Neutral Citation Number: [2010] IEHC 410

THE HIGH COURT

2008 9395 P

BETWEEN

ELLEN ANNE ORPEN

PLAINTIFF

AND

THE HEALTH SERVICE EXECUTIVE

DEFENDANT

JUDGMENT of O'Neill J. delivered on the 27th day of October, 2010

1. The plaintiff in this case sues the defendant on behalf of the statutory dependants of Michael Orpen, deceased, for damages arising from the death by suicide of Michael Orpen on or about 16th November, 2006. The plaintiff is the mother of the deceased.

Background

2. The background to the case is as follows.

3. On 14th November, 2006, Michael Orpen presented to the Accident and Emergency Department at Letterkenny General Hospital shortly after 10.00pm and gave a history of having taken an overdose of tablets, approximately fifty to sixty tablets, at about 6.00pm. To the Accident and Emergency Senior House Officer, he described himself as depressed lately, had dropped out of his IT course at the Letterkenny Regional College, could not cope with life's pressures and he said he regretted his action and would not attempt suicide again. He said he was willing to speak to a psychiatrist.

4. On examination, it was found that he had no visual or auditory hallucinations. He was tearful; his clinical examination was normal, apart from Tachycardia, namely, a raised pulse rate at 126. He was given a range of toxicology tests, all of which were reported as normal.

5. At approximately 11.30pm, he was cleared, medically, and referred to Dr. Margaret McGrory, the psychiatric Senior House Officer on duty. Dr. McGrory was doing her GP training programme, part of which was a rotation in psychiatry.

6. In the meantime, a nurse rang the deceased's sister, Mary Ellen, and requested her to come to hospital to collect Michael. I infer that Michael had requested that this be done, otherwise the nurse could not have known who to contact. Mary Ellen came to the Accident and Emergency Department at about midnight. She saw Michael lying on a bed in a cubicle in an obviously despondent state. Soon, thereafter, she was introduced to Dr. McGrory who had arrived. They knew each other from their schooldays. Mary Ellen went to the waiting room and Dr. McGrory commenced a psychiatric assessment of Michael at approximately 12.30pm in the Ophthalmology room.

7. The notes taken demonstrate that this assessment was thorough and comprehensive. Details of the suicide attempt were explored. Michael revealed the type of tablets he had taken, and that he had taken these at about 6.00pm and then drove around the Dunkineely area of Donegal for about two to three hours, waiting for something to happen. He went to the pier and thought about driving off it, but could not do it. When he realised he could not do it, he rang his sister, Mary Ellen, but she was not there, so he went to Letterkenny General Hospital. He rang his parents' home, talked to a younger brother, and told him to tell the parents he had gone to hospital but he did not give the reason.

8. He told Dr. McGrory that he had not taken any alcohol that day. He detailed his personal and family history including medical and psychiatric history. He denied any history of psychiatric illness in any members of his family. He detailed his school and work history and his hobbies, culminating in the IT course that he had been doing in Letterkenny College, which he had dropped out of, approximately two days previously. He described his feelings, and in particular, that he felt unable to cope with the course and that he was falling behind and was holding the class back. He described his present living arrangements, namely, sharing rented accommodation with his sister, Hannah, and her boyfriend, but that she was getting annoyed with him for dropping out of the course. He also felt that his parents were annoyed with him for not settling in any job, even though they had never expressed any opinion on that. He described himself as close to both of them, and that they had a good relationship. He felt he was letting them down by dropping out of the course.

9. His psychosexual history was explored, as was his pre-morbid personality. He described himself as unhappy at times, that is, that he was up and down and that he was too serious at times.

10. A mental state examination was carried out. Dr. McGrory noted Michael to be slightly unkempt and unshaven. There was no eye-to-eye contact. His head was down and he was hunched over and he was sad looking. She found his speech coherent and relevant and his mood, subjectively and objectively, low. She found he had no visual or auditory hallucinations or delusions.

11. There had been suicidal ideation during that day. There was obsessive worrying about his course. She noted that his memory was okay and that his concentration had been poor over the last week. She found his insight to be intact and she noted that he told her that he did not feel like killing himself at present, and did not have any suicidal ideation.

12. In her evidence, Dr. McGrory says she had concluded that Michael was suffering from a depressive illness. She discussed admission to hospital with Michael and asked him whether he felt he needed to be admitted. He said he did not need to be admitted.

He expressed himself as not having any intention of harming himself and was regretful of what he had done.

13. Dr. McGrory's evidence was that she agreed he did not need admission. She did not pressurise him into accepting admission. She felt that she had developed a good rapport with Michael and wanted to get him to engage with his treatment plan.

14. Michael had told her that he was going home with Mary Ellen. Dr. McGrory enquired if he could talk easily to Mary Ellen if he felt he was slipping. Michael said he could. Dr. McGrory asked his consent to bring Mary Ellen into the consultation and he agreed. Dr. McGrory went to the waiting room and escorted Mary Ellen into the room to join them. No conversation took place between them until they got into the room.

15. There, a brief conversation ensued, in respect of which Mary Ellen's evidence differs with that of Dr. McGrory. Mary Ellen says that immediately, or very soon after getting into the room, Michael said something to the effect that he "*really intended to drive off the pier*". Her evidence was that Dr. McGrory did not appear to pay any heed to this remark, which greatly upset and shocked Mary Ellen. Mary Ellen also said that Dr. McGrory said that Michael was suffering from low self-esteem which tended to give her a sense of relief.

16. Dr. McGrory had no recollection of Michael making this remark concerning driving off the pier at this time, but he had said something similar earlier in the assessment. Neither had she any recollection of mentioning low self-esteem.

17. Dr. McGrory's evidence was that when Mary Ellen came into the room with her, she (Dr. McGrory) said that she had had a long chat with Michael; that Michael felt he did not need to be admitted and that she agreed with this, and that Michael was going to go home with her (Mary Ellen). Dr. McGrory said that Mary Ellen said very little in the conversation, it going mainly between Michael and her. She indicated that she would have to speak to Dr. Gallagher, the on-call consultant psychiatrist, before finalising anything. This conversation took a short time, about five minutes. At this stage, Dr. McGrory left to phone Dr. Gallagher. She made this call from the Nurses' Station. It was now approximately 2.00am. The consultation with Michael had taken in excess of one hour and ten minutes.

18. In her conversation with Dr. Gallagher, Dr. McGrory went through her notes of the interview with Michael. Dr. Gallagher, in her evidence, said that she felt Michael was suffering with depression. She did not think Michael was suicidal at that time because he had repeatedly said that he had no intention of harming himself and was remorseful for what he had done. The fact that he had voluntarily come to the hospital further indicated a low suicide risk at that time.

19. In light of his attempt that day, she regarded him as a suicide risk, but she was happy that he was not suicidal at that time. Dr. Gallagher was particularly interested in who would care for Michael that night. She was told that Mary Ellen was with him at that time and she would take him home. Dr. Gallagher felt comfort in the fact that a caring relative was available to take Michael home. In her view, Michael needed to go to somebody who could provide an environment in which he could feel safe, which was non-threatening and was comfortable for him. As Mary Ellen's home had all of that, and that fact that she clearly cared a great deal for Michael, Dr. Gallagher was reassured that it was appropriate to discharge Michael into the care of Mary Ellen for that night.

20. Dr. Gallagher's treatment plan was that he was to be referred the next morning to Parkview Day Hospital for counselling. Reference to Parkview would involve further immediate assessment, and whatever psychiatric treatment was required would be provided there, or if necessary, in the psychiatric unit in Letterkenny General Hospital.

21. Following the conversation with Dr. Gallagher, Dr. McGrory returned to the room and another short conversation of about five minutes duration ensued. Mary Ellen's evidence in relation to this was that Dr. McGrory reported that Michael was to be discharged to go home with her, that counselling was to be arranged in Parkview, commencing in a few weeks, and that the only advice she was given was to get Michael to drink a litre and a half of water. She said no advice was given as to Michael's risk of suicide or how to manage Michael in that situation.

22. Dr. McGrory's evidence of the conversation differs somewhat. She said that she agreed or confirmed that Michael was to be discharged into the care of Mary Ellen, that he was to be referred the next day to Parkview for counselling, which would take a few weeks, meaning that it would commence next day and continue over a few weeks. She was adamant that she did not give any advice about drinking water and she advised that if there was any deterioration in Michael's condition, to contact the hospital, as is recorded in the notes. She also took Michael's mobile phone number to contact him the next morning.

23. Thereafter, Michael and Mary Ellen left, each driving their own car, to Mary Ellen's home in Letterkenny. When they arrived, Mary Ellen prepared a bed for Michael in the spare room. She offered him food, which he declined. Mary Ellen spoke to him, reassuring him that all would be well, and specifically mentioned low self-esteem in the context of reassuring him. She also measured out a litre and a half of water, using a milk carton to get the measure correct.

24. While speaking to Michael, Mary Ellen said she told him that she would not say anything about what had happened to their parents. She said that this was her decision. Dr. McGrory, in her evidence, said that, during her interview with Michael, alone, he had said he did not want his parents to know, and she also said that, in the conversation before Michael and Mary Ellen left the Accident and Emergency Department, they discussed not telling their parents, and that it was Michael's wish that he did not want his parents to know. Thereafter, all retired to bed. It was probably, at this stage, approximately 3.00am.

25. The next morning, 15th November, 2006, having attended to her children aged three years and one year, Mary Ellen went back to bed as she had no commitments until that afternoon, when she had to attend a smoking cessation conference in Letterkenny.

26. At about 12 noon, Michael came to her room, and told her he had got a phone call to go to Parkview House for counselling.

27. Back at Letterkenny General Hospital, at approximately 9.00am, or soon, thereafter, Dr. McGrory discussed Michael's case with Dr. Sharkey, the clinical director of the psychiatric unit. She filled out the referral form for Parkview. Her evidence was, and in this respect, Dr. Sharkey agreed, that the change in the form from 1/52 to "*urgent*" was not directed by Dr. Sharkey. Dr. McGrory's evidence was that it had always been her intention, from the previous night, to refer Michael to Parkview to be seen that day, namely, 15th November, which required an "*urgent*" classification, and the initial writing in of 1/52 was an inadvertence on her part which she immediately crossed out and corrected.

28. Dr. Sharkey advised Dr. McGrory to ensure that Michael was seen in Parkview that day. I accept Dr. McGrory's explanation of the change in the referral form.

29. Dr. Sharkey promptly faxed the referral form to Parkview where it received the attention of Jim Blake, a senior psychiatric nurse.

Dr. McGrory later rang Michael on his mobile at 11.45am, as recorded in the notes, and found him much better, stating that, by seeking help, he had started to feel better. Jim Blake also rang Michael and made the arrangement for Michael to attend at Parkview at 3.30pm, the time chosen by Michael. Michael attended Parkview at the appointed time and had a lengthy assessment carried out by Jim Blake which took approximately one and a half hours. This entailed giving a detailed history and then the completion by Michael of a questionnaire known as the Beck's DPSN Inventory, which is designed to measure the severity of depression.

30. In the course of the history taking, much of the information that was given in the interview with Dr. McGrory was repeated. A significant addition was in relation to abuse of alcohol by Michael. This arose on an exploration by Mr. Blake of Michael's drinking habits. Michael revealed that for a number of years, he had been abusing alcohol, although on the day of the attempted suicide, he had not taken any alcohol.

31. He reported low moods following bouts of drinking. Throughout the assessment, Michael said he had no intention of harming himself and had no suicidal ideation then, and regretted the attempt he had made. As part of the process of engaging Michael with his treatment plan, he was asked to sign a form agreeing to abstain from alcohol and keep himself safe.

32. The Beck questionnaire filled out by Michael was designed to measure the severity of depression. Michael's answers attracted a score of twenty, which put his depression in the category "*Borderline Clinical Depression*", i.e. 17 to 20. The range 21 to 30 is categorised as "*Moderate Depression*". In Category I of the questionnaire, he selected the answer "0" meaning, "*I don't have any thoughts of harming myself*".

33. Mr. Blake wanted Michael to attend Parkview the following day, Thursday 16th November, but Michael said he wanted to go to work in Malin, as he had a commitment there, so his next review was arranged for the day after that, Friday 17th November, when he was to be reviewed by a psychiatrist. Over the following week, he would have been visited at home by Mr. Blake who was on duty for the weekend. It is Mr. Blake's evidence that he was quite happy for Michael to go to work in Malin, as that would have been a distraction and a benefit to him.

34. After Michael left Parkview, he rang Mary Ellen. Her evidence was that he seemed in better form. He told her he was going to Malin to work. She expressed concern about this, but he reassured her that Parkview had agreed to it, and he was leaving it in the hands of the professionals. Michael then travelled to Malin, and after that, he journeyed to his parents' house in Dunkineely, a considerable distance away. He declined to stay that night and he left at about 2.00am.

35. He did not turn up for work as expected in Malin the next morning. By mid-afternoon of the following day, the tragedy of his death was confirmed. He had driven his car off the pier at Bruckless. The car was discovered upside down when the tide went out.

36. Arising out of these circumstances, the plaintiff claims that the defendant was negligent in the treatment of Michael in a number of ways, as described in the evidence of Dr. Cookson, an expert psychiatrist. Dr. Cookson is a consultant psychiatrist at Mile End Hospital, East London, and is an honorary consultant psychiatrist at the Royal London Hospital. Dr. Cookson did not make any criticism of the treatment of Michael in Parkview.

37. Before going into the criticisms which he made, it is important to set out what was the appropriate duty of care which was owed by the defendant and the doctors in its employment to Michael. That duty of care is now well settled and it is expressed by Finlay C.J. in *Dunne v. The National Maternity Hospital* [1988] I.R. 91 at page 109, as follows:

> *"1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he is 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.*
>
> *2. If the allegation of negligence against the medical practitioner is based on proof that he deviated 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 with like specialisation and skill would have followed, had he been taking the ordinary care required from a person of his qualifications."*

Mr. Lyons S.C., for the plaintiff, also referred to the case of *Kelly v. The Board of Governors of St. Laurence's Hospital* [1988] 1 I.R. 1, and the following passage from the judgment of Walsh J. in that case, where he says as follows:

> *"I agree with the Chief Justice's judgment on the grounds of appeal which complained of the trial judge's direction to the jury on the issue of negligence in respect of which the defendants claimed that the judge's charge to the jury on the general standard of proof was deficient by reason of the use of the expression a real possibility that harm would come to [the plaintiff] if he was allowed to go into this room, the toilet, on his own".*
>
> *Like Chief Justice, I am of opinion that this did not amount to a misdirection. The duty the defendant owed to the plaintiff was to take reasonable care to avoid permitting him to be exposed to injury, which a reasonable person ought to perceive. In this case, the reasonable person concerned and the standard involved was the reasonable hospital administration and nursing service. In my view, it would not be correct to tell the jury that they must be satisfied that what has to be foreseen is a probability of injury. To maintain that position would amount to saying to the jury that, even if they were satisfied that the nursing staff foresaw, not merely that there was a possibility which was more than a vague or very remote possibility, but even a substantial possibility, that because it did not reach the height of being a probability, that they could safely take no precautions.*
>
> *In my view, once there is foreseeable possibility, then persons involved are on notice."*

38. In relying upon that passage from the judgment of Walsh J., Mr. Lyons was submitting that it applied to the circumstances of this case, and I would readily accept that. In itself, the application of that passage does not solve the problem. If there is a reasonable possibility of something happening, then, clearly, medical practitioners are on notice and must provide or devise the appropriate intervention. The question of how one tests the correctness of that intervention goes back to the test which is set out in the judgment of Finlay C.J in the *Dunne* case which I have just quoted. Ultimately, the determination of the issues in this case must fall to be determined on the basis of the tests set out in the *Dunne* case.

39. Mr. Lyons also relied on two other cases: *Marie Armstrong v. The Eastern Health Board and St. Patrick's Hospital* in which judgment was delivered by Egan J. on 5th October, 1990, and *Brigid Healy v. The North Western Health Board* in which judgment was delivered by Flood J. on 31st January, 1996. I do not find these cases helpful. They both concern persons who had a long history of

mental illness and both of them were inmates in mental institutions, and one case (*Marie Armstrong v. The Eastern Health Board and St. Patrick's Hospital)* concerns the discharge of a patient from a mental institution without the carrying out of an appropriate assessment before discharge. The other case concerns the making of a decision or determination in circumstances where the medical records of the person involved were not properly consulted and were not considered before the decision was made. None of these kind of circumstances, in my view, exist in the case I have to deal with.

40. Dr. Cookson's criticisms were as follows, and I will deal with them in turn. 41. Dr. Cookson criticised the absence of a diagnosis of depression, having regard to the information elicited by Dr. McGrory in her assessment. At the very least, he contended there should have been a differential diagnosis of depression. He was persuaded that there had not been such a diagnosis made because of the absence of such a diagnosis being recorded in the notes taken by Dr. McGrory. His evidence was that the necessary elements of a depressive illness were clearly present in the information imparted in the assessment.

42. In her evidence, Dr. McGrory acknowledged that the elements of depression were present. She agreed that the dots were present and available to be joined up, but she said that she had reached the conclusion that Michael had a depressive illness, but she contended it would be unusual to reach a firm diagnosis of clinical depression at the first assessment. Nonetheless, she proceeded on the basis that Michael was suffering from depression and she said that depression was discussed in the notes. As a result of her conversation with Dr. McGrory, Dr. Gallagher also formed the view that Michael was suffering with depression and she too approached Michael's treatment plan on that basis.

43. I am quite satisfied that both Dr. McGrory and Dr. Gallagher were of a mind that Michael had a significant depression and treated him on that basis. Thus, there was no failure on the part of these doctors to realise, as apprehended by Dr. Cookson, that Michael was suffering with a depressive illness.

44. Whilst depression is mentioned in the notes, the notes do not record an unequivocal diagnosis, be it either differential or clinical, of depression. I am satisfied this omission did not at all affect the treatment plan for Michael and had no bearing whatsoever on his management or the outcome.

45. I am also not persuaded that in the context of the comprehensive note of the assessment, together with the mentioning of depression, that it could be said that the omission of an express mention of a differential diagnosis amounted to a breach of the standard of care to be expected from a doctor of the rank in the medical profession of Dr. McGrory at that time.

46. Dr. Cookson next criticised the failure to take a collateral history. It was accepted by Dr. McGrory that she should have taken a collateral history from Mary Ellen, or at least sought the consent of Michael to her doing that. Had she taken a collateral history from Mary Ellen, she would have revealed a different perspective on some of the information given by Michael and, in particular, she may have revealed that the plaintiff's father, and a brother and sister of the plaintiff, had committed suicide.

47. In this context, Michael, when queried about psychiatric illness affecting members of his family, had denied this. Although Dr. McGrory did not specifically ask whether any family members had committed suicide, she was not criticised by Dr. Cookson for not so doing. Even if she had asked, it is doubtful that Michael would have revealed his tragic family history. When Jim Blake specifically queried whether any family members, including extended family members, had committed suicide, Michael denied this history.

48. It was Dr. Cookson's evidence that Michael's depressive illness, combined with his suicide attempt, his delaying while driving around, together with suicide in his mother's family, rendered Michael at very high risk of suicide.

49. In addition to the foregoing, he pointed to the other well known suicide risks that applied, namely, that he was male, young, single and experiencing difficulty in his vocational life. Dr. Cookson was of the opinion that this high risk warranted admission and if Michael was unwilling to be admitted, Dr. McGrory, with the aid of Mary Ellen, who should have been involved in this, should have actively persuaded Michael to accept admission.

50. Dr. Cookson accepted that resort to legal powers to detain Michael as an involuntary patient was not justified. He said there should have been a discussion with Michael, involving Mary Ellen, of his depressive illness, and it should have been made clear to Michael that, notwithstanding his present lack of any intention to harm himself, and his regret for the attempted suicide, that his depressive illness rendered him prone to a relapse and to suicidal ideation, if his mood sank. Dr. Cookson says that if this persuasion failed to overcome Michael's resistance to admission, he needed to be released into the care of someone who fully understood his suicidal risk and was in a position to cope with this and manage it. This would involve a high level of supervision of and communication with Michael.

51. In addition, Dr. Cookson was of opinion that Michael's known methods of attempted suicide needed to be discussed so that Michael could be advised to avoid risks associated with these. That would involve avoidance of tablets and also avoidance of the risk associated with driving his car, either by not driving or not driving unaccompanied. Dr. Cookson also criticised Dr. McGrory and Dr. Gallagher for not carrying out a proper suicide risk assessment and recording this in the notes.

52. It was Dr. McGrory's evidence, in which she was supported by Dr. Gallagher and Dr. Sharkey and Dr. Daly, an expert psychiatrist called on behalf of the defendant, that the assessment carried out by Dr. McGrory explored the relevant suicide risk factors as part of the overall psychiatric assessment.

53. As indicated above, the approach of Dr. McGrory and Dr. Gallagher to the treatment of Michael was informed by their opinion that Michael was suffering from a depressive illness. Both Dr. McGrory and Dr. Gallagher said that, even if they had been aware of the history of suicide in the plaintiff's family, it would not have altered the treatment plan that was devised, namely, to discharge Michael into the care of Mary Ellen for that night, bringing him back the following day to Parkview to commence treatment for his depressive illness, thereby addressing and reducing the suicide risk.

54. Both accepted that Michael was a suicide risk, but both were convinced, Dr. McGrory, in particular, having conducted the assessment, that Michael was not then suicidal and did not present a risk of harming himself. Their view, in that regard, was based on the fact that he had voluntarily come to Letterkenny General Hospital, seeking help. He repeated that he did not have any intention of harming himself and he repeatedly expressed remorse for the attempted suicide. In addition, he opened up to Dr. McGrory and she felt she had a rapport with him and that he was willing to engage with this treatment and appeared to gain some relief from speaking to somebody.

55. The fact that Mary Ellen was available to take Michael home significantly impressed both doctors, in particular, Dr. Gallagher, as a significant risk reducing factor, in that he was going into the care, overnight, of someone who cared a great deal about him and could

provide him with a safe, comfortable environment in which he could easily communicate.

56. Dr. McGrory felt it important to gain Michael's confidence and trust and, hence, did not think it appropriate to engage in persuasion to overcome Michael's intimation that he did not need to be admitted. She herself did not think he needed admission, particularly when the care of Mary Ellen was available to him.

57. Both Dr. McGrory and Dr. Gallagher disagreed with the regime suggested by Dr. Cookson that should have prevailed in the context of Michael going home with Mary Ellen. Neither felt that the intensity of supervision envisaged by Dr. Cookson was necessary or appropriate. Both rejected the opinion of Dr. Cookson that there needed to be advice given concerning tablet taking or driving, particularly in the context where a car was a necessity to normal functioning for Michael.

58. Mr. Blake's evidence was that the critical factor in reducing the suicide risk was to prevent Michael's mood from collapsing which, in turn, would stave off suicidal ideation, rather than focusing on suicide methodologies. In this context, Mr. Blake felt it of great importance to get Michael to agree to abstain from alcohol, because abuse of alcohol led to lowering of Michael's mood. The testimony of these witnesses was supported by the expert evidence of Dr. Daly.

59. I am quite satisfied that Dr. McGrory did carry out an appropriate suicide risk assessment as part of her overall psychiatric assessment. With all attempted suicides, or potential suicides, there is a well established menu of risk factors: some or all may be present in any individual case. Critically, however, the weight to be attached to any individual risk factor will vary depending upon the circumstances of each individual. Thus, the doctor assessing suicide risk cannot merely add up the relevant risk factors in a formulaic way, but must instead assess the real weight to be attached to each relevant factor when assessed in the context of the overall circumstances of the patient.

60. In this case, it could be fairly said that Michael was affected by several risk factors, as discussed earlier. Foremost of these must have been the previous recent attempt, his depression, and his family history of suicide. Other relevant factors were that he was single, young, male and perceived himself to be having difficulty in his vocational life. Against all of these factors, Dr. McGrory and Dr. Gallagher had to weigh the other relevant factors, namely, that he had come to Letterkenny General Hospital voluntarily, seeking help; that he said, repeatedly, that he did not intend to harm himself and he regretted making the attempt, and also the fact that Mary Ellen was there to care for him for that night, and that his treatment would be commenced the following day. Also relevant in assessing the risk was the apparent willingness of Michael to open up to and engage with Dr. McGrory and the fact that speaking to someone appeared to give him some relief.

61. The evidence of Dr. Sharkey revealed that very few depressions are treated in a hospital context and that of those who attempt suicide by overdose, only two percent commit suicide within the following year, meaning that 98% do not commit suicide.

62. If Dr. Cookson's evidence is correct, it would mean that statements by a person with depression who had made a suicide attempt, to the effect that they no longer had any intention of self-harming and did not have suicidal ideation, would have to be given little weight in the assessment of suicide risks and the selection of treatment options. The inevitable consequence of such an approach would be that there would be far more admissions to hospitals in those circumstances than occurs under present prevailing psychiatric practice.

63. Such an approach would also seem to militate against gaining the trust and confidence of a patient so as to get them fully engaged and cooperate in their treatment. To that extent, this approach would seem inconsistent with prevailing standard psychiatric practice.

64. I am unable to accept Dr. Cookson's criticism of Dr. McGrory and Dr. Gallagher for excessive optimism or excessive reliance on Michael's statements as to his current state of mind on the question of self-harm. Apart from any inconsistency with established practice, in my view, it does not make good sense. It can readily be appreciated that a person who has attempted suicide, partly on account of that experience and also other factors, may recoil from the horror of what nearly happened. Thus, statements of the kind made by Michael would seem to me to be of crucial importance in assessment of suicide risk in the immediate future, which was the timescale that was involved in this case. On the other hand, and particularly where the attempt was the first suicide attempt, to not accept these statements and to not give to them the meaning an effect intended by the person making the statement would probably hinder the process of treatment for the underlying depression which created the suicide risk in the first place.

65. In assessing the suicide risk, I have come to the conclusion that neither Dr. McGrory nor Dr. Gallagher failed in their duty of care as each of them owed that duty to Michael.

66. On the choice of options available that night, *i.e*. admission or discharge into the care of Mary Ellen, I am quite satisfied that the approach taken by Dr. McGrory and Dr. Gallagher was entirely consistent with good psychiatric practice. As said earlier, very few depressions are treated in hospital. Dr. Cookson categorised Michael's depression as moderate in terms of severity. The other doctors did not disagree with this and the Beck's questionnaire completed by Michael in Parkview placed the severity of the depression as just below that level.

67. As said earlier, Dr. McGrory and Dr. Gallagher dealt with the suicide risk in an entirely appropriate manner. Faced with a choice between admission to a psychiatric ward, which, itself, could be a traumatic experience for a young person, as indicated by Dr. Sharkey, or a discharge into the care of a caring relative, namely, Mary Ellen, with whom Michael 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 Mary Ellen's care was a failure by the defendant or by Dr. McGrory or by Dr. Gallagher of their duty of care to Michael.

68. I found Dr. Cookson's evidence on this aspect of the case wholly unconvincing.

69. Next, there was the criticism of the advice given to Michael and Mary Ellen concerning the risks arising and the management of these. It must be borne in mind that Michael was discharged at 2.00am and was to be brought back to the psychiatric services *i.e*. Parkview, the following day, where a further assessment would initially occur, as, in fact, happened, followed by whatever treatment was appropriate. Thus, the period during which the suicide risk had to be managed was quite short and most of it would be taken up by sleeping. In fact, and in this regard, I accept the evidence of Dr. McGrory, Michael and Mary Ellen were advised to return to the hospital if Michael deteriorated.

70. Mary Ellen was well aware of the suicide attempt and had heard Michael say he really wanted to drive off the pier. No doubt, also, the family history must have been present in her mind.

71. In the context of the short period envisaged before Michael was back to the psychiatric services, explicit advice on the suicidal risk was, in my view, unnecessary, and perhaps, in the circumstances, superfluous and unrealistic.

72. Criticism was made on the basis that no enquiry was made as to Mary Ellen's commitments and therefore her ability to supervise Michael. I cannot see any merit in this criticism. The crucial aspect of the availability of Mary Ellen to take Michael home was that she was a close relative who obviously cared deeply for Michael and she enjoyed good communication with him. Her home was a very familiar place to Michael and therefore it was a comfortable, safe environment for him. I do not think constant supervision of Michael was required or desirable. Indeed, Dr. Cookson seemed to stop short of exhorting this.

73. Again, having regard to the period of time envisaged, Mary Ellen's work commitments should not have been a decisive factor and I am quite satisfied that those commitments could not have had the result of disqualifying her from taking Michael home on the night of 14th November, 2006. The more one looks at that suggestion, the more unmeritorious it becomes.

74. There was a criticism of Dr. McGrory for not discussing with and advising Michael and Mary Ellen on the methodologies of suicide that had arisen, namely, overdosing with tablets or driving off a pier. I find it hard to see any reality in these criticisms, particularly in light of the likely duration of the period of risk contemplated.

75. In the context of a person who had relatives and work in Malin, whose family home was in Dunkineely in North West Donegal and who was living in Letterkenny, a restriction on driving would have been a very severe inconvenience, at the very least. Where Michael was adamant that he had no intention of self-harming and had no suicidal ideation and was engaging in treatment, advice of the kind recommended would have been wholly unrealistic and more likely to impede the progress of treatment than to help it.

76. The advice on avoidance of drugs, likewise in the context of the period involved and the state of mind of Michael at the time would have seemed unrealistic.

77. I am quite satisfied that the advice given by Dr. McGrory to Michael and Mary Ellen was, in the circumstances, appropriate, and in this respect, she properly discharged her duty of care to Michael.

78. Finally, it was suggested that antidepressant drug therapy could have or should have been commenced on the night of 14th November, 2006. I am satisfied that this suggestion lacks any merit. It was agreed that antidepressants did not take full effect for several weeks and, hence, would have no benefit for Michael in the immediate period after 14th November, 2006. It was suggested by Dr. Cookson that these medications improve sleep in the short-term, although that was contradicted by Dr. Daly who said a short-term side effect of antidepressants was insomnia. Dr. McGrory was adamant that Michael was not agitated and did not need sedation and I accept her evidence in that regard.

79. I am quite satisfied that there was no breach of duty to Michael by Dr. McGrory or Dr. Gallagher in failing to commence antidepressant drug therapy on the night of 14th November, 2006.

80. I have come to the conclusion that the plaintiff has failed to demonstrate any breach of duty on the part of the defendant and therefore I must dismiss this action.