights and Equality Commission Report to the Minister for Justice and Equality and Defence detailed the practical arrangements with regards the merging of these two bodies into a new Human Rights and Equality Commission.\textsuperscript{1352} Among the recommendations it has considered is the need for public bodies to have a statutory duty to take account of equality and human rights. The reasons for the need for human rights training apply equally to workers in private nursing homes and ultimately the ‘other’ beneficiaries of such training (as referred to in No. 6 above) are the older people in a residential care setting.

Equality Authority
The Equality Authority is an independent body set up under the Employment Equality Act 1998 and established on 18th October 1999. As discussed previously the Equal Status Act, 2000 prohibits discrimination based on nine distinct grounds.\textsuperscript{1353}

The Authority clearly recognises the importance of older people residing in their own community should they so wish with the appropriate supports and services where needed and the importance of key workers in this regard.\textsuperscript{1354} Where long term care is required the Authority states that “[i]f quality and systems for policing quality standards are not to the

\textsuperscript{1350}IHRC Annual Report 2011 published June 2012, p. 34 details types of training modules in place and records that face to face training was given to 350 civil and public servants. http://www.ihrc.ie/download/pdf/ihrc_annual_report_2011.pdf Last accessed July 8\textsuperscript{th} 2012.

\textsuperscript{1351}Available at http://www.ihrc.ie/humanrightseducation/civilandpublics.html Accessed 13th September 2010.

\textsuperscript{1352}19\textsuperscript{th} April 2012.

\textsuperscript{1353}See this Ch. para titled Equal Status Act 2000 and para titled Equality Provision.

fore also there is a danger that we may be simply warehousing older people who can no
longer survive in our existing communities.” 1355

Equality Tribunal
The Equality Tribunal is an independent, quasi-judicial forum responsible for, among other
things, the interpretation and application of the Equal Status Acts 2000–2011.1356 The
Tribunal is empowered to mediate and investigate complaints of alleged discrimination.
However to date there has been no recorded cases relating to discrimination and older people
in residential care.

Additional Legal Provisions
In this section criminal provisions have the potential to apply to older people in residential
care. These include issues around personal security, sexual offences and theft and fraud
offences which are recognised as applying to older people generally. For completeness this
discussion also takes account of torts and harm to the person including assault, battery with
particular emphasis on false imprisonment, emotional suffering and duty of care.

Personal security trumps many of the requisites for living in a civilized society no matter
where the location. In the words of Fawsitt J.: 1357

Security for the person is among the first conditions of civilized life. The law, therefore,
protects us, not only against actual hurt and violence, but against every kind of bodily
interference and restraint not justified or excused by allowed cause, and against the
present (immediate) apprehension of any of these things. 1358

Crimes are considered public and moral wrongs and “are generally acts which have a
particularly harmful effect on the public and do more than interfere with merely private
rights.” 1359 Article 19 CRPD affirms the importance of living independently and being part
of the community. 1360 Crime in the community especially local crime can have a detrimental
effect on an older person who normally has full control of her own life; as a consequence of
crime a person may begin to lose this control as fear may propel an older person to seek
residential care. Crime may have an adverse impact on all our lives both physically and

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1355 Ibid.
1356 See http://www.equalitytribunal.ie/
1358 As cited in Mc Mahon, B. and Binchy, W., Law of Torts 3rd ed. (Dublin, Butterworths (Ireland)
p. 5.
1360 (n 1255, n 126, n 127).
mentally. However the impact of crime on older people already vulnerable by disability and illness may also greatly diminish the quality of their last remaining years.

Criminal provisions are highlighted in this section where breaches of such provisions could adversely impact on an older person in residential care. Any person who assists in the commission of an indictable offence may be considered as the principal offender. Failing to disclose such an offence may attract penalties under s. 8 of the Criminal Law Act, 1997.

Section 10 of the Criminal Justice Act, 1951 prohibits the procurement by false pretences of anything capable of being stolen. Corruption by a public official or offences carried out by a body corporate or its officers may attract sanctions on conviction of ss. 8 and 9 of the Prevention of Corruption (Amendment) Act, 2001 respectively.

**Sexual offences**

All crimes against older people can be harrowing and give rise to great distress. Crimes of a sexual nature may be especially traumatising and may “cause injury, humiliation or degradation of a grave nature to the person assaulted.” Sexual offences are prohibited by various legislative provisions depending on the type of offence, for example, the Criminal Law (Rape) (Amendment) Act 1990, the Criminal Law (Sexual Offences) Acts 1993 and the Criminal Law (Sexual Offences) (Amendment) Act 2007.

The Offences Against the State (Amendment) Act 1998 No. 39 of 1998 provides for an offence of withholding information with regard to serious offences but sexual offences are excluded. The proposed legislation, the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Bill 2012 will close a lacuna in the law by requiring persons who have knowledge of any serious offence including sexual offences against vulnerable adults and children to notify the Gardaí.

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1363 No. 2 of 1951.
1364 No. 27 of 2001.
1366 Criminal Law (Rape) (Amendment) Act 1990 s. 3.
1367 No. 32 of 1990.
1368 No. 20 of 1993.
1369 No. 7 of 2007.
Theft and Fraud Offences

Criminal Justice (Theft and Fraud Offences) Act 2001\textsuperscript{1370} s. 11 (1) states:

A person is guilty of an offence if he or she dishonestly, with the intention of making a gain for himself or herself or another, or of causing loss to another, destroys, defaces or conceals any valuable security, any will or any testamentary document or any original document of or belonging to, or filed in, any court or any government department or office.

Torts and Harm to the Person\textsuperscript{1371}

The most relevant torts or civil wrongs in this context include assault, battery, false imprisonment, infliction of emotional suffering, negligence,\textsuperscript{1372} and breach of duty. The remedy for the wrong is damages and/or an injunction. The injunction is not available for negligence.

Assault arises where the wrong doer creates an apprehension of immediate battery by virtue of their conduct. Battery may be considered physical contact with an older person in the absence of their consent. The battery may not be intentional. In \textit{Re F}\textsuperscript{1373}, Lord Goff said: “A prank that gets out of hand, on over-friendly slap on the back, surgical treatment by a surgeon who mistakenly thinks that the patient has consented to it-all these things may transcend the bounds of lawfulness without being characterised as hostile.”\textsuperscript{1374}

A precise exposé of the tort of false imprisonment is provided by Fawsitt J.\textsuperscript{1375} when he said:

False imprisonment is the unlawful and total restraint of the personal liberty of another ... The essential element of the offence is the unlawful detention of the person, or the unlawful restraint on his liberty. The fact that a person is not actually aware that he is being imprisoned does not amount to evidence that he is not imprisoned, it being possible for a person to be imprisoned in law, without his being conscious of the fact and appreciating the position in which he is placed, laying hands upon the person of the party imprisoned not being essential. There may be an

\textsuperscript{1370} No. 50 of 2001.
\textsuperscript{1371} For further discussion see, for example, Mc Mahon and Binchy, 2000 (n 1358) ch. 22; Mc Mahon, B. and Binchy, W., \textit{Casebook on the Irish Law of Torts} 3\textsuperscript{rd} ed. (Haywards Heath, Tottel Publishing, 2005) p. 689.
\textsuperscript{1372} In the case of medical negligence causing injury to an older person, s. 7 of the Civil Liability and Courts Act 2004 No. 31 of 2004 provides that legal proceedings must be taken within two years from the date of the injury or two years from the date that the injured person realised that the injury resulted from negligence.
\textsuperscript{1373} \textit{Re F (mental patient: sterilization)} [1990] 2 A.C. 1.
\textsuperscript{1374} Ibid. p. 73.
\textsuperscript{1375} \textit{Dullaghan v Hillen} [1957] Ir. Jur. 10, at 15 (CC).
effectual imprisonment without walls of any kind. The detainer must be such as to limit the party’s freedom of motion in all directions. In effect, imprisonment is a total restraint of the liberty of the person. The offence is committed by mere detention without violence.\textsuperscript{1376}

In \textit{Wilkinson v Downton}\textsuperscript{1377} the court considered the intentional or reckless infliction of emotional suffering and held that the defendant was guilty since he had

wilfully done an act calculated to cause physical harm to the plaintiff, that is to say, to infringe her legal right to personal safety, and has in fact thereby caused physical harm to her. That proposition without more appears to me to state a good cause of action, there being no justification alleged for the act.\textsuperscript{1378}

More recently the English Courts have taken a more restrictive view. In \textit{Wainwright v Home Office}\textsuperscript{1379} the House of Lords rejected a claim in tort where a mother and her son were subjected to strip-searching when visiting the prison. It would appear that no tort exits in the English Courts for the unlawful infliction of distress unless associated with a physical injury.

Negligence and breach of duty arises where a duty holder breaches their duty of care resulting in damage to an older person in residential care. As Quill explains, “[a] core feature of negligence is that the law places an obligation on persons in control of risks to take precautions to ensure that they do not harm vulnerable persons.”\textsuperscript{1380} Failure of a “registered provider” of a nursing home to appoint a “person in charge” of the nursing home in compliance with the conditions of the registration\textsuperscript{1381} may foreseeably give rise to an action in tort where an older person is injured by virtue of the failure. For example successful claims for negligence have been brought in the UK as a result of patients developing pressure sores.\textsuperscript{1382}

A remedy of damages for successful actions in tort for cases falling either inside or outside the ambit of statutory provisions is unlikely to bring any solace for an older person seeking redress. Damages do not take account of the fundamental rights of a person not to be

\textsuperscript{1376} As cited in Mc Mahon and Binchy, 2000, (n 1358) para. 22.35.
\textsuperscript{1377} [1897] 2 QB 57.
\textsuperscript{1378} Ibid. p. 58-59 per Wright J.
\textsuperscript{1379} [2003] UKHL 53.
\textsuperscript{1380} Quill, E., \textit{Torts in Ireland} 3\textsuperscript{rd} ed. (Dublin, Gill and Macmillan Ltd., 2009) 27.
\textsuperscript{1381} See for example s. 56 of the Health Act 2007 No. 23 of 2007.
Chapter 3

Irish Legal Provisions

harmed. The major concern for the victim is a cessation of the intolerable behaviour. The advantage therefore for taking an action in tort is the possible remedy of an injunction.\footnote{Townshend-Smith, R., “Harassment as a Tort in English and American Law: The Boundaries of Wilkinson v Downton” (1995) 24 Anglo-Am. L. Rev 299, 306.}

**Discussion**

The evolving landscape in terms of Irish legislative provisions in the context of the older person in residential care settings has been comprehensively explored. Of particular recent significance is the Health Act 2007 and its attendant regulations that provide much needed clarity and precision in terms of augmenting rights for older people in residential care. Historically residential care was based on a medical model where human rights principles were largely ignored. It was not until 1989 that workers\footnote{Exceptions arose, for example, with the Factories Act 1955 No. 10 of 1955.} in residential care settings came within the ambit of health and safety legislation. Consequently older people in residential care settings became indirect beneficiaries. For example the Safety, Health and Welfare at Work (General Application) Regulations 1993 brought about changes such as the use of hi lo beds instead of fixed divan type beds as needs arose together with the improvements in terms of accessible bathroom facilities.

The more recent residential care settings legislative provisions\footnote{For example the Health Act 2007 No. 23 of 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 sch. 5. Where the registered provider is also the person in charge they are likely to be the most competent person on full time duty in the premises. There is no denying the benefits of having specific policies and procedures and other documentation as specified in the legislation in place. The downside is that the most qualified worker is likely to be engaged in the administrative requirements of the post consequently the skilled professional is therefore unlikely to be providing any direct care in the residential care setting. Much of the primary care will be delivered by the care staff. It is crucial that a standardised training system is in place to deliver optimal care and safeguard the rights of older people in residential care settings.} seek to put older persons front stage as actors in their own lives rather than someone providing care in their best interests. However a personalised care plan is of little value if not implemented, reviewed and updated by competent workers. There is an extensive burden on the registered provider, who may or may not be the person in charge, in terms of documentation that must be maintained. This includes, for example, eighteen operational policies and procedures as provided by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 sch. 5. Where the registered provider is also the person in charge they are likely to be the most competent person on full time duty in the premises.


\footnote{1384 Exceptions arose, for example, with the Factories Act 1955 No. 10 of 1955.}

\footnote{1385 For example the Health Act 2007 No. 23 of 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 S.I. No. 236 of 2009, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 S.I. No. 245 of 2009 and the Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No. 551 of 2006.}

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However this is only part of the picture. Of critical importance is the enactment of the proposed capacity legislation and reform of the mental health legislation. If we are to translate the CRPD provisions into effective policy and practice Irish legislation will need to be harmonised with the CRPD. Central to this evolving process of promoting respect for the fundamental rights of the older resident in residential care is their active participation either independently or with the relevant assistance to enable their participation.
Chapter 4  Autonomy, Consent and Capacity

The concepts of autonomy, consent and capacity are components in an ethical legal framework explored in this chapter in the context of the older person and residential care. A discussion on confidentiality is located in the section titled autonomy in the law. Ethics are a set of values emanating from philosophical understandings that have evolved over the centuries. Such values provide guidance for principled discussion and decision-making with regard to the law and the older person in residential care. However the answers to questions posed may not be elucidated easily generating more questions and perhaps problems for the older person in the process. Decisions concerning health care will of necessity be germane to such deliberations.

Theoretical Perspectives in Autonomy

Autonomy is fundamental to the discourse on healthcare ethics and law. The antecedents to modern theories of autonomy are located in utilitarian and deontological philosophies. Current theories have also embraced more recent developments. A brief exposition of the theoretical perspective in autonomy is outlined under the following headings, utilitarianism, Kantian view, rights theory, communitarianism and an ethics of care. These philosophical underpinnings are significant since the law, albeit at a later stage, tends to take account of the foremost lines of reasoning.

Utilitarianism

Teloelogical or consequentialist theories focus on the achievement of a purpose or consequence. For utilitarians, actions may be considered right or wrong depending upon the degree of positive or negative consequences. Herring argues that the consequentialist approach appeals to and is adopted by most people because it is “common sense...” He recognises however that this approach is limited by its shortcomings. For example pleasure and happiness are deemed to be good outcomes. Decision-making is driven by the selection that optimizes one’s greatest chance for either happiness or pleasure. Herring

1386 For a more extensive discussion on medical ethics see, for example, Herring, J., Medical Law and Ethics 3rd ed. (Oxford, Oxford University Press, 2010); Madden, D., Medicine, Ethics and the Law 2nd ed. (Dublin, Bloomsbury Professional, 2011); Mason, J., K. and Laurie, G., T., Mason and McCall Smith’s Law and Medical Ethics 8th ed. (Oxford, Oxford University Press, 2009); Beauchamp, T. L. and Childress, J. F., Principles of Biomedical Ethics 6th ed. (Oxford, Oxford University Press, 2009).
1389 Madden, 2011 (n 1386) p. 43.
1391 Herring, 2010 (n 1386) 13.
1392 Ibid. For a more extensive discussion on consequentialism see pp. 12-19.
poses the question, “[b]ut is pleasure all there is to life”? Another question that can readily be asked and indeed is often asked in the health care setting is “‘good’ for whom?” Dare I suggest, in some circumstances, the benefits that may accrue from decisions made in residential care settings for older people may be in terms of the effective use of resources, to aid research, to increase the skill level of the professional or profiteering at the expense of the older person.

The principle of autonomy in the context of medical ethics and law is mainly attributed to Mill’s utilitarian philosophy. An example may be found in the principle of non-interference. Donnelly argues that Mills’ view of autonomy as non-interference where the person is an adult and has understanding does not add value to the quality of decision-making other than to refuse treatment.

**A Kantian Perspective**

Deontological theory has value in itself; it considers what ought to be done as a moral imperative. The categorical imperative is the central principle of Kant’s moral philosophy. Kantianism is not about free choice. The deontological approach differs quite radically from the consequentialist approach in that for the deontologist actions are right or wrong irrespective of the consequences.

Kant considered that a person has intrinsic worth or dignity. Personhood is a central tenet of Kant’s philosophy. He believed that “man and in general any rational being exists as an end in himself, not merely as a means to be arbitrarily used by this or that will....” The notion that there are limits on what an individual may do is Kantian. While the word autonomy appears throughout Kant’s treatise, the work centres on moral authority for action or inaction rather than on options or choices a person may make in terms of health care decision-making.

As stated above a Kantian approach does not favour the use of a person as a means to an end. A person should not be included in a human research study without his or her consent.

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1393 Ibid. p. 13.
1394 Ibid.
1399 Ibid.
Recent anecdotal information relates to an elderly man suffering from a rare cancer. The man was in receipt of chemotherapy to relieve symptoms (rather than curative) and was given an appointment to return to the hospital. The patient and his family were of the opinion that he would gain comfort as a result of the visit. Accordingly he travelled in excess of 150km to the hospital to have his condition and medication reviewed only to discover that he was assessed as part of a research project. Dispirited by the experience, without any benefit to himself, he travelled home again on the same date in a more weakened condition. A week later he got a hospital appointment to review his condition and the adequacy of his medication in terms of symptom relief in a hospital located nearer to his home. The patient was not aware that he was participating in a research project and had no memory of consenting to such a project. His family had no knowledge of whether his consent was ever sought. The benefits that may accrue from the research did not save this man. As Herring states, “[k]ey to deontological theories is the principle that you cannot justify the breach of a deontological principle just by referring to the consequences.”

Rights Theory

Rights theory may be expressed as legitimate entitlements that an individual or a group may make on another or on society. Rights may be positive or negative. Positive rights require another person or the state to do something for an individual. Negative rights require another person to refrain from doing something. Nozick is a proponent of such thinking. Mason and Laurie while upholding the value of a patient’s individual rights offer a caution on the language of rights in that its use may limit the rights of another by virtue of the individualistic nature of the language that may be “unduly assertive and combative” hindering rather than enhancing a doctor patient relationship. As Lord Walker has said: “There is no general human right to good physical and mental health any more that there is a human right to expect (rather than pursue) happiness.”

Communitarianism

Communitarianism theory considers that the good of the community trumps individual rights. While this approach is at complete variance with liberal individualism, Mason and Laurie recognise that communitarian ethics have resonance with deontological and utilitarian theories with regard to our duties to others as well as consequences for our own

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1405 R (Razgar) v Secretary of State for the Home Department [2004] UKHL 27, para. 34.
individual decisions.\textsuperscript{1407} Singer considered that the intentional meaning of autonomy from a liberal perspective was not one that embraced individual autonomy as an isolated entity but rather viewed the individual as an autonomous relational being within a community setting.\textsuperscript{1408} Article 19 CRPD\textsuperscript{1409} that addresses living independently and being included in the community supports Singer’s view.

A criticism of the communitarian approach is that actions may be undertaken without the individual’s consent to advance a community benefit.\textsuperscript{1410} Also the promotion of community interests may adversely impact the most vulnerable members of society.\textsuperscript{1411}

\textbf{Care Ethics}

Care ethics arose out of Carol Gilligan’s seminal work that established the concept of care ethics.\textsuperscript{1412} She distinguishes between the ethics of care and an ethics of rights based on principles and rules. The central element of the ethics of care has been considered as caring for others.\textsuperscript{1413} It is acknowledged that the concept of care is complex.\textsuperscript{1414} As Phillips points out,

\begin{quote}
[i]ncreasing risk of abuse and neglect has led to care being redefined as protection and people being recast as vulnerable. Professionals have to strike a delicate balance when making decisions between autonomy and empowerment and the rights of the care recipient versus protection. It is this delicate balance which forms considerable debate within professional arenas of care.\textsuperscript{1415}
\end{quote}

An integral part of caring is the development of a relationship between the care giver and the recipient. Beauchamp and Childress have considered core qualities for health professionals. These virtues include caring “the fundamental orientating virtue”, compassion, discernment, trustworthiness, integrity and conscientiousness.\textsuperscript{1416}

\begin{footnotes}
1407 Ibid. Mason and Laurie.
1409 (n 125, n 126, n 127).
1410 Herring, 2008 (n 1401) pp. 29-30.
1415 Ibid. p. 154.
1416 Beauchamp and Childress 2009, (n 1386) p. 38.
\end{footnotes}
Compassion engenders a body, feelings, mind response from a compassionate care giver to help alleviate another’s suffering. Of critical importance is the therapeutic professional relationship that fosters sound judgement. Discernment connotes a sense of common-sense, the wisdom to know what to do or indeed not do in particular circumstances. Trust is a vital component of a heath care relationship. Where the older person in a residential care setting is likely to be frail, vulnerable, separated from their former lives in terms of their home, family, neighbours, pets, where perhaps loss of bodily function, disability, powerlessness, fear for example arise, it is crucial that the recipient of care has faith not just in the competency of the carer but that the carer recognises and does not hinder in any way the will and preferences of the older person.\textsuperscript{1417} Integrity connotes a sense of honesty, wholeness, the ability to compromise appropriately with maintaining standards and complying with professional codes of practice. As Beauchamp and Childress rightly state, “[t]o compromise below the threshold of integrity is simply to lose it.”\textsuperscript{1418}

The core qualities for health care professionals identified by Beauchamp and Childress are an important integral element of a more expansive discussion on biomedical ethics.\textsuperscript{1419} Indeed their work is considered the “most influential” in the area of medical ethics.\textsuperscript{1420} According to Beauchamp and Childress a set of four principles may be operational in any bioethical situation. These include:

- Respect for autonomy\textsuperscript{1421}
- Non-malfeasance or intentionally refraining from doing harm\textsuperscript{1422}
- Beneficence or actions that are of benefit to others\textsuperscript{1423}
- Justice – this includes procedural safeguards, equality and social inclusion.\textsuperscript{1424}

While Beauchamp and Childress give equal weighting to the four principles, others afford autonomy a more prominent position.\textsuperscript{1425} Donnelly supports the continued critical examination of autonomy in the development of a legal system for health care decisions.\textsuperscript{1426} She promotes the vision of “autonomy as empowerment” in place of a utilitarian view of

\textsuperscript{1417} Article 12.4 CRPD.
\textsuperscript{1418} (n 1386) p. 43.
\textsuperscript{1419} Ibid. p. 38.
\textsuperscript{1420} See, for example, Donnelly, 2010, (n 1388) p. 14; Herring, 2010 (n 1386) p. 24; Madden, 2011 (n 1386) p. 364.
\textsuperscript{1421} For a detailed discussion on this principle see Beauchamp and Childress 2009, (n 1388) ch. 4.
\textsuperscript{1422} Ibid. ch. 5.
\textsuperscript{1423} Ibid. ch. 6.
\textsuperscript{1424} Ibid. ch. 7.
\textsuperscript{1425} See, for example, Donnelly, 2010, (n 1388) pp. 14-16.
\textsuperscript{1426} Ibid. pp. 47-48.
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non-interference. Autonomy, she argues, enables the individual to remain at the centre of the debate and thereby helps protect him or her from “potentially oppressive forces.”

**Autonomy in the law**

Autonomy or self-determination is a central expression of capacity. The emanation of autonomy in law can be evidenced by the notion of consent. According to Dworkin

> [a]utonomy is a second-order capacity to reflect critically upon one’s first-order preferences and desires, and the ability either to identify with these or to change them in light of higher-order preferences and values. By exercising such a capacity we define our nature, give meaning and coherence to our lives, and take responsibility for the kind of person we are.

Autonomy implies that an individual has choices and is able to make a decision regarding a preferred action or indeed inaction. As Held put it, “[a]utonomy connotes the capacity of the human being to reason self-consciously, to be self-reflective and to be self-determining. It involves the ability to deliberate, judge, choose and act upon different possible courses of action...”

In the context of health care, recognition by the health care worker that an older person (who has capacity or the circumstances are not of a medical emergency) is an autonomous being helps demonstrate the respect the health care worker has for the individual who has choices to make. Beauchamp and Childress consider that

> [s]uch respect involves respectful action, not merely a respectful attitude.... Respect, in this account involves acknowledging decision-making rights and enabling people to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult, or demean others’ rights of autonomy.

Herring distinguishes between the right to reject treatment that is protected by law and the right to receive treatment that is sought but may not be forthcoming. Accordingly he

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1427 Ibid. p. 48.
1428 Ibid. p. 47.
1430 Ibid. pp.
1431 For example a person with high cholesterol level may have a basic desire or preference for fried food but on reflection may select a healthier option in the interest of their health.
suggests it may be less ambiguous to refer to the right to bodily integrity rather than the right to autonomy.\footnote{Herring, 2010, (n 1386) p. 21.}

Autonomy is considered by the Supreme Court by virtue of the right to self-determination which is implicit in the right to bodily integrity and the right to privacy.\footnote{\textit{In re a Ward of Court} (n 4) 129-130.} The right to bodily integrity was established as an unenumerated constitutional right under Article 40.3 of the Constitution.\footnote{\textit{Ryan v The Attorney General} (n 520) (313-314).} It was affirmed by Denham J. in \textit{In Re a Ward of Court (withholding medical treatment) (No. 2)}\footnote{[1996] (n 4), p. 156.} stating “that the right to bodily integrity must be recognised by private individuals as well as the State.”\footnote{Ibid. Denham J. cited \textit{The People (Director of Public Prosecutions) v JT} (1988) 3 Frewen 141 in support.} While the right to bodily integrity is welcomed many eminent legal scholars are quite rightly sceptical of the manner of its adoption.\footnote{Quinn, G., “Reflections on the Legitimacy of Judicial Activism in the Field of Constitutional Law” (1991) \textit{Dli} 30; Hogan, G., “Unenumerated Personal Rights: Ryan’s Case Re-evaluated” (1990-1992) 25-27 \textit{Irish Jurist} (ns) 95. At p. 114 Hogan argues “the gist of the objection is that the rather loose language of Article 40.3.1. has resulted in a vast – and, it must be said, somewhat unprincipled – expansion of the power of judicial review”; Hogan and Whyte, 2003, p. 1389; Keane, R., “Judges as Lawmakers: The Irish Experience” (2004) 4 (2) \textit{Judicial Studies Institute Journal} 1, p. 14 when he said “I would also share the unease ... as to the somewhat dubious premises on which the doctrine of unenumerated rights rests and the dangers for democracy of unrestrained judicial activism in this area.” In contrast Whyte has argued that the courts are empowered to recognise fundamental rights. See, for example, Whyte, G. \textit{Social Inclusion and the Legal System: Public Interest Law in Ireland} (Dublin, Institute of Public Administration, 2002) ch. 1. (n 4).} The right to privacy was confirmed in \textit{McGee v Attorney General}\footnote{[1984] IR 36 (S.C.).} and considered in the words of Henchy J. in \textit{Norris v The Attorney General}\footnote{Ibid. para. 61.} as “a complex of rights which vary in nature, purpose and range (each necessarily being a facet of the citizen’s core of individuality within the constitutional order) and which may be compendiously referred as the right of privacy.”\footnote{Ibid. paras. 61 and 63.}

Autonomy was given due recognition by the ECtHR in \textit{Pretty v United Kingdom},\footnote{Ibid. paras. 61 and 63.} which observed “that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.”\footnote{Ibid. para. 61.} Of particular import is the right of personal integrity (physical and psychological) considered as part of the right of respect for private life.\footnote{Ibid. para. 61.}
The right to personal integrity was affirmed in the case of Glass v The United Kingdom.\textsuperscript{1447} The ECtHR stated “the decision to impose treatment ... gave rise to an interference with the ... applicant’s right to respect for his private life, and in particular his right to physical integrity.”\textsuperscript{1448}

Personal autonomy and deprivation of liberty were at issue in the case of Shtukaturov v Russia.\textsuperscript{1449} The applicant was detained in a psychiatric hospital without his consent and deprived of his legal capacity in the absence of fair procedures.\textsuperscript{1450} The Court held that this deprivation constituted an interference with the applicant’s private life.\textsuperscript{1451} The applicant’s hospitalization was deemed unlawful.\textsuperscript{1452}

Autonomy is undermined when older people\textsuperscript{1453} are not given sufficient information or are denied the opportunity to seek clarification about their condition to enable them to make informed choices about current and future care needs.\textsuperscript{1454} In a similar manner a family member or the older person’s representative\textsuperscript{1455} who is not afforded sufficient information is unable to liaise with the health care professionals in any meaningful way for the benefit of the older person. Beauchamp and Childress state “[o]ne has dignity ‘only insofar as’ one is an autonomous agent.”\textsuperscript{1456} In their view, older people with dementia “deserve special protection.”\textsuperscript{1457} As Donnelly notes, “‘respect for patients’ autonomy remains of central importance; not because it solves patients’ problems but because it recognizes their fundamental human value.”\textsuperscript{1458}

\footnotesize{\textsuperscript{1447} (n 176).  \\
\textsuperscript{1448} Ibid. para. 70.  \\
\textsuperscript{1449} (n 232).  \\
\textsuperscript{1450} Ibid. para. 76.  \\
\textsuperscript{1451} Ibid. para. 96.  \\
\textsuperscript{1452} Ibid. para. 116.  \\
\textsuperscript{1453} Or their representative (when the older person does not have capacity) or to a family member (who has been given such authority by the individual who has capacity to make a decision) to obtain this information.  \\
\textsuperscript{1455} The appointed representative when the older person does not have capacity or where the person has capacity to make a decision, a family member who has been given such authority by the individual to obtain this information.  \\
\textsuperscript{1456} Beauchamp and Childress 2009, (n 1386) p. 74.  \\
\textsuperscript{1457} Ibid. p. 75.  \\
\textsuperscript{1458} Donnelly, M., Consent: Bridging the Gap between Doctor and Patient (Cork, Cork University Press, 2002) p. 20.}
Confidentiality

Patient confidentiality is an important aspect of autonomy. Confidentiality arises from the constitutional right to privacy and under Article 8 of the ECHR. Diamond enumerates five areas for discussion namely the duty arising from a contract of employment, equity, a duty of care where negligence arises, requirements of professional bodies, and statutory duties, for example, the European Convention on Human Rights Act 2003.

With regard to a contract of employment an employee has a responsibility to keep confidential matters arising out of that employment private, in particular in this context relating to patients.

Confidentiality is a fundamental component of any clinical relationship. Trust is the critical core of a relationship between a potentially vulnerable older person who is largely dependent on the other in the professional setting. Preserving a confidence is a measure of respect and due regard the duty holder has for the older person. The Medical Council’s Guide provides that “patient information remains confidential even after death.”

In the English Court Baroness Hale of Richmond said in Campbell v MGN Limited it has always been accepted that information about a person’s health and treatment for ill-health is both private and confidential. … As the European Court of Human Rights put it in Z v Finland (1997) 25 EHRR 371, para. 95: “Respecting the confidentiality of health data….is crucial….Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, in the case of transmissible diseases, that of the community.”

1459 Madden, 2002, (n 1429) 25 para. 1.79.
1460 (n 523).
1461 See Ch. 2 of this work for discussion on Article 8 of the ECHR.
1463 See, for example, the three conditions laid down in Saltman Engineering Co. Ltd v Campbell Engineering Co Ltd (1948) [1963] 3 All ER 413 as summarised by Megarry J. in Coco v A N Clark (Engineers) Ltd. [1969] RPC 41 at 47 that must be satisfied by an English Court before a breach of confidence is upheld.
1464 For further discussion see Dimond, 2008 (n 1462) ch. 1.
1465 For further discussion see Ch. 6 in this work.
1466 No. 20 of 2003.
1470 Ibid. para. 145.
The confidentiality of a psychiatric patient’s medical records was considered and emphasised in the English Courts in Ashworth Hospital Authority v MGN\textsuperscript{1471} in which the Court referring to the opinion of the patient’s physician considered that confidentiality and integrity of patients’ notes “is essential for the care and safety of individual patients and the safety of other patients and staff.” The Court said that “[m]edical records will always be confidential but this is particularly important in the case” of psychiatric patients.\textsuperscript{1472}

**Exceptions to the duty of confidentiality**

- **Consent**

The patient can authorise disclosure of medical information to whoever they wish such as family members, carers or insurance companies. The Irish Medical Council states that if a patient is incapable of giving or withholding consent to disclose information, the doctor “should consider whether disclosing the information to family and carers is in the best interest of the patient.”\textsuperscript{1473}

- **Where patient interest and public interest co-exist**

Multidisciplinary teams are often responsible for the care of older people in residential settings. Accordingly it may be in the best interests of both the patient and the care team for the care team to have relevant knowledge concerning the patient’s condition. For example, a patient with a mental health condition may exhibit challenging behaviour such as violence and aggression. There may be associated avoidable triggers to this behaviour. If the carers have the relevant information, training and experience, they may be able to prevent or minimise such events.

In the absence of such information, experience and training, there may be an increased risk of violence and aggression causing self-harm, or injury to another resident, a worker or member of the public and consequently a corresponding likelihood of an increase in the use of inappropriate medication and their associated complications. In these circumstances the health and safety of workers trumps the patient’s right to confidentiality. Of paramount importance therefore is giving the appropriate information and training to all healthcare personnel with regard to the significance of patient confidentiality and ensuring that staff is competent by virtue of the information, instruction, training and supervision they receive with regard to patient care and their own safety.

\textsuperscript{1471} [2002] UKHL 29, para. 63.
\textsuperscript{1472} Ibid. para. 63.
\textsuperscript{1473} IMC Guide 2009, (n 1468) para. 26.2.
An older person with an intellectual disability in residential care may require routine and certainty in their lives over and above what others may desire or require and may find it much more difficult to accommodate a change in routine or a lack of certainty. For example the resident may enjoy an outing in a motorised vehicle. Should the driver indicate verbally on such an outing that they are unsure which way route to take at a T junction, this may be sufficient to provoke behavioural change in the resident from a minor to a serious violent episode. Incorrectly the resident may be labelled violent thereafter and staff may believe (in the absence of relevant information, instruction, training and supervision) that additional workers are required with the resident when next on an outing or that the resident is restricted from outings with other residents.

Often workers have a reservoir of experience and knowledge in institutional care settings in terms of the residents. Some organisations may have systems in place to capture this wisdom. Others may not and the subsequent outcomes may not only be a source of great distress for both the resident and workers but also give rise to unnecessary aggression and violence. Systems may already be in place to afford the resident expert individual psychological and psychiatric support. These records will be confidential except where the interests of others arise.

Crucially the organisation itself must be fit for purpose. As Brown has pointed out “training isn’t helpful if there are ‘culture’ issues to address.” The organisation must have up to date policies and procedures in place with regard to patient confidentiality that takes account of the nature of the resident’s condition to ensure that both the resident and others are protected. In terms of prevention of avoidable incidents systems need to be developed (if not already done) in residential care settings that take account among other things of the latent knowledge of many of the workers to ensure positive outcomes for the resident and consequently the staff member.

- Legal Requirement to Disclose

There are limited occasions when disclosure of medical information is required for example:

(a) by court order; in the case of personal injury when the plaintiff’s medical information sought by the defendant is not forthcoming, the defendant may seek a court order for discovery of the medical record,

(b) in the case of prevention of infectious disease, for example, tuberculosis or salmonella enteric,\footnote{Infectious Diseases (Amendment) (No. 3) Regulations 2003 S.I. No. 707 of 2003.}

(c) a duty to warn as in the frequently referenced U.S. case of \textit{Tarasoff v Regents of the University of California}.\footnote{\textit{Tarasoff v Regents of the University of California} 529 P 2d 55 (Cal, 1974); on appeal 551 P 2d 334 (Cal, 1976). The Supreme Court of California held that a psychotherapist’s duty to warn a patient of the threat to kill her.}  

Public interest has similarly been identified in the English case of \textit{W v Egdell}\footnote{[1990] 1 All ER 835.} when the Court held that a consultant psychiatrist’s disclosure of medical information when there was a danger to public safety was not a breach of medical confidentiality,

(d) Data Protection (Amendment) Act 2003.\footnote{No. 6 of 2003.}  

- Access to one’s own medical record

The applicant contends that he was ill-treated in care, and since his majority has wished to obtain details of where he was kept and by whom and in what conditions in order to be able to help him to overcome his problems and learn about his past.

The applicant contended that the case records held by the local authority should be made available to him on the general principles of discovery, for the purpose of his proposed proceedings for personal injuries against the local authority. He further argued that it was also in the public interest that some measure of review of the standard of care provided by a local authority to a child in care be available.

The applicant’s right to access his case file was affirmed in \textit{Gaskin v United Kingdom}.\footnote{(Application no. 1045/83) Judgment 07 July 1989.} Following the death of his mother when Mr Gaskin was boarded out in foster homes from the time he was a few months old until he was 18 years of age.\footnote{Ibid. para 10.} There were short times during this period when he resided with his father.\footnote{Ibid. para 12.} It was the practice of the local authority to keep a confidential case record on each child in care.\footnote{Ibid. para 13.} On reaching the age of majority Mr. Gaskin sought his case record.\footnote{Ibid. para 11.} The applicant alleged that he was ill-treated in care, and “wished to obtain details of where he was kept and by whom and in what conditions in order to be able to help him to overcome his problems and learn about his past.”\footnote{Ibid. para 11.} His request was refused. The ECtHR held that there was a violation of Article 8,
the applicant had a special interest in obtaining relevant information about himself and the procedures (that Liverpool City Council had implemented) “failed to secure respect for Mr. Gaskin’s private and family life as required by Article 8 ... of the Convention.” However the right of access to medical records is not automatic. When the record also pertains to other persons the records may be refused. A refusal of access to the record may also arise if sight of the record is judged not to be in the best interests of the person. Furthermore the Freedom of Information Acts 1997 to 2003 are limited to public bodies. Therefore medical records held in private residential centres do not come within the ambit of this legislation.

Consent
The ethical principle of the inherent right to self-determination “finds its expression in law through the concept of consent.” Consent is one of the most fundamental concepts in health care law.

A patient’s consent to medical treatment is always required unless the patient is admitted in an emergency and is unconscious, is a minor or is incapable due to intrinsic mental incapacity. Mason and Laurie explain in relation to adults “no other person not even the next of kin, has an automatic legal right to consent to or refuse treatment...”

In relation to this issue the Supreme Court in In Re a Ward said that “[t]he loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution ... including self-determination, and the right to refuse medical treatment.” This case concerned a family’s request to cease feeding the ward by artificial means even though the ward’s life was dependant on this means of nutrition.

Treatment without consent must be based on law and “only relate to strictly defined exceptional circumstances.” These circumstances were addressed in In Re a Ward of Court (withholding medical treatment) (No. 2) by Denham J. when she said:

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1485 Ibid. para. 49. The Access to Health Records Act 1990 came into existence in the UK following this judgment.
1489 Mason and Laurie, 2006, (n 1404) p. 128.
1490 Ibid. p. 353.
1492 Ibid. 428.
Medical treatment may not be given to an adult person of full capacity without his or her consent. There are a few rare exceptions to this, for example, in regard to contagious diseases or in a medical emergency where the patient is unable to communicate. The right arises out of civil, criminal and constitutional law. If medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach of the individual’s constitutional rights. The consent which is given by an adult of full capacity is a matter of choice.\textsuperscript{1495}

Capacity therefore is an essential element of the decision-making process. In order to make a decision an older person must be given the requisite information (including the nature and consequence of the treatment) and the decision must be given freely, voluntarily without coercion or undue influence. It is immaterial that a decision is perhaps seen to be irrational in the mind of the man on the ‘Clapham omnibus’.\textsuperscript{1496} In other words “[f]or this freedom to be meaningful, people must have the right to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others....”\textsuperscript{1497}

Communication is crucial. In the absence of dialogue or communication by any means problems are likely to arise. The process of active engagement and appropriate responding facilitates understanding and promotes autonomy.

Ethically valid consent is not merely the completion of a form. It involves “a process of shared decision-making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form that details the risks of particular treatments.”\textsuperscript{1498} Kirby J. considered informed consent to be “[t]hat consent which is obtained after the patient has been adequately instructed about the ratio of risk and benefit involved in the procedure as compared to alternative procedures or no treatment at all.”\textsuperscript{1499} In addition ‘core’ disclosures from an ethical perspective include the doctor’s recommendation with regard to

\textsuperscript{1494} (n 4).
\textsuperscript{1495} Ibid. 156.
\textsuperscript{1496} Dimond, B., “Medicinal products and consent to treatment by the older person” (2004) 13 (1) \textit{British Journal of Nursing} 41.
\textsuperscript{1497} Robins, JA \textit{Mallette v Shulman} (1990) 67 DLR (4th) 321 (Ont CA) as cited in Kennedy and Grubb, 2000, (n 1488) 575.
\textsuperscript{1499} Kirby, J., “Informed Consent: what does it mean?” (1983) 9 (2) \textit{Journal of Medical Ethics} 69; the term “informed consent” was first used in the U.S. case \textit{Salgo v Leyland Stanford Jr. University Board of Trustees} (1957) 317P 2d 170; see also the opinion of Robinson J. in \textit{Canterbury v Spence} (1972) 464 F 2d 772 for a more expansive legal analysis.
the procedure, details of other professionals likely to be involved, the cost of procedures and follow up, and the presence of students.\textsuperscript{1500} The English courts have held that a competent person may refuse treatment even though the refusal is likely to result in their premature death.\textsuperscript{1501} Similarly unnecessary touching a competent patient in the absence of consent is unlawful.\textsuperscript{1502} The Court of Appeal said “[w]here a competent patient makes it clear that he does not wish to receive treatment which is, objectively, in his best interests, it is unlawful for doctors to administer that treatment. Personal autonomy or the right of self-determination prevails.”\textsuperscript{1503}

In developing a relationship with a patient a health care worker will seek to optimise the health benefits to the patient though nurturing a relationship of trust and co-operation. Such a relationship does not imply a legal consent to treatment.\textsuperscript{1504} More recently the concept of consent has been explained in the UK Court as,

\begin{quote}
[a] rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient.\textsuperscript{1505}
\end{quote}

Historically, the right to physical integrity can be located in the common law.\textsuperscript{1506} The absence of consent for medical treatment may give rise to a case of assault and battery. In the seminal case \textit{Schloendorff v Society of the New York Hospital}\textsuperscript{1507} Cordozo J. provides a clear account of application of the law with regard to the commission of assault and battery in the absence of consent when he stated that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”\textsuperscript{1508}

\begin{footnotes}
\textsuperscript{1500} See, for example, Donnelly, 2002 (n 1458) ch. 3 and Laffoy, J. in \textit{Fitzpatrick and Anor -v- K. and Anor}, [2008] IEHC 104 (2008).
\textsuperscript{1501} Re \textit{T (Adult: Refusal of Treatment)} [1992] 4 All ER 649 at 652-3; \textit{St. George’s Care Trust v S} [1998] 3 All ER 673.
\textsuperscript{1502} In \textit{Collins v Ward} [1984] 3 All ER 374 lawful touching is considered as that “physical contact which is generally acceptable in the ordinary conduct of daily life.”
\textsuperscript{1503} \textit{R (on the application of Burke) v GMC} [2005] 3 FCR 169, para. 30.
\textsuperscript{1504} \textit{In Re W} [1992] 4 All ER 627.
\textsuperscript{1505} Lord Steyn in \textit{Chester v Afshar} [2004] UKHL 41, para. 18.
\textsuperscript{1506} Mason and Laurie, 2006, (n 1404) p. 349.
\textsuperscript{1507} 501 NE 92 (NY, 1914).
\textsuperscript{1508} \textit{Schloendorff v Society of New York Hospital} 211 NY 125 (1914).
\end{footnotes}
Since then, when an action arises in tort for failure to obtain informed consent it is more likely to result in the tort of negligence rather than the tort of battery. In Irish law two causes of action may arise from medical negligence, one for a breach of the doctrine of informed consent and the second for negligent diagnosis and/or treatment. To succeed in an action for damages for a breach of the doctrine of informed consent a claimant must prove (a) that the doctor should have provided the relevant information and failed to do so and (b) if the claimant had the relevant information he or she would not undergone the surgery or treatment.

To succeed in an action for damages for medical negligence a claimant must prove that he was owed a duty of care, there was a breach of that duty and as a result of the breach damage arose that was foreseeable and avoidable. A statute of limitations applies to both causes of action.

Two different standards co-existed in Ireland with regard to informed consent, the professional standard approach and the test of the reasonable patient.

The amount of information the patient should receive prior to an operation has been considered in the courts in the context of professional negligence principles. The English courts set out the standard in *Bolam v Friern Hospital Management Committee* (Bolam test) when McNair J. in the High Court said “[t]he test is the standard of the ordinary skilled man exercising and professing to have that skill.” This approach can be distinguished from the man on the Clapham Omnibus because that man has not got that particular skill. The duty to disclose risks to the patient was based on what a responsible body of medical doctors would disclose. Formerly the Irish case of *Dunne v National Maternity Hospital* provided legal guidance on disclosure. This approach was essentially the Bolam Test. However the Supreme Court in *Dunne v National Maternity* considered that following a particular approved practice may not be sufficient for the doctor to “escape liability if in

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1511 *Walsh v Family Planning Services* (n 1509) 496; the professional standard approach referred to the amount of information the professional gives the patient to enable them to make a decision to give or withhold consent.

1512 *Geoghegan v Harris* [2000] 3 IR 536.

1513 McNair J. [1957] 1 WLR 582.

1514 Ibid. 586.

1515 Ibid. 587.

reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.”

Informed consent was at issue in the Irish case, *Geoghegan v Harris*. Kearns J. in the High Court held that there was an obligation to warn the patient of any complication of an operation that was ‘known or foreseeable’ and the test affirmed by the Court was that of the ‘reasonable patient.’ The High Court said: “The reasonable man [is] entitled ... to full information of material risks, does not have impossible expectations nor does he seek to impose impossible standards.” The Court considered that material risk would involve consideration of two elements, “the severity of the consequences and the statistical frequency of the risk.” Once the patient was apprised of any material risk, he or she could then make the decision to accept or reject the treatment/surgery offered.

The case concerned an elective medical procedure which resulted in significant adverse consequences for the patient. Kearns J. stated that “as a general principle the patient has a right to know and the practitioner a duty to advise of all the material risks associated with a proposed form of treatment.” The decision of the High Court was welcome.

This view was affirmed by the Supreme Court in *Fitzpatrick v White*. In dismissing the appeal the Court held that “[a] medical practitioner’s duty to warn is assessed in accordance with the reasonable patient test; if there is a significant risk which would affect the judgement of a reasonable patient,” the doctor must advise the patient of that significant risk. Furthermore the Court held that a material risk is one which “a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it. Any consideration of materiality involves consideration of both the severity of the consequences and the statistical frequency of the risk.”

The duty to warn of an unavoidable risk was upheld in the UK case of *Chester v Afshar*. Lord Stern observed that the benefits to the patient of informed consent are twofold in that

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1517 Ibid. 109.
1518 [2000] (n 1512) 536.
1519 Upholding the decision in *Walsh v Family Planning Services Ltd.* (n 1509) 496.
1520 *Geoghegan v Harris* (1512) 549.
1522 Ibid. *Geoghegan v Harris* (n 1512) 549.
1523 Ibid.
1525 Ibid. p. 101.
1526 Ibid. p. 100.
1527 (n 1505) 41.
the patient is aware in advance of any potential negative outcomes of the intervention and that the doctor demonstrates due regard for the autonomy and dignity of the patient.\textsuperscript{1528}

Varying the conventional approach to causation Lord Stern stated that the case “cannot neatly be accommodated within conventional causation principles.”\textsuperscript{1529} In conclusion he said that “as a result of the surgeon’s failure to warn the patient, she cannot be said to have given informed consent to the surgery in the full legal sense. Her right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles.”\textsuperscript{1530} He considered that Ms. Chester was “entitled in law to succeed”\textsuperscript{1531} and that the result was in accordance “with one of the most basic aspirations of the law, namely to right wrongs.”\textsuperscript{1532} Lord Stern’s more subjective approach viewing Ms Chester in her particular circumstances has relevance for older people with intellectual disability.

The reasonable patient position exists in other jurisdictions (United States, Canada and Australia); all potential risks of any procedure are communicated to the patient so that they are more fully informed to enable them to make a decision.

With regard to elective surgery the Court in \textit{Walsh v Family Planning Services Ltd.}\textsuperscript{1533} recognised that the warning was more rigorous given that there was more time in advance of the treatment/surgery to inform the patient and respond to their wishes. More recently the Court\textsuperscript{1534} has accepted a warning given shortly before an operation but cautioned against such a short time frame. For many older people a short time frame may be problematic. For some short term memory may be a problem and they may want to write things down to help them to remember to think about it later and perhaps to discuss with someone else. Others may be slow in processing their thoughts. Many like to mull over what the doctor has told them and they do not like to be rushed in their decision-making. Consideration of particular risks might generate further questions for them. An older person who is continent may have fears about the insertion of a catheter pre-operatively—he or she may fear the potential loss of continence following removal of the catheter rather than the operation itself. In this regard, the number of trained staff in the area of continence management both before and after surgery may be of particular importance.

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{1528} Ibid. para. 18.
\item\textsuperscript{1529} Ibid. para. 22.
\item\textsuperscript{1530} Ibid. para. 24.
\item\textsuperscript{1531} Ibid. para. 25.
\item\textsuperscript{1532} Ibid. para.
\item\textsuperscript{1533} \textit{Walsh v Family Planning Services Ltd.} (n 1509) 496.
\item\textsuperscript{1534} Fitzpatrick \textit{v White} (n 1524) 99, 101.
\end{enumerate}
\end{footnotesize}
Chapter 4  Autonomy, Consent and Capacity

Legal Capacity

Capacity is essential in order to participate in the legal world. The law presumes that adults are competent to make their own decisions about themselves.\(^{1535}\) Competence in this context incorporates the concepts of capacity, rationality, autonomy, dignity and freedom.\(^{1536}\) In the reduction and or absence of these elements the person’s capacity may be diminished or indeed the presumption of capacity may be rebutted\(^{1537}\) in contrast to the CRPD. Although the CRPD is new some of the strongest commentary indicates that there is a shift towards an assumption of capacity.\(^{1538}\) This could potentially have a transformative shift in attitude to older people in residential care settings.

Legal capacity has been defined,

as the capacity and power to exercise rights and undertake obligations by way of one’s own conduct, i.e. without assistance or representation by a third party. This concept logically presupposes the capacity to be the potential holder of rights and obligations (static element), and entails the capacity to exercise these rights and to undertake these duties to create, modify or extinguish legal relationships (dynamic element).\(^{1539}\)

In the case of *In re Beany*\(^ {1540}\) the English High Court recognised that different degrees of capacity could exist. A person can make a decision with regard to one aspect of their life but be unable to do so in another context. In that case Nourse Q.C. sitting as Deputy Judge of the High Court stated:

The degree or extent of understanding required in respect of any instrument is relative to the particular transaction which it is to effect. In the case of a will the degree required is always high. In the case of a contract, a deed made for

\(^{1536}\) Ibid. p. 267.
\(^{1537}\) Ibid.
\(^{1538}\) Quinn, (n 113).
\(^{1539}\) Legal Capacity: Background conference document prepared by the Office of the United Nations High Commissioner for Human Rights, 13 para. 24. https://docs.google.com/viewer?a=v&q=cache:PQwehTbCF1EJ:www.un.org/esa/socdev/enable/rights/documents/ahc6ohchrlegalcap.doc+legal+capacity+office+of+the+united+nationsandhl=enandgl=ieandpid=blandsrcid=ADGEESz2gV-4lz0ZJFdv0wzjKwRUhrKBJKK0vDRhutpVa0aWRVHYyDDi2F4rwvQjkgvym6RAP7_dKhqRrCCS_PgdS554Iyi1j1u7Ptcjii5e1PcbRlRlYsz9kIj6efiTEyCXM0v51Ft0Wandsgj=AHIElbSWGhKdcFr2AJAtWtgPwTf177jDCRg. Last accessed 17th July 2012. See also (n 67).
\(^{1540}\) [1978] 2 All ER 595.
consideration or a gift inter vivos, the degree varies with the circumstances of the transaction.  

While an older person may have been diagnosed with dementia, intellectual disability, mental ill-health, acquired brain injury or the inability to communicate decisions, this diagnosis does not necessarily mean that the older person lacks capacity. Dementia, for example, causes impairment in cognitive functioning, however this does not automatically imply that the person loses their decision-making capacity in all areas or only in some.  

Decisional capacity or incapacity relates to a specific context and time and the particular older person’s ability to make a judgement.  

The difficulties in defining legal capacity have been considered by the Law Reform Commission (LRC). Different models of defining or assessing capacity have been distinguished namely, the ‘status approach’, the ‘outcome approach’ and the ‘functional approach’. The ‘status approach’ assigns capacity by virtue of the presence or absence of a particular attribute, for example, the presence or absence of dementia regardless of degree. The ‘outcome approach’ considers the outcome of an individual’s decisions as deemed acceptable by ‘right thinking people’ in determining the presence or absence of capacity. In *Re C (Adult: Refusal of Medical Treatment)* the English High Court upheld the patient’s decision not to have his leg amputated. The patient suffered from paranoid schizophrenia and when he was in prison developed gangrene in his foot that required amputation from below the knee to arrest the gangrene and save his life. The Court considered that C did have the requisite understanding to enable him to make a decision rejecting the medical advice to have an amputation in the knowledge that he was likely to die without surgery.

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1541 Ibid. p. 774.
1542 Dementia includes alzheimer’s disease and other forms of dementia including neuro-degenerative diseases, for example, ataxias, fronto-temporal degeneration and huntington’s disease, infective diseases, for example, human prion diseases and aids dementia complex, metabolic diseases, for example, cerebral lipidoses and dementia in hepatic and renal failure, traumatic diseases, for example, repeated head trauma, toxic diseases, cerebro-vascular diseases and other rare causes of dementia. 


1545 Ibid. Bonnie and Wallace p. 142.


1547 As cited in LRC. Consultation Paper, *Vulnerable Adults and the Law: Capacity* LRC CP 37-2005 (Dublin, 2005), para. 2.03.

1548 [1994] 1 All ER 819.
Both the first two approaches (status and outcome) are clearly flawed as they fail to recognize a person’s uniqueness as a human being and their ability to make perhaps bizarre decisions. Furthermore the ‘status approach’ fails to recognize the degrees of a particular characteristic a person has attained and that ownership of a given particular characteristic does not necessarily mean it is fixed in degree.\textsuperscript{1549}

The ‘functional approach’, on the other hand, takes these factors into account and is favoured by the LRC.\textsuperscript{1550} In a functional assessment a person’s capacity to make a decision is both time and issue specific. Recent legislation reflects this approach.\textsuperscript{1551} Section 21(2) of the Nursing Home Support Scheme Act 2009 recognizes that a person has full mental capacity unless the contrary is established. Section 21(43) provides for circumstances when a person lacks capacity to make a decision.\textsuperscript{1552} The prescribed report form for capacity assessment with regard to the nursing home support scheme is located in sch. 1 of the Nursing Homes Support Scheme (Assessment of Capacity Report) Regulations 2009.\textsuperscript{1553} The functional approach to capacity has been included in National Quality Standards for Residential Care Settings for Older People in Ireland.\textsuperscript{1554} This approach engages with the decision maker’s capacity to make a decision at the time when the decision is reached.\textsuperscript{1555} This view is largely in harmony with the CRPD.\textsuperscript{1556} Article 12(2) provides that “[s]tate Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.” Support as required by Article 12(3) for a person with a disability to enable them to exercise their capacity may include, for example, the provision of an advocate. This might be a willing family member who meets with the approval of the older person with a disability.

\textsuperscript{1549} For example, when there is no change in a patient’s condition—the patient is in a coma or persistent vegetative state then there is no requirement to re-assess capacity each time a decision is made. There should be a formal system of accountability. For further discussion see LRC, 2003 (n 1546) para. 1.22 and LRC, 2005 (n 1547) paras. 2.10 and 2.21.
\textsuperscript{1550} Ibid. LRC, 2005 para. 2.38. At para. 7.86, the LRC has recommended the publication of a code of practice for professionals to enable them to assess capacity to make health care decisions.
\textsuperscript{1551} Nursing Home Support Scheme Act 2009 (n 898); see also proposed legislation—the Scheme of Mental Capacity Bill 2008.
\textsuperscript{1552} Section 21 (43) provides: “For the purposes of this section a person shall be considered not to have the capacity to make a decision relating to a matter to which this section applies if he or she is unable—(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision or (d) to communicate his or her decision (whether by talking, using sign language or any other means) or, if the decision requires the act of a third party to be implemented, to communicate by any means with that third party.”
\textsuperscript{1553} S.I. No. 409 of 2009.
\textsuperscript{1554} HIQA, 2009 (n 37) Standard 3.8 adopts a functional approach to capacity.
\textsuperscript{1555} Ibid. pp. 45-50.
\textsuperscript{1556} See Ch. 2 of this work for further discussion on CRPD; for a more extensive historical discussion on the deliberations on Article 12 see, for example, Dhanda, 2006-2007 (n 112) 438-56.
With regard to health care, capacity has been described as the “competence to make decisions,” in other words the ability to accept or reject treatment. The World Health Organisation distinguishes between capacity and competence, in that capacity is considered a health concept and accordingly must be diagnosed by a health professional while competence is deemed to be a legal concept and therefore its determination is made by a legal body. In definition terms there seems to be some confusion with the concepts of capacity and competence. The three elements of competence have also been considered as “capacity, information and voluntariness.” This confusion seems to have largely abated with the more recent acceptance of the terms “capacity” rather than “competency”; however the terms may be used interchangeably.

In determining whether a patient is competent to consent to medical treatment, Donnelly outlines three basic principles to be applied. Firstly the task (operation or treatment) must be specific, secondly the person must be facilitated in understanding the task or function and thirdly it should be accepted that the patient may make an irrational decision.

Historically patients tended to accept treatment passively. However, while this tendency is now diminishing among the younger population, older patients may continue to give tacit approval for the proposed treatment. The LRC point out that “[a]dults who are legally capable have the right to refuse services—a right to care and treatment should not be turned into an obligation to receive them.” In the U.K. the individual’s right to refrain from seeking medical treatment was upheld in *R v Smith*.

Older persons’ capacity in a given aspect of their lives is not necessarily static. There can be diurnal fluctuations, variation with altered location, medication or perhaps with transient

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1560 Beauchamp and Childress, 2009, (n 1386) 111.
1561 Donnelly, 2002, (n 1458) 47.
1562 Locke, J., *The Second Treatise of Government* 15th ed. (New York, Liberal Arts Press, 1952) 68. Locke in his discussion on consent states that “every man that hath any possession or enjoyment of any part of the dominions of any government thereby gives his tacit consent, and is as far forth obliged to the laws of that Government during enjoyment, as any one under it, whether this his possession be of land to him and his heirs forever, or lodging only for a week.”
1563 LRC, 2003 (n 1546) p. 159.
1564 [1979] Crim LR 251. Mrs Smith died following the home birth of her still born child when neither she nor her husband sought medical treatment. Her husband was subsequently charged with manslaughter and found not guilty.
A question, considered in the English Courts, concerns the presumption of incapacity once episodic incapacity has occurred. The English Court of Appeal rejected this notion with Kennedy LJ, stating “if there is clear evidence of incapacity for a considerable period then the burden of proof may be more easily discharged, but it remains on whoever asserts incapacity.” Equally the burden of proof rests on the individual who asserts that an incapacitated individual has reverted to being competent, for example, during a short lucid period.

For some others who may lack capacity their consent may be assumed by health care professions in the absence of any rejection of treatment since it was given in their best interests. This common law paternalistic rule was acknowledged by the House of Lords in *F v West Berkshire*, by Goff LJ, who said “the doctor must act in the best interests of his patient just as if he had received his patient’s consent to do so.” In contrast, where capacity was not at issue the English Court has taken the view that “[i]n modern law paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery.”

Dimond, worryingly, points out however, that rejection of proposed treatment can give rise to problems for some older persons in that their refusal of treatment can attract questions regarding their mental capacity. Similarly Buchanan recognises that in clinical practice question marks concerning a person’s competence to make a decision only arise “when a patient decides contrary to what others regard as their best interest.” In this regard the English Court of Appeal in *Bailey v Warren* offer this caution “however much judges may wish to protect an individual from the ill-advised consequences of his or her own actions, courts should tread very carefully and only interfere with an individual’s rights when absolutely necessary.” In a similar vein Quinn acknowledges that the provisions of Article 12 of the CRPD “dealing with recognition in law as a person is profound in the

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1568 Dimond, 2004, (n 1496) pp. 41-42.
1569 [1989] 2 All ER 545.
1570 Ibid. para. 567.
1571 Lord Steyn in *Chester v Afshar* (n 1505) para. 16.
1572 Dimond, 2004, (n 1496) pp. 41-42.
1573 The status of being older and posing questions may disturb the normal acquiescence to treatment in the some residential care settings and an older person in such circumstances may have their rightful decision over-ridden; see also Dhanda, 2006-2007, (n 112) p. 432.
1576 Ibid. para. 76.
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extreme....” since it emphasises “the notion that persons should be supported in their decisions and in their decision-making capacity if needed-but not substituted.”\textsuperscript{1577} Article 12 reflects the principle of proportionality that requires any intervention in a person’s life to be proportionate to the purpose sought.

The issue of capacity as it relates to liberty was considered by the Court in \textit{H.L. v UK}\textsuperscript{1578} In this case, the ‘detention’\textsuperscript{1579} of a mentally disabled man under the common law was held to be in violation of Article 5 of the ECHR by the ECtHR.\textsuperscript{1580} The ECtHR restated that,

\begin{quote}
the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention, especially when it is not disputed that person is legally incapable of consenting to, or disagreeing with, the proposed action.\textsuperscript{1581}
\end{quote}

\textbf{HL} who was autistic had been admitted as an informal patient to a psychiatric hospital and was kept there against the express wishes of his carers. HL “was under continuous supervision and control and was not free to leave.”\textsuperscript{1582} The House of Lords’ decision held by a 3 to 2 majority that his informal detention was lawful under the common law doctrine of necessity since it was considered in his ‘best interests.’\textsuperscript{1583} The ECtHR considered that the conditions of detention (under the common law) did not provide adequate safeguards to protect HL from “deprivations of his liberty.”\textsuperscript{1584} Furthermore the ECtHR held that the “requirements of Article 5(4) were not satisfied ... by judicial review or habeas corpus proceedings.”\textsuperscript{1585}

As Fennell observes, the significant factor relates to whether the person is under the total care of the institution or carer and whether they “exercise complete and effective control over his [the patient’s] care and movements.”\textsuperscript{1586} Additional legislative safeguards were

\begin{footnotes}
\footnote{\textsuperscript{1578} (n 221).}
\footnote{Ibid. para. 79.}
\footnote{Ibid. para. 94.}
\footnote{Ibid. para. 90.}
\footnote{Ibid. para. 91.}
\footnote{Ibid. paras 38 and 47; \textit{R v Bournewood Community and Mental Health NHS Trust, ex parte L}}\footnote{(Secretary of State for Health and others intervening [1998] 3 All ER 289; HL was not detained compulsorily within the provisions of the UK Mental Health Act since he did not resist admission. For further discussion see Mason and Laurie, 2006 (n 1404) paras. 20.32 to 20.34.}
\footnote{Ibid. para. 124.}
\footnote{Ibid. para. 45.}
\end{footnotes}
introduced in the UK to bridge the lacuna\textsuperscript{1587} that existed between the Mental Health Act 1983 and the Mental Capacity Act 2005.\textsuperscript{1588}

In \textit{Storck v Germany}\textsuperscript{1589} the ECtHR expressed the view that it has consistently held that the responsibility of a State is engaged if a violation of one of the rights and freedoms defined in the Convention is the result of non-observance by that State of its obligations under Article 1 to secure those rights and freedoms in its domestic law to everyone within its jurisdiction.\textsuperscript{1590}

In this regard the Court held that the State was obliged to take positive action to protect those rights against infringement by organs of the State or private persons.\textsuperscript{1591} Accordingly, the Court held that the first sentence of Article 5 is to be interpreted as having a positive obligation for the State to protect the liberty of its citizens.\textsuperscript{1592} Furthermore, the State is obliged to protect an individual’s right to physical integrity especially those in receipt of psychiatric treatment under Article 8 of the Convention.\textsuperscript{1593} The partly dissenting opinion of Judges Tulkens, Spielmann and Laffranque in \textit{Stanev}\textsuperscript{1594} is significant. They recognise that “the judgement is likely to strengthen considerably the protection of persons in a similarly vulnerable situation to the applicant.”\textsuperscript{1595}

A statutory presumption of capacity to make health care decisions exists in English Law.\textsuperscript{1596} A non-statutory presumption exists in Ireland and similar to that in the UK the presumption is rebuttable in both jurisdictions. Laffoy J. stated in \textit{Fitzpatrick v FK (No. 2)}\textsuperscript{1597} “that an adult patient has the capacity, this is to say the cognitive ability, to make a decision to refuse medical treatment, but that presumption can be rebutted.”\textsuperscript{1598} In law the test for assessment for capacity irrespective of whether a person has a permanent or temporary capacity is to establish whether the person’s

\textsuperscript{1587} As Richardson, explains there was “no express provision for the lawful detention in hospital of incapable, non-objecting patients.” As cited in Richardson, G., “Mental capacity at the margin: the interface between two Acts” (2010) 18 Med. L. Rev 56-77, p. 58.

\textsuperscript{1588} The UK Mental Health Act 1983 and the Mental Capacity Act 2005 were amended by the Mental Health Act 2007 that became fully operational in April 2009.

\textsuperscript{1589} (n 226).

\textsuperscript{1590} Ibid. para. 101.

\textsuperscript{1591} Ibid.

\textsuperscript{1592} Ibid. para. 102.

\textsuperscript{1593} Ibid. para. 103.

\textsuperscript{1594} \textit{Case of Stanev v Bulgaria} (n 120).

\textsuperscript{1595} Ibid. p. 40.

\textsuperscript{1596} S. 1(2) of the Mental Capacity Act 2005.


\textsuperscript{1598} Ibid. [2009] p. 8.
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.\footnote{1599}

The case concerned the refusal on the ground of being a Jehovah witness by Ms K of an urgent blood transfusion (following a massive haemorrhage) that was deemed necessary by her medical team. The hospital sought and was granted an \textit{ex parte} order in the High Court to allow the giving of the blood transfusion that was against the express wishes of Ms K. Abbott J. held that while Ms K was competent to make the decision, the rights of the child to have a live parent (Ms K. had in error indicated that the other parent was not in the State) took precedence over her right to refuse treatment.\footnote{1600}

In \textit{Fitzpatrick v FK (No. 2)} Laffoy J. affirming the functional assessment of capacity held that Ms K did not have capacity to make a valid refusal to accept the blood transfusion and that the hospital staff did not act unlawfully by transfusing Ms K.\footnote{1601}

Incapacity may manifest itself in the older person in residential care in different situations, for example, the person may in particular circumstances suffer from varying degrees of dementia, intellectual disability, mental ill health, acquired brain injury and in such circumstances the patient may be unable to either consent to or refuse treatment.

\textit{H.M. v Switzerland}\footnote{1602} has direct relevance for the older person because it deals with arbitrary deprivation of liberty. H.M. was placed in a nursing home because of neglect and senile dementia\footnote{1603} even though she was not examined by a medical expert and she was not allowed a right of reply to the Commission.\footnote{1604} When she agreed to stay in the nursing home the placement order was lifted.\footnote{1605} The ECtHR considered H.M.’s allegation of a breach of Article 5 of the ECHR was unfounded,\footnote{1606} “that the applicant’s placement in the nursing home ... was a responsible measure taken by the competent authorities in the applicant’s interest.”\footnote{1607}

The sole dissenting judgement of Loucaides J. is worth noting. If the detention appears to be a “responsive measure to the [older person’s] own good” he said it may “open the door to

\footnotesize{\begin{itemize}
\item \footnote{1599} Ibid. para. 84.
\item \footnote{1600} [2006] IEHC 392 High Court.
\item \footnote{1601} [2008] IEHC 104 [2009] 2 IR 7 para. 263.
\item \footnote{1602} (n 226).
\item \footnote{1603} Ibid. para. 23.
\item \footnote{1604} Ibid. para. 33.
\item \footnote{1605} Ibid. para. 27.
\item \footnote{1606} Ibid. para. 49.
\item \footnote{1607} Ibid. para. 48.
\end{itemize}}
uncontrolled arbitrariness and real and unwarranted dangers to the freedom of the individual which the Convention aims to avert.”

Furthermore a question arises and remains unanswered (the applicant was admitted to the nursing home on the 20th December 1996 and the placement order was lifted on the 14th January 1997, twenty-five days later when the applicant agreed to stay in the nursing home); after a little over three weeks had the applicant become institutionalised and therefore passive in her acceptance of her new residence because she had become dis-empowered?

The function of the ECtHR was reaffirmed by the Court in *Storck*. At issue in *Storck* was the alleged detention in various German psychiatric hospitals of the physically disabled applicant without her consent and without a court order. She further alleged that she was medicated without her consent and that these infringements of law violated her right to liberty under Article 5 and her right to personal integrity under Article 8 of the Convention.

The Court held that the applicant’s detention was in violation of Article 5.1 of the ECHR. Article 8 was held to be violated by virtue of the giving of medical treatment against the applicant’s will and the failure of the State to adequately protect the applicant’s private life. More recently the Court in *Stanev* said that “the detention of an individual is such a serious measure that it is only justified where less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained.” These seminal cases have important implications for residential care settings for older people with regard to the protection of residents’ human rights.

1608 Ibid. p. 16.
1609 O’Reilly v Moroney and the Mid Western Health Board SC unreported 16th November 1993; SC v Smith and others HC unreported, 31st July 1995.
1611 Storck v Germany (n 226); at p. 14 the Court considered it was not its responsibility to “deal with errors of law or law allegedly committed by the national courts” since it is the function of the national courts to interpret their own law but rather its duty is to ascertain whether the outcomes of the national courts are compatible with the ECHR.
1612 Ibid. paras 13, 15, 54, 104. The 15 year old applicant was admitted to the children’s and young person’s psychiatric unit for seven months between 1974 and 1975 at her father’s instigation. When she reached eighteen she was placed in a locked ward at a private psychiatric clinic without her consent again at her father’s instigation. She managed to escape but was brought back to the clinic by the police. The private clinic was not permitted under German Law to accept detained patients. Detention in a public psychiatric hospital without consent is not permitted by German law without a court order.
1613 Ibid. paras. 150-151.
1614 Stanev v Bulgaria (n 120).
1615 Ibid. para. 143.
Richardson is doubtful that the safeguards introduced in the UK to comply with the ECHR have sufficient protections for a person with a mental health disorder who lacks capacity, requires treatment and who has been deprived of their liberty. These provisions are notable for a number of reasons in this context. Firstly the provisions also extend to older persons who are suffering, for example, from severe dementia and secondly Ireland would appear to be developing a similar two pronged legislative overlapping approach with the Mental Health Acts and the proposed Scheme of Mental Capacity Bill 2008. A further challenge is that the responsibility for the review of the Mental Health Act falls to the Department of Health while the proposed Scheme of Mental Capacity Bill 2008 is the responsibility of the Department of Justice. As Donnelly states the dual-model system “at a fundamental level, militates against ‘joined up thinking’ ” and allows for “inter-departmental games of ping pong where the more difficult or controversial issues are regarded by each department as more appropriately to be dealt with within the other Act.”

Undue Influence

In the case of Bourke v O’Donnell and the Bank of Ireland the presumption of undue influence was not rebutted and accordingly the transaction was set aside. The Court said:

The doctrine of undue influence enables a court to set aside transfers of property inter vivos whenever it appears that one party has not freely consented to the transaction. The law assumes that certain relationships of their very nature give rise to a presumption of undue influence and where this occurs the burden of proof shifts and the onus falls upon the party seeking to uphold a transaction to show the other party freely consented to it.

The case concerned “a highly vulnerable elderly lady” who had divested herself of the majority of her assets for no consideration to the first and second named defendants Mr and Mrs O’Donnell. A relationship of trust had existed between the plaintiff and Mr and Mrs O’Donnell. They helped look after Ms. Bourke and were in receipt of payment for this

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1616 Richardson, 2010, (n 1587) p. 60.
1617 See Ch. 3 of this work for a more detailed discussion.
1621 Ibid. para. 8.3.
1622 Ibid. para. 8.2.
work. Mr. O’Donnell had a key to Ms. Bourke’s house and for some time he collected her pension.\textsuperscript{1623} The Court considered her history of ill-health that incorporated “long periods of confusion and disorientation” together with the transaction itself and the failure of the respondents to rebut the presumption gave rise to the finding that the “presumption is unrebutted.”\textsuperscript{1624}

With regard to the bank Hedigan J. said that it had “breached a duty to enquire as to their customer’s capacity where substantial grounds to doubt existed.”\textsuperscript{1625} He advised that written protocols should be drafted by the banks to provide guidance to bank managers in such situations.

In a similar manner the courts have advised that due care should be taken by other professionals including solicitors.\textsuperscript{1626} The UK Court in the case of \textit{Key and Another v Key and Others}\textsuperscript{1627} acknowledged that bereavement was a factor capable of impairing testatorial capacity.\textsuperscript{1628} In this case Briggs J. was critical of the solicitor who failed to satisfy himself of the deceased’s testamentary capacity and his failure to keep a record of his meeting with the deceased and the deceased’s daughter when he took instructions regarding the new will. Briggs J.\textsuperscript{1629} reiterated\textsuperscript{1630} the importance of the golden rule that where a solicitor has received instructions to prepare a will for an older testator or for a person who has been seriously ill he should in the first instance ensure that the testator’s capacity is affirmed by a medical practitioner and that a contemporaneous record is maintained of the examination and results.

A solicitor must ensure that a person is acting independently of anyone and that they have made full enquiries of all the relevant circumstances. In \textit{Carroll v Carroll}\textsuperscript{1631} Denham J. in the Supreme Court said that “the legal advice (Mr. Carroll senior) received was inadequate....in all the circumstances ... that (he) was an unequal party.”\textsuperscript{1632} She affirmed the decision of the High Court that Mr Carroll had not received the “necessary independent advice...”\textsuperscript{1633} With regard to the solicitor Barron J. added “whatever independence (he) may

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\textsuperscript{1623} Ibid. para. 4.2.
\textsuperscript{1624} Ibid.
\textsuperscript{1625} Ibid. para. 8.8.
\textsuperscript{1626} \textit{Kenward v Adams} The Times, 28 November 1975; \textit{Key and Another v Key and Others [2010]} EWHC 408 (Ch).
\textsuperscript{1627} Ibid. \textit{Key and Another v Key and Others}.
\textsuperscript{1628} Ibid. para. 101.
\textsuperscript{1629} Ibid. para. 7.
\textsuperscript{1630} \textit{Kenward v Adams} (n 1626).
\textsuperscript{1632} Ibid. para. 43.
\textsuperscript{1633} Ibid. paras. 33-34.
have had has been destroyed by his acting in the present proceedings as solicitor to the personal representative of the donee.”

The intention of the proposed Legal Services Regulation Bill 2011 is to provide independent regulation of legal practitioners in Ireland. The doctrine of undue influence may arise where the advisor is the beneficiary. This can be contrasted with fraud where the advisor is obtaining a benefit for someone else as in the case of the *DPP v Heather Perrin*.

**Doctrine of Necessity**

When a capacity assessment has been carried out and the person is deemed not to have capacity to consent to or reject medical treatment the doctrine of necessity permits medical procedures to be carried out if it is in the best interests of the patient in a medical emergency. Such a defence for medical professionals is also available in the event of medical emergency where the patient is unconscious, is unable to give consent and requires emergency treatment in an accident and emergency department.

The doctrine of necessity was upheld by the ECtHR in *Herczegfalvy v Austria* where the vulnerability and powerlessness of individuals detained on grounds of mental ill-health was considered with the Court stating that “[t]he established principles of medicine are admittedly in principle decisive...” While the Court deemed that Article 3 had not been breached it emphasised the role the courts and the national authorities played in ensuring that medical necessity must be “convincingly shown to exist” in a therapeutic intervention and such ministration must not be either “inhuman or degrading.”

In the UK case of *Re F* the Marshall J. said “that the ‘gateway’ test for the engagement of the Court’s powers under s. 48 must be lower than that of evidence sufficient, in itself, to rebut the presumption of capacity.” The correct test for the engagement of s. 48 of the Mental Capacity Act 2005 the Court said,

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1634 Ibid. para. 79. In Ireland the courts may exercise authority under the parens patriae jurisdiction where decisions are made in the best interests of the person lacking capacity.
1635 At the time of writing the proposed Legal Services Regulation Bill 2011 contains 12 parts and 123 sections. It makes provision for setting up a legal services regulatory authority, a new complaints procedure and an independent legal practitioner’s disciplinary tribunal.
1636 Unreported CC 20 November 2012.
1637 (n 193).
1638 Ibid. para. 82.
1639 Ibid.
1640 Court of Protection, Case No. 11649371.
1641 Ibid. para. 37.
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is whether there is evidence giving good cause for concern that \( P \) may lack capacity in some relevant regard. Once that is raised as a serious possibility, the court then moves on the second stage to decide what action, if any, it is in P’s best interests to take before a final determination of his capacity can be made.\(^{1643}\)

Following the introduction of the Mental Capacity Act 2005 in the UK the case of *Dorset County Council v EH*\(^{1644}\) is of relevance given the difficulties that may arise when determining what is in the ‘best interests’ of someone who lacks capacity. EH was an 82 year old woman with Alzheimer’s disease who lacked capacity to make her own decisions with regard to her health and welfare or her place of residence.\(^{1645}\) An unnecessary dichotomy arose between autonomy on the one hand and welfare on the other with the applicant’s solicitor promoting autonomy over welfare and the official solicitor stressing the need for welfare. To assist the Court in reaching a decision in the “best interest” of EH Parker J. used a “balance sheet” setting out the pros and cons for EH remaining at home or going into residential care.\(^{1647}\) In reaching her decision Parker J. stated

\[
\text{[i]t is in EH’s best interests for her to be placed at Colindale, and for her liberty to be restricted consistent with her being in a locked care home and for her not to be allowed out without supervision. It is necessary for her to be deprived of her liberty in order to prevent harm to herself and is proportionate to the likelihood of her suffering harm and the seriousness of that harm.}\]

Dunn and Forster welcomed this discussion and suggested the principles of autonomy and welfare should be viewed as *amici curiae* and “encouraged to meet and talk respectfully with one another.”\(^{1649}\)

**A Lacuna in the Law**

A weakness of the Irish Mental Health Act 2001 is that it does not provide a definition of capacity and a further weakness pertains to the application of the test for capacity with

\(^{1642}\) S. 48 provides that “[t]he court may pending the determination of an application to it in relation to a person (“p”), make an order of give direction in respect of any matter if-

(a) there is reason to believe that P lacks capacity in relation to the matter,  
(b) the matter is one to which its powers under this Act extend, and  
(c) it is in P’s best interests to make the order or give the directions, without delay.”

\(^{1643}\) Court of Protection, Case No. 11649371 para. 44.  
\(^{1644}\) [2009] EWHC 784.  
\(^{1645}\) Ibid. para. 22.  
\(^{1646}\) Ibid. para 106.  
\(^{1647}\) Ibid. para 123.  
\(^{1648}\) Ibid. para 136.  
regard to consent to treatment. There is a limited test for capacity with regard to consent in that s. 57 pertains to those who have been admitted compulsorily. Where s. 57 does apply, questions may still arise as patient consent need not be taken into consideration where the patient is “unable or unwilling” to give consent. Of equal significance is that s. 57 which applies the reasonable patient standard test does not apply to voluntary admissions. The omissions can give rise to the treatment of an “unwilling” competent patient.

There is an absence of safeguards for the voluntary incapacitated patients who may or may not be able to communicate their wishes. In the case of E. H. v Clinical Director of St. Vincent’s Hospital the Supreme Court held that that applicant was lawfully detained. The Court stated,

that any interpretation of the term ‘voluntary patient’ in the Mental Health Act 2001 must be informed by the overall scheme and paternalistic intent of the legislation. The definition of voluntary patient was not framed in terms of a person who freely and voluntarily gave consent to an admission order but rather someone who was not the subject of an admission or renewal order.

An involuntary patient in an approved centre is subject to an automatic review of their medication for their mental illness by a second psychiatrist where the prescribing psychiatrist is of the opinion that the medication is required for a continuous period of three months. The voluntary patient is not afforded any review of their treatment or detention. Donnelly is concerned about the lack of review for the voluntary patient and that this second opinion on treatment for an involuntary patient is not independent.

Wards of court in mental health residential care settings are deprived of their liberty and are not afforded safeguards under the Mental Health Act 2001 by virtue of an exclusion clause. The absence of such protection is in breach of Article 5(4) of the ECHR since there is no automatic review of detention unless carried out by the High Court. In the absence of such a review the person is detained under a presumption of incapacity. There are no guidelines for capacity assessment with a view to potential discharge.

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S. 57 (1) provides “[t]he consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.” For an interpretation of this provision by the HC see, for example, HSE v X (n 763) para 54.

S. 57 (2) states “[t]his section shall not apply to the treatment specified in sections 58, 59 or 60.”


Donnelly, 2012 (n 1619).
With increased longevity there is increased incidence of dementia. One in 5 people aged 80 years and older will develop some form of dementia.\textsuperscript{1656} The LRC clearly recognise that capacity legislation needs “a broad gateway to possible use of enabling and empowering provisions.”\textsuperscript{1657} They emphasise the importance of an appropriate test for capacity. It argues for such a test using a consistency of language stating that “a decision that a person lacks capacity will be the gateway to a removal of autonomy and to another person having responsibility to make or assist in the making of the relevant decision.”\textsuperscript{1658}

Laffoy J’s\textsuperscript{1659} observations with regard to the need for future guidance where immediate medical interventions are deemed necessary are significant in that specific elements may equally apply in the context of the older person and a valid refusal to reject medical treatment such as

(a) the provision of specific guidelines by the Medical Council to ascertain how a valid refusal to reject medical treatment is to be assessed and to take account of the issues that may arise “giving effect to advance directives to refuse medical treatment.”\textsuperscript{1660}

(b) the appointment of an interim\textsuperscript{1661} legal officer to undertake duties similar to those carried out by the Official Solicitor in England and Wales with regard to the refusal of medical treatment by those with diminished capacity and\textsuperscript{1662}

(c) the development of a practice direction in the High Court detailing the steps to be followed in the event of medical emergencies where the permission of the Court is sought to carry out medical procedures including the administering of blood transfusions where the person lacks capacity or there is some doubt as to their capacity.\textsuperscript{1663}

To enable compliance with both constitutional and human rights law, the LRC has recommended that the law on capacity should empower rather than dis-empower thus maximizing the individuals’ potential for completeness in terms of their capacity.\textsuperscript{1664} The LRC further recommends the development of a Code of Practice to underpin the proposed capacity legislation.\textsuperscript{1665} The provision of guidelines on best practice with regard to capacity

\textsuperscript{1657} LRC 2005 (n 1547) p. 70 fn 50.
\textsuperscript{1658} Ibid. p. 69.
\textsuperscript{1659} Fitzpatrick v FK (No. 2) [2008] IEHC 104, part X1.
\textsuperscript{1660} Ibid. No. 3.
\textsuperscript{1661} While awaiting the implementation of the LRC’s recommendations.
\textsuperscript{1662} Fitzpatrick v FK (No. 2) (n 1659) part X1 No. 4.
\textsuperscript{1663} Ibid. No. 5.
\textsuperscript{1664} LRC, 2005 (n 1547) para. 1.47.
\textsuperscript{1665} Ibid. para. 7.81.
for the kindred professionals would benefit the recipient. Auditing would enable uniformity to flourish while attaining excellence. While emphasis on the assessment of capacity as a notion for enhancing legal protection is welcome, further mechanisms are required to advance the rights of vulnerable older people.\textsuperscript{1666}

The CRPD provides clear direction for law, policy and practice. Different types of decision-making enable older people express their needs and wishes in their given situation. These include in the first instance autonomous decision-making with reasonable accommodation for independent decision-making. An older person may or may not consult with family, friends or perhaps with a legal or medical professional. Ultimately the decision they make is theirs.

A second type is a supported decision-making system. Gunn et al. have shown that it is possible to enable some people who were incapable of meeting the requirements of a capacity assessment to meet those requirements by the provision of need specific information.\textsuperscript{1667} Furthermore to enable consistency of clinical practice Bellhouse et al argue convincingly that “capacity can be assessed with a reasonable level of agreement....\textsuperscript{1668} Supported decision-making has been defined as “the process whereby a vulnerable person is enabled to make and communicate decisions with respect to personal care or his or her property and in which advice, support or assistance is provided to the vulnerable person by members of his or her support network.”\textsuperscript{1669} Giving a person the necessary tools to make and communicate decisions may involve seeking the services of, for example, a speech therapist, an interpreter, other professional or an interlocutor (person with whom older people can relate).\textsuperscript{1670} For some people only minimal support may be required, for example, accessible written information.

The third type is facilitated decision-making. Bach suggests that this could arise, for example, when a person with significant disabilities was unable to act independently and had no person in their lives with a “personal knowledge about them sufficient to understand their ways of communicating, their will and/or intention as a basis for decision-making (as in a

\textsuperscript{1666} These mechanisms will be developed in the later chapters.
\textsuperscript{1669} Civil Code of Quebec, S.Q. 1991, c. 64, art. 258; see also AG’s Department of NSW “Capacity Toolkit” (AG’s Department of NSW 2008), pp. 147-161.
\textsuperscript{1670} Ibid. AG’s Department of NSW p. 154.
supported status.)\textsuperscript{1671} In another example Quinn\textsuperscript{1672} advances the case for facilitated or co-decision-making rather than substitute decision-making or guardianship where

\[\text{[f]acilitated co-decision-making involves an appointed person taking a decision based on a detailed understanding of the person’s life plan, wishes and intention, and one which has the potential to enhance the capabilities of the person in question, rather than one which is taken in their 'best interests'.}\textsuperscript{1673}\]

Representation could arise for example by way of advance directives including mental health advance directives and/or power of attorney.\textsuperscript{1674}

Substitute decision-making may be considered a fourth type of decision-making. Substituted decision-making Bach explains is “[a] legally-authorised removal of personhood from an individual, and a vesting of their ‘person’ in another authority for the purposes of making a decision about that individual’s health care, personal care/welfare, or property/finances.”\textsuperscript{1675} There is a notion that substitute decision-making is likely to be in violation of Article 12 CRPD.\textsuperscript{1676} However there is a place for substitute decision-making as a last resort. Bach is of the opinion that with “safeguards on its administration” substitute decision-making comes within the ambit of Article 12.4 of the CRPD.\textsuperscript{1677} The older person may be in a persistent vegetative state; that is not to say there is “any diminution of his or her personal rights…”\textsuperscript{1678} For example advance directives and other safeguards must be honoured and respected in compliance with the CRPD.

The requirement for safeguards against misuse of powers\textsuperscript{1679} and the need for training with regard to the obligations contained in the CRPD have been acknowledged.\textsuperscript{1680}

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\textsuperscript{1671} Bach and Kerzner, 2010 (n 112) p. 91.
\textsuperscript{1672} Quinn, 2012 (n 113) p. 6.
\textsuperscript{1673} Ibid. fn 1.
\textsuperscript{1674} Advance directives and power of attorney are addressed in Ch. 4 of this work.
\textsuperscript{1677} Bach, Dublin, 2009 (n 1675).
\textsuperscript{1678} In re a Ward of Court [1995] 2 ILRM 401, 428.
\textsuperscript{1679} European Foundation Centre Study on Challenges and Good Practices in the Implementation of the UN Convention on the Rights of persons with Disabilities (VC/2008/1214) Final Report Executive Summary p. 3. (Brussels, EFC, October 2010).
\textsuperscript{1680} Ibid. p. 5.
\end{flushleft}
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A brief mention is made here of outdated current legislative provisions and arrangements with regard to ‘best interests’ and health care decisions that gives rise to enormous distress to families, friends and professional bodies and carers. Where an older person is not competent to make a health care decision the following may be instigated: either Doctrine of Necessity, an Order of the High Court\textsuperscript{1681} or Ward of Court.\textsuperscript{1682}

**Discussion**

Legal capacity reform is of critical importance to us all. At first blush it may seem that its central value is the preserve of those who lack capacity. However as Quinn argues it has the potential to apply to each of us as it “cuts to the heart of what we mean to be human.”\textsuperscript{1683} He recognises “that persons with disabilities are ‘subjects’ and not ‘objects’ – sentient beings like all others deserving equal respect and equal enjoyment of their rights.”\textsuperscript{1684} Capacity according to Bickenbach is the “most profound paradigm shift” contained in Article 12 CRPD.\textsuperscript{1685} To animate the core concepts in Article 12 CRPD (they exist currently in theory and values), Bach has emphasised the need for law, policy and practice to enable persons with disability to “realise a good life.”\textsuperscript{1686} Equal recognition before the law, access to support and safeguards\textsuperscript{1687} are central to securing and safeguarding human rights for persons with disabilities.\textsuperscript{1688}

The proposed Scheme of Mental Capacity Bill 2008\textsuperscript{1689} (the proposed Bill) is long awaited. Capacity (in the proposed Bill) is considered as having the requisite knowledge to understand the nature, choices and consequence of a decision at the time of decision-making. All adults are presumed to have capacity unless proven otherwise. A person is considered to lack capacity to make a decision if they are unable (a) to understand the information relevant

\textsuperscript{1681} The High Court under the *parens patriae* jurisdiction may make an order in the best interests of the individual who is the subject of the court order; s. 9 (1) of Courts (Supplemental Provisions) Act 1961 No. 39 of 1961.

\textsuperscript{1682} The Court will appoint a wardship committee (friend or family member) who can make minor health care decisions, more serious decision-making is undertaken by the Court. See Ch. 5 of this work for a more extensive discussion.


\textsuperscript{1684} Ibid. p. 3-4.

\textsuperscript{1685} As discussed at the Mental Health Law Reform: New Perspectives and Challenges Conference in the National University of Ireland Galway 23\textsuperscript{rd} June 2012.

\textsuperscript{1686} Bach, M., “Key Rights – Personhood - The Right to Make Your own Decisions and have them Respected by others (Article 12 and Legal Capacity)” Paper presented at 4\textsuperscript{th} International Disability Summer School, National University of Ireland Galway, 19\textsuperscript{th} June 2012.

\textsuperscript{1687} Article 16 CRPD, for example, also requires freedom from exploitation, violence and abuse.

\textsuperscript{1688} See generally, Quinn, 2011 (n 41); see also A/HRC/10/48, 2009 (n 1676).

\textsuperscript{1689} The Adults with Incapacity (Scotland) Act 2000 provided a statutory framework for the medical treatment of incapacitated adults (aged 16 or over) in Scotland. S. 5 of the Act relating to medical treatment and research was amended by the Smoking, Health and Community Care Act 2005.
to the decision, (b) to retain that information, (c) to use or weigh that information in the
decision-making process and (d) to communicate the decision by any means including using
a third party.\footnote{1690} Where a person lacks capacity decisions may be made in their best
interests, focusing on the person’s wishes as far as they can be ascertained, having first
considered all the relevant circumstances.

The proposed Bill has a number of shortcomings. Of particular significance is that there is
no legal avenue to take account of the will and preferences of the individual with diminished
capacity in the present and in the future.\footnote{1691} The proposed Bill makes provision for the
appointment of a personal guardian where a person lacks capacity to make decisions with
regard to their personal welfare, property and other related matters. The CRPD on the other
hand brings a shift from guardianship and substitute decision-making to a “continuum of
support measures” to enable the older person exercise their legal capacity.\footnote{1692} The absence
of advocacy in the proposed Bill is unacceptable and requires inclusion. The shortcomings
in the proposed Bill need to be amended.

The need for reform of the mental health legislation is well acknowledged.\footnote{1693}
Implementation of the aforementioned will enable ratification of the CRPD that is now
overdue. This will also address the difficulty that has arisen with regard to the clash
between the ECHR Article 5.1(e) and Article 14 CRPD\footnote{1694} as the European provision allows
deprivation of liberty on particular grounds that is at variance with Article 14 CRPD.

Rights that are theoretical or illusory are of no value to the older person in residential care
unless they are transposed into law, policy and practice that are practical and effective.

\footnote{1690} Scheme of Mental Capacity Bill 2008.
\footnote{1691} Quinn, 2012, (n 113).
\footnote{1692} Ibid.
\footnote{1693} Donnelly, M., 2012 (n 1619); Kelly, B., “Key Elements of Mental Health Law Reform: A Clinical
Perspective”; paper presented at the Mental Health Law Reform: New Perspectives and Challenges
Conference in the National University of Ireland Galway 23rd June 2012.
\footnote{1694} Fennell, P., has spoken about the clash between Article 5.1.(e) ECHR and Article 14 CRPD.
Paper presented at the Mental Health Law Reform: New Perspectives and Challenges Conference in
the National University of Ireland Galway, 23rd June 2012.
Chapter 5    Legal Institutions

Wardship, Enduring Power of Attorney, Advance Directives and Advocacy

This chapter presents a discussion on the present position in Ireland with regard to wardship, enduring power of attorney (EPA), advance directives, and advocacy, highlighting the barriers that exist for the older person and their family and/or close friends in their attempts to secure rights and protection for both potentially vulnerable and vulnerable older people given the inadequacy of these legal institutions. One of the key issues for each of the topics is how capacity is assessed i.e. the test for incapacity. Robust safeguards are required to protect the older person and their interests as they become increasingly frail with illness and for many older people more vulnerable in residential care settings. This poses an immediate question with regard to our understanding of vulnerability. For the healthy octogenarians that I know increasing frailty may be an undesirable but normal part of ageing and Quinn’s words readily apply here in that they “all instinctively repudiate any assertion of power that effectively canalizes (their) existence.”1695

Vulnerability on the other hand is not and should not be considered an acceptable expectation of ageing. At different stages of the life course we may all experience episodes of vulnerability but this is usually intermittent and not continuous and may result from a life event such as bereavement. Vulnerability may imply weakness and defencelessness with the person becoming a victim. A paternalistic residential care setting can give rise to increasing vulnerability for the older person when, for example, autonomous decision-making is denied or the specific support that an individual may require to uphold their personhood is absent.

Personhood according to Bach “is made in relationship with others who come to recognize and know us as persons, and who on that basis engage with us as persons in personal, social and legal relations (contract, consent, etc.).”1696 Quinn reflecting on disability and the “social construct of vulnerability” recognises that a person’s “vulnerability is as much a social creation in the sense that it is brought about by social arrangements that are not sensitive to circumstances.”1697 While this is true of social arrangements it can similarly occur in terms of both the organisational arrangements and the attitudes and knowledge of people an older person may engage with in a residential care setting.

1695 Quinn, 2011 (n 41) p. 18-19.
1696 Bach, 2009, (n 1675).
Furthermore within a short period of time (anecdotally this is considered within two to three weeks) institutionalization may occur where organisational arrangements and/or the attitudes and knowledge of residential care workers can adversely impact the rights of the older person. In the vernacular ‘if you don’t use it you lose it’ or as Quinn more elegantly provides in the context of legal capacity, “the loss of legal capacity might prove to be self-perpetuating since it can be difficult to restore capabilities that have become degraded through the lack of use.”

Such a discussion cannot take place in isolation. The ascent in the development of human rights instruments in recent years in the context of adults and diminished capacity has placed particular emphasis on self-determination and autonomy. The ECHR, Article 9 of the European Convention on Human Rights and Biomedicine and Recommendation Rec(2006)5 of the Committee of Ministers to member states on the Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015 deserve special mention. The latter gives clear direction for policy makers so that programmes may be designed, refashioned and implemented to meet their population’s needs.

Account is taken of the Hague Convention on the International Protection of Adults in particular Articles 15, 16 and 38 and the CRPD.

1699 ETS No 5, 1950
1700 Oviedo Convention, ETS No. 164, 1997; Article 9 provides that “the previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account.” However the explanatory note on this point states: “nevertheless, taking previously expressed wishes into account does not mean that they should necessarily be followed. For example, when the wishes were expressed a long time before the intervention and science has since progressed, there may be grounds for not heeding the patient’s opinion.”
1701 See Mission statement para. 1.1.2
1702 2000; it entered into force on January 1st 2009 and concerns jurisdiction.
1703 A mandate in case of incapacity is located in Article 15 that provides: “(1) The existence, extent, modification and extinction of powers of representation granted by an adult, either under an agreement or by a unilateral act, to be exercised where such adult is not in a position to protect his or her interests, are governed by the law of the State of the adult’s habitual residence at the time of the agreement or act, unless one of the laws mentioned in paragraph 2 has been designated expressly in writing. (2) The States whose laws may be designated are-(a) a State of which the adult is a national; (b) the State of a former habitual residence of the adult; (c) a State in which property of the adult is located, with respect to that property. (3) The manner of exercise of such powers of representation is governed by the law of the State in which they are exercised.”
1704 Article 16 pertains to termination or modification of powers. It provides: “Where powers of a representation referred to in Article 15 are not exercised in a manner sufficient to guarantee the protection of the person or property of the adult, they may be withdrawn or modified by measures taken by an authority having jurisdiction under the Convention. Where such powers of representation are withdrawn or modified, the law referred to in Article 15 should be taken into consideration to the extent possible.”
Considering its importance it is appropriate to refer briefly\textsuperscript{1707} to Recommendation No. (99) 4 on the principles concerning the legal protection of incapable adults. These public measures of protection include procedural rules and the functions of those appointed to implement the protective measures. The explanatory memorandum to Recommendation CM/Rec (2009) 11 of the Committee of Ministers\textsuperscript{1708} affirms the importance of Recommendation No. R (99) 4 since it “continues to be of great relevance and remains entirely up-to-date.”\textsuperscript{1709}

The CPRD in its preamble among other things reaffirms “the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination.”\textsuperscript{1710} The importance of individual autonomy is recognised.\textsuperscript{1711} Article 4 of the CRPD is relevant here. It sets out general obligations that require State Parties to “ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability.” Article 12 provides “equal recognition before the law.” Article 12.3 also has particular relevance in this context where a person has capacity but may need support to enable them to exercise their legal capacity to make an enduring power of attorney, in such circumstances full support must be given. As Dhanda points out the “paradigm of interdependence” emanating from the CRPD “allows both autonomy and support to co-exist.”\textsuperscript{1712}

Developing on the principles of “necessity and subsidiarity” in Principle 5 of Recommendation No. (99) 4, Recommendation CM/Rec (2009) 11 contributes to the growth of rights for older people to enable them to plan for potential future incapacity. Specifically Recommendation CM/Rec (2009) 11 has recommended that “governments of member states

\textsuperscript{1705} Article 38 deals with an international certificate to enable the appointed representative to act on behalf of the person in the case of incapacity. Article 38 provides: “(1) The authorities of the Contracting State where a measure of protection has been taken or a power of representation confirmed may deliver to the person entrusted with protection of the adult’s person or property, on request, a certificate indicating the capacity in which that person is entitled to act and the powers conferred. (2) The Capacity and powers indicated in the certificate are presumed to be vested in that person as of the date of the certificate, in the absence of proof to the contrary. (3) Each Contracting State shall designate the authorities competent to draw up the certificate.”
\textsuperscript{1706} See Ch. 2 of this work for further discussion.
\textsuperscript{1707} Ibid.
\textsuperscript{1708} Recommendation to Member States on Principles concerning continuing powers of attorney and advance directives for incapacity (Adopted by the Committee of Ministers on 9 December 2009 at the 1073\textsuperscript{rd} meeting of the Ministers’ Deputies) available at https://wed.coe.int/wcd/ViewDoc.jsp?id=1563397andSite=CM Last accessed 1\textsuperscript{st} July 2011.
\textsuperscript{1709} Ibid. p. 15, para. 5.
\textsuperscript{1710} CRPD, Preamble, para. C.
\textsuperscript{1711} Ibid. para. n.
promote self-determination for capable adults by introducing legislation on continuing powers of attorney and advance directives or by amending existing legislation… to take account of the principles as detailed below under sections titled power of attorney and advance directives. As already stated above, Recommendation No. (99)4 is a public measure of protection while the more recent recommendation is essentially a private measure that an individual engages for themselves. The private measures or anticipatory actions, either enduring power of attorney and/or advance care directives may be instituted by a capable person in advance of any diminished capacity.

Wardship

The ward of court system is designed to protect those persons or more frequently the property1714 of those who do not have legal capacity.1715 In other words a ward of court is not deemed capable of making legal decisions due to their incapacity. Wardship jurisdiction rests with the President of the High Court under the parens patriae principle1716 (guardian of the people) or under Article 40.3 of the Constitution.1717 The High Court Proceedings are located in the Lunacy Regulation (Ireland) Act 1871 and in the Rules of the Superior Courts 1986.1718 The Courts (Supplemental Provisions) Act 1961, s. 22(2), as amended by Courts Act 1971, s. 2(3) permits the Circuit Court to become the legal guardian when a prospective ward has property not exceeding €6348.69 or the income generated from the property does not exceed €380.92 per annum.1719 The procedure for admission to wardship of the Circuit Court is detailed in Order 47 of the Circuit Court Rules 2001.1720

The impact on the ward becoming a ward of court was explained by Hamilton J. in In the matter of a Ward of Court (withholding medical treatment) (No 2),1721 “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....”1722

1714 The Courts Service website says “[t]he principle purpose of wardship is to protect the property of the ward and to manage it for his benefit and that of his dependants (if he has any).” Available at http://www.courts.ie.nsf/0/19111E254B2EF547802573D2006CCF26?OpenD. Last accessed 15/5/2011. The Office of Wards of Court information booklet (May 2003) states that “[t]he main purpose of Wardship is to look after the welfare and to protect the property of a person where this is considered necessary....”
1715 See, for example, s. 68 of the Lunacy Regulations (Ireland) Act 1871.
1717 LRC, 2003, (n 1546) ch. 4 ss. B-C.
1719 See also s. 9 Courts (Supplemental Provisions) Act 1961 with regard to serious health care decisions.
1721 (n 4).
1722 Ibid. 106.
The test for admission to wardship is whether a person “is of unsound mind, and incapable of managing himself or his affairs.” In practice a status approach is used to assess capacity. No account is taken, for example, of fluctuating capacity. The consequence for the ward is harsh in that the law (wardship law) in effect denies the person legal personhood and there is no automatic review. Denial of legal personhood effectively means a loss of legal right to autonomy and self-determination with regard to all aspects of the older person’s life, for example, welfare, health or property considerations. Given that a status approach is used the person may have capacity at particular times and in relation to specific issues. Denial of the person’s capacity gives rise to a breach of the person’s human rights.

The petitioner is normally a family member who makes an application to the court to make an inquiry regarding the older person’s state of mind and whether they are capable or incapable of managing their own affairs. The petitioner makes a verifying affidavit that is attested by his solicitor. This petition must be supported by two registered medical practitioners’ affidavits one of whom should be a consultant psychiatrist. Psychologists’ sworn affidavits are also accepted by the Registrar of Wards of Court. When the three affidavits have been lodged to the Wards of Court Office the Registrar of the Wards of Court submits them to the President of the High Court for consideration. The President of the High Court makes an “inquiry order” if satisfied with the medical evidence. Where an “inquiry order” is made the proposed ward (the respondent) is examined by a consultant psychiatrist and the report forwarded to the President of the High Court. The respondent is notified by the petitioner’s solicitor by way of a notice of the petition. Other persons as directed by the Judge may be notified of the petition. The respondent has seven days in which to object to the wardship proceedings. If no objection arises within that time the case is then listed for hearing. On foot of the hearing either a Declaration Order is made or the petition for wardship is dismissed.

1723 Lunacy Regulation (Ireland) Act 1871 s.2; the Rules of the Superior Courts 1986, Order 67.
1724 For a more extensive discussion on capacity see Ch. 4 of this work.
1725 An exception arises in that the ward may be able to make a will.
1727 Ibid.
1729 Ibid.
1731 Ibid. Rule 6.
1732 Ibid. Rule 7.
Chapter 5

An informal system exists for admission to wardship where an individual is deemed by one medical assessment to be of unsound mind and not capable of managing their own affairs and where the person has less than €50 thousand and no property. The person who acts for the ward must be attested by the solicitor to be trustworthy and honest.

Where a declaration order is made the court appoints a committee to oversee the normal welfare arrangements for the individual. However, more serious considerations are referred to the court. Consent to serious medical treatment for the ward is normally obtained from the Courts in the absence of an emergency. In the event of an emergency, usual medical considerations apply. This was affirmed by Denham J. in In the matter of a Ward of Court (withholding medical treatment) (No 2) who stated “in a medical emergency where the patient is unable to communicate...” medical treatment may be given to a person without their consent and “where the patient is a ward of court, the court makes the decision.”

A ward of court must be visited four times a year by medical or legal visitors if they reside in a private hospital. Where the hospital is public the requirement to visit is reduced to once a year. The purpose as detailed in the Act is to assess the arrangements for the care and welfare of the resident. A report is subsequently prepared for the President of the High Court. In reality there is a weak supervisory mechanism for the care and welfare of a ward of court and as Rickard Clarke points out, in general the visits do not occur in practice. This is a state failure to protect these individuals. O’Neill recommends (among other things) that the qualifications of the medical visitor should be prescribed by law given the importance of their role and that their reports are forwarded to the ward’s legal representative. The distinction between public and private residential care settings in terms of the frequency of the medical and legal visit has no validity. All wards require frequent visits irrespective of the type of residential setting to ensure adequate care and welfare arrangements are in place.

The wardship law is outdated, its language is derogatory and it fails to take cognisance of the differing degrees of capacity as considered by a functional approach to capacity. A

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1733 In Re an Application by the Midland Health Board [1988] ILRM 251 the ability of the wardship committee to give consent to treatment with respect to minor matters was confirmed.
1734 (n 4).
1735 Ibid. p. 156.
1736 Ibid.
1737 S. 56 of the Lunacy Regulation (Ireland) Act 1871. See Appendix 11 in this work.
1738 Ibid. s. 57. See Appendix 11 in this work.
1739 Ibid. s. 58.
1740 Rickard-Clarke, P. T., “Elder Abuse- Legal Solutions” in O’Dell, 2006 (n 7) p. 255.
1742 Lunacy Regulation (Ireland) Act 1871.
similar view is espoused by the LRC who state that wardship in the context of the elderly is now considered “too cumbersome, expensive and outdated.”\textsuperscript{1745} Furthermore the system exists in isolation from other state agencies and other providers of services to older people in residential care. Essentially there is an absence of procedural safeguards and review to protect the individual.\textsuperscript{1746} While the application for wardship must be served on the proposed individual, a vulnerable older person with diminished capacity may be overwhelmed by the process and their vulnerability in and of itself may be sufficient to deter them should they wish to object to the procedure.\textsuperscript{1747}

The LRC recognises the limitations of the still current legal provisions.\textsuperscript{1748} This compares well with O’Neill who is equally concerned with the shortcomings of the current provisions.\textsuperscript{1749} The legislative lacuna was not bridged in any way by the provisions of the Mental Health Act, 2001 as the ward of court has no rights under this legislation.

The figure for admission of older people to wardship on the grounds of mental infirmity has remained fairly constant.\textsuperscript{1750} For many families seeking to protect vulnerable older people in residential care the avoidance of wardship is paramount. The Nursing Homes Support Scheme Act 2009\textsuperscript{1751} euphemistically known as the fair deal scheme and substituted decision-making as part of that scheme, while flawed, have helped families avoid wardship for their older relatives in residential care. Wardship is very likely to breach Articles 5, 6, and 8 of the ECHR. As Quinn states with regard to substitute decision-making “[i]n a way substitute-decision-making is a symptom of civil death – of the surrender of the personhood of one person to another.”\textsuperscript{1752} Given that Article 12.4 of the CRPD refers to “safeguards … that … apply for the shortest time possible…” Quinn more recently said “[t]his would seem to suggest that ‘substitute decision-making’ and some form of guardianship is indeed acceptable provided it is time-bound.”\textsuperscript{1753} However he cautioned that regularizing

\textsuperscript{1743} In Re. Dolan 2008 IEHC 264, para. 32; the respondent and his family sought to escape wardship by the creation of a trust. Sheehan J. held that the Court did not have the jurisdiction to create the trust scheme that the parties sought.
\textsuperscript{1744} O’Neill, A. M., 2004 (n 1716) p. 185. The limitations of the functional approach are now recognised. Article 12 CRPD requires us to move beyond that approach to consider what specific supports an older person may need to enable them to exercise their legal capacity.
\textsuperscript{1745} LRC, 2003 (n 1546) p. 7; for further discussion, see generally, ch. 1, legal capacity and ch. 4, the wards of court system.
\textsuperscript{1746} O’Neill, A. M., 2004 (n 1716) p. 92-93.
\textsuperscript{1747} LRC, 2003. (n 1546) p. 7; according to the Court Service website the main aim of wardship is “to protect the property of the ward and to manage it for his benefit and that of his dependents.” See www.courts.ieHome.nsf/LookupP.Link/Courts+Opening.
\textsuperscript{1748} See, for example, the status approach to capacity and the emphasis on property arrangements.
\textsuperscript{1750} See Appendix 12 in this work.
\textsuperscript{1751} No. 15 of 2009.
\textsuperscript{1752} Quinn, 2011 (n 41) p.11.
\textsuperscript{1753} Quinn, G., “A: State of the Art and Objectives” (n 1698) p. 9.
“substitute decision-making ... shouldn’t come at the cost of innovating towards a newer and more supportive paradigm.”

The Commission of Investigation (Leas Cross Nursing Home) reports that at the time of their transfer from St. Ita’s Hospital in Portrane to Leas Cross Nursing Home four patients were wards of court and that three other patients were subsequently made wards of court when in Leas Cross. The notification to the Wards of Court Office about the transfer of the wards was either delayed or did not take place. The Commission expressed particular concern about the poor communication between the health services and Wards of Court office deeming it to be “totally unacceptable.”

Safeguarding and maximizing the right to self-determination is now generally accepted by international and common law jurisdictions as the proper way to protect the personhood and property rights of disabled individuals of all ages. This can be achieved in Ireland by emulating approaches in other jurisdictions, by embracing the rights to natural justice in the context of the wardship arrangements, by curtailing the powers of guardians or committees to those activities that the ward cannot possibly be able to undertake for themselves so that the vulnerable older person in residential care can maximise their full potential in their individual circumstances and that the guardian only step in where the potential has not been realised and further measures are required to address the needs of the individual.

To ensure that robust systems of protection for safeguarding the rights of vulnerable older people in residential care are in place for those who are made wards of court, the considerations under the proposed Scheme of Mental Capacity Bill 2008 as outlined above in the context of EPA’s are equally important in terms of wardship. Germane to this discussion is the functional assessment test of mental capacity. However Article 12 CRPD requires us to move beyond that approach and to consider what specific supports an older person may need to enable them to exercise their legal capacity. The proposed Bill when enacted will abolish the Lunacy Regulation (Ireland) Act 1871, provide power to the Court to issue declarations regarding a person’s capacity, to appoint personal guardians to make decision(s) on behalf of the older person taking account of the guiding

1754 Ibid.
1755 O’Donovan, 2009, (n 32); see also Ch. 7 of this work.
1756 Ibid. p. 242.
1757 Ibid. p. 243.
1758 See, for example, the Recommendation No. R (99)4 (n 351); the CRPD; Quinn, 2011 (n 1688).
1760 Proposed Scheme of the Mental Capacity Bill 2008, Head 2.
1761 Ibid. Head 23.
1762 Ibid. Head 5.
principles of the Act,1763 and the person’s best interests,1764 to confer responsibility for the “custody, control and management” of the older person’s property on the Public Guardian where it deems it appropriate,1765 to make interim orders,1766 seek the assistance of professional services (medical, social or health care or financial) to assist them in their decision-making,1767 to review a capacity decision at intervals not exceeding 36 months and to make provision for legal representation.1768 The High Court has sole jurisdiction to alter a will in exceptional circumstances1770 and to determine any matters with regard to: “(b) withdrawal of artificial life-sustaining treatment or, (c) organ donation.”1771 The proposed Bill needs to be amended to incorporate the changes brought about by the CRPD. In particular the functional test in assessing capacity may need to be augmented with supports to give voice to the will and preference of the individual. Furthermore Quinn suggests that facilitated or co-decision-making instead of guardianship and substituted decision-making should be considered as a last resort where there is no other means of securing legal capacity for an individual.1772

The maximum capacity review period is excessive and needs to be altered to take account of the potential of an individual’s altering capacity. Also where an older person in residential care is already a ward of court the legislation should be amended to incorporate a requirement for review of capacity for such persons on enactment of the legislation and at regular intervals. The differentiation of mandatory review for applications following enactment of the legislation with an optional arrangement for those already in wardship gives rise to discrimination.

Over the years a number of people have been admitted ‘voluntarily’ to mental health approved centres and are currently de facto detained in these centres.1773 Given the length of their detention they have aged in these settings. Since ‘voluntary’ admissions who are not truly voluntary do not come within the scope of the Mental Health Act 2001 these residents are not afforded the legislative protections contained in that Act. Their informal detention is

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1763 Ibid. Head 1.
1764 Ibid. Head 6 as it relates to Head 3; However, Article 12.4 of the CRPD refers to the will and preferences of the individual.
1765 Ibid. Head 8 (4).
1766 Ibid. Head 12.
1767 Ibid. Head 13.
1768 Ibid. Head 14.
1769 Ibid. Head 15.
1770 Ibid. Head 19.
1771 Ibid. Head 21; (a) relates to non-therapeutic sterilisation.
1772 Quinn, 2012 (n 113) pp. 5-6.
1773 Mental Health Act 2001 Part 5; the Mental Treatment Act, 1945 referred to “approved institution;” the Mental Treatment Act, 1945 was repealed by The Mental Health Act 2001 save for Part V111 and ss. 241, 276, 283 and 284. See also E.H. v Clinical Director of St. Vincent’s Hospital [2009] IESC 46.
not reviewed by the Mental Health Tribunal and is at variance with the requirements of Article 12 of the CRPD.\(^\text{1774}\)

Two different sets of circumstances surrounded the admission of these elderly residents. Firstly, for those that had capacity to accept or refuse admission, their admission in the first instance may have arisen out of fear of being detained involuntarily should they refuse to be admitted. Secondly for others who did not have the capacity to consent to admission, they were admitted as ‘voluntary’ patients because they did not object to their admission to the mental health residential centre. These circumstances have resonance with *H.L.*\(^\text{1775}\) In *H.L.*\(^\text{1776}\) the ECtHR noted “the lack of any formalised admission procedures...”\(^\text{1777}\) there was “no time limits in terms of time, treatment or care attached to his admission”\(^\text{1778}\) and there “were no specific provisions for requiring a continuing clinical assessment of the persistence of a disorder warranting detention.”\(^\text{1779}\) Accordingly H.L.’s detention was deemed to be in violation of Article 5.1 of the ECHR.\(^\text{1780}\) In *Winterwerp*\(^\text{1781}\) the ECtHR said “sub-paragraph (e) of Article 5 para. (art. 5-1-e) obviously cannot be taken as permitting the detention of a person simply because his views or behaviour deviate from the norms prevailing in a particular society.”\(^\text{1782}\)

A legal vacuum exists for older people who no longer have capacity. Urgent legislative reform is required to embrace robust safeguards for older people in residential care. The CPT trusts that the proposed mental capacity legislation will embrace all wards of court.\(^\text{1783}\)

The benchmark for best interests, as provided by Mason and Laurie, is the older person’s “inner world must be assessed subjectively and not related to the observer’s own youthful or middle-aged experience.”\(^\text{1784}\) In an Irish context clarity is required with regard to ‘best interests’ since this traditional approach enhances paternalism and such an approach is at complete variance with Article 12 that emphasises the “will and preference” of the older person. Training is required for all duty holders with regard to capacity assessment, best interests assessment and to ensuring that the duty holders work cohesively with the will and preference of the older person centre-stage. These assessments must be objective. Duty holders may include, for example, a registered medical practitioner, registered nurse, an

\(^{1774}\) See Ch. 2 of this work.
\(^{1775}\) (n 221).
\(^{1776}\) Ibid.
\(^{1777}\) Ibid. para. 120.
\(^{1778}\) Ibid. my inclusion in italics.
\(^{1779}\) Ibid.
\(^{1780}\) Ibid. para. 124.
\(^{1781}\) (n 222).
\(^{1782}\) Ibid. para. 37.
\(^{1783}\) CPT/Inf (2011) 3 para. 149.
\(^{1784}\) Mason, and Laurié, 2006, (n 1404) para. 12.36.
occupational therapist, a social worker, a chartered physiotherapist, lawyer, care representatives, banks and other financial institutions, the Health Information Quality Authority, employees of the HSE and employees of other residential care settings, employees of the Departments of Justice and Social Welfare and persons nominated under Social Welfare (Consolidated Claims, Payment and Control (Amendment) No. 6 (Nominated Persons) Regulations 2009.

Power of Attorney

Part 1 of the Appendix to Recommendation CM/Rec (2009) 11 sets out the scope of application contained within Principle 1 and Principle 2. Principle 1 concerns the promotion of self-determination. Included in the terms defined in Principle 2 are a “continuing power of attorney,” the “granter” and the “attorney.” Part 11 of the Appendix to Recommendation CM/Rec (2009) 11 is concerned specifically with continuing powers of attorney. Principle 3 addresses content. It states that “[s]tates should consider whether it should be possible for a continuing power of attorney to cover economic and financial matters, as well as health, welfare and other personal matters, and whether some particular matters should be excluded.”

Principle 4 pertains to the appointment of an attorney(s). The granter selects one or more appropriate persons “to act jointly, concurrently, separately, or as substitutes….” and to apply restrictions as they consider necessary to protect the granter. To ensure validity the power should be in writing and States are advised to “consider what other provisions and mechanisms may be required” to protect the validity of the document. For example the Committee of Ministers (Commission) recommends that systems should be in place to enable a capable individual to revoke the continuing power should they so wish. Where an enduring power of attorney arises the member states must ensure that its adoption is regulated and that criteria are set for

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1786 S.I. No. 378 of 2009; these regulations amend the Social Welfare (Consolidated Claims, Payments and Control) Regulations 2007 S.I. No. 142 of 2007. S.I. No. 378 of 2009 Regulation 2 (b) excludes wards of court and those who have appointed enduring power of attorney where “(i) the attorney in not prohibited or restricted by the terms of the power from performing any matter to which this article applies, and (ii) the ensuring power of attorney has been registered and the registration has not been cancelled.”
1787 (n 1708).
1788 Ibid. Principle 2.1 states that “[a] “continuing power of attorney” is a mandate given by a capable adult with the purpose that it shall remain in force, or enter into force, in the event of the granter’s incapacity.”
1789 Ibid. Principle 2.2 states that “[t]he “grantor” is the person giving the continuing power of attorney. The person mandated to act on behalf of the grantor is referred to as the “attorney.”
1790 Ibid. Principle 3
1792 Ibid. Principle 5 – Form.
determining incapacity. Provisions for the certification, registration and notification should be instituted for the granting, revocation, commencement and termination of the enduring power of attorney. The Commission point out the legal capacity of the donor is not affected by the commencement of the enduring power of attorney. Principle 10 details the role of the attorney as follows:

1. The attorney acts in accordance with the continuing power of attorney and in the interests of the granter.
2. The attorney, as far as possible, informs and consults the granter on an on-going basis. The attorney, as far as possible, ascertains and takes account of the past and present wishes and feelings of the granter and gives them due respect.
3. The granter’s economic and financial matters are, as far as possible, kept separate from the attorney’s own.
4. The attorney keeps sufficient records in order to demonstrate the proper exercise of his or her mandate.

Systems should be in place to regulate matters should a conflict of interest arise between the attorney and the donor. In terms of supervision of the attorney the Commission recognises that the donor may appoint a third party to oversee the attorney. Principle 12.2 also pertains to supervision and given its importance is included fully here:

States should consider introducing a system of supervision under which a competent authority is empowered to investigate. When an attorney is not acting in accordance with the continuing power of attorney or in the interests of the granter, the competent authority should have the power to intervene. Such intervention might include terminating the continuing power of attorney in part or in whole. The competent authority should be able to act on request or on its own motion.

**Power of Attorney Act, 1996**

The Power of Attorney Act, 1996 is the current legislative provision that addresses powers of attorney in Ireland. As will be shown it falls well short of the recommendations of the Committee of Ministers as outlined above.

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1794 Ibid. Principle 7 - Entry into force.
1795 Ibid. Principle 8 - Certification, registration and notification.
1796 Ibid. Principle 9 - Preservation of capacity.
1797 Ibid. Principle 10 - The Role of the Attorney.
1798 Ibid. Principle 11 - Conflict of interest.
1799 Ibid. Principle 12.1.
A power of attorney enables an individual (the donor) to convey by way of an instrument (may be contained in an instrument) either signed by or signed at the donor’s direction to another (called the donee or attorney) allowing them to act on behalf of the donor according to the terms of the instrument.\textsuperscript{1801}

There are two types of power of attorney, the general or common-law type and the enduring power of attorney (EPA). The EPA can be distinguished from a general power in that the general power is automatically revoked should the donor become mentally incapable.

With an enduring power of attorney the donor intends the power to be used should they incur reduced or diminished mental incapacity.\textsuperscript{1802} Mental incapacity is defined as “mental incapacity by reason of a mental condition to manage and administer his or her own property and affairs....”\textsuperscript{1803} The document is fixed on the person’s wishes at the time of creation unless altered. The EPA system allows for alternative decisions only where the individual has adapted the system themselves.\textsuperscript{1804} To become effective the EPA must be registered\textsuperscript{1805} when the donee is of the opinion the donor “is or is becoming mentally incapable.”\textsuperscript{1806} This legislative view of capacity is especially problematic as it upholds a ‘status approach’ to capacity.\textsuperscript{1807} The LRC recommends that the 1996 Act is amended to incorporate a functional view of capacity.\textsuperscript{1808}

At the time of appointment the donor must have legal capacity.\textsuperscript{1809} An EPA can, if authority is vested in them by the donor, make decisions with regard to property and other financial affairs together with personal care decisions for the donor.\textsuperscript{1810} Regulation 5\textsuperscript{1811} requires an attorney appointed to act in respect of a donor’s property to “keep adequate accounts” with

\begin{itemize}
  \item \textsuperscript{1801} Ibid. ss. 2(1) and 4.
  \item \textsuperscript{1802} Ibid. s. 5 (1).
  \item \textsuperscript{1803} Ibid. s. 4 (1).
  \item \textsuperscript{1804} LRC, 2003, (n 1546) ch. 3.
  \item \textsuperscript{1805} See Appendix 13 in this work.
  \item \textsuperscript{1806} S. 9 (1) of the Powers of Attorney Act, 1996.
  \item \textsuperscript{1807} See discussion on capacity in Ch. 4 of this work.
  \item \textsuperscript{1808} LRC, 2005, (n 1547) p. 105.
  \item \textsuperscript{1809} Enduring Powers of Attorney Regulations, 1996 S.I. No 196 of 1996 part E, schs. 1 and 2; see also Guidelines for Solicitors –Enduring Powers of Attorney (Dublin, 2004) with regard to capacity at Appendix 5.
  \item \textsuperscript{1811} Ibid. Enduring Powers of Attorney Regulations, 1996.
\end{itemize}
Chapter 5  
Legal Institutions

regard to the management of such property. However no High Court Registrar to date has requested an attorney to file accounts.1812

Health care decisions are not included in the personal care decisions that may be undertaken as defined by s. 4 of the 1996 Act.1813 The LRC provisionally recommends that an EPA should be able to make “minor or emergency healthcare decisions” if that authority has been vested in them by the donor.1814 The proposed Scheme of Mental Capacity Bill 2008 at Head 48 includes provision for the EPA to make welfare decisions that includes all health care decisions with the exception of those that concern the withdrawal of artificial life sustaining treatment, or organ donation.1815 The proposed Bill vests such power in the High Court.1816

A further weakness of the power of attorney system is that there is no provision made for auditing the appointed attorneys. The Report of the Working Group on Elder Abuse Protecting our Future has recommended that “adequate supervision and review be put in place for the EPA in the management of the older person’s finances and welfare to prevent abuse.”1817 In the UK it is estimated that 10 per cent of those given powers under enduring power of attorney abuse the granted powers.1818 A more recent Irish report The Report on the National Study of Elder Abuse and Neglect in Ireland1819 identified financial abuse as the most prevalent type of mistreatment at 1.3 per cent of the study group. Of those 4 per cent related to misuse of power of attorney.1820 The study involved capable adults over 65 years of age and the greatest percentage of financial abuse was carried out by a family member.1821

The earlier Report1822 suggested that promotional programmes to advance the merits of the EPA should be undertaken by the relevant professional groups dealing with the elderly to enable them to advise their clients. While the Report recommends that procedures should be

1814 LRC, 2003, (n 1546) para. 3.14-3.15.
1815 Non-therapeutic sterilization is included in Head 21 but clearly does not apply to this cohort.
1816 Head 21.
1819 National Centre for the Protection of Older People (NCPOP) Abuse and Neglect of Older People in Ireland: Report on the National Study of Elder Abuse and Neglect (Dublin, NCPOP, 2010).
1820 Ibid. p. 44.
1821 Ibid. p. 47.
developed and integrated into the EPA system the LRC is more specific in this regard. It recommends that an attorney should be under the supervision of the proposed Office of the Public Guardian.\textsuperscript{1823} The courts according to O’Neill\textsuperscript{1824} should be able to revoke an EPA where the facility exits within the terms of the EPA and where it would be in the best interests of the donor to do so.

Another perspective is offered by Costello who sees the benefit of EPA in terms of the family, in that, legal matters can be sorted in advance minimising problems of a legal nature that would otherwise arise.\textsuperscript{1825} Wardship, it has been shown, is best avoided. In order to escape wardship Costello suggests an EPA should be considered.\textsuperscript{1826}

The number of registered EPA’s while growing continues to remain low.\textsuperscript{1827} At first glance the low take-up may appear unfortunate; an individual should be able to plan with some degree of certainty that if they become mentally incapacitated decisions would be made for them in the manner that they would have wished. However given the shortcomings of the legislation it is not altogether surprising that there is a low take-up especially given the status approach to capacity. These shortcomings highlight yet again the need for appropriate legislative safeguards for the vulnerable older person.

The enactment of the proposed mental capacity legislation is crucial to help safeguard the rights of older people. In particular in this context is the replacement of the 1996 Act with the proposed Scheme of the Mental Capacity Bill 2008. However, EPA’s drawn up before the enactment of Part 3 of the Mental Capacity Bill would remain unaffected by this part.\textsuperscript{1828} This effectively creates a two-tier system.

Significantly capacity assessment in this section (Part 3) has been assigned the same meaning as in the earlier part of the Bill i.e. a functional approach.\textsuperscript{1829} Other reforming elements of the Bill include permitting the attorney to make health care decisions subject to restrictions, for example, matters confined to the jurisdiction of the High Court, in particular “(b) the withdrawal of artificial life-sustaining treatment, or (c) organ donation.”\textsuperscript{1830} The Bill stipulates that welfare decisions (this includes health care decisions) are to be made in

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\textsuperscript{1823} LRC, 2003, (n 1546) p. 79.
\textsuperscript{1825} Costello, J., “Assisting Clients and Their Families to Plan for Incapacity” in O’Dell, 2006 (n 7) p. 166.
\textsuperscript{1826} Ibid.
\textsuperscript{1828} Proposed Scheme of Mental Capacity Bill 2008, Head 57.
\textsuperscript{1829} Article 12 of the CRPD provides for supported decision-making.
\textsuperscript{1830} Ibid. Head 21 as it relates to Head 48.
the best interest of the donor.\footnote{Ibid. Head 48 (2)(a); Article 12 of the CRPD requires a move away from best interests to ensuring that the will and preferences of the individual are respected.} In addition to supervision and review in terms of the older person’s finances and welfare the Bill needs to accommodate safeguards including auditing to prioritise the supports necessary in a prompt and expedient manner as the needs of the older person change. For example, if an older person has a cerebro vascular accident (stroke) they will perhaps require speech therapy, physiotherapy and occupational therapy.

In other words spending of the donor’s money must be focused on the specific needs of the donor as and when the needs arise.

The Bill is silent on the need for training and supervision with regard to those assessing best interests.\footnote{Ibid. Best interests has been highlighted; it is associated with paternalism and is the subject of discussion of law reform. A statutory requirement for training and supervision is not a new phenomenon, for example, s. 8. (2)(g) of the Safety, Health and Welfare at Work Act 2005 No. 10 of 2005 requires the provision of information, instruction, training and supervision for the assessor (the person making the determination\footnote{Proposed Scheme of Mental Capacity Bill 2008, Head 39.}) is required and the competencies that the trainers require.} This anomaly could be addressed either through an amendment to the Bill or perhaps more realistically through a code of practice\footnote{Ibid. Head 3 (1).} stipulating what information, instruction, training and supervision for the assessor is required and the competencies that the trainers require.

As proposed, restraint of a donor by a donee may only be carried out where the donor lacks capacity in relation to a particular matter or the donee is of that opinion and the restraint serves to protect the donor and is proportionate to the risk of the harm occurring.\footnote{Ibid. Head 48 (5).}

An offence is created where a donee “ill-treats or wilfully neglects” a donor.\footnote{Ibid. Head 27.} An omission in the Bill is the absence of a definition of ill-treatment and neglect.\footnote{S. 254 of the Mental Treatment Act 1945 provided an offence for ill-treatment or neglect. Ill-treatment or neglect is not defined under this legislation; S. 4 of the Criminal Law Amendment Act 1935 No. 6 of 1935 may also have relevance with regard to an offence against an older woman in residential care. Sch. 5 as it relates to Regulation 27(1) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 requires written and operational policies for among other things, 1. “[t]he prevention, detection and response to abuse and 13 [t]he handling and investigation of complaints...”; Regulation 10 of the Health Act 2007 (Care and Welfare of Resident in Designated Centres for Older People) (Amendment) Regulations 2010 S.I. No. 36 of 2010 requires records to be kept with regard to “all complaints made by residents or representative or relatives of residents or by persons working at the designated centre...”} Different meanings may be ascribed to ill-treatment and neglect and some donees may not consider their behaviour as giving rise to ill-treatment or neglect. To help protect the donor by
preventing such an occurrence clarity is required for the donee so that they are clear as to what constitutes ill-treatment and neglect.\footnote{See also, for example, Article 16 (1) of the CRPD that stipulates that State Parties must take “all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities … from all forms of exploitation, violence and abuse, including their gender-based aspects.” Among other things monitoring the implementation of the CRPD by State Parties is located in Article 33 CRPD.} An individual donee may then view their attitudes and behaviours through a new lens and consequently attitudes and behaviours towards the older person can be positively altered. Also as in other areas of law, prosecution and the possibility of sanctions on conviction by way of a fine and/or custodial sentence would be a powerful deterrent.

Provision is made for the establishment of the Office of the Public Guardian under the new Bill.\footnote{Proposed Scheme of Mental Capacity Bill 2008 Head 28.} Its function will include, for example, maintaining a register of enduring powers of attorney and a register of court orders and other court matters,\footnote{Ibid. 32 (2) (a) and (b).} supervision,\footnote{Ibid. 32 (2) (c), (d) and (k).} dealing with complaints concerning a donee,\footnote{Ibid. 32 (2) (i).} the provision of advice,\footnote{Ibid. 32 (2) (j).} appointment of a special or general visitor\footnote{Ibid. 32 (6).} and the preparation of codes of practice.\footnote{Ibid. 39.}

Detailed submissions have been made to the Department of Justice, Equality and Law Reform (as it was then known) on the Bill.\footnote{NDA submission x 2, Law Society of Ireland (LSI) submission, Amnesty International x 2, Irish Human Rights Commission, Madpride Ireland, Mental Health Commission, Inclusion Ireland, Irish Mental Health Lawyers Association, Irish Brain Injury Advocacy Association, Age Action Ireland, College of Psychiatry of Ireland, Crisis Pregnancy Agency, Mental Health Reform and the Citizen’s Information Board as obtained from the Department of Justice and Equality May 2011.} For example, the NDA recommends that supported decision-making should be specifically included.\footnote{Ibid. NDA submission, p. 3.} This is to be welcomed. However, as Quinn points out, supported decision-making only goes part of the way to enabling the person to exercise their legal capacity as the process is an evolving one, many steps may have to be taken with the individual in advance of the actual decision being made.\footnote{Quinn, 2011 (n 411) p.17.} An independent advocacy service is required and the advocates trained to enable them to respond as fully as possible to the needs of those they are supporting.\footnote{Advocacy is addressed in greater detail later in this chapter.}

Provision for review of informal decision-making is required. The Citizens Information Board recommends that the Bill incorporates provision for the monitoring of informal
decision-making by the Office of the Public Guardian. Also, the Law Society recommends that among the functions of the Office of the Public Guardian in the context of enduring powers of attorney “regulation must provide that there is a requirement of donees of enduring powers of attorney to file accounts and report on the welfare of the person who lacks capacity. There should also be a requirement that the Public Guardian report on the discharge of his functions.”

In advancing rights of older people regular review of capacity is of paramount importance. The frequency of review of capacity at a minimum of 36 months is excessive given that an older person’s lifespan may be nearing a close. The NDA consider that the review could be undertaken by the Office of the Public Guardian. However with regard to older people in residential care who do not come within the ambit of the Mental Health Act 2001 consideration should be given to undertaking this review as part of the HIQA inspection procedure. For those older people who come within the ambit of the Mental Health Act 2001 the review could be undertaken by the Office of the Public Guardian. The merits of the dual system is that all those who lack capacity will be reviewed and it obviates the need for another public body to visit private and public residential care centres that are already visited by HIQA.

In terms of legal capacity and property rights the Law Society has recommended that s. 9 of the Health (Repayment Scheme) Act 2006 should be reviewed and amended and that the role of the Public Guardian in the Proposed Scheme of Mental Capacity Bill 2008 should be expanded to “include e.g. supervising the HSE in its management of patients’ private property accounts on behalf of persons who lack capacity to manage accounts personally.”

Court jurisdiction is dependent on property valuation. The last thing an older person is likely to countenance is attendance at the High Court as it is likely to give rise to fear and insecurity and, secondly, they may be unlikely to be willing or able to incur the costs involved. Time is not necessarily on the side of the older person and the delay in getting to Court could of itself be a barrier to attendance. A number of observations and recommendations have been made with regard to a court-based system as a primary

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1850 Citizens Information Board Submission on Scheme of Mental Capacity Legislation, (n 1846) p. 7.
1851 LSI submission (n 1846) para. 2.3.
1852 Scheme of Mental Capacity Bill 2008 Head 14.
1853 NDA submission (n 1846) p. 9-10; also see The Council of Europe’s Recommendation (99)4 Principle 14 in this regard.
1854 LSI submission (n 1846) p. 10.
1855 Scheme of Mental Capacity Bill 2008 Head 4; see also, for example, LSI submission (n 1846) para. 1.2.
1856 NDA submission (n 1846) p. 3; LSI submission (n 1846) throughout document.
decision-maker including alternative arrangements.\textsuperscript{1857} For example one of the key recommendations of the Law Society of Ireland is that “the powers of the Court as specified in Head 5 be specifically subject to the guiding principles in Head 1 and the best interest principle in Head 3.”\textsuperscript{1858} The NDA in their submission on the proposed Mental Capacity Scheme Bill identify the Courts as “the appropriate forum in which to hear appeals, but” they have highlighted serious reservations about a courts-based system for primary decision-making. One of their key reservations states:

Decisions on legal capacity bear on people’s fundamental rights. In this complex area, it is essential for those making decisions to have adequate training and to build up the expertise to inform soundly-based and consistent judgements. It is difficult to deliver that expertise and consistency in a court system carrying a varied general caseload.\textsuperscript{1859}

The NDA further recognise that “fundamental decisions relating to a person’s autonomy and well-being should not be made in a person’s absence, or without the person concerned being seen by the deciding body.”\textsuperscript{1860} The NDA recognises that perhaps the person is confined to bed.\textsuperscript{1861} NDA asks “that alternatives to a court-based system be seriously considered.”\textsuperscript{1862} These are eminently sensible recommendations. In terms of governance this is a win win for all.

\textbf{Advance Care Directives}

Historically most people died in their own homes. Recent trends show an increase in the numbers of people dying in health care institutions.\textsuperscript{1863}

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Deaths</th>
<th>Deaths in Acute Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74 years</td>
<td>5,280</td>
<td>2,453</td>
</tr>
<tr>
<td>75-84 years</td>
<td>9,412</td>
<td>4,079</td>
</tr>
<tr>
<td>85+ years</td>
<td>7,382</td>
<td>2,286</td>
</tr>
<tr>
<td>Total</td>
<td>20,074</td>
<td>8,818</td>
</tr>
</tbody>
</table>

Source: Vital Statistics, 2004; Hospital In-patient Enquiry System (HIPE), 2004 taken from End-of-life Care for Older People in Acute and Long Stay Care Settings in Ireland p. 29\textsuperscript{1863}

\textsuperscript{1857} Ibid. NDA submission. (n 1846) p. 3.
\textsuperscript{1858} LSI submission (n 1846) para. 1.1; as discussed ‘best interest’ is a cause of concern.
\textsuperscript{1859} NDA submission (n 1846) p. 4.
\textsuperscript{1860} Ibid.
\textsuperscript{1861} Ibid.
\textsuperscript{1862} Ibid. p. 5.
In 2006 28,488 deaths were registered in Ireland. Of those 25% of people died in their own home, 48% in acute hospitals, 20% in long-stay facilities, 4% in Hospices and other places accounted for 3%.\textsuperscript{1864}

This change together with changes in medical technology that prolongs life indefinitely is a cause of fear for many. This increased anxiety in the loss of control in the management of one’s own end of life decisions has resulted in extensive worldwide debate to ameliorate the quality of dying.\textsuperscript{1865} This interplay (the human body and the machine) found expression in the Supreme Court of Arizona in \textit{Rasmussen v Fleming}\textsuperscript{1866} the Court stating,

\begin{quote}
[n]ot long ago the realms of life and death were delineated by a bright line. Now this line is blurred by wondrous advances in medical technology – advances that until recent years were only ideas conceivable by such science-fiction visionaries as Jules Verne and HG Wells. Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity.
\end{quote}

As more individuals assert their right to refuse medical treatment, more frequently do the disciplines of medicine, law, philosophy, technology and religion collide. This interdisciplinary interplay raises many questions to which no single person or profession has all the answers.\textsuperscript{1867}

In its definition of advance care directives the LRC does not limit the application of advance care directives to end of life decisions but embraces all health care decisions.\textsuperscript{1868} The LRC defines advanced care directives as “a decision or series of decisions” made by an individual “on future medical treatment, which is designed to take effect should the person lack the requisite capacity to make the relevant decision at a future date.”\textsuperscript{1869}

Much discussion has already taken place about the importance of Article 12 of the CPRD and enduring power of attorney in the ascent of rights for all. These provisions are equally

\textsuperscript{1865} LRC Consultation Paper: \textit{Bioethics: Advance Care Directives}, CP 51 (Dublin, LRC, 2008) 8-9.
\textsuperscript{1866} (1987) 154 Ariz 207 cited in \textit{Re a Ward of Court} (No 2) (n 4) at 131 per O’Flaherty J.
\textsuperscript{1867} Ibid.
\textsuperscript{1868} LRC 2008, (n 1865) p. 13.
\textsuperscript{1869} LRC 2005, (n 1547) para. 3.36; the Report contains twenty five recommendations on advance care directives.
important in the context of advanced care directives that enable an individual to be a power-broker in charting their later years should they lack the capacity to make decisions.

Advance care directives have been considered by the Committee of Ministers and while Ireland does not have a formal legal framework for advance care directives the recommendations from the Committee of Ministers is of particular relevance. Their holistic view of advance directives is welcome. Principle 14 states that advance directives “may apply to health, welfare and personal matters, to property and financial matters, and to the choice of a guardian, should one be appointed.” The Committee recommends Member States to establish “what extent advance directives should have binding effect. Advance directives which do not have binding effect should be treated as statements of wishes to be given due respect.”

Where the effect is binding the advance directive should be in writing. The advance directive should be sufficiently clear to take account of changing circumstances. Principle 16.2 provides that “States should consider what other provisions and mechanisms may be required to ensure the validity and effectiveness of those advance directives.” For example there is little value in drafting an advance directive if the information contained therein is not available to those making the decisions should incapacity arise. Importantly Principle 17 provides that an advance directive is revocable at any time and without any formalities. This presupposes that the person has mental capacity.

In the UK case of *HE v A Hospital NHS Trust* the court held that “there are no formal requirements for the creation or revocation of a valid advance directive” nor need it be “either in or evidenced by writing.” The Law Commission for English and Wales had recommended that an advance directive should be in writing, given that such an approach would afford a vulnerable patient safeguards to ensure, for example, that the person had capacity to create an advance directive, full understanding of the consequences and escape from undue influence. An advance decision is now defined in the UK in s. 24 of the Mental Capacity Act 2005 as:

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1871 Ibid.
1872 Ibid. Principle 15.
1873 Ibid. Principle 16.
1874 [2003] EWHC 1017 (Fam); [2003] 2 FLR 408
1875 Ibid. p. 409.
1876 Ibid.
a decision made by a person (‘P’), after he has reached 18 and when he has capacity to
do so, that if-

(a) At a later time and in such circumstances as he may specify, a specified
treatment is proposed to be carried out or continued by a person providing health
care for him,

and

(b) at that time he lacks capacity to consent to the carrying out of continuation of
the treatment,

the specified treatment is not to be carried out or continued.

The legislation provides that a person who has attained the age of 18 and has legal capacity
may make decisions concerning the refusal of medical treatment should incapacity arise at a
later time. Where a decision contains the refusal to accept life-saving treatment it must be in
writing, signed by P and witnessed by a third party.\textsuperscript{1878}

The first UK case to address advance directives was \textit{Re C (Adult: Refusal of Medical
Treatment)}\textsuperscript{1879} where his capacity to refuse treatment was recognised and his advance
directive upheld. The UK Court has considered that “[a]n advance directive is inherently
revocable.”\textsuperscript{1880} Any attempt to fetter an individual’s ability in this regard is considered
“contrary to public policy and void.”\textsuperscript{1881}

A material change in circumstances has been addressed in the English Courts. Donaldson LJ
said “‘what the Doctors cannot do is to conclude that, if the patient still had the necessary
capacity in the changed situation he would have reversed this decision .... What they can do
is to consider whether at the time the decision was made it was intended by the patient to
apply in the changed situation.”\textsuperscript{1882} In \textit{HE}\textsuperscript{1883} Mumby J. said “a patient’s anticipatory refusal
of treatment will not survive a material change of circumstances.”\textsuperscript{1884}

\textsuperscript{1878} \textit{Mental Capacity Act 2005} s. 25 (6); for a discussion on advance care planning in other
jurisdictions see, for example, Dunbrack J., \textit{Advance care planning: the Glossary project Final
report, August 22, 2006 Prepared For Health Canada} available at \url{http://www.he-sc.gc.ca/hcss-
the Australian case \textit{Hunter and New England Area Health Service v A [2009] NSW SC 761} provides
guidance on advance health care decisions in Australia where the Supreme Court accepted the validity
of an advance care directive to refuse medical treatment in the knowledge that the patient would die
as a result of the decision.

\textsuperscript{1879} [1994] 1 All ER 819; see also discussion on capacity in Ch. 4 of this work.

\textsuperscript{1880} \textit{HE v A Hospital NHS Trust} [2003] EWHC 1017 (Fam); [2003] 2 FLR 408408.

\textsuperscript{1881} Ibid. para. iii.

\textsuperscript{1882} \textit{Re T (adult: refusal of medical treatment)} [1992] 4 All ER 649 at 662; see discussion on capacity
and undue influence in Ch. 4 of this work.

\textsuperscript{1883} (n 1880).

\textsuperscript{1884} Ibid. p. 416 para. 29.
The question of the validity of a living will arose in the case of *Ms B v An NHS Hospital Trust.* Ms B who had a malfunction of blood vessels executed a living will when she was informed by her doctors that she could incur a severe disability as a result of a serious bleed or surgical intervention. The advance directive made provision for the withdrawal of treatment should she suffer from a “life-threatening condition, permanent mental impairment or permanent unconsciousness.” Although her condition improved and she returned to work she later incurred a relapse that left her tetraplegic and required the use of a ventilator. One hospital consultant took the view that the living will was not sufficiently clear to remove artificial ventilation and two consultant psychiatrists were of the opinion that Ms B lacked capacity to make a decision with regard to withdrawal of treatment. As a result of her continued treatment she raised the matter with the Court alleging that hospital’s treatment was unlawful. At issue for the Court was the question of Ms. B’s mental capacity. Ms B’s view was at variance with her carers who sought to override her decision to have the artificial ventilator removed. Butler-Sloss stated that the “case is not about [Ms. B’s] best interests ... but about her mental capacity.” The Court affirmed that Ms B “has been treated unlawfully by the trust” during the period in question and that she did have capacity to accept or reject treatment, stating that “her mental competence is commensurate with the gravity of the decision she may wish to take.”

Advance care directives can be both positive and negative, for example, an advance directive giving consent to or refusal of a particular treatment. In the UK negative and positive advance care directives have been considered in *R (Burke) v General Medical Council (Official Solicitor intervening)* in the context of the General Medical Council (GMC) guidance on the provision of nutrition and hydration by artificial means (ANH). The case concerned a patient who suffered from a progressively degenerative condition and wanted “to be fed and provided with appropriate hydration” until he died of natural causes. He did not want the ANH to be withdrawn, he did not want to die of thirst and he did not want the medical team to decide that his life was no “longer worth living.” In granting the relief sought the Court recognised that the GMC guidance on Withholding and Withdrawing Life-

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1885 Ibid. at p. 418, Mumby J. distinguished a living from an advance directive. He said, “[t]he popular term ‘living will’ may be misleading. The Wills Act 1837 does not apply to an advance directive. An advance directive does not need to be in writing and signed, nor need it be attested by witnesses. Nor, unlike a will, can an advance directive be revoked only by physical destruction or by another document in writing.”
1886 [2002] EWCH 429 (Fam).
1887 Ibid. para. 4.
1888 Ibid. para. 12.
1889 Ibid. para. 96.
1890 Ibid. para. 95.
1892 Ibid. para. 6.
prolonging Treatments was “properly vulnerable to criticism in four respects.” The emphasis throughout the document was on the right of a competent patient to refuse treatment and failed to recognise the right to require treatment in this particular context. The guidance did not adequately advise “a doctor who is unable or unwilling to carry out the wishes of the patient” that he or she was duty bound to continue treating the patient until an alternative doctor is found. The guidance did not adequately “acknowledge the heavy presumption in favour of life-prolonging treatment and to recognise that the touchstone of best interests is intolerability.” Finally the guidance did not address the “legal requirement to obtain prior judicial sanctions for the withdrawal of ANH” in certain circumstances. The Court of Appeal however rejected the court’s findings and affirmed the guidance lawful. Accordingly the Irish LRC state that “advance care directives should provide that a patient can refuse, but not request treatment.”

This position has been criticised. O’Neill, for example, argues for an emphasis on present instead of advance directives, suggesting that education of the general public is required to enable them to recognise that the best application of advance directives is to use them to promote reflection and communication and enable discourse on options and worries. He recognises that the medical professionals will require sufficient ethical knowledge to address the difficulties with decision-making in the context of diminished capacity. A legal framework for advance care directives is urgently required in Ireland. The Law Reform Commission recognises there are valid concerns in the absence of a legal framework for advance care directives. An advance directive offers the possibility of advancing rights for all should incapacity arise whereby the person’s right to self-determination is maximized and safeguarded thereby helping to protect the personhood and interests of the older person in residential care. Accordingly it may help diminish anxiety for the individual, their family/guardian and kindred professionals who may be satisfied that they are carrying out the wishes of the person who has made an advance care directive. The burden on service providers may be lessened obviating the need for perhaps extensive discussions or court time.
attempting to discern what the patient would have wanted should they have capacity.\textsuperscript{1904} A further welcome benefit may be that of economics; the saving that emanates from this clarity again obviating the need for extensive discussion and “an inordinate amount of court time”\textsuperscript{1905} for all concerned. The absence, presence and details of advance care directive(s) should be documented in each person’s care plan in a residential care setting including whether the directive was made orally or in writing.

**Advocacy**

Article 12.3 of CRPD provides that “State Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.” Essentially this provides a re-orientation of thinking, a shift from treating the person as an object to be cared for to seeing the person as subject whose personhood is acknowledged and respected.\textsuperscript{1906} The care may be still provided but in a relationship of respect for the older person that embraces the wishes of the older person. The older person may need the support of another person to have their ‘voice heard’. Advocacy therefore is not about legal representation but voicing values on the older person’s behalf.

The Comhairle Act, 2000\textsuperscript{1907} introduced an element of advocacy\textsuperscript{1908} for a person seeking a social service to enable them to secure such an entitlement. It does not include legal representation. Raising concerns at the narrowness of the definition during Dáil debates Deputy J. O’Keeffe then in opposition stated:

> I am sorry that it is precluded ... It could mean that somebody who received the information and advice from one of the Comhairle offices would not then be able to fully prosecute his entitlements because he would not have the advocacy available which in some instances can only be provided by legal representation.\textsuperscript{1909}

The Citizens Information Act 2007\textsuperscript{1910} amending the Comhairle Act 2000 augmented the provisions relating to advocacy services by inclusion of a ‘Personal Advocacy Service’ whose functions are set out in s. 7(d) of the Act. Legal representation is not included; s. 7 (b)(ii) specifically excludes a personal advocate pursuing any “right of review, reference or

\textsuperscript{1904} In the Irish case of Fitzpatrick v FK (n 1659) 104, Laffoy J. considered that Ms K lacked capacity to such an extent that she was unable to refuse the blood transfusion on religious grounds.

\textsuperscript{1905} Ibid. part X1.

\textsuperscript{1906} Quinn, 2010 (n 1683).

\textsuperscript{1907} No. 1 of 2000.

\textsuperscript{1908} S. 2 (1) of the Comhairle Act, 2000.

\textsuperscript{1909} Dáil Debates 513, Col. 54.

\textsuperscript{1910} No. 2 of 2007.
appeal to a court” where a service(s) is refused. The Citizens Information Board (CIB)\textsuperscript{1911} enables the provision of advocacy services to the general public through the five regional Citizens Information Services.

The National Quality Standards for Residential Care Settings for Older People in Ireland consider advocacy as:

A process of empowerment of the individual which takes many forms; includes taking action to help people say what they want, secure their rights, represent their interests or obtain the services they need; it can be undertaken by older people themselves, by their friends and relations, by peers and those who have had similar experiences, and/or by trained volunteers and professionals.\textsuperscript{1912}

An advocate is considered as an independent person,

purchasing or providing (an advocacy)\textsuperscript{1913} service, who acts on behalf of, and in the interests of, the person using the service. In the context of residential care settings for older people, an advocate facilitates a resident, insofar as possible, to make informed choices regarding health care, social care and quality of life.\textsuperscript{1914}

Advocate/advocacy is specifically referred to in the HIQA standards in the context of consent.\textsuperscript{1915} Criteria 3.5 provides that “[t]he resident is facilitated to access an advocate/advocacy services when making decisions relating to consent to treatment or care, if necessary and in accordance with his/her wishes.” Standard 5 addresses civil, political and religious rights. The criteria at 5.2 state that “[t]he resident has access to citizen’s information and advocacy services.” Later at criteria 5.5 it states “[t]he resident is facilitated to access legal advice.”

Advocacy is a relatively new phenomenon in Ireland and the majority of older persons in residential care are largely unaware of its existence. Additionally an advocacy service may not exist in a particular geographical area.\textsuperscript{1916}

\textsuperscript{1911} S. 3 of No. 2 of 2007 changed the name of Comhairle to the CIB. In the Irish language this became An Bord um Fhaisnéis do Shaoránaigh.

\textsuperscript{1912} HIQA, 2009 (n 37).

\textsuperscript{1913} My inclusion in italics.

\textsuperscript{1914} HIQA, 2009 (n 37) p.74.

\textsuperscript{1915} Ibid. Standard 3. See also p. 77 that explains the terms standards and criteria. “A standard is a measure by which quality is judged. It sets out an expected or desired level of performance. The criteria are the supporting statements that set out how a service can be judged to meet the standard.”

\textsuperscript{1916} See Pillinger, 2001, (n 22) and the outcomes of the advocacy programme. See also discussion in this chapter.
The proposed Scheme of Mental Capacity Bill 2008 does in a limited way address supported decision-making under the guise of ‘Best Interests’ and the ‘Guiding Principles’ but would not satisfy the requirements of Article 12 of the CRPD. However the proposed Scheme of Mental Capacity Bill is silent on advocacy. This is an important omission. The Office of the Public Guardian could be expanded to incorporate responsibility for “setting up of a panel of informal advocates to support those with nobody else to support them,” setting out the role and functions of the advocates and facilitating their training and supervision together with the preparation of a code of practice and guidelines. In addition to the earlier recommendation for the inclusion of advocacy in the proposed Scheme of Mental Capacity Bill 2008, the proposed Bill should also be amended to include provision of legal representation within the context of advocacy. Quinn’s comments in the context of the rights of person with disabilities are persuasive, “[a] way will have to be found to ensure that the voice of the person that emerges – whether directly or as mediated through representation agreements – is actually respected.” Furthermore he states that:

Article 12 calls for support to enable persons with disabilities to exercise legal capacity – which includes but stretches beyond supported decision-making. I see supported decision-making as something that happens as a decision is being made. I see supports for legal capacity as encompassing some of the essential building blocks to enable legal capacity to evolve. As so it makes little sense to me to view Article 12 in complete isolation. It necessarily involves putting in place the essential ingredients for enabling capacity to evolve. This requires a place of one’s own – stamped with one’s own personality even if that is something as simple as a treasured photo.

By way of example, the vulnerable older person in need of residential care requires the provision of choice in terms of selection of a residential care setting and a place that readily enables the older person to imprint their own personality in their own room or, if in shared accommodation, in the area around their own bed and immediate surroundings.

As described by Quinn, legal capacity can be used as either a sword or a shield. When used as a sword it enables the older person to make decisions and most importantly to have those decisions “respected by others.” When used as a shield, legal capacity enables the older person to ward off those who might be inclined to make decisions that are, in their

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1917 NDA submission (n 1846) p. 18.
1918 Quinn, 2011 (n 41) p.19.
1919 Ibid. p.17.
1920 Ibid. p. 11.
1921 Ibid.

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opinion, best for the older person but in fact do not reflect the wishes of the older person. A non-instructed\textsuperscript{1922} advocacy policy is currently under development by the National Advocacy Service.\textsuperscript{1923}

In their \textit{Report on Alternative Dispute Resolution: Conciliation and Mediation}\textsuperscript{1924} the LRC recognise the need for elder mediation to facilitate communication between family members themselves and professionals.\textsuperscript{1925} The trained personal advocate would be ideally placed to facilitate such communication.

Personal advocacy services should be available to those in long-term care wishing to avail of such support. To enable such a service, relationships need to be established between the personal advocate and the person in residential care prior to the older person entering residential care or soon after admission to enable a trusting relationship to become established. Education about and promotion of advocacy is recommended to enable rights of older people in residential care to be respected and supported.

The Mental Capacity Act \textsuperscript{2005}\textsuperscript{1926} and the UK Mental Capacity Act 2005 (Independent Mental Capacity Advocates)\textsuperscript{1927}(Expansion of Role) Regulations 2006\textsuperscript{1927} include the arrangements for the provision of an independent mental capacity advocate service (“IMCA”) for a vulnerable person who lacks capacity to make decisions at a particular time and in relation to a particular issue(s). The appropriate authority\textsuperscript{1928} may make regulations with regard to the role of the IMCA in particular to provide support, for example, to an older person with dementia to enable the older person to “participate as fully as possible in any relevant decision,”\textsuperscript{1929} to get and assess relevant information,\textsuperscript{1930} to ascertain what an older person’s wishes and feelings would be likely to be and what would impact on their decision-

\textsuperscript{1922} Henderson, R., “Defining non-instructed advocacy” (2006) 18 Planet Advocacy 5-7; Henderson offers an explanation of non-instructed advocacy. He suggests “it is taking affirmative action with or on behalf of a person who is unable to give a clear indication of their views or wishes in a specific situation. The non-instructed advocate seeks to uphold the person’s rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for their unique preferences and perspectives.”

\textsuperscript{1923} The National Advocacy Service is funded by the CIB.

\textsuperscript{1924} LRC 98 2010.

\textsuperscript{1925} Ibid. paras. 690-697; for further discussion see www.alzheimer.ie

\textsuperscript{1926} Ss. 35 – 41. The IMCA service commencement date was the 1\textsuperscript{st} April 2007 in England with the commencement of The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 (2006 No. 1832).


\textsuperscript{1928} Appropriate authority here refers to the Secretary of State in England and the National Assembly for Wales in Wales.

\textsuperscript{1929} UK Mental Capacity Act 2005 s. 36 (2) (a).

\textsuperscript{1930} Ibid. s. 36 (2) (b).
making if they had capacity, to explore alternative courses of action and where further medical treatment is proposed to seek another medical opinion if they are of the opinion such a course of action is warranted. These provisions are important in that on the one hand an older person may be supported and represented when their capacity is diminished and on the other hand it allows the IMCA to challenge decisions that may have been made perhaps by medical personnel or a family member. A major weakness of these provisions is that the advocate is appointed after the older person has diminished capacity.

The National Advocacy Programme Alliance (NAPA) was established by the HSE Consumer Affairs in 2006 aimed at addressing needs of older persons in residential care settings. In addition to the HSE the NAPA membership includes Nursing Homes Ireland, the Citizens Information Board, Care Local, Alzheimer Society, National College of Ireland, Volunteer Centres Ireland and Age Action Ireland. Three proposals were identified by NAPA, “the development of an independent advocacy service, values training for care workers” and “the provision of information via My Home from Home website.”

An evaluation of the Advocacy Programme has been carried out. The outcomes provided in the evaluation are detailed below:

- 67 (out of a total of 607) residential care settings are currently participating in the advocacy programme.
- 150 volunteers trained to FETAC Level 6.
- A further 36 (30) volunteers have attended a continuing professional development course in gerontology. While the evaluation states also that 100

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1931 Ibid. s. 36 (2) (c).
1932 Ibid. s. 36 (2) (d).
1933 Ibid. s. 36 (2) (e).
1934 Ibid. s. 37 (1).
1935 Information available at http://www.hse.ie/eng/services/ysys/SUI/NAPA/ last accessed 17th July 2011 however at http://www.hse.ie/eng/services/newscentre/2011archeve/feb2010/advicatesmayo.htm the information provided states that “[t]he National Advocacy Programme was set up in January 2009 to provide an independent advocacy service for older people in residential care, to help them to effectively express their wishes, access their entitlements and assert their rights. The service is aimed at anyone living in a nursing home or community unit who has issues to resolve. It aims to promote, protect and defend the rights of older people in residential care. In Pillinger, 2011, (n 22) p. 5 it states: “The Advocacy Programme for Older People in Residential Care was launched in 2007 ... and commenced in 2008.”
1936 Ibid. at http://www.hse.ie/eng/services/ysys/SUI/NAPA/
1937 Pillinger, 2011 (n 22) p. 6-7; see also Ch. 6 of this work, section titled Qualifications, (Education and Training) Act, 1999 and the Qualifications (Education and Training Act, 1999 (Charter) Regulations 2007.
1939 Ibid. p. 6.
1940 Ibid. p. 9.
1941 Ibid; the Report states “a further 30 Volunteer Advocates have participated in the CPD programme in Gerontology ...”
advocates attended a training day in 2010 it does not state if these are part of the 150 identified above or the nature of the training they received.\textsuperscript{1942}

- 133 volunteers are current volunteer advocacy service providers.\textsuperscript{1943}
- 12 volunteer development officers give support to the advocacy service providers.\textsuperscript{1944}
- 118 staff in eight residential care settings has received training in ‘Personal Excellence’ values on compassion and dignity in care.\textsuperscript{1945}
- Policies and procedures for the programme are detailed in the National Advocacy Programme Handbook and the Volunteer Advocate Policy.\textsuperscript{1946}
- \url{www.myhomefromhome.ie} that provides details on 295 residential units/homes, information on paying for nursing homes and alternatives to nursing homes.

The findings show that only 11\% of residential care settings are participating in the advocacy programme. The results do not show how many residents in these centres wished to or were able to avail of the programme. From the perspective of the older person and access to an advocate the availability of an advocate is disappointingly very low. Given the low number of advocates trained this is hardly surprising.

The evaluation recognised the importance of the establishment of an independent advocacy programme for older people and sets out proposals in this regard in terms of design, governance and budget requirements.\textsuperscript{1947} However further discussion is needed in terms of, for example, “independence” given the degree of involvement advocated for the HSE.\textsuperscript{1948}

On the one hand the “evaluation” recommends that:

It is essential that the Advocacy Programme be independent of the HSE and that there is a robust organisational structure that has clarity of roles. There are various reasons for this. The service cannot be independent if it is located and managed by the HSE, while the current low levels of trust of the HSE undermines the credibility of the programme….\textsuperscript{1949}

\begin{flushright}
\textsuperscript{1942} Ibid. p. 6.
\textsuperscript{1943} Ibid.
\textsuperscript{1944} Ibid.
\textsuperscript{1945} Ibid.
\textsuperscript{1946} Ibid.
\textsuperscript{1947} Ibid. p. 11-12.
\textsuperscript{1948} Ibid. p. 12; para. 10 states that “[t]he HSE will need to continue to play a key role both as a funder and as a partner, under the remit of the HSE Director of Advocacy (Quality and Clinical Care Directorate).”
\textsuperscript{1949} Ibid. p. 108.
\end{flushright}
and on the other hand it later states that “[t]he HSE will need to continue to play a key role both as a funder and as a partner, under the remit of the HSE Director of Advocacy. 1950

The evaluation has suggested the establishment of an independent National Advocacy Programme Board. Importantly the report suggests that the advocacy programme is established in an independent organisation centred on the needs of older people. The arrangements require careful consideration. The recommendation of the NDA has merit. 1951 Funding could be channelled directly to the independent body through one of the Government Departments such as Health and Children or Social Welfare and not through the HSE as the report suggests. 1952

There is an urgent need for detailed legislation, clarity on the role of advocacy in advancing rights of older people in residential care and government commitment to fund a comprehensive robust and independent advocacy programme. As noted above advocacy under the U.K. Mental Capacity Act 2005 only becomes operational after the advocate is appointed when the person has diminished capacity. Where the goal is to empower the older person and/or provide supports for legal capacity 1953 ideally the relationship between the advocate and the older person is established well in advance of any decisions regarding residential care. Such an arrangement would also embrace the past and present wishes of the individual and voice values on behalf of the older person where the need arises.

Finally it is recommended that the legislative lacunae with regard to the legal institutions should be bridged to also incorporate criminal sanctions for an offence by a person who purports to act as a duty holder with regard to the safety, health, welfare, personal matters, property and financial matters of an older person in residential care. 1954

**Conclusion**

This chapter has examined the progression in the development of human rights instruments in recent years in the context of adults and diminished capacity (where the rights of the

1950 Ibid.
1951 NDA submission, (n 1846) p. 18.
1952 Pillinger, 2011 (n 22) p. 111 para. e.
1953 Article 12 (3) of the CRPD.
1954 S. 254 of the Mental Treatment Act 1945 No. 19 of 1945 provided an offence for ill-treatment or neglect. Ill-treatment or neglect is not defined under this legislation; S. 4 of the Criminal Law Amendment Act 1935 may also have relevance with regard to an offence against an older woman in residential care. Sch. 5 as it relates to Regulation 27(1) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 requires written and operational policies for among other things, 1. “[t]he prevention, detection and response to abuse and 13 [t]he handling and investigation of complaints...”; Regulation 10 of the Health Act 2007 (Care and Welfare of Resident in Designated Centres for Older People) (Amendment) Regulations 2010 S.I No 36 of 2010 requires records to be kept with regard to “all complaints made by residents or representative or relatives of residents or by persons working at the designated centre...”
individual are centre-stage) and their particular relevance for older people in residential care. The transformation of the international legal instruments from welfare to rights has enormous significance in this discussion on Wardship and the underdevelopment of Irish legal institutions namely Enduring Power of Attorney, Advance Directives and Advocacy. The international provisions provide the roadmap for the transformation of the Irish legal institutions. The specific provisions of Article 12 of CRPD and Recommendation CM/Rec (2009) 11\textsuperscript{1955} are vital.

One of the key issues for these legal institutions is how capacity is assessed. The test for incapacity for both wardship and enduring power of attorney is the status approach that merely stereotypes and is completely outdated. Ireland does not have a legal framework for advance care directives. Both enduring power of attorney and advance care directive are private measures instituted by a capable person in advance of any diminished capacity. It is acknowledged that measures responsive to incapacity may require intervention by the courts or other public body. Interventions should take place in the least restrictive manner to minimise an unwarranted intrusion into the life of the older person. Such intrusion may be warranted where for example an older person is in “frail health and sometimes confused”\textsuperscript{1956} as in the case *Bourke v O’Donnell, O’Donnell and the Bank of Ireland*\textsuperscript{1957} where the bank was deemed to have “a duty to make an enquiry”\textsuperscript{1958} when there were grounds for doubting Ms Bourke’s capacity to give instructions due to her state of health and the bizarre transaction of transferring all her worldly wealth for no consideration.\textsuperscript{1959} Wardship on the other hand could be considered as an extreme state response.

Respect for personhood celebrates the uniqueness of the individual, enabling the older person in residential care to secure and or maintain his or her legal capacity at the latter stages of their life. Central to this discussion is the right of the individual to make decisions, free from interference and abuse.

For many older people decision-making may be autonomous. For others their decision-making may be supported with assistance as needed. Of particular import here is the word ‘may’ in Article 12.3 of the CRPD. Central to supported decision-making is the right to autonomy and self-determination. Appropriate supports may include assistance with communication such as interpretation. Facilitated decision-making may arise, for example, where an EPA has been registered. For others substitute decision-making might be the only

\textsuperscript{1955} (n 1708).
\textsuperscript{1956} *Bourke v O’Donnell, O’Donnell and the Bank of Ireland* (n 1620) 348.
\textsuperscript{1957} Ibid.
\textsuperscript{1958} Ibid.
\textsuperscript{1959} Ibid.
option, to enable individuals secure their legal capacity. For example the person may be in a coma as in the case of *In re a Ward.*\(^{1960}\) In affirming the right of all persons to legal capacity Dhanda points out “[t]he text of Article 12 does not prohibit substitute decision-making...”\(^{1961}\)

Robust safeguards are required to protect the older person and their interests. While the proposed Scheme of Mental Capacity Bill 2008 goes some of the way towards securing rights for older people it is not adequate. What is required is legislative reform that emulates the protections and safeguards of the international instruments. The starting point is a functional test for capacity assessment that is time and issue specific but as Quinn points out this has its shortcomings as it emphasises cognitive ability and as the Commissioner for Human Rights states “the functional approach … is not fully compatible with Article 12 of the CRPD.”\(^{1962}\) Therefore Quinn suggests that we need to look beyond cognitive ability to the support necessary to “augment residual capacity and assist people make decisions.”\(^{1963}\) Training for workers is crucial to enable the transformations to take place at both institutional and individual level if behaviours are to be altered and new practices implemented.

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\(^{1960}\) *In re a Ward of Court (No. 2)* (n 4).


Chapter 6 Regulation and Education, Experience and Training

This chapter will examine the regulatory framework with regard to education, experience, training and maintenance of standards in the context of care providers within residential care settings for older people. Education embraces teaching and learning with specific learning outcomes. Experience provides knowledge gained through learned experience(s). The benefits of training may be considered in terms of the knowledge, skills and competence that may become operational as the situation demands. The objective of training is to enhance the performance of the individual to a set standard ensuring that they have the capability and capacity to affect the required standard.¹⁹⁶⁴

EC Law on Education and Training

Directive 2005/36/EC on the recognition of professional qualifications¹⁹⁶⁵

Directive 2005/36/EC was adopted on the 7th September 2005¹⁹⁶⁶ to combine and update the rules regulating the recognition of professional qualifications. Professional qualifications are covered by either a ‘general’ or ‘sectoral’ system. The ‘general’ system provides for the mutual recognition of professional qualifications between member states with the exception of those professions covered by the ‘sectoral’ system. The ‘sectoral’ system provides for the harmonisation of minimum training requirements and the automatic recognition of professional qualifications for seven professional groups that include doctors, general nurses, dental practitioners and pharmacists.¹⁹⁶⁷

Recognition of Professional Qualifications (2005/36/EC) Regulations, 2008¹⁹⁶⁸

These Regulations came into operation on the 4th June 2008. The Regulations transpose Directive 2005/36/EU as amended by 2006/100/EC providing mutual recognition of professional qualifications awarded in another Member State of the European Union and or in particular cases in a Third Country, by professions that are regulated in the State and not subject to automatic recognition under the harmonised training conditions for doctors with basic training and specialists, nurses responsible for general care, dental practitioners, midwives, architects and veterinary surgeons.¹⁹⁶⁹

¹⁹⁶⁴ See generally Geoff, P., Evidence Based Teaching a Practical Approach (Cheltenham, Nelson Thornes Ltd., 2006).
¹⁹⁶⁶ Came into force on the 20th October 2007.
¹⁹⁶⁷ The ‘sectoral’ system also concerns the professions of midwives, architects and veterinary surgeons.
¹⁹⁶⁸ S.I. No. 139 of 2008; came into operation on the 6th May 2008.
specialised dental practitioners and pharmacists. Linguistic competence is an important requirement. Regulation 25 requires that person(s) seeking recognition of their professional qualifications must have linguistic competence to enable them to carry out their profession in the State. However member state regulators are unable to systematically test other EU nationals for their language competency. The duty to ensure English language competency in Ireland is on the individual and the employer. The Evaluation of the Professional Qualifications Directive records that “according to some stakeholders, the provisions of the Directive concerning the assessment of language skills are not sufficiently clear for health professionals who benefit from automatic recognition and who will treat patients.” The ability to communicate is core both for professional and non-professional workers in this context.

**Recognition of the Professional Qualifications of Nurses and Midwives (Directive 2005/36EC) Regulations, 2008**


**Qualifications (Education and Training) Act, 1999 and the Qualifications (Education and Training) Act 1999 (Charter) Regulation 2007**

The National Qualifications Authority of Ireland (NQAI) was set up in 2001. It provides for a framework for the development, recognition and awarding of qualifications based on knowledge, skills and competence of the candidate. Among other things, it provides for

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1972 No. 26 of 1999; the whole act is to be repealed with the proposed Qualifications and Quality Assurance (Education and Training) Bill 2011 Bill No. 41 of 2011 that makes provision for the establishment of a new single national agency, the Qualifications and Quality Assurance Authority of Ireland (QQAI) replacing the HETAC, FETAC, the NQAI, and the Irish University Quality Board (Universities Act 1997 No. 24 of 1997 s. 35 to be repealed); see also Department of Public Expenditure and Reform, [Public Service Reform 17th November 2011 Appendix 11a paras. 1-3, FETAC, HETAC and NQAI are to be amalgamated in 2012.](http://per.gov.ie/wp-content/uploads/Public-Service-Reform-181120111.pdf) Last accessed 5th January 2012.

1973 S.I. No. 571 of 2007; the Charter Regulations detail the requirements for inclusion in an institution’s charter as provided in s. 31 of the Qualifications (Education and Training) Act, 1999 Act.

1974 Established under s. 5 of the Qualifications (Education and Training) Act, 1999.

1975 Ibid. s. 7.
the establishment, promotion of maintenance and improvement of standards with regard to education and training awards of the Further Education and Training Awards Council (FETAC). The NQAI also provided for the establishment of the Higher Education and Training Awards Council (HETAC). HETAC established under s. 21 of the Act is the qualifications awarding body for third-level education and training outside the university sector.

The FETAC system allows the candidate to build on their award to progress to their desired standard. The FETAC award in ‘Healthcare Support’ for care assistants provides a ‘major type’ award at level 5. In 2006 two minor type award categories were included that are relevant in this context. These include ‘care of the older person’ and ‘care support’. These foundational courses (albeit they are of short duration, 4-5 days) are significant in that they provide formal elementary training for care assistants working with older people.

The FETAC system also provides for awards in the context of information and advocacy. The following details the types of courses, the method for advancement, examples of costs and availability. For example the Citizen Information Board has a FETAC accredited Information Programme (IPP) at Level 6. To enable a successful participant to advance to a higher level requires IPP or 2 years advocacy experience to progress to Advocacy Practice Programme (APP) level.

Examples of courses provided by third level institutions include the Dublin Institute of Technology (DIT) which provides an accredited Citizens Information Board (CIB) Advocacy Practice Programme (APP) while Sligo Institute of Technology has a course in advocacy titled: Higher Certificate in Arts (Advocacy Studies) (NQAI Level 6) a twelve module course that may be completed in a minimum of two years. Each module costs €350. The cost may be prohibitive for some unless sponsored.

In 2009 the School of Community Studies of the National College of Ireland (NCI) were engaged to provide eight advocacy training courses at various locations around the country and a 12 month continuing professional development programme for those advocates who had already completed a preliminary training programme.

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1976 Ibid. s. 12, FETAC was set up as a statutory body on 11th June 2001.
1977 Ibid. s. 7.
1978 Ibid. s. 8 (2)(d) as it relates to s. 14 (2)(d).
1979 Directory of FETAC Awards: http://www.fetac.ie/fetac/awardsDirectory.do?method=getMinorAwardDetails&minorAwardId=3480 Last accessed 29th July 2012; other courses detailed at level 5 minor that are relevant include Recovery in Mental Health publication date 5/11/2007; Intellectual Disability Studies and Person Centred Focus Disability. The latter two courses do not contain a publication date.
1980 Costs vary from 350€ - 495€ depending on the course provider. The cost may be prohibitive for some.
Chapter 6  Regulation and Education, Experience and Training

Health Act 2007 (Care and Welfare of Residents in Designated Centres For Older People) Regulations 2009

Regulation 17 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres For Older People) Regulations 2009 specifically addresses training and staff development.

Professional Regulatory Bodies

A ‘regulatory body’ is considered as having statutory recognition and has functions in at least two out of three of the following activities:

1. The formulation of goals, the making or rules, [and/or] the setting of standards;
2. Monitoring, gathering information, scrutiny, inspection, audit and evaluation;
3. Enforcement, modifying behaviour, applying rewards and sanctions.

Additionally, in order to qualify as a regulatory body the body must be independent, able to contribute to or make its own decisions, have a future and have some funding. The Health Act 2004 (as amended) defines a ‘professional regulatory body’ as An Bord Altranais, the Dental Council, the Health and Social Care Professionals Council, the Medical Council or the Pharmaceutical Society of Ireland.

(a) An Bord Altranais

An Bord Altranais is the statutory regulatory body for the nursing and midwifery professions established under the Nurses Act, 1950 to make provision for education and examination, to compile a register of nurses and to develop rules for removing

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1981 (n 515).
1982 For a more expansive discussion see paragraph titled Health Act 2007 (Care and Welfare of Residents in Designated Centres For Older People) Regulations 2009 in Ch. 3 of this work.
1983 Department of the Taoiseach, Bodies in Ireland with Regulatory Powers as of February 2007 (Dublin, Department of the Taoiseach, 2007) 3.
1986 The Nursing Board.
1987 S. 7 of No. 27 of 1950. This legislation repealed the Nurses Registration (Ireland) Act, 1919 and the Nurses Registration Act, 1948 No. 19 of 1948. The General Nursing Council of Ireland was established by Nurses Registration (Ireland) Act, 1919 and its terms extended by the Nurses Registration Act, 1948.
1988 Ibid. ss. 50 – 53.
1989 “Registered nurse” means a person whose name is entered in the register of nurses maintained by An Bord Altranais under s. 27 of the Nurses Act, 1985. Nurses registered under the Nurses Registration (Ireland) Act, 1919 were included in the new register.
from 1990 and restoring 1991 names to the nursing register. 1992 The Nursing Board comprise of members appointed by the Minister 1993 and elected by the nurses. 1994 Currently there is no specific nurse representative on the Nursing Board for geriatric care. 1995 This demonstrates a lack of voice for older people. The Nursing Board now operates under the Nurses Act 1985. The Act requires the Board to maintain a “live” register and has expanded the role of the Nursing Board in terms of fitness to practice. 1996 The Nursing Board also has responsibility for the approval of Healthcare Institutions and Educational Institutions for Education. 1997 The functions of the Nursing Board were further extended by the Health (An Bord Altranais) (Additional Functions) Order 2010 to include among other things provisions for the accreditation and registration of advanced nurse practitioners taking account of the National Council for the Professional Development of Nursing. 1998

S.38 (1) of the 1985 Act permits the Nursing Board or any member of the public to apply to the Fitness to Practise Committee if they have concerns about a nurse’s ability to practice on “grounds of “(a) Alleged professional misconduct, or (b) Alleged unfitness to engage in such practice by reason of physical or mental disability.” A disclosure to the Nursing Board

1990 S. 45(c) of the Nurses Act, 1950; in exercising its powers under the under the Nurses Act, 1985 the Nursing Board developed the current rules, the Nurses Rules 2010 S.I. No. 689 of 2010.


1994 Ibid. s. 13.

1995 354 Dail Debates Col. 1028, 109 Seanad Debates Col. 339; see also s. 9 of the Nurses Act 1985 No. 18 of 1985 and Rule 16 of the Nurses Rules, 2010 S.I. No. 689 of 2010 that provides for the number, category and qualifications of candidates to be elected by the five panels of electors. S. 4 of the Nurses and Midwives Act 2011 when enacted will among other things repeal the Nurses Act 1985; the 2011 Act makes provision for a nurse representative for geriatric care on Bord Altranais agus Chnámhseachais na hÉireann Nursing Board (the Board). At the time of writing eight elected nurses and midwives to the Bord Altranais agus Chnámhseachais na hÉireann have been forwarded to the Minister of Health for appointment to the Board. The full list of board members has to be appointed by the Minister.


1999 S.I. No. 3 of 2010.

2000 The Council was established under the National Council for the Professional Development of Nursing and Midwifery (Establishment) Order 1999 S.I. No. 376 of 1999; Part 12 of the Nurses and Midwives Act 2011 provides for the dissolution of the National Council for the Professional Development of Nursing and Midwifery. It was dissolved on the 1st of January 2012 by the Nurses and Midwives Act 2011 (Commencement) Order 2011 S.I. No. 715 of 2011.

2001 S. 38 (1) of the Nurses Act 1985; see, for example, the case of Ann O’Ceallaigh v An Bord Altranais and the Fitness to Practise Committee of an Bord Altranais and the Chief Executive Officer of an Bord Altranais [2011] IESC 50; 2009 [IEHC] 470.
under s. 38 that is made in good faith where a concerned person has reason to believe that a 
member of the public is at risk or is likely to be at risk to their health or welfare by the 
actions of a registered member is a protected disclosure under 55F of the Health Act 2004 as 
inserted by s. 103 of the Health Act 2007.

Such allegations are then examined by the Fitness to Practise Committee who may undertake 
an inquiry as provided by ss. 38(2) and (3) of the Act. The findings are reported to the 
Nursing Board who may make a decision on the findings. The Report is not published 
without the consent of the person unless the person is found guilty or unfit to practice.

The Nurses and Midwives Act 2011 heralds a departure from self-regulation with the 
provision of a non-nursing/midwifery majority on the Nursing and Midwifery Board and 
on the Fitness to Practise Committee and a stronger governance and accountability structure 
for the Nursing and Midwifery Board. This was acknowledged by An Bord Altranais in 
their submission to the Minister for Health and Children where they stated that the 
"proposed Bill ... introduces a new dynamic to regulation of professions aimed at increasing 
public confidence in professional regulation by placing transparency and accountability at 
the centre of a new model of regulation." The legislation will reduce the number on the 
Nursing Board from 29 members to 23 persons reverting to the number under the Nurses 
Act, 1950. Another welcome provision is s. 22. (1)(c)(v) that makes explicit provision 
for the appointment of a nurse “engaged in the care of older persons” to the Board thereby 
providing a voice for older persons.

The legislation provides a more expansive list of complaints that may be referred to the 
Preliminary Proceedings Committee. Consideration of complaints by the Preliminary 
Proceedings Committee is provided by s. 57. The matter may be referred to the Fitness to 
Practise Committee. These enquiries may be held in public. Under the 1985 legislation such 
enquiries are held in private. The Nursing and Midwifery Board may

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2003 S. 22 of the Nurses and Widwives Act 2011 commenced by the Nurses and Midwives Act 2011 (Commencement) Order 2012 S.I. No. 275 of 2012 as provide in Oris Oifigiúil No.60 on the 27th July 2012. An Bord Altranais or the Nursing Board is the name of the regulatory body under the Nurses Act 1985 S.I. No. 18 of 1985; the Nurses and Midwives Act 2011 changes the name of the nursing regulatory body, An Bord Altranais or the Nursing Board to Board Altranais and Cnáimhseachais na hÉireann, or the Nursing and Midwifery Board of Ireland.


2006 Nurses and Midwives Act 2011 s. 55 (1).

2007 Ibid. s. 24 (2)(a).
make an *ex parte* application to the Court to have a nurse suspended when it is of the opinion that an immediate suspension is necessary to protect the public.\textsuperscript{2011} The legislation includes provision for alternative dispute mechanisms to resolve the complaint\textsuperscript{2012} and the provision of sanctions that may include a censure and or fine\textsuperscript{2013}, restrictions on the work activities\textsuperscript{2014}, transfer of registration to another division\textsuperscript{2015}, suspension\textsuperscript{2016} or cancellation of registration\textsuperscript{2017} or prohibition from applying for restoration to the nurse’s register.\textsuperscript{2018}

Maintenance of the nurses’ professional competence is set out in Part 11 which include a requirement for the Nursing Board to develop, establish and implement a scheme for monitoring the nurses’ professional competence.\textsuperscript{2019} The legislation makes provision for the inclusion of a duty on employers with regard to facilitating the nurses to maintain their professional competence.\textsuperscript{2020}

**The National Council for the Professional Development of Nursing and Midwifery (NCNM)** \textsuperscript{2021}

The NCNM created in 1999 was dissolved on the 1\textsuperscript{st} January 2012.\textsuperscript{2022} Its functions have largely been absorbed into the Nursing Board. A brief mention is made of the position paper

\begin{footnotesize}
\begin{itemize}
\item 2008 Ibid. part 8. See Nurses and Midwives Act 2011 (Commencement) (No. 2) Order 2012 S.I. No. 385 of 2012. As stated in Oris Óifigiúil No. 80 on the 5\textsuperscript{th} October 2012 “[t]his Order brings into operation, on the 2nd October, 2012, certain provisions of the Nurses and Midwives Act 2011, in relation to the continuance and renaming of the Board, Members, Committees and Employees of the Board, governance matters, the new registers, the fitness to practise procedures and the Board’s education and training duties. A small number of provisions in relation to offences come into operation on the 3rd October, 2012.”
\item 2009 Ibid. s. 63 (3).
\item 2010 At the time of writing most provisions of the 1985 Act are still in place; only ss. 1, 2 and 12 of the Nurses and Midwives Act 2011 have been enacted.
\item 2011 Ibid. s. 58.
\item 2012 Ibid. s. 60.
\item 2013 Ibid. s. 69 (a) and (b).
\item 2014 Ibid. s. 69 (c).
\item 2015 Ibid. s. 69 (d).
\item 2016 Ibid. s. 69 (e).
\item 2017 Ibid. s. 69 (f).
\item 2018 Ibid. s. 69 (g).
\item 2019 Ibid. s. 89.
\item 2020 Ibid. s. 90 provides “(1) [a]n employer of a registered nurse … shall facilitate the maintenance by that nurse … of his or her professional competence pursuant to a professional competence scheme applicable to the nurse.… (2) Without prejudice to the generality of subsection (1), the employer may facilitate the maintenance of professional competence … by providing learning opportunities … in the workplace.”
\end{itemize}
\end{footnotesize}
developed with regard to care of the older person in particular in the context of guidance to service providers with specific reference to the role of the clinical nurse specialists and advanced nurse practitioner. The role of the clinical nurse specialist and the advanced nurse practitioner in residential care for older persons “is distinguished by the scope of practice, the educational preparation required, the levels of clinical decision-making, the level or responsibility and ... the level of autonomy.”

The figure overleaf maps the clinical career pathway for nurses detailing the levels of practice and corresponding levels of educational preparation required.

NCNM. Clinical Nurse Specialist and Advanced Nurse Practitioner Roles in Older Persons Nursing: Position paper 3 (Dublin, NCNM, 2007), p. 4
### Clinical Career Pathway for Nurses

#### Levels of Practice and Corresponding Educational Preparation

<table>
<thead>
<tr>
<th>Levels of practice</th>
<th>Levels of educational preparation required</th>
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</thead>
<tbody>
<tr>
<td><strong>Core concepts/domains of competence</strong></td>
<td><strong>Master’s degree</strong></td>
</tr>
<tr>
<td><strong>Advanced Nurse Practitioner</strong></td>
<td>Level 9 on NQAI Framework</td>
</tr>
<tr>
<td>Core Concepts: Autonomous and expert clinical practice, professional and clinical leadership, research</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Nurse Specialist</strong></td>
<td>Post-registration qualification</td>
</tr>
<tr>
<td>Core Concepts: Specialist clinical practice, patient/client advocacy, consultancy, education and training, research and audit</td>
<td>Level 8 on NQAI Framework</td>
</tr>
<tr>
<td><strong>Staff Nurse with post-registration education/training in specialist practice area</strong></td>
<td>Engagement in continuing professional development</td>
</tr>
<tr>
<td>Domains of Competence: Integrate specifically focused education with competencies for registration to augment knowledge, skills and abilities with relevance to the specialist area of practice</td>
<td>Certificate/diploma/degree/postgraduate level</td>
</tr>
<tr>
<td><strong>Registration qualification</strong></td>
<td>Bachelor’s degree</td>
</tr>
</tbody>
</table>

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2024 Ibid. as cited in p. 3.

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The clinical nurse specialist (CNS) role as an advocate “involves communication, negotiation and representation of the patient/client values and decisions in collaboration with other health care workers and community resource providers.”

40 Six posts had been established in services for older people in 2007.

Among the recommendations of *The Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner Roles in Ireland (SCAPE) Final Report* is targeted use of clinical specialists and expansion of their roles with regard to chronic illness management. One of the findings of the Report highlighted the need for those in leadership positions within the area of intellectual disability nursing to expand development of clinical specialist and advanced practitioner posts “in the interest of excellence in health service delivery and client care.” This is crucial given the particular changing needs that emerge with ageing and intellectual disability.

There are three Registered Advanced Nurse Practitioners in care of the older person posts in Ireland and their post titles are: ‘Older Person with Dementia’, ‘Rehabilitation of the Older Person’ and ‘Community Older Adults.’ In addition there are a further two accredited ANP posts in the area of care of the older person however there are no RANP’s in either post. The latter two post titles are ‘Older Person with Dementia’ and ‘Care of the Older Person.’

The Code of Professional Conduct for each Nurse and Midwife provides a framework with key principles to guide the registered nurse “to practice safely and effectively [within his or her] scope of practice.”

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2027 NCNM, 2007 (n 2023).

2028 Begley and others 2010, (n 2026) p. 319.

2029 Ibid. p. 53; at p. 181, para. 7.4.7.5 the *Report* states “[a]t the time of sampling, there were no advance nurse practitioners working in intellectual disability nursing, so only clinical nurse specialists could be recruited.”

2030 Ibid. p. 53; among the *Report’s* additional research recommendations was “the application and appropriateness of the Clinical Specialist and Advance Practitioner models in intellectual disability nursing” p. 321.

2031 Information obtained as requested from An Bord Altranais on the 31st August 2011.

2032 (Dublin, An Bord Altranais, 2000).

2033 Ibid. p. 6; the present code is currently under review; see also An Bord Altranais, *Guidance for New Nurses and Midwife Registrants*, (Dublin, An Bord Altranais 2010), p. 5 that defines ‘scope of practice’ as “the range of roles, functions, responsibilities and activities, which a registered nurse ... is educated, competent, and has the authority to perform” available at www.nursingboard.ie Last accessed 31st August 2011.

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Training in end-of-life care for workers is crucial to enable the older person to receive optimal care appropriate to their needs and wishes. The Report on the End-of-Life Care for Older People in Acute and Long-Stay Care Settings in Ireland recognise that “[l]ack of appropriate education and training in gerontological care and end-of-life care among care staff and medical staff in all care settings can impede good quality care.”2034 The National Audit of End-of-Life Care in Hospitals in Ireland, 2008/2009 state, not surprisingly, that “[n]urses who have done a formal training course on end-of-life or palliative care, since qualifying generate better care outcomes compared to nurses who do not.”2035 The report reveals that end-of-life care is not normally an integral part of staff induction training. It further shows that less than 16% of community hospitals have documentation detailing supports in place for workers who provide end-of-life care to residents.2036 In matters with regard to death and dying, Professor Allan Kellehear challenges us about the quality of our own death and reminds us that “affluence and intellectualising will not provide their customary immunisation so faithfully offered ... in the past when dealing with other people’s injustice experiences.”2037 Where the older person in residential care is “at the centre of the decision-making process”,2038 the older person as an autonomous person can “exert a degree of control over how and when she dies.”2039

Regulation 14 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 20092040 requires written operational policies and protocols for end of life care2041 to take account of the residents’ care and comfort,2042 to facilitate so far as is reasonably practicable their religious and cultural practices2043 and the presence of

2036 Ibid. p. 187.
2039 Ibid.
2040 (1041.
2041 Ibid. Regulation 14 (1).
2042 Ibid. Regulation 14 (2) (a).
2043 Ibid. Regulation 14 (2) (b).
family and friends and where possible to facilitate the dying person with regard to their choice of place of death.

Staffing of residential care centres for older people is addressed in standards numbers 22, 23 and 24 of the National Quality Standards for Residential Care Settings for Older People in Ireland. Standard no. 22 pertains to recruitment, that “[s]taff are recruited in accordance with best human resource management practices.” In addition to the usual criteria, for example, verification of qualifications, submission of two references (one from last employer), verification for nurses that they are on the active register of An Bord Altranais, the criteria includes satisfactory Garda vetting, which may include vetting from another jurisdiction. The person in charge of the residential care setting is responsible for ensuring that “all new staff are competent to communicate effectively with residents, including those with communication difficulties, in particular in relation to speaking, listening, reading and writing.” The terms and conditions of employment together with a written job description must be provided to each employee before they start work. A written agreement is required between volunteers and the residential care setting.

Standard 23 addresses staffing levels and qualifications. Staffing levels taking account of number and skill mix are determined by the outcome of the assessment tool. At least one nurse must be on duty at all times. The staffing levels are determined by the assessed needs of the residents in the context of their particular environment. Because of its importance it is cited in full: “The staffing number and skill mix of qualified/unqualified staff are at all times appropriate to the assessed needs of the residents and the size, layout and purposes of the residential care setting.”

As HIQA refers, in a more general context but which applies equally in this context, the three factors that can propel residential care settings for older people to improve the quality and safety of the services they provide are “professionalism, regulation and market

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2044 Ibid. Regulation 14 (2) (c).
2045 Ibid. Regulation 14 (2) (d).
2046 HIQA, 2009 (n 37) p. 77 define standard as “a measure by which quality is judged. It sets out an expected or desired level of performance. The criteria are the supporting statements that set out how a service can be judged to meet the standard.”
2047 Ibid. No. 24 of Public Service Doc. Nov 2011 state that “[t]he Programme for Government envisages the creation of a Patient Safety Authority incorporating HIQA with a licensing role.”
2048 Ibid. HIQA, 2009 (n 82) Standard 22.
2049 Ibid. Criteria 22.2.
2050 Ibid. Criteria 22.5.
2051 Ibid. Criteria 22.4.
2052 Ibid. Criteria 22.6.
2053 Ibid. Criteria 23.3.
2054 Ibid. Criteria 23.4.
forces.” Professionalism refers to the various professional groups within the residential health care sector for older people that set and monitor standards for their own members. Regulators may directly, for example, by failing to renew a licence or indirectly, for example, by advising of the consequence for failure to comply with hard or soft law provisions, change the quality of care provided. Market pressure is a recognised driver for quality improvement since purchasers seeking accommodation in residential care settings will examine the history in terms of delivery of quality care. For some consumers however their criteria for selection of a residential care setting may of necessity be one solely of finance. As Berwick states: “The dynamics of choice in health care tend to be based on cost alone, making information on variation in other qualities of care uninteresting to those who select.” I would suggest that ‘desirable but unattainable and very distressing’ might be substituted for the word ‘uninteresting’ in this context.

Guidance for safe quality professional practice with regard to older people has been specifically addressed by the Nursing Board with the publication of the Professional Guidance Document for Nurses Working with Older People. Its purpose is twofold, one to provide support and guidance to nurses to ameliorate the care of the older person in every setting and secondly to be used as a resource by the older person and/or the older person’s family. The Board recognises the need for continuous improvements in nursing practice that is responsive to the changes and challenges of society and technology. Standards for the delivery of highly skilled professional care focus on two themes, nursing practice standards and nursing quality standards. Germaine to standard setting is the dignity, autonomy and independence of the older person. One objective of the guidance standards is to provide a starting point for the development of policies and protocols relevant to the particular setting that are based on national guidelines, evidence based nursing practice and optimum practice, to include, for example, care of the older person with challenging behaviour, with

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2057 Ibid. pp. 1-32.
2058 Ibid.
2060 Ibid. p. 3.h.
2061 Ibid. p. 9.
2062 Ibid. the term is explained on p. 29. It states “evidence-based practice is based on successful strategies that improve outcomes of care and are derived from a variety of sources of evidence, for example, the older person’s perspective, research, national guidelines, policies, expert opinion and quality improvement data.”
delirium, with dementia, medication management including self-medication, end of life care and elder abuse. Nurses are duty bound to intervene and to report to senior management all incidences of suspected or actual elder abuse, incompetence, failure to adhere to best practice and unlawful and unethical behaviour. The Board has published a leaflet titled – Nursing Care of Older People that is directed at the public and outlines what a person should expect from a nurse caring for an older person. The leaflet provides information for people on what to do if they have concerns about nursing care. At the time of publication this leaflet was disseminated widely, for example, to public libraries, doctor’s surgeries and citizen information centres.

In 2003 An Bord Altranais introduced English language competency requirement for non-EU nurses. While An Bord Altranais does not assess English language competency of EU applicants as a pre-requisite to registration an employer may make an assessment of language competency. An employer may require formal confirmation of such competence.

A brief mention is made here of reminiscence therapy, a psychosocial intervention that may be either of a general/simple type or an intervention of a more specialised nature specific for older people with dementia. It is about “the discussion of past activities, events and experiences with another person or group of people, usually with the aid of tangible prompts such as photographs, household and other familiar items from the past, music and archive sound recordings.” The benefits of reminiscence therapy have been acknowledged. For meaningful engagement it is critically important that workers have knowledge of history especially social history and have been trained in reminiscence therapy to use it effectively. Woods et al have identified positive benefits for older people with dementia including more active social engagement, (while the person may be dealing with

2063 Ibid. see Appendix 1 for the extensive list of areas that require the development of local policies and guidelines.
2064 Ibid. p. 17.
2066 Information obtained by telephone to An Bord Altranais on the 3rd August 2012.
2067 Such applicants must meet the minimum standards in one of two tests, the International English Language Testing System (IELTS, academic test) or Test of English as a Foreign Language/Test of Written English/Test of Spoken English.
2068 It has relevance for workers irrespective of their discipline and for families.
2071 Ibid; see also, for example, Bohlmeijer et al, 2003, (n 2069) pp. 1088–94.
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the past the relationship is in the present), enhanced attention span and enhanced mood and self-worth.  

(b) The Dental Council

The Dentists Act, 1985 regulates the practice of dentistry in Ireland. The Dental Council was established under s. 6 of the Act “to promote high standards of professional education and professional conduct among dentists....” Education and training is specifically addressed in Part 4 of the Act. The Dental Council is made up of 19 members 7 of whom are registered dentists. The Minister appoints four members. Of those two may not to be dentists. The Act provides for appointment of two people by both University College Cork and the University of Dublin. This creates an anomaly; there is no caveat to prevent both universities from appointing four registered dentists between them. This legislative provision should be amended to ensure that self-regulation cannot occur.

An inquiry may be made by the Fitness to Practise Committee under s. 13 (2) (b) of the Act into a registered dentist’s conduct on the grounds of:

(a) a dentist’s alleged professional misconduct

(b) a dentist’s alleged unfitness to engage in the practice of dentistry on the grounds of physical or mental disability.

An application made in accordance with s. 38 (fitness of practice) of the Dentists Act 1985 is a protected disclosure under s. 55F of the Health Act 2004 as amended by s. 103 of the Health Act 2007. The Dental Council has power (subject to a High Court decision in some circumstances) to “advise, admonish or censure” attach conditions to registration, suspend or erase a dentist’s name from the Register of Dentists.

Oral health is important for all ages and is equally important for older people in residential care settings irrespective of whether they are dentate or edentate (toothless). A very important part of the day for many residents is meal times and often enjoyment of a meal is dependent on well-fitting teeth. The first symptoms of mouth cancer may be problems with swallowing, loose teeth, a mouth ulcer or painless lump on the mouth or tongue. The

importance of relevant information, instruction, training and experience for workers in terms of oral health and hygiene in residential care settings cannot be overstated. Referral to a dentist should be made in a timely manner. This is especially important where an older person has difficulties with communication.

(c) Health and Social Care Professionals Act 2005 and the Health and Social Care Professionals Council

This Act makes provision for the setting up of and the function of the Health and Social Care Professionals Council and of Registration Boards for initially 12 health and social care professions, and for the registration of qualifying persons. Standards of conduct, performance and ethics must be adopted for each group by their respective registration boards. Disciplinary committees are to be established to hear complaints concerning the conduct or competence of registrants. Sanctions may emanate from the hearings.

A health or social care professional is defined by s. 4(3) as:

- any profession in which a person exercises skill or judgement relating to any of the following health or social care activities:
  - The preservation or improvement of health or wellbeing of others;
  - the diagnosis, treatment or care of those who are injured, sick, disabled or infirm;

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2081 Ibid.

2082 No. 27 of 2005.

2083 As provided by Health and Social Care Professionals Act 2005 No. 27 of 2005 Part 2; first appointed in March 2007 and operational in May 2008; the Pre-Hospital Emergency Care Council and the Opticians Board are to merge into the Health and Social Care Professionals Council as detailed in the Department of Public Expenditure and Reform, Public Service Reform document, Appendix 11 – Rationalisation of State Agencies 17th November 2011 paras. 26 and 27.


2085 Health and Social Care Professionals Act 2005 s. 4 (1) provides a list of 12 designated professionals which are, clinical biochemists, dieticians, medical scientists, occupational therapists, orthoptists, physiotherapists, podiatrists, psychologists, radiographers, social care workers, social workers and speech and language therapists; the list is not exhaustive and may be extended by satisfying the conditions of s. 4 (2) of the Act.

2086 Ibid. s. 31 (2).

2087 Ibid. s. 51.

2088 Ibid. s. 52.
(c) the resolution, through guidance, counselling or otherwise, of personal social or psychological problems;

(d) the care of those in need of protection, guidance or support.

The protection of the service user from an incompetent or unethical designated professional or from the use of impaired practice by a designated professional underpins this legislation. The purpose of the Health and Social Care Professions Council (the Council)\(^{2089}\), a single regulator for initially twelve professional groups is to “protect the public by promoting high standards of professional conduct and professional education, training and competence among” the designated professionals registered members.\(^{2090}\) Among the functions of the Council are the enforcement of professional standards\(^{2091}\) and the establishment of complaints committees.\(^{2092}\) The council is made up of 25 members, one from each of the 12 professional groups and 13 other members. With regard to the appointment of the 13 members by the Minister for Health and Children, the position of chairperson may not be from one of the professions to be regulated. Other members may come from among the professional groups.

Section 4 (5) of the Act provides for the making of regulations including the establishment of registration boards. When established, the registration board of each designated professional body is charged with establishing and maintaining a register\(^{2093}\) and promoting high standards of professional practice and “professional education, training and competence” of its members.\(^{2094}\) The registration boards with the Council’s approval may make bye-laws, relating to among other things, language competency.\(^{2095}\)

The Council has developed a Fitness to Practice document and Generic Rules of Professional Conduct (Code of Ethics and Standards of Performance and Conduct) to enable the designated professions form the basis for each of the Registration Board’s bye-laws on their professions’ Code of Conduct, Ethics and Performance.\(^{2096}\) The first Registration Board was established and commenced by the Health and Social Care Professionals Council (Establishment Day) Order 2007 S.I. No. 124 of 2007 and the Health and Social Care Professions Act 2005 (Commencement) Order 2007 S.I. No. 126 of 2007 on the 20\(^{\text{th}}\) March 2007.


\(^{2090}\) S. 7 Health and Social Care Professionals Act 2005.

\(^{2091}\) Ibid. s. 8 (2)(d).

\(^{2092}\) Ibid. s. 8 (2)(e).

\(^{2093}\) Ibid. s. 27 (3)(a).

\(^{2094}\) Ibid. s. 27 (1).

\(^{2095}\) Ibid. s. 31 (1) (d) as it relates to s. 38 (1)(d).

Board of the professional groups designated under the Act, the Social Workers Registration Board (SWRB), was appointed in August 2010. The SWRB, building on the generic code, developed the Code of Professional Conduct and Ethics for Social Workers Bye-Law 2011\(^{2097}\) which came into effect on the 29\(^{th}\) March 2011.\(^{2098}\)

The Health and Social Care Professionals Act 2005 also makes provision for the establishment of three disciplinary committees namely, (a) a preliminary proceedings committee, which following preliminary investigation, may find that there is insufficient cause for further action\(^{2099}\) or where there is sufficient cause may refer the matter to be resolved by mediation when both parties are in agreement to such a course of action.\(^{2100}\) In the event that mediation is not an acceptable course of action the complaint may be referred to either (b) a professional conduct committee or (c) a health committee.\(^{2101}\)

A complaint made under s. 52 of the Health and Social Care Professionals Act 2005 to the Council that is made in good faith where a concerned person has reason to believe that the actions of one of their members poses a risk or is likely to be a risk to the health or welfare of a member of the public is a protected disclosure.\(^{2102}\) However s. 53 (3) of the Health Act 2007 states that: “[t]he preliminary proceedings committee shall notify the registrant of the complaint, its nature and the name of the complainant.” Where a disciplinary sanction is imposed by the Council on a registrant other than an admonishment or a censure, such a measure requires confirmation by the High Court before it can take effect.\(^{2103}\) A toolkit\(^{2104}\) is now\(^{2105}\) available detailing how and where to make complaints about health and social care services.

(d) Medical Council

Entrance to undergraduate medical schools is through the Central Applications Office and a satisfactory HPAT Ireland result\(^{2106}\) or through post graduate entry. The Medical Council

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\(^{2097}\) S. I. No. 143 of 2011.
\(^{2098}\) Ibid. p. 2 No. 4.
\(^{2099}\) S. 54 (1) Health and Social Care Professionals Act 2005.
\(^{2100}\) Ibid. s. 56 (1); s. 55 (3) provides that “[n]o attempt may be made to resolve a complaint by mediation or other informal means without the consent of the complainant and the registrant against whom the complaint was made.”
\(^{2101}\) Ibid. s. 56 (1)(b).
\(^{2102}\) S. 55F(2) of the Health Act 2004 as inserted by s. 103 of the Health Act 2007.
\(^{2103}\) S. 68 of the Health and Social Care Professionals Act 2005.
\(^{2104}\) The toolkit consists of a guide for the public, a leaflet, a poster, a staff training guide and the website – www.healthcomplaints.ie
\(^{2105}\) The initiative was launched on the 19\(^{th}\) September 2011; see www.healthcomplaints.ie
\(^{2106}\) Health Professions Admission Test-Ireland measures a prospective candidate’s suitability in terms of, for example, their logical reasoning and problem-solving skills.
was established under the Medical Practitioners Act 19782107 and it came into operation in 1979.2108 One of the functions of the Medical Council is the provision for ‘registration and control’ of individuals engaged in the practice of medicine. Registered members must display their registration certification at their place of work.2109 The Medical Council have the power to refuse to register an individual if they are of the opinion that the person is unfit to practise.2110 When a person has been furnished in writing with a dated notice refusing registration, accompanied by reasons for same, the person may within two months of the date of the notice apply to the High Court for cancellation of such a decision. On foot of hearing of the application the High Court may either uphold the Medical Council’s decision or cancel the decision and require the Medical Council to register the applicant.2111

A Fitness to Practise Committee established by the Medical Council under s. 13(2)(b) of the Act is empowered to carry out its functions as detailed in Part 5 of the Act with regard to fitness to practice. This may include for example carrying out an inquiry into the conduct of one of its members and implementing sanctions such as erasure or suspension from the register. Such a decision may be appealed to the High Court within 21 days from the date of the decision. Findings of the High Court may be either cancellation of the Council’s decision or upholding the Council’s decision. Where such a ruling by the Medical Council is not appealed to the High Court within 21 days the Medical Council may apply ex parte to the High Court for confirmation of the decision. The High Court will accede to the application unless there are good reasons denying the applicant (Medical Council).2112

Under s. 45 of the Medical Practitioners Act 1978 an application for an inquiry into a medical doctor’s conduct may be made by the Medical Council or any person to the Fitness to Practise Committee where the applicant is alleging that the medical doctor has engaged in

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2107 No. 4 of 1978; the Medical Registration Council established under s. 3 of the Medical Practitioners Act, 1927 No. 25 of 1927 was dissolved by s. 7 of the Medical Practitioners Act, 1978; the Medical Practitioners Act 1978 was repealed by the Medical Practitioners Act 2007. Part 2 of the Medical Practitioners Act 2007 provides for the continuance in being of the Medical Council together with the object and functions of the Medical Council.


2110 Ibid. s. 27 (3).

2111 Ibid. s. 5.

2112 Ibid. s. 46.
professional misconduct or is unfit to practise by virtue of a physical or mental disability. An application in accordance with s. 45 is a protected disclosure by virtue of s. 55F of the Health Act 2004 as amended by s. 103 of the Health Act 2007.

Section 69(2) of the Medical Practitioners Act provides that “[i]t shall be the function of the Council to give guidance to the medical profession generally on all matters relating to ethical conduct and behaviour.” The High Court considered the meaning of poor professional conduct in *O’Laoire v Medical Council.* Keane J stated that “[c]onduct which could not properly be characterised as ‘infamous’ or ‘disgraceful’ and which does not involve any degree of moral turpitude, fraud or dishonesty may still constitute “professional misconduct” if it is conduct connected with his profession in which the medical practitioner concerned has seriously fallen short, by omission or commission, of the standards of conduct expected among medical practitioners.”

Decisions of the Medical Council may be overturned by the High Court. In the case of *Prendiville v The Medical Council* Kelly J. held that among other things the “Council ... had acted ultra vires in regarding itself as bound by the substantive decision of the Fitness to Practise Committee.” Furthermore Kelly J. was prescriptive in detailing how the Council was to deal with reports it received from the Fitness to Practise Committee in the future:

a) the council should not have members of the Fitness to Practise Committee who conducted the hearing and prepared the report under consideration sitting when a meeting was taking place;

b) the council should hear and consider any relevant submissions from the doctor concerned and the Registrar; if it wished to obtain legal advice it should obtain it from an independent lawyer;

c) the Council having obtained any advice should, at a resumed hearing, inform the parties of the nature of the advice they had obtained and give the parties an opportunity of making submissions in regard to it;

d) having heard the submissions, the members of the Council should, on their own, without further reference to the Registrar, arrive at their own conclusion on the issue;

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2113 High Court (Keane J) 27 January 1995 unreported, High Court.
2114 Ibid. p. 109.
2116 Ibid. p. 123.
e) the Council should then decide whether or not to confirm the Fitness to Practise Committee report both as to guilt and sanction.  

Medical Practitioners Act 2007

The purpose of the Act is to enhance public protection and information in addressing matters with medical practitioners by augmenting the arrangements for education, training and competence of medical practitioners and for related matters including the amending of membership and functions of the Medical Council, the investigation of complaints and greater public accountability of the Medical Council.

Section 17 of the Act prescribes the number (25) and composition of the Medical Council in that eleven members must be non-medical members, 10 must be medical doctors and the remaining four members may or may not be doctors. This essentially allows self-regulation to continue if the two people appointed by the HSE and the two people nominated by the body providing basic medical education are medical doctors. A legislative amendment to s. 17 of the Medical Practitioners Act 2007 is required to change this anomaly.

The Council may set up committees of the Council to undertake particular tasks, for example, the Preliminary Proceedings Committee (PCC) that initiates complaint investigations and the Fitness to Practise Committee that investigates complaints. A complainant may bring a complaint pertaining to a registered medical practitioner to the attention of the PPC in the event of

(a) professional misconduct,

(b) poor professional performance,

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2117 Ibid. p. 124
2120 S. 20 of the Medical Practitioners Act 2007.
2122 Poor medical performance by a medical practitioner has been defined by s. 2 of the 2007 Act as “a failure by the practitioner to meet the standards of competence (whether in knowledge and skill or the
(c) a relevant medical disability,

(d) a failure to comply with a relevant condition,

(e) a failure to comply with an undertaking or to take any action specified in a consent given in response to a request under section 67 (1),

(f) a contravention of a provision of this Act (including a provision of any regulations or rules made under this Act), or

(g) a conviction in the State for an offence triable on indictment or a conviction outside the State for an offence consisting of acts or omissions that, if done or made in the State, would constitute an offence triable on indictment.2123

The grounds for the complaint may emanate from an event (‘professional misconduct or poor professional performance’) occurring outside the State.2124 Any complaint coming within the ambit of s. 57(1)(g) is referred immediately by the PPC to the Medical Council.2125 On foot of its investigation with regard to alleged matters (a) to (f) the PCC informs the Medical Council.2126 The PCC refers complaints to the Fitness to Practise Committee when they believe that a “prima facie case” requires further response or the Council directs given the nature of the complaint that further action is warranted.2127 Where complaints have been notified to the Fitness to Practise Committee, the chief executive officer is required to notify the registered medical practitioner who is the subject of the complaint about the complaint and their right to defend the accusation.

The medical practitioner under investigation and any witnesses may seek to have all or some of the hearing of the complaint held in private where they can demonstrate “reasonable and sufficient cause.”2128 Following the hearing the Fitness to Practise Committee furnishes the Medical Council with a written report of its findings. The complaint is dismissed by the Medical Council where the Fitness to Practise Committee finds that the allegation is unfounded. Where the allegation is upheld by the Fitness to Practise Committee the Medical Council may impose sanctions on the practitioner. Such sanctions may include one or more of the following:

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application of knowledge and skill or both) that can reasonably be expected of medical practitioners practising medicine of the kind practised by the practitioner.”

2123 S. 57 (1) of the Medical Practitioners Act 2007.
2124 Ibid. s. 57 (2).
2125 Ibid. s. 57 (5).
2126 Ibid. s 61.
2127 Ibid. s 63; on the 4th March 2009 the first Medical Council fitness-to-practise committee inquiry to be held in public under the 2007 Medical Practitioners Act concerned the “rumpy pumpy” advise given by the GP to his patient. The complaint of professional misconduct was not upheld.
2128 Ibid. ss. 64. (1)(a)(iv) and 64. (1)(b).
(a) an advice or admonishment, or a censure, in writing;

(b) a censure in writing and a fine not exceeding €5,000;

(c) the attachment of conditions to the practitioner’s registration;

(d) the transfer of the practitioner’s registration to another division of the register;

(e) the suspension of the practitioner’s registration for a specified period;

(f) the cancellation of the practitioner’s registration;

(g) a prohibition from applying for a specified period for the restoration of the practitioner’s registration.\textsuperscript{2129}

To take effect, sanctions (b) to (g) must be confirmed by the High Court following an application by the Medical Council, the application to be made in a timely manner after 21 days following the hearing.\textsuperscript{2130} The practitioner may appeal such a decision with regard to sanction(s) to the High Court within 21 days of receipt of the decision from the Medical Council.\textsuperscript{2131} The decision of the High Court is final unless an appeal is lodged to the Supreme Court by either the Medical Council or the Medical Practitioner on a point of law.\textsuperscript{2132} The Medical Council is required to notify the Minister for Health and Children and the Health Service Executive in respect of sanction imposed with regard to particular matters.\textsuperscript{2133}

Duties of the Medical Council in respect of medical education and training are detailed in s.88 of the Medical Practitioners Act 2007. Maintenance of professional competence is located in Part 11 of the Act.

In its publication \textit{Guide to Professional Conduct and Ethics for Registered Medical Practitioners}\textsuperscript{2134} the Medical Council provide a range of ethical principles which must be employed by doctors in their work. Importantly it affirms the dignity of the person.\textsuperscript{2135} It specifically provides for the shared responsibility the medical practitioner has to ensure that “the patient dies with dignity, in comfort and with as little suffering as possible.”\textsuperscript{2136}

\textsuperscript{2129} Ibid. s. 71.
\textsuperscript{2130} Ibid. s. 76.
\textsuperscript{2131} Ibid. s. 75.
\textsuperscript{2132} Ibid. s. 77(2).
\textsuperscript{2133} For example, ss. 71(c), (d), (e), (f) and (g) of the Act as provided on previous page of this work.
\textsuperscript{2134} 7\textsuperscript{th} ed. (Dublin, Medical Council, 2009).
\textsuperscript{2135} Ibid; at para. 5.1 it states that “[a]ll patients must always be treated with respect for their dignity.”
\textsuperscript{2136} Ibid. para. 22.1.
Chapter 6  
Regulation and Education, Experience and Training

Germane to the patient doctor relationship is the concept of confidentiality. Disclosure of information to others without the patient’s consent is prohibited except in limited circumstances.

It is the responsibility of the doctor that carries out investigative procedure(s) and/or treatment to ensure that the patient has given permission for the proposed investigation or treatment. Where a person is deemed to lack capacity to give consent, the responsible doctor is charged with taking reasonable steps to ascertain if a legal authority has been appointed to make such decisions. Where no legal authority is appointed, the responsible doctor must consider the appropriate treatment based on best clinical outcome for the patient, the wishes of the patient both past and present, whether the patient’s capacity is likely to improve, views of others who know the patient and to seek the opinion of other relevant health professionals.

The Guide requires the medical practitioner to have the requisite professional and language skills for each patient. Where the required professional or language skill is absent the attending medical practitioner is required to refer the patient to another medical practitioner with the necessary skills. Regulation 25 of the Recognition of Professional Qualifications (2005/36/EC) Regulations, 2008 requires that person(s) seeking recognition of their professional qualifications must have linguistic competence to enable them to carry out their profession in the State. Until recently there was no requirement for doctors who came to Ireland from EU member states where English is not their first language to sit a language proficiency test. The Commission in its Evaluation of the Professional Qualifications Directive recognises that:

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2137 Ibid. paras. 26-30. See also section titled confidentiality in Ch. 4 of this work.
2138 Ibid. the circumstances where exceptions may be justified in the absence of permission from the patient are detailed paras. 27-30 that provide as follows: para. 27 “when ordered by a Judge in a Court of Law, or by a tribunal or body established by an Act of the Oireachas, or where mandated by infectious disease regulations.” In such circumstances the patient must be informed of the disclosure and the reasons for it; para. 28 provides where necessary to protect the interests of the patient or others and para. 29 provides for disclosure when necessary to protect the welfare of society.
2139 Ibid. section D. See also section titled consent in Ch. 4 of this work.
2140 Ibid. para. 34.5.
2141 Ibid. para. 34.6.
2142 Ibid. para. 12.1.
2143 Professor Murphy president of the Medical Council, The Irish Times Health Plus 23rd November 2010, p. 5; he understands that from July 2011 the HSE will ensure that all interns who had graduated outside of Ireland will undergo an English language test. See also Berlin Statement 13th September 2010 available at http://www.europarl.europa.eu/documents/activities/cont/201010/20101027ATT90655/20201027ATT90655EN.pdf that requests the Commission in the context of Directive 2005/36/EC among other things to “[e]xamine the language provisions in the Directive to address the concerns of competent authorities in relation to language proficiency of migrant doctors in the interest of patient safety” and
Some provisions of the Directive need to be further examined in order to reach the right balance between the need to facilitate mobility and the public interest (e.g. provisions on language skills to be clarified in view of strengthening patients’ safety; minimum training requirements to be reviewed in order to adapt to the evolution of the professions).  

The International English Language Testing System (IELTS) is now a requirement for HSE interns that graduate outside Ireland.  

With regard to nutrition and hydration the Guide to Professional Conduct and Ethics for Registered Medical Practitioners provides as follows:  

Nutrition and hydration are basic needs of human beings. All patients are entitled to be provided with nutrition and hydration in a way that meets their needs. If a patient is unable to take sufficient nutrition and hydration orally, you should assess what alternative forms are possible and appropriate in the circumstances. You should bear in mind the burden or risks to the patient, the patient’s wishes if known, and the overall benefit to be achieved. Where possible, you should make the patient and/or their primary carer aware of these conclusions.  

While the Guide is silent on “do not resuscitate orders”, it does include guidance on advance care planning. In the absence of or where doubt arises with regard to the advance care plan the Guide directs that treatment decisions are made in the best interests of the patient having consulted with any duty holder with legal authority and the patient’s family if possible. Article 12 CRPD shuns the concept of “best interests” and instead emphasises the will and preference of the individual taking account that supports may be necessary for the older person to have their voice heard.

"[e]xamine with the course of the revision of the Directive the increasing occurrences of false documents and fraud and find means of combating these effectively.” Last accessed 5th January 2012.


Ibid. p. 89.

The HSE requires a pass in the four modules listening, reading, writing and speaking and an overall score of seven. Information obtained from the recruitment section of the HSE by telephone on the 3rd August 2012. A language proficiency score of seven is based on a scale range from 0 to 9 where 0 indicates that the candidate did not attempt the test to 9 has full proficiency in its understanding and use. http://www.ielts.org/institutions/institutions_faqs/test_scores.aspx  Last accessed 3rd August 2012.

7th ed. (Dublin, Medical Council, 2009).

Ibid. para. 19.1.

Ibid. para. 41; see also In re a Ward of Court (withholding medical treatment) (No. 2) (n 4) 118-119.
(e) The Pharmaceutical Society of Ireland and the Pharmacy Act 2007 as amended by the European Communities (Recognition of Professional Qualifications relating to the Profession of Pharmacist) (No. 2) Regulations 2008

The Pharmacy Act 2007 amends the regulation of pharmacy practice in Ireland to include the setting up of new standards for the profession, dealing with complaints and pharmaceutical registration.

The Pharmaceutical Society of Ireland (P.S.I.) is an independent statutory body, established under s. 6 of the Pharmacy Act 2007. Among its functions are the regulation of pharmacy services in the country and ensuring supervisory compliance with the Act.

The Council of the Society appointed by the Minister for Health and Children and established under s. 10 of the Pharmacy Act 2007 presides over the P.S.I. The Council consisting of 21 members has a non-pharmacist majority. The Pharmaceutical Society of Ireland (Council) Rules 2008 provides for the governance and administration of the Council and its Committees.

Qualified EU pharmacists may work in Ireland. Among the criteria for registration is the requirement for linguistic competence. Where a pharmacist is an Irish national or from another Member State and is lacking in this competency the person may satisfy the registration criteria in this regard if such a person “undertakes to acquire” a competency in the language. However the Council of the [Pharmaceutical] Society may restrict the worker from dealing directly with the public until she or he has acquired the linguistic competence.

The P.S.I. has developed a Code of Conduct for Pharmacists. A disclosure to the P.S.I. that is made in good faith where a concerned person has reason to believe that a registered member of the P.S.I. is a risk or is likely to be a risk to the health or welfare of the public is a protected disclosure under 55E of the Health Act 2004 as inserted by s. 103 of the Health Act 2004.
Chapter 6  Regulation and Education, Experience and Training

Act 2007. Sections 35-36 of the Pharmacy Act 2007 make provisions for complaints about registered pharmacists and registered retail pharmacy businesses. The grounds for the complaint may include among other things professional misconduct or poor professional performance. Complaints in the first instance are referred to the Preliminary Proceedings Committee for direction. In the event of the committee forming the opinion that further action is warranted, it may consider referring the matter for mediation or refer the complaint to either the Professional Conduct Committee or the Health Committee. The Disciplinary Committee prepares a report that is forwarded to the Council for their consideration. The Council must review the report within 30 days and either dismiss the complaint in the absence of sufficient evidence or, where the grounds for the complaint have been substantiated, impose one of the penalties as detailed in s. 48 (1) of the Act, for example, a censure or suspension or cancellation of registration or attach a condition to the registration. To become effective the disciplinary sanction imposed (other than admonishment or censure) must be confirmed by the High Court. The High Court may confirm, cancel, or vary the disciplinary sanction. Section 54 of the Pharmacy Act 2007 provides that the decision of the High Court is final except where an appeal is allowed to the Supreme Court on a point of law.

2161 The Pharmacy Act 2007 S. 35 (1)(a) and (b), the professional misconduct or poor performance may have occurred either within or outside the State.
2162 Ibid. s. 38.
2163 Ibid. s. 40. (1)(a).
2164 Ibid. s. 40. (1)(b)(i).
2165 Ibid. s. 40. (1)(b)(ii).
2166 Ibid. s. 52. (3).
2167 Ibid. s. 51. (1).
2168 Ibid. s. 51. (4).
Discussion

Variability in practice inevitably leads to variability in outcomes and expenditure in care.\textsuperscript{2169} In the context of the older person in residential care this may have a devastating effect. By way of example, inappropriate prescribing can be considered where an older person has been prescribed medication with iatrogenic effects outweighing the anticipated benefits. Adverse drug reactions from inappropriate prescribing have been well documented.\textsuperscript{2170} The results of the Second National Prevalence Survey on Healthcare Associated Infections and Antibiotic use in Irish Long-Term Care Facilities\textsuperscript{2171} found that one in ten residents were on antibiotics.\textsuperscript{2172} Within this cohort\textsuperscript{2173} antibiotics had been prescribed for treatment\textsuperscript{2174} and prevention\textsuperscript{2175} of infection. These figures indicate a much higher use of antibiotics in the long term care facilities surveyed in Ireland (10.1%) compared to an EU prevalence of 5.9%.\textsuperscript{2176} As a result of the survey each participating residential care setting was issued with their report, and the outcomes discussed to enable preventative programmes to be implemented. Programmes include ensuring that both residents and staff are offered the relevant vaccinations to prevent respiratory infection in residents, that controls for the relevant risk factors (e.g. urinary catheters) are in place to minimise infection and that the guidelines for correct antibiotic prescriptions are implemented.\textsuperscript{2177} While there may be improvements in the study cohort what about those in other residential care settings? In the absence of the relevant education, training and experience and auditing of practices against a set standard, the high level of antibiotic use is likely to continue.

\textsuperscript{2169} HIQA, 2010 (n 2055) p. 6.
\textsuperscript{2171} HPSC, National Report, August 2011. The findings result from a survey of 82 public and 24 private long term care facilities that included residential care facilities for older people and those with intellectual disability surveyed on a particular date. Available at http://www.hpsc.ie/hpsc/A-Z/MicrobiologyAntimicrobialResistance/InfectionControlandHAI/Surveillance/HCAInlongtermcarefacilities.com Last accessed 7th September 2011.
\textsuperscript{2172} Ibid. 601 out of 5,922 residents surveyed.
\textsuperscript{2173} Ibid. 601 residents receiving antibiotics.
\textsuperscript{2174} Ibid. 58%, 340 residents.
\textsuperscript{2175} Ibid. 39%, 244 residents.
\textsuperscript{2176} Ibid. p. 28.
\textsuperscript{2177} Ibid. Summary Report.
A UK report on the inappropriate and extensive use of antipsychotic drugs in people with dementia is alarming. The report highlighted the lack of dementia care training for workers in the residential care settings, a lack of leadership in the residential care settings, inadequate support from external services including poor systems in place for monitoring and reviewing prescriptions and the “exclusion” of loved ones from decision-making. The Report referring to the UK National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (NICE-SCIE) draws attention to their guidance both for pharmacological and non-pharmacological solutions. The Report highlights the barriers to good practice citing “a lack of training and lack of support from external services.”

The letter from the Irish Pharmacy Regulator to Superintendent Pharmacists highlights the “serious concerns” the PSI have with regard to the arrangements for providing medicinal products to older people in residential care settings. The letter in affirming the responsibilities of the Superintendent Pharmacists provides among other things that it is essential that the pharmacist personally attends on the patient in the residential home. Records of these visits to individual patients and the associated reviews, including any interventions made by the pharmacist, should be recorded appropriately in the pharmacy and in the residential home records.

Given the level of over-prescribing in older people in residential care this direction is welcome.

**Conclusion**

This chapter focused on the critically important area of education, experience and training for workers in residential care. Legislative change does not necessarily bring about institutional reform in terms of increased quality of care and services for the older person. Professional self-regulation or self-policing may potentially give rise to a conflict of interest and be a source of public disquiet in the absence of independent strong governance and accountability. Any organisation with a high level of monopolistic control and corresponding low levels of public accountability can unintentionally facilitate exploitative

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2178 APPG 2008, (n 2170).
2179 Ibid. p. ix.
2181 Ibid. pp. x, 9, 11, 25.
2183 Ibid.
and abusive behaviour by an aberrant member. As Harding Clarke J. stated “[t]here have to be systems of independent safeguards in place to recognise aberrant practice soon after it occurs.” Historically governance of professional bodies was carried out by representatives of the professions themselves. In terms of the composition of Boards of professional bodies, a shift is slowly taking place where the majority of a Board are not or have never been a member of the given profession.

At present it could be argued that self-regulation exists for nurses, doctors, and dentists. This needs to be addressed. The Council of the Pharmaceutical Society has a non-pharmacist majority. Among Health and Social Care Professionals, the sole Registration Board appointed is the Social Workers Registration Board.

High standards of professional conduct and professional education, training and competence are required to deliver optimal protection and care for older people in residential care. The challenge therefore is to combine effective legislation with consistent implementation of both hard and soft law by both the regulators and the professions themselves in the interest of augmenting the quality and safety of services for the older person in residential care settings. Independent inspection is critical to ensure that the standards set are implemented and maintained.

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2187 s. 22 of the Nurses and Midwives Act 2011. However this section has not been fully enacted at the time of writing.
2188 Ibid.
2189 For example, the COP’s published by the MHC for approved centres under mental health legislation.
2190 Disappointingly the most recent report for approved centres in terms of Article 15 individual care plans reveals that only 27 of a total of 73 approved centres are fully compliant. Report available at http://www.mhcirt.ie/Inspectorate_of_Mental_Health_Services/Themed_Reports/Article_15_Care_Plans_compliance_2010.pdf Last accessed 11th August 2012.
2191 At an international level: Report to the IECSCR and CAT. Regional Level: The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) periodically carry out inspections in a number of residential centres. Local Level: HIQA among other things inspects residential care centres for older people and intellectual disability residential services (relevant in this context with regard to older residents). The Inspectorate for Mental Health Services among other things inspects the implementation of the Codes of Practice prepared by the MHC in approved centres under mental health legislation. The MHC appoints Mental Health Tribunals to review the admission of every involuntary patient admitted to an approved centre. See sections titled Mental Health Act 2001 and Mental Health Act 2001 (Approved Centres) Regulations 2006 in this work for further discussion. The Health and Safety Authority among other things inspects workplaces to ensure compliance with health and safety legislation. Also when Ireland ratifies the CRPD Article 33 will be relevant in this context.
Chapter 7  Leas Cross Nursing Home: A Catalyst for Change

An investigation focusing on the care or more correctly its absence in a residential care setting for older people has become a key element in the law reform in residential care. On the 30th May 2005 Radio Telefís Éireann’s (RTE) reported on its Prime Time Programme on the treatment of residents at Leas Cross Nursing Home in Co. Dublin. The harrowing programme detailed information and film footage obtained by an undercover reporter who had been employed at the nursing home for a few weeks.

Following the programme the Health Service Executive, Northern Area (HSE NA) initiated an investigation into complaints arising from the programme contents. At the same time the HSE NA sought the support of Professor O’Neill to investigate the deaths of patients at the nursing home between 2002 and 2005.

It was not until 6th June 2007 that the Commission of Investigation (Leas Cross Nursing Home) was set up under s. 3 of the Commission of Investigation Act 2004. The Commission’s findings were published on the 16th July 2009. The cost of the inquiry was €2.1 million.

Under its terms of reference the Commission was charged with examination of the following matters:

the role and responses of such relevant parties as the Commission may determine ... in relation to

(a) the establishment, ownership, operation, management, staffing and /or supervision of Leas Cross Nursing Home (hereinafter “the nursing home”);

(b) complaints made by or in respect of residents or former residents of the nursing home; and

2192 The Broadcasting Act, 2009 No. 18 of 2009 s. 2 changed the spelling of RTE to Raidió Teilifís Éireann.
2193 See Dáil Debates 31st May and 1st June 2005.
2195 No. 23 of 2004; the purpose of the Act is to enable the setting up of and the provision of power to commissions to investigate matters of significant public concern. A commission’s extensive powers are set out in ss. 16, 17 and 28 of the Act. These include powers to examine and question witnesses, obtain and examine documents, require persons to pay certain costs, powers of entry to any premises and inspection of documents or information.
2196 O’Donovan, 2009 (n 32).
2197 The Irish Times July 1st 2009.
(c) the transfer of residents from medical and residential care facilities to the nursing home.\textsuperscript{2198}

With regard to (a) above and staffing, the Commission examined “the assessment of staffing requirements; recruitment of staff; numbers and qualifications of staff; staff training and development; and supervision and discipline.”\textsuperscript{2199}

The Commission acknowledged that most people co-operated with the Commission in their investigation by complying with their instructions regarding the provision of information and documentation. However the failure by a number of people to comply with these instructions resulted in 22 directions being issued under s. 16 of the 2004 Act that compelled the persons concerned to furnish the Commission with the requested information/documentation.\textsuperscript{2200} It is disappointing that the Commission was only able to make contact with 5 of the 156\textsuperscript{2201} former care attendants who worked at the nursing home from 1998-2005.\textsuperscript{2202}

The proprietors of the nursing home sought and were granted registration by the Health Board of a 31 bedded unit on the 24\textsuperscript{th} June 1998 (backdated to 1\textsuperscript{st} June 1998) with no conditions attached\textsuperscript{2203} and according to the report “it does not appear from the information available to the Commission that consideration was ever given by the Health Board to limiting the dependency levels of residents in Leas Cross Nursing Home.”\textsuperscript{2204}

Problems with staffing levels were identified by the Health Board in 1998\textsuperscript{2205} and on three separate occasions in 1999.\textsuperscript{2206} The matter would appear to have been resolved at this time. The nursing home was re-registered on the 1\textsuperscript{st} June 2001 for a further 3 years with no conditions attached.\textsuperscript{2207} On the 29\textsuperscript{th} October 2002 the owner of the nursing home sought re-

\textsuperscript{2198} O’Donovan, 2009, (n 32), p. 9.
\textsuperscript{2199} Ibid. p. 10.
\textsuperscript{2200} Ibid. p. 13.
\textsuperscript{2201} Ibid. p. 101.
\textsuperscript{2202} Ibid. p. 110.
\textsuperscript{2203} Ibid. p. 40; s.4. (8)(a) of the Health (Nursing Homes) Act, 1990 provided that “a health board may (i) at the time of registration or subsequently attach to the registration conditions in relation to the carrying on of the nursing home concerned and such other matters as it considers appropriate having regard to its functions under this Act...”
\textsuperscript{2204} Ibid. O’Donovan, 2009, (n 32), p. 35.
\textsuperscript{2205} Ibid. p. 46.
\textsuperscript{2206} Ibid. p. 52-53.
\textsuperscript{2207} Ibid. p. 53; s. 4. (11) of the Health (Nursing Homes) Act, 1990 states that “[t]he registered proprietor of a nursing home who proposes to carry on the home immediately after the expiration of the period of registration of the home may apply under subsection (3) to the health board concerned not less than 2 months before such expiration for the registration of the home and, if the board does not notify him before such expiration that it proposes to refuse to register the home, it shall register the home and its date of registration shall be the day following the day of such expiration.”
The registration of the nursing home with 111 beds and new registration was granted for 111 residents covering the period from 1st June 2001 for a further 3 years with no conditions attached. The Commission expressed concern given the “history of the nursing home” that such a decision made by such a senior manager was made based on only one standard inspection. It went on to say that the registration of the additional beds was sanctioned “without adequate regard to the wellbeing” of the older people who would be resident in the new wing of the nursing home. Protection of future residents could have been achieved, it suggested, if the Northern Area Health Board (NAHB) had taken a tripartite approach to safeguarding those residents: first, by satisfying themselves at the outset that such a large establishment could provide optimum care and welfare for the residents and by ensuring a proper management system was in place; second by granting registration on a conditional basis so that staff levels were tailored to meet the increasing numbers of residents with varying needs and thirdly more frequent inspections should have taken place following registration.

The Commission Report refers to Regulation 10.5 of the Nursing Homes (Care and Welfare) Regulations 1993 with regard to “competent staff” in the context of the application form for registration of Leas Cross. The application form contained the following, “[e]ach resident will have access to a G.P. of their choice and an on-call system will operate for emergencies. A registered nurse will be on duty at all times supported by additional staff to provide a high standard of care for the residents.”

The Commission did not address the deficiency in the legislation that failed to define what is meant by “competent staff” with regard to care providers. The Commission rightly recognised that the Health Board had the power to limit the nursing home to low dependency residents. An increase of beds from 31 to 38 was sanctioned on the 16th February 1999 with no conditions attached. It is difficult to see how one registered nurse with additional staff could provide a high standard of care for 31 patients of varying levels of dependency, let alone 38 patients.

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2209 Ibid. p. 55.
2210 Ibid. p. 54 where it states that General Manager CCC 8 (Community and Continuing Care Grade 8) “approved the registration....”
2211 Ibid. pp. 55, 341.
2212 Ibid. p. 56.
2213 Ibid.
2214 Ibid. p. 35.
2215 Ibid.
2216 Ibid; sch 1 of The Nursing Home (Subvention) Regulations 1993 distinguish three levels of dependency (medium, high and maximum). See Ch. 3 of this work.
2217 Ibid; this covered the remainder of the 3 year registration period which commenced on 1/6/98 until the 31/5/01.
The Commission suggests that it would be “preferable”\textsuperscript{2218} for the nursing home legislation to provide greater clarity to the term “appropriate” in the context of nurses’ post registration experience and to stipulate the post graduate qualifications for a director of nursing. This has been discussed.\textsuperscript{2219}

A person is considered to be unfit to be in charge of a nursing home where such a person is convicted of an offence under the Health (Nursing Homes) Act, 1990, the Health (Homes for Incapacitated Persons) Act, 1964 or “any other offence that is such as to render the person unfit to be in charge.”\textsuperscript{2220} However, the Commission suggested that “it would appear to be open to the H.S.E. to conclude that the person in charge does not have the appropriate experience.”\textsuperscript{2221} Essentially this would mean that the HSE would have been the assessor of professional competency that was not defined in legislation.\textsuperscript{2222} There are some difficulties here in terms of professional practice. This would more properly be the function of the nursing and medical Fitness to Practise Committees.

The (Nursing Homes) Act, 1990 makes provision for the making of regulations with regard to among other things the “numbers, qualifications and availability of members of the staffs (including the medical staffs) of nursing homes.”\textsuperscript{2223} With the exception of the meagre provisions of regulation 10 of the Nursing Homes (Care and Welfare) Regulations, 1993 the opportunities afforded by s. 6 were never realised. It is disappointing that the Commission did not identify the prominent lacuna in the nursing homes legislation and recommend a remedy by legislative amendment to include explicit qualifications and training requirements for all health care workers. As O’Neill states “the outcomes of care improve when older patients are cared for by nurses with demonstrated competence in gerontological knowledge and skills.”\textsuperscript{2224}

The Commission Report merely said “it would have been preferable for the Regulations to have specified minimum numbers of nursing and care staff required, or at least to have provided a method by which staffing numbers (in particular numbers of nursing staff) should be calculated.”\textsuperscript{2225} Unfortunately the Commission affirmed the adequacy of the regulations with regard to staffing, stating it “is satisfied that the regulations made clear the need to

\textsuperscript{2218} Ibid. p. 69.
\textsuperscript{2219} See Ch. 3 of this work, para. titled Nursing Homes (Care and Welfare) Regulations, 1993.
\textsuperscript{2220} S. 4 (6)(ii) of the Health (Nursing Homes) Act, 1990.
\textsuperscript{2221} O’Donovan, 2009, (n 32) p. 76.
\textsuperscript{2222} Competence in terms of those working in residential care settings was not defined until the publication of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 which considers a competent person to have the same meaning as that provided by s. 2 of the Safety, Health and Welfare at Work Act 2005.
\textsuperscript{2223} S. 6. (2) (b).
\textsuperscript{2224} O’Neill, D., 2006, (n 33) p. 12.
\textsuperscript{2225} O’Donovan, 2009, (n 32) p. 89.
provide adequate staffing.\textsuperscript{2226} The Commission was “also satisfied that there was ample provision in the legislation to enable the Health Board or the H.S.E. to take action in circumstances where they identified a failure to meet the required levels of staffing.”\textsuperscript{2227} The Commission does acknowledge that there is no legislative provision that requires the employment of specialist nurses. While there may be Health Board/HSE guidelines on staffing levels, the legislation does not specify numbers or training requirements.\textsuperscript{2228}

The \textit{Commission Report} deems the law to be adequate. However legislative shortcomings include, for example, the lack of precision in terms of standards and qualifications. Also terms such as “appropriate”, “suitable” and “sufficient” allow too much scope for individual interpretation. In the interests of the residential care residents, it is essential to specify the specific qualification for not just the director of nursing but all residential care workers.

Issues with care have been identified throughout the \textit{Commission Report}.\textsuperscript{2229} The \textit{Commission Report} is deeply disturbing for example in the references to pressure sores.\textsuperscript{2230} By November 2003 (perhaps much earlier) one third of the residents approximately had been transferred from St. Ita’s Hospital in Portrane.\textsuperscript{2231} No indication is given in the report if any staff member had any mental health training. With regard to the transfer of patients from St. Ita’s Hospital to Leas Cross, Consultant Psychiatrist A expressed deep concern to the Commission about the absence of care, stating,

it was the circumstances around the deaths, the type of patients and our perception of the skill mix [of staff] that caused the most concern. Also the presence of dehydration, aspiration pneumonia or bedsores can all be taken as indicators of the quality of nursing care. These were noted in some of those who had succumbed.\textsuperscript{2232}

O’Neill described the care provided to residents as “deficient at many levels and highly suggestive of inadequate numbers of inadequately trained staff...”\textsuperscript{2233} aligned with inadequate and under-informed clinical leadership.\textsuperscript{2234} The television documentary findings he said are “consistent ... with institutional abuse.”\textsuperscript{2235} Such abuse, he added, may consist of “poor care standards, lack of positive response to complex needs, rigid routines, inadequate

\begin{footnotesize}
\begin{enumerate}
\item Ibid. p. 88.
\item Ibid.
\item Department of Health \textit{Code of Practice for Nursing Homes} (Dublin, Department of Health, 1995) \url{http://lensus.ie/hse/handle/10147/46681} Last accessed 22\textsuperscript{nd} August 2012.
\item For example, pp. 98, 163, 246, 247, 251, 254, 258, 262, 271-275, 321-322, 325.
\item Ibid. pp. 191-192, 275, 276, 283. See also Walsh, K. and Bennett, G., “Pressure ulcers as indicators of neglect” (2000) 2 (11) \textit{Nursing and Residential Care} 536.
\item Ibid. p. 247.
\item O’Neill, D., 2006, (n 33) p. 60.
\item Ibid.
\item Ibid.
\end{enumerate}
\end{footnotesize}
staffing, and an insufficient knowledge base within the service.” U.S. studies indicate that the most susceptible residents to abuse and neglect are those suffering from cognitive impairment and those that experience behavioural problems.

O’Neill was equally critical of the regulatory process of the Health Board/HSE (NA) stating that there was a deficiency

at all levels in its response to the clear deficits uncovered, and in its assessment that the proprietor and senior clinical management at Leas Cross had the insight or capability to effect meaningful change. There is no record of senior management in the H.S.E. (N.A.) appearing to give due weight to written concerns by senior clinicians about standards of care.

The Commission stated “the evidence … suggests that the nursing home was not equipped to deal with the number and dependency level of residents in its care from September 2003 until June 2005.” The increase in the admission of patients, the Commission concluded, “coincided with a significant deterioration in standards of care in the Nursing Home.” The Commission recognised that is was the “[p]oor standard of care which led to the deterioration of the residents’ health.”

The Commission also recognised that staffing numbers should have increased to accommodate the increased number of patients transferred from St. Ita’s Hospital and “consideration should have been given to engaging some specialist nurses to care for them.” Elsewhere the Commission does state that the “N.A.H.B. should have taken steps to ensure that an acceptable standard of care was maintained at Leas Cross for all residents, including the new arrivals from St. Ita’s.”

According to the proprietor of the nursing home, the nursing home received “no written formal reports” from the HSE of visits that it had undertaken within the 21 month period prior to May 2005. Given the extent of the information available to the HSE the

2236 Ibid.
2239 O’Donovan, 2009 (n 32), large number of complaints p. 121-122.
2240 Ibid. chs. 8, 13 and 17 and p. 121.
2241 Ibid. p. 258.
2242 Ibid. p. 191.
2243 Ibid. p. 262.
2244 Ibid. p. 263.
2245 Ibid. p. 319.
Commission is of the opinion that the HSE had “ample evidence”\(^{2246}\) to alert them to the anomalies within the nursing home prior to the broadcasting of the television programme.

The Commission recognised that there were “deficiencies with the inspection process,”\(^{2247}\) given the differences in findings by the inspection teams in April 05 and 8\(^{th}\) June 2005. The Commission further stated that given that the April 2005 inspection was carried out over two days rather than one day as was previously the practice and given the discrepancies between the two visits, it “casts even more doubt on the efficacy of the old inspection regime which was in place between 1998 and 2004.” The Commission further adds that given the amount of information that the HSE had accumulated on the nursing home, it should have alerted them “to impending problems, which could have been avoided.”\(^{2248}\)

There was a catastrophic failure of the inspection system. The nursing home inspection process was fragmented–reports were written, cumulative complaints were investigated but a cohesive response to the findings did not occur until after the Prime Time Programme. Given that the NAHB sought to purchase contract beds from nursing homes as far back as 2001, it is surprising that a more robust system of inspection was not implemented.\(^{2249}\)

Conflicts of interests were highlighted where one nursing home inspector in a statement to the Commission in the context of nursing home inspections in 2004/2005 stated, among other things, that there was

a major conflict of interest in the Nursing Home Inspection process namely [that] the HSE section which was responsible for inspecting the homes was also the principal purchaser of beds in these homes. The senior administrators responsible for purchasing nursing home beds in the HSE were also responsible for overseeing the regulation of these homes.\(^{2250}\)

The following table details the dates of routine inspections and the numbers of residents present on those dates, together with the numbers of professional and non-professional workers present at the time of inspections.

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\(^{2246}\) Ibid. p. 203.

\(^{2247}\) Ibid. p. 165.

\(^{2248}\) Ibid.

\(^{2249}\) Nursing Homes (Subvention) Amendment) Regulations, 1996 provided for “contract beds.”

\(^{2250}\) O’Donovan, 2009 (n 32), p. 131.
Table indicates dates of health board/HSE nursing home inspections, the number of: staff (nurses and care attendants) employed, at work and residents present on the date of inspection.  

<table>
<thead>
<tr>
<th>Date</th>
<th>Nurses No. on Roster</th>
<th>Nurses No. on Duty</th>
<th>Care Attendants No. on Roster</th>
<th>Care Attendants No. on Duty</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/1998</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>16/02/1999</td>
<td>9</td>
<td>2</td>
<td>N/A</td>
<td>24</td>
<td>3</td>
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<tr>
<td>21/04/1999</td>
<td>Spot check</td>
<td>N/A</td>
<td>1</td>
<td>1</td>
<td>28</td>
</tr>
<tr>
<td>18/06/1999</td>
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<td>N/A</td>
<td>N/A</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>09/07/1999</td>
<td>7</td>
<td>2</td>
<td>N/A</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>18/08/1999</td>
<td>Spot check</td>
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<td>1.5</td>
<td>N/A</td>
<td>2**</td>
</tr>
<tr>
<td>15/10/1999</td>
<td>Spot check</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>3</td>
</tr>
<tr>
<td>15/02/2000</td>
<td>7</td>
<td>2</td>
<td>N/A</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td>06/10/2000</td>
<td>7</td>
<td>2</td>
<td>N/A</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>25/03/2001</td>
<td>6</td>
<td>2</td>
<td>N/A</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>18/06/2001</td>
<td>6</td>
<td>2</td>
<td>N/A</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>20/05/2002</td>
<td>&gt;6/12 mts.</td>
<td>5</td>
<td>N/A</td>
<td>18</td>
<td>N/A</td>
</tr>
<tr>
<td>20/11/2002</td>
<td>5</td>
<td>2</td>
<td>N/A</td>
<td>18</td>
<td>7</td>
</tr>
</tbody>
</table>

N/A = specific details not included in report  
** = less than min standard

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2251 Ibid. p. 94-95.
2252 O’Donovan, 2009 (n 32) p. 93 of the report states that there were 38 residents however p. 139 states there were 36 residents on this date.
2253 Ibid. p. 93 states it was the 6/10/00, while p. 140 refers to the 16/10/00. P. 186 refers to complaint investigation carried out on 6/10/00.
2254 Regulation 24 of the Nursing Homes (Care and Welfare) Regulations, 1993 provided that “[I]nspections of a nursing home pursuant to article 23.1 shall be made by designated officers not less than once in every period of six months.”
<table>
<thead>
<tr>
<th>Date</th>
<th>Nurses</th>
<th>Care Attendants</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. on Roster</td>
<td>No. on Duty Day</td>
<td>No. on Roster Day</td>
</tr>
<tr>
<td>09/07/2003</td>
<td>10</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>Incomplete inspection(^{2255})</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>17/11/2003</td>
<td>10</td>
<td>2 + *</td>
<td>2</td>
</tr>
<tr>
<td>22/12/2003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint investigation: Head of Quality at the Corporate Governance Department in the Health Board present(^{2257})</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/01/2004</td>
<td>Follow up to visit of 22/12/2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16/03/2004</td>
<td>Investigation of complaint made on 15/01/2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/06/2004</td>
<td>10</td>
<td>3 + *</td>
<td>N/A</td>
</tr>
<tr>
<td>05/07/2004</td>
<td>Visit conducted by Nursing Home Inspector H and G to show Matron use of dependency assessment tool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/2005</td>
<td>Visit conducted by Nursing Home Inspector H and G to show Acting Matron use of dependency assessment tool.(^{2258}) Not in place by next visit on 7/4/09.(^{2259})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>07/04/2005</td>
<td>12</td>
<td>3 + *</td>
<td>N/A</td>
</tr>
<tr>
<td>08/04/2005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28/05/2005</td>
<td>Visits by head of the Nursing Home Inspectorate following viewing preview of Primetime Programme(^{2260})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29/05/2005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30/05/2005</td>
<td>Purpose: to ascertain staffing levels and patient’s health status</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A = Specific details not included in report. * = Matron ** = less than min standard. In 2005 inspections were carried out by a dedicated inspection team.(^{2262}) In early May 2005 a team and person in charge were assigned by the HSE.(^{2263})</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{2255}\) O’Donovan, 2009 (n 32), p. 143.
\(^{2256}\) Ibid. p. 95 states that on the 9\(^{th}\) July 2003 there were seven care attendants rostered for duty; at p. 143 it states that there were 5 care attendants on duty.
\(^{2257}\) Ibid. p. 145 and p. 190. Ms Black died as a result of pressure sores. The inquest verdict was “death by medical misadventure” as cited in p. 190.
\(^{2258}\) Ibid. p. 147.
\(^{2259}\) Ibid. p. 148.
\(^{2260}\) Ibid. p. 155; see also para. 4, p. 188, letter regarding complaint sent to Head of Quality at the Department of Corporate Governance.
\(^{2261}\) Ibid. p. 295.
\(^{2262}\) Ibid. p. 128.
\(^{2263}\) Ibid. p. 68 and ch. 21.
With regard to complaints made to the Health Services the Commission recognises the weaknesses in Regulation 26 of the Nursing Homes (Care and Welfare) Regulations 1993. It acknowledges the ambiguity of Regulation 26.1 and considers that the provision could be amended. This is the strongest statement the Commission made with regard to amendment of legislation. Procedurally the Commission suggests that all verbal complaints made to the HSE regarding a nursing home should be documented and sent to the Nursing Home Section within the HSE.

Complaints made towards the end of 2003 to 2005 contain allegations pertaining to “inadequate supervision of residents, unwarranted use of physical or chemical restraints and lack of regard for residents’ hygiene and personal care.” Furthermore the Commission acknowledged that the presence of pressure sores, dehydration and urinary tract infection could also highlight poor treatment of residents.

In 2005 a public bed procurement process was established with the aim of transferring patients with permanent care needs from acute hospital settings to non-acute settings. As part of this process the HSE carried out assessments of nursing homes which had tendered for business. A four member HSE evaluation team carried out an assessment of Leas Cross on the 15th March 2005 and the report to the Commission by the Senior Commissioner in the Eastern Health Board Authority included the following statement:

We were particularly concerned by the following issues in Leas Cross:

- The lack of staffing, in particular the number of trained nurses
- The overcrowding
- The lack of activities for residents
- The visibly distressed residents
- Record keeping

The Senior Commissioner informed the Commission that she reported her findings to senior health board management. One of the Inspectors that carried out an inspection at the nursing home in April 2005 reported to the Commission:

In my opinion, the most significant issue at the inspection of Leas Cross was staffing... Although there were a large number of care assistants rostered to work in the
home, they were no substitute for nurses and were not trained to provide or oversee the complex nursing care required by these residents.}\(^{2270}\)

This view is supported by Ms Mary Flanagan Acting Director of Nursing appointed by the HSE to manage the team (also appointed by the HSE) and manage the operation of the nursing home (following the Primetime Programme). She made a progress report to the HSE on the 8\(^{th}\) June 2005 and with regard to staffing stated:

The total nursing complement is 12 [nurses], including the Director of Nursing, supported by 45 care attendants and other support staff. This leaves large deficits in the provision of 24 hour care with care being delivered in task-orientated manner by untrained care attendants with limited supervision from [nurses]. This results in a lack of continuity of care for residents and families.\(^{2271}\)

Consequently care standards “were very poor in areas such as continence and personal care. Pressure are [areas] and wound management … also gave cause for concern.”\(^{2272}\) With regard to nursing staff O’Neill has stated “[t]he staffing and qualifications as documented at Leas Cross were clearly deficient in terms of specialist expertise, nursing numbers and nursing infrastructure.”\(^{2273}\) He considered this to be “perhaps the single most grievous area of concern of practice within the nursing home….”\(^{2274}\)

In terms of care attendants, the Commission stated that “the continued absence of qualification requirements for care attendants, including competency in the English language, is regrettable…”\(^{2275}\) The Commission is particularly concerned with the language communication difficulties that existed between staff and “elderly vulnerable and highly dependent residents.”\(^{2276}\) Over the last number of years there has been a marked increase in the numbers of foreign workers working in Irish nursing homes. According to the Annual Private Nursing Home Survey in 2007, 49% of nurses and 36% of all workers in private nursing homes were from outside Ireland.\(^{2277}\)

\(^{2270}\) Ibid. p. 98.
\(^{2271}\) Ibid.
\(^{2272}\) Ibid. p. 164.
\(^{2273}\) O’Neill D., 2006, (n 33) p. 25.
\(^{2274}\) Ibid.
\(^{2275}\) O’Donovan, 2009 (n 32) p. 107.
\(^{2276}\) Ibid. p. 106.
\(^{2277}\) As cited by Walsh K. and O’Shea E., on p. 1 of the Report on The Role of Migrant Care Workers in Ageing Societies: Context and Experiences in Ireland (Irish Centre for Social Gerontology, National University of Ireland Galway, 2007).
Among other things the Irish Centre for Social Gerontology (ICSG) sought to investigate the effect of engaging migrant workers on the well-being of older people.\textsuperscript{2278} The ICSG Report stated that according to nursing home employers quality of care was either maintained or improved with the engagement of migrant care workers.\textsuperscript{2279} Importantly the authors acknowledge that no examination has been undertaken to ascertain the effect on older people when care is provided by a migrant care worker.

Where a shared religious belief existed it was considered a vector for enhancing acceptance of the migrant worker by the older person.\textsuperscript{2280} However, not surprisingly language proficiency is considered germane to facilitating a mutually satisfactory caring relationship.\textsuperscript{2281} The authors considered that limited knowledge of Irish culture together with language barriers was challenging for the older person.\textsuperscript{2282} The ICSG Report recognises the need for setting minimum training standards for all care workers working with older people\textsuperscript{2283} and the requirement for significant funding to address the rights and legitimate entitlements of all including both the older person and their carer(s).\textsuperscript{2284} A further worrying finding in a recent report concerning literacy and numeracy indicates that those employed in the Irish health services had the second highest incidence of literacy problems in Irish workplaces.\textsuperscript{2285}

The Commission Report did not address the impact of a twelve hour working day/night on the care workers, nursing staff or residents. The physical and emotional demands placed on residential care workers is recognised by Manthrope who expresses concern about the effect a twelve hour working day places on residential care staff.\textsuperscript{2286} She suggests that a 6-8 hour day might be more appropriate. Equally the ability of the residential staff to deliver optimal care over a 12 hour shift is questionable. Changes are required to reduce the working day where many residential care workers are undertaking 12 hour work days in residential care settings. This includes those that come within the ambit of mental health legislation.

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{2278}] Ibid. vi. 3 groups of older persons were organised to elicit their opinion on the impact of migrant care workers providing care for older people.
\item[\textsuperscript{2279}] Ibid. viii.
\item[\textsuperscript{2280}] Ibid. viii.
\item[\textsuperscript{2281}] Ibid. vii.
\item[\textsuperscript{2282}] Ibid. viii.
\item[\textsuperscript{2283}] Ibid. iv-v.
\item[\textsuperscript{2284}] Ibid. iv-v.
\end{itemize}
\end{footnotesize}
Discussion
The Department of Health and Children and the Health Board/HSE spectacularly failed the elderly residents in Leas Cross and *The Commission of Investigation (Leas Cross Nursing Home) Final Report* did not recognise the degree of failure of the Department of Health or the HSE. O’Neill’s comments were penetrating and succinct; he said “[t]he deeply deficient Nursing Home Legislation and Regulations have been tolerated well beyond what the time span of what might be considered to be reasonable…” The inadequacy of legislation was not fully recognised in the *Commission Report*. However O’Neill in his article in the Irish Times on the 13th 10 2010 states, “[i]t is barely a year since the second review of Leas Cross by senior counsel Diarmuid O’Donovan confirmed that the State had failed to provide an adequate regulatory framework of regulation and inspection for nursing homes up until 2009.”

O’Neill recommended that,

[t]he Nursing Home Legislation needs to be urgently updated to put the above provisions into place, to place the older person at the centre of its deliberations, and to adequately guide both provision of quality of care and quality of life, as well as providing timely and appropriate powers to the Social Service Inspectorate to effect change.

The potential for human rights abuse increases with escalating dependency since the need for more intimate care is required. Equally the potential for enhancement of human rights by the care giver is increased in the same circumstance. O’Neill comments that “[w]ith a few honourable exceptions there has been a systematic failure by government, health boards and professional bodies to address the issue of appropriate quality of care for older people with the highest levels of health and social needs in Irish Society.”

The *Commission Report* referring to the HSE’s appointment of a team to the nursing home stated,

the fact that the H.S.E.’s actions appear to have been driven as much by the media and the public as by its own inspection process gives rise to disquieting questions

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2287 (n 32).
2288 O’Neill, D., 2006 (n 33) p. 53.
2289 Ibid. Recommendation 5.
2291 O’Neill, D., 2006 (n 33) p. 5.
Chapter 7  Leas Cross Nursing Home: A Catalyst for Change

regarding the adequacy of that inspection process and the standard of care at other nursing homes not the focus of public attention.\textsuperscript{2292} Consultant Geriatrician A and Consultant Psychiatrist A who reported concerns to the Commission regarding inadequate follow up by hospitals who had discharged patients to nursing homes, stated respectively that the follow-up “was not adequate for the on-going care of frail older patients with complex care needs and multiple medical problems”\textsuperscript{2293} and “[m]y recent experience of discharging patients to nursing homes has been very mixed in terms of my own feeling regarding appropriate provision of care, our ability to monitor that care and the outcome for one particular patient group, the frail with end-stage dementia.”\textsuperscript{2294}

It is important to acknowledge the actions of the silent, committed, kind carer or competent professional who deliver high standards of care. Sub-standard care often arises from well-meaning care staff undertaking delegated tasks beyond their level of competence in the absence of adequate supervision.\textsuperscript{2295} Morris argues that the provision of care must be provided by a reliable carer with competence and respect.\textsuperscript{2296} In his presentation titled ‘Generally Unwell’ what it takes to care for the acutely ill older adult, O’Brien emphasised that the ‘knowledge deficit’ with regard to nursing care of older people must be addressed at undergraduate level. While older people in residential care settings are not normally acutely ill they do develop acute illnesses. Early recognition and intervention is crucial. O’Brien provides the example of infections in older adults that is harder to diagnose, where the first and only presenting feature of the condition may be delirium that may manifest as fluctuating levels of consciousness, inattention and under or over activity.\textsuperscript{2297}

The devastating vista as described has been a catalyst for change with the publication of the new legislative provisions and their implementation.\textsuperscript{2298}

In terms of accountability only one person to date has faced the full rigors of the law. Ms. Conway’s (the former Director on Nursing at Leas Cross Nursing Home between June 1999 and March 2005) name was erased from the register of An Bord Altranais and

\textsuperscript{2292} O’Donovan, 2009 (n 32) p. 326.
\textsuperscript{2293} Ibid. p. 268.
\textsuperscript{2294} Ibid. p. 255.
\textsuperscript{2296} Morris, 2001 (n 2290) p. 26.
\textsuperscript{2298} For example, the Health Act 2007 (n 1000) and Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (n 1041); see Ch. 3 of this work for a more detailed discussion.
Cnáimhseachais na hÉireann on the 22\textsuperscript{nd} October 2012 on foot of an application by An Bord Altranais to the High Court. The Fitness to Practice Committee had found Ms Conway guilty of professional misconduct and according referred the matter to the High Court.

However, as O’Neill states, “it would be a very major error to presume that the deficits in care shown in Leas Cross represent an isolated incident.”\textsuperscript{2299} Crucial to safeguarding the rights of older people in residential care are independent inspections and enforcement where necessary.

\textsuperscript{2299} O’Neill D., 2006 (n 33) p. 5; see also, for example, Irish Independent article titled “Elderly patients abused in new nursing home scandal” 4\textsuperscript{th} August 2009.
Chapter 8  Conclusion

“You would like to hear how it is in old age?
Certainly, not much is known about that country
Till we land there ourselves, with no right to return.”

Given the vagaries of the Irish weather system most older people living in the community own an umbrella and a winter coat. The coat like themselves may have seen many a wet cold winters’ day. That coat and umbrella however are precious and help shield the older person from the worst of the inclement weather. International and regional human rights instruments are like the coat and the sturdy umbrella in a downpour that have the potential, where implemented, to provide robust safeguards for protecting the older person’s fundamental rights. In a comprehensive examination of the development of the law in Ireland in the context of older people in residential care since the foundation of the State, the paucity of safeguards for protecting the rights of those older people who have remained largely invisible to the State, until quite recently, is clearly evident. The weak or absent legislative provisions might be considered like a flimsy umbrella on a blustery day that sways with the breeze and is likely to cause a trip hazard where the older person attempts to shield themselves unsuccessfully from the worst of the weather.

The UN Principles for the Protection of Persons with Mental Illness 1991 and the ECHR did influence the drafting of the Mental Health Act 2001. The CPT/Inf (2003) 36 Report highlighting some of the deficiencies in residential care settings for persons with intellectual disability helped improve arrangements for some service users. However International and regional human rights instruments had little impact on the lives of those in Leas Cross Nursing Home and arguably other residential care settings for older people. More recently the Committee against Torture has sought a review of the Mental Health Act 2001 “in order to ensure that it complies with international standards.”

International and regional human rights instruments may also be seen as an unopened gift. If opened it could illuminate the way for legislators, policy makers and workers in residential care settings, a roadmap for protecting and advancing fundamental rights.

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2301 (n 454 and n 791).
2302 (n 330 and n 331).
2303 (n 73) para. 28.
2304 While their impact can be evidenced in the publication of the Mental Health Act 2001 and The European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations, 2004 (as amended) the human rights instruments have had little impact on the lives of the vast majority of older people who have lived or are living in residential care.
The CRPD is a shining light that heralds a new departure in its arrangement for protecting and advancing human rights. At its core is the equality of all persons with disabilities. A key element of this is recognition of legal capacity. Arguably residential care in itself does lead to a reduction in a person’s capacity. This gives rise to a tension between care and a right to legal capacity. Lawful supported decision-making arrangements are an evolving concept and are likely to have commenced well in advance of an older person seeking residential care. It is recognised that substitute decision-making may arise as a last resort where administered safeguards are in place.2305

Other tensions may arise, for example, the right to choose to be in a residential care setting and the possibility of public policy phasing out them out. A further consideration is the legality of ‘voluntary’ admission given the involvement of third parties. ‘Voluntary’ admission therefore to a residential care setting with the involvement of third parties in the absence of the older person’s consent is clearly at variance with the Article 12 (legal capacity) of the CRPD.

A number of State Parties have made a reservation or interpretive declaration with regard to Article 12 of the CRPD. The CRPD Committee’s consideration of these interpretative declarations is awaited. To enable its deliberation of issues raised by State Parties the Committee has sought submissions of practical and theoretical papers on the implementation of Article 12.2306

While the CRPD does not provide any new rights it significantly puts the individual centre-stage the main player in their own life who may or may not need supports to exercise their legal capacity.2307 Article 12 will transform the position of some older people in residential care who are currently invisible, where their personhood is denied, to a position of visibility where the older person is capable of holding and exercising their legal capacity on an equal footing with others in all aspects of their lives. The central tenets of legal capacity enshrined in the CRPD have yet to be examined by the ECtHR.

Ratification of the CRPD by Ireland is overdue. The proposed capacity legislation needs to be amended to incorporate the core concepts of the CRPD to ensure that the older person retains their authority and voice. Germane to promoting respect for the fundamental rights of the older resident in residential care is their active participation either independently or

2305 See Ch. 4 of this work at section titled A Lacuna in the Law at para. commencing with:’Substitute decision-making.’
2307 See generally Bach and Kerzner, 2010 (n 112).
with the relevant assistance to enable their participation. One of the most important aspects of life in a residential care centre is the maintenance of links with family, friends and the community from where the older person has come. Forging new relationships in the residential centre is critical for their wellbeing. We are not divorced from our current reality. As relational beings we grow and flourish or wilt where we plant ourselves or are planted. It has been acknowledged that the “CRPD is a declaration of interdependence; grounded in liberal individualism and it recognises that all our lives are pursued in conjunction with others.”

In contrast informal and formal decision-making carried out in the best interests of the older person restricts and may indeed deny the will and preference of the older person thereby negating their personhood. Such “a violation … brings social and legal harm.” Continuing to use the analogy of the coat and umbrella wardship and guardianship might be considered the removal of both coat and umbrella and perhaps the person’s shoes too. The removal of the clothing and shoes is detention without the possibility of release.

Recommendation CM/Rec (2009) 11 is another guiding light for legislative amendment in terms of advance care directives and enduring power of attorney to enable a capable adult in any area of their lives to plan in the event of future incapacity. Allied to these provisions is the concept of advocacy where the advocate could voice values on behalf of the older person. Advocacy services are in their infancy in Ireland and the older person in residential care is unlikely to be aware of the concept or its development. A robust and independent advocacy service is required.

Reform of the mental health legislation is awaited. The mental health legislation is fragmented. The involuntary patient is inside the zone of protection while the voluntary incapacitated person resides beyond the reach of the legislative provisions. Wardship is outside the zone of protection and will continue if the proposed Mental Capacity Bill is implemented in the current format. For the older person outside the zone of protection their coat and shoes are removed and their umbrella is missing. As Kelly comments the “[b]est ways to increase observance of human rights of the mentally ill is mental health law and

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2309 Bach and Kerzner 2010, (n 112) 7.
2310 (n 1708).
policy and social policy.” In this regard the State has failed to provide adequate strategies to keep older people out of residential care settings.

The provision of reasonable accommodation is germane to securing equality in the CRPD. The ECtHR has increasingly acknowledged the CRPD in its decisions. Demand for residential care is motivated by four factors. These include “population growth, development in life expectancy, disability trends and trends in household composition.” Article 19 of the CRPD recognises the right to independent living. Some older people do not want to go into residential care but feel it is their only option in the absence of the particular supports necessary in their particular situation to live in the community. Sheltered housing with community multidisciplinary supports tailored to the particular needs of the residents should be expanded to enable rather than hinder older people. Where the supports reflect the needs of the residents, many older people can live out their lives in the manner that they wish in their own community. Of critical importance is supported decision-making where necessary to enable the older person exercise their legal capacity. Multidisciplinary supports may include, for example, monthly presence of a multidisciplinary team in the residential centre or the local community centre such as a public health nurse, dietician, social worker, and chiropodist. Other supports may include for example creative art programmes, fitness/wellness activities, intergenerational and cultural activities.

Professionalism is one of the key drivers for improving the quality and safety of care and quality of life for older people in residential care. Professional self-regulation is a matter of public concern. It is difficult to see how bodies that set, monitor and enforce their own standards can be independent. Amending legislation is required for the medical and dental professional bodies to overcome monopolistic control. The Nurses and Midwives Act, 2011 needs to be fully implemented.

Of fundamental importance to the older person in residential care is competent staff that is not worn out given the length of their working day. The twelve hour working day needs to be shortened if we are truly interested in advancing rights for the older person in residential care. The competencies of the residential care workers must be consistent with their roles.

2312 For example Stanev v Bulgaria (n 120) and D.D. v Lithuania (n 40).
2314 (n 125, n 126, n 127).
2315 Berwick in HIQA, 2010 (n 2055) fn 3.
and responsibilities. HIQA and the MHC are charged with ensuring that the law and published standards are being met. They are also ideally placed to ensure that workers have the requisite competencies to offer and deliver optimum care and services in consultation with the older person.

This research has exposed the legislative deficits for the older person in residential care in Ireland from the foundation of the state to date and the harrowing conditions that continue to prevail for some of our most vulnerable citizens in the absence of robust legislative safeguards, policy and practice. It was not until the 1st July 2009 that inspection of residential centres for older people was first commenced by an independent statutory body. The National Quality Standards for Residential Care Settings were published in 2009.\footnote{HIQA, 2009 (n 37). At the time of writing not activated for persons in disability services.}

Where legislation exists it is fragmented with varying legislative provisions and standards and therefore treatment depending on where the resident is domiciled. For example, persons with dementia in an approved mental health centre come within the MHC standards and those outside this area fall within the HIQA standards where service delivery and treatment may be a very different experience for the older person.

The vision of a rights based approach to disability has been incorporated into the CRPD. This vision can inform the incorporation of a human rights approach in the design, delivery of care and the quality of life for the older resident in a residential care setting. A re-orientation in attitude and behavioural change is required by the kindred professional bodies and some workers within residential care settings. Training needs to be addressed as a matter of urgency. The real challenge is the provision of core competencies for all workers together with a re-orientation in thinking to question reflectively on their practice to embrace human rights principles such as dignity and autonomy.

It would be a serious error to omit acknowledging the committed, caring workers (“the honourable exceptions”\footnote{O’Neill, 2006 (n 33) p. 5.}) who over the years helped alleviate in some way the harshness of the system in a practical and effective manner. For example the civil and public servant\footnote{For example the Department of Health Code of Practice for Nursing Homes (Dublin, Department of Health, 1995) \url{http://lenus.ie/hse/handle/10147/46681} Last accessed 22nd August 2012.} or the person who sat with the dying older person well after their work day had ceased or where there was illiteracy or inability to write, who would write a letter with the older person to their family abroad to maintain the links with their loved ones. Such workers were and are the linchpin of the residential care service. These key workers are often the link that the older person has with their former community and they are a repository for unrecorded information about the resident. They have close up personal knowledge of the
individual that is invaluable where the older person may need supports to exercise their decision-making.

Bratza has stated “[a]s clear from the terms of the Convention (ECHR) and as the Court (ECtHR) has consistently stressed the primary responsibility for securing the Convention rights and freedoms falls on the Contracting States themselves.” O’Neill has cautioned that the happenings in Leas Cross are likely to have occurred elsewhere. In Ireland a best interests approach is alive and well in residential care settings for older person. The legislative changes introduced following the Prime Time Programme on Leas Cross and where implemented have demonstrated tangible benefits for the older person. However they do not go far enough and some older people continue to be virtually excluded from any legislative safeguards. This indefensible vista needs to be addressed as matter of urgency. Older people in residential care have multifaceted needs requiring an immediate state response to ensure that they all have equal recognition before the law. Of critical importance is the provision where necessary of supported decision-making, a gerontological informed service both in the public and private sector with competent (by virtue of their qualifications, experience and training) workers to meet the particular needs of the older person in residential care.

The demographic changes in Ireland are well recognised as is the shift from public to private provision of residential care for older people. The reduction in public residential care beds has been criticised. The Nursing Home Support Scheme is currently under review. O’Neill concisely comments that “[s]tandards in care homes cannot be discretionary.” Multidisciplinary involvement is essential to addressing the complex care needs of older people and training and the length in the working day are pivotal to ensuring that the older person remains visible wherever they reside.

A UN Convention on the rights of older persons has been proposed. Awareness raising is key to advancing rights for the older person in residential care. The older person in

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2320 O’Neill, 2006 (n 33) p. 5.
2321 See Irish Times 29th October 2012.
2322 Ibid. at the time of writing, public consultation has closed and the review may be completed in early 2013.
2323 O’Neill, 2010 (n 21).
residential care needs to become more visible. Their time is now. They do not have too many tomorrows. While the critical theoretical debates and development of legislation and policy continue, practical and effective measures can be implemented in the interim. There are no barriers in place to commencing advancing rights for the older person in residential care-just ourselves. While no new rights are required, human rights need to be urgently embedded into the manner in which residential care is managed and delivered.

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_Australia_

_Hunter and New England Area Health Service v A_ [2009] NSW SC 761

_Canada_

_Reibl v Hughes_ (1980) 114 DLR (3d) 1

_U.S._

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_Rasmussen v Fleming_ (1987) 154 Ariz 207

_Salgo v Leyland Stanford Jr. University Board of Trustees_ (1957) 317 P 2d 170
_Schloendorff v Society of New York Hospital_ 211 NY 125 (1914)

_Tarasoff v Regents of the University of California_ 529 P 2d 55 (Cal, 1974)

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_Falmanio Costa v ENEL_ [1964] ECR 585, 593.
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**Australia**

**Hunter and New England Area Health Service v A** [2009] NSW SC 761

**Canada**

**Reibl v Hughes** (1980) 114 DLR (3d) 1

**U.S.**

**Mallette v Shulman** (1990) 67 DLR (4th) 321 (Ont CA)

**Rasmussen v Fleming** (1987) 154 Ariz 207

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Appendices

Appendix 1

Trend of Life Expectancy at 65 Years by Gender: Irish Average from 1996-2006

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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>13.9</td>
<td>14.1</td>
<td>14.2</td>
<td>14.1</td>
<td>14.7</td>
<td>15.1</td>
<td>15.5</td>
<td>15.9</td>
<td>16.3</td>
<td>16.6</td>
<td>16.8</td>
</tr>
<tr>
<td>Female</td>
<td>17.5</td>
<td>17.7</td>
<td>17.8</td>
<td>17.6</td>
<td>18.0</td>
<td>18.6</td>
<td>18.9</td>
<td>19.2</td>
<td>19.7</td>
<td>19.9</td>
<td>20.3</td>
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</table>

Source: European Health For All database, WHO Regional Office for Europe, Copenhagen, Denmark, January 2009
Appendices

Appendix 2

The tables show the total number of beds available in long stay units and the increased capacity provided by private nursing homes from 2001 to 2010.

<table>
<thead>
<tr>
<th>Beds</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
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<tbody>
<tr>
<td>Long Stay</td>
<td>n/a</td>
<td>n/a</td>
<td>19,411</td>
<td>19,171</td>
<td>21,713</td>
<td>21,584</td>
<td>22,967</td>
<td>18,605</td>
<td>20,784</td>
<td></td>
</tr>
<tr>
<td>Short Stay</td>
<td>n/a</td>
<td>n/a</td>
<td>1,830</td>
<td>2,298</td>
<td>2,485</td>
<td>2,440</td>
<td>2,242</td>
<td>2,286</td>
<td>2,214</td>
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<tr>
<td>Total</td>
<td>21,949</td>
<td>23,059</td>
<td>23,825</td>
<td>23,772</td>
<td>21,478</td>
<td>24,253</td>
<td>24,029</td>
<td>25,209</td>
<td>20,891</td>
<td>22,998</td>
</tr>
<tr>
<td>Total Residents</td>
<td>19,886</td>
<td>20,959</td>
<td>21,169</td>
<td>21,404</td>
<td>19,320</td>
<td>21,455</td>
<td>21,595</td>
<td>22,613</td>
<td>18,654</td>
<td>21,048</td>
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</table>

<table>
<thead>
<tr>
<th>Private Nursing Home Beds</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Stay</td>
<td>n/a</td>
<td>n/a</td>
<td>9,042</td>
<td>9,774</td>
<td>13,285</td>
<td>13,517</td>
<td>14,932</td>
<td>11,399</td>
<td>13,795</td>
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</tr>
<tr>
<td>Short Stay</td>
<td>n/a</td>
<td>n/a</td>
<td>299</td>
<td>572</td>
<td>718</td>
<td>694</td>
<td>683</td>
<td>727</td>
<td>509</td>
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<tr>
<td>Un-designated</td>
<td>n/a</td>
<td>n/a</td>
<td>1,653</td>
<td>4</td>
<td>31</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9,678</td>
<td>10,445</td>
<td>11,486</td>
<td>10,994</td>
<td>10,350</td>
<td>14,034</td>
<td>14,216</td>
<td>15,615</td>
<td>12,126</td>
<td>14,304</td>
</tr>
<tr>
<td>Total Residents</td>
<td>8,777</td>
<td>9,294</td>
<td>9,965</td>
<td>9,713</td>
<td>9,166</td>
<td>12,109</td>
<td>12,736</td>
<td>13,826</td>
<td>10,789</td>
<td>13,308</td>
</tr>
</tbody>
</table>


2325 These include, HSE Extended Care Unit, HSE Welfare Home, Voluntary Welfare Homes, Voluntary Home/Hospital for Older People and Private Nursing Homes.
2326 Since 2006 a more accurate breakdown of activities in long stay units has been published by the DoHC. Beds are differentiated by their type and activity. Such differentiation provides greater clarity regarding for example the numbers of older people requiring residential care, their medico/social status and their dependency levels. The most recent long stay unit survey carried out by the DoHC in 2010 quantified the number of beds available for long-term care, ascertained bed use and established what kinds of patients occupy these beds. See Department of Health and Children, Long Stay Activity Statistics 2010 (Dublin, DoHC, 2011). Available at http://www.dohc.ie/statistics/publications.html. Last accessed October 2012.
Appendix 3

Long-Stay Units by Category: Percentage Distribution of All Patients Residents at 31/12/2010 by Age

<table>
<thead>
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<th>Category of Unit</th>
<th>&lt;65 years</th>
<th>65 - 70 years</th>
<th>70 - 75 years</th>
<th>75 - 80 years</th>
<th>80 - 84 years</th>
<th>85 - 89 years</th>
<th>90 - 94 years</th>
<th>95 &amp; Total years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSE Extended Care Unit</td>
<td>6.2%</td>
<td>3.2%</td>
<td>7.9%</td>
<td>14.7%</td>
<td>22.7%</td>
<td>24.6%</td>
<td>15.3%</td>
<td>5.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>HSE Welfare Home</td>
<td>2.6%</td>
<td>3.4%</td>
<td>8.9%</td>
<td>15.2%</td>
<td>22.7%</td>
<td>24.7%</td>
<td>16.0%</td>
<td>6.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Voluntary Home/Hospital for Older People</td>
<td>8.1%</td>
<td>2.9%</td>
<td>5.0%</td>
<td>11.4%</td>
<td>21.0%</td>
<td>27.6%</td>
<td>17.4%</td>
<td>6.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Voluntary Welfare Home</td>
<td>45.2%</td>
<td>1.1%</td>
<td>3.4%</td>
<td>6.9%</td>
<td>13.1%</td>
<td>16.0%</td>
<td>13.1%</td>
<td>1.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Private Nursing Home</td>
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<td>12.7%</td>
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2327 Ibid. Table B 3.
Appendices

Appendix 4

Health Act 2007 (Care and Welfare of Residents In Designated Centres For Older People) Regulations 2009 S. I. No. 236 of 2009

Schedule 1 Information to be included in the Statement of Purpose

1. The name, address and telephone number of the designated centre.
2. The name and address of the registered provider and of any person in charge.
3. The current professional registration, relevant qualifications and experience of the registered provider and any person in charge.
4. The name and position of each other person participating in the management of the designated centre.
5. The registration number, date of registration and the expiry date.
6. Any conditions attached by the Chief Inspector to the designated centre’s registration under section 50 of the Act.
7. The maximum number of residents who can be accommodated in the designated centre.
8. The maximum number of residents who will be accommodated at the designated centre in accordance with the information provided by the applicant under the Health Act 2007 (Application for Registration of Designated Centres) Regulations 2009.
9. The total staffing complement, in whole time equivalents, for the designated centre with the management and nursing complements given by grade.
10. The organisational structure of the designated centre.
11. The age-range and sex of the residents for whom it is intended that accommodation should be provided.
12. The range of needs that the designated centre is intended to meet.
13. The type of nursing care to be provided.
14. Any criteria used for admission to the designated centre, including the designated centre’s policy and procedure (if any) for emergency admissions.
15. The arrangements for residents to engage in social activities, hobbies and leisure interests.
16. The arrangements made for consultation with residents about the operation of the designated centre.
17. The fire precautions and associated emergency procedures in the designated centre.

18. The arrangements made for residents to attend religious services of their choice.

19. The arrangements made for contact between residents and their relatives, friends and/or carers.

20. The arrangements made for dealing with complaints.

21. The arrangements made for dealing with reviews of the resident’s plan referred to in article 8(1).

22. The number and size of rooms in the designated centre.

23. Details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision.

24. The arrangements made for respecting the privacy and dignity of residents.

25. Any separate facilities for day care.
Appendices

Appendix 5

Health Act 2007 (Care and Welfare of Residents In Designated Centres For Older People) Regulations 2009 S.I. No. 236 of 2009

SCHEDULE 2 DOCUMENTS TO BE HELD IN RESPECT OF PERSONS MANAGING OR WORKING AT A DESIGNATED CENTRE

1. Proof of the person’s identity, including a recent photograph.
2. A copy of the person’s birth certificate.
3. Evidence of Garda vetting.
4. Details of any criminal offences.
5. Details and documentary evidence of any relevant qualifications or accredited training of the person.
6. Relevant current registration status with professional bodies in respect of nursing and other health and social care professionals employed in the designated centre.
7. A full employment history, together with a satisfactory history of any gaps in employment.
8. Details of any previous experience (if any) of carrying on the business of a designated centre.
9. Three written references, including a reference from a person’s most recent employer (if any) in a format specified by the Chief Inspector.
10. Evidence that the person is physically and mentally fit for the purposes of the work that they are to perform at the designated centre or, where it is impracticable for the person to obtain such evidence, a declaration signed by the person that they are so fit.
Schedule 3 of S.I. 236 of 2009 Records to be Kept in a Designated Centre in Respect of Each Resident

1. The resident’s care plan referred to in article 8.

2. A recent photograph of the resident.

3. A record of the following matters in respect of each resident:

   (a) the name, address, date of birth, sex, marital status, PPS number, ethnic or cultural background of each resident

   (b) the name, address and telephone number of the resident’s next of kin or of any person authorised to act on their behalf;

   (c) the name, address and telephone number of the resident’s general practitioner and of any officer of the Executive whose duty it is to supervise the welfare of the resident;

   (d) the date on which the resident was first admitted to the designated centre;

   (e) the date of which the resident was discharged from the designated centre;

   (f) if the resident is transferred to another designated centre or to a hospital, the name of the designated centre or hospital and the date on which the resident is transferred;

   (g) if the resident died at the designated centre, the date, time and cause of death;

   (h) the name and address of any authority, organisation or other body, which arranged the resident’s admission to the designated centre;

   (i) a record of all medicines kept in the designated centre for the resident, and the dates and times on which they were administered to the resident;

   (j) a record of any accident affecting the resident in the designated centre and of any other incident in the designated centre which is detrimental to the health or welfare of the resident, which record shall include the nature, date and time of the accident or incident, whether medical treatment was required and the name of the persons who were respectively in charge of the designated centre and supervising the resident, and the names and contact details of any witnesses;

   (k) a record of all nursing care provided to the resident, including a record of their condition and any treatment or surgical intervention;

   (l) details of any specialist communication needs of the resident and methods of communication that may be appropriate to the resident;

   (m) details of any plan relating to the resident in respect of medication, nursing care, specialist health care or nutrition;
(n) a record in incidence of pressure sores or treatment provided to the resident;

(o) a record of falls and of treatment provided to the resident;

(p) a record of any restraint used on the resident; and

(q) a record of any limitations agreed with the resident as to the resident’s freedom of choice, liberty of movement and power to make decisions.

4. A copy of correspondence to or from the designated centre relating to each resident.
Appendices

Appendix 7

Schedule 4 of S. I. 236 of 2007  Other records to be kept in a designated centre

1. A copy of the statement of purpose.

2. A copy of the resident’s guide.

3. A record of all residents’ accounts kept in the designated centre.

4. A copy of all inspection reports.

5. A record of all persons employed at the designated centre, including in respect of each person so employed:
   (a) their full name, address, date of birth, qualifications and experience;
   (b) a copy of their birth certificate and passport;
   (c) a copy of each reference obtained in respect of them;
   (d) the dates on which they commence and cease to be so employed;
   (e) the position they hold at the designated centre, the work that they perform and the number of hours for which they are employed each week;
   (f) correspondence, reports, records of disciplinary action and any other records in relation to their employment; and
   (g) a record of current registration details of nursing staff.

6. A copy of the duty roster of persons working at the designated centre, and a record of whether the roster was actually worked.

7. A record of the designated centre’s charges to residents, including any extra amounts payable for additional services not covered by those charges, and the amounts paid by or in respect of each resident.

8. A record of all money or other valuables deposited by a resident for safekeeping or received on the resident’s behalf, which-
   (a) shall state the date on which the money or valuables were deposited or received, the date on which any money or valuables were returned to a resident or used, at the request of the resident, on their behalf and, where applicable, the purpose for which the money or valuables were used; and
   (b) shall include the written acknowledgement of the return of the money or valuables.

9. A record of furniture brought by a resident into the room occupied by them.

10. A record of all complaints made by resident or representatives or relatives of residents or by person working at the designated centre about the operation of the
Appendices

designated centre, and the action taken by the registered provider in respect of any such complaint.

11. A record of any of the following events that occur in the designated centre;

(a) any accident;

(b) any outbreak of infectious disease in the designated centre;

(c) any injury or illness

(d) any fire;

(e) except where a record to which paragraph 13 refers is to be made, any occasion on which the fire alarm equipment is operated;

(f) any theft or burglary;

(g) any unexplained absence of a resident from the designated centre;

(h) any allegation, suspected or confirmed abuse of any resident;

(i) any allegation of misconduct by the registered provider or any person who works in the designated centre; and

(j) any incident where evacuation of the centre took place.

12. Records of the food provided for residents in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory, in relation to nutrition and otherwise, and of any special diets prepared for individual residents.

13. A record of every fire practice, drill or test of fire equipment (including fire alarm equipment) conducted in the designated centre and of any action taken to remedy defects in the fire equipment.

14. A statement of the procedure to be followed in the event of a fire, or where a fire alarm is given.

15. A statement of the procedure to be followed in the event of accidents or in the event of a resident going missing.

16. A record of all visitors to the designated centre, including the names of visitors.
Schedule 5 of S.I. 236 of 2009

Policies and Procedures to Be Maintained in Designated Centres

The registered provider shall ensure that the designated centre has written and operational policies and procedures on all of the items listed in this schedule:

1. The prevention, detection and response to abuse;

2. Residents’ personal property and possessions;

3. Communications;

4. End of life care;

5. Recruitment, selection and vetting of staff;

6. Monitoring and documentation of nutritional intake;

7. Provision of information to residents;

8. The creation, access to, retention of and destruction of records;

9. Health and safety, including food safety, of residents, staff and visitors;

10. Risk management;

11. The ordering, prescribing, storing and administration of medicines to residents;

12. The handling and disposal of unused or out of date medicines;

13. The handling and investigation of complaints from any person about any aspect of service, care and treatment provided in, or on behalf of a designated centre;

14. Missing persons;

15. Temporary absence or discharge of patients;

16. Emergencies;

17. Behaviour management; and

18. Admissions.
Appendices

Appendix 9

Schedule 3 as amended by Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010 S.I. No. 36 of 2010

Schedule 3 Records to be Kept in a Designated Centre in Respect of Each Resident

1. The resident’s care plan referred to in article 8.

2. A recent photograph of the resident.

3. A record of the following matters in respect of each resident in the directory of residents referred to in article 23:

   (a) the name, address, date of birth, sex, marital status, PPS number, ethnic or cultural background of each resident

   (b) the name, address and telephone number of the resident’s next of kin or of any person authorised to act on their behalf;

   (c) the name, address and telephone number of the resident’s general practitioner and of any officer of the Executive whose duty it is to supervise the welfare of the resident;

   (d) the date on which the resident was first admitted to the designated centre;

   (e) the date of which the resident was discharged from the designated centre;

   (f) if the resident is transferred to another designated centre or to a hospital, the name of the designated centre or hospital and the date on which the resident is transferred;

   (g) if the resident died at the designated centre, the date, time and cause of death;

   (h) the name and address of any authority, organisation or other body, which arranged the resident’s admission to the designated centre.

4. A record of the following matters in respect of each resident:

   (a) a record of all medicines kept in the designated centre for the resident, and the dates and times on which they were administered to the resident;

   (b) a record of any accident affecting the resident in the designated centre and of any other incident in the designated centre which is detrimental to the health or welfare of the resident, which record shall include the nature, date and time of the accident or incident, whether medical treatment was required and the name of the persons who were respectively in charge of the designated centre and supervising the resident, and the names and contact details of any witnesses;

   (c) a record of all nursing care provided to the resident, including a record of their condition and any treatment or surgical intervention;

   (d) details of any specialist communication needs of the resident and methods of communication that may be appropriate to the resident;
Appendices

(e) details of any plan relating to the resident in respect of medication, nursing care, specialist health care or nutrition;

(f) a record in incidence of pressure sores or treatment provided to the resident;

(g) a record of falls and of treatment provided to the resident;

(h) a record of any restraint used on the resident; and

(i) a record of any limitations agreed with the resident as to the resident’s freedom of choice, liberty of movement and power to make decisions.

5. A copy of correspondence to or from the designated centre relating to each resident.
Appendices

Appendix 10

Financial Assessment

Subject to subsection (4), the financial assessment of an applicant’s means shall be made on the basis of—

(a) Subject to paragraph (b), all the applicant’s assets and sources of income including the applicant’s—

(i) wages, salary, pension, allowances, payments for part time and seasonal work, income from rentals, investments and savings and all contributions from whomsoever arising,

(ii) property (excluding household chattels but, if paragraph (b)(ii) is applicable, including an imputed annual income equivalent to so much of the estimated market value of the principal residence of the applicant as is not excluded by the operation of that paragraph),

(iii) stocks, shares and securities,

(iv) moneys on hand, in trust or lodged, deposited or invested,

(v) interest in any company or business (including any farm),

(vi) interests in property,

(vii) life assurance and endowment policies,

(viii) valuables held as investments,

(ix) any benefit or privilege, and

(x) assets (including moneys) which have been transferred (by whatever means) by the applicant to another person—

(I) for no consideration,

(II) for nominal consideration, or

(III) for consideration which is significantly less than the estimated market value of the asset concerned at the time the asset was so transferred,

2328 Health Nursing Homes (Amendment) Act 2007.

2329 Ibid. S. 7B.(4) provides “[w]here an applicant is a married or cohabiting person, subsection (3) shall be construed to be a financial assessment made on the basis of 50 per cent, or the prescribed percentage, whichever is the lesser, of the combined means of the married couple or cohabiting couple, as the case may be.”
at any time within the 5 years immediately preceding the date on which the application is made,

\[(b) \text{ excluding—}\]

\[(i) \text{ subject to subparagraph (vi), the principal residence of the applicant if at the time of the application and thereafter it is continuously occupied by—}\]

\[(I) \text{ the applicant’s spouse,}\]

\[(II) \text{ a child of the applicant of less than 21 years of age,}\]

\[(III) \text{ a child of the applicant in full-time education,}\]

\[(IV) \text{ a relative of the applicant in receipt of—}\]

\[(A) \text{ disability or similar allowance,}\]

\[(B) \text{ blind person’s pension,}\]

\[(C) \text{ illness benefit,}\]

\[(D) \text{ invalidity pension,}\]

\[(E) \text{ state pension (contributory) in any case where, before 28 September 2006, the relative would have been entitled to invalidity pension,}\]

\[(F) \text{ state pension (non-contributory),}\]

\[(G) \text{ any successor to an allowance, pension or benefit referred to in this subclause in any case where that allowance, pension or benefit, as the case may be, ceases to be provided, or}\]

\[(H) \text{ any European Union equivalent to an}\]
allowance, pension or benefit, or any successor thereto, referred to in this subclause,

Or

(V) a relative of the applicant in receipt of—

(A) state pension (contributory),

(B) any successor to a pension referred to in this subclause in any case where that pension ceases to be provided, or

(C) any European Union equivalent to a pension, or any successor thereto, referred to in this subclause,

which is the relative’s sole income,

(ii) subject to subparagraphs (v) and (vi), if subparagraph (i) is not applicable, 95 per cent, or the prescribed percentage, whichever is the greater, of the estimated market value of the principal residence of the applicant as determined not later than 6 months after receipt of the application by the Executive,

(iii) one-fifth of the weekly rate of—

(I) subject to clause (II), state pension (non-contributory),

(II) any successor to that pension in any case where that pension ceases to be provided,

and whether or not the applicant is in receipt of that pension or any successor thereto,

(iv) the first €11,000, or the prescribed amount, whichever is the greater, of the applicant’s assets,

(v) without prejudice to the generality of subparagraph (i), the principal residence of the applicant in any case where not excluding that residence from falling within paragraph (a) could reasonably give rise to the destitution or homelessness of a person having a close connection with the applicant for a period of not less than 12 months immediately before the application was made, and

(vi) without prejudice to the generality of subparagraph (i), the principal residence of the applicant in any case where the applicant has been paid in accordance with this Act a relevant subvention for not less than 3 consecutive years at any time following the commencement of this subsection.
Appendices

Appendix 11

The Lunacy Regulation (Ireland) Act 1871

Section 56

It shall be the duty of the medical and legal visitors to visit persons of unsound mind within the meaning of this Act as such times and in such rotation and manner, and to make such inquiries and investigations as to their care and treatment and mental and bodily health, and the arrangements for their maintenance and comfort, and otherwise respecting them, [as may be provided for by rules of court or from time to time ordered by the High Court in any particular case].

Section 57

Provided always, that every lunatic shall be personally visited and seen by one of the medical or legal visitors four times at least in every year, and such visits shall be so regulated as that the interval between successive visits to any such lunatic shall in no case exceed four months; provided always, that lunatics who are resident in licensed houses, asylums, or registered hospitals shall not necessarily be visited by any of the said visitors more than once in the year unless [the High Court] shall otherwise direct.
### Wardship

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* approximate number of cases pending at any one time

** number of miscellaneous letter received in 2009

*** number of cases pending with inquiry order signed at 31 December

### Reason person admitted to wardship

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× Implies No Data

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2331 Ibid.
2336 Ibid.
2338 Ibid. p. 55.
Appendices

Appendix 13

The number of enduring powers of attorney registered each year under the
Powers of Attorney Act, 1996

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Figures obtained from the Ward of Court Service for years June 1997 to 2006 (these figures include 4 foreign EPAs) and the Courts Service Annual Reports 2005 – 2011.