THE COURT OF APPEAL

Neutral Citation Number: [2019] IECA 4

Appeal Number: 2016 472

Peart J.
Whelan J.
McGovern J.

BETWEEN:

M.C.

APPLICANT/APPELLANT

- AND -

CLINICAL DIRECTOR - CENTRAL MENTAL HOSPITAL

RESPONDENT

- AND -

MENTAL HEALTH (CRIMINAL LAW) REVIEW BOARD

NOTICE PARTY

JUDGMENT OF MR. JUSTICE MICHAEL PEART DELIVERED ON THE 18TH DAY OF JANUARY 2019

1. This is an appeal against an order of the High Court (Eagar J.) dated the 25th July 2016 refusing certain reliefs by way of judicial review for reasons explained in a written judgment delivered on the 20th June 2016 ([2016] IEHC 341).

2. The need for the various declarations which the appellant sought in these proceedings no longer exists in the light of subsequent events. However, she submits that the proceedings are not moot as she maintains a claim for damages for breach of her constitutional rights resulting from the breach of statutory duty by the respondent alleged by her.

3. There is a tragic background to the issues that arise. M.C is a married woman, now aged 44 years. On the 20th January 2006 she was found guilty but insane of killing her infant son and of attempting to drown her three-year old daughter on the 29th July 2002 whereupon she was committed to the Central Mental Hospital ("CMH") with a diagnosis of schizophrenia.

4. Upon the enactment of the Criminal Law (Insanity) Act, 2006 ("the Act"), M.C. was reclassified as a person found not guilty by reason of insanity. Thereafter, while detained at the CMH she underwent 15 periodic reviews by the Mental Health (Criminal Law) Review Board ("the Board") pursuant to s. 13 of the Act.

5. While at the CMH, M.C. was under the care of Dr Helen O'Neill, Consultant Forensic Psychiatrist. M.C. had responded very well to the treatment she received and was able to avail of periods of temporary release from the CMH. According to Dr O'Neill's affidavit sworn on the 12th March 2015, by mid-2012 M.C. was able to spend two overnights per week in a named supervised and supported hostel in the community where she had previously resided, another two nights in her mother's house, and three nights in her own home. This régime was put in place following a case conference held on the 21st May 2012. At that point Dr O'Neill considered that M.C. was engaging fully with therapeutic services available locally, that she was making positive and sustained progress, that her mental state was stable, and that her schizophrenia remained in remission.

6. As stated in the same affidavit, Dr O'Neill was of the opinion that the applicant no longer required continued care, treatment or rehabilitation in conditions of therapeutic security. M.C. had expressed a wish to participate more fully in the care of her children. She had remained stable for some years, and had participated fully in her treatment and care plan such that Dr O'Neill felt able to recommend that M.C. should not be the subject of a renewed detention order under the 2006 Act, or an absolute discharge under s. 13, but rather should be conditionally discharged under s. 13A of the Act. She recommended certain specific conditions that should be contained in a conditional discharge order so that M.C. would continue to be supported in her ongoing recovery and her gradual transition into community living.

7. On the 26th July 2012 the Board made a conditional discharge order pursuant to s. 13A(1) of the Act which directed that M.C. be conditionally discharged on or before the 29th August 2012, subject to the various conditions set forth in the order. The conditions relevant to the present appeal are those relating to M.C.'s place of residence. Those conditions were stated as follows:

> "1.1 [M.C.] must comply with the conditions laid down by the National Forensic Mental Health Service Treating Team in relation to her residing at any location and any change of location.
>
> 1.2 Place of residence will be determined by the legally responsible Consultant Psychiatrist, Dr. Helen O'Neill or, in her absence, another Consultant Psychiatrist nominated by the Clinical Director of the National Forensic Mental Health Service, in consultation with the local Consultant Psychiatrist and Community Mental Health Team. At all times the place of residence will be discussed with [M.C.] and any decision in relation to the place of residence will be based on clinical reasons and, insofar as practicable, by agreement with [M.C.]."

8. Thereafter it was agreed that M.C. would reside in her family home with her husband and her children. Nevertheless, Dr O'Neill had concerns that there continued to be a risk of domestic violence and that this had the capacity to destabilise the great progress that

M.C. had made, and for that reason it was agreed also as a condition of her discharge that M.C. would inform certain identified persons in the event that certain events occurred. M.C. complied with these reporting conditions.

9. Dr O'Neill states in her affidavit that there was an acute incident in June 2013 which caused her to direct M.C. to change her residence from her family home to that of her mother. In addition, Dr O'Neill instructed M.C. that she was not to spend time alone with her husband. This decision was based on Dr O'Neill's clinical concern about the potential for an acute psychotic relapse associated with the psychosocial stress of marital disharmony. The said incident had involved verbal abuse by her husband, and he had also uttered verbal threats to one of their sons. There had been an earlier incident in January 2013 when M.C. had suffered an acute relapse of her psychotic illness. She was admitted to hospital, and discharged to her home in April 2013.

10. In the autumn of 2013, M.C. applied to the Board for either an absolute discharge from the CMH, or to have the conditions attached to her conditional discharge varied in such a way as to enable her alone to determine where she should reside, without reference to Dr O'Neill or other professionals. A multi-disciplinary meeting was convened on the 9th October 2013 to consider M.C.'s request for an absolute discharge/variation of her residence conditions, at which the risks and potential outcomes associated with M.C. residing in her family home were identified and were considered to be high. Those risks and possible outcomes were (i) suicide by M.C., (ii) serious or fatal injury to M.C., and (iii) serious or fatal injury to her husband.

11. A meeting of the Board was convened to consider this application on the 14th November 2013. The respondent herein, Prof. Kennedy, attended this meeting along with other professionals. Dr O'Neill advised the Board that she was of the opinion that conditions 1.1 and 1.2 attached to the conditional discharge order already in place were necessary and should not be removed. Prof. Kennedy in his affidavit has stated that the proposed variation of the residence conditions "was a variation of clinical and practical significance", and he expressed his agreement with the clinical opinion given by Dr O'Neill in relation to the residence conditions.

12. Despite the serious clinical reservations expressed by Dr O'Neill and Prof. Kennedy, and in the absence of any other professional opinion in favour of acceding to the application for a variation being made by M.C., the Board was nonetheless satisfied that a variation order should be made. However, before the variation order could be signed by the Board, it was necessary that certain arrangements be put in place by the Clinical Director of the CMH (Prof. Kennedy) in compliance with the provisions of s. 13A of the Act. The Board wrote to the Clinical Director for this purpose by letter dated the 13th December 2013 in which it sought his written confirmation that the arrangements described in that letter had been made. The terms of the letter were as follows:

> "Dear Professor Kennedy,
>
> Please find enclosed the decision of the Mental Health (Criminal Law) Review Board in relation to a hearing held on 14 November 2013 (resumed on 21 November 2013) to consider an application to vary the conditions of discharge of [M.C.]. Enclosed also is a draft Varied Conditional Discharge Order in relation to [M.C.].
>
> Prior to making a final Varied Conditional Discharge Order, the Board requests your written confirmation that such arrangements as appear necessary to you have been made to:
>
> (a) facilitate compliance by the patient with the conditions of the enclosed order,
>
> (b) supervise the patient, and
>
> (c) provide for the return of the patient to the Central Mental Hospital in the event that she is in material breach of the conditional discharge order.
>
> Yours sincerely (etc.)"

13. It must be recalled that at the meeting of the Board at which M.C.'s application to vary the conditions of her conditional discharge was considered, both Prof. Kennedy and Dr O'Neill expressed their expert clinical opinion that it would not be appropriate to permit M.C. to make her own decisions as to where she should reside. Given the importance which these views have to the issues that arise on this appeal, I will set out the entire text of Prof. Kennedy's reply dated the 19th December 2013 to the Board's letter:

> "Dear Ms. Hayes [Secretary to the Board],
>
> I have carefully read the varied conditional discharge order.
>
> (a) I regret that I am not able to make the arrangements necessary to facilitate compliance by [M.C.] with the conditions of the order enclosed by you with your letter of the 13th December 2013.
>
> (b) I regret that I am not able to make arrangements to supervise [M.C.] according to these conditions.
>
> (c) I regret that I would not be able to provide for the return of [M.C.] to the Central Mental Hospital in the event that she is in material breach of the conditional discharge order because the variation does not appear to me to allow for circumstances when a breach would be directly relevant to risk to herself and others.
>
> By way of explanation, I note that you are proposing to vary conditions 1.1 and 1.2. I note that this is contrary to the advice of the treating Consultant Psychiatrist, Dr. Helen O'Neill. I am in agreement with Dr. O'Neill about this. All risk assessments indicate that [M.C.] would be vulnerable if living under the same roof as her husband. Living with her husband has been the source of high expressed emotion leading to relapses of her illness and in the past this has been directly relevant to risk. Risks at present are that [M.C.] would harm herself or would harm her husband. I note that in the past she has made a serious suicide attempt and I note also that in the past she has stabbed her husband in the back.
>
> Condition 1.1 reads "[M.C.] will liaise with the National Forensic Mental Health Services treating team in relation to her accommodation and keep them informed of her domestic and social situation in accordance with the conditions of her discharge. For the time being she should reside at [address specified]".

It is difficult to see how this would ever form a useful "condition". For example if [M.C.] informed us as required that her domestic and social situation while living with her husband was much worse involving verbal abuse, physical violence, heavy drinking, she would in fact be complying with the condition and not in breach of any condition. Allowing her to live at [specified address] would in fact expose her to these risks and the consequential problems arising from it.

Condition 1.2 says "… place of residence will be determined by [M.C.] after consultation with her Consultant Psychiatrist…". This essentially gives [M.C.] the status of an absolutely discharged patient. It does not represent a condition that would either ameliorate risk or allow an intervention.

Might I suggest that there are two possibilities which fall to be decided by the Board.

(a) [M.C.] remains mentally incapacitated and in asking to live at home with her husband, she is proposing to make a choice which is the product of impaired mental capacities. I would respectfully suggest to the Mental Health Review Board that it would be unsafe to comply with her request and if it is the view of the Board that her request is the product of impaired mental capacities then a duty of care would oblige the Mental Health Review Board not to comply with the request.

(b) If it is the view of the Mental Health Review Board that [M.C.]'s request, though obviously unwise is nonetheless the product of intact mental capacities, then it is time the Mental Health Review Board granted her an absolute discharge.

Should the Mental Health Review Board grant [M.C.] an absolute discharge, I am assured that Dr. Helen O'Neill and her team would continue to offer [M.C.] voluntary contact and would continue to work with the catchment area mental health team in [town specified].

Yours sincerely [etc.]"

14. There was further correspondence between the Board and the Clinical Director, as well as with M.C.'s solicitors. The Board considered the position taken by Prof. Kennedy, and took legal advice. By letter dated the 6th January 2014, the Board wrote to M.C.'s solicitor to inform her that having regard to the fact that the Clinical Director was unable to make such arrangements as appear necessary to him with regard to the proposed varied Conditional Discharge Order, the Board was unable to proceed with the variation of conditions, and therefore that the Conditional Discharge Order remained in place.

15. Having taken its own legal advice in the meantime, the Board wrote to Prof. Kennedy by letter dated the 3rd February 2014. The Board stated that, while appreciating that Prof. O'Neill disagreed with the Board's decision, almost every decision relating to conditional discharge involved a balancing of risk against the rights of, and benefits to, the patient. The Board went on to state that it did not understand the particular difficulties identified by Prof. O'Neill. The Board then referred to the provisions of s. 13A(2) of the Act which provides:

"(2) The Review Board shall not make a conditional discharge order in respect of a patient until it is satisfied that such arrangements as appear necessary to the clinical director of the designated centre concerned have been made in respect of the patient, and for that purpose, the clinical director concerned shall make such arrangements as may be necessary for –

(a) facilitating compliance by the patient who is the subject of the proposed order with the conditions of the order,

(b) the supervision of the patient, and

(c) providing for the return of the patient to the designated centre under section 13B in the event that he or she is in material breach of his or her conditional discharge order." [Emphasis provided]

16. Having set out the provisions of s. 13A(2), the Board's letter continued:

"By reason of this provision the Board considers that you, as clinical director, are under an obligation primarily to [M.C.] to make the necessary arrangements under the sub- section. In the light of these provisions the Board would ask you to reconsider your position.

With regard to the possibilities set out in your letter [dated 19th December 2013] the Board would comment:–

(a) In the view of the Board there is no question of [M.C.]'s request to live at home with her husband being "the product of impaired mental capacities", nor did her treating psychiatrist ever make any such suggestion.

(b) The question of granting an unconditional discharge does not arise at this time as [M.C.] has not sought such a discharge."

17. Prof. Kennedy responded by letter dated the 4th March 2014. He expressed his regret that he was unable to make the arrangements requested by the Board in its earlier letter dated the 13th December 2013. He then outlined the conditions to which M.C. was subject at that time, stating:

"Conditions 1.1 and 1.2 as presently in place allow the consultant psychiatrist, Dr. Helen O'Neill, to allow [M.C.] to spend time in the family home including overnights but also empowers Dr. O'Neill to limit this in accordance with the necessity to reduce [M.C.]'s exposure to high expressed emotion including the forms of verbal behaviour which have in the past caused her to relapse. The current conditions enable Dr. O'Neill and team to act flexibly in response to [M.C.]'s own requests and her confidential disclosures to the team.

Varying the conditions as you suggest at draft 1.1 and 1.2 would oblige her to reside at [family home] or would allow her to reside anywhere she chooses. This would mean that should she suffer domestic stresses of any sort, including those

known to cause her to relapse, she would not be in material breach by remaining there and we would have no power to protect her by removing her to a more appropriate place of residence in the community or by recalling her. We would be obliged to wait until [M.C.] showed signs of relapse or had breached some other condition.

Condition 2.9 would not be beneficial under these circumstances. I should point out also that neither I nor my colleagues have any power to oblige the local team to admit [M.C.] to the local psychiatric service and it is unlikely that a bed would be available urgently when required in the local psychiatric service. I assume that the [Board] would not be available to respond to urgent requests to vary the conditions.

For all these reasons I regret that I am not able to facilitate compliance by the patient with the varied conditions 1.1 and 1.2 of the draft order since they would in my view be impossible to use for the benefit of [M.C.].

The conditions as they are actually allow [M.C.] to spend substantial periods at home, as she wishes. Might I respectfully urge you once again to leave the conditions as they are. They have been shown to be beneficial.

In the alternative, based on your own view that [M.C.] is making a competent decision and your own view that she is able to withstand the obvious stresses that would follow from it, then it is open to [M.C.] to apply for an absolute discharge. As before, should the Board make an order for absolute discharge, both Dr O'Neill's team and the local community mental health team would of course continue to offer [M.C.] voluntary follow-up, care and treatment."

18. With that letter, Prof. Kennedy enclosed a letter to him from Dr O'Neill dated the 20th February 2014 in which she updated him in relation to M.C.'s progress since her conditional discharge on the 28th August 2012, including that she was compliant with the conditions attaching to that conditional discharge. She then referred to the Board's letter to Prof. Kennedy dated the 13th December 2013 requesting his confirmation as to the arrangements necessary for a variation of the conditions. Dr O'Neill maintained her objection to the variation of the residence condition which would permit M.C. alone to make the decision as to where she lives. In that regard, Dr O'Neill stated:

"There is consensus clinical opinion that the main potential destabiliser to [M.C.]'s mental state would be marital/domestic dysharmony (sic) and violence. This opinion is based on the background history to date and also on structured professional judgement tools regarding domestic and general violence (HCR-20, S-RAMM, and the SARA). A relapse of her mental illness would also increase the risk of violence to her husband.

The National Forensic Service team has repeatedly emphasised these risks to [M.C.], but she has made the informed choice to live with her husband, on the basis that he is no longer drinking alcohol, and that she will seek assistance if there is any significant degree of disharmony (sic). She has in fact, acted on the latter on three occasions since January 2012. She has denied any physical violence by her husband or herself.

It remains my opinion, as [M.C.]'s legally responsible consultant psychiatrist, that I should retain the authority to determine her place of residence, thus empowered to request that [M.C.] move to alternative accommodation, if the assessment of risk warrants this.

At all times, the place of residence would be discussed with [M.C.] and any decision in relation to her place of residence, would be based on clinical reasons and, insofar as practical, by agreement with [M.C.].

If conditions 1.1 and 1.2 are revoked by the [Board], I am of the opinion that I would be unable to continue to take legal responsibility in this case, under the Criminal Law (Insanity) Act 2010. I would however, be willing to provide the support of the National Forensic Service to the Community Mental Health Team in Mayo, on a voluntary basis.

Yours sincerely … "

19. The Board responded by letter dated the 18th March 2014, stating:

"The Board acknowledges that there is a fundamental and legitimate disagreement in relation to the management of risk in this case. However, your letter and Dr O'Neill's letter do not address the legal issue which the Board raised in its letter of 3 February. The Board is of the view that the Clinical Director is under an obligation to make necessary arrangements to implement the Board's order in relation to [M.C.] under the wording of section 13A(2) of the Criminal Law (Insanity) Act 2006, as amended:

"the clinical director concerned shall make such arrangements as may be necessary …" (emphasis in original).

20. Ultimately, the Board wrote to the appellant's solicitor by letter dated the 3rd June 2014. Having stated that the Board remained prepared to vary the conditions of [M.C.]'s discharge "if it is entitled to do so", this letter went on to state:

"However, despite its efforts, the Board has still not received confirmation from the Clinical Director that such arrangements as appear necessary to him have been made in relation to the proposed variations. Having regard to the provisions of section 13A(2) of the Criminal Law (Insanity) Act 2006, as amended, in the circumstances it appears to the Board that it is not empowered to order the proposed variations in the absence of such confirmation.

The Board has today again written to the Clinical Director requesting his confirmation, and I enclose herewith a copy of this request."

21. This *impasse* between the Board and the Clinical Director remained unresolved, resulting in the appellant seeking leave of the High Court to commence judicial review proceedings, with the Clinical Director being named as respondent, and the Board named as notice party. Leave was granted by order dated the 30th July 2014 (Baker J.), to seek certain declarations, including:

"(i) A Declaration … that the Respondent's refusal to make such arrangements as are necessary for facilitating compliance by the Applicant with the conditions of a Conditional Discharge Order the subject of the Notice Party's decision at a hearing held on 14 November 2013 (and resumed on 21 November 2013), is unlawful, unreasonable and in breach of the provisions of the Criminal Law (Insanity) Act 2006 section 13A as inserted by the Criminal Law (Insanity) Act 2010 section 8;

(ii) A Declaration … that the Respondent is under a statutory, non-discretionary duty to facilitate compliance by the Applicant with the conditions of the Order as aforesaid."

22. Those two declarations capture the essence of the appellant's complaint. However, other declaratory reliefs were sought, as well as an order of certiorari to quash the Clinical Director's refusal, and an order of mandamus directing him to make the necessary arrangements. In addition, the appellant sought "damages for breach of the applicant's constitutional and Convention rights".

23. It is accepted on all sides that the primary reliefs by way of orders of *certiorari* and *mandamus* are moot, given that shortly after the commencement of these proceedings, the Board considered an application by the applicant for an unconditional discharge on the 7th August 2014, and made such an order on the 14th December 2014. In addition, the appellant accepts that for some weeks prior to the commencement of the judicial review proceedings on the 30th July 2014, she had been residing at her residence of choice notwithstanding the conditions that attached to the August 2012 conditional discharge order.

24. However, the appellant submits to this Court that her appeal herein is not moot, because for a relatively short period of time she was prevented from residing with her husband and children, because of what she contends was a breach of statutory duty on the part of the Clinical Director, and that her claim for damages for breach of constitutional and Convention rights remains, notwithstanding that the primary orders are no longer being pursued.

25. I will come to the question of mootness in due course, but I should emphasise at this point that while the appellant maintains that the Clinical Director was in breach of his statutory duty by refusing to confirm that the arrangements necessary for the implementation of the Board's decision to vary the conditions were in place, the appellant makes no claim for damages for breach of statutory duty as such. Her claim for damages is confined to an alleged breach of her constitutional rights to privacy and family life under Article 41 and/or Article 40.3 of the Constitution, and/or her rights under Article 8 of the European Convention on Human Rights.

26. I should also state in this regard that the appellant makes no allegation of *mala fides* or misfeasance in public office against the Clinical Director.

The High Court judgment

27. In his judgment, the trial judge gave a summary of the background to the proceedings. He referred to the Board's letter to M.C.'s solicitors dated the 3rd June 2014 which had stated its willingness to vary the conditions as to residence, and its inability to do so in the absence of the confirmations sought from the Clinical Director. The trial judge went on at para. 21 to note that, in the weeks leading up to the leave application to the High Court on the 30th July 2014, M.C. had in fact been residing in the family home with her husband and family on a full time basis despite the conditions attaching to the August 2012 discharge order which was still extant. He noted also that on that ex parte leave application the High Court had been informed that it was M.C.'s intention to apply to the Board for an unconditional discharge.

28. The trial judge referred to the fact that M.C.'s application for unconditional discharge came before the Board for consideration on the 4th August 2014, and that on the 14th December 2014 an unconditional discharge order was made.

29. The trial judge went on to consider the question of mootness, and some authorities to which he was referred, including the judgment of Murray C.J. in *Irwin v. Deasy* [2010] IESC 35 who stated:

> "The mootness doctrine was applied by the courts to restrain parties from seeking advisory opinions on abstract, hypothetical or academic questions of law by requiring the existence of a live controversy between the parties to the case in order for the issue to be justiciable."

30. Having then referred to the appellant's submissions that three issues remained live, namely breach of statutory duty by the clinical director, breach of the appellant's constitutional/Convention rights, and damages, the trial judge expressed his conclusions as follows at paras. 30 – 34 of his judgment:

> "30. There is, in the Court's view, a duty upon the Review Board to respond to the concerns raised by Dr. O'Neill and the Clinical Director. A public body established by statute should give reasons that respond to issues raised by experienced professionals. This Court notes that Dr O'Neill and the Clinical Director raised such concerns in light of their duty to the general public and to society to assess the appropriateness of the terms of the conditional discharge of [M.C.]. This Court is conscious of the facts of the case, including that in June, 2013 [M.C.]'s husband had been verbally abusive and threatened physical violence to their son and which resulted in her contacting the Gardaí, and as a result of this, she was removed by Dr. O'Neill from the family home. It was also noted that [M.C.] had a psychotic relapse in February of that year.
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> 31. In the absence of detailed responses to these issues, the acknowledgement that the Clinical Director was entitled to disagree with the decision of the Board, and the Review Board requesting the Clinical Director to reconsider his position in correspondence put before the Court, I am satisfied that there has not been a breach of statutory duty.
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> 32. For these reasons I also believe that the respondent's refusal does not violate the applicant's rights pursuant to the provisions of Bunreacht na hÉireann, Article 41 and/or Article 40.3 and/or the provisions of the European Convention on Human Rights and Fundamental Freedoms, 1950, Article 8.
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> 33. In relation to the question of damages, this Court is of the view that having regard to the background issues, of which little has been explained by counsel for the applicant, regarding the killing of her infant son, this Court will not grant damages where the respondent had acted in the interest of the applicant and the public at large.
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> 34. In those circumstances, this Court considers that the issues remaining in the case are moot, but the Court has taken the opportunity to identify its view on these issues."

31. While I would agree with the trial judge's overall conclusions, I would, respectfully, reach that same terminus by travelling a somewhat different route. The views that he expressed on those issues could therefore be said to be *obiter*.

32. Firstly, I would regard what the trial judge stated at para. 30 of his judgment, as to the duty of the Review Board to give reasons that respond to the concerns raised by Prof. O'Neill and Dr O'Neill, as an obiter comment, as that question does not arise in these proceedings. The focus of these proceedings was on whether or not the Clinical Director was in breach of his statutory obligations by

failing to provide the confirmation sought by the Board as to necessary arrangements being in place so that the Board could sign off on the variation order that it had decided should be made.

33. I would also refer to para. 4 of the judgment where the trial judge stated:

> "It is also noted that no information was provided to this Court in relation to the reasons for the applicant's detention, namely the drowning incident that involved the killing of her infant son and the attempted killing of her youngest daughter. This omission appears to this Court to be without explanation, as it was of relevance to the issues to be determined by the Court."

34. The trial judge returned to that matter at para. 33 of his judgment as set out above when, although holding that the proceedings were moot, he went on to state that the lack of explanation in relation to the killing of her son was the basis on which he would not have awarded damages "where the respondent had acted in the interest of the applicant and the public at large". Again, I would disagree with the trial judge's comment in this regard. I cannot see that in the context of these proceedings there was any need for further explanation as to the reasons behind the tragic episode that resulted in the killing of the appellant's son. The absence of explanation was the reason why the trial judge would not have awarded damages. I fail to see any nexus between the entitlement to damages for breach of constitutional/Convention rights, and the failure to explain further the "reasons for the applicant's detention, namely the drowning incident etc. …" (para. 4 of the judgment) for which she was reclassified under the 2006 Act as not guilty by reason of insanity.

35. Para. 34 of the trial judge's judgment indicates with clarity that the ratio of his decision is that the issues remaining in the proceedings are moot following the appellant's unconditional discharge by decision dated the 14th December 2014. It is clear also that he did not consider that the remaining claim in damages saved the proceedings from being regarded as moot now.

Grounds of appeal

36. The core issue on this appeal is whether or not these proceedings are now moot. The appellant contends that the trial judge was wrong to conclude that they are moot. She contends also that the trial judge erred by not concluding that the Clinical Director was in breach of his mandatory statutory obligation under s. 13A of the Act to put the necessary arrangements in place when requested to do so by the Board. She contends that the trial judge was in error in not finding that she was entitled to an award of damages for breach of her constitutional/Convention rights. Apart from these issues the appellant appealed against the trial judge's comment as to the absence of explanation for the appellant's detention to which I have already referred, as well as his statement that the Board was under a duty to respond with reasons to the concerns expressed by Prof. Kennedy and Dr O'Neill. Again, I have already addressed that ground.

37. As to mootness, the appellant accepts that, following her unconditional discharge on the 14th December 2014 pursuant to her application for such an order on the 4th August 2014, she can no longer can derive any benefit from obtaining relief by way of certiorari and/or mandamus. In these circumstances the only basis on which she contends that the appeal is not moot is her claim for damages for breach of her constitutional/Convention rights as set forth which, it is submitted, would require this Court's determination in relation to the central question whether or not the trial judge was correct to conclude that the Clinical Director did not breach his obligations under s. 13A of the Act.

38. I have already emphasised that the appellant does not claim damages for breach of statutory duty. Therefore, even if the Court concluded that the Clinical Director had been in breach of s. 13A of the Act, no damages could follow upon that finding alone, since none are claimed. In those circumstances damages for breach of statutory duty simply do not arise for consideration. In addition, as I have stated, the appellant has specifically stated to this Court that no allegation of *mala fides* is being levelled against the Clinical Director.

39. What remains in the case is simply a claim for breach of constitutional rights, factually based upon a period of approximately six months between late December 2013 and May 2014 when it is claimed her family life was disrupted because she was unable to make her own decision as to where to live, as she would have been had the Clinical Director provided the confirmation as to necessary arrangements for the variation of the conditions attaching to her conditional discharge. The appellant has submitted that even though that claim does not fit neatly into any of the ordinary forms of action under the law of tort or in equity, her rights are guaranteed under the Constitution, and she is entitled to have her right vindicated in the event of a breach, that vindication in her case being, as claimed, an award of damages. Similar arguments are made by reference to her equivalent rights under the Convention.

40. It is of course true that ever since *Meskell v. C.I.E* [1973] I.R. 121 it is in principle permissible to bring a free-standing claim for damages for breach of constitutional rights. However, I consider that in the particular circumstances of this case this Court is entitled to look at the factual basis on which that claim is advanced in the present case when considering whether it provides a proper basis for deciding that the proceedings are not moot.

41. What then are those particular circumstances? The claim advanced for damages must be seen in the light of the very short period in respect of which the appellant has claimed that, by reason of the alleged breach of statutory duty by the Clinical Director, she was deprived of the right to make her own decision as to where to reside, and also in the light of the un-contradicted fact that she was by January 2014 able to reside in the family home with her husband and children for six nights a week, with the remaining night at her mother's house, and that by the 28th May 2014 she was residing on a full time basis at her family home. It seems to me that even if there was a breach of statutory duty (which is denied strenuously, and which in any event was found by the trial judge not to be the case), the present claim that her constitutional or Convention rights were breached is so minimal, tenuous and insubstantial as to not warrant the conclusion that there was a breach of those rights by the Clinical Director. At very best, if at all, in the unlikely event of some success, any award of damages would be purely nominal. It is certainly not in the nature of a claim that would warrant a continuation of these proceedings where the primary claims are by now rendered entirely moot by subsequent events. This is perhaps especially so where, as here, the underlying claim for damages for breach of constitutional rights could not itself be determined without also resolving the otherwise moot s. 13A issue. It would not serve the interests of the orderly administration of justice if this Court were now to find itself obliged to determine an important legal issue (namely the s. 13A question) which was otherwise moot simply because the appellant has also elected to pursue what in substance amounts to a purely theoretical case for damages.

42. I would dismiss the appeal against the finding of mootness made by the trial judge.

43. Having done so, it is unnecessary to reach any definite conclusion in relation to the core issue that was raised in the proceedings, namely whether the Clinical Director was on the facts of this case in breach of his duties and obligations under s. 13A where in his professional opinion he felt unable to confirm to the Board, in the words of s. 13A(2) of the Act, that "such conditions as appear necessary to [him] … have been made in respect of the patient" in order to fulfil the varied conditions of discharge proposed by the

Board.

44. Had it been necessary to decide that question on this appeal, I should have found great difficulty in concluding that the Clinical Director was in breach of his statutory obligation in this regard. There is no doubt that the Board's view as to the wisdom of a decision to allow the appellant to make her own decision as to where she wished to live did not coincide with the views of the Clinical Director, and of Dr O'Neill. They had expressed their views clearly and unambiguously at the meeting of the Board which was convened to consider the appellant's application for a variation of her conditions.

45. Nevertheless, under the provisions of s. 13A of the Act the decision as to whether it is appropriate to vary the conditions of discharge is a decision to be taken by the Board. There is no doubt that it can make such a decision even against the advice of the clinicians, including the Clinical Director. They (*i.e.* the clinicians) hold no veto in respect of any such decision.

46. It seems to me that the section envisages that the Board may decide that a discharge order or a variation of a discharge order should be made, but subject to some conditions as may be considered by it to be appropriate, "including" those actually specified in s. 13A(1), *i.e.* relating to outpatient treatment or supervision or both. It would follow that there might be other conditions also that could be considered by the Board to be appropriate in any particular case. The Board has a discretion as to the conditions it may consider appropriate in any given case.

47. But, as provided by s. 13A(2), the order proposed to be made by the Board cannot be made until it receives the confirmation from the Clinical Director that "such arrangements as appear necessary to [him] have been made in respect of the patient". It would be wrong to characterise that provision as giving the clinical director a veto over the decision of the Board. Nevertheless, the Act is clearly involving the clinical director in the question of what arrangements are necessary in order to fulfil the conditions proposed by the Board. The Act makes no provision for what is to happen in the circumstances which have arisen in this case, where the clinical director is of the view that he/she cannot from a clinical perspective put in place the necessary arrangements to ensure, or at least assist in relation to, compliance with the conditions by the patient. The absence of any provision catering for such a situation would seem to indicate that it would be expected that such difficulties would be capable of resolution informally by way of continuing discussions between the clinical director and the Board.

48. Nevertheless, there is clearly a tension between s. 13A(1) and s. 13A(2), as evidenced by the facts of the present case. I would point to the fact that insofar as the clinical director is under the obligation, as evidenced by the use of the word "shall" in s. 13A(2), to "make such arrangements as may be necessary for (a), (b) and (c) [as specified therein]", that obligation relates, firstly, only to arrangements that may be necessary for (a), (b) and (c) specified in the section, and secondly, those particular specified matters are qualified by the preceding words "such arrangements" – those being "such arrangements as appear necessary to the clinical director".

49. While I wish to again emphasise that I reach no concluded view on this question, given that it is moot, and therefore the Court should abstain from giving purely advisory opinions in a case where no live controversy remains between the parties, it does seem to me that, at least on the facts of this case, there could be no question of the Clinical Director having been in breach of his statutory obligation by maintaining his professional opinion that, for the reasons which he explained in some detail to the Board (albeit that the Board took a different view), he was unable to confirm the arrangements which the Board wished to have in place so as to vary the conditions of the earlier discharge order.

50. There is no suggestion, much less an allegation, by the appellant that the Clinical Director has acted other than in a completely bona fide manner. It is beyond doubt that both he and Dr O'Neill have acted only in the appellant's best interests as they, in their professional clinical opinion, see them.

51. I have expressed these views knowing that any final word on the interpretation of s. 13A must await a case where the controversy is not moot. Also, anything I have said is in the context only of the particular facts of this case. Other cases will inevitably have different facts which may be relevant to how the section is to be construed. The views expressed are given in case they assist in ensuring that the Board and any clinical director concerned continue to engage with each other, as they have done in the past, in a way that is professional, cooperative and respectful of their respective roles in the interests of very vulnerable patients, and where the interests of such patients are always their paramount consideration.