THE HIGH COURT

[2013 No 3355 P.]

BETWEEN

ANGELO CLOONAN

PLAINTIFF

AND

HEALTH SERVICE EXECUTIVE

AND

DR. KISHAN BROWNE

DEFENDANTS

JUDGMENT of Mr. Justice Hanna delivered on the 27th day of July, 2018.

1. The plaintiff is a health care worker, presently residing in Galway and previously at 30, Ballinfoyle Park, Headford Road, Co. Galway. He was born on the 13th August, 1964. He brings these proceedings for himself and on behalf of the dependents of his late wife, Josephine Cloonan. The dependents within the statutory meaning of the Civil Liability Act, 1961, are the plaintiff and the three children of his marriage to Josephine, namely Stephen, Stephanie and Jennifer. All of these are of full age.

2. Josephine was born on 20th March, 1966. Prior to her death she was employed on a full time basis by An Post. The tragic circumstance which gives rise to these proceedings took place in the early hours of the morning of Tuesday the 19th April, 2011. Josephine ended her life by hanging herself at the family home.

3. Late on the night of the preceding Sunday (17th April) the deceased had been admitted to the Emergency Department at University College Hospital, Galway following a significant episode of self-harm by overdose of prescribed and other medication. She was discharged from that hospital on the afternoon of the next day, 18th April. She was taken home by the plaintiff and their son Stephen. Her daughters made the harrowing discovery of her body after searching for her in the early hours of the next morning.

4. The Health Service Executive is cited as the first named defendant in its capacities as owner, occupier, manager and controller of University College Hospital Galway. That defendant, *inter alia*, employs doctors and nurses at the said hospital.

5. The second named defendant was, at the material time, engaged as a doctor at the said hospital in the role of a senior house officer in psychiatry. The defendants were jointly represented. Where I refer to the defendant in the singular, I intend reference to Dr. Browne.

6. To outline the case in the most general of terms, the plaintiff alleges, *inter alia*, that the defendants failed properly to assess, diagnose and treat the deceased. He complains that she was sent home without proper regard to her mental state of well-being and should have been detained in the hospital. The plaintiff complains that the defendants were guilty of negligence and breach of duty (including statutory duty) in their failure, *inter alia*, properly to assess and diagnose the imminent risk of Josephine Cloonan committing suicide which resulted from her being discharged home when such ought not to have occurred.

7. As a consequence of the death of Josephine Cloonan, the plaintiff and dependents have suffered great mental distress, loss and damage. The plaintiff has also suffered direct financial loss and loss of consortium.

8. The defendants, while recognising the scale of the tragic events and expressing sympathy with the deceased's family, nevertheless fully deny any liability to the plaintiff and the dependents of the deceased and refute the allegations of negligence and breach of duty laid against them.

9. The defendants assert that, at all material times, they acted in a manner compliant with general and approved psychiatric practice as would be adopted by other practitioners of like specialisation and skill when acting with ordinary care. Appropriate treatment, diagnosis and assessment of the deceased, including risk assessment, was carried out in a manner and to the extent required by the circumstances. They say that the deceased was offered in-patient care but declined this. An action and treatment plan was agreed both with the deceased and the plaintiff.

Background

10. The plaintiff had been married to the deceased for 25 years by the time of her death. Their wedding anniversary was on the 5th April before she died. The plaintiff says that, up to times recent to her death, it had been a happy and harmonious marriage with no more than the usual "ups and downs" of married life. They had three children, all of whom appeared to have got on very well with their parents.

11. The plaintiff worked as a carer in a nursing home. Josephine was in full time employment with An Post. Her job involved cleaning and some security tasks which included locking and unlocking the premises where she worked. Both of their jobs appear to have been reasonably secure. The deceased had been earning in the order of €40,000 per annum and the plaintiff around €20,000. The plaintiff maintained that they were financially comfortable, were not in any debt and had savings in the order of €10,000. They had been operating their financial arrangements through a joint bank account. In general terms, up to a point in recent times, they seem to have been following an unremarkable but basically happy married life, both socially and domestically.

12. In the background, however, dark family secrets lurked dormant, only to emerge in the year or so before Josephine's death. During their courtship, Josephine made revelations to Angelo about sexual abuse which she had suffered over a prolonged period during her childhood years, meted out to her by her brother. These allegations included similar, perhaps more extensive, abuse being visited by him upon her sister. The plaintiff said that the deceased decided to put these experiences behind her. The issue did not again arise until some eighteen months before her death.

13. Around that time, the sister in question had informed Josephine that she proposed to take action against their brother. This resulted in the whole "business" being resurrected. With reluctance, Josephine became involved in the proceedings and made a

statement to the gardaí. According to the plaintiff, this was a traumatic experience for the deceased and affected her terribly. All of this put considerable pressure on their relationship. She underwent counselling to help her to come to terms with these developments.

14. According to the plaintiff's account, all of this cumulated in his leaving the family home a few days before the deceased killed herself. Mr. Cloonan maintained this was a temporary break with the hope that this "space" would help them to deal with the adverse impacts of all of these events on their relationship. They still communicated, however, and throughout the difficulties they continued to maintain their joint bank account. He simply moved to a bedsit in Oranmore.

15. Even by this point in the narrative, significant controversy arises. As the evidence in the case evolved, including a number of adjournments, discovery ordered mid-trial and the re-visiting of evidence, the tone of the case changed somewhat. Further suggestions of childhood sexual abuse emerged, this time with the plaintiff as the alleged victim. The circumstances and measure of his separation from the deceased was challenged vigorously. Allegations of perjury were levelled against him - an uncommon occurrence in a case of these unfortunate, complex and tragic dimensions.

16. This sequence of events which led to these proceedings began on the evening of Sunday 17th April, 2011. The plaintiff's son, Stephen, went to the family home at Ballinfoyle Park between 7.30 and 8.00 pm. There he found his mother in a semi-conscious state. It appeared to him that she had taken an overdose of pills. She was taken by car to the Accident and Emergency Department ("ED") in University College Hospital, Galway. She was admitted there at 9.15 pm. The plaintiff met them at the hospital.

17. Josephine was detained in the ED overnight where the plaintiff remained with her. At various times during the night and the next day, the plaintiff's son Stephen and daughter Stephanie were also at the hospital.

18. The next morning, Josephine was interviewed by the second named defendant Dr. Browne. At some later point, Dr. Browne spoke to the plaintiff and later still to Stephen. All of the encounters between Dr. Browne on the one hand and Josephine, the plaintiff and Stephen on the other took place in the ED. The parties disagree on a number of significant points in their recollection of what occurred. There is dispute as to the time Dr. Browne's interview with Josephine commenced, the length of time it took, the nature, duration and location of Dr. Browne's conversation with the plaintiff and the detail of Dr. Browne's encounter with Stephen. Also in dispute is the precise nature of the course of treatment prescribed by Dr. Browne. These areas of dispute will be set out in some greater detail in the outline of the evidence hereunder.

19. The only physical document given to Mr. and Mrs. Cloonan was a torn-off (albeit neatly so) piece of paper. This contains the details " Psych unit Galway 091 544450" written by Dr. Browne.

20. Dr. Browne decided that the deceased was fit to return home once she had been cleared to do so by the medical staff. He noted that both Josephine and the plaintiff were happy that this was the case, another disputed matter. At some point around midday the deceased was returned to the care of the ED staff. She was discharged later that afternoon at some time between 2.30 and 3.00 pm and returned home.

21. While at home for the rest of the day and during the evening (it was her daughter Stephanie's birthday) family and friends observed her and the court heard somewhat bleak accounts in evidence of Josephine's physical and mental demeanour.

22. At approximately 5.00 am, on Tuesday 19th April, Josephine's daughters made the horrifying discovery of their mother's body in a shed at the family home. An Inquest into Josephine's death took place on 29th June, 2012, at Galway Courthouse. Among the deponents on that occasion were Jenny Cloonan and Stephanie Cloonan and the second named defendant, Dr. Browne. The coroner recorded a verdict of death by asphyxia due to hanging.

23. No issue of any significance was raised during the Inquest concerning the quality of care afforded to the deceased. The absence of complaint either by the plaintiff and his family or on their behalf was commented upon by the defence in cross-examination. The family, in broad terms, said that they did not think it appropriate to intervene in the proceedings. It was not a court. They did not feel it was their place to do so.

Material documents

24. The proceedings herein were commenced by way of personal injury summons issued on 4th April, 2013. The formulation of certain particulars and the requisite Affidavit of Verification gave rise to some heated controversy which shall be touched upon later.

25. The issue of discovery, also, was a matter of great contention in the course of the trial. Incomplete discovery and matters which emerged unexpectedly (according to the defence) caused considerable difficulty leading, at one stage, to my giving serious consideration to abandonment of the trial when it was at an advanced stage but, despite my misgivings, we pressed on.

26. Discovery had been dealt with, prior to the hearing, on a voluntary basis without any formal order or, indeed, affidavit. The process of voluntary discovery began on 17th June, 2013. It proceeded thereafter without recourse to any remedy provided by the Rules of the Superior Courts up to and including the opening of the trial on 9th November, 2017.

27. Obviously, both parties were content to proceed with the matter before me on that date. Nevertheless, arising from evidence given by the plaintiff on the 9th and 10th November, the defence felt itself at a disadvantage due to absent documentation relating, *inter alia*, to certain counselling records relating to the plaintiff and the deceased and to records of prescriptions emanating from a Dr. Little. A formal Affidavit of Discovery was requested on 13th November, 2017, leading to yet further avenues of inquiry concerning marriage guidance counselling and bereavement counselling records. All of this ended up with a formal application for discovery being made by the defence to me on 7th March, 2018 (after a number of adjournments to accommodate the making of further inquiries, the attendance of expert witnesses and the facilitation of the parties). The plaintiff had to be recalled and submitted to further cross-examination. None of this was in ease of the hearing and determination of this difficult matter.

28. Pertinent details of the medical documents will be referred to in the summary of the evidence hereunder. Apart from the hand-written fragment described above, the relevant medical documents are:

> (i) The medical and nursing notes of the Emergency Department, University Hospital, Galway. These cover the period from the deceased's admission at 9.15 pm on the night of the 17th April, 2011, up to her discharge which was noted at 3.00 pm the next day. In addition to the entries made thereon by medical and nursing staff, there is also an entry made on the 18th April, 2011, under the heading "Liaison Psych. Review" which was made by Dr. Browne of his treatment and advice in respect of the patient.

(ii) The Psychiatric Core Assessment. This is an extensive *pro forma* document which is part of the psychiatric records of the hospital and which was filled in by Dr. Browne during the course of his interview with Josephine when he consulted with her on 18th April, 2011. In brief summary, it comprises notes of what he says she said to him, her psychiatric and medical history, her personal history and medication. It also records his observations relevant to the patient's mental state noting such matters as appearance, behaviour, rapport, speech, eye contact and other matters. It makes reference to his speaking to the plaintiff and the plaintiff's son, sets out what is described as his assessment/impression and the course of the treatment that was decided upon under the heading "action plan".

(iii) The Liaison Psychiatry Emergency Referral Book.

This is a book best described as a large, old-fashioned ledger. It is kept in the Psychiatric Department of the Hospital and comprises a record of assessments made during that day by the medical personnel attached to the Psychiatric Unit. It contains a number of printed headings and spaces for the insertion labels containing patients' names, addresses and other basic details and provision for hand-written entries by medical staff of details including the reference source for the patient, the team and consultant and so forth.

Evidence as to Fact

The plaintiff, Angelo Cloonan

29. The plaintiff described how he and Josephine were married for just over 25 years at the time of her death. Up until approximately a year prior to her death, the couple got on very well and he described her as a cheerful and hard-working person.

30. Things changed, however, when her sister instigated criminal proceedings against their brother. The plaintiff began to notice a change in Josephine's behaviour. Her unwanted involvement in the investigation caused her extreme distress, anxiety and paranoia. She attended counselling as a result (from 2 different counsellors: Bernadette Divilly and a counsellor from An Post) right up until the time of her death. She also attended two GPs: Dr. Little (from An Post) and Dr. Brennan.

31. The plaintiff was aware that Josephine was attending counselling for this distress; however, he was unaware of the gravity of her mental anguish. Specifically, he was unaware of her psychosis and the medication she was on. Up until the weekend of the 17th April, 2011, he had no idea whatsoever that she was suicidal. Neither was he aware of the extent of the counselling that she was receiving. He was not aware that she had attended Accord or the Rape Crisis Centre.

32. The plaintiff fell out with Josephine on Friday, 15th April. He spent the weekend away from the family home in a rented room although he did visit to talk with her on the Saturday morning. He later became aware of her attempted overdose when his son rang him to say that he had found her "very dopey in the bed" and that he and a neighbour were bringing her to the hospital. The plaintiff met them at the hospital at approximately 9pm and observed her as being like "somebody that drank too much and wasn't able to stand up".

33. Upon entering the ED, a brief introduction and subsequent 10-minute conversation ensued whereby the plaintiff provided the staff with information about Josephine and her condition. When a space became available, she was placed on a trolley and into a cubicle. The plaintiff stayed with her overnight in the hospital and their son Stephen visited several times. Her state was "dopey", "sleepy" and "incoherent". He felt that there was "something radically wrong with her" and that her condition disimproved as time went on. Throughout the morning of Monday, 18th April, the plaintiff attempted to talk to Josephine but there was "no proper conversation from her".

34. At approximately 10:30 am, the second named defendant, Dr. Browne, introduced himself to them as the psychiatrist and suggested that he first have a conversation with Josephine alone in a nearby interview room. She was "very shaky" when walking into the room which was about 5 feet away. From approximately 10:50 am, the doctor spoke with her and this interview lasted for around 20 to 25 minutes.

35. After the interview, the second named defendant invited Angelo to join himself and Josephine in the interview room. There was no one-on-one conversation between the two men at any point. The only occasion on which they spoke was in the interview room with Josephine. In her presence, the plaintiff says that he voiced his concerns and asked, in effect, that his wife be kept in for 24 hours to see what the hospital could do to help her.

36. The plaintiff says he was "fobbed off". The defendant said to him that Josephine was sorry for what she had done, that she did not mean any harm, that she was going to be fine and that he would organise an appointment for the day ward of the psychiatric hospital. To this end, the defendant gave Angelo the telephone number for the day ward on a scrap of paper and said that he could ring up and get an appointment on the day. Although pressed on this, the plaintiff stated that he understood this to mean that down the line they could bring her to the day centre if she wanted. No inpatient care was offered at all. The plaintiff disagreed with the defendant's account that Josephine was pleasant and chatty or that she had insight into what was going on and understood it. She was "mixed up"; "out of it"; in a "daze"; and "her speech definitely wasn't normal". He said she didn't understand what she was saying and "she hadn't good eye contact because she was shaking on her legs". Some information obtained was accurate, but there were many inaccuracies in the records taken.

37. The only treatment option discussed by the defendant was the torn piece of paper with the phone number on it for the day centre, if needed. Specifically, inpatient care was not offered, contrary to what was asserted by Mr. Hanratty S.C. If such care had been offered, the plaintiff would have agreed to it.

38. He was not happy with the decision not to change her medication in the circumstances. In any event, he was not sure what medication she was on. He did not agree that his wife be sent home, but he felt he had no choice and had to trust the doctor.

39. He was not asked anything about the GP care that his wife had received.

40. The interview, the plaintiff said, concluded at approximately 12pm. He denied that the interview lasted 2 hours. Rather, the whole interview (firstly with Mrs. Cloonan alone and subsequently with her and the plaintiff) lasted a maximum of 35 minutes.

41. Between the time of the interview and the time they left the hospital (approximately 3pm), Mr. Cloonan described his wife's condition as perhaps worse than she was beforehand. As far as he was concerned, she still wasn't right and didn't know what was

going on. He didn't complain to hospital staff to the effect that he wanted her kept in and that Dr. Browne would not agree to this because he thought that the defendant was the main person in charge that day and did not think that it was his place to complain.

42. When they returned to the family home, the deceased continued to be confused and muddled. The plaintiff left at approximately 7pm. Before departing, he told his wife that he would call her first thing in the morning and that they would have a good talk. She went upstairs to bed and that was the last time he saw her alive. Early next morning he received a phone call from their daughter Jennifer who was screaming down the phone "Mammy is dead down the shed". The plaintiff returned immediately to the family home. The Gardaí were already there and Mrs. Cloonan was on the ground in the shed.

43. Dealing with the issue of alcohol use, the plaintiff maintained that his wife was a social drinker. She did not misuse alcohol as she had an important job and was driving and working at night-time. Alcohol was never an issue.

44. During the course of his initial evidence-in-chief and cross-examination, the question of the deceased's alleged alcohol misuse had not been a significant point of dispute. Subsequently, when the plaintiff was recalled, he was vigorously challenged and criticised by Mr. Hanratty S.C., *inter alia*, on this issue with reference to an assertion in the pleadings (a Reply to a Notice for Particulars) that the deceased had had two emergency hospital admissions which were alcohol-related prior to the events with which we are concerned in these proceedings. The plaintiff was berated for this apparent contradiction with his evidence and the fact that he averred as to the truthfulness of the matters pleaded in his Affidavit of Verification.

45. Turning to the issue of marriage break-down, the plaintiff claimed that he had temporarily left the family home from Friday, 15th April in order to try and wake his wife up to the reality that they needed to sort things out. He rented a "bedsit" nearby and they continued to use their shared bank account. She was aware of where he was staying and why he left.

46. The plaintiff was never asked to attend counselling with Accord. He denied that their marriage was in trouble. He produced anniversary cards and bank statements. In addition, in re-examination, the plaintiff introduced undoubtedly poignant photographs of himself and his late wife taken during their last holiday together. They there appear to be relaxed and at ease.

47. When asked about the counselling notes stating that their relationship was in difficulty, the plaintiff stated that it was not in trouble but that his wife was in distress over the abuse and her brother's trial. The suicide was not the result of their marital breakdown.

48. He was pressed by Mr. Hanratty S.C. regarding a note of an interview with a counsellor, Mr. Keaveney, where she was reported as saying that Mr. Cloonan had told his daughter that "…mum and dad are separating". He completely denied saying anything to his daughters about separating. He knew Mr. Keaveney very well personally and is sure that he would have raised the issue with him had he been told that. They had not separated despite what was stated in the pleadings. There was a breakdown in their relationship as regards communication and getting along, but it was not a separation.

49. There were no financial stressors at that time. They had plenty of savings and good wages between the two of them. The plaintiff maintained this description of their circumstances despite a clear assertion to the contrary in the pleadings.

50. The plaintiff, in his initial evidence, denied emphatically that he had been sexually abused as a child, referring to the defendant's note in the Psychiatric Core Assessment during the interview with the deceased to that effect. Presumably, the court was being asked to infer from this either inaccurate note-taking or untruthful allegations uttered by Mrs. Cloonan.

51. When re-called and asked about the allegations of child sexual abuse committed on him and which were so noted, the plaintiff qualified his evidence considerably. He was aware of allegations of childhood sexual abuse inflicted upon him. He did attend the Rape Crisis Centre as his wife asked him to do so and had arranged the appointment for him. He had no actual memory of being abused but, as he would have been 3-4 years of age at the time, he agreed to attend in case the counsellor did retrieve some memory or information from him about it. His father had already been prosecuted for abusing the plaintiff's brother.

52. Again, he was strongly challenged because he did not inform the Court of these matters earlier when the issue of Dr. Browne's record of the interview with Mrs. Cloonan was being discussed. Indeed, he had flatly denied that he had been abused and had suggested that Mrs. Cloonan's account to Dr. Browne was untrue. The plaintiff sought to explain this earlier lack of candour, if not outright falsehood, by saying that, in his own mind, he was never abused. He never admitted to his wife that he had been abused.

53. Dealing with Mrs. Cloonan's previous suicide attempt (involving the pipe in the car), the plaintiff said that he did not know anything about this attempt until he read Dr. Browne's notes after his wife's death. Approximately 2 weeks after the attempt, he had found the pipe in the boot of the car but thought that it was for work purposes as she had previously asked him to acquire a pipe for the hoover. He had understood that she required this for work and he had said to her that An Post would sort it out. This was the cause of a dispute between them.

54. In addition, she could not have made this attempt at home, as they parked the car outside their house. She must have been in another location and, therefore, must have had to drive back from wherever she was. In order to be able to drive the car, she would have had to remove the pipe so it was not possible that he could have found the pipe in the position that she would have placed it to commit suicide.

55. On the question of her medication, the plaintiff was not aware of the medicines that his wife had been prescribed until after she died. He later found prescriptions in a folder of hers at their home. He requested a printout from the pharmacist from January 2011 onwards and gave both documents to his solicitor. The prescriptions had been issued by Dr. Little and the printout was dated from 19th January, 2011, to 16th April, 2011. They detailed the various medications that his wife had been taking. These included two anti-depressants (Cymbalta and Lexapro).

56. When asked why he did not challenge Dr. Browne's statement at the Inquest, the plaintiff said he felt it wasn't the day for him to be challenging anybody. His family were with him and he wasn't capable of challenging or shouting at anybody that day. The family also did not think it was a court or that they were supposed to be questioning anyone's evidence.

57. The plaintiff agreed with some elements of the Psychiatric Core Assessment (regarding poor sleep, appetite, energy, concentration) but disputed the timeline, whether or not a one-on-one conversation was had and whether or not inpatient care was discussed. He also disagreed with certain parts of what his wife is reported to have said during her private interview with Dr. Browne. He specified, in this regard, the suggestion that he suffered child sexual abuse himself (later revisited) and that he had found the pipe in or around the window of the car.

58. As regards Dr. Little's involvement (the An Post doctor), the plaintiff was certain that he prescribed antidepressant medication for Mrs. Cloonan in 2011. He obtained this information from the pharmacist.

59. He disagreed with the view expressed in Professor Patricia Casey's report that his wife was *compos mentis*.

Stephen Cloonan
60. Stephen Cloonan is the son of Josephine and the plaintiff. He was born on 24th October, 1987 and works as a postman with An Post. He was living in the family home at the time of Josephine's death.

61. At approximately 3 or 4 pm on the 17th April, he, the plaintiff and Thomas Murphy (a cousin) went out for a "spin" on their motorcycles. They returned to the family home at approximately 6 or 7 pm. He did not see Josephine straight away.

62. After the others had gone, at approximately 8pm, he went upstairs to check on his mother as he knew she was in bed. He found her in a semi-conscious state. She was not very alert and was slurring her words as if she was in a really deep sleep. She said that she had taken "a load of tablets". Stephen immediately rang 999 for an ambulance but was told that there would be a wait so he and his friend Derek Folan brought Josephine to the hospital in Derek's car. They arrived at approximately 9pm and met the plaintiff there.

63. The witness stayed in the hospital until approximately 11 pm in the waiting room. He described his mother as acting very strange, disorientated and confused. The plaintiff was also present.

64. Stephen did not talk to any hospital staff that night. He went to work at approximately 5.30 am and returned at approximately 10 am. When he arrived, Josephine was in a cubicle lying down on a bed. He found her, he described, as being "off her head" and like someone that was drunk. She was slurring her words.

65. At approximately 12/12.15 pm, the plaintiff told Stephen of the decision to send his mother home. He was not impressed by this. He says that he followed Dr. Browne down the hallway and asked him: "Are you not keeping her in? What do we do?" He says that the defendant tried to reassure him and told him repeatedly that his mother would be perfectly fine. Unlike the witness, the doctor seemed very relaxed about the whole situation. According to Stephen, he remonstrated with Dr. Browne saying that his mother was "off her head" and that the doctor responded "She'll go home, she'll go to sleep. She'll be perfectly fine." Challenged by Mr. Hanratty S.C. that he had not given any indication to Dr. Browne that he had any view about what had been decided regarding his mother's treatment, Stephen stated that he went looking for the doctor and "accosted" him in the hallway for this very reason - to communicate his concern. He asked, *inter alia*, why were they not keeping her in. Their discussion lasted 2 or 3 minutes.

66. As far as he was concerned, his mother should not have been allowed home. He did not complain after his discussion with Dr. Browne because he did not know how hospitals worked, and he did not know who to complain to. He left the hospital at approximately 12.30 pm.

67. Stephen subsequently went for a walk with his friend in the woods to clear his head. He returned to the family home at approximately 4 or 5 pm. There were a couple of people over for his sister Stephanie's birthday. There was no drinking. During this time, he observed that his mother was gaunt and pale, and her behaviour was very strange. She was slurring her words and was almost drunk-looking. He described her as swinging around in response to his work uniform at one point. Josephine went to bed early enough and Stephen checked in on her before going to bed himself. Then, in the early hours, he woke to the sound of his sister screaming "She did it, she did it". His sisters said that their mother was in the shed but not to go in. He knew that she was dead at this stage.

68. He was challenged under cross-examination that his account of his mother's confusion was not consistent with either the information that she had given to the defendant or with the accounts given by his sisters to the Inquest. He reiterated that his mother was in an absolute state of confusion and was behaving very strangely. He did not recall being told about a conversation between Stephanie and his mother which took place at approximately 1 am. He did not attend the Inquest as he was too upset. He did not discuss much about what had happened at it. As far as he was concerned, his mother would still be alive if she had been kept in hospital and given the treatment that she needed. She was intoxicated when she died.

Thomas Murphy
69. Thomas Murphy, a nephew of the deceased and the plaintiff, lives across the road from the Cloonans and was in and out of their house every day. On the Sunday, the plaintiff, Stephen and he were out on their motorcycles. He did not see Josephine that day.

70. The next day, he arrived at the Cloonan household at approximately 5 pm for Stephanie's birthday. Josephine was sitting at the kitchen table.

71. Generally, she was very chatty, out-going and would talk to anyone. By contrast, on this day, she was not talking much, was not herself and was "a bit dopey". She appeared not to know that it was Stephanie's birthday. Any time he talked to her she was very slow to respond.

72. When cross-examined, he said he was aware that the deceased had taken an overdose the day before, that she had spent the night in hospital and that she had been discharged at approximately 3 pm that afternoon. He was still very surprised at her condition. He had seen her being helped out of the car when she arrived home.

73. He remained in the house that evening with Josephine for approximately an hour. Jennifer called over to his house after she found her mother.

Derek Folan
74. Derek Folan is a friend of Stephen Cloonan and lives close to the Cloonan household. He knew Josephine very well. He helped Stephen bring her to the hospital on the night of the 17th April. He waited at the hospital for about half an hour and observed her weak, debilitated and incoherent state.

75. Next day, he went for a walk with Stephen in Barna Woods and then to the Cloonans' house for Stephanie's birthday.

76. He observed a "mild improvement" in Josephine's demeanour from the night before but she was just sitting down at the table. She was different from the "normal Josephine" (always laughing and having fun). She was not very alert to what was going on, was still a bit weak, was staring into space and her head was sagging.

77. It was put to him that exhaustion could account for the way she was. He maintained, however, that both physically and mentally, this was a lot more than exhaustion. This was completely different. He had known Josephine for a long time and had never seen her anything like this.

78. Mr. Folan was in the house from approximately 5 until 9 pm and he left the house before she went to bed. During this time, Josephine's condition did not improve at all and she probably got worse as she tired.

Stephanie Cloonan
79. Stephanie Cloonan, Josephine's and the plaintiff's daughter, was born on 18th April, 1989. She currently works as a Project Officer with Enable Ireland. She told the court that she had been in the family home between 5 and 6 pm and was out with her friends for the evening when she got a call at 10 pm about the overdose.

80. She went to the Emergency Department with her sister Jennifer. They saw their mother on a chair in the main foyer area in her pyjamas. Josephine was brought in to a cubicle and Stephanie stayed in the foyer until approximately 4.30 am when she left to go to work for 6 am.

81. She described her mother as being generally very fun, loving, chatty, quick-witted and opinionated. On this evening, she was unable to get the words out to tell her what had happened or why she was upset. She was incoherent and unable to pick up her head to make eye contact. Her condition did not improve as the night went on.

82. Stephanie's next encounter with Josephine was the following day. The deceased was not aware that it was Stephanie's birthday. She wasn't normal. She was also unaware of her surroundings and did not seem to have any idea what was going on. She was unable to pick up a cup of tea and eat a slice of bread. She was incoherent and talking gibberish.

83. When Mr. Hanratty S.C. suggested that this demeanour was due to exhaustion, Stephanie accepted that obviously, after such an experience, one would be exhausted. However, her mother had slept while she was in and out of consciousness all night (the night before). In any event, her mother very hard-working (she managed 3 children and a husband and worked all of the time) and it would take a lot for her to become exhausted to the point where she was unable to do anything. What Stephanie saw was not exhaustion; it was an impact from the medication that she had taken. She had seen her mother look very tired but that is not what she looked like on this day.

84. Stephanie put her mother to bed at approximately 6 pm - she felt Josephine was just slouching in the chair in the kitchen. She briefly left the house at around 10 pm to get a DVD. On returning, she overheard her mother on the phone talking to someone (she knows not whom) saying that she loved Angelo. Josephine put the phone down without saying goodbye. Perhaps the call was cut-off. In any event, without having any proper interaction, Stephanie brought Josephine back up to bed and watched the DVD by herself downstairs.

85. As Stephanie was going to bed at around 1 am, Josephine called her name twice. She went into the room and sat on the side of the bed. Her mother said "everything will be okay, we'll get help now". She never stated that this meant help from the hospital or any form of medical help. Stephanie believes she meant help from the family as they were so close-knit, that they would deal with it as a family unit now that they understood the gravity of Josephine's situation. Her mother would have known that Stephanie would not have presumed she meant medical help.

86. Counsel for the defendants asked whether she knew of the phone number for Station B and the treatment plan that had been put in place for the deceased. Stephanie dismissed this as an idealistic description of what had happened, referring to a phone number on a torn piece of paper with no indication what it was for. As of that night, she had no knowledge of any management plan or anything that was going to happen. Their goal was to get through that day alone. If there had been a management plan which had been communicated to her, Stephanie would have included this in her statement to the Coroner.

87. Describing her mother's demeanour, she observed that what should have taken 10 seconds probably took 2 minutes for it to come out and for Stephanie fully to comprehend. Stephanie thought that her mother was appeasing her because she was upset.

88. Josephine had described her actions as "just a hiccup, it won't happen again". This was far from the way she normally spoke to Stephanie. She was always very strong. Stephanie felt her mother was fobbing her off to get her to go to bed.

89. Mr. Hanratty S.C. asked her about the comment in her statement to the effect that her mother had seemed better than she was earlier during the day. The witness responded that this was compared to earlier in the evening when Josephine could only speak perhaps 4-5 sentences. Even then, this much would have taken a huge amount of time to get out. Of course she seemed a bit better later. However, when Stephanie was talking to her mother in the bedroom, she did not have to move out of her bed, lift her head, coordinate raising a cup of tea to her mouth or engage in proper conversation.

90. At approximately 1 am, she gave her mother a hug, told her she would talk to her in the morning and went to bed.

91. She heard her mother get up at some point but assumed she was going to the toilet and fell back asleep. Her sister Jennifer woke her to say that their mother's light was on but that she was not in the bedroom. The girls went downstairs and Josephine was found in the shed.

92. When counsel contended that it was not surprising that Josephine was not her normal self around this time (because of the case involving her siblings and Angelo leaving the home), Ms. Cloonan stressed that her father had only left the family home on the previous Friday and that they had not separated or planned to sign divorce papers. Her mother was not herself because of the copious amount of pills she had taken. If she was sad about whatever was happening in her life this did not impact on her daily life as a mother to her children. What impacted on her as a mother and on her character was her taking the pills and the fact that this was not managed correctly.

93. When Stephanie was living in England (until September 2010), her mother told her that she was receiving counselling (between March 2010 and June 2010). She was not aware of any other period of counselling.

94. With regard to the Inquest, Ms. Cloonan remembered disagreeing with what was being said, but did not realise that she was permitted to voice this disagreement. She thought that the Inquest was for everyone to give their statements, nothing more. If she had known that she could have raised her hand and voiced her disagreement, she would have done so.

95. She was asked why she didn't raise any questions when the Coroner invited them. She observed in response that there is a difference between asking a question and giving an opinion. Her understanding was that she was not permitted to give her opinion. Further, as a lay person, she would not have felt comfortable standing up and asking questions of a trained doctor. If she misunderstood or misheard the Coroner's instruction, it may have been because of the emotional state she was in that day.

Dr. Gregory Little
96. Dr. Little is in general medical practice in Galway. In such capacity he is also retained by An Post in relation to staff health matters and, in this context, he saw Josephine Cloonan on a number of occasions going back to 2005.

97. His most relevant encounters with her were in 2010 (when he prescribed Nexium & Zimovane) and in 2011 (when he prescribed Nexium, Zimovane, Difene & Cymbalta). He says that he prescribed Zimovane for insomnia and Cymbalta for suspected depression & insomnia. He did not prescribe Seroxat.

98. During this period, he had no suspicions that Josephine was abusing alcohol. Nor was he aware of the sexual abuse issue and did not become so until after her death. He did not know she was attending counselling.

99. He gave evidence as to what he would have advised had he been consulted by Dr. Browne during the period of Mrs. Cloonan's emergency admission. However, since he was never noted as her physician it is improbable that his views would have been sought, even if such an area of enquiry was necessary. That aspect of his evidence, therefore, is not relevant.

Dr. Gerard Brennan
100. Dr. Brennan is a medical doctor in general practice in Galway. Mrs. Cloonan was a patient of his since the 1980s.

101. He clearly recollects her attendance with him on 18th March, 2011. Josephine was normally a positive and bubbly person. On that occasion she was very distressed. On a scale of 1-10, 10 being the worst, she was at about 5 or 6.

102. He felt she was severely distressed due to the pressure from her family to proceed with the abuse case. He concluded that this had caused her depression. She was experiencing severe difficulties in sleeping, anxiety symptoms and difficulty concentrating. Pressed by Mr. Hanratty S.C., he said that there is a high degree of overlap of symptoms between anxiety and depression. Often, those with depression also present with symptoms of anxiety. He prescribed her Lexapro for depression. He did not prescribe Seroxat.

103. He was not aware of her previous suicide attempt, that she had been attending counselling or that she was taking medication other than what he had prescribed.

104. Dr. Brennan never suspected any issues with alcohol or financial difficulties.

105. Had Dr. Browne contacted him, he would have been in a position to tell the defendant of his previous diagnosis of depression, the reasons for the depression and the prescriptions he had given.

106. Given the fact that Mrs. Cloonan had already made 2 attempts at self-harm, he would strongly have suggested that she be admitted or that a consultant's opinion on her condition be obtained.

107. When asked by Mr. Hanratty S.C. why the word "depression" was not included in his note, Dr. Brennan stated that the notes are more of a guideline so that he can remember what happened on the particular day.

Dr. Kishan Browne
108. Dr. Kishan Browne, the second named defendant, is a psychiatrist and has been working in the County Hospital in Roscommon since 2012. He qualified in 1996 and began working in psychiatry when he came to Ireland in 2000. From 2002, he worked with HSE West in the Department of Psychiatry rotating around various psychiatric establishments.

109. At the time of these events, he was working as a liaison psychiatrist in University College Hospital Galway. This was his "second or third stint" there. His role consisted of working as part of a team alongside an advanced nurse practitioner and led by a consultant psychiatrist. Their remit was to respond to any queries or calls coming from the medical or surgical departments and also from the Emergency Department (ED).

110. From time to time, ED would ask psychiatry to assess a patient for a particular reason, including situations where the patient had taken an overdose. In this circumstance, ED would first assess the reason for the patient's presentation and carry out a medical/surgical intervention as required; if a psychiatric issue arose, the patient would be referred to the psychiatry team by the nursing staff (each department is assigned an emergency bleep/mobile phone). The team would then present to that department.

111. The defendant's colleague had been on call-out (out of hours) on the 17th and received a call from ED at approximately 7 am on the 18th. ED indicated that the patient was not yet medically fit for interview, so he handed the case over to Dr. Browne at 9 am when the shift changed.

112. At approximately 9.45 am, Dr. Browne says that he received a call from ED. Before calling the psychiatry department, ED would have made sure that the patient was able for the review which typically lasts at least an hour.

113. The psychiatry department is in the same building as ED and it would take approximately 4-5 minutes for Dr. Browne to get there. The first port of call is to have a brief discussion with the staff regarding the patient and the issue. He must then check the patient's location, read the ED notes and check whether an interview room is free. After all that, he would approach the patient.

114. He said that he first saw Mrs. Cloonan, and commenced the interview, at 10 am. This time is recorded in both the Liaison Psychiatry Emergency Referral Book and the Psychiatric Core Assessment. In cross-examination by Mr. Maguire S.C., Dr. Browne said that it would have taken him less than a couple of minutes to read the ED notes. The commencement time of the interview was disputed by reference, *inter alia*, to the nursing notes which stated: "At 10.45 psychiatry present to speak with patient. Family aware and present". The note goes on to record that, at 12 noon: "Patient seen by psychiatry today".

115. The interaction between the defendant and the deceased is documented in (i) the Psychiatric Core Assessment and (ii) the Liaison Psychiatry Emergency Referral Book. The former is a contemporaneous note of the consultation between doctor and patient guided by numerous *pro-forma* headings prompting, *inter alia*, history, observations and action to be taken. The latter is a large ledger and is intended to enable the doctors to keep a record of all the assessments that they do. It is also used to audit their work

and is a way of ensuring that nothing is missed when they do an assessment (e.g. to account for staff-turnover).

116. Entries are made in the referral book when the doctor returns to the psychiatry department, after the patient has been seen. The defendant pointed to the fact that here, too, he had recorded the interview commencement time as being 10 am. He stated that it was his practice to replicate the relevant details contained in the Psychiatric Core Assessment (including the time of commencement of each interview) in this referral book. An examination of the ledger revealed, however, that Dr.. Browne had not, in fact, recorded the commencement time in numerous other cases.

117. In response to counsel's question as to why he wrote the time seen in Josephine's case but did not do so in most other cases, he replied that this discrepancy is due to time constraints and not being as vigilant as they are supposed to be which results in "slip-ups" and "let down in standards".

118. He said that he wrote the time seen and the management details in the referral book towards the end of the shift, at approximately 4.30/5 pm. The majority of his colleagues would wait until the end of the shift to make all of their entries from the day.

119. When the times recorded in the nursing notes ("10:45: Psychiatry present to speak with patient", "12:00: Patient seen by Psychiatry") were put to him, the only explanation he could give was that the nursing booth is away from the interview room.

120. The defendant did not have the core assessment documents in front of him when he entered the details in the referral book. He would have written the time and the order in which he had seen the patients on a "post-it" and carried it in his pocket, along with the labels on his hand or coat sleeve, with him all day. The labels would then be stuck into the referral book and the "post-its" would be discarded. Other details (management etc.) would be entered from memory.

121. The referral book contains the following details: Label (unique patient identifier which every patient gets); PSY No. (unique psychiatry number); Time Seen; Reference Source (where the patient was seen, ED in this case); Team (he did not know which consultant led which department or which consultant Mrs. Cloonan came under. As there was no psychiatry number, he entered "New Patient" in this field); Management (referenced patient's overdose, previous attempt, history of child sexual abuse, recent marital breakdown, current lack of suicidal ideation and urgent day hospital referral); Seen by (the medical staff member who saw the patient). "New Patient" denotes that there was no prior contact with any psychiatric services.

Psychiatric Core Assessment

122. The defendant stated that the handover was given to him at 9 am. He referenced the ED notes which recorded details concerning the tablets taken by the deceased and the tests performed on her (recorded as "normal"). He stated that she was medically cleared (i.e. conscious, alert, responded well to commands, understood why the psychiatric review had been requested and consented to same) and came willingly to the interview. He described her as "pleasant, chatty" and said that she had a Glasgow Coma Scale of 15 by 15 on admission. He had a very long conversation during which she agreed with the treatment plan. None of this indicated a clouding of her judgment or consciousness.

123. Dr. Browne conceded that the Glasgow Coma Scale is a measure of how conscious or alert you are. It is not a guide in terms of mental well-being and would not indicate how the patient had been affected by medication. There was nothing in the ED notes to advise him of Mrs. Cloonan's level of stupefaction. He said he had not given any consideration to the type of drugs she had ingested. He was satisfied with ED stating that she was fit for interview.

124. He noted her description of her presenting complaint *verbatim*: overdose in response to recent stresses due to (i) brother-in-law's comments, (ii) marital breakdown, (iii) financial stresses:

> (i) He stated that, at the time, he did not actually know who the brother-in-law was and that he just took it down. He thought he was her sister's husband.
>
> (ii) Despite the fact that more details are now known about this (in particular, the
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> fact that the couple had a row leading to the plaintiff staying in temporary
>
> accommodation), the defendant stated that, at the time, he just took down what
>
> Josephine described.
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> (iii) Similarly, he just noted what he was told regarding financial pressures. This
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> was all at the start of the interview. The deceased said she was having some
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> difficulty with the finances but was still working and would put it right. Dr.
>
> Browne did not check this issue with the plaintiff.

125. In response to how she came to take the overdose, she told him that it was "impulsive", that she "never meant to hurt her family" and that she "didn't think it was a 'suicidal attempt'". She told the defendant that she had gone to her GP a fortnight ago, had begun taking antidepressants/sleepers, and had felt "some improvements". He noted that she had not made prior plans for the overdose but had attempted self-harm 4 weeks prior when she changed her mind and her husband had found the hose. She said that she could not go ahead with it because she could not hurt her children.

126. Dr. Browne went on to note that she complained of poor sleep/initial insomnia and "up and down" energy, but that her appetite and concentration were "okay". She displayed "vague helplessness, lot of frustration" due to the court case and her sense of obligation to join.

127. Cross-examined on this, he said that he explored the issue of "hopelessness" with her. The fact that she agreed to treatment in the day hospital and to address her relationship issues indicated to him that she was hopeful for the future. Colleagues would have understood this despite the fact that he did not reference "hopelessness" specifically.

128. Under "psychiatric history: including admissions/diagnosis" he wrote: "index contact" (meaning that it was her first time meeting a psychiatrist); that she "had been treated by GP with Lexapro, Zimovane since last 2 weeks"; and that "it was beginning to help".

129. Under "medical history/allergies", she mentioned diverticulitis but she was not sure so he put a question mark beside it. She could not remember what medications she got from her GP.

130. He took details under "personal/social history" by asking Mrs. Cloonan specific questions (e.g. whether there were any health issues within the family). This included details of the child sexual abuse and her family background.

131. Under "drugs/alcohol", he noted that she was an occasional smoker, a social drinker and did not use illicit drugs.

132. Turning to the heading "Mental State Examination" (MSE), this is a structured way of testing prevailing mood and identifying the problems to be addressed. In other departments, scans/x-rays/blood tests can be used and they do not have to rely on structured questioning. In psychiatry, however, MSE is the only way of ascertaining whether the patient has any prevailing mental illness. By the time MSE is carried out, the doctor has spent some time with the patient. Part of MSE is subjective but there are also specific guidelines and criteria to be followed by the doctor.

133. "Appearance/Behaviour" (she was "dressed in PJs, pleasant, cheerful") and "Rapport" ("good, chatty") are more subjective. Dr. Browne did not specifically address "Affect".

134. For the next sections ("Speech", "Eye Contact" "Mood" etc.), if it is normal, he will just write "N" (normal) or "gd" (good) to avoid appearing rude to the patient by constantly writing while they are speaking. If it is not normal, he would explain and give more details. The next sections ("Thought", "Delusions", "Hallucinations", "Passivity Phenomena") are called psychotic symptoms. He put a stroke under these as a shortcut to indicate that none of these were noticed in Mrs. Cloonan.

135. "Cognition" is assessed by asking questions such as "are you aware of where you are and the date, time etc.?" Unless there is a specific deficit, he would not elaborate on that but "it would be part of the questioning when he takes a history". Queried in cross-examination, he said that "Cognition" refers to whether the patient was oriented in time, place and person. Is she confused? If there are no deficits, the doctor just writes "intact". No further explanation is provided as to how the doctor arrived at the conclusion as psychiatrists would understand what it means.

136. As regards "Insight", by the time the defendant arrived at this category, Mrs. Cloonan would have given him a good history and showed a good understanding that there was an issue she had to deal with and that she was happy to talk about it, to listen and to continue treatment. To save time and to progress the interview, he just noted "present". Mrs. Cloonan understood and had insight into her situation and fully agreed that she needed treatment. Cross-examined, he said he believed that his notes regarding both cognition and insight did convey sufficient information if a superior wanted to find out how he had arrived at his conclusions and what the position was regarding the patient. He disagreed with Professor Casey's criticism of his lack of detail and one-word answers.

137. "Current Thoughts of Self-Harm" were elicited through questions and answers. Initially, she was "very forthcoming" and described the events of both the previous episode and her recent overdose (e.g. what her thinking was and how she regretted the attempt).

138. He did not go into "premorbid personality" at all. Under "Additional Information", he noted that he spoke to her husband with the patient present in the interview room (this was at approximately 11.15 am) and to them in the ED (closer to 12 noon).

139. Under "Assessment/Impression", the defendant noted "deliberate self-harm attempt against a background of long-standing social stressors and recent alcohol misuse". When questioned as to why he referenced alcohol misuse, he stated that she had told him she had a few cans of beer prior to taking the tablets. When cross-examined, he said that this was the extent of the misuse to which he was referring. He did not ask the plaintiff about this misuse because Josephine had gone on to state that she was a social drinker. When asked why he noted "Deliberate self-harm attempt against background of long-standing social stresses and recent alcohol misuse", he stated that that was what she presented with and that was his formulation. According to him, this was a factor which led to her taking the overdose. When asked by counsel whether this made her an extraordinarily sensitive person to the risk of suicide, he said that it was possibly so but that he did not think it on the day as "she would have convinced [him] that there was no active plan. She was very receptive. She agreed with the plans. She did say that she would attend the day hospital".

140. These issues (the previous attempt, the financial stresses and the alcohol misuse) did raise question marks with him and that is the reason why he sent her to the appropriate place, i.e. the day hospital. Any question that she was lying was resolved in his mind soon after speaking with her husband.

141. The defendant was asked about the Nurses' notes from ED where it was noted at 3pm, "Patient discharged home at this time. Appears more aware now. Tolerated coffee and toast". He agreed that this indicated that, while better than she was sometime before that, Josephine was still not bounding out of hospital in the fullness of health. When counsel put it to him that she must have been less than fully aware some 3 hours previously (when the interview finished), he maintained that she was perfectly well when he left her.

142. Under "Action Plan", Dr. Browne noted that: he discussed the options with the patient and her husband; he offered in-patient care but this was declined; they accepted the Station B contact details and day hospital referral; he informed them that there was no change in medication and that this could be reviewed in the day hospital; they were both happy for Josephine to go home once medically fit and cleared. He informed the ED staff about this plan.

Emergency Department Records

143. The ED records are separate to the Psychiatric Core Assessment. However, the defendant made an entry in them. There he stated that: the case was handed over from the psyche on call the day before; full details of the patient's history and presentation were in the psyche files; she had no current thoughts of self-harm or suicidal ideation; she may be allowed home once medically cleared; the defendant had obtained collateral from the plaintiff who agreed to his wife being allowed home once medically fit.

144. The defendant said that he corroborated the history that she had provided with the plaintiff. He then brought Angelo into the interview room with Josephine where they discussed the management plan.

145. As regards his note "Husband and patient happy to go home once medically fit and cleared", this meant that ED (not psychiatry) was still in charge of the patient and that it was up to them to determine whether they wanted to accept the advice given by psychiatry, whether the patient had completed the treatment they were providing and whether she should be discharged.

Information Gathering

146. Dr. Browne says he spoke to Josephine alone for 1 – 1 ¼ hours. After discussing a plan of action with her, he obtained her consent to speak with her next-of-kin and left the interview room. As there was no separate room to meet a patient's relatives, he took the plaintiff to an area facing the interview room which was an extension of the corridor. This was the closest thing to a private area the defendant could find.

147. This one-to-one interview lasted about 5-7 minutes. Due to respect and confidentiality requirements, the defendant was not obliged to discuss fully what the patient would have said to him. Overall, he spent approximately 2 hours with the patient and the plaintiff.

148. Under cross-examination, Dr. Browne said that when a doctor interviews a patient, it is under the understanding that whatever the patient says will remain between the doctor and the patient. The doctor is not at liberty to discuss the exact details with the next-of-kin. Just because Mrs. Cloonan gave her consent for him to discuss the issues with her husband, that extended only to talking about the issues but not to divulge exactly the full details. The defendant did not tell the plaintiff about the prior suicide attempt involving because of his obligation of confidentiality to Mrs. Cloonan. Josephine had volunteered the information to him but, as she said it in confidence, he felt that he should not break that confidence. Once doctors have consent to speak with the next-of-kin, they assume that the consent is limited to talking and does not extend to disclosing any information (a distinction which doctors have been taught by Medical Council Guidelines and senior staff). When counsel put it to the defendant that he was wrong not to disclose this to the plaintiff, to fact-check it with him, he stated he "… did fact-check with him, I wanted to know whether her events did corroborate. He did find a hose and that's what I was looking for. Whether she chose voluntarily not to disclose to the family or not, that is beyond my jurisdiction". He did not feel that there was an exceptional circumstance justifying (as outlined in the Medical Council Guidelines) the disclosure of the context of the previous suicide attempt involving the hose pipe. When counsel put it to Dr. Browne that his decision not to tell the plaintiff about the prior attempt was wrong, the defendant said that Mrs. Cloonan had convinced him that the risks had subsided and that she regretted the attempt.

149. Notwithstanding the plaintiff's evidence that they did not speak alone, Dr. Browne maintained that his notes were a contemporaneous record of events. During the course of the interview they discussed if the plaintiff was aware of why his wife had presented and whether he had found the hose as mentioned by Josephine (not the full context, just whether he had found it). They spoke about their separation. The defendant says he informed the plaintiff that he and Josephine had discussed a plan and asked would he join them in the interview room to discuss it further.

150. Dr. Browne agreed that obtaining collateral information was important. It could, for example, cause warning flags to be raised as to the truthfulness of the patient's narrative on a number of fronts. So, why did he not record this information? He said that the only defence he had was that if there was a discrepancy he would record it. If there was no discrepancy between the patient's version and the next-of-kin's, he wouldn't. It was time-saving. That was his "only little difference" with the approach advocated on behalf of the plaintiff.

151. The defendant viewed her earlier suicide attempt as impulsive, thus explaining the paucity of information concerning it. The subsequent attempt was a further escalation brought about by her own social situation and consumption of alcohol.

152. Dr. Browne maintained that he did conduct a collateral interview with the plaintiff and that he did remember what was said. He mentioned the hosepipe and the child sexual abuse allegations merely as topics without further specificity or forensic enquiry as to the purposes for which the hose was used or to whom the abuse allegations referred. His function did not, in his view, extend that far. He did not consider the unusualness of the carbon monoxide poisoning attempt *per se*. The issue which concerned him was the attempt and how long it lasted. This did raise a flag.

153. He did not write a note of having spoken independently to the plaintiff. His note "Spoke to husband with the patient present in the interview room" was written under the heading of "additional information". His only defence for not having made a note of the independent conversation of what Mr. Cloonan had said is that, if there was a discrepancy, he would have made a note of it. This was the best he could do on the day. He did accept that it is good practice to keep a full note though these would not be exhaustive and there will be gaps to be filled in later.

154. When Mr. Maguire S.C. put Professor Casey's opinion to him that the notes were inadequate and that every contact and its' content should be recorded, he disagreed. The notes were sufficient and his superiors would have understood them and assumed that he would have done everything that he should have done up to that point.

155. The defendant described what then transpired. In the interview room, with both the patient and Mr. Cloonan present, he informed the plaintiff that he had offered Mrs. Cloonan in-patient care but that she had declined and was happy to attend the day hospital. He said that the plaintiff enquired about the services offered by the day hospital but he did not recall the plaintiff asking if he would keep Mrs. Cloonan in for at least 24 hours. If there had been disagreements, they would have been recorded and the defendant would have raised them with the patient.

156. Dr. Browne described Station B as the female ward in the psychiatric department. The telephone number is given in cases of emergency and can be called on a 24-hour basis. The liaison works from 9 am to 5 pm. After 5pm, a call goes directly back to the unit where the nurses and doctors are based.

157. The day hospital is, for all practical purposes, a hospital without a bed at night. The patient undergoes intensive therapy but sleeps at home. It operates from 9 am to 5 pm Monday to Sunday. It is used for mainly complex needs and emergencies. It is led by a consultant and his or her team, occupational therapy, physiology, addiction counsellors and allied staff. Treatment and management is tailor-made according to the patient's needs.

158. In his notes, Dr. Browne stated "spoke to son in ER" but did not keep any record of what was said, done or requested. He said that after the interview he headed back towards the main ED reception area. Initially, he said in evidence that, at the request of a member of staff, he had agreed to meet Stephen Cloonan who was waiting in that area. He said that, in his view, there were constraints as regards how much he could discuss with him as the plaintiff had been nominated as next-of-kin. He informed Stephen of the plan that he had discussed with his parents and that Josephine was going to get help.

159. The defendant claimed that he did not recall any satisfaction/dissatisfaction being expressed by Stephen. However, he later told the Court that he did not remember having a conversation with Stephen.

Diagnosis

160. Dr. Browne was pressed by Mr. Maguire S.C. on his failure to make a diagnosis of depressive illness. Making a diagnosis in the

circumstances was one way of doing things but he felt that he was not obliged to do so. The out-patient clinic would be a less stressful environment in which to make a diagnosis. In his view, he should not lead the ultimate treating team in a particular direction nor pigeonhole Mrs. Cloonan's treatment. He was providing an inventory to assist them rather than leading them in a particular direction. He conceded that so limiting himself may be viewed as a denial of his own particular expertise.

161. He conceded that Professor Casey may be correct in her opinion that Mrs. Cloonan suffered from a probable depressive illness against a complex background. On the day, however, he didn't think so.

Involuntary Admission
162. As regards involuntary admission, he said that the pre-requisite circumstances were very stringent, particular and exact. One could not initiate involuntary admission where a patient has agreed to a treatment plan, particularly where the patient was not psychotic. In this particular case, Mrs. Cloonan had denied any suicidal ideation, was very remorseful and had agreed to attend the day hospital. Thus, the need for involuntary admission did not arise.

Contact with GPs
163. Turning to Professor Casey's criticism that he did not contact Mrs. Cloonan's GPs, Dr. Browne said that if there were 2 or 3 versions of events from the patient and the next-of-kin or other sources, he then would contact the GP. But this case, he maintained was straight-forward and she was forthcoming with all the information. Therefore, he didn't refer to Mrs. Cloonan's own doctor.

164. Dr. Browne accepted that he did not know that the patient had previously consulted two GPs. When asked if he would have altered his position regarding the necessity of admission on discovering that Mrs. Cloonan had concealed the previous suicide attempt from her GP he responded by saying that he did offer her admission. In any event, because she said she was remorseful, it would not necessarily have altered his view. He would, however, have looked for more information.

Consultation with Superior
165. The defendant's immediate superior and on-call and supervising consultant that day was Dr. Laura Mannion. He did not discuss the case with her. Nor did he think it appropriate to do so. The patient had been forthcoming, was corroborated by the family and there had been agreement for further management. Apart from discussing the case with a consultant at the departmental bimonthly meeting, on that day there were not sufficient flags for him to involve the consultant.

Predictability of Suicide
166. Dr. Browne was asked about Professor Casey's comment that, had he acted as she said he should, Mrs. Cloonan would probably still be alive today. He said in response that one cannot predict what is going to happen next. One has to make a balanced decision at a given point in time on where the red flags are but that will not establish what will happen in the future. Mental state changes frequently.

167. There was nothing in her case, even with the benefit of hindsight, that would have caused him to classify her as being at a high or immediate risk of suicide. There was no way he could have predicted that she would commit suicide not long after being discharged. She was going home to the care of her family where there would have been more what he described as "checks and balances". She had overdosed and did not have any further prescription. He had taken as much precaution as he could.

Inquest
168. In his statement to the Coroner, Dr. Browne stated, *inter alia*, that the deceased was very remorseful and regretted her actions. He offered her in-patient care which she refused. She was receptive and open to attending the psychiatric day hospital and he says he discussed the various options and therapies available there. He spoke to the plaintiff who did not request in-patient care but was concerned that his wife would receive continued treatment and follow-up.

169. In the presence of both husband and patient he again offered in-patient care but both declined. Both accepted a telephone number for Station B and agreed to an appointment for the day hospital and for Mrs. Cloonan to attend her GP with regard to her medication. They also discussed the possibility of specialist therapy after attending the day hospital.

170. When cross-examined, the defendant agreed that the only physical thing that was given by him was the phone number for Station B on a piece of paper. He stated that the day hospital could have sent on more detailed information when Mrs. Cloonan presented there.

Assessment of Risk
171. The risk the defendant was evaluating he described as twofold: dynamic (what the patient said at the time) and static (based on the patient's history). The risk to be evaluated was: is this woman at risk of committing suicide? If he had reached a different conclusion as to risk, the patient would have been admitted to hospital for treatment, supervision and observation.

Evidence of Medical Experts

Professor Patricia Casey
172. Professor Patricia Casey is a consultant psychiatrist. She was engaged in this case on behalf of the plaintiff. Amongst her extensive academic and professional commitments and accomplishments she counts being in charge of the self-harm service of the Mater Hospital in Dublin. Like Professors Thakore and Sheehan, both of whom were called by the defence, she presented an extensive and impressive *curriculum vitae*, which abundantly demonstrated her (and their) qualifications and expertise with regard to assisting the court in addressing the issues in this case.

173. She identified five principle areas of concern. These were:

(i) The interview with the husband;

(ii) Contact with the GP;

(iii) The prior suicide attempt;

(iv) The diagnosis or its' absence;

(v) The role of the Consultant Psychiatrist.

174. Professor Casey criticised the paucity of information recorded in Dr Browne's notes of his interview with the plaintiff. It is best practice, she said, to obtain collateral information from sources other than the patient and other than in the patient's presence. The interviewee would then be more likely to be forthcoming with negative information and concerns as well, of course, as providing a mechanism for cross-checking and verifying the patient's history and general narrative.

175. She observed that the interviews with both the plaintiff and his son were only mentioned in passing so it is difficult to ascertain what they actually said during the conversations. These interviews should have been recorded as separate entries in the case notes and in greater detail. The notes suggest not so much an information gathering exercise as a means of conveying a decision that had already been made concerning Mrs. Cloonan's discharge.

176. Had the interview been conducted separately, it would have afforded the plaintiff the opportunity, *inter alia*, to describe the change that had occurred in his wife, the impact that it was having on her day-to-day life and on her relations within the family, the reasons why they separated, details of the sexual abuse issue and whether he agreed with her apparent view that she was improving and ascertain his views about her possible management. It would also have presented an opportunity to discuss the previous suicide attempt with the plaintiff.

177. Agreeing with the views of Professors Thakore and Sheehan as put by Mr. Hanratty S.C., she said that an important reason for having collateral interviews is to obtain corroboration of the information provided by the patient. They should be conducted separately from the patient.

178. Potential inaccuracies with regard, for example, to medication, the background to the sexual abuse allegations, so-called financial stressors and so forth should have been identified or cleared up if raised with the plaintiff had Dr Browne interviewed him sufficiently and on his own. The notes should have recorded such interviews and what the plaintiff had said. Further, every communication with the patient or their families by telephone or face to face or by letter should be included and described in the case records.

179. If the information was not recorded, she assumed that it was not gathered.

180. Professor Casey stressed the importance of evaluating sufficiently the previous suicide attempt and taking account of the possibility that self-harming patients might minimise the risk of further harmful activity in order to get home. Further, there were questions of potential concealment of prior problems or significant inaccuracies. Dr Browne appeared to have relied on what Mrs. Cloonan told him rather than other rich sources of information available to him from collateral sources such as the patient's husband, son and GP. These were very serious and very grave errors.

181. Dr Browne should have contacted Mrs. Cloonan's GP (Dr Brennan) in order to obtain information from him as to the duration of her antidepressant therapy, about which there was uncertainty, as well as relevant details of such treatment as she might have been undergoing. Such consultation would also have provided independent collateral information on the state of Mrs. Cloonan's mental health, the reason for prescribing antidepressants and family and marital background information including details of her previous suicide attempt (about which, as was later confirmed, Dr Brennan had no idea, a matter of some significance).

182. In psychiatry, absent the relevance and utility of diagnostic aids and tools such as scans, blood tests and so forth, the collection of objective information from sources other than the patient is of great importance. For example, the discrepancy regarding the duration of her antidepressant medication between the plaintiff's contention (several months) and the hospital's records (a few weeks) is significant in relation to both the treatment plan and the diagnosis. The danger period for suicide in people suffering with depression is in the early stages of recovery because, while their depressed mood may improve, suicidal ideation is usually late in improving.

183. Under cross-examination by Mr. Hanratty S.C., she said that improvement in the early stages of antidepressants occurs piecemeal with some improving in motivation but not in suicidality.

184. In response to counsel pointing out that the word "distressed" was written down by Mrs. Cloonan's GP when she visited him on 18th March, 2011, Professor Casey observed that "distress" can also be a term used to describe depression in GP parlance. He prescribed an antidepressant, Lexapro, for her. This is prescribed for both anxiety and depression. One would not contact the GP in all circumstances but it should have been done in this case. Failure to do so was a very serious and grave error.

185. Professor Casey observed that very little attention appeared to have been paid to the prior suicide attempt *via* carbon monoxide poisoning, apart from simply describing what happened. This method of committing suicide is rare in women. No information was gathered regarding whether a suicide note had been left, how long the attempt had been planned for, what her reason was for the attempt or whether the plaintiff or her GP discussed it with her subsequently. This appeared to be a serious suicide attempt. Detailed information about these issues is important because such an attempt requires a degree of planning.

186. Since the plaintiff had found the hose, he should have been asked whether he had discussed it with his wife and, if so, what her response was and what he advised her to do (if anything).

187. Professor Casey was disturbed that Mrs. Cloonan had actually asked her husband to get her the hosepipe. This demonstrated a very clear plan in mind, that she actively sought out the means to do it, that she changed her mind halfway through and that she concealed it afterwards. This very serious suicide attempt was very much a red flag.

188. Cross-examined, she said that if Dr Browne had raised the issue of the prior attempt with the plaintiff (as was suggested that he did), the plaintiff would have stated that he did not find the hose attached to the exhaust. This contradiction between accounts should have raised a red flag for the defendant, regardless of whether Mrs. Cloonan was trying to minimise the attempt or just making it up.

189. Professor Casey noted that no psychiatric diagnosis was provided. Dr Browne noted "a deliberate self-harm attempt against a background of long-standing social stressors and recent alcohol misuse". That is not a diagnosis; rather, it is a description of what happened and of the patient's circumstances.

190. A diagnosis was important because this was a lady who had been prescribed antidepressants, was having trouble sleeping, and was almost certainly suffering from a depressive illness (which is a risk factor for suicide).

191. The term "depressive illness" would focus the mind on the relationship between the illness and the patient's behaviour. Instead,

in this case, the focus seemed to be exclusively on stressors and things external to the patient rather than on any illness that she might have had. The emphasis was wrong and, therefore, the focus of intervention and treatment were wrong.

192. One of the deficiencies of the *pro forma* document was that there was no space provided, as such, for a diagnosis. Nor was there any mention of premorbid personality. However, despite that and the fact that it may not be possible to diagnose correctly in every case, most medics make some sort of presumptive or working psychiatric diagnosis because it would direct treatment. Dr Browne should have taken a step back and evaluated the features of the case and come to the conclusion that Mrs. Cloonan had some sort of depressive illness. Instead, he focussed entirely on her social circumstances.

193. While a diagnosis could be right or wrong, a diagnostic label focuses one's thinking more clearly on an intervention and treatment rather than a simple description of the behaviour observed. It would have constituted another red flag for Dr. Browne (a high risk of suicide attaching to that diagnosis, particularly alongside the other features of the case) and would possibly have led to a different course of action.

194. With regard to the role of the consultant psychiatrist, Dr. Browne did not consult the psychiatrist on call. While such consultation is not common practice for every occasion, a number of features in this particular case should have raised alarm bells and led to him making contact with the psychiatrist on duty for further advice.

195. Dr Browne was a junior doctor in psychiatry, a Senior House Officer (SHO). He should have phoned someone more senior, ideally, the consultant psychiatrist, to discuss the case because it was very unusual and complex and was probably outside the competence of a SHO. Dr. Browne obviously did not think it was necessary to do this. However, had he gathered the collateral information and attempted to make a diagnosis, in her view Dr. Browne would have felt the need to do so.

196. In general summary, Professor Casey was of the view that there were major deficiencies in the management of Mrs. Cloonan. These were very serious, very grave errors. In particular, she instanced the failure to evaluate the previous serious suicide attempt, the failure to interview the plaintiff adequately and independently and the failure to contact the GP. It seemed that the defendant's decision was based exclusively on what Mrs. Cloonan herself said, rather than on the other "rich sources of information that may have given information completely different to what Mrs. Cloonan herself had provided".

197. Had appropriate investigations and enquiries been carried out and followed up, Mrs. Cloonan ought to have been kept in as an inpatient. This ought to have occurred with or without reference to the consultant on call. Professor Casey herself "potentially" would have pursued involuntary admission. However, the question is hypothetical. It may or may not have arisen had the defendant involved the plaintiff and his son more in the decision-making and asked them to encourage Mrs. Cloonan to consider admission. When their family are behind them in a particular course of action, patients frequently agree to voluntary admission once the benefits have been carefully explained to them. After this has been done and refused then the day ward could be considered.

198. She expressed the view that Dr. Browne's actions met the criteria raised by the test for medical negligence as enunciated in *Dunne v. National Maternity Hospital* [1989] I.R. 91.

199. If Mrs. Cloonan had been involuntarily admitted, she would probably still be alive. She was berated for this assertion by Mr. Hanratty S.C. He asked her, *inter alia*, why her first expert report did not suggest that involuntary admission was an option or that, had Dr Browne done what she stated, Mrs. Cloonan would be alive today. Professor Casey replied that she assumed that what she was saying was quite obvious, that there were deficiencies in this lady's management and that a better outcome might have resulted in a different treatment plan. If the patient had been diagnosed with a depressive illness, she would have had access to therapy. These kinds of crises usually abate when a patient has been admitted. Another vigorous exchange took place concerning the predictability of suicide and the outcome of modalities of treatment, referencing the chapter written by Professor Casey in the textbook entitled "Suicidal Thoughts and Behaviour". Suggesting, *inter alia*, that counsel was extrapolating from a theoretical chapter to an individual case, she said that this was a case with a high risk of suicide and that suicide is unpredictable in the long-term. But within a few hours or days, you can identify people at high risk. That is why suicide risk assessments are conducted in every Emergency Department in the country and why people are admitted to hospital. Intervention could have made a difference in this case because you have to apply clinical judgment when you interpret these statistics. Otherwise, self-harm assessments would not be carried out and patients would not be admitted to hospital.

200. Mrs. Cloonan would have qualified for involuntary admission (if it came to that) under s. 3(a) of the Mental Health Act, 2001, (serious likelihood of the person causing immediate and serious harm to herself) as she had a depressive illness and was very likely to harm herself in the immediate future. This would not have violated the provisions of s.4 of the Act of 2001. Nor was it contrary to international norms or to the principle of least restriction.

201. The treatment plan was based on limited and incomplete information and was deficient.

202. The mental state assessment was very brief. The records were deficient as they did not go into any detail. For example, the single word "present" being used to answer the question of Mrs. Cloonan's "insight" (a very complex thing) is completely insufficient.

203. The records were not sufficient so as to allow a superior member of the team to make any decision on the patient's management (particularly the absence of any record of the defendant's conversations with the plaintiff or his son). If the information was not recorded, Professor Casey assumed that it was not gathered. Every contact, and the content of every contact, should be recorded.

204. While the records did not give an impression of somebody who was "out of it", they were cursory.

205. Absent a diagnosis of depression, Professor Casey was asked, what "alarm bells" should be set-off by a case such as this (two recent suicide attempts - one aborted and one followed through)? She said that it depended on the severity of the attempt. Scratching wrists is of a different magnitude to attempting carbon monoxide poisoning and an overdose. Concealment, minimisation, alcohol and substance misuse or dependence and personality disorders were material considerations. In addition, concealment would be a top consideration. People who are in full physical health do not end their lives unless there is some major background issue. Collateral information would clarify these issues.

She was also asked how often would a patient resist admission (e.g. for a period of observation etc.) after their family have been persuaded that it is the best course of action? She said that sometimes younger patients in their early twenties might resist, but older people who have a good relationship with their family will not usually resist. In her experience, family have a huge part to play in determining the outcome when the patient is refusing admission, particularly if the patient is not psychotic.

Professor Jogin Thakore
206. Professor Thakore is Professor of Psychiatry at Trinity College Dublin. His hospital practice is based in St. Vincent's Hospital, Fairview. He was called on behalf of the defence and, in considering the case to prepare his report and give evidence, he relied on documentary evidence, specifically, what was recorded by Dr. Browne in his notes and other clinical notes.

207. With regard to entries under the heading "Mental State Examination" he said that there was nothing written to indicate that Mrs. Cloonan was confused at the time.

208. On the issue of involuntary admission, he said that one must balance the statutory requirements under the Mental Health Act and the Mental Health Commission's "least restrictive environment" policy. Mrs. Cloonan did not appear to be suffering from depression or addiction and she appeared happy with the plan to attend the day hospital. There was, therefore, no reason for involuntary admission if she had been offered voluntary admission and refused it. Specifically, according to Dr. Browne's notes, the patient was distressed rather than depressed and was willing to accept help.

209. As regards being a threat to herself, while she had made a deliberate self-harm attempt, it is incredibly difficult to predict those people who commit self-harm who will then actually commit suicide.

210. Predictability of suicide is complex and almost impossible. Those deemed to be at a high risk of committing suicide almost never commit suicide and roughly half of the people who do commit suicide are deemed to be "low risk". There is no individual risk factor or combination of risk factors with respect to suicide or risk assessment tools that you can actually use that will confidently allow you to predict who will commit suicide. The scales (low, moderate, strong risk) are meaningless.

211. Referring to the hosepipe incident, strictly speaking, there was no previous attempt as she did not commence or carry out the actual act in question. This was an aborted attempt. As such it would not allow you confidently to predict whether or not the patient would go on to self-harm or attempt suicide.

212. Cross-examined by Mr. Conor Maguire S.C., Professor Thakore persisted in his view that, because the previous incident was not an attempt, there was no need to call the consultant. While he agreed that this was an unusual method for a woman to commit suicide and that concealing it from her husband and GP was significant, he stated that concealment is not unusual and knowledge of it would not have made a significant difference to Dr. Browne's action plan because suicide is not predictable. You have to take what the patient says themselves about their intentions at face value.

213. Dealing with the efficacy of the assessment on its face, he said that, from a practice point of view, the core assessment is very similar to the one used in his hospital. Some things would be added but, more or less, it is the same type of document everywhere.

214. With regard to the question of making a diagnosis of depression, there was no indication in the recorded history and Mental State Examination that Mrs. Cloonan suffered from depression. Sometimes it is not possible to make a diagnosis at the initial assessment. This could be done later at the day hospital. In this instance, it was reasonable not to make the diagnosis.

215. Contacting a GP is not done routinely. It usually occurs when the doctor is worried about something or has a specific question to ask. It is a judgment call. The practice of ringing the GP if the doctor is unsure about the information or if it is incomplete is reasonable. Further, the GP could have contacted the Emergency Department or liaison psychiatry to voice any concerns. This often happens in his practice.

216. Professor Thakore did not see any reason why Dr. Browne should contact a consultant as he was fairly confident that there was no depression, that he had a sufficient collateral history, that he had offered voluntary admission and that Mrs. Cloonan had agreed to attend the Day Hospital.

217. Professor Thakore then turned to various aspects of criticism levelled at the defendant by Professor Casey. Regarding the interaction with the plaintiff, he said that Mr. Cloonan could have asked to speak with Dr. Browne separately if he had concerns. Usually, if it is discovered that the patient is minimizing or denying symptoms, the doctor would take that collateral history seriously and might decide, on balance, to admit the person.

218. Questioned by Mr. Maguire S.C., he said that he would not dictate to his staff that collateral information had to be obtained on an independent basis. Judgments are made on a case-by-case basis. His practice would be that he and his team would record collateral histories even if they did not add any additional information but simply to state that it had been done. He accepted that he did not know what was said in the alleged collateral interviews as it was not recorded. He agreed that the interaction with the son could not be described as obtaining collateral history.

219. In his view, the defendant's stated policy of only noting what was relevant is a matter of individual preference. He would write it down himself but if it was not written down, he would assume that the information was not clinically relevant or that there was no additional information.

220. The defendant took a good history, conducted a satisfactory Mental State Examination and decided on a reasonable management plan. Adherence to the form of the document that he was using, the conclusions that he reached and the plan that he made were not below a reasonable standard of care for an experienced SHO in psychiatry.

221. He disagreed with Professor Casey's assumption that Mrs. Cloonan suffered from depression. There were no clinical entries to support this. He agreed with Professor Casey that she had capacity.

222. If someone is suffering from depression, antidepressants can take up to six weeks to kick in and there can be a risk period but, as he did not think Mrs. Cloonan was suffering from depression, he does not think this is relevant.

223. Professor Thakore was pressed by Mr. Maguire S.C. with regard to the failure of the defendant to contact the patient's GP. The fact that Mrs. Cloonan had been prescribed 3 antidepressants was an important matter that should be taken into consideration, if known. It would be important to go to the source to know why the person was taking them - was it for something mild (anxiety disorder) or for something more serious (depression).

224. If Professor Thakore had rung the GP and been informed of Mrs. Cloonan's state some weeks previously, this would not necessarily have influenced him in relation to her current condition as this was historic rather than current. However, it would be relevant because it would give you a backdrop as to why someone is feeling distressed or upset. Her previous attempt would also

have been relevant.

225. He set out a number of criteria for advising admission to a patient's family, for example, mental disorder of sufficient severity (severely depressed, psychotic, manic etc.). Also, admission would be advised if it was felt that admission could make a difference. One could obtain more information from the patient to come to a firmer diagnosis. Treatment and supervision of the patient could be provided.

226. When questioned as to a hypothetical exchange between Dr. Browne and the GP (sharing knowledge of the diagnosis of depression, the previous attempt and the concealment), the professor agreed that this would raise alarm bells.

227. On the documentary evidence provided, there was nothing to suggest that there was any real analysis of what Mrs. Cloonan had taken by way of overdose or of the medication that she might have been on. He accepted that further enquiries into the medication would have brought numerous issues to light, specifically that she had been prescribed antidepressants, that her GP considered her to be depressed and that her GP placed her degree of depression at about 6 out of 10.

228. In the context of taking collateral histories he does not think that confidentiality would come into play unless the patient had explicitly stated "I don't want you to speak to anybody" or if there was a specific reason for maintaining confidentiality (which did not arise in this case from what he could see). The doctor would then have to make a judgment as to what was in the best interests of the patient.

229. Professor Thakore stated, when cross-examined, that he was unaware of the defendant's reservations regarding confidentiality when he was writing his report and that, in his view, Dr. Browne should have asked more questions and gathered more information from Mr. Cloonan as to what had happened and clarified whether the family knew about the previous attempt. He did not get all of the facts that he needed to get.

230. The defendant's method of recording on slips of paper and labels which he carried around for the day was not a desirable practice and went against guidelines. Doctors are not allowed to make notes anywhere other than in the chart.

231. Overall, in his view the Psychiatric Core Assessment was adequate in terms of its layout.

232. Regarding Professor Casey's view that Dr. Browne made very serious and grave errors, Professor Thakore disagreed. He would not consider them all as being very grave errors. The defendant's failure to record collateral history was serious. However, suicide is highly unpredictable and the suicide risk assessment is of little or no value.

Professor John Sheehan

233. Professor Sheehan is a consultant psychiatrist in the Mater and Rotunda Hospitals. He has been Associate Clinical Professor in the UCD School of Medicine since May 2016.

234. He said that there were five treatment options available for Mrs. Cloonan ranging from the most intensive to the least intensive. These comprised: admission (involuntary or voluntary); day hospital care; outpatient appointment; self-harm nurses; referral back to GP. Intervention, treatment and management are determined on a case-by-case basis. They are tailored to the psychological and social needs and risk of the patient.

235. In his view, Mrs. Cloonan was not detainable under the Mental Health Act as she did not present with depression. She presented as someone who had self-harmed against a background of significant recent stressors (child sexual abuse, marriage break-up, financial stressors). Her overdose was impulsive, spur-of-the-moment.

236. It is good practice to contact the GP but this is more usually done when the doctor is missing information or is unclear about the situation, or if the patient cannot give a history. Dr. Browne, however, had gathered a substantial amount of information. He agreed with Dr. Browne's approach and stated that many doctors would not have phoned the GP, especially when the person was accompanied by family and was as forthcoming with information as Mrs. Cloonan.

237. Failure to contact the consultant was not, he thought, a grave error as he or she would have agreed with the defendant's management plan anyway.

238. Regarding Mrs. Cloonan's capability to be interviewed, he said that a coherent and detailed account given by her is recorded in the notes. The reference to her being "medically cleared" means that the patient's physical status has been addressed.

239. Pressed by Mr. Maguire S.C. as to the defendant's failure to make a diagnosis, Professor Sheehan said that in the ED the key factor is more the management of self-harm rather than the treatment of depression. The label of depression is secondary to the management issue. The defendant's description in the section headed "Assessment/Impression" was sufficient. Using a narrative to describe the clinical situation is not unusual. The ED is a snapshot, whereas you can get all of the extra information to make a diagnosis following admission at the day hospital. The management would have been the same whether Mrs. Cloonan was classified as suffering from distress or from depression.

240. The documentary evidence suggests that Mrs. Cloonan was suffering from extreme distress caused by major stressors, not a depressive episode or illness. However, the professor said that he would seriously have considered the GP's opinion that Mrs. Cloonan was depressed had this information been known to him and it would have been a significant factor in his decision-making process as to the next steps and the appropriate approach regarding the patient and the family.

241. Mr. Maguire S.C. questioned Professor Sheehan regarding the defendant's failure sufficiently to evaluate the earlier suicide attempt. Whereas the level of detail is not important, he agreed that the main point is that it was significant and highlighted the seriousness of the situation. He agreed that it is an unusual means of suicide for women. This should probably have been discussed with the plaintiff.

242. Collateral information, he said, is ideally better to be obtained in a separate environment. He agreed that the content of the conversation should be recorded.

243. Asked under cross-examination about the impact of confidentiality, Professor Sheehan said that when someone has taken a serious overdose, the doctor overrides the notion of confidentiality - patient safety comes first. According to Medical Council Guidelines, the doctor is fully entitled to, and should, discuss all aspects of a case if the patient may be at risk, as in this case. He

would teach his students to follow this approach.

244. With regard to using labels to record and transmit information, this is standard practice among junior doctors. He drew a distinction between Professor Thakore's experience in St. Vincent's Hospital and his own experience in the Mater Hospital where there is an Emergency Department.

245. Professor Sheehan would have classified Mrs. Cloonan as having a moderate risk of suicide. A management plan is based on an assessment of need and an assessment of risk. Predicting outcome is almost impossible but stratifying low/moderate/high risk does determine action so it is practically useful.

The Plaintiff's Submissions
246. In identifying the nature and scope of the duty of care owed by the defendants to the plaintiff, reference was made to the established authority, *Dunne v. National Maternity Hospital* [1989] I.R. 91. Finlay C.J. says at p. 109:

> "(i) The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.
>
> (ii) If the allegation of negligence against a medical practitioner is based on proof that he de*via*ted from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.
>
> (iii) If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.
>
> (iv) …
>
> (v) It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant.
>
> (vi) …"

247. The areas of fault identified by the plaintiff essentially concern the second named defendant. No complaint is made against the medical or nursing staff at the hospital. The plaintiff identifies five principal areas in which he alleges that Dr Browne was guilty of negligence. As a consequence of these acts of negligence, the plaintiff complains that the deceased was not admitted to hospital. Had she been admitted as an in-patient, she probably would not have taken her own life.

248. Firstly, the plaintiff complains that Dr Browne failed to take proper account of the deceased's previous suicide attempt and that he failed fully to appreciate its seriousness. This episode was never discussed with the family. The plaintiff's submissions accept that Dr Browne did inquire as to whether or not Mr. Cloonan had found a hosepipe; however, the defendant's perception of patient confidentiality should not have prevented him from discussing the matter further with the plaintiff. More questions should have been asked.

249. Secondly, the plaintiff complains that the defendant failed to interview the plaintiff independently or failed adequately to record information obtained during the course of such interview. Even on Dr Browne's recollection, this was a short interview which lasted no longer than seven minutes. Given that fact and the fact that no notes were recorded, it cannot be said to have been a meaningful interview or gathering of collateral information. All of the expert witnesses agreed that collateral information should be obtained from the family and that this information should be recorded.

250. Incidental to the issue of note-taking, the plaintiff condemns Dr Browne's habit of making notes on "post-it" pads and sticking them on his sleeve for the purpose of making up a fuller note later on. Professor Thakore did not approve of this although Professor Sheehan was rather more sympathetic from the perspective of his own practice in an accident and emergency unit in a major Dublin hospital. Dr Browne's practice in this regard was not considered by Professor Casey.

251. Thirdly, Dr Browne should have made contact with the plaintiff's general practitioner, Dr Brennan. Professor Casey was firmly of this view as far as this case was concerned, but not in every case. The fact that Dr Brennan had prescribed anti-depressants prior to Mrs. Cloonan's admission to hospital was important information and warranted further enquiry. As we discovered during the course of the evidence, the general practitioner could, further, have informed Dr Browne that he had diagnosed depression and would have recommended that the deceased be admitted to hospital for supervision.

252. The fourth area of complaint identified on behalf of the plaintiff is the failure of the defendant to make a diagnosis of depressive illness. Professor Casey was of the view that such a diagnosis was necessary even at this early stage of potential treatment. Contact with the patient's general practitioner would have put Dr Browne in a better position to diagnose depressive illness. Professor Casey also complained about the failure to evaluate properly the prior suicide attempt and the indicators, all red flags, suggestive of depressive illness. The diagnosis of depression would have made it easier to decide how to treat the late Mrs. Cloonan.

253. Finally, the plaintiff relies on Professor Casey's criticism of Dr Browne for failing to contact a consultant before releasing Mrs. Cloonan from hospital.

254. As a consequence of the five failings identified by the plaintiff, the deceased was not offered in-patient care. The plaintiff was adamant in his evidence that in-patient care was never offered to his wife. In evidence, he went somewhat further and alleged that in-patient treatment was requested and refused. It was accepted by the defendants' medical experts that admission ought to have been offered to the deceased. Professor Sheehan agreed that failure to offer in-patient care would fall below an appropriate standard of care.

255. Because of the shortfall in the standard of care provided to the deceased, the defendant was not in a position to assess

whether or not involuntary admission ought to have been considered in the circumstances. Professor Casey gave evidence that involuntary admission could have saved the deceased's life but, ultimately, she was not given the chance to survive the first crucial period of 48 hours.

The Defendants' Submissions
256. The defendants, relying, *inter alia*, upon decided cases, argue that the plaintiff has not met the threshold identified in *Dunne v. National Maternity Hospital* [1989] I.R. 91.

257. The defendants seek to attack the credibility of the plaintiff and invite the court to hold that the plaintiff has given extensive false sworn testimony to the court. In identifying credibility as a central pillar of the defence case, Mr. Hanratty S.C. on behalf of the defence made it clear that it is inappropriate, given the nature of this case, to rely upon the provisions of s. 26 of the Civil Liability and Courts Act, 2004, and he does not seek to do so.

258. The defendants seek, however, to rely on recent decisions handed down by the Supreme Court. Deliberate falsehoods with regard to one aspect of a claim may have implications for the plaintiff's credibility in general and lead to his failure to discharge the burden of proof generally or as regards a particular aspect of his claim. Further, it is inappropriate for a court to engage in speculation or benevolent guesswork in an attempt to rescue a claim or a particular aspect of it (see *Morris v. Bus Atha Cliath* [2003] 1 I.R. 232).

259. Further, a plaintiff is personally responsible for the factual content of replies to particulars and affidavits. Plaintiffs cannot and must not be allowed to hide behind professional advisors (see *Vesey v. Bus Eireann* [2001] 4 I.R. 192).

260. The defendants submit that, even if I were not disposed to dismissing the claim on the basis referred to above, the nature and extent of the false sworn evidence given by the plaintiff on virtually all of the important factual issues in the case is such that it would be impossible for the court to accept his evidence on any disputed issue of fact. If I accept this to be the case, the defendants submit that the plaintiff has thus failed to discharge the burden of proof.

261. Moving to the allegations of breach of duty of care, no issue arises between the parties as to the general principles to be considered and applied in determining negligence in medical negligence cases. The defendants seek, in addition, to rely on a number of recent decisions of the High Court concerning decision-making in a psychiatric context.

262. In *C. v. North Western Health Board* [1997] Ir. Log. Weekly 13, White J. dismissed a case which involved a patient escaping from a psychiatric hospital and assaulting the plaintiff and his wife. The patient in question had been admitted to a day room in the hospital rather than a special care unit which would have involved closer supervision. In dismissing the claim, White J. held that it was not for a judge or a jury to decide whether one of two possible choices was the correct one. In the particular case, the doctor had examined the patient for 30 minutes and the referral letter from the patient's general practitioner did not show a propensity for violence. The regime that he ordered was reasonable in the circumstances and the defendants had therefore discharged the duty of care.

263. Applying this approach to the instant case, taking into account the unpredictability of suicide even in patients that have engaged in self-harm and the fact that the deceased was remorseful and denying any further suicidal intent, the correct approach for the court with regard to the questions of involuntary admission or reference to the day hospital was not to decide whether the decision made by Dr Browne was the correct one but whether it was reasonable in the circumstances.

264. The defendants rely upon the case of *Orpen v. Health Service Executive* [2010] IEHC 410. This case, in factual terms, bears comparison to the issues arising in the instant case. O'Neill J. said at para. 67:

> "… Faced with a choice between admission to a psychiatric ward, which, itself, could be a traumatic experience for a young person … , or a discharge into the care of a caring relative, (his sister) with whom (the deceased) could easily communicate and whose home offered a safe, comfortable and non-threatening environment, and bearing in mind that he was to come back to the psychiatric services the following day, it simply cannot be said, in my opinion, that the discharge into (his sister's) care was a failure by the defendant or by Dr McGrory or by Dr Gallagher of their duty of care to (the deceased)."

265. Following this reasoning, the defendants argue that there is no basis for finding that Dr Browne was in breach of his duty of care in not admitting the deceased. The deceased told Dr Browne that her overdose was impulsive, that she never meant to hurt her family and that she didn't think it was a suicidal attempt. She told him that she did not go through with the "hosepipe" attempt four weeks previously because "I wouldn't do the hurt to my children". The patient was being released to the care of her family with an emergency number and day care.

266. Dr Browne's treatment plan was also the least restrictive option. All of the expert witnesses accepted the principle of the least restrictive option as guiding the treatment of persons with mental health problems. In *Corrigan v. Health Service Executive* [2011] IEHC 305 at para. 35 Irvine J. stated:

> "It was not disputed that it is now a fundamental and guiding principle that all persons with mental health problems should be managed in the least restrictive environment possible consistent with their safety and the safety of others."

Discussion/Findings
267. There are a number of discrete areas of dispute at the heart of this case which I feel I should address at the outset. Other findings of fact will be made subsequently.

268. However, before this, I must take account of the fact that front and centre to the defendants' case is the issue of the plaintiff's credibility. The defendants have not held back in making allegations of lying and outright perjury. As I have already observed, given the tragic dimensions of this case, it is no easy task to confront such allegations but it seems to me that I must do so at the outset.

The Issue of Credibility
269. It is appropriate that I preface my consideration in this aspect of the case by acknowledging the immense personal trauma which these unhappy circumstances have visited upon Mr. Cloonan and his children. One can hardly begin to imagine the torrent of emotions that this sad experience has brought to each one of them.

270. Nonetheless, the case must be decided in accordance with the evidence. Significant aspects of the case hinge on the credibility of the plaintiff and the defendant and the reliability of their respective evidence. The plaintiff bears the burden of proof.

271. Turning first to the plaintiff, he swore an Affidavit of Verification pursuant to O. 1A, r. 10 of the Rules of the Superior Courts (see s. 14 of the 2004 Act). It would seem that the plaintiff was reluctant to swear this affidavit and did so, after some pressurising from the defence solicitors, on the 21st November, 2017, the case having opened on the 9th November prior to that. By that time, the plaintiff had already completed his evidence and had been cross-examined. However, he was later recalled and further examined and cross-examined arising from matters which emerged from discovery during the course of the trial.

272. In his affidavit, the plaintiff purports to verify matters contained in the pleadings and in replies to particulars in the following terms:

> "the assertions, allegations and information contained in the said Replies to Particulars which are within my own knowledge are true. I honestly believe that the assertions, allegations and information contained in the said Personal Injury Summons which are not within my knowledge are true".

273. He goes on to state that he is aware that it is an offence to make a false or misleading statement in the affidavit.

274. The following matters, *inter alia*, are verified in the foregoing terms by the said affidavit.

> (a) Negligence Particular (d):-
>
> "failed to discover and diagnose that Josephine Cloonan made a deliberate self-harm attempt against a background of longstanding social stressors, recent alcohol misuse and overdose of drugs."
>
> (b) The personal injuries summons, at particular n, refers to:-
>
> "… (her) recent prior attempt at suicide, being a lady with a history of child abuse, a recent history of depression and a recent separation from her husband …".
>
> (c) Invited by a notice for particulars to identify the background of longstanding social stressors, in a reply dated 25th July, 2013, the plaintiff particularised as follows:-
>
> "sexual abuse by brother from a young age, the possibility of it being made public and the embarrassment it would cause her amongst her friends and work colleagues as well as extreme anxiety and stress, financial stressors, job and breakdown of marriage."
>
> (d) Particulars referred to a significant increase in her alcohol intake due to ongoing (stress) in her life.
>
> (e) A further notice for particulars asked the plaintiff to specify, *inter alia*, the precise history of alcohol misuse. On 4th September, 2013, the plaintiff replied that:-
>
> "the (deceased) consumed alcohol daily. On two separate occasions as a result of alcohol intake, she was taken by ambulance to the accident and emergency department at Galway University Hospital for treatment …".

275. Contrary to what was averred, the plaintiff was vociferous in stating that his late wife did not have issues with alcohol, that their marriage had not broken down and that they were not under any financial stress. He sought to deny that which he had sworn in his affidavit. As far as the evidence at the hearing goes, even leaving the plaintiff's testimony to one side, there was nothing to suggest any significant long-term problem with alcohol nor any evidence of financial difficulties. The extent of the marital problems could be open to debate. Therefore, one might validly regard the swearing of that affidavit as a wholly voluntarily self-inflicted wound. Self-inflicted or not, it was properly seized upon by counsel for the defendants and relied upon to invite me to discount totally and *in limine* the plaintiff's evidence or otherwise to treat it as so tainted as to be completely unreliable.

276. The swearing of an Affidavit of Verification in support of false or misleading pleadings or particulars is a serious matter. It is a "stand-alone" wrong as well as being a potentially lethal source of infection to the credibility of otherwise pristine and reliable evidence. Apart from being a breach of criminal law, it may impact adversely upon a civil case, perhaps fatally. The advice and drafting of lawyers does not confer immunity or shelter.

277. In approaching Mr. Cloonan's evidence, I must bear in mind the inconsistencies between his sworn evidence and the Affidavit of Verification. Further, it may be that some other aspects of his evidence are implausible. By way of general observation, I found the plaintiff (perhaps understandably) to be somewhat fraught and defensive in giving evidence. On other occasions I found him to be evasive, indeed almost in denial, of concrete matters of evidence that were put to him.

278. However, in fairness to the plaintiff, I feel that I should view the evidence as a whole in weighing his credibility as a witness. Given the scale of the trauma which the plaintiff and his family have suffered, I would not wish to be harsh in my judgment of him. Among the myriad emotions affecting him, I do not number avarice. Nonetheless, the reliability of his evidence has legitimately been called into question and I feel that I must weigh his evidence with care. No challenge was made to the credibility *per se* of the other witnesses as to fact apart from glancing reference in written submissions to the understandable supportive loyalty of the plaintiff's children.

279. Dr Browne was not confronted with a credibility assault to the same degree as Mr. Cloonan. Nonetheless, the reliability of his note-taking and recollection of events was very much to the fore as well, of course, as matters pertinent to the parameters of his duty of care and how he perceived them.

280. He presented some difficulties in assessing evidence, not least by his persistent habit of wandering from the direct tense to the subjunctive, at times almost seamlessly. This presented difficulties when I understood him to swear that he recorded dates in the referral book as a matter of practice (the detail of which does not concern us) when he subsequently confessed that he had not in fact done this. Further, I must confess that I found his description of his discussion with the plaintiff about discovering the hosepipe from the previous suicide attempt to be initially implausible. However, the plaintiff, in effect, seemed to endorse what Dr Browne had said, at least in a "back-handed" way. This view of his evidence was adopted by his counsel in written submissions.

281. A further difficulty arose when Dr Browne purported to give an account of his encounter with Stephen Cloonan in a manner which suggested that he had a clear recollection. He subsequently said that he did not actually remember this exchange.

282. When giving his direct evidence, a significant part of his account of his encounter with the Cloonans, separately and jointly, consisted of his agreeing with his deposition to the Coroner as read out to him by counsel. This deposition, admittedly sworn by him, consisted of his statement (pre-prepared, with or without legal advice-I don't know) as given to the Inquest. I did not find this passage of evidence on such a crucial aspect of this case to be of much assistance.

283. Despite my misgivings, I did not form the view that Dr Browne was an untruthful witness. He is, of course, subject to the same infirmities of recollection as anyone else. Further, he has, without doubt, a significant interest in the outcome of this case in terms of his professional standing, and understandably so.

284. Insofar as any dispute may arise as to matters of fact or observations recorded by him, I am satisfied that the same were made in good faith at the time and with the belief that the same were true. That they may necessarily be accurate is another question. Insofar as he is open to criticism, such criticism relates to the accuracy of those notes and not least his professed practice of not recording matters on occasion where the information obtained did not disturb the overall narrative. I say this with particular reference to his failure to take notes of the contents of his extremely limited conversation with the plaintiff.

285. I now turn to the main areas of factual dispute between the parties. I will make certain findings of fact under each individual heading.

The Deceased's Mental Capacity and Disposition During and Around the Time of the Interview
286. The plaintiff alleged that his wife was in an extremely confused state during the time and after she was interviewed by Dr Browne. He described her in a way that suggested that she "wasn't all there" or was "out of it". If anything, she seemed worse after the interview. She did not know what she was saying and Dr Browne should not have believed what she was telling him or, at least, he should have been very wary of her narrative. The consultation notes compiled by Dr Browne do not accurately reflect her condition.

287. To some extent, the plaintiff's recollection is supported by Stephen Cloonan as far as her condition afterwards went. Both of them had been with the patient most of the night and the next day. Stephen was absent for a period when he went to work. It is probable that both the plaintiff and Stephen were exhausted and emotionally traumatised.

288. Mrs. Cloonan, obviously, had endured an appalling experience. She presented to the hospital in a medically challenging physical and psychological state. She received careful and appropriate emergency medical care in the ED. She was monitored there. At 04.55 hours her Glasgow Coma Scale rating was at its' optimal level of 15/15. She was cleared as fit for psychiatric interview by the medical staff. This is consistent with Dr Browne's evidence as to the deceased's general disposition and capacity to engage in the interview process with him. During this time, neither the plaintiff nor Stephen were present. I accept the defendant's evidence as to how he found her and communicated with her during the course of an interview lasting between one and one and a quarter hours.

289. I am satisfied as to the general accuracy of Dr Browne's note of Mrs. Cloonan's physical condition and general mental disposition. That is not to say that I believe that she was in robust good health. Far from it. Dr Browne's notes and recollection must be viewed in context. She must have been in a sorry state given all that had happened up until then. Further, some 4 or 5 hours would pass, according to the medical notes, before she could tolerate coffee and toast and be sufficiently alert to be considered fit for discharge. This sets the subjective context in which Dr Browne interviewed her.

290. The note in the Psychiatric Core Assessment was taken contemporaneously and is reasonably detailed in part at least. It gives a full history and reflects how Mrs. Cloonan dealt with what brought her to take the overdose, the family history including child sexual abuse, the stresses at home, the previous suicide attempt and so forth.

291. The plaintiff sought to attack the accuracy of Dr Browne's notes citing, *inter alia*, references to alleged alcohol misuse, marital breakdown, financial difficulties and allegations of child sexual abuse involving himself as a victim. I will deal with these matters further hereunder. He pointed to the untruthfulness of these as indicative of Mrs. Cloonan's want of capacity. It is, therefore, somewhat ironic that, absent the sexual abuse allegations, these were the very items that he averred to be true in his Affidavit of Verification of the pleadings and particulars of his claim.

292. I am satisfied that Mrs. Cloonan was medically competent to be interviewed and gave a reasonably full interview to Dr Browne. I am satisfied that Dr Browne's note broadly reflects both her condition, as viewed in context by him, and the content of the interview. However, taken out of context, the description "bright and cheerful" does not, I believe, accurately reflect her general physical and mental condition. Even treating the plaintiff's evidence with caution I am still persuaded by the evidence of Stephen Cloonan as to his mother's significantly debilitated state. This is supported by the fact that she was not noted as fit for discharge until some 3 hours later. During this period it is implicit from the ED notes that her awareness was impaired to some degree and she was intolerant of sustenance.

The Duration of the Interview with the Deceased and the Plaintiff
293. A core aspect of the plaintiff's case is that insufficient time was given to interview the deceased and no time at all was given to interview him. He rejects Dr Browne's note which, according to the defendant, gives a starting time of 10 am. The plaintiff says that Dr Browne showed up at around 10:30, proceeded with Mrs. Cloonan about 5 feet across a narrow corridor to an interview room and then interviewed the deceased for a period of about 20 or 25 minutes at most. After that, the defendant spent a short time with both of them. He says that this second interview began at approximately 10:50 and concluded at sometime between 11:45 and 12:00. The latter time is supported by a corresponding note in the ED records.

294. If it is the plaintiff's case that the effective interview with the deceased lasted for 20 to 25 minutes then, even if he was correct in his starting time, two things are clear. Firstly, it makes no sense at all that the meeting would have concluded even as early as 11:45 let alone 12:00. Secondly, I am satisfied that the extent of the detail recorded by Dr Browne in his contemporaneous notes could only have been harvested over a considerably longer period than that suggested by the plaintiff.

295. What do the hospital records say? In the Psychiatric Core Assessment, Dr Browne notes the interview as commencing at 10:00. Or is it 10:50? I must confess that I was of the view that the timing noted looked as if it could be 10:50. However, in the absence of a handwriting expert and having been presented with other examples of Dr. Browne's handwriting, we have Dr. Browne's evidence that it says 10:00.

296. For what it is worth, the 10:00 time is replicated in the referral book. That, however, is recorded by reliance on the "post-it" stickers which Dr. Browne carried around during the day. I regard it as being of neutral significance in assisting us on this aspect of the case.

297. The court was referred to a nurse's note recorded at 10:45 in the ED notes stating "psychiatry present to speak with patient. Family aware and present." The person who made the note was not called. I was invited to consider on behalf of the defendant that the note was made at 10:45 by a nurse at a time when the interview with the deceased was already underway. The notes themselves are not "minute by minute" accounts of what is going on. The previous note was at 08:30 where it states that the patient was awaiting psychiatry. The next note was at 12:00 noting, *inter alia*, that the patient had been seen by a psychiatrist.

298. Apart from speculation that this time may reflect the time the entry was made, there is nothing to challenge the broad accuracy of this note. No other note in the ED records is mis-timed to the extent such speculation would allow. Allowing the most generous interpretation, it seems to me that the interview with Mrs. Cloonan began at some time after 10.30.

299. In my view, the time of 10.00 noted by Dr. Browne is wrong. If it were 10.50 it might be closer to the reality. However, whatever timing one accepts, 10:00 or 10:45/50, for the commencement of the interview with Mrs. Cloonan, neither corresponds with the 20/25 minutes' duration suggested by the plaintiff. The timing recalled by Dr. Browne (1 hour to 1 ¼ hours' interview followed by 5 to 7 minutes with the husband) seems more plausible particularly when viewed in the context of the detail set out in the notes.

300. I am persuaded that the entire process, including the interview with the plaintiff, had concluded by 12 o'clock.

The Alleged Marital Breakup

301. An uncomfortable and, at first blush, distasteful aspect of the case pursued by the defence was the allegation that the plaintiff's marriage to the deceased had broken down in a significant way and that this was a factor contributing to the deceased's despondent mental state. The plaintiff was rigorously cross-examined on this, most particularly when recalled to give evidence after the further discovery of counselling records.

302. The plaintiff's description of the state of the marriage was of a basically harmonious relationship. I was presented with copies of recent holiday photographs of the plaintiff and his late wife and of wedding anniversary cards recently exchanged. It was the plaintiff's case that the child sexual abuse allegations concerning his wife had led to any difficulties they were experiencing. These boiled over the Friday before she took her life, leading him to move out to a bedsit. He returned home for a time the next day.

303. The plaintiff was around the house on the Sunday. He met up with his son Stephen and a friend to go for a spin on their motorcycles. There is no indication that he met his wife on the Sunday. I was struck by the fact that, on a couple of occasions, by way of pointing to the continuing nature of their relationship, the plaintiff stressed that they continued to use the same joint bank account. I must confess that I found it difficult to understand the relevance of that observation if the only period of separation in mind was a sudden departure from the scene on Friday and the unhappy circumstances of the overdose on Sunday.

304. Stephanie, the plaintiff's daughter, who was at home but had been absent for some time in England for part of these events, took a positive view of the state of her parents' relationship.

305. Notwithstanding all of this, the plaintiff undoubtedly makes a case in the particulars (and verified by affidavit) that marriage breakdown was one of the stressors which afflicted the deceased. Further, the mid-trial discovery of counselling records does indicate marital difficulties to a greater degree than indicated by the plaintiff. To be fair to the plaintiff, he did acknowledge in evidence that the deceased had gone to Accord (the marriage advisory organisation) because she felt their marriage was in difficulty.

306. I do not wish to dwell on the minutiae of this aspect of the case. As far as the plaintiff's initial evidence on the first and second days of the trial goes, I feel there were probably more profound difficulties in the marriage than he then led us to believe. It may be that a state of marital breakdown existed and that the plaintiff's Affidavit of Verification speaks the truth. It would not be surprising if the deceased (or the plaintiff for that matter) would wish to keep this state of affairs from their children. What I do not doubt is that Mrs. Cloonan was concerned about the state of the marriage and this concern was appropriately recorded by Dr. Browne.

Financial Difficulties

307. One of the plaintiff's criticisms of Dr. Browne's notes is the fact that he records the deceased as reporting "some financial stressors but still working at her job". The plaintiff pointed to this as an example of the inaccuracy of Dr. Browne's notes. In support of the plaintiff, there was no evidence of any out of the ordinary financial difficulties affecting them.

308. On the other side of the picture, we have Dr. Browne's evidence that he recorded what he was told. Allied to this is the reference in the further reply to particulars to financial stressors which was verified by affidavit as already noted. The interview notes apart, the pleadings so verified are the only, substantive indicator of financial problems. Leaving the plaintiff's verbal testimony to one side, there was no evidence from the family or any other source of financial problems. The Cloonans appear to have been solvent and with modest savings. There was no evidence of any impending expenditure crisis.

309. I am satisfied that Dr. Browne's note was accurate in reporting what was said to him by the deceased at the time.

The Prior Suicide Attempt

310. This was an important event for a number of reasons. Firstly, it was a significant red flag as far as all of the expert witnesses were concerned (perhaps Professor Thakore gave a more tepid view of this on the grounds that the lady did not proceed to execute her plan). It may be useful to quote the relevant entry in full from the "presenting complaint section" of Dr. Browne's interview notes.

> "No prior plans made though she had admitted to trying another self-harm episode some 4 weeks ago – got a hosepipe, put to the exhaust of her car – closed the window but then changed her mind, didn't start the car but forgot to take the pipe "hose" off – husband found it later. Reason for not attempting – 'I couldn't do the hurt to my children'."

311. In evidence, the plaintiff said he was unaware of this prior attempt at suicide. He claimed that he first became aware of this when he gained access to Dr. Browne's notes. As noted above, he described a conversation with his wife about obtaining a hosepipe for a hoover and complaining to her that this was really the function of her employer since, as far as he was concerned, she required this for work. He appears to have become quite annoyed about it all. It would seem they had some sort of *contretemps* about it. He later found the pipe in the boot.

312. The plaintiff complains that he was not told about this incident by Dr. Browne. The court was invited to infer that, had Dr. Browne mentioned this incident to him, he would then have alerted Dr. Browne to the fact that he was unaware of it. This would have added another "red flag" (i.e. concealment) to the overall picture. This revelation by itself or possibly *via* other avenues of enquiry (e.g. the plaintiff's G.P.) ultimately would have led to a change in the course of Mrs. Cloonan's treatment. She probably would not then have committed suicide.

313. The plaintiff, when giving evidence on the first and second days of the trial, maintained that there was no separate interview between himself and Dr. Browne. No collateral information of any sort was sought by Dr. Browne.

314. Between the time the plaintiff first gave evidence and his recall, Dr. Browne was called in evidence by the defence. He gave evidence that during the course of a separate interview with the plaintiff (which the plaintiff denied ever occurred) he did mention the "hose" incident which the plaintiff acknowledged. Dr. Browne did not go any further into that episode feeling constrained by his views on confidentiality.

315. When the plaintiff was recalled, he maintained his denial that there was any discussion between himself and Dr. Browne but then pointed to the fact that the defendant had mentioned the hose as being the only collateral enquiry made. This was how he characterised that passage of evidence.

316. Here, the plaintiff's credibility issues do not assist either him or me. This could be viewed as a somewhat evasive and back-handed concession that some discussion took place between the two of them. If so, this contradicted the plaintiff's earlier assertion of no collateral discussion.

317. Professor Sheehan offers the view that the note implicitly suggests that the plaintiff was, in fact, aware of the previous suicide attempt. Employing the caution with which I weigh the plaintiff's evidence, I think not. Firstly, were the plaintiff motivated opportunistically to discredit the written record, his purpose would have been better suited by total denial, including denial of knowledge of the presence of the hosepipe. Secondly, no family member, for what it was worth, had knowledge of any such incident. Finally, and perhaps significantly, Dr. Brennan was unaware of the incident or any plans to that effect. This was notwithstanding his consultation with the deceased, during which he diagnosed depression, 4 weeks earlier.

Alleged Sexual Abuse of the Plaintiff

318. In Dr. Browne's interview notes, he observes that the plaintiff had also alleged that he had been a victim of child sexual abuse, that he knew about the deceased's abuse and that he was supportive and understanding of her. When first he gave evidence, the plaintiff trenchantly denied that he had been a victim of child sexual abuse. The court, presumably, was invited to conclude that the deceased was confused and/or Dr. Browne got the details wrong.

319. Following upon the mid-trial discovery, the plaintiff was recalled in evidence. He was questioned about counselling notes prepared by Mr. Keaveney (who was interviewing and counselling the deceased). These notes record a phone conversation witnessed on the 20th January, 2011. Mr. Keaveney notes the deceased as reporting that the plaintiff had attended the Rape Crisis Centre, that he had admitted to the deceased that he was sexually abused in childhood and that he was going back to the Rape Crisis Centre the next Monday.

320. When confronted with this information by Mr. Hanratty S.C., the plaintiff denied that this was true and said that Mr. Keaveney must have taken the matter up incorrectly. However, he later accepted that there were allegations that he had been sexually abused as a child and that at least one of his brothers had been sexually abused by his father. He said that he himself had no recollection of such sexual abuse. This would have occurred when he was around four years of age.

321. Therefore, when first he gave evidence, I am satisfied that he was fully aware of these allegations. Even if he believed the allegations to be false or if he was unsure if he had been abused, his obligations under oath mandated that he bring these matters to the court's attention. This reflects, at the very least, a lack of candour on his part. It may be that the plaintiff is in a state of denial about the very possibility of such awful matters. Such was the impression he gave me in evidence. Perhaps complex emotions, unlocked by such revelations, played a role in his earlier unsatisfactory evidence.

322. Notwithstanding this, the plaintiff chose to dispute Dr. Browne's note no doubt with a view to bringing into question Mrs. Cloonan's capacity and/or Dr. Browne's competence.

323. In the circumstances, I am persuaded that the note is an accurate account of what the late Mrs. Cloonan told Dr. Browne. Were the defendant to have enquired as to the veracity of this from Mr. Cloonan, it is difficult to know how he would have responded. Approaching his evidence with caution, given the manner in which he dealt with this issue in court, I believe he probably would have denied it.

The Collateral Interview

324. In his first tranche of evidence, the plaintiff denied that he had any separate meeting with Dr. Browne. The only encounter he had with Dr. Browne, he said, was with his late wife present.

325. Dr. Browne said that he did conduct a collateral interview with the plaintiff. He says this was conducted in a corridor, away from the patient. There was no separate interview room as such and Dr. Browne said that this was the best he could do in the circumstances. During this meeting the patient remained in the interview room. There is no complaint made in evidence by the plaintiff about the state of the facilities or their suitability for the conducting of an interview with next of kin.

326. Dr. Browne recalls the meeting, saying that it was a short meeting – perhaps five or seven minutes. Part of its purpose was to check what he had been told and, during this encounter, he did raise the question of the hose and the marriage breakdown. He says that he did feel constrained by the balance of confidentiality as to how far he could go. He then told the plaintiff about the treatment plan.

327. Dr. Browne did not take any actual notes of the contents of the discussion. He did record two items. Firstly, in the Psychiatric Core Assessment and under the heading of "additional information", he recorded that he had spoken to the husband with the patient present in the interview room and that he spoke to the son in the emergency room. Secondly, in the ED notes he wrote that he obtained collateral from the husband who had agreed for his wife to come home once she was medically cleared.

328. I prefer Dr. Browne's recollection. However, the defendant admitted that the topics raised at the meeting comprised the hose pipe and the marriage breakdown. It is probable, not knowing about the previous suicide attempt, that the plaintiff understood the defendant to refer to the fractious incident about the hose for the hoover. There any further line of enquiry by Dr. Browne appears to have stopped. This was because of his perception of the constraints of patient confidentiality.

329. He then informed the plaintiff of the treatment plan and then brought him to meet with Mrs. Cloonan. That was as far as the meeting and the enquiry went.

The Deceased's Alleged Alcohol Misuse
330. Another issue that arose was whether or not the deceased had been misusing alcohol. There is no suggestion recorded by Dr. Browne of any long-standing misuse of alcohol. In truth, Dr. Browne's notes of his interview with Mrs. Cloonan are not indicative of any prolonged, chronic drinking problem. Indeed, it is noted that the late Mrs. Cloonan was a social drinker. Under the heading of "presenting complaint", Dr. Browne noted the deceased as denying any recent increase in alcohol consumption although she admitted to drinking a few cans of beer on the morning of the Sunday that she took the overdose. This would appear to have been out of line with her prior habits of alcohol consumption. Stephanie Cloonan, as well as the plaintiff, confirmed that the deceased was a social drinker. Consuming cans of beer on a Sunday morning was out of the ordinary for her.

331. Under the heading of "assessment/impression" which was noted at the time of the interview, Dr. Browne refers to "recent alcohol misuse". The plaintiff took exception to this. Again, one must assume that he was inviting the court to infer that the history given to Dr. Browne was inaccurate due to the confused state of mind of the deceased or, alternatively, that Dr. Browne's note and analysis of the situation were incompetent and below an appropriate standard.

332. On its face, the plaintiff's attack on Dr. Browne's note would seem somewhat overblown. However, when set against the matters pleaded and verified by the plaintiff, the assault on Dr. Browne's notes is particularly difficult to explain.

333. In the pleadings and replies to particulars, the following matters are alleged by the plaintiff and verified by him by affidavit.

(i) In the personal injuries summons, complaint is made of "recent alcohol misuse".

(ii) In a reply to notice for particulars, complaint is made of "significant increase in her alcohol intake due to ongoing (stress)".

(iii) In a further reply to notice for particulars, it was stated that the deceased consumed alcohol daily and, on two separate occasions as a result of alcohol intake, was taken by ambulance to the accident and emergency department at Galway University Hospital for treatment.

334. The hospital admissions were not put to the plaintiff when first he gave evidence and, on the application of the plaintiff's counsel, I felt it appropriate not to allow the records in as evidence. It should, in fairness, be noted that both the plaintiff and Stephanie did make reference to one incident where the plaintiff apparently fell and injured herself but it is not entirely clear how this related to either of the incidents noted in a reply to particulars.

335. What is of significance, however, is that the plaintiff chose to berate Dr. Browne for his relatively tepid note of an increase in the deceased's drinking while, at the same time, seeking to put forward in pleadings and verify by affidavit a more serious problem with the deceased's consumption of alcohol.

336. I am satisfied that Dr. Browne noted accurately what he was told and that his note of recent alcohol misuse was, in the circumstances, appropriate.

In-patient Care
337. The plaintiff's case hinges upon the proposition that, had Mrs. Cloonan been admitted as an in-patient, she would then not have taken her own life in the early hours of the morning of 18th April. This is because, as an in-patient, she then would have been under close supervision and would have by then been treated appropriately so as to ward off any prospect of taking her own life.

338. The pleadings in the case make the claim that Mrs. Cloonan should not have been let out of the hospital. Dr. Browne ought to have persuaded her to remain. As the hearing evolved, the plaintiff's case expanded to include the possibility of compulsory detention in hospital under the Mental Health Act, 2001 (or "sectioning" as it is commonly called), a course of action suggested in evidence, but not in her pre-trial report, by Professor Casey and vigorously disavowed by Professors Thakore and Sheehan.

339. On the other hand, Dr. Browne's evidence is that in-patient care was offered but declined both by the patient herself and jointly by herself and the plaintiff subsequent to the separate, collateral discussion with the plaintiff. Further, Dr. Browne gave an account of the process in which he consulted first with the deceased and then with the plaintiff and then with the two of them. He set this out in his statement to the Coroner and when giving evidence at the Inquest. This account was read out in detail in court. He stated that that in-patient care was offered and declined, that the deceased and the plaintiff were happy with referral to the day hospital, that they were content with the plan for medication (which was no change) and that Mrs. Cloonan could be discharged home once she had been cleared as medically fit.

340. It appears that Dr. Browne was cross-examined by the plaintiff's solicitor at the Inquest and that nothing arose there that would, essentially, disturb the case made on the pleadings. At the hearing, however, during his first appearance in the witness box, the plaintiff went considerably further, making the specific allocation that he requested that his wife be kept in for 24 hours but that Dr. Browne didn't agree and said that his wife would be fine. No allegation that in-patient treatment had been requested and refused had been made at the Inquest, in the pleadings or in the particulars.

341. I have grave misgivings about the accounts given on this aspect of the case both by the plaintiff and by Dr. Browne. Approaching the plaintiff's evidence with the reserve it warrants, I am not persuaded that he requested in-patient treatment for his wife as he alleges. He may well wish he had looking back on things. Be that as it may, I cannot accept his evidence. I am, however, satisfied that the topic of in-patient care for the deceased was raised with Dr. Browne by Stephen Cloonan and that Dr. Browne refused to entertain discussion on this with him.

342. I was unconvinced by the account given by Dr. Browne, with reference to his statement to the Coroner. This struck me as a somewhat rehearsed account of what transpired. His reference in his own and the hospital notes give an inaccurate picture of the fact of and extent of his collateral engagement with the plaintiff and Stephen Cloonan. I am not persuaded that he explained to the plaintiff and Mrs. Cloonan jointly the available treatment options. I believe it more likely that, prior to his brief encounter with the plaintiff after the interview with the deceased he had decided upon day care as the appropriate treatment. The plaintiff was invited to hear what had been decided in joint consultation with his wife.

343. I am of the view that Dr. Browne set his mind on the day care "option" even before he embarked on the collateral enquiry. This is reflected in what I believe is an accurate description by him of the perfunctory meeting with the plaintiff. This course of treatment was decided upon by him based upon over-reliance on his interview with Mrs. Cloonan to the exclusion of other important avenues of investigation. His concept of the constraints of doctor/patient confidentiality in treating an emergency case such as this was out-of-

line with accepted medical practice and rudimentary practice as instructed to intending practicing psychiatrists. Such advice as he offered to the Cloonans was, therefore premature and insufficiently informed.

344. I do not accept that in-patient care was properly offered to Mr. and Mrs. Cloonan. I accept that it may well have been mentioned to Mrs. Cloonan individually but was past the point of debate when the joint phase of the interview began.

Conclusion
345. I am satisfied that Dr. Browne presented himself to Mr. and Mrs. Cloonan sometime between 10:30 and 11:00. The time of 10:00 noted by him is wrong. The time of 10:45 recorded in the ED notes is more likely to be accurate. This timing coincides more accurately with that suggested by the plaintiff although I am unsure if that is a genuine recollection on his part or an opportunistic one with reference to the records. My reservations with regard to his evidence have already been discussed. Since I prefer the note recorded in the records as being approximately correct, it is of no consequence that I pronounce upon the provenance of the plaintiff's evidence as to the timing of the arrival of Dr. Browne and the commencement of the interview.

346. It follows that the timing noted in the referral book is inaccurate. This may have resulted from the "post-it" system employed by Dr. Browne in gathering certain details of the case.

347. The interview between Dr. Browne and Mrs. Cloonan lasted in excess of one hour and probably in the order of one hour and fifteen minutes. In this regard, I prefer the evidence of Dr. Browne to Mr. Cloonan. Dr. Browne has been criticised for not spending sufficient time with Mrs. Cloonan for the purpose of interviewing her. Arising from Professor Sheehan's evidence, I am not persuaded that the time devoted to the interview was insufficient *per se* for the purpose of conducting the said interview.

348. There were shortfalls in the note-taking as observed by Professor Casey but, nonetheless, I am not persuaded that there was any materially relevant inadequacy or shortage of detail in Dr. Browne's notes of the interview with the deceased up to the point where Dr. Browne sought out the plaintiff.

349. No space was provided for a diagnosis in the *pro forma* document used by Dr. Browne. The absence of a diagnosis was criticised by Professor Casey. Professors Sheehan and Thakore, on the other hand, disputed this. They said a diagnosis was not required. Rather, Dr. Browne was concerned with addressing the immediate medical needs of the patient and accommodating any risk of further self-harm. Professor Sheehan did go some way towards suggesting that a working diagnosis should be made. In any event, Dr. Browne tells us that he took the view that Mrs. Cloonan was not suffering from depression. Dr. Browne was of the view that any information that he should write in the notes should be such as to assist the team who would ultimately come to treat the patient rather than seek to lead them in a particular direction. The argument as to whether or not a diagnosis should be made as a general proposition in these circumstances is not one which I feel I am required to resolve in this particular instance.

350. Dr. Browne did conduct a very brief collateral interview with Mr. Cloonan. This was conducted with the plaintiff in the corridor at a remove of a few feet from the interview room in which the patient was still sitting. This was an extremely limited interview and lasted, at most, in the order of five to seven minutes. The only matters raised were the hose and the recent marital difficulties. At that point, Dr. Browne informed the plaintiff that he had agreed a plan with Mrs. Cloonan and brought him back to the interview room to discuss same with him in the presence of Mrs. Cloonan. After this, Dr. Browne gave the piece of paper with the phone number and address of the psychiatric day unit to Mr. Cloonan.

351. Dr. Browne viewed himself as being severely restricted in the extent of the enquiries which he could make of the plaintiff (despite being nominated as next of kin) by reason of his perception of patient confidentiality. Guided by this approach and thus having obtained the most limited of information from the plaintiff, he did not proceed to obtain any further information from Stephen Cloonan.

352. Dr. Browne's extremely restrictive views on patient confidentiality, and the consequent limits that he perceived as impeding his ability to enquire from persons other than the patient, were out of keeping with the views of medical practitioners of similar standing. The correct approach, where one is dealing with a significant risk of suicide (which, given the history, this was), would indicate that any questions of patient confidentiality are subjugated to the interests of the patient's well-being. Doctors in such a situation are free to enquire fully from the family members of the patient with a view to obtaining collateral information confirming or contradicting material that has been garnered from the patient.

353. In my view it is probable that, had Dr. Browne followed an appropriate standard of practice and enquired in greater depth and over a more prolonged period from the plaintiff, he would have obtained information which would have contradicted certain elements of the deceased's narrative. I shall deal with those issues separately.

The Previous Suicide Attempt
354. For the reasons stated above, I am satisfied that the plaintiff was unaware of the previous suicide attempt involving the hosepipe attached to the exhaust of the deceased's motor car.

355. Given the caution with which I feel I must approach the plaintiff's credibility in general, I am not satisfied that a discussion of the financial stressors complained of by the deceased would have been contradicted by the plaintiff.

356. Having regard to what I have said above, in a somewhat ironic twist, enquiry about the child sexual abuse allegations involving the plaintiff may well have resulted in him contradicting what his late wife had said.

357. Given the contradictory positions adopted by the plaintiff in evidence and in his Affidavit of Verification with regard to issues of alcohol misuse, I am not in a position to find one way or the other as to what the plaintiff would have said had he been asked about this issue.

358. Since the plaintiff had only recently departed the family home, it is unlikely that he would have contradicted any reference to marital breakdown.

359. Accordingly, I am satisfied that the fuller collateral enquiry would have revealed important information from the plaintiff with regard to the issues of the previous suicide attempt and the allegations of child sexual abuse.

360. It is probable that additional collateral enquiry from Stephen Cloonan would have raised, at the very least, question marks in relation to these matters. There is no evidence to suggest that he was aware of any of the other matters referred to in the notes taken by Dr. Browne. What is clear is that, insofar as a significant, potential source of information was there, Dr. Browne chose not to tap it.

361. In my view, Dr. Browne, having concluded his brief interview with the plaintiff, brought him into the interview room with Mrs. Cloonan to explain his treatment plan. I believe it probable that Dr. Browne presented what was, in effect, a *fait accompli* and left matters at that apart from giving Mr. Cloonan the piece of paper with the day ward details. This paper gives no indication that the phone number on it was intended for use in emergencies. If such was its intended importance as an integral part of a care plan, this fragment of paper falls well short of conveying that impression to any onlooker, including a family member.

362. The defendant did not engage further with Mr. and Mrs. Cloonan and refused to engage to any meaningful degree with Stephen Cloonan. He did this, it is probable, in part at least, because of his mistakenly restrictive views on the limits of patient confidentiality.

The Five Headings of Complaint against the Defendants

The Interview with the Plaintiff
363. Dr. Browne did conduct an interview with the plaintiff after he had consulted with Mrs. Cloonan.

364. Dr. Browne describes this as a short meeting lasting perhaps five to seven minutes. It was certainly short; however, the period of time is of secondary importance to the effort expended during it to enable Dr. Browne to discharge appropriately his functions and duties as a medical practitioner. His approach to engagement with the plaintiff and, beyond that, with other members of his patient's family, was informed by his views on the limits of his obligations regarding patient/doctor confidentiality. These self-imposed restraints would not have been adopted by any other medical practitioner of equal specialist or general status when dealing with a case of this difficulty and complexity. As a consequence, his chosen approach impeded him from having sufficient regard to the significant features of this complex case including the previous suicide attempt and its concealment.

365. Dr. Browne should have set aside his concerns about the limits of patient confidentiality in view of the specifics of this case. In so doing, he would be following general and approved medical practice and a course that would be, indeed, instructed at training level for doctors in his area of speciality. No medical practitioner of like specialisation and skill would have adopted the approach chosen by Dr. Browne in his encounters with the plaintiff and the family.

366. As a consequence of the foregoing, Dr. Browne shut himself off from a potentially rich harvest of information which could inform his view and guide him as to the appropriate course of treatment to be followed in response to the emergency with which he was confronted.

367. I am satisfied that Dr. Browne did speak to the plaintiff away from the immediate presence of Mrs. Cloonan. I accept his evidence that there was no separate interview room available and that this rendered more awkward the conduct of this necessary enquiry. No complaint is made, however, either by the plaintiff or the defendants that the available facilities impeded or were capable of interfering with Dr. Browne in carrying out his important enquiries. Further, I am satisfied that the interview was conducted at a sufficient remove from Mrs. Cloonan, in physical terms, to eliminate the possibility of any compromise in the process in which Dr. Browne was engaged with Mr. Cloonan. Having said that, as a matter of practicality, the facilities for the interview with the plaintiff were less than ideal. They would not have been conducive to a prolonged and searching interview.

368. The interview with the plaintiff was, therefore, inadequate to the task. It should have been much more thorough. In my view, the plaintiff probably was unaware of the previous suicide attempt but did remember the hosepipe incident which had created a *contretemps* between himself and his late wife. Dr. Browne confirmed in evidence that he made little more than passing reference to the hose and I am persuaded that it was to the hosepipe dispute that the plaintiff understood him to refer. The briefest, yet more searching enquiry, by Dr. Browne would have cleared up this misunderstanding and would have alerted him to the possibility of concealment.

369. As I have indicated above, it is my view, having observed the plaintiff give evidence on this matter on two separate occasions, that the plaintiff probably would have denied that he had been a victim of child sexual abuse. Again, this is an issue which a medical practitioner ought to have raised. It may have been a "false flag" but, to a medical practitioner acting appropriately, it would have spurred further enquiry or, at least, consideration.

370. I am not persuaded to find that enquiry into the issues of alcohol misuse and financial stressors would have raised question marks either as to veracity or significance.

371. On this aspect of the case, I am satisfied that the issues of the previous suicide attempt and child sexual abuse inflicted upon the plaintiff were not addressed, either appropriately or at all, by Dr. Browne by reason of his erroneous, self-imposed constraints on collateral enquiry.

372. Dr. Browne took no notes of his collateral meeting, such as it was, with the plaintiff. This fell below an acceptable standard. I do not propose to adjudicate on the issue of the "post-it" notes employed by Dr. Browne. Professor Casey did not offer any view on this. Professor Thakore did not agree with this practice. Written records should be made in the hospital notes. Professor Sheehan, on the other hand, said that Dr. Browne's note recording method was commonly engaged in busy accident and emergency departments.

The Previous Suicide Attempt
373. This was a significant "red flag" event. Both Professors Casey and Sheehan were agreed on this. Professor Thakore, on the other hand, seemed to dispute whether or not it was a suicide attempt since Mrs. Cloonan had not proceeded with the act. I am satisfied that a medical practitioner acting appropriately in the circumstances would have treated this prior incident as significant and would have engaged in further enquiry to verify what had occurred.

374. Dr. Browne noted the previous attempt in some detail and one may assume from this that he treated this as a matter of some significance. There is no note, however, by way of confirmation of any collateral enquiry with the plaintiff or anyone else. Since I have decided that there was a brief, passing reference to the hose and nothing more, Dr. Browne appears to have been satisfied with some recognition of a previous "incident". It is probable that he and the plaintiff were at cross-purposes as regards the relevance of the hose. Insofar as Dr. Browne was misinformed as a consequence of this recognition and wrongfully treated it as verifying collateral information, he was mistaken because of his curtailed and limited approach to collateral enquiry. He failed to enquire in sufficient depth with the plaintiff and failed to discuss the matter at all with Stephen Cloonan. I am satisfied that a medical practitioner acting appropriately in the circumstances would have engaged in a more detailed discussion and would have become alerted to the fact that, at a minimum, there was no collateral confirmation of the previous suicide attempt.

375. In those circumstances, and for the purpose of properly equipping himself to offer the appropriate medical advice to the patient, a medical practitioner acting appropriately would have sourced information further afield or, possibly, advice from a consulting

psychiatrist.

Failure to Consult the Patient's General Practitioner
376. At the outset, it should be observed that there was no evidence that there was any difficulty whatsoever in making contact with Dr. Brennan, Mrs. Cloonan's general practitioner. Thus, one may presume that such light that Dr. Brennan might shine upon the case and such advice that he might offer was readily available.

377. No diagnosis of depression was made by Dr. Browne. The Psychiatric Core Assessment did not make explicit provision for a diagnosis. Professor Casey said that it should. Professors Sheehan and Thakore said that a diagnosis was unnecessary and that the focus should be on addressing the immediate problem, with diagnosis coming later. I think, however, that it would be not unfair to Professor Sheehan to say that he conceded, to some extent, that a working diagnosis may be useful.

378. Dr. Browne says that he formed the view that the patient was not suffering from depression. She was, of course, greatly distressed and a combination of circumstances drove her to the impulsive act of overdosing on prescription and other medication which was consumed together with alcohol on the Sunday morning.

379. Professors Sheehan and Thakore were not satisfied from reading the various documents in the case that Mrs. Cloonan was suffering from a depressive illness. Were she to be so suffering, this would be an important factor in deciding on her treatment.

380. Professor Casey gave evidence that, given the state of his knowledge, Dr. Browne ought to have contacted the general practitioner and that his failure to do so was a grave error. Professor Thakore seemed to have it in his head that the general practitioner knew about Mrs. Cloonan's admission to hospital and it is not clear to me what assistance his evidence provides on this aspect. Professor Sheehan, while supporting Dr. Browne's handling of the case, acknowledged that, ideally, a medical practitioner in Dr. Browne's position would phone the general practitioner for collateral information. All of the expert witnesses agree that it is not necessary on all occasions to phone the family doctor. Professor Casey felt that it should have been done in this case as a matter of course. Professor Sheehan disagreed but said that the family doctor should be phoned where the doctor feels that there is a shortfall in the information available to him or her and that enquiry is necessary.

381. Professor Casey also attached significance to the prescription of anti-depressant medication although Professors Thakore and Sheehan did not agree with her that this added to the overall picture as they understood it. This, of itself, would not have prompted further enquiry.

382. Neither Professor Thakore nor Professor Sheehan were aware, when advising, of the particularly constricted view of patient confidentiality adopted by Dr. Browne. Both of them, in particular Professor Sheehan, effectively condemned this approach and said that, once one was dealing with suicide risk, the niceties of patient confidentiality were set to one side in the interests of patient treatment. This was a case of significant suicide risk.

383. Dr. Browne refused to discuss the details of the case with Stephen Cloonan. His collateral discussion with the plaintiff was, I have held, insufficient and wrongly shackled by an erroneous view of patient confidentiality. Dr. Browne clearly viewed this case as a suicide risk; however, he left himself in a position of possessing inadequate detail properly to assess the scope of that risk.

384. Had Dr. Browne pursued sufficiently his enquiries with the plaintiff, he would probably have discovered the plaintiff's lack of awareness of any previous suicide attempt and this should have raised a potential red flag at least warranting further enquiry. Further, other issues may well have been raised challenging the veracity of Mrs. Cloonan's account of matters.

385. At that point, a medical practitioner acting appropriately would have telephoned the patient's general practitioner with particular reference to the prior suicide attempt and its potential concealment. Enquiry may also have been made, at that point, of Stephen Cloonan who would probably have confirmed the plaintiff's information about Mrs. Cloonan's narrative.

386. Alternatively, a medical practitioner acting appropriately in Dr. Browne's position would regard the information gleaned from such a curtailed view of collateral enquiry as so limited as to require, as a matter of course, contact to be made with the general practitioner.

387. Had Dr. Brennan been telephoned, as he ought to have been, he would have confirmed that he was wholly unaware of any prior suicide attempt or any avowed intent to commit an act of self-harm. Further, he would have informed Dr. Browne of his diagnosis of depression some four weeks previously pointing, *inter alia*, to the fact that he had diagnosed medication for this. Thirdly, and importantly, he would have recommended that Mrs. Cloonan be treated as an in-patient.

388. In my view, Dr. Brennan's opinion ought to have weighed heavily with the doctor receiving it and would probably have influenced his view on treating Mrs. Cloonan.

Failure to Diagnose Depressive Illness
389. I am not persuaded that, of itself, the failure to diagnose depressive illness amounted to a breach of the duty of care in this instance. The question of whether or not a diagnosis should be made in circumstances such as these was a matter of debate between eminent psychiatrists. Professor Casey feels that a diagnosis should have been made. Professors Sheehan and Thakore disagreed and felt that the emphasis should be on addressing the immediate medical issues and that a diagnosis could follow at a later point, even as late as discharge from hospital. Dr. Browne was of the view that he did not want to guide the hand of the team who might be treating Mrs. Cloonan as a day patient. Professor Sheehan, perhaps, conceded that a working diagnosis might be appropriate if only to direct the course of treatment.

390. I am not persuaded that Dr. Browne's failure to diagnose depression was, in itself, an act of negligence. I will leave the matter of the appropriateness or otherwise of such a diagnosis to debate in another forum.

391. However, what is not factored into what occurred in the hospital is Dr. Brennan's diagnosis of, and indeed treatment of, depression. With or without a specific provision for diagnosis in the Psychiatric Core Assessment, this fact, when ascertained, would have, or ought to have weighed heavily in devising the appropriate care plan for Mrs. Cloonan.

Failure to Admit the Deceased as an In-patient
392. There is no dispute between the parties that the range of treatments material to this case were three in number. Firstly, compulsory detention, or sectioning, under the Mental Health Act. Secondly, in-patient treatment and care and, thirdly, day care as was, ultimately, offered to Mrs. Cloonan. The issue of involuntary in-patient treatment was raised for the first time during Professor

Casey's evidence. She had not previously suggested that course of treatment in her reports. Professors Thakore and Sheehan were vigorous in opposing the idea. Mrs. Cloonan, by any yardstick, did not satisfy the criteria of the Mental Health Act, 2001 and to detain her in the circumstances would have constituted a serious breach of her human rights. They argued that there was no evidence to support her involuntary detention. She was not an immediate threat to herself or to anyone else.

393. On this point, whilst it may have been appropriate to consider involuntary admission, as one might consider any available range of options in a course of treatment, in my view there is no evidence that the issue would have arisen. This was a case of significant suicide risk and it was necessary that this risk be accommodated in the advice and treatment of Mrs. Cloonan. Both the risk and treatment should be guided by the principle of the least restrictive option.

394. Dr. Browne says and notes that he offered in-patient treatment to Mrs. Cloonan and that she refused it, preferring the day ward treatment which he proposed. Mrs. Cloonan's attitude is not surprising. There remains a stigma attached to mental illness in this country and, not least, to hospital admission for treatment of same.

395. Having concluded his discussion with Mrs. Cloonan, I believe that Dr. Browne had probably made up his mind that day ward treatment was the appropriate option. He did this on the basis of his interview with Mrs. Cloonan alone and his view of her. His evidence of his brief interview with the plaintiff suggests to me that the plaintiff was being brought along to meet with his wife and the doctor to discuss the plan already decided upon. Whether through physical or mental exhaustion or for whatever reason, I do not believe that the plaintiff demurred from what he was told. As we know, Dr. Browne did not discuss the treatment modality with Stephen Cloonan. I am satisfied, however, that he was aware that Stephen Cloonan was upset and concerned that his mother was coming home and remonstrated with him to this effect. Dr. Browne paid no heed to this, constrained by his erroneous views on patient confidentiality and by the fact that the decision had been made as to the course of treatment

396. In my view, a medical practitioner in Dr. Browne's situation would, after he had discussed matters with Mr. Cloonan, have telephoned Dr. Brennan for collateral information. The doctor would then have been informed of Dr. Brennan's views including his opinion that Mrs. Cloonan should be brought into hospital as an inpatient.

397. In addition to the foregoing and either before or after phoning Dr. Brennan, I believe that the doctor would have discussed the matter with Stephen Cloonan and that this would have reinforced the view that Mrs. Cloonan be admitted as an in-patient.

398. In my view, a medical practitioner acting appropriately and having been informed by the views of Dr. Brennan and Stephen Cloonan and, probably of the plaintiff as well, would have engaged in further advice and discussion with Mrs. Cloonan, probably in the presence of her husband in the interview room and would have advocated in-patient treatment for a number of days.

399. Professor Casey gave evidence that the combined effect of the doctor and the family can be a persuasive force in pointing a patient towards voluntarily accepting in-patient treatment in these circumstances. In the particular circumstances of this case, Dr. Brennan's advice could have been added to the corps of persuasion. In those circumstances, I feel it probable that Mrs. Cloonan would have agreed to remain as an in-patient.

If he had, given the additional information that would have been harvested from discussing the matter in greater detail with the plaintiff and Stephen Cloonan and armed with the information and views and, indeed, a diagnosis of depression from Dr. Brennan, I could not see circumstances in which a consultant psychiatrist would disagree with Mrs. Cloonan becoming a voluntary in-patient.

Failure to Contact the Consultant on Call

400. A Consultant Psychiatrist was available on call. Given the complexities of this case, Dr. Browne should have made contact and discussed it before Mrs. Cloonan was released from hospital for this reason alone. I prefer the views of Professor Casey in this regard. Alternatively, given the incomplete state of the collateral information, a medical practitioner, acting appropriately, would probably have taken this course at some point.

401. An extensive debate arose during the course of the case and, in particular, between Mr. Hanratty S.C. and Professor Casey on the question of the unpredictability of suicide. It is not necessary to engage to any great degree with this debate. I do not think there was any serious dispute between Professor Casey and Professor Sheehan that, notwithstanding the unpredictability of suicide, there are risk factors and indicators that one must bear in mind in adopting a course of treatment. Judged statistically, predictors can be immensely unreliable. However, risk assessment is a useful tool. Professor Thakore viewed such assessments differently but his views appeared out of kilter with his colleagues.

402. Mrs. Cloonan was at significant risk of self-harm. Even assuming Dr. Browne had taken all necessary steps to meet the necessary standard of care (which he did not) failing to offer in-patient care would have been negligent.

403. Had Mrs. Cloonan been admitted as an in-patient, she would then have been in a secure environment and under the watchful eye of the hospital staff. Immediate attention would have been given to her treatment and this would have carried on over the next number of days. Past the point of care, left unaided and alone, she took her own life. It was probable that she would have survived.

404. Further, I accept Professor Casey's view that appropriate treatment would have assisted Mrs. Cloonan back towards reasonable mental health. The ongoing stressors of the criminal trial involving her brother would have been addressed more urgently given the fact that she was a lady who now had experienced two previous significant self-harm events. Whereas I accept the evidence that suicide can be unpredictable, it is not inevitable. One is entitled to take the view that, with the appropriate medical care and the undoubted love and care of her family, Mrs. Cloonan would have learned to accommodate the difficulties which she experienced with regard to the child sexual abuse issues and her marriage. There is no evidence to suggest that Mrs. Cloonan would have been impervious to treatment and it is appropriate to take a cautiously optimistic view as to what her future mental health and wellbeing would be.

405. In conclusion and for the reasons outlined, I am satisfied that Mrs. Cloonan was not afforded an appropriate standard of medical care. This state of affairs was brought about for the reasons stated above including, *inter alia*, unwarranted reliance by Dr. Browne on his interview with the deceased and an over-optimistic view of the risk of her further self-harming resulting from the inadequacy, indeed near absence, of collateral enquiries conducted by him. This was a consequence, substantially, of his erroneous views on the limits of doctor/patient confidentiality which were contrary to generally accepted practice. Further, I am persuaded that no medical practitioner of like specialisation and skill would have adopted a similar view.

406. A medical practitioner, appropriately informed, as a matter of probability, would have persuaded Mrs. Cloonan to remain as an in-patient in the hospital. In so doing, he would have had the potent support of Mrs. Cloonan's husband and son and, further, Dr.

Brennan, her personal physician. She would then have been admitted to a regime which would have provided supervision, monitoring and appropriate treatment during this crucial early period as identified by Professor Casey. This would have been informed, *inter alia*, by the fact of a recent, prior diagnosis and medical treatment of depression.

407. Had this course been adopted, in my view it is probable that she would have not taken her own life in the early hours of the morning of 19th April, 2011. Accordingly, I am satisfied that the plaintiff has made out a case in negligence against the defendants. The plaintiff must, therefore, succeed on the issue of liability.

Damages

408. Little time was spent during the course of the hearing on the issue of damages. Given the intensity of the dispute between the parties on the issue of liability this is scarcely surprising. Apart from such reference as was made to material matters in the course of the evidence I was given copies of two reports prepared by Actuaries and a list of agreed special damage.

409. The actuaries' reports were compiled respectively on behalf of both parties, the plaintiff's being dated 7th May, 2015 and the defendant's 6th November, 2017. When the plaintiff's actuary, Mr. John Byrne FIA prepared his report he felt uncertain as to the allowance to be made for possible reduction in the assumed future real rate of investment return due to a pending appeal against the decision of Cross J. in *Russell v. Heath Service Executive* [2014] IEHC 590. The report of Ms. Maura Carter FIA FSAI, the more current of the two reports and prepared at the behest of the defendants, post-dates the appeal in that case and applies the figure of 1.5% as the real rate of return per annum above inflation. I propose to adopt that report for the purposes of this judgment because it has the advantage of being the more recent of the two and I accept as reasonable the assumptions it makes for the purpose of assisting me in assessment of damages.

410. The plaintiff's claim is made on his behalf and on behalf of the dependants of the deceased within the meaning of a Civil Liability Act, 1961. The dependents within the meaning of that Act are:

(i) The plaintiff, Angelo Cloonan, born on 13th August, 1964.

(ii) Stephen Cloonan, son of the deceased, born on 24th October, 1987.

(iii) Stephanie Cloonan, daughter of the deceased, born on 18th April, 1989.

(iv) Jennifer Cloonan, daughter of the deceased, born on 4th July, 1991.

411. Although it seems that all of the above named dependants were residing in the family home at the time of Mrs. Cloonan's death, some seven years have elapsed since these unhappy events and, as far as I can ascertain, all the children have since moved away. In any event, there was no evidence of any financial dependency in being when Mrs. Cloonan died. No actual financial loss was itemised in oral evidence. All three children have long since attained the age of 25 years which would seem to be an appropriate age to adopt for presumed cessation of dependency in the absence of evidence to the contrary. Ms. Carter assumed a notational dependency for Jennifer is. In the absence of specific evidence, I propose to disregard it.

412. The heads of damages claimed are:

(i) Damages for mental distress under the provisions of the Civil Liability Act, 1961 (as amended).

(ii) Damages for loss of consortium.

(iii) Damages for financial loss.

(iv) Special damage as specified and agreed between the parties over and above other items of financial loss.

413. Dealing with first damages for mental distress, I note that Mrs. Cloonan died prior to 11th January, 2014 and the limit of damages recoverable by the plaintiff and the dependants of the deceased is €25,394.76. In the absence of any application which might be made at the conclusion of this judgment I propose to award this amount in full under this heading and direct that it be disbursed as to 50% to the plaintiff and the balance to be distributed in equal shares between the three children.

414. Turning to the question of damages for loss of consortium, there is both a general and a special damage aspect to this claim. As regards the general damages, I have regard to the view of O'Flaherty J. as expressed in *McKinley v. the Minister for Finance* [1992] 2 I.R. 333 as clarified by Geoghegan J. in *Coppinger v. Waterford County Council* [1996] 2 ILRM 427. I also have regard to the observations of Carney J. in *McKinley v. Minister for Finance* (No. 2) [1997] 2 I.R. 176. Under this heading, I propose to award the plaintiff damages in the sum of €25,000.

415. Turning to the more general question of financial loss, I do not propose to award any sum to the children (see my observations above).

416. Since the report of Ms. Carter is more up to date than the report from Mr. Brennan, which I was presented I propose to use that for reference. Excluding the allowance made for Jennifer, I adopt the valuation of the financial loss therein set out as an appropriate guideline. Further, through no fault of Mr. Byrne, her figures would appear to be more up to date. For the purpose of assessing the extent of the financial loss to the plaintiff and before deductions made pursuant to *Reddy v. Bates* [1983] I.R. 141, I note and adopt her valuation of the net claim as being €362,750.

417. In ordinary terms, one approaches these figures as a guideline only. One must then take account of the exigencies of everyday life such as the impact of ill health, and unemployment and so forth. In the instant case, however, the question of mental health and previous significant self-harm must be treated as particularly significant. This could have impacted considerable upon the late Mrs. Cloonan's life had she survived and upon her employment. Against this, one takes account of the fact that she had relatively secure employment in a job which it appears she enjoyed.

418. The figure arrived at by the actuary also assumes normal longevity. Given the evidence of the unpredictability of suicide and the fact that, even on the basis that she would have "weathered the storm" had she been admitted to hospital and treated and observed appropriately, the future outlook could not have been regarded as certain.

419. In the circumstances, there should be a substantial discount to accommodate all of the material factors in this case. I would

propose to measure the net loss to the plaintiff in the sum of €200,000.

420. The sum for special damage is agreed as €12,826.05. This sum represents the agreed items of funeral and related expenses.

421. Accordingly, the total sum awarded for damages in this case will be €263,220.81.