

**UNAPPROVED**

**NO REDACTION NEEDED**



**THE COURT OF APPEAL  
CIVIL**

**Neutral Citation Number: [2022] IECA 129  
Record Number: 2018/423**

**Faherty J.  
Ní Raifeartaigh J.  
Power J.**

**BETWEEN/**

**ANGELO CLOONAN**

**PLAINTIFF/RESPONDENT**

**- AND -**

**THE HEALTH SERVICE EXECUTIVE AND DR. KISHAN BROWNE**

**DEFENDANTS/APPELLANTS**

**JUDGMENT of Ms. Justice Power delivered on the 3<sup>rd</sup> day of June 2022**

**TABLE OF CONTENTS**

<b>1. Introduction</b>	<b>2</b>
2. The Essential Conflict	4
3. The Issues on Appeal	9
4. The Documentary Evidence	10
5. Overview of Expert Evidence	21
<b>Discussion</b>	
<b>6. Issue 1: The Challenge to the Plaintiff's Credibility</b>	<b>27</b>
➤ The Legal Framework	27
➤ Nine Contested Issues of Fact	29

➤ Conclusions on Issue 1	47
<b>7. Issue 2: On the Trial Judge’s Material Findings of Fact</b>	<b>53</b>
➤ The Legal Framework	53
➤ The Finding on the Hosepipe Incident	55
➤ The Finding on the Decision to Discharge	67
➤ Engagement with Expert Evidence	72
○ The Legal Framework	73
○ Evidence on the Predictability of Suicide	77
○ Evidence on the Consequences of a Brief Collateral	89
➤ Patient Confidentiality	97
➤ The Treatment Plan	102
➤ Conclusions on Issue 2	106
<b>8. Issue 3: On Discharging the Burden of Proof</b>	<b>108</b>
➤ The <i>Dunne</i> Principles	109
➤ The Court’s Assessment	114
➤ The Impact of Untruthful Testimony	125
➤ The Court’s Assessment	131
<b>9. Miscellaneous Matters</b>	<b>139</b>
<b>10. Conclusion</b>	<b>139</b>
<b>11. Decision</b>	<b>141</b>

## **Introduction**

1. This is an appeal against the judgment of the High Court (Hanna J.), [2018] IEHC 454, delivered on the 27<sup>th</sup> day of July 2018 and the subsequent order arising therefrom and made on the 3<sup>rd</sup> day of October 2018. The proceedings were initiated by the respondent (hereinafter and

for ease of reference ‘the plaintiff’) in a representative capacity, he and his three adult children being the statutory dependents of Josephine Cloonan, who died on 19 April 2011.

2. The appellants are the Health Service Executive (the ‘HSE’) and Dr Kishan Browne, a psychiatrist. It is claimed that the HSE is vicariously liable for the wrongful actions of Dr Browne.

3. The plaintiff claims that the death of his wife (hereinafter ‘Josephine’), by suicide, was caused by negligence and breach of duty on the part of the appellants.

4. The proceedings before the High Court had several distinguishing features. First, there was a 180-degree conflict on the facts concerning the events that occurred on the day before Josephine died. The plaintiff and Dr Browne gave utterly irreconcilable evidence in this regard.

5. Second, there was the disjointed and fragmented manner in which the evidence emerged and the trial advanced. Commencing on 9 November 2017 and ending on 13 March 2018, eleven witnesses—eight for the plaintiff and three for the defence—gave evidence during the trial, which lasted 14 days. In some cases, testimony was interrupted and given in a piecemeal manner, some witnesses were called and recalled, and, at one stage, matters had become so unsatisfactory that the trial judge considered abandoning the proceedings altogether.<sup>1</sup>

6. Third, there was a significant turn of events in the middle of the trial when discovery was made, belatedly, by the plaintiff. This led to serious questions of credibility arising and an accusation of perjury being levelled against him.<sup>2</sup> The issue of credibility was central to the two important findings of fact made by the trial judge and these two findings were material to his ultimate finding of negligence against Dr Browne.

7. A fourth unusual feature of the case was the fact that the plaintiff’s sworn oral testimony departed significantly from his pleadings which he had also sworn, on affidavit, to be true.

---

<sup>1</sup> Paragraph 25 of the High Court judgment. Note: There is some discrepancy between the paragraph numbers as they appear in the judgment submitted with the file and other publications of the judgment that are available online. References to the High Court judgment in this appeal are to the version of the judgment that was received from the parties.

<sup>2</sup> Transcript, Day 10, page 52, line 25 – page 53, line 3.

Thus, whereas he had pleaded, *inter alia*, that Josephine's overdose occurred against a background of marriage breakdown, recent alcohol misuse, and financial stress, these were matters in respect of which he made vehement denials at trial. Moreover, his affidavit of verification in respect of his pleadings was sworn at a time *after* he had given his sworn oral testimony to the court.

### **The Essential Conflict**

8. Although there were 11 witnesses in total, the central conflict on the facts in the case arose between the plaintiff and Dr Browne as to what had occurred on the morning of 18 April 2011 after Josephine's admission the previous evening to Galway University Hospital's Accident and Emergency Department (hereinafter 'A & E') following an overdose. The testimony of the plaintiff's son and one of his daughters was generally supportive of his position although neither of them was in the interview room when Josephine was assessed by Dr Browne, nor when she was interviewed, again, in the company of the plaintiff. Leaving to one side the case as pleaded, the core of the plaintiff's oral testimony when he was first called to the witness box may be summarised as follows.

9. On foot of her attempted suicide by overdose, Josephine was assessed by Dr Browne for '*[a]bout 20 minutes, maybe 25 minutes at the most, about 20 minutes really*'.<sup>3</sup> The assessment started at 10:50. Josephine was totally confused at the time and did not understand what was going on.<sup>4</sup> She told the doctor things that were completely untrue. She said that there had been a break up in the marriage. That was not true. She told Dr Browne that he, the plaintiff, had a history of child sexual abuse. That definitely was not true; in fact, the plaintiff stated: '*Where that came from I don't know*'.<sup>5</sup> She had told Dr Browne about financial stress. That was not

---

<sup>3</sup> Transcript, Day 1, page 38, lines 16-17.

<sup>4</sup> Transcript, Day 1, page 46, lines 13 and 24.

<sup>5</sup> Transcript, Day 1, page 95, lines 4-5.

true. There were ‘*no financial stressors at all*’.<sup>6</sup> Dr Browne had noted ‘*recent alcohol misuse*’.<sup>7</sup> That was not true. Josephine was a ‘*social drinker*’.<sup>8</sup> Dr Browne had noted down everything Josephine said and he believed, wrongly, that it was true.

**10.** The plaintiff claimed that he did not know anything about a previous suicide attempt involving a hosepipe and the car. He did find a hosepipe in the boot of the car, but he never ‘*put two and two together*’.<sup>9</sup> In a joint interview with Dr Browne and Josephine, he asked Dr Browne to admit Josephine to hospital, to ‘*keep her in*’, but Dr Browne ‘*fobbed [him] off*’ and refused.<sup>10</sup> Dr Browne never spoke to him on his own, but brought him into the interview room later.<sup>11</sup> The whole process lasted ‘*about*’ 30 to 35 minutes of which he was there for 10 or 15 minutes.<sup>12</sup>

**11.** The interview finished at about 12:00.<sup>13</sup> Dr Browne wrote down a phone number for the day hospital.<sup>14</sup> They had no choice but to go home. Dr Browne’s assessment of the interview was ‘*a fabrication*’.<sup>15</sup>

**12.** Dr Browne, on the other hand, confirmed the content of his assessment notes, and his testimony may be summarised thus. He had spoken to Josephine for up to an hour and 15 minutes on her own and he had taken detailed contemporaneous notes of that meeting.<sup>16</sup> Josephine did not lack capacity. She came willingly for review and was forthcoming in discussion. She had insight into her problems and, whilst tearful at times, disclosed, openly and coherently, significant details about the stressors in her life which led to the overdose. These included the revival of the issue of historical child sexual abuse which she and her sister

---

<sup>6</sup> Transcript, Day 1, page 51, line 12.

<sup>7</sup> Transcript, Day 1, page 55, lines 24-25.

<sup>8</sup> Transcript, Day 1, page 55, line 27.

<sup>9</sup> Transcript, Day 1, page 52, lines 24-25.

<sup>10</sup> Transcript, Day 1, page 59, lines 9 and 13; Day 2, page 12, line 27, page 15, lines 12-13; page 17, line 1.

<sup>11</sup> Transcript, Day 1, page 78 lines 22-23.

<sup>12</sup> Transcript, Day 1, page 60, lines 26-28; Day 2, page 8, lines 9-10.

<sup>13</sup> Transcript, Day 1, page 44, lines 9-10.

<sup>14</sup> Transcript, Day 1, page 39, lines 19-21.

<sup>15</sup> Transcript, Day 1, page 82, line 10.

<sup>16</sup> Transcript, Day 5, page 41, lines 28-29.

had suffered, the recent breakup with her husband, and some financial stress. She admitted to drinking ‘*a few cans of beer*’ on the morning of the Sunday on which she overdosed.<sup>17</sup> She had a previous episode of self-harm about four weeks earlier. She had put a hosepipe to the exhaust of the car and closed the window. She didn’t start the car. She changed her mind as she could not cause hurt to her children. She forgot to disconnect the hosepipe and her husband had found it later.<sup>18</sup> She said that the overdose was ‘*impulsive*’.<sup>19</sup> She was very remorseful and regretted what happened. Her mood, Dr Browne noted, was ‘*normothymic*’ or ‘*normal*’ and her being tearful at times indicated to him a degree of distress at the time.<sup>20</sup> There was no suicidal ideation evident and Josephine denied any current thoughts of self-harm.<sup>21</sup> He discussed inpatient care with Josephine, and she declined the offer, but she agreed to accept treatment as a patient in the day hospital.<sup>22</sup> In the Liaison Psychiatry Referral Book he had recorded her referral to the day hospital as ‘*[u]rgent*’.<sup>23</sup>

**13.** Dr Browne testified that he then left Josephine and had a meeting with the plaintiff on his own, which lasted some five to seven minutes. For reasons of patient confidentiality, he did not go into detail but he wanted to ascertain in broad terms whether Josephine had given an accurate account.<sup>24</sup> He asked the plaintiff whether he was aware of the reason for Josephine’s presentation, whether he had found the hosepipe that she had mentioned, and whether there had been a separation.<sup>25</sup> Having established to his satisfaction that the information he received from the patient concurred with that given by the next-of-kin, he then invited the plaintiff back to the interview room to discuss the situation further.<sup>26</sup> Back in that

---

<sup>17</sup> Transcript, Day 5, page 39, lines 12-13.

<sup>18</sup> Transcript, Day 5, page 22 line 26 – page 23 line 5.

<sup>19</sup> Transcript, Day 5, page 22, line 10; page 76, line 13.

<sup>20</sup> Transcript, Day 5, page 30, lines 9-21.

<sup>21</sup> Transcript, Day 5, page 34, lines 23-26.

<sup>22</sup> Transcript, Day 5, page 48, lines 17-21.

<sup>23</sup> Transcript, Day 5, page 16, lines 7-8.

<sup>24</sup> Transcript, Day 5, page 42, lines 20-26.

<sup>25</sup> Transcript, Day 5, page 43, lines 15-20.

<sup>26</sup> Transcript, Day 5, page 42, lines 18-28 and page 43, lines 15-28.

room, they discussed a number of things, starting with his offer of inpatient care to Josephine and her not being happy to come into hospital but being happy to attend day hospital instead.<sup>27</sup> He said that the plaintiff wanted to know what the day hospital entailed and that they had ‘*a long discussion*’ about what was available there, including relationship counsellors, anxiety management, as well as specific counselling for abuse.<sup>28</sup> He gave them the telephone number of the psychiatric ward, ‘Station B’, which was available to call 24/7.<sup>29</sup> He said he wanted Josephine to go straight away to Station B if there were difficulties.<sup>30</sup> On this basis, they were happy for Josephine to go home. The entire process took approximately two hours.<sup>31</sup> Afterwards, he met the plaintiff’s son, briefly, on the corridor. He told him that he had discussed the plan with his parents and that his mother would be getting help.<sup>32</sup> He left it at that. Dr Browne explained to the court that the day hospital was, for all practical purposes, a hospital without a bed at night, a place where patients undergo intensive therapy but sleep at home.<sup>33</sup>

**14.** On the tenth day of trial, the plaintiff was recalled to the witness box, having made discovery mid-trial upon the insistence of the appellants’ legal advisors. The documentation which was produced raised questions concerning the credibility of aspects of his earlier sworn testimony. For example, discovery of counselling records retained by a Mr Noel Keaveny, a counsellor Josephine had attended in January 2011, disclosed that, contrary to the plaintiff’s denial of any separation, Josephine had been troubled over the marriage breakdown before her attempted suicide and the plaintiff was aware of this. He was also aware of the fact that she had gone for marriage counselling.<sup>34</sup> All of this had occurred within in the months prior to his

---

<sup>27</sup> Transcript, Day 5, page 44, lines 10-14.

<sup>28</sup> Transcript, Day 5, page 44, lines 14-20.

<sup>29</sup> Transcript, Day 5, page 46, line 9.

<sup>30</sup> Transcript, Day 5, page 45, lines 16-21.

<sup>31</sup> Transcript, Day 5, page 49, lines 26-27.

<sup>32</sup> Transcript, Day 5, page 50, lines 5-7.

<sup>33</sup> Transcript, Day 5, page 46, lines 18-19.

<sup>34</sup> Transcript, Day 10, page 34, lines 7 and 23-24.

departure from the family home on the Friday before the Sunday on which Josephine tried to end her life by overdose.<sup>35</sup>

**15.** Discovery also disclosed that, contrary to his earlier denial, the plaintiff did, in fact, know from where Josephine had gotten the idea that he was sexually abused as a child. Mr Keaveny's notes recorded that the plaintiff had discussed the subject of his own familial history of child sexual abuse with Josephine and that, with her encouragement, he had attended the Rape Crisis Centre for counselling in connection with that history, following which he admitted to Josephine that he was sexually abused in childhood.<sup>36</sup> The plaintiff agreed that he had discussed the subject of his own childhood abuse with Josephine and that he had attended the Rape Crisis Centre in connection therewith, but, in terms of his admission to having been sexually abused, she must have '*taken it up wrong*'.<sup>37</sup>

**16.** Since credibility was so prominent an issue in the case, particular consideration was given to the stark conflict between what Josephine said about the plaintiff finding the hosepipe following her having attached it to the exhaust and forgetting to remove it, and what the plaintiff said about this issue. Arising from this conflict, a question was posed as to whether Josephine *may* have been concealing a previous attempt at self-harm.

**17.** In particulars furnished by the plaintiff to the appellants, he had pleaded that, on two separate occasions, as a result of alcohol misuse, Josephine was taken by ambulance to the A & E Department of Galway Hospital for treatment. Records obtained late in the day relating to Josephine's hospital attendances were put to the plaintiff. However, although aware of the potential impact which those records had, including, on the plaintiff's expert's evidence which was '*premised on certain bases*',<sup>38</sup> the judge decided not to allow them to be admitted into evidence. I shall return, in due course, to his decision in this regard.

---

<sup>35</sup> Transcript, Day 10, page 55, lines 9-12.

<sup>36</sup> Transcript, Day 10, page 35, lines 21-23 and 25; page 36, lines 12-15.

<sup>37</sup> Transcript, Day 10, page 35, lines 19-24 and page 36, line 1.

<sup>38</sup> Transcript, Day 10, page 59, lines 21-23 and page 61, lines 27-29.



## **The Issues on Appeal**

**18.** The appellants bring this appeal because in their view, ‘*a serious miscarriage of justice*’ has occurred.<sup>39</sup> They say that the plaintiff’s extensively untruthful evidence on virtually every important factual issue in the case has resulted in him successfully passing the blame for Josephine’s suicide to Dr Browne who, they say, did his job conscientiously and professionally. They submit that the extent of his untruthfulness was such that his credibility, generally, on any issue of fact must be seriously questioned and that the trial judge failed to appreciate this. Instead, by engaging in speculation, the judge had, impermissibly, ‘*rescued the claim*’ from the unsatisfactory state in which the plaintiff’s falsehoods had left it (*a contrario Shelly-Morris v. Bus Átha Cliath* [2003] 1 IR 232). They also say that the plaintiff failed to discharge the onus of establishing a breach of duty by reference to the principles governing clinical negligence as set out in *Dunne v. National Maternity Hospital and anor* [1989] IR 91 and that he failed in his obligation to discharge the onus of proof in a truthful and straightforward manner (*Vesey v. Bus Éireann* [2001] 4 IR 192).

**19.** Arising from the brief summary outlined above, it seems to me that there are three issues to be determined on this appeal:

- (i) whether the trial judge’s reliance on the plaintiff’s evidence on any disputed issue of fact was misconceived and inappropriate having regard to the extent of the plaintiff’s lack of credibility and untruthfulness;
- (ii) whether there is any basis for this Court to interfere with the trial judge’s two findings of fact which were material to his conclusion that Dr Browne was negligent; and
- (iii) whether the plaintiff has discharged the onus of establishing a breach of duty on the part of Dr Browne having regard to the principles in *Dunne*, and whether he has discharged the onus of proof in a truthful and straightforward manner.

---

<sup>39</sup> Appeal Transcript, page 13, line 10.

20. The broad outline of the conflict has been set out above and further detailed references to the oral testimony given at trial will be made when considering the issues that arise on this appeal. Before turning to those issues, however, it is necessary to set out, in some detail, the documentary evidence that was before the High Court, including, the medical records created on Josephine's admission to hospital following her overdose (with textual explanations given, where appropriate), and the witness deposition that had been sworn by Dr Browne at the Inquest. Thereafter, I shall outline, briefly, the expert evidence in the case. Having considered the issues to be determined on appeal, I shall then address such further matters, if any, that require to be considered in the light of the conclusions reached.

### **The Documentary Evidence**

21. On the morning of 18 April 2011, Dr Browne started his shift at 09:00, having received a '*handover*' from a colleague in the Psychiatry Department who told him that a call had come in from the Emergency Department but that it was '*still pending*' as the patient had not, by then, been cleared for interview. Once cleared, the Psychiatry Team was '*bleep[ed]*'.<sup>40</sup> Dr Browne said that his practice was to have a brief word with the Emergency Department staff in order to identify the issue and the patient. Thereafter, he would read the A & E Department's notes and proceed to meet the patient in an interview room that was available for use.<sup>41</sup>

22. The medical records created upon Josephine's admission to the Emergency Department of Galway University Hospital were as follows:

- (i) the Liaison Psychiatry Referral Book—a ledger style log book retained in the Psychiatry Department which records the names of patients assessed each day, the time of their assessments, their management and other outline details;

---

<sup>40</sup> Transcript, Day 5, page 8, lines 1-7.

<sup>41</sup> Transcript, Day 5, page 8, lines 20-26.

- (ii) the Psychiatric Core Assessment—a detailed document completed by Dr Browne in the course of his assessment of Josephine; and
- (iii) the Emergency Department Notes which included the ‘A & E Nursing Notes’.

*The Liaison Psychiatry Referral Book*

**23.** Having confirmed that he started the assessment of Josephine at 10:00 (as noted on the Psychiatric Core Assessment), Dr Browne was first taken through the entries he made in the Liaison Psychiatry Book which he said was used to audit the Psychiatry Department’s work.<sup>42</sup> In this book, each page has several columns with headings, such as, ‘*Label*’, ‘*Psy. No.*’, ‘*Time Seen*’, ‘*Ref Source*’, and so on. On the left column there is inserted a typed label, and a bar code which is a ‘*patient identifier*’ containing details unique to each patient seen by the Psychiatry Department.<sup>43</sup> The penultimate entry in that column contained Josephine’s details. Under ‘*Time seen*’ the entry is noted as 10:00. The following extract from the transcript records Dr Browne’s reading out of the text under the column with the heading ‘*Management*’:

“A: *Management: History of DSH (deliberate self-harm) attempt. O/D (overdose) of prescribed’ and the squiggle is the usual way to write ‘prescribed tablet’ perhaps – ‘Zimovane Lexapro, Piriton, Brufen against a background history of CSA and in response to recent marital breakdown.’*

Q: *CSA?*

A: *Child sexual abuse.*

Q: *‘And in response to’, yes*

A: *‘Recent marital breakdown. Impulsive today but has attempted self-harm in the past. Changed her mind. No suicidal ideation evident. Urgent DH (day hospital) referral.’”<sup>44</sup>*

<sup>42</sup> Transcript, Day 5, page 13, lines 5-7.

<sup>43</sup> Transcript, Day 5, page 13, line 28.

<sup>44</sup> Transcript, Day 5, page 15, line 25 – page 16, line 8. Note: The emphasis here and throughout the judgment is mine unless otherwise indicated.

*The Psychiatric Core Assessment*

24. The document entitled '*Psychiatric Core Assessment*' is a pre-printed form (eight pages) which is completed by the assessing psychiatrist. It is a document that was central to the case. To its cover page is attached Josephine's patient identifier label and bar code and her personal details. It is a contemporaneous record of Dr Browne's assessment of Josephine on the morning of 18 April 2011. Each page, as completed, contains Dr Browne's signature. The document records the details of what Josephine had told him and sets out her personal and social history and her medical history, including, the medication she was taking at the time. It also records Dr Browne's own observations upon examining Josephine's mental state—that is, the view he formed on how she presented, her behaviour, her rapport, her speech, her eye contact and other such matters. It has a section on the patient's current and previous thoughts in respect of self-harm or suicidal ideation. It records, under '*Additional Information*', that Dr Browne spoke to the plaintiff in the interview room (with the patient present) and to her son in the ER (Emergency Room). It includes an account of Dr Browne's '*Assessment/ Impression*' and concludes with a summary of options discussed with the patient and her husband and the proposed '*Action Plan*'. I shall refer, from time to time, to this document as 'the assessment notes' or 'Dr Browne's notes'. The document requires to be set out in some detail together with Dr Browne's explanation of his entries.

25. Dr Browne confirmed that the time he started his interview with Josephine was 10.00 as recorded on the assessment record, and he rejected the proposition that the entry actually read '10.50'.<sup>45</sup> His testimony, when taken through the contents of the Psychiatric Core Assessment, may be summarised as follows. Josephine was not '*in a zombie like state*' or '*dopey*' or '*out of it*'<sup>46</sup> when he saw her, she, having been '*medically clear prior to interview*'.<sup>47</sup> Before the

---

<sup>45</sup> Transcript, Day 5, page 9, lines 6-17.

<sup>46</sup> Transcript, Day 1, page 18, lines 19-26.

<sup>47</sup> Transcript, Day 5, page 18, line 19 – page 19, line 28.

Emergency Department (ED) decide to call the psychiatric team, they would have ensured that the patient was able for review, for ‘a long lengthy interview’. Routine tests completed by the ED were reported as ‘normal’.<sup>48</sup> As per the Psychiatric Core Assessment, the deceased ‘came willingly to the review’ and was ‘pleasant, chatty’. Under the heading ‘Presenting Complaints’, Dr Browne recorded *verbatim* exactly what Josephine told him.<sup>49</sup> As written therein,<sup>50</sup> Josephine said that the:

*“OD (overdose) was in response to recent stressors -*

*1. Brother in law was out drinking and passed two remarks re her CSA (child sexual abuse) and was upset.*

*2. Broke up w (with) husband last week in response to the CSA issue.*

*3. Some financial stressors but still working @ (at) her job.*

*Said it was impulsive – Never meant to hurt her family and doesn’t think it was a ‘suicidal attempt’.*

*Was in contact with GP last fortnight and GP had started her on anti-depressants + (and) sleepers.*

*Admits to some improvements.*

*No prior plans made though she admitted to trying another self harm episode some 4 weeks ago – Got a hoose (sic), 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 (hoose) (sic) off –*

*Husband found it later.*

*Reason for not attempting – ‘I couldn’t do the hurt to my children’”*

**26.** When counsel pointed out that this information was different to what the plaintiff had told the court, Dr Browne confirmed that the notes here recorded Josephine’s words, the information that she gave to him.<sup>51</sup> He continued going through his assessment notes:

*“C/O (complaining of) poor sleep – II (initial insomnia)*

*Appt (appetite) ✓(good) Energy - ↑↓ (up and down)*

---

<sup>48</sup> Transcript, Day 5, page 17, lines 24-26.

<sup>49</sup> Transcript, Day 5, page 20, lines 6-12.

<sup>50</sup> The cited extracts from the Psychiatric Core Assessment are as written in the document and the explanations of symbols (such as, ↑↓) and shorthand terms (such as, C/O) are as given by Dr Browne in evidence.

<sup>51</sup> Transcript, Day 5, page 23, lines 5 and 11.

*Conc. (Concentration) - ok (okay).*

*Vague helplessness, lot of frustration –”*

Dr Browne testified that he had qualified the entry about helplessness and frustration saying:

*“[Said her 2<sup>nd</sup> younger sis (sister) is taking her brother to court over the CSA.*

*Feels she should also join but cannot face discussing the details in front of lot of people].*

*- Denies any recent ↑ (increase in) alcohol consumption though admitted drinking few cans of beer of Sun mane (morning).”*

**27.** Dr Browne testified that he had elicited from Josephine her ‘*Personal/Social History*’ by asking her a series of questions, such as, where she was from, whether there were any mental health issues in the family, whether any relatives had suffered from anxiety, depression and if there were any specific issues, say, a history of family suicide. The notes he recorded reflected her answers as follows:

*“- Born in Galway. Parents RIP*

*- Youngest - 9 sibs (siblings), 5 brothers + (and) 4 sisters.*

*- Said she and one of her sisters were subjected to CSA by one of her brothers - Started when she was aged 4 / 5 and lasted x 10 yrs (years). Abuse she alleges - Inappropriate touching, masturbation, attempted penetration [He succeeded with her sister]*

*Parents when aware - sent him out of the house.*

*Currently he is married and the wife was not aware of this and is questioning them*

*[The sister has taken a Court case and hence has become public].”*

**28.** Having crossed out ‘*Family Psychiatric History*’ because Josephine denied any problem under this heading, Dr Browne’s note continued to record her Social History:

*“- Left scoil (school) early.*

*- Married x 25 yrs. 3 children -1 boy and 2 girls.*

*- [Husband also has alleged h/o (history of) CSA. He knew about her own CSA.*

*Supportive, understanding.]<sup>52</sup> Broke up with him last week - See presenting complaints for full details.”*

---

<sup>52</sup> Dr Browne testified that when he used brackets this was to reflect the patient’s own words.

Under the heading ‘*Drug/Alcohol*’, the following was recorded:

“- *Occasional smoker.*

- *Social drink – few pints beer once every twice a week 2/52 (once every two weeks) or 1/12 (once a month). No illicit drugs.”*

**29.** The assessment notes then recorded the medication Josephine was taking:

“*Lexapro 10 mg mane      Commenced: Fortnite (fortnight) ago*

*Zimovane 7.5 (night)      Commenced: Fortnite ago*

*Piroton.*

*Neurofen”*

**30.** The next section of the Psychiatric Core Assessment, the ‘*Mental State Examination*’, was, according to Dr Browne, a structured way of testing what is the prevailing issue or mood or problem, and is the only way in which the psychiatrist can try to ascertain whether the patient has any prevailing mental illness or otherwise.<sup>53</sup> The note recorded Josephine’s appearance as ‘*Dressed in PJ (Pyjamas). Pleasant, cheerful*’. Rapport was noted to be ‘*Gd (good), chatty*’ and her speech was normal. Under ‘*Mood*’ the notes record what, subjectively, the patient describes and, objectively, how the doctor perceives her. Josephine was noted to be ‘*[c]urrently normothymic*’ (indicating that her mood was normal),<sup>54</sup> and was tearful at times during the interview. The respective headings of ‘*Affect*’, ‘*Thought*’, ‘*Delusions*’, ‘*Hallucinations*’, and ‘*Passivity Phenomena*’ all had a line or a stroke after each word, indicating that there was nothing of relevance under these categories.

**31.** Dr Browne had noted under the heading of ‘*Cognition*’ that this was ‘*[i]ntact*’, and that ‘*Insight*’ was ‘*[p]resent*’. He testified:

“*Insight, again by the time I arrive at this, the patient would have given me a good history and good understanding that, yes, there is an issue going on and that she understands*

---

<sup>53</sup> Transcript, Day 5, page 27, line 20 – page 28, line 4.

<sup>54</sup> Transcript, Day 5, page 30, line 9.

*there is an issue which she has to deal with and she is happy to talk about it and she is also ready to listen and continue treatment.”*<sup>55</sup>

Under the heading of ‘*Current / recent attempts at self-harm*’ the entry reads: ‘*H/O (History of) OD (overdose) of multiple tabs (tablets)*’. The next heading was ‘*Current thoughts of self-harm (intent; methods’ degree of planning and preparation)*’ and Dr Browne’s entry, which he said was based upon questions he asked of Josephine, read:

*“Currently denies any TSH (thoughts of self-harm) or intent. Very remorseful – regrets the attempt”*.<sup>56</sup>

**32.** Dr Browne testified that Josephine was ‘*very forthcoming*’ and confirmed that she had no plans to take her own life and that she regretted her attempt.<sup>57</sup> Under ‘*Previous thoughts of self-harm/suicidal ideation*’, it was inserted: ‘*Approx[imately] some 4 wks (weeks) ago – See presenting complaint*’. There were strokes beside ‘*Homicidal Ideation*’ and headings relating to the risk posed to or by others, indicating that no issue of concern arose under these headings.

**33.** Under the heading ‘*Additional Information*’ the entry reads: ‘*[s]poke to husband with the present patient in the IV (interview) room. Spoke to son in ER.*’ When questioned about the time when he spoke to the plaintiff with Josephine present, Dr Browne testified that it was ‘*well after*’ 11:00, around 11:15. He spoke to the son ‘*closer to 12 o’clock.*’<sup>58</sup> Dr Browne’s notes then set out his ‘*Assessment/Impression*’ of Josephine, and the entry reads: ‘*DSH (deliberate self-harm) against BG (background) of long standing social stressors and recent alcohol misuse.*’

**34.** On the final page of the assessment notes under the heading ‘*Action Plan*’, the following was entered and confirmed in evidence:

*“Discussed with patient and husband re options.*

---

<sup>55</sup> Transcript, Day 5, page 33, lines 22-27.

<sup>56</sup> Transcript, Day 5, page 34, lines 21-27.

<sup>57</sup> Transcript, Day 5, page 35 lines 2-7.

<sup>58</sup> Transcript, Day 5, page 39, line 4.



1. *IP (in-patient) care offered – Declined but accepted St. (Station) B contact details if needed to use.*
2. *DH (day hospital) referral for further assessment and supports – Both happy with this – agreed to attend*
3. *No change in meds suggested and informed patient that this can be reviewed once in DH (day hospital). Happy with this.*
4. *Husband and patient happy to go home once medically fit and cleared. A&E staff informed.”*

**35.** Dr Browne testified that his note regarding ‘*Deliberate self-harm against the background of long-standing social stressors and recent alcohol misuse*’ was his formulation of how Josephine presented.<sup>59</sup> In his view, alcohol was a factor which had led to her taking the overdose because Josephine had told him that she had consumed a few cans of beer on the Sunday morning prior to taking the tablets.<sup>60</sup>

*The Emergency Department notes*

**36.** Dr Browne confirmed that the following entry made into the A & E Notes was made by him. It reads:

**“18/4/11 - Liaison Psych Review –**

- *Handover from psych (psychiatrist) on call on 17/4/11.*
- *Noted the history and presentation.*  
*Full details in Psych files.*
- *Currently no TSH/SI (thoughts of self-harm/suicidal ideation)*
- *May be allowed home once medically cleared*
- *Collateral from husband obtained and he agrees for his wife to come home once medically fit.”*

---

<sup>59</sup> Transcript, Day 5, page 78, lines 17-20.

<sup>60</sup> Transcript, Day 5, page 78, line 24.

There were further entries made by the nursing staff in the A & E Nursing Notes and, where relevant, these will be mentioned later in the judgment.

*The sworn deposition at the Inquest*

37. A little over a year after Josephine's death, an Inquest was held. The plaintiff attended, accompanied by his lawyer. Dr Browne gave a sworn deposition that may be paraphrased in following terms:

*At approximately 10:00 he attended at the Emergency Department and reviewed the Emergency Department notes. He then arranged to meet Josephine in an interview room. She was pleasant and chatty and engaged throughout the interview. She described her action in taking the tablets as 'impulsive' and that she never meant to harm her family, nor did she consider it a 'suicide attempt'.*

*He discussed her past presentation history and discussed with her the prospect of in-patient care, which he offered to her. Josephine did not wish to be admitted but was receptive and open to attending the psychiatry day hospital. She was very remorseful and regretted her actions. He then discussed the various options and therapies available at the day hospital (to include assessment for possible intervention from psychological services to include counselling, anxiety management and general supportive work) with which she fully agreed.*

*Josephine had been accompanied to the hospital by her husband and he then met with the plaintiff and obtained a collateral history from him. Whilst the plaintiff did not have any request for in-patient care, he was concerned that Josephine would receive continued treatment and follow up. He then invited him (having previously obtained Josephine's consent) to join them in the interview room.*

*The three of them then discussed the management plan in circumstances where he, again, offered in-patient care but both declined but did so having agreed that if either of them felt it necessary or if the situation deteriorated they would contact the relevant part of the hospital. He provided them with telephone numbers for Station B, which is the female*

*psychiatric ward. The ward may be called directly after 5 p.m. or at weekends to avail of help in an emergency situation.*

*He then discussed attendance by Josephine at the day care hospital in circumstances where he would seek a speedy appointment.*

*They discussed Josephine's medication but in the circumstances of the recent overdose, he advised that he would not review or renew the medication and instead recommended that Josephine would attend her GP to renew the prescription for antidepressants or for sleeping tablets (Zimovane). They also discussed the prospect of Josephine obtaining some specialist therapy and she agreed to do so after she had attended with the day hospital.*

*Overall, he spent approximately two hours with both the plaintiff and Josephine and by that time he had assessed Josephine who denied any suicidal ideation at the time, did not wish to avail of inpatient care and had agreed to avail of the Day Hospital services and stay with her husband. He therefore assessed Josephine for discharge home. He also informed the A&E staff of his assessment and advised of the follow up plans.*

*He had a brief discussion with Josephine's son in the Emergency Department and advised him of the management plan.*

*Josephine was ultimately discharged at approximately 15:00 on 18th of April 2011.*<sup>61</sup>

Dr Browne was questioned by the plaintiff's solicitor at the Inquest. At no stage was Dr Browne's account of what had transpired on the morning of 11 April 2011 challenged, nor was it put to him that the plaintiff had requested inpatient admission and that he, Dr Browne, had refused. The plaintiff's daughter, Ms. Stephanie Cloonan (hereinafter 'Stephanie'), also gave a statement setting out how the events of the weekend in question unfolded and how her mother

---

<sup>61</sup> Although Dr Browne's statement was in the first person singular, for ease of the reader, I have presented it in the third person.

was in the hours prior to her death. She said that her mother had stated: ‘*Don’t worry about today, it was only a hiccup*’ and had further said ‘*At least I’ll get help now*’.<sup>62</sup>

*The collateral discussion and the joint consultation*

**38.** Before considering the expert testimony given to the High Court, it is necessary to pause and recall some further details of the conflict that arose on the question of the collateral and the subsequent joint consultation. Psychiatrists use the word ‘collateral’ to mean the obtaining of independent or objective information from persons other than the patient. Whilst under oath, the plaintiff had insisted, repeatedly, that Dr Browne had never had any independent collateral or ‘*one to one*’ discussion with him.<sup>63</sup> Dr Browne stated that he did have a collateral interview and that he remembered it and he described where it had taken place.<sup>64</sup> As already noted, Dr Browne agreed that the discussion, covering a number of issues, was brief—lasting some five to seven minutes—and that he had not gone into detail because of patient confidentiality.<sup>65</sup> He said that he asked the plaintiff whether he was aware of the reason for Josephine’s presentation; whether he found the hose as mentioned by Josephine; and about the marriage separation which, he said, the plaintiff acknowledged. He testified that he told the plaintiff that he had discussed a plan with Josephine, and asked whether he would mind coming in to the interview room so that they could ‘*talk further*’.<sup>66</sup> He said a collateral interview was important ‘*to arrive at whatever judgment we are going to make and also to ascertain whether the situation is as factual as the patient is telling us*’.<sup>67</sup> The reason he gave for not taking notes of that independent discussion was that he found no discrepancy between what the patient had told him and what the plaintiff had said.<sup>68</sup>

---

<sup>62</sup> Transcript, Day 12, page 17, lines 21-23.

<sup>63</sup> Transcript Day 1, page 37, line 28; page 58, line 23.

<sup>64</sup> Transcript, Day 5, page 65, lines 1-3.

<sup>65</sup> Transcript, Day 5, page 42, lines 20-26.

<sup>66</sup> Transcript, Day 5, page 43, lines 15-28.

<sup>67</sup> Transcript, Day 5, page 65, lines 16-19.

<sup>68</sup> Transcript, Day 5, page 66, lines 1-5.

39. Dr Browne described the conversation that took place when he had gone back to the interview room with the plaintiff to ‘*talk further*’. He acknowledged that based on considerations of confidentiality, he did not discuss the full history in front of the plaintiff, but that a number of matters were discussed, starting with the fact that he had offered inpatient care to Josephine and that she had declined it but was happy to attend the day hospital. The plaintiff, he said, wanted to know what the day hospital would entail, and they had a long discussion about what it had to offer in terms of relationship counsellors, anxiety management and specific counselling for sexual abuse.<sup>69</sup>

40. Dr Browne said that he wanted Josephine to go straight away to Station B if there were difficulties, explaining that this was the female ward in the Psychiatric Department of the hospital.<sup>70</sup> He gave them the telephone number of Station B and confirmed that it could be called ‘24/7’.<sup>71</sup> The day hospital, he testified, was led by a consultant and had occupational therapy, physiology, addiction counsellors and allied staff. Once a patient was assessed and their needs established, a further management plan would then be put in place. Being a day hospital, there was no waiting period.<sup>72</sup>

41. Dr Browne testified that after the interview, he met the plaintiff’s son, briefly, on the corridor. As Josephine had nominated her husband as next-of-kin, he was constrained in discussing all the history with her son. He told him that he had discussed the plan with his parents and that his mother would be getting help, and he left it at that.<sup>73</sup>

### **Overview of Expert Evidence**

42. Professor Patricia Casey gave evidence on behalf of the plaintiff and made five criticisms of Dr Browne’s assessment of Josephine. These were: (i) the failure to have a collateral

---

<sup>69</sup> Transcript, Day 5, page 44, lines 7-21.

<sup>70</sup> Transcript, Day 5, page 46, lines 16-21.

<sup>71</sup> Transcript, Day 5, page 46, line 9.

<sup>72</sup> Transcript, Day 5, page 46, line 26 – page 47, line 1.

<sup>73</sup> Transcript, Day 5, page 47, lines 25-29.

discussion with the plaintiff; (ii) the failure to evaluate a previous suicide attempt; (iii) the failure to contact the GP; (iv) the failure to make a diagnosis of a depressive illness; and (v) the failure to contact a consultant. There were two issues on which Professor Casey introduced new evidence at trial and which had not been mentioned in her reports. The first was that this was an appropriate case for involuntary admission, if necessary, and the second was that Josephine would probably still be alive if only Dr Browne had done what she said he should have done.<sup>74</sup>

**43.** Professor Casey acknowledged that the comments she made in her report were based upon information she had received and included ‘*an assumption*’ that a collateral interview ‘*didn’t happen*’.<sup>75</sup> When it was put to her, on cross-examination, that a collateral discussion had, in fact, taken place, she persisted in her view that one had not. She said that she assumed that none was conducted because the information was not recorded.<sup>76</sup> In her view, such failure compromises patient management and information sharing. She went on to refer to a ‘*passing mention*’ of Dr Browne having spoken to the plaintiff which suggested to her that: ‘*it was not so much an information gathering exercise as a means of conveying a decision that had been made concerning [Josephine’s] discharge.*’<sup>77</sup>

**44.** During the course of trial, Professor Casey introduced the idea that the involuntary detention of Josephine under the Mental Health Act 2001 ought to have been considered by Dr Browne. When it was put to her that involuntary detention would have been entirely inappropriate in this case her reply was: ‘*Well, if she had been involuntarily admitted, she’d probably be still alive.*’<sup>78</sup> This remark, counsel considered, was ‘*an absolutely outrageous statement to make*’ to which Professor Casey replied that he was ‘*entitled to [his] view.*’<sup>79</sup> She

---

<sup>74</sup> Transcript, Day 2, page 122, lines 12-22.

<sup>75</sup> Transcript, Day 2, page 138, lines 10-12.

<sup>76</sup> Transcript, Day 2, page 113, lines 21-25; page 138, lines 10-12.

<sup>77</sup> Professor Casey’s Report of 5 March 2013, page 3.

<sup>78</sup> Transcript, Day 2, page 122, lines 21-22.

<sup>79</sup> Transcript, Day 2, page 124, lines 7-9.

later conceded, however, that inpatient treatment ‘*might have prevented [Josephine] from dying by suicide*’ adding that ‘*[t]he chances are she would still be alive*’.<sup>80</sup> Details of her academic publication on the inherent difficulties in predicting suicide were put to her and the evidence she gave on this point is a matter to which I shall return.<sup>81</sup>

**45.** Professor Casey considered that the failure to diagnose depression, to contact the GP and to appreciate the significance of the prior suicide attempt were ‘*very grave errors*’<sup>82</sup> which met the legal test in *Dunne*.<sup>83</sup> The previous attempt at self-harm should have raised ‘*a red flag*’ for Dr Browne.<sup>84</sup> The deficiencies in the psychiatric management of Josephine relating to information gathering could, potentially, have altered the treatment plan which she said was based on limited and incomplete information.<sup>85</sup>

**46.** Both Professor Jogin Thakore and Professor John Sheehan testified on behalf of the appellants. Both experts were categorical in their evidence that involuntary detention was not an option in this case because Josephine did not fulfil the required statutory criteria. She did not suffer from a mental disorder and could not be considered an *immediate* risk to herself or another,<sup>86</sup> having expressed remorse for her actions and denied any current thoughts of either self-harm or suicide. Both experts also considered that there was no evidence that Josephine was depressed but that there was clear evidence of distress arising from a number of significant stressors in her life.<sup>87</sup>

**47.** In the context of Professor Casey’s criticism of Dr Browne’s failure to appreciate the hosepipe incident, and her view that this feature distinguished the case from the norm, as the overdose was not the first attempt at self-harm, Professor Thakore testified that the incident in

---

<sup>80</sup> Transcript, Day 2, page 126, lines 12-14.

<sup>81</sup> Transcript, Day 2, page 123, lines 12-29.

<sup>82</sup> Transcript, Day 2, page 89, lines 12-13.

<sup>83</sup> Transcript, Day 2, page 91, lines 22-23.

<sup>84</sup> Transcript, Day 2, page 97, lines 22-24.

<sup>85</sup> Transcript, Day 2, page 94, lines 6-8.

<sup>86</sup> Transcript, Day 12, page 23, lines 19-27 (Professor Sheehan’s synopsis of the relevant criteria under the Mental Health Act, 2001 and the requirements of Form 6, MHC Admission Order).

<sup>87</sup> Transcript, Day 11, page 96, lines 24-26; Day 12, page 32, lines 13-18.

the car was what clinicians refer to as an ‘*aborted attempt*’ as distinct from ‘*an attempted suicide*’. This, he said, was because Josephine did not commence or carry out the act in question.<sup>88</sup> Such recognised definitions that distinguish between different types of behaviours around suicide assist clinicians in understanding what they are dealing with. In his view, Dr Browne sufficiently evaluated the earlier event and it was his call as to whether he needed to discuss it with the consultant or not. When cross-examined about potential concealment around the earlier suicide attempt, Professor Thakore repeated that, strictly speaking, it was an ‘*aborted attempt*’. Even if what was alleged to have been ‘*concealment*’ on Josephine’s part had been known, it would not have made any significant difference in terms of what Dr Browne did.<sup>89</sup> His treatment plan reflected the fact that he took the previous incident with the hosepipe seriously.<sup>90</sup> Dr Browne’s view on patient confidentiality was ‘*fresh knowledge*’ to him.<sup>91</sup> He would have assumed that Dr Browne asked questions of the plaintiff apart from merely outlining a treatment plan.<sup>92</sup>

**48.** The fact that Josephine had agreed to day hospital care was ‘*really critical*’, in Professor Thakore’s view, as she was actually accepting of help in the second least (*sic*) restrictive environment.<sup>93</sup> As to not recording the content of a collateral which was *not* at variance with the patient’s account, that, he said, was not a breach of the duty of care, but was a matter of individual preference.<sup>94</sup> If his team did not write something down, he would assume that it was not clinically relevant or had not added anything to the history of what was already known. He could not comment on Professor Casey’s view that information had simply been passed on to the plaintiff, because he was not privy to the conversation nor, indeed, was Professor Casey.<sup>95</sup>

---

<sup>88</sup> Transcript, Day 11, page 100, lines 10-15.

<sup>89</sup> Transcript, Day 13, page 9, lines 22-27.

<sup>90</sup> Transcript, Day 13, page 11, lines 1-2.

<sup>91</sup> Transcript, Day 13, page 11, lines 20-21.

<sup>92</sup> Transcript, Day 13, page 18, lines 20-24.

<sup>93</sup> Transcript, Day 11, page 113, lines 9-11.

<sup>94</sup> Transcript, Day 11, page 113, line 22.

<sup>95</sup> Transcript, Day 11, page 115, lines 16-20.



49. Professor Thakore described suicide as being ‘*almost impossible*’ to predict.<sup>96</sup> Whether one takes one individual risk factor (such as a history of self-harm) or a series of factors, one could not predict, confidently, which person will go on to die by suicide. His evidence in this regard will be considered later.

50. Professor Sheehan testified that the relevant guidelines on risk assessment and management were those published by the National Institute for Clinical Excellence (the ‘NICE Guidelines’).<sup>97</sup> He disagreed with Professor Casey that Dr Browne should have made a diagnosis of depression. In his view, all the evidence indicated that Josephine was severely distressed but was not suffering from a mental illness.<sup>98</sup> He described the stark reality that psychiatrists face when a patient, with capacity to decide upon treatment, refuses inpatient admission and yet does not meet the statutory criteria required for involuntary detention. In his view, admission to the day hospital was a very significant and an appropriate intervention and he noted that contact details had been given in the event of an emergency.<sup>99</sup> Finally, he testified that had he been the consultant on call and had been contacted about this case, he would have gone through the treatment options available, just as Dr Browne had done, and he would have agreed with the proposed plan.<sup>100</sup>

#### *Other witnesses*

51. Two General Practitioners (GPs) with whom Josephine had consulted testified at trial. It appeared from pharmacy records produced by the plaintiff that a prescription for Seroxat issued by Dr Gregory Little<sup>101</sup> in March 2011<sup>102</sup> had been filled two weeks before Josephine’s death.

---

<sup>96</sup> Transcript, Day 11, page 101, line 17.

<sup>97</sup> Transcript, Day 11, page 101, line 17.

<sup>98</sup> Transcript, Day 12, page 32, lines 13-18.

<sup>99</sup> Transcript, Day 12, page 41 line 23 – page 42, line 2.

<sup>100</sup> Transcript, Day 12, page 42, line 7.

<sup>101</sup> Dr Little provided a GP service for Josephine’s employer, An Post.

<sup>102</sup> Transcript, Day 1, page 8, lines 10-13.

However, Dr Little did not think that he issued Seroxat at any stage.<sup>103</sup> He issued a prescription for Cymbalta on 9 March 2011. In any event, he had no consultation notes of Josephine's attendance in March 2011 when he issued this prescription. He attributed his failure to have records of the March 2011 consultation to the fact of his having '*moved surgery*' in 2009 and to his filing system leaving a lot to be desired.<sup>104</sup> Nor did he have any records wherein he had made a diagnosis of depression or recorded any suspicion in respect thereof.<sup>105</sup> The only attendance records he did have concerned three visits Josephine had made to him well before the time of her death and none of which had indicated any relevance to subsequent events.

**52.** Dr Gerard Brennan testified that he had seen Josephine on 18 March 2011.<sup>106</sup> She was very distressed about events concerning the disclosure of her history of familial child abuse. He prescribed Lexapro medication. He did not prescribe Seroxat.<sup>107</sup> Had he been contacted by Dr Browne, he would have said Josephine was depressed. His consultation notes from 18 March 2011, however, did not contain any diagnosis of depression.<sup>108</sup> He would have recommended admission had he been called. From a factual perspective, he confirmed that he did not have any other information which Dr Browne did not already have.<sup>109</sup>

**53.** Further details of the evidence of other witnesses—which included the plaintiff's two adult children, a neighbour and a cousin—can be found in the judgment of the High Court. These witnesses described, generally, how Josephine appeared to them prior to her death.

---

<sup>103</sup> Transcript, Day 11, page 32, lines 25-26.

<sup>104</sup> Transcript, Day 11, page 29, lines 3-4.

<sup>105</sup> Transcript, Day 11, page 32, lines 5-8.

<sup>106</sup> Transcript, Day 11, page 35, lines 16-19.

<sup>107</sup> Transcript, Day 11, page 42, lines 15-20.

<sup>108</sup> Transcript, Day 11, page 48, lines 12-14.

<sup>109</sup> Transcript, Day 11, page 51, lines 26-28.

## **Discussion**

### **Issue 1: The Challenge to the Plaintiff's Credibility**

54. The first question to be determined is whether this Court may conclude that, in reaching his finding of negligence, any reliance by the trial judge on the plaintiff's evidence on contested issues of fact was misconceived and inappropriate having regard to the extent of his untruthfulness, and the doubt as to his credibility. In approaching this question, it is important to recall that the credibility of a witness is, primarily, a matter for the trial court in the assessment of the evidence. As observed (at p. 217) by McCarthy J. in *Hay v. O'Grady* [1992] 1 IR 210, an appellate court does not enjoy the opportunity of seeing and hearing witnesses in the same manner as does the trial judge, and '*[t]he arid pages of a transcript seldom reflect the atmosphere of a trial.*' However, it is equally important to reiterate that part of the function of an appellate court is to ascertain whether there may have been significant and material errors in the way in which the trial court reached its conclusions as to facts (*Doyle v. Banville* [2012] IESC 25, [2018] 1 IR 505). Findings of fact that are not supported by credible evidence, for example, would constitute a material error and, as such, are not binding upon this Court. It is, therefore, appropriate to examine the legal framework within which the credibility of a witness falls to be assessed.

### **The Legal Framework**

55. How a court should approach issues of credibility has been considered in several judgments, including, *Vesey, Shelly-Morris, Ahern v. Bus Eireann* [2006] IEHC 207, and, more recently, in *WL Construction Ltd v. Chawke* [2016] IEHC 539, *McCormack v. Timlin & Ors* [2021] IECA 96, and *Morgan v. Electricity Supply Board* [2021] IECA 29. Later, when examining the third issue to be determined on this appeal, namely, whether the plaintiff has discharged the burden of proof, I shall consider, in greater detail, the applicability of the findings in *Vesey, Shelly-Morris* and *Ahern* to the facts of this case. For now, suffice it to say

that significant consequences may follow if the evidence of a witness is seriously undermined by engaging in falsehoods.

**56.** A contract dispute over the renovation of a shopping centre was the subject of *WL Construction*. Noonan J. considered that the principals for the plaintiff gave evidence that was ‘*grossly dishonest*’ and ‘*entirely lacking in credibility*’ and which could not be disentangled from any truthful evidence proffered to the court. Referring to the above authorities, Noonan J. reasoned (at para. 87) that ‘*the court has not only a power but a duty to protect its own process from abuse of the kind that occurred in this case.*’ He struck out the proceedings following his finding that the gross dishonesty of the plaintiff amounted to an abuse of process. He distinguished his finding in the case from the case law wherein the courts had declined to strike out all or part of the claim where there had been deliberate dishonesty by the plaintiff in the prosecution of an otherwise valid claim. Noonan J. considered (at para. 95) that the dishonesty in question was ‘*coupled with the constant advancement of new claims and abandonment of old ones [which] had led directly to the prolongation of the trial in a manner and to an extent that can only be regarded as an abuse of process in itself.*’

**57.** More recently, in *McCormack*, this Court reiterated (at para. 99) that in a complex case where there are multiple conflicts of evidence, the resolution of the case requires a ‘*more detailed articulation of the Judge’s findings of fact and the reasons for the conclusions he reached.*’ A similar observation was made in *Morgan*, where Collins J. noted that while the High Court clearly found the plaintiff to be a credible witness, and preferred his evidence over others, it failed to give any indication as to why this finding was made. This, he said, was a fundamental difficulty with the judgment. A finding of credibility, whether in respect of specific evidence or generally, ought to be the product of analysis and reasoning. He stated (at para. 21):

“*The credibility of a witness is a matter of fact – a point made by Hardiman J for the Supreme Court in McCaughey v Anglo Irish Bank Resolution Corporation [2013] IESC*

*17, at page 49 and subsequently emphasised by that Court in Leopardstown Club Limited v Templeville Developments Limited [2017] IESC 50, [2017] 3 IR 707, per Denham CJ at paras 39 and 80 and per McMenamin J at para 105. Nonetheless, where there is a material conflict of evidence, it can hardly be ‘sufficient for the [trial] court simply to declare that it accepts the evidence of the plaintiff’ – or, I would add, the evidence of any other witness – ‘or that it is satisfied that he is a truthful witness without saying why that is the case’’: per Irvine J (as she then was) in Nolan v Wirenski [2016] IECA 56, [2016] 1 IR 461, at para 48. Such an approach would be wholly at odds with Doyle v Banville and indeed with Hay v O’ Grady itself. A finding of credibility, whether in respect of a witness’s evidence generally, or some specific evidence given by them, ought generally to be the product of analysis and reasoning that is capable of explanation in a judgment.”*

### **Nine Contested Issues of Fact**

**58.** The appellants say that the allegations of negligence in this case are based *almost entirely* on a false narrative constructed by the plaintiff along the following lines: that Josephine’s mental state was such that she lacked capacity to give a coherent account of events; that Dr Browne’s assessment was inaccurate and incomplete; that information he recorded in the notes about alcohol misuse, marriage breakdown, the plaintiff’s own child abuse, and financial stress was all untruthful; that Dr Browne falsely recorded that inpatient care was offered and declined; that Josephine and the plaintiff were happy with a day hospital referral; and that they were happy to go home once medically cleared.<sup>110</sup> In support of this false narrative, they say that the plaintiff swore to the court that he had persistently asked that Josephine be admitted to hospital and that Dr Browne had refused. Moreover, they say that the plaintiff failed to disclose important relevant medical information about events in early 2011 which concerned himself and Josephine, and that this information only emerged in belatedly discovered records which contradicted his earlier sworn testimony.<sup>111</sup>

---

<sup>110</sup> Paragraph 1.3 of appellants’ submissions.

<sup>111</sup> Paragraph 1.4-1.5 of appellants’ submissions.

**59.** To substantiate their claim about his lack of credibility, the appellants point to nine issues of fact on which the plaintiff gave sworn testimony that was demonstrably untruthful, or which contradicted what he had pleaded and which he had also sworn to be true. It is clear from the High Court judgment that the trial court did not accept the plaintiff's evidence on almost all of the issues in question. The nine issues on which the facts were contested were:

- Josephine's capacity during her interview with Dr Browne;
- the time and duration of the interview;
- the marriage separation issue;
- the issue of the plaintiff's own alleged history of child sexual abuse;
- the issue of whether there had been any collateral discussion;
- the alcohol misuse issue;
- the financial stressors issue;
- the issue involving the hosepipe; and,
- the issue of inpatient care.

Some consideration of each issue is merited as they are interwoven with and relevant to the ultimate findings of the trial judge. Combined, they set a context within which the plaintiff's credibility, generally, might be viewed.

#### *The capacity issue*

**60.** The appellants submit that the plaintiff's evidence created an alarming impression of Josephine as being '*out of it*' and utterly incapable of understanding what was going on. This, they say, was comprehensively rebutted by the psychiatric experts who reviewed the notes and found no sign of confusion, thus indicating that she had capacity to make decisions.<sup>112</sup> They say that the plaintiff gave '*grossly misleading*' testimony on this issue, with the intention of

---

<sup>112</sup> Transcript, Day 11, page 92, lines 1-3; Day 12, page 43, lines 15-19; Day 13, page 27, lines 4-11.

undermining the accuracy of Dr Browne's notes, thus, bolstering the allegation that the doctor was negligent. The plaintiff, on the other hand, says the judge accepted the '*general accuracy*' of Dr Browne's record on the point, noting that it had to be read '*in context*'.

**61.** Self-evidently, a woman who was '*off her head*'<sup>113</sup> or completely confused could not, as a matter of common sense, have given the detailed and coherent account of her life, including, the factors that were causing her distress, as recorded in the assessment notes of Dr Browne. Although he queried a 15:00 entry in the A & E chart about Josephine being '*more aware*',<sup>114</sup> I am satisfied that the judge accepted that Josephine did not lack capacity when interviewed by Dr Browne. Thus, he did not accept the plaintiff's evidence, corroborated as it was by his son, as to Josephine's '*zombie like*' state. It follows that the plaintiff's evidence (and that of his son) on this point was exaggerated and misleading.

*The time and duration of interview issue*

**62.** The appellants say that the commencement time of Dr Browne's interview with Josephine is recorded by him as 10:00, both in the Psychiatric Core Assessment and in the Liaison Psychiatry Book. Dr Browne says it lasted an hour to an hour and a quarter,<sup>115</sup> after which, he spoke to the plaintiff for some five to seven minutes alone and, thereafter, invited him back to the interview room to discuss the matter further.<sup>116</sup> The whole process took, approximately, two hours; that is, from 10:00 to 12:00.<sup>117</sup> Implying inadequacy in the duration of Dr Browne's interview with Josephine, the plaintiff swore that it did not commence until

---

<sup>113</sup> Transcript, Day 3, page 11, line 27.

<sup>114</sup> Transcript, Day 3, page 57, lines 10-18.

<sup>115</sup> Transcript, Day 5, page 41, lines 28-29.

<sup>116</sup> Transcript, Day 5, page 42, lines 20-21.

<sup>117</sup> Transcript, Day 5, page 49, lines 26-27.

10:50,<sup>118</sup> that it lasted no more than 30 to 35 minutes,<sup>119</sup> after which he was then invited to join the meeting for a further 15 or 20 minutes.

**63.** The judge rejected (at para. 291 of the judgment) the plaintiff's testimony regarding the inadequacy of the duration of the interview and the appellants say this was a '*very significant finding*' in respect of a core aspect of the plaintiff's case. Although he went on to find that the interview with Josephine began sometime after 10:30, a finding which the appellants say is unsustainable, he nevertheless rejected, fully, the plaintiff's evidence on the duration of the interview. In answer, the plaintiff concedes that the judge found that the interview with Josephine lasted longer than the 25 minutes he had '*suggested*' but points out that a 10:00 start time was rejected by the judge by reference to the A & E Nursing Notes, and that he found the entry in the ledger to be of '*neutral significance*'.

**64.** I am satisfied that the plaintiff's evidence on the duration and adequacy of the interview with Josephine was rejected by the trial court. The judge found that the notes taken by Dr Browne were far too extensive to have resulted from a truncated interview.<sup>120</sup> As with his evidence on Josephine's lack of capacity at the time of interview, the purpose of the plaintiff's untruthful evidence on its duration was, again, to discredit Dr Browne.

#### *The marriage separation issue*

**65.** This was an important issue in the case. Josephine had said that her overdose on Sunday was in response to a number of stressors, the second of which she identified as the recent break up with her husband. The break up, she considered, was itself in response to the child sexual

---

<sup>118</sup> Transcript, Day 1, page 38, line 13-14. Even on his own evidence, the plaintiff's testimony around the timing and duration of the interview did not stand up. A 30 to 35 minutes interview that started at 10:50 had to be over by 11:10 or 11:20 and yet, he also testified that it ended closer to 12:00. (Transcript, Day 1, page 38, lines 16-17; page 60, lines 26-28; page 74, lines 13-14; page 75, lines 5-6; Day 2, page 50, lines 2-5.)

<sup>119</sup> Transcript, Day 1, page 60, lines 26-28. The plaintiff also gave evidence that the interview lasted '*[a]bout 20 minutes, maybe 25 minutes at the most, about 20 minutes really*'. See para. 9 above and footnote 3.

<sup>120</sup> Paragraph 291 of the High Court judgment.



abuse issue. Later, during her interview, she referred again to the break up with her husband the previous week.<sup>121</sup>

**66.** As of the date of Josephine’s attempted suicide, she and her three adult children were living together as a family unit.<sup>122</sup> It is common case that the plaintiff had left the family home two days earlier, that is, on the Friday before Josephine’s attempted suicide (on Sunday), and, indeed, her completed suicide early on Tuesday morning. In his sworn evidence, the plaintiff vigorously denied any marital breakdown. The marriage was basically harmonious, and his moving out of the family home into rental accommodation prior to Josephine’s suicide was only a temporary arrangement.<sup>123</sup>

**67.** The appellants submit that the judge provided ‘*a surprisingly benign description*’ of what he clearly recognised as untruthful evidence in relation to marital breakdown. On any objective assessment, they say, the evidence constituted ‘*blatant and deliberate lies*’ in support of allegations that Dr Browne’s entries were inaccurate or untruthful. They say that the judge’s eventual recognition that the verified pleadings may ‘*speak the truth*’ meant that he considered that the plaintiff’s evidence on the state of the marriage was untruthful. The judge found that Josephine was concerned about the marriage and that this was appropriately recorded by Dr Browne.<sup>124</sup>

**68.** The plaintiff, in his submissions, makes two points by way of reply on the marriage separation issue. He says the judge noted his acknowledgment that Josephine had attended Accord because their marriage was in difficulty and that the judge did not make a significant factual finding on marriage breakdown but merely speculated that ‘*[i]t may be that a state of marital breakdown existed*’.<sup>125</sup>

---

<sup>121</sup> Psychiatric Core Assessment, pages 2 and 5.

<sup>122</sup> Transcript, Day 1, page 62, line 14.

<sup>123</sup> Transcript, Day 1, page 69, lines 1-3.

<sup>124</sup> Paragraph 303 of the High Court judgment.

<sup>125</sup> Paragraph 303 of the High Court judgment.

69. It seems to me that the trial judge's attempted resolution of the utterly contradictory positions adopted by the plaintiff in relation to the state of the marriage was inadequate. To my mind, he adopted an overly benign approach to the plaintiff's untruthfulness—whichever way one looks at this case. The plaintiff's oral evidence in relation to the state of his marriage was particularly problematic. First, it constituted a complete contradiction of what he said in his pleadings wherein he identified, specifically, that marriage breakdown was a background longstanding social stressor for Josephine, she being a lady with a history of '*a recent separation from her husband*' which ought to have raised '*alarm bells*'.<sup>126</sup> Second, it was irreparably undermined by his belated discovery of documentary evidence which confirmed that Josephine had been concerned about the state of the marriage immediately prior to her attempted overdose and subsequent suicide. Her counselling notes recorded that she had told her counsellor that the plaintiff informed their daughter that her parents were breaking up and that she had gone to Accord, specifically, for marriage counselling. Further, it is noted that Josephine had told her counsellor about a good conversation she had with the plaintiff and that she thought that he would go to personal and couples counselling.<sup>127</sup> Third, and importantly, Josephine herself had identified the break up with her husband as a significant stressor and there was nothing that emerged at trial to suggest, let alone establish, that she was anything other than truthful when she spoke to Dr Browne.

70. On the tenth day of trial, the plaintiff was recalled and questioned as to why he had not previously disclosed to the court the fact that in January 2011 Josephine had attended Accord. His initial response, upon recall, was to deny that he knew that she had gone to Accord and, indeed, that she had, in fact, gone. At one point he stated that there was '*no proof*' that she had gone.<sup>128</sup> Under further cross-examination, however, the plaintiff agreed that he *did know* that

---

<sup>126</sup> See his Replies to Particulars, 25 July 2013 at para. 5 (b), and his Particulars of Negligence in his Endorsement of Claim at para. (n). See also Report of Professor Casey.

<sup>127</sup> Transcript, Day 9, page 17, lines 2-5.

<sup>128</sup> Transcript, Day 10, page 17, line 16.

Josephine had attended marriage counselling and that she had gone because she felt that the marriage was in trouble.<sup>129</sup> After extensive cross-examination on what Josephine had told her counsellor about the conversation she had with the plaintiff and her optimism about going for personal and couples counselling, his testimony on this issue continued to be evasive and shift:

*“Q. Is it your evidence to this Court that you never had any conversation of any kind with your wife about going into Accord or any other marriage counselling service?”*

*A. I didn’t go into Accord. I am sure we talked about different things.*

*Q. The question I asked was did you have a conversation with her about it?*

*A. About which?*

*Q. About going into Accord or any other marriage service?*

*A. For what.*

*Q. For marriage counselling.*

*A. We never talked about us going for marriage counselling, each of us together.”<sup>130</sup>*

**71.** Where there is a clear conflict of evidence, a judge is required to address that conflict and to give clear reasons for the conclusion reached (see *McCormack*). Somewhat unusually, in this case, the irreconcilable conflict that existed was, firstly, *within* the plaintiff’s evidence. His pleadings, which he had verified on affidavit, referred to the fact that the breakdown of the marriage was a background stressor for Josephine, and his oral testimony, also given on oath, was that the ‘*marriage wasn’t breaking down*’ and he and his wife had not separated.<sup>131</sup> During the recall of the plaintiff, the trial judge warned him about the inconsistency that confronted the court in circumstances where the pleadings referred to the breakdown of his marriage with ‘*abundant clarity*’ and the plaintiff was now ‘*trying to explain it away*’.<sup>132</sup> The judge stated:

*“And I need to find an explanation for that, because I will remind you, as I am sure your lawyers have carefully pointed out to you, that the burden of proof in this case is on you and on me making a finding based on credible evidence. And if your evidence falls short*

---

<sup>129</sup> Transcript, Day 10, page 24, lines 10-16.

<sup>130</sup> Transcript, Day 10, page 34, line 20 – page 35, line 3.

<sup>131</sup> Transcript, Day 10, page 31, line 13-18 and page 33, line 16.

<sup>132</sup> Transcript, Day 10, page 51, line 21 – page 52, line 4.

*on credibility, that can have an obvious knock-on effect for this case. Now perhaps you should confront the reality of that and deal with [counsel's] questions.”*<sup>133</sup>

**72.** By the time it came to the writing of the High Court judgment, no explanation had been found by the judge for the plaintiff's attempt to explain away his pleadings. Since his pleadings and oral testimony could not both be true, the plaintiff cannot but have sought to mislead the court, but, regrettably, that reality is not addressed by the judge. The judgment states only that it may be that the pleadings speak '*the truth*'. Aware of the obvious discrepancy, the trial judge stated only that he did not wish '*to dwell on the minutiae of this aspect of the case*'.<sup>134</sup> It seems to me that it was not appropriate, in a case such as this, for the judge to take such a benign approach to the plaintiff's contradictory accounts of the state of his marriage. If his pleadings were not true, then he had sworn an oath to the contrary. If his testimony was untrue, he had sworn that it was the truth. One way or another, he had sworn something which he knew not to be true. That is a matter of serious concern in this case. Where a claim for loss of consortium is made, the truth as to the existence or otherwise of marital breakdown cannot be described in terms of '*minutiae*', as that aspect of the case was central to the appropriateness of bringing such a claim in the first place.

**73.** Nor was any '*obvious knock-on effect*' of the plaintiff's dubious credibility considered by the trial court. The judge's unduly benign view of the plaintiff's untruthfulness regarding his marriage was particularly evident at para. 302 of the judgment. The judge's recognition of the plaintiff's eventual acknowledgement that Josephine had gone for counselling because she felt her marriage was in trouble, took no cognisance of the fact that such acknowledgment came *only* after the plaintiff was faced with strongly probative records that undermined his earlier testimony, and against a background of having denied, repeatedly, the existence of any

---

<sup>133</sup> Transcript, Day 10, page 52, lines 6-14.

<sup>134</sup> Paragraph 303 of the High Court judgment.

marriage separation. Instead of voicing criticism for such an aggravating about-turn, the judge's recognition of this acknowledgment was recorded in order '*[t]o be fair to the plaintiff*'. There was no recognition 'in fairness to Dr Browne', that the plaintiff's evidence, up to that point, on the state of his marriage, was entirely misleading and was given for the purpose of undermining the doctor's competence. At this point, serious doubts as to the plaintiff's overall truthfulness and reliability as a witness ought to have been raised. Whereas the judge recognised that the purpose of the untruthful account was to discredit Dr Browne's assessment of Josephine, including the accuracy of his note taking, he failed to recognise that any consequences should flow from the plaintiff's untruthful evidence. I am satisfied that the judge failed to confront, in any meaningful way, the fact that the plaintiff had given utterly contradictory accounts of the important question of the state of the marriage—the breakdown of which was, clearly, a matter of significant concern to Josephine in the lead up to her attempted suicide. Josephine's concern in this regard was reflected in the testimony of her daughter, Stephanie, who described having heard her mother, on the night before she died, crying while talking on the telephone and saying that she loved her husband.<sup>135</sup> The plaintiff, at that time, had already returned to his rental accommodation.<sup>136</sup> The judge's failure to weigh the plaintiff's evasive and dishonest testimony on the issue of the marriage breakdown, and to assess, appropriately, the cumulative weight of that untruthful testimony led him into error.

*The issue of the plaintiff's own alleged history of child sexual abuse*

**74.** The plaintiff had denied, trenchantly, the truthfulness of what Josephine had told Dr Browne regarding his own experience of child sexual abuse.<sup>137</sup> The judge recognised that the purpose of this denial was to support his own narrative that Josephine was confused and/or that

---

<sup>135</sup> Transcript, Day 3, page 61, lines 14-16.

<sup>136</sup> Transcript, Day 1, page 46, lines 27-28.

<sup>137</sup> Paragraph 314 of the High Court judgment.

Dr Browne got the details wrong.<sup>138</sup> The stridency of the denial on this issue is evident in several parts of the plaintiff's evidence.<sup>139</sup> Mid-trial discovery of attendance records from the Rape Crisis Centre, however, disclosed that the plaintiff had, in fact, attended the Centre in January 2011 in relation to his own child sexual abuse, and Mr Keaveny's counselling notes recorded that '*[f]ollowing this he admitted to [Josephine] that he was sexually abused in childhood.*'<sup>140</sup>

**75.** Upon recall to the witness stand, the plaintiff persisted in denying that he was sexually abused as a child. He agreed that his father was a child sexual abuser.<sup>141</sup> His brother had been abused. He admitted that he had discussed his own history with Josephine. He said that, with her encouragement, he attended the Rape Crisis Centre in connection with his own history just in case he had been sexually abused and had forgotten about it.<sup>142</sup>

**76.** The appellants say that, having regard to such strident and repeated denials and to the plaintiff's '*ultimate admission in the face of irrefutable contradictory evidence*', the judge's characterisation of his testimony on this issue as lacking in '*candour*' does little justice to '*the mendacious nature of this evidence and the perjurious and discreditable purpose for which it was given*'. In reply, the plaintiff submits that the judge acknowledged the difficulties he was facing in addressing this issue and he observed that the judge made a remark that the plaintiff's denial of such '*awful matters*' may have arisen due to the complex emotions unlocked by such revelations.

**77.** The plaintiff's dishonest challenge to the truthfulness of what Josephine had told Dr Browne was unequivocal: '*Where that came from I don't know*'.<sup>143</sup> In his view, her disclosure of this information meant that '*she definitely wasn't all there*' in that '*she didn't understand*

---

<sup>138</sup> Paragraph 318 of the High Court judgment.

<sup>139</sup> Transcript, Day 1, page 44, line 28 – page 45, line 2; page 50, lines 19-23; page 89, lines 7-8. Day 10, page 12, lines 4-6; page 21, line 24 – page 22, lines 1 and 16-20; page 26, lines 20-26.

<sup>140</sup> Transcript, Day 10, page 36, lines 12-15.

<sup>141</sup> Transcript, Day 10, page 39, lines 4-5 and 19-22.

<sup>142</sup> Transcript, Day 10, page 36, lines 26-29.

<sup>143</sup> Transcript, Day 1, page 95, lines 4-5.

*what was going on*', and Dr Browne's noting of it demonstrated his want of judgement in that *'he believed everything she said'*.<sup>144</sup> There may be many reasons why people with a history of personal or familial sexual abuse in childhood may want to deny it, perhaps, even to themselves. Whilst that, in itself, may be understandable, it was altogether improper for the plaintiff to use such a denial for the dishonourable purpose of trying to undermine a vulnerable patient's capacity and to discredit the competence of a doctor who had noted, attentively and accurately, what his patient had told him.

**78.** The plaintiff had sworn an affidavit but had not disclosed records which were critical to several issues of fact, including this one.<sup>145</sup> Confronted with irrefutable documentary evidence, he was forced to admit that he and Josephine had, in fact, discussed the subject of his own sexual abuse in detail and that he had attended the Rape Crisis Centre in connection therewith.<sup>146</sup> His discomfiture was evident when questioned, twice, by the trial court as to why he had not disclosed this information, in circumstances where he was faulting Dr Browne for believing what Josephine had said. He claimed not to understand the simple question he was being asked by the judge: *'I really don't, I am sorry, Judge, I don't understand. [...] Sorry, Judge, I don't understand'*.<sup>147</sup>

**79.** On any view, the plaintiff's untruthful evidence on this issue was an important factor in this case and, to my mind, cannot but have had serious ramifications for his overall credibility. The trial judge's approach to this false evidence was problematic. In my view, the dishonourable purpose for which this evidence was given ought to have been regarded by him as a matter of grave concern, but no such concern is evident in the High Court judgment. Nor did the judge appear to recognise the weight this carried in respect of Josephine's reliability as a truth teller. This was particularly significant because the judge was critical of Dr Browne for

---

<sup>144</sup> Transcript, Day 1, page 44, line 25 – page 45, line 4.

<sup>145</sup> Transcript, Day 10, page 27, line 29 – page 30, line 1.

<sup>146</sup> Transcript, Day 10, page 36, line 27.

<sup>147</sup> Transcript, Day 10, page 23, lines 1-7.

his over reliance on what she had told him and for not taking a longer collateral from the plaintiff. It was only after discovery was made well into the trial that Josephine's truthfulness and Dr Browne's judgment were vindicated, and the plaintiff's untruthfulness exposed for what it was.

**80.** For the judge to describe the plaintiff's testimony given under oath on this issue as '*unsatisfactory*' and reflecting '*a lack of candour*' appears, to my mind, to minimise the significance of what had transpired at trial. Although he acknowledged that the plaintiff did not speak truthfully, the trial judge, nevertheless, appeared to excuse his misleading evidence by reference to the possibility that the plaintiff was in '*a state of denial*' about the very possibility of such '*awful matters*'.<sup>148</sup> No regard was had to the awful consequences which such untruthful testimony had for the doctor who had assessed Josephine and who formed the view that she was coherent and telling the truth. Both Josephine's reliability and Dr Browne's competence were vindicated by the triumph of the truth in this instance. The judge's obvious sympathy for the plaintiff ought not to have detracted from the fact that his misleading evidence was given for discreditable purposes, namely, to reinforce the plaintiff's allegation that Dr Browne had been negligent. The motivation for and consequences of the plaintiff's untruthful evidence on this issue should have carried significant weight in the judge's overall assessment of the evidence.

*The issue of a collateral discussion*

**81.** The conflict on this issue has already been noted and Dr Browne's testimony was outlined above (see para. 13). Recalling, briefly, that testimony, he said that he *had* taken a collateral from the plaintiff. It had lasted some five to seven minutes, during which he asked the plaintiff about finding the hosepipe and the marriage separation, not in detail but in order to check

---

<sup>148</sup> Paragraph 317 of the High Court judgment.



whether what Josephine had told him was correct. He said he also talked about the treatment plan which he had discussed with Josephine.<sup>149</sup> A collateral interview, he said, was important ‘to arrive at whatever judgment we are going to make’ and to check the veracity of what the patient had said.<sup>150</sup> It was only where a discrepancy arose that he would record it. Since his discussion with the plaintiff indicated no such discrepancy, he did not take a note of it.<sup>151</sup> The fact of a collateral having been obtained from the plaintiff was recorded by Dr Browne in the A & E chart.

**82.** The plaintiff denied that a collateral discussion involving only himself and Dr Browne had taken place and he maintained this denial when he was recalled to the witness box. Later, however, he admitted that Dr Browne had spoken to him on his own and he said that just two topics were discussed. The plaintiff’s submissions before this Court confirm his acceptance that an independent discussion had, indeed, taken place, albeit a brief one. The brevity of it was due, primarily, he says, to Dr Browne’s misinterpretation of his obligations in relation to the duty of confidentiality. The plaintiff says that the discussion was ‘*wholly inadequate*’ and that it was quite possible that he could have forgotten it.

**83.** The trial judge preferred the evidence of Dr Browne. He accepted (at para. 324) that a collateral discussion did, in fact, take place. He found that it was curbed by Dr Browne’s views on confidentiality and that Dr Browne had ‘*informed the plaintiff of the treatment plan*’,<sup>152</sup> a finding that was interwoven with his finding of negligence.

**84.** Whereas the judge described the plaintiff’s later evidence as ‘*an evasive and backhanded concession*’,<sup>153</sup> it was, in fact, a straightforward contradiction of his earlier testimony. The plaintiff’s abandonment of his earlier denials that any collateral discussion had taken place, occurred ten days into the trial, undermining further, in my view, his already damaged

---

<sup>149</sup> Transcript, Day 5, page 42, lines 20-21; page 43, line 15-20.

<sup>150</sup> Transcript, Day 5, page 65, lines 16-17.

<sup>151</sup> Transcript, Day 5, page 66, lines 4-5.

<sup>152</sup> Paragraph 325 of the High Court judgment.

<sup>153</sup> Paragraph 312 of the High Court judgment.

credibility. His submission that its short duration and the absence of any notes suggested that it was a brief enough encounter to be forgotten, is not persuasive. A five to seven minute conversation with a psychiatrist about such a critical matter and at such a critical time as the aftermath of an attempted suicide, is not something one is likely to forget. All of the psychiatrists agreed that a collateral interview was important in the context of this case. For the plaintiff to deny, emphatically and repeatedly, that no such discussion took place, was a serious and wrongful allegation to make against Dr Browne. To my mind, once the trial judge accepted that the plaintiff had not told the truth on this critical matter of fundamental importance, he ought to have considered that serious questions arose as to the plaintiff's *bona fides* and credibility in respect of other allegations he made against Dr Browne.

#### *The alcohol misuse issue*

**85.** In his testimony to the court, the plaintiff denied that Josephine had any problem with alcohol, rejecting, indignantly, the reference to her '*recent alcohol misuse*' in Dr Browne's assessment notes.<sup>154</sup> Upon recall, he maintained his denial even in the face of his verified pleadings which referred, specifically, to Josephine's '*recent alcohol misuse*', to '*a significant increase in her alcohol intake*', to the fact that she had '*consumed alcohol daily*' and that '*on two separate occasions as a result of alcohol intake, she was taken by ambulance to [...] hospital for treatment.*'<sup>155</sup> When confronted with such a blatant contradiction of what he had pleaded and verified on affidavit, the plaintiff's reply was '*I didn't write this*'.<sup>156</sup>

**86.** The appellants point out that the judge recognised that the plaintiff was inviting the court to infer either that Josephine's mind was confused and her account to Dr Browne was inaccurate, or that the latter's note and his analysis of the situation were incompetent and below

---

<sup>154</sup> Transcript, Day 1, page 55, lines 27-29.

<sup>155</sup> See para. d of the Particulars of Negligence dated 4 April 2013, para. 5 (c) of his Replies to Particulars of 25 July 2013 and para. 5 of her Replies to Further Particulars, dated 4 September 2013.

<sup>156</sup> Transcript, Day 10, page 46, line 28.

the appropriate standard. In his judgment, the judge recalled (at para. 330) that he had declined to allow the records of Josephine's two hospital admissions to be put into evidence. He did accept, however, that Dr Browne had accurately recorded what he had been told and that his note of '*recent alcohol misuse*' was appropriate.<sup>157</sup> The appellants say that apart from noting the extraordinary discrepancy between the plaintiff's sworn testimony and his sworn pleadings, the judge did not, in any meaningful way, address the implications of his false evidence on this point.

**87.** In reply, the plaintiff says that the trial judge found that Dr Browne's notes were not indicative of any prolonged, *chronic* drinking problem and that both the plaintiff and his daughter confirmed that Josephine was '*a social drinker*'.<sup>158</sup> He also says that whilst Dr Browne's note was accepted as accurate, his evidence that the deceased did not have a problem with alcohol was also accepted. The plaintiff's submission does not address the multiple references in his verified pleadings to Josephine's problems with alcohol.

**88.** It was not sufficient, in my view, for the judge to leave the sworn but contradictory positions of the plaintiff on this issue with the observation (at para. 328) that when set against matters pleaded and verified, the attack on Dr Browne's notes was '*particularly difficult to explain*'. This was a matter that called for an explanation and, as with the marriage separation issue, the only possible explanation is that, on one or other of the two contradictory positions adopted by the plaintiff, he had sworn to the truth of a matter that he had also sworn to be untrue. To leave the matter with the mere observation made by the trial judge, risks diminishing the gravity that attaches to the swearing of an oath. Consequences must flow for a plaintiff who gives, not once, but repeatedly, sworn but false testimony. The judge had acknowledged (at para. 327) that one must assume that the plaintiff's evidence was employed to undermine the competence and standards of Dr Browne, or to question the state of mind of the deceased.

---

<sup>157</sup> Paragraph 332 of the High Court judgment.

<sup>158</sup> Transcript, Day 1, page 55, line 27.

However, in coming to his finding of negligence, he attributes no significant weight to the malign attempt to disparage the competence of a doctor who had recorded a misuse of alcohol by Josephine which, on its face, reflected a far less serious problem than the one pleaded by the plaintiff and verified. Nor was there anything in the judgment to indicate that the judge had considered the *'knock-on effect[s]'* of the plaintiff's increasingly dubious credibility, and his difficulty with telling the truth. He observed only that the swearing of the affidavit was *'a wholly voluntarily self-inflicted wound.'*<sup>159</sup> To my mind, the level of contradiction in respect of the plaintiff's evidence and pleadings, both given under oath, ought to have been seen as far more than a mere wound to the plaintiff's own case; it was an affront to the dignity and the discipline of the court process itself.

**89.** Under cross-examination, counsel reminded the plaintiff of what he had pleaded in relation to Josephine's alcohol misuse and, in particular, to a reply dated 4 September 2013 wherein he had referred to alcohol being consumed daily and to two occasions when, as a result of alcohol, Josephine was taken by ambulance to hospital.<sup>160</sup> He then proceeded to read from records of Josephine's hospital admissions and, in particular, an admission on 14 April 2008 when she fell from a kerb at 05:00 and fractured her left collar bone.<sup>161</sup> The judge was astounded that the hospital admission records had not been put to the plaintiff *'first time round'* because *'it affect[ed] matters in a significant and material way'*.<sup>162</sup> Counsel for the appellants explained that they had been trying to get records from University College Hospital Galway, which were subsequently obtained, and which confirmed two relatively recent admissions. The judge observed that the plaintiff had now *'to try and field all this material'* when it should have been put to him before.<sup>163</sup>

---

<sup>159</sup> Paragraph 272 of the High Court judgment.

<sup>160</sup> Transcript, Day 10, page 56, lines 21-26.

<sup>161</sup> Transcript, Day 10, page 58, lines 6-13.

<sup>162</sup> Transcript, Day 10, page 58, line 29 – page 59, line 1.

<sup>163</sup> Transcript, Day 10, page 58, lines 26-29

90. The record shows that the judge recognised the impact of such records running, as they did, ‘*entirely contrary to what [he was] being told*’.<sup>164</sup> Moreover, he also commented that all this evidence ‘*should have been available for Professor Casey*’<sup>165</sup> and that ‘*[i]t now turns out that [Professor] Casey may have to entirely reconsider her diagnosis or her consideration of the case.*’<sup>166</sup> Noting that certain matters of particular significance, including, Josephine’s alcohol dependence, had been put to the plaintiff upon recall (he having pleaded it), the judge decided to allow counsel for the plaintiff to recall Stephanie so as to permit ‘*a certain amount of adjustment as far as the plaintiff’s case [was] now facing a more robust defence*’.<sup>167</sup> In these circumstances, it seems to me that his decision to deny the appellants the opportunity to admit belatedly obtained hospital admission records into evidence was somewhat disproportionate in a trial, the running of which he recognised had been ‘*fragmented*’.<sup>168</sup>

91. The judge acknowledged that he had not read the pleadings in the case and was taken by surprise.<sup>169</sup> In refusing to admit the records, however, he appears to have overlooked the fact the plaintiff had been asked on 17 June 2013 to make discovery of Josephine’s medical records, including her hospital records, for a period of five years prior to her death in April 2011. The records of a hospital admission dated 14 April 2008 fell clearly within that category.

92. In any event, all this, the judge considered, was making the case ‘*very difficult to resolve*’.

He continued:

“*And then we have all the other issues that I have, I think, in fairness, flagged to [the plaintiff] that are issues of no small significance and indeed of statutory significance. That is another problem that I didn’t think for one moment I would have to confront in this case.*”<sup>170</sup>

---

<sup>164</sup> Transcript, Day 10, page 57, lines 23-24.

<sup>165</sup> Transcript, Day 10, page 59, lines 13-14.

<sup>166</sup> Transcript, Day 10, page 59, lines 21-23.

<sup>167</sup> Transcript, Day 10, page 85, lines 18-21 and page 86, lines 3-16.

<sup>168</sup> Transcript, Day 10, page 84, line 22.

<sup>169</sup> Transcript, Day 10, page 60, lines 27-28.

<sup>170</sup> Transcript, Day 10, page 60, lines 1-6.

Acknowledging the difficulty confronting the court, the judge continued:

*“Prof[essor] Casey’s evidence is premised on certain bases, which include inter alia the accuracy of certain details. We now know what they are. Alcohol abuse is coming up, financial stressors, sexual abuse and alleged sexual abuse involving [the plaintiff] when he was a child and so on and so forth. I don’t know if this is going to kick away the whole basis upon which Prof[essor] Casey has – maybe it doesn’t, I don’t know.”*<sup>171</sup>

**93.** The transcript, therefore, discloses that the trial judge clearly recognised the impact which the plaintiff’s untruthful evidence had for his overall credibility, and, indeed, for the reliability of the basis upon which Professor Casey had premised her evidence. For reasons not stated, none of this made its way into the judgment.

#### *The financial stressors issue*

**94.** Josephine had told Dr Browne that the overdose was in response to some financial stressors. The plaintiff, in his pleadings, had pointed to ‘*financial stressors*’ as one of Josephine’s background social stressors. The plaintiff then gave extensive evidence denying any financial stress.<sup>172</sup> This was, again, to support his assertion that Josephine was mistaken and/or Dr Browne was inaccurate. His evidence in this regard contradicted directly what he had pleaded and verified in his Replies to Particulars.<sup>173</sup> Again, the plaintiff never explained the contradictory positions he adopted on this point, referring only to the fact that Dr Browne said that Josephine did not ‘*discuss*’ financial stresses<sup>174</sup> and that the court found that the family appeared to have been solvent with modest savings.<sup>175</sup>

**95.** The trial judge recognised, perhaps reluctantly, that there were, in fact, financial stressors, and he did so by reference to the pleadings and to the fact that Josephine herself had

---

<sup>171</sup> Transcript, Day 10, page 61, line 28 – page 62, line 7.

<sup>172</sup> Transcript, Day 1, page 86, line 16.

<sup>173</sup> Para. 5(b) of Replies to Particulars, dated 25 July 2013.

<sup>174</sup> Transcript, Day 5, page 73, line 13 – page 74, line 16.

<sup>175</sup> Paragraph 305 of the High Court judgment.

thought so. It follows that he rejected the plaintiff's evidence that Dr Browne's note on this issue was inaccurate. Once again, this rejected evidence can only have been proffered in support of the plaintiff's allegation of negligence.

*The hosepipe issue and the inpatient care issue*

96. These were the two remaining issues on which, the appellants say, the plaintiff gave untruthful evidence. As the trial judge's approach to the evidence on these two issues will be considered in the next part of this judgment, I will leave over any consideration of these matters until then. The only observation I would make at this stage is that the judge did not accept the plaintiff's evidence on the issue of inpatient care.

**Conclusions on Issue 1**

97. What is clear from the above is that on eight of nine important issues of fact, the trial judge did not accept the plaintiff's evidence. That, in itself, is very significant. The issues in question were not incidental matters of minor importance but were central planks in support of the plaintiff's case: that Dr Browne had been negligent in his care of Josephine; that he had interviewed a patient who lacked capacity; that the duration of that interview was inadequate; that he had believed Josephine when she said things that were definitely not true; that he never spoke to the plaintiff alone; that he had inaccurately recorded incorrect information about marriage breakdown, alcohol misuse and financial stress; and, as we shall see, that he had rejected the plaintiff's request to admit Josephine as an inpatient. No part of this narrative was accepted by the trial judge. This was not a case where it could be said that the plaintiff was 'overall a truthful witness' but had, occasionally, given imprecise details in his narrative (*a contrario Ahern* at para. 33). This was a case where, as the appellants correctly point out, the central factual pillars of the plaintiff's case collapsed under the weight of his own untruthful evidence. That being so, the case called for a particularly 'detailed articulation of the ...

*findings of fact*’ on which the trial judge based his decision as to negligence coupled with a justification for why he believed the plaintiff on one specific issue when he had been untruthful on so many others. A clear explanation for the conclusions reached by the judge was required (*McCormack* at para. 99).

**98.** The records show that, at several stages during the trial, the judge noted the difficulties presented by the plaintiff’s contradictory evidence and, indeed, warned him of the ‘*the knock-on effect[s]*’ for the case if his evidence fell short on credibility.<sup>176</sup> Whereas he stated in his judgment that he must treat the plaintiff’s evidence with caution, the judge, in my view, did not, in fact, follow through on the warnings he had given at trial by drawing the appropriate or any adverse inferences from the plaintiff’s damaged credibility. Nor does he address the fact that the case on the pleadings was markedly different from the case at trial.

**99.** The judge found that the extent of the marital problems could be ‘*open to debate*’.<sup>177</sup> This was an unusual finding in circumstances where almost all of the sources of information in relation to the state of the marriage pointed to separation or breakdown. First, there was the plaintiff’s own pleadings asserting marriage breakdown; second, there was Josephine’s account of marriage breakdown as a stressor identified to and noted by Dr Browne—she was shown, irrefutably, to have been telling the truth in other instances where the plaintiff had sought, vociferously, to undermine her credibility and reliability; and third, there were the records created by her counsellor which corroborated what Josephine had said to Dr Browne and which showed that she had attended marriage counselling and had discussed it with the plaintiff.

**100.** Moreover, the fact that the plaintiff chose not to remain in the family home but to return to his rented accommodation on the evening of Josephine’s discharge from hospital following her attempted suicide, drew neither comment nor observation from the trial judge. At the very least, it does not suggest that the extent of the marriage difficulties was quite as ‘*open to debate*’

---

<sup>176</sup> Transcript, Day 10, page 52, lines 6-12.

<sup>177</sup> Paragraph 272 of the High Court judgment.



as the judge considered them to be. The evidence indicated that the breakdown of the marriage was a source of considerable upset for Josephine in the days and hours before her death (see para. 73 above).<sup>178</sup> Whilst Stephanie did not think that her parents' marriage was in difficulty, she had not been living at home in the year preceding the death. Despite the overwhelming weight of the evidence pointing towards marriage breakdown, the judge described (at para. 122) the difficulties only in terms of the couple having had 'a row', which led to the plaintiff staying in temporary accommodation. In fact, the plaintiff's evidence on this was contradictory. At one stage he testified that there was no row or argument,<sup>179</sup> and at another had stated that there had been a falling out. In his own words, the cause of his leaving the home was because Josephine had become 'so uncontrollable' and 'just wasn't right'.<sup>180</sup>

**101.** Noting only that the affidavit of verification may have been a 'self-inflicted wound'<sup>181</sup> and that the marriage difficulties may have been 'more profound' than he was led to believe,<sup>182</sup> the judge did not proceed to attribute any weight to the plaintiff's dishonesty in presenting contradictory sworn evidence on the vital issue of marriage breakdown in the context of a significant claim for loss of consortium.

**102.** The judge's analysis of the issue of the plaintiff's credibility was prefaced by his acknowledgment of the immense personal trauma that had been visited upon him and his children. Nevertheless, he observed that significant aspects of the case hinged on the credibility of the plaintiff and the defendant and the reliability of their respective evidence, and he noted that it was the plaintiff who bore the burden of proof. The judge then recalled the various matters which the plaintiff had verified on affidavit, including, the presence of financial stressors, the breakdown of marriage, and the history of alcohol misuse based on Josephine's daily alcohol consumption. The judge stated (at paras. 272-275):

---

<sup>178</sup> Transcript, Day 3, page 48, lines 15-21.

<sup>179</sup> Transcript, Day 1, page 69, line 22.

<sup>180</sup> Transcript, Day 1, page 86, lines 3-4.

<sup>181</sup> Paragraph 272 of the High Court judgment.

<sup>182</sup> Paragraph 303 of the High Court judgment.

*“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 of 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.*

*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.*

*In approaching [the plaintiff’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.*

*However, in fairness to the plaintiff, I feel 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.”*

**103.** A number of observations might be made about the trial judge’s analysis of the plaintiff’s credibility. First, he acknowledges that the swearing of an affidavit in support of false or misleading pleadings or particulars is a serious matter, a ‘stand-alone’ wrong as well as a

potentially lethal source of infection to the credibility of otherwise pristine and reliable evidence. There was little in this case identified in terms of pristine and reliable evidence on the part of the plaintiff. Second, the judge referred only to the ‘*inconsistencies*’ in the plaintiff’s presentation between his sworn evidence and his affidavit of verification. He did not examine or take that ‘*serious matter*’ any further by recognising that the plaintiff had to be telling lies—one way or another—or by assessing the impact which the plaintiff’s untruthfulness had for the rest of his evidence. Third, the judge decided that he should ‘*view the evidence as a whole*’ in weighing the plaintiff’s credibility, but most of that evidence within the plaintiff’s construct, the trial judge had, in fact, rejected. Fourth, the judge found that aspects of the plaintiff’s evidence were ‘*implausible*’. Finally, he described certain characteristics of the plaintiff based upon his general observation of him. The plaintiff was fraught, defensive, evasive, in denial.

**104.** What was left of the plaintiff’s evidence ‘*as a whole*’ was, essentially, his testimony in relation to the hosepipe incident and his request for inpatient admission. Having rejected most of the pillars of his narrative, as outlined above, the judge went on to make two findings of fact on the basis of which he concluded that Dr Browne was negligent. The erosion of the plaintiff’s credibility on so many topics, and his inability or unwillingness to explain the contradictions in his position, cannot but be viewed as having serious implications for his credibility, generally, and, in particular, his credibility on the remaining issues on which he testified.

**105.** To my mind, had the trial judge viewed the plaintiff’s evidence *as a whole*, he could not but have concluded that his evidence was unreliable. As observed by Noonan J. in *Brown v. Van Greene* [2020] IECA 253, (at para. 75), the plaintiff’s untrue claims and deliberate vagueness and reticence about revealing details of specific activities could not ‘*but have undermined her credibility on all issues to a significant extent*’. It seems to me that this is a case in which the trial judge permitted the immense sadness of Josephine’s suicide to lead him to a position where, far from being harsh in his judgment of the plaintiff, he took an overly benign view of him and his consistently untruthful testimony. No adverse consequences

flowed from the extraordinarily inconsistent and contradictory positions which he had sworn to the court were true.

**106.** In view of the extent of the plaintiff's credibility difficulties, his repeated attempts to mislead the court, his efforts to undermine his wife's capacity and to discredit the professionalism of the psychiatrist who assessed her, the trial judge, in my view, ought to have regarded everything the plaintiff said with a high degree of scepticism. He was obliged to address the impact of the plaintiff's dishonesty on the overall reliability of his claim before the court.

**107.** There were significant credibility concerns attaching to the plaintiff's case and it seems to me that the trial judge did not appreciate, sufficiently, the impact which such dishonest testimony had on the overall credibility of the plaintiff. The extent of that lack of credibility ought to have been factored in to his overall assessment of the claim. The judge's failure to draw any adverse inferences for the plaintiff's general credibility from so many strands of untruthful testimony, is a remarkable omission from the judgment. Moreover, his failure to confront the plain contradiction in the plaintiff's case insofar as the state of his marriage was concerned, presents a fundamental difficulty in proceedings of this nature. The trial judge, for example, never attempted to explain or inquire into why the plaintiff had sought to mislead the court into believing something other than the truth about the state of his marriage. The judge's failure so to do was a glaring omission and constituted a serious deficiency in the judgment.

**108.** The appellants submit that the judge failed to address '*the moral and legal implications*' of the extent of the plaintiff's untruthful evidence. It is difficult to disagree. I am bound to conclude that, given the extensive nature of the untruthful, contradictory and misleading evidence proffered by the plaintiff, the trial judge was obliged to address the consequences which such untruthfulness had on the plaintiff's overall credibility before proceeding to place reliance on any aspect of his evidence. In the circumstances that prevailed, he was obliged to approach the plaintiff's evidence as a whole with the utmost caution and to subject it to a

heightened scrutiny. In the face of such a framework of fabrication on the part of the plaintiff, it was incumbent on the judge to ensure that any findings of fact he was prepared to make on the basis of what the plaintiff had said were (i) founded, firmly, upon credible evidence, and (ii) accompanied by a careful analysis and reasoning. To the two material findings of fact that were made by the trial judge I shall now turn.

## **Issue 2: On the Trial Judge's Material Findings of Fact**

**109.** There are, as noted, two distinct findings of fact under challenge in this appeal. Both were material to the judge's conclusion that Dr Browne was negligent. The appellants contend that the judge's two findings were '*unsupported*' by the evidence, and were against the weight of the evidence. They also contend that, in reaching his findings, the trial judge failed to engage with the expert evidence. As this is a separate ground of appeal I will consider that issue, separately, at a later stage.

### **The Legal Framework**

**110.** In *McDonagh v. Independent Newspapers* [2018] 2 IR 79, Charleton J. observed that the '*template*' for the review of facts on an appeal is to be found in the seminal judgment of *Hay v. O'Grady*. In that case, McCarthy J. recalled that, unlike an appellate court, it is, of course, the trial judge who hears the substance of the evidence, who observes the manner in which it is given and the demeanour of those who testify. If the trial judge makes findings of fact that are supported by **credible** evidence, then an appellate court is bound by those findings. Where a trial judge finds that a witness is honest, even if he exaggerated his injuries, it is not open to an appellate court to set aside that finding subject to the proviso that there may be circumstances '*such as incontrovertible facts or uncontested testimony*' which indicate that the determination of the trial judge was erroneous (see Denham J. in *O'Connor v. Bus Átha Cliath/Dublin Bus* [2003] 4 IR 459 at p. 467).

**111.** A comprehensive summary of the legal principles governing an appellate court’s role in reviewing findings of fact was set out by Collins J. recently in *McDonald v. Conroy and Gorey Community School* [2020] IECA 239. At para. 17, Collins J. observed that the appellate self-restraint mandated by *Hay v. O’Grady* has an important *quid pro quo* which is that the trial court must provide a clear statement of its findings of fact, the inferences to be drawn, and the conclusion that follows. That requirement of *Hay v. O’Grady* was considered by the Supreme Court in *Doyle v. Banville*. A ruling or judgment must enable a party to litigation to know why the party won or lost. To that end, Clarke J. (as the former Chief Justice then was) considered (at p. 510) that ‘*[i]t is important that the judgment engages with the key elements of the case made by both sides and explains why one or other side is preferred.*’ Where a case turns on very minute questions of fact as to what precisely occurred, ‘*then clearly the judgment must analyse the case made for the competing versions of those facts and come to a reasoned conclusion as to why one version of those facts is to be preferred.*’

**112.** Before determining that a trial judge reached an erroneous conclusion, an appellate court must be satisfied that there was a real ‘*non-engagement*’ with important evidence given in a case. In *Leopardstown Club Ltd v. Templeville Developments Limited* [2017] 3 IR 707, McMenamin J. explained matters thus (at p. 748):

*“Non-engagement’ with evidence must mean that there was something truly glaring, which the **trial judge simply did not deal with** or advert to, and where what was omitted went to the very core, or the essential validity, of his findings. There is, therefore, a high threshold. In effect, an appeal court must conclude that the judge’s conclusion is so flawed, to the extent that it is not properly ‘reasoned’ at all. This would arise only in circumstances where findings of primary fact could not ‘in all reason’ be held to be supported by the evidence (...) ‘Non-engagement’ will not, therefore, be established by a process of identifying other parts of the evidence which might support a conclusion other than that of the trial judge, when there are primary facts, such as here.”*

**113.** In *Spencer v. Irish Bank Resolution Corporation Ltd* [2018] 2 IR 669, the Court of Appeal (Hogan J.) reversed a finding of fact in a High Court judgment, in which the plaintiff's claims for negligent misstatement and misrepresentation were dismissed. The defendants argued that the Court of Appeal could not interfere with this finding on *Hay v. O'Grady* grounds. However, Hogan J. found (at p. 708) that the finding of fact could not stand and recalled that the Supreme Court had made it clear in *Wright v. AIB Finance and Leasing Ltd.* [2013] IESC 55 that findings of fact '*are not inviolate*' where there has been a '*material and significant error in the assessment of the evidence*' or where there has been '*a failure to engage with a significant element of the evidence put forward*'. See also *Doyle v. Banville*.

**114.** It seems to me that certain principles may be distilled from the relevant case law on the scope of appellate review in respect of findings of fact. This Court is required to consider: whether the findings made were supported by credible evidence; whether they were based on a reasoned conclusion; whether there were any significant and material errors in the way in which the trial court reached its findings; and whether the trial judge engaged sufficiently with essential parts of the evidence. If an issue of non-engagement is raised, it is not established by identifying other parts of the evidence that might support a different conclusion. Rather, what must be shown is a failure to deal with something that went to the very core or essential validity of the trial court's findings.

**115.** It is within those parameters that the trial judge's findings in respect of the hosepipe incident and the issue of inpatient admission must be reviewed.

### **The Finding on the Hosepipe Incident**

**116.** The first finding made by the trial judge and now under challenge by the appellants was the finding that the plaintiff was probably unaware of the previous suicide attempt involving

the hosepipe.<sup>183</sup> This was an important finding because the judge considered that when Dr Browne raised this issue with the plaintiff, they were at ‘*cross-purposes*’ as to what was being addressed. The judge considered that if a longer collateral had taken place, Dr Browne would have realised that the plaintiff had something else in mind. If that ‘misunderstanding’ had been cleared up by a more searching inquiry, Dr Browne would have been ‘*alerted*’ to the possibility of concealment on Josephine’s part which, in turn, would have had an impact on the treatment plan.

**117.** The appellants contend that the judge’s finding that the plaintiff did not know about the previous hosepipe incident was perverse. They give several reasons for this. First, the finding was contradicted by the evidence of Dr Browne who the trial judge accepted was a truthful witness. Dr Browne had satisfied himself that the plaintiff had corroborated Josephine’s disclosure of a prior suicide attempt involving a hosepipe.<sup>184</sup> Second, the finding was not consistent with the fact that neither the plaintiff nor his solicitor challenged Dr Browne’s evidence about the hosepipe at the Inquest. Third, they say that there was no reference at all to the plaintiff’s alleged unawareness of the incident in the letter of instruction to Professor Casey, which had referred to the prior suicide attempt. Finally, they say that the judge’s finding was not consistent with Josephine’s account as she had told it to Dr Browne. This is important, they say, because the evidence established that Josephine was telling the truth in circumstances where her husband had sought, dishonestly, to discredit what she had said. In view of these factors and combined with the plaintiff’s extensive untruthfulness on other issues, they say that there was no basis for the judge to prefer the plaintiff’s account of the hosepipe incident over Josephine’s, whose factual narrative to Dr Browne was shown to be accurate in all other respects.

---

<sup>183</sup> Paragraph 364 of the High Court judgment.

<sup>184</sup> Paragraph 280 of the High Court judgment.



**118.** In answer, the plaintiff submits that Dr Browne failed to evaluate freely or appreciate the seriousness of the prior suicide attempt, as he was, wrongly, under the illusion that issues of confidentiality prevented him from discussing it in any meaningful way. His own experts agreed that considerations of confidentiality should not have prevented him from discussing the matter with the plaintiff. The judge had found that Dr Browne and the plaintiff were at ‘*cross-purposes*’ as to the relevance of the hosepipe, with the former treating the plaintiff’s recognition of the hosepipe incident as verifying collateral information.

*Was the finding based on credible evidence?*

**119.** The starting point is that this court is bound by the trial judge’s finding that the plaintiff was unaware of the previous hosepipe incident, if that finding was made on the basis of credible evidence. Since credibility was a significant issue in this case, it would be unwise, if not naïve, to examine to the plaintiff’s version of the hosepipe incident without viewing it in the context of his evidence as a whole. As Hardiman J. observed in *Shelly-Morris*, a plaintiff who has systematically misrepresented the truth must face the fact that his credibility in general, and not just on a particular issue, is undermined.

**120.** Taking the plaintiff’s evidence in the round, it is incontrovertible that he gave sworn testimony as to facts on several issues that flatly contradicted facts which he asserted in his verified pleadings. When such obvious and blatant contradictions were put to him, his answer was either to point the finger at his solicitors,<sup>185</sup> or to make a lame and unconvincing attempt to present himself as credible. For example, at the end of his testimony, when it was put to him that Dr Browne’s notes on several issues were correct in contrast to what was established as his inconsistent and/or untruthful evidence thereon, his only reply was to make a rather dismal observation about the 15:00 entry into the A & E chart about Josephine being ‘*more aware*

---

<sup>185</sup> Transcript, Day 10, page 46, line 28.

now' which, in his view, this meant that he was telling the truth.<sup>186</sup> He did not address, let alone explain, the stark irreconcilability between his sworn oral evidence on several issues and his verified pleadings. It is against that background that the plaintiff's testimony in respect of the hosepipe incident ought to have been assessed by the trial judge.

**121.** Dr Browne testified that Josephine had admitted to attempting another self-harm episode some four weeks earlier. She told him that she got a hose, put it to the exhaust of her car, closed the window but then changed her mind. She said that she didn't start the car, but forgot to take the pipe off and that her husband had found it later. Dr Browne said he had recorded *verbatim* what Josephine had told him as set out in his assessment notes (see para. 25 above).

**122.** In contrast to what Josephine had told Dr Browne, the plaintiff testified as follows:

*"I found the hose, yes, but I - - I found the hose but if I found the hose, do you know what I'm saying, it was in the boot of the car."*

*"The story of the pipe is, for starters, as already I explained, she was looking for a part for the Hoover, wanted to know could it (sic) get the pipe for the Hoover and I said that that's silly, you know, the post office, they will sort out all that for you, whatever you want they will give it to you, you know, not be -- and I wouldn't have anything to do with it."*<sup>187</sup>

Asked when, exactly, he found the pipe, the plaintiff did not answer directly but did so only by calculating it against when Josephine had said that it had occurred.<sup>188</sup> This was rather odd to say the least.

**123.** What is clear is that the plaintiff strongly contested what Josephine had told Dr Browne about her forgetting to remove the hosepipe and his finding it. The judge noted (at para. 308) that *'[t]he court was invited to infer that, had Dr Browne mentioned this incident to him, he*

---

<sup>186</sup> Transcript, Day 10, page 69, lines 19-23.

<sup>187</sup> Transcript, Day 1, page 70, lines 15-17; page 71, lines 9-15.

<sup>188</sup> Transcript, Day 1, page 72, lines 19-23.

would then have alerted Dr Browne to the fact that he was unaware of it.’ The ‘story’ as described by the plaintiff was characterised by the judge (at para. 364) as some sort of ‘*contretemps*’ between the plaintiff and Josephine. He accepted the plaintiff’s account, finding that he was probably unaware of the previous attempted suicide involving the hosepipe. He proceeded to fault Dr Browne for not uncovering potential concealment by way of further inquiry. In these circumstances, the reliability of the plaintiff’s evidence on the hosepipe incident takes on a particular gravity. Given the plaintiff’s established difficulties with the telling the truth, his evidence in respect of the hosepipe incident required that it be subject to a heightened scrutiny.

**124.** Such scrutiny would recognise, firstly, that the plaintiff’s acknowledgement of a collateral in which the hosepipe was mentioned took place against the background of his vehement denials that Dr Browne had ever spoken to him on his own. Only later did the plaintiff modify his evidence in this regard, and concede that there was, in fact, a discussion between them and that the hosepipe had, indeed, been raised by Dr Browne. The judge described (at para. 312) this as an ‘*evasive and back handed concession*’ on the part of the plaintiff but attributed no weight to the fact that it was a clear contradiction of the earlier testimony.

**125.** Second, doubts as to the plaintiff’s truthfulness which inevitably impact upon his general credibility have already been noted. Although caution is to be exercised when citing extracts from a transcript, Professor Casey made a statement that raises and, arguably, compounds the doubt about the plaintiff’s alleged unawareness of the previous suicide attempt. Although inconsistent with her views about possible concealment on Josephine’s part, she said that she was very disturbed to learn in consultation ‘*the other day*’, that Josephine had actually asked the plaintiff to get her the hosepipe. She said: ‘*I was unaware of that. I was actually unaware*

that he was aware what she had tried to do with it.<sup>189</sup> Such evidence, at least on its face, serves to undermine the claim that the plaintiff was not aware of the prior suicide attempt.

**126.** Third, when it came to a choice between Josephine’s version of the hosepipe incident and the account proffered by the plaintiff, the trial judge, in my view, ought to have attached significant weight to the fact that Josephine’s reliability as a truth teller in the face of her husband’s efforts to undermine her, had already been well established (see para. 80 above).<sup>190</sup> In such circumstances, it was wholly insufficient, in my view, for the court to accept the plaintiff’s evidence concerning the hosepipe without explaining why the account given by Josephine was to be rejected as untruthful (see *Nolan v. Wirenski* [2016] 1 IR 461 at 475). To my mind, this was all the more so in circumstances where the plaintiff had ‘*systematically misrepresented the truth*’ (*Vesey*).

**127.** Fourth, the obligation on the trial judge to subject the plaintiff’s ‘*story*’ about the hosepipe to heightened scrutiny was necessary in circumstances where the plaintiff’s version of events had influenced Professor Casey’s views. Her report, she confirmed, was based on information she received, including that there had been no independent collateral discussion at all.<sup>191</sup> In her view, had such a collateral occurred, it would have uncovered an element of possible ‘*concealment*’ of a previous suicide attempt. The absence of a collateral had impeded Dr Browne from uncovering this ‘*red flag*’. Dr Browne testified that he *did* have a collateral discussion with the plaintiff and was satisfied that the plaintiff was aware of the hosepipe incident. Although the judge accepted that a collateral had taken place, the fundamental untruth that one had not, cannot but have influenced Professor Casey’s overall assessment of the case and it was her view that, on balance, was preferred by the judge.

---

<sup>189</sup> Transcript, Day 2, page 84, lines 14-16.

<sup>190</sup> See for example her reporting of the plaintiff’s own history of child sexual abuse (‘*Where that came from I don’t know.*’) and her concern about the breakup of the marriage. See Transcript, Day 1, page 95, lines 4-5.

<sup>191</sup> Transcript, Day 2, page 44, lines 19-24; page 76-80; page 113, lines 24-29.

**128.** There are other instances in the transcript which show that Professor Casey was influenced by what she had been told by the plaintiff. That she was misled by the plaintiff's untruthfulness was evident, for example, in her testimony on the issue of sexual abuse, which fed in to her appraisal of Josephine (as possibly '*confused*' or '*mistaken*') and, by extension, of Dr Browne's assessment of the patient who presented before him. She pointed to certain information in the assessment notes as being '*clearly incorrect*', citing the reference to the plaintiff having been sexually abused. She stated:

*"I can't imagine how somebody would say that their husband had been the victim of sexual abuse as stated in the notes if they hadn't been so it suggests she may have been confused or mistaken or perhaps deluded."*<sup>192</sup>

Of course, ultimately, it was established that Josephine was neither mistaken nor delusional when she told Dr Browne that the plaintiff also had an alleged history of child sexual abuse. It was she who had been speaking the truth on this point and it was the plaintiff who had been untruthful. The fact that the plaintiff's untruthfulness had influenced, demonstrably, Professor Casey's testimony ought to have weighed heavily upon the trial judge when reaching any finding of fact upon which he would base his finding of negligence in the light of that expert evidence. Although during the trial he had recognised, immediately, that in view of what emerged following belated discovery, Professor Casey may have to entirely reconsider her diagnosis or consideration of the case (see para. 90 above), no such recognition or concern is to be found in the judgment.

**129.** The plaintiff's version of the hosepipe incident was highly dubious. The trial judge's failure to scrutinise his evidence in this regard was a deficiency in the judgment and resulted in his permitting the plaintiff to escape the fact that his credibility in general had been undermined (*a contrario Vesey*). In my view, by failing to subject the 'story' of the hosepipe to the scrutiny it required, the trial judge fell into error. Treating it with the caution it required,

---

<sup>192</sup> Transcript, Day 2, page 79, line 20-24.

he ought to have subjected the plaintiff's evidence on this issue to a heightened level of scrutiny. No such scrutiny is evident in the trial judge's finding.

**130.** In addition to that failure, the trial judge also erred by reaching a finding that was demonstrably against the weight of the evidence. The finding that the plaintiff was unaware of the previous attempt involving the hosepipe, contradicted Dr Browne's evidence that he was satisfied that the plaintiff was aware of it. It contradicted Josephine's account and she was shown to have spoken the truth on all the other issues on which the plaintiff sought to undermine her, motivated, as he was, by a desire to discredit the written record. Moreover, Josephine's account as recorded in the assessment notes and confirmed in sworn evidence before the Coroner, was not challenged in any way by plaintiff even though he and his solicitor were present at the Inquest. Nor was his alleged unawareness of the previous incident raised in the letter of instruction to Professor Casey. The weight of the evidence strongly favours the view that in denying awareness of the hosepipe incident, the plaintiff, once again, had seized upon what he perceived to be an opportunity to discredit Dr Browne.

**131.** In view of the foregoing, I am satisfied that the trial judge erred (i) in failing to subject the dubious account of an untruthful witness to a level of heightened scrutiny, and (ii) in preferring to accept non-credible evidence against the overwhelming weight of the credible evidence. These were material errors in the way in which the judge reached his finding in respect of the hosepipe incident.

*Was the finding accompanied by a clear and convincing explanation?*

**132.** The trial judge was obliged to have explained, in clear and convincing terms why, when it came to his finding on the hosepipe issue, he had chosen to prefer the evidence of a demonstrably untruthful witness, over both the testimony of Dr Browne and the disclosure that was made about it by Josephine. Josephine had said that having attached the pipe to the exhaust, she had forgotten to remove it and that the plaintiff had found it. The plaintiff said

that he found the pipe in the boot two weeks later<sup>193</sup> and that wherever the incident happened, ‘she had to take it all apart herself and put all the pieces away’.<sup>194</sup> As the judge’s finding on this contentious issue was material to his decision in negligence, there was an obligation on him to analyse ‘the competing versions of those facts’ and to come to ‘a reasoned conclusion as to why one version of those facts is to be preferred’ (see *Doyle v. Banville* at p. 510).

**133.** The judge’s ‘*rationale*’ (at para. 313) for preferring the plaintiff’s account and, necessarily, rejecting the truth of what Josephine has said, was based, essentially, on three points. These were: (i) that if the plaintiff had been ‘*motivated opportunistically to discredit the written record*’, then he would have denied ever finding the hosepipe; (ii) that no other family member knew about it; and (iii) that Dr Brennan didn’t know about it even though Josephine had attended his practice four weeks earlier.

**134.** There are manifest flaws in the ‘*reasoning process*’ by which the judge arrived at his conclusion. First, it was an ‘*incontrovertible fact*’ that on several other issues, the plaintiff gave untruthful evidence motivated to ‘*discredit*’ the written record.<sup>195</sup> The fact that, on this issue, his account was not a total denial (unlike, say, the marriage breakdown or sexual abuse issue) hardly serves to restore his already damaged credibility. The judge’s first reason for accepting the plaintiff’s version is tantamount to concluding that the plaintiff was unlikely to have been lying about the hosepipe because if he were, he would have told a greater lie. That, as a matter of logic, is entirely unsound. Second, Josephine had never indicated to Dr Browne that, having forgotten to take the hosepipe off, anyone other than the plaintiff had found it. Thus, for the judge to rely on the fact that no other family member knew about it as a basis for concluding that the plaintiff did not know, is equally unsound. Third, there was nothing on the record to show that the incident with the hosepipe had occurred *before* Josephine’s last

---

<sup>193</sup> The plaintiff calculated the time by reference to the fact that she told Dr Browne that it happened approximately four weeks before the overdose. See Transcript, Day 1, page 72, lines 21-22.

<sup>194</sup> Transcript, Day 1, page 71, lines 27-28.

<sup>195</sup> As regards CSA, see Transcript, Day 10, page 23, lines 8-27, and as regards alcohol misuse, see page 57, lines 19-24.

consultation with Dr Brennan.<sup>196</sup> That being so, the fact that Dr Brennan did not know about it may well have been explained by the fact that the incident post-dated her last consultation with him. There was no evidence upon which the judge could conclude that Josephine had concealed her attempt with the hosepipe from Dr Brennan.

**135.** None of the judge's 'reasons' provide a reasoned or convincing explanation for preferring the plaintiff's version. A finding that the plaintiff's version should be preferred, on this one issue, in circumstances where, incontrovertibly, he had given false or misleading or untruthful evidence on almost every other important issue, called, all the more, for a clear and compelling explanation. The failure to provide one coupled with material errors in the way in which the judge reached his conclusion indicate, to my mind, that the judge's finding in respect of the hosepipe was flawed. If, as I have found, the judge erred in his finding on the hosepipe issue, that necessarily impacts upon his overall assessment of what transpired on the morning of 18 April when Dr Browne conducted the psychiatric core assessment and satisfied himself that there was nothing in the collateral obtained from the plaintiff which diverged from what Josephine had told him.

**136.** It is common case that Dr Browne felt restrained by his restrictive view of patient confidentiality when speaking to the plaintiff and that he did not go into detail. He was criticised harshly for this. It was, essentially, the basis for the judge's finding of negligence and it is a matter to which I shall return. Whereas the judge (at para. 370) considered it probable that the plaintiff and Dr Browne were '*at cross-purposes*' over the relevance of the hosepipe, that, of course, presupposes that the plaintiff was telling the truth about the hosepipe and that

---

<sup>196</sup> All that the record shows is (i) that Josephine's last attendance with Dr Brennan was on 18 March 2011 (See Transcript, Day 11, page 35, line 18) and (ii) that she told Dr Browne of a previous self-harm incident '*some four weeks ago*', as per: Transcript, Day 1, page 52, lines 2-3. Strictly speaking, four weeks prior to the 18 April (the date of her assessment) was 21 March 2011—three days *after* she had attended Dr Brennan. Thus, if anything, the evidence tilted towards a finding that the incident with the hosepipe post-dated her consultation with Dr Brennan. The trial judge on Day 12, page 62, lines 15-19 had, in fact, acknowledged that the precise date was not known.



his version of events was credible. I have already noted the dubious nature of his account in this regard.

**137.** Moreover, if the plaintiff was telling the truth, I find it utterly implausible that, in the wake of his wife's attempted suicide by overdose and upon being asked a mere random question about finding a hosepipe, that he would *not* immediately have asked what that had to do with anything. Even if, as the judge considered (at para. 364), the plaintiff understood Dr Browne to be referring to the alleged '*contretemps*', it is inconceivable that he would not have asked what that '*silly*' incident had to do with his wife's attempted suicide.<sup>197</sup> The fact that the plaintiff did not ask that most obvious of questions but acknowledged that he found the hosepipe, led Dr Browne to believe, not unreasonably, that the plaintiff was, indeed, aware of the previous incident. Professor Sheehan pointed out that the implication of what Josephine told Dr Browne was that the plaintiff did know about it. Essentially, it was a statement of the obvious. Other things which she told Dr Browne turned out to be true despite the plaintiff's attempt to undermine her. To my mind, the judge's rather benign hypothesis that the parties were at '*cross-purposes*' when the question of finding the hosepipe was raised in collateral simply does not stand up to analysis.

**138.** The judge's resolution of the conflict in the evidence on the hosepipe issue was critical to his finding of negligence. I am satisfied that, in reaching his finding, the judge failed to subject the plaintiff's evidence to the level of scrutiny it required. He provided a flawed '*rationale*' for preferring the plaintiff's version of the incident over what Josephine told Dr Browne and he believed what was, in my view, an utterly implausible account.

**139.** Accordingly, and without straying beyond this Court's appellate function, and recognising the significant deference owed to the views of the trial judge, I am satisfied that the finding he made in relation to the hosepipe incident was marked by several errors in that:

---

<sup>197</sup> '*Silly*' is how the plaintiff described the exchange between himself and the deceased on the issue of the hosepipe. See Transcript, Day 1, page 52, line 18.

(i) it was made without proper scrutiny of the evidence on which it was based; (ii) it was not supported by credible evidence; (iii) it was against the weight of the evidence; and (iv) it was not accompanied by a clear and convincing rationale. These were significant and material errors in the way in which the court's finding on the hosepipe incident was reached and such failures, in my view, led to an erroneous determination on the part of the trial judge.

**140.** This necessarily has implications for the judge's overall assessment, including, his finding that Dr Browne had wrongfully treated the plaintiff's recognition of the previous '*incident*' as verifying collateral confirmation when it was not. It also means that his finding (at para. 364) of possible or potential '*concealment*' on the part of Josephine, and of Dr Browne's failure to uncover such possible or potential concealment was equally not well founded. These are also matters to which I shall return. For now, suffice it to say that Josephine had readily disclosed her previous suicide attempt and her husband's finding of the hosepipe to Dr Browne. The judge considered that the latter's restricted view of confidentiality impeded him from having sufficient regard '*to the previous suicide attempt and its concealment*'. The finding on the hosepipe incident and the question of '*concealment*' are, therefore, clearly related. When it was put to Professor Sheehan that, due to an absence of additional collateral information Dr Browne, '*had wrongly concluded that there was not an element of concealment*', Professor Sheehan stated:

*"As I said earlier, any doctor hearing that someone has tried to gas themselves with a hosepipe, is a serious matter. (...) [Y]ou don't need any more information. It rings the bell, that is serious."*<sup>198</sup>

Dr Browne testified that he did appreciate the significance of the previous incident with the hosepipe, and that he *did* recognise it as a '*red flag*' and that is why the treatment he offered,

---

<sup>198</sup> Transcript, Day 13, page 76, lines 1-9.

in the first instance to Josephine, was inpatient admission.<sup>199</sup> This takes us to the trial judge's second finding which the appellants have challenged in this appeal.

### **The Finding on the Decision to Discharge**

**141.** The trial judge found that when Dr Browne met with the plaintiff, independently, he had already decided that day hospital admission was the appropriate treatment plan for Josephine. This decision was, as it were, a *'fait accompli'* (para. 357) and the judge concluded that Dr Browne had not fully explained the available treatment options to the plaintiff or to the deceased. This finding, the appellants submit, was perverse and unsupported by any or any credible evidence. They say that it is contradicted by Dr Browne's evidence at trial and the judge had found him to be a credible witness. Moreover, it is contradicted by the sworn statement and evidence that Dr Browne gave at the Inquest, just over a year after Josephine died. No challenge or objection was made to that evidence at the time. The appellants say that the finding is also contradicted by the plaintiff's own evidence, which was that he had asked for Josephine to be admitted and that Dr Browne had refused. Additionally, they say, it is contradicted by the contemporaneous documentary records of what happened, as set out both in the *'Action Plan'* and in the A & E chart, in which it is expressly recorded that *'[c]ollateral from husband obtained and he agrees with his wife to come home, once medically fit.'* They say that the finding made, if correct, is not capable of any interpretation other than that Dr Browne's notes were a dishonest fabrication of what had transpired. Such a conclusion, they say, is entirely inconsistent with the judge's findings elsewhere in the judgment that he was a truthful witness who had accurately recorded what had occurred.

**142.** In answer, the plaintiff submits that the judge made the finding on Josephine's discharge having heard and considered all the evidence. His submissions refer, again, to Dr Browne's

---

<sup>199</sup> Transcript, Day 8, page 17, lines 18-19.

restrictive views on patient confidentiality and his refusal to engage with the plaintiff's son. The finding was reached, he says, having regard to those matters and to the '*perfunctory*' nature of the discussion that took place.<sup>200</sup>

*Was the finding based on credible evidence?*

**143.** As with his finding on the hosepipe incident, the trial judge's second finding—that Dr Browne had already decided upon day care as the appropriate treatment option before meeting the plaintiff—was of significant materiality to the overall outcome of the case. That being so, it was necessary for it to have a credible foundational basis. The judge rejected the plaintiff's evidence that he had requested inpatient care and that Dr Browne had refused to accede to that request. I should observe that, if the plaintiff's claim had been well founded, such a response on the part of Dr Browne would have demonstrated a remarkable degree of defiance. If, on the other hand, the allegation was not well founded (as the judge ultimately concluded), then the fact that it was made constituted another serious and unjustified attack on Dr Browne's integrity. This should have had significant implications for the veracity of the plaintiff's other allegations made against the doctor and for his credibility, generally.

**144.** In reviewing the judgment of the High Court, it is difficult to identify any adverse consequences that followed from the plaintiff's unfounded and rejected allegation. The judge accepted Dr Browne's testimony that he had discussed with and offered inpatient care to Josephine. Indeed, he considered that her rejection of the offer was '*not surprising*', there remaining a '*stigma*' attached to mental illness and hospital admission for treatment thereof (para. 390). What the trial judge found, however, was that Dr Browne '*had probably made up his mind that day ward treatment was the appropriate option*' (para. 391) and that the plaintiff

---

<sup>200</sup> Paragraph 339 of the High Court judgment.

was simply informed of this treatment plan and ‘*brought along (...) to discuss the plan already decided upon*’ (para. 391). The decision to discharge Josephine was thus a *fait accompli*.

**145.** Staying firmly within the jurisdictional boundaries of the *Hay v. O’Grady* principles, I consider that this finding was problematic for several reasons. Whereas this Court, as noted above, will not set aside a finding that is based on credible evidence, the most obvious difficulty with the judge’s finding in this instance lies in locating *any* evidence to support it. First, the *fait accompli* finding was contradicted by Dr Browne’s testimony that he offered inpatient care to Josephine which she declined, and that, having met with the plaintiff alone, he then brought the plaintiff into the interview room ‘*to discuss the situation further*’ and that it was discussed and offered but declined once again.<sup>201</sup> Whilst critical of certain aspects of Dr Browne’s evidence, the judge found that, on the whole, he was a credible witness. His finding that the decision to discharge was a *fait accompli* flies in the face of this appraisal.

**146.** Second, the finding was not supported by the plaintiff’s testimony that he had expressly *requested* inpatient admission and that Dr Browne had *refused* to accede to it. For good reason, that testimony was rejected by the trial court. There was no mention of such a request having been made and refused at any point either in the pleadings or the proceedings prior to the plaintiff’s oral testimony. Indeed, the first time that the topic of a *request* for inpatient care arose, was not in anything said by the plaintiff but was rather in something that was mentioned by Dr Browne. In his statement to and evidence at the Inquest, he said that ‘*[w]hilst [the plaintiff] did not have any request for in-patient care, he was concerned that Josephine would receive continued treatment and follow up*’. If that statement constituted a complete and utter contradiction of what had occurred, then—even allowing for the sadness that prevailed on the day—I consider it entirely implausible that not a word of objection was made thereto either by the plaintiff or his solicitor.

---

<sup>201</sup> Transcript, Day 5, page 43, lines 15-28.

**147.** Third, the judge's *fait accompli* finding is contradicted by the contemporaneous documentary evidence and, in particular, by the entries made under 'Action Plan' in Dr Browne's assessment notes and by his entry in the A & E Chart. The assessment notes expressly record that inpatient care was discussed as an option with the patient and her husband, that it was offered, and that the patient and husband both declined it but accepted the Station B contact details if needed for use, and were both happy and agreed to referral to the day hospital for further assessments and supports. There was, therefore, no evidential basis at all for the trial judge's finding on inpatient care and it was clearly a finding made against the weight of the credible evidence in the case.

**148.** Having rejected the evidence that was actually given on the issue of inpatient care, the trial judge did precisely what he was not entitled to do. He proceeded to speculate about what had occurred in relation to inpatient care. The source of his speculation may be traced to a throw-away observation unsupported by any evidence that had been made by Professor Casey.<sup>202</sup> She described a '*passing mention*' in the assessment notes of Dr Browne speaking to the plaintiff as suggesting that '*it was not so much an information gathering exercise as a means of conveying a decision that had been made concerning Josephine's discharge*'.

**149.** The problem with the judge basing his speculation on this throw away remark is obvious. Professor Casey herself confirmed that her observation was based on an assumption—if what was discussed in the collateral was not recorded, then she assumed that it did not take place. That assumption, in itself, is untenable, not least because the plaintiff himself later conceded that a collateral had taken place. Moreover, Professor Casey was not present at the material time, so her view that the collateral was '*a means of conveying a decision that had been made*' was, in itself, entirely speculative.<sup>203</sup> Notwithstanding the manifest frailties inherent in

---

<sup>202</sup> Transcript, Day 4, page 77, lines 10-14.

<sup>203</sup> It had been pointed out to the trial court that Professor Casey was not privy to the collateral discussion which suggested that she was not in a position to comment on what had transpired (see para. 43 above).

Professor Casey’s speculative assumption, the trial judge nevertheless proceeded to accept her throw away remark as the principal basis for his finding that the decision to discharge Josephine was made as a *fait accompli* by Dr Browne and prior to his meeting with the plaintiff.

*Was the finding accompanied by a clear and convincing explanation?*

**150.** On several occasions, the judge concluded that Dr Browne’s notes were accurate, and he rejected the plaintiff’s repeated invitations to infer otherwise. Although he observed (at para. 281) some ‘*shortfalls*’<sup>204</sup> in the note-taking, (the principal one being the failure to record information that did not disturb the patient’s narrative), the judge was not persuaded that there was any materially relevant inadequacy or shortness of detail arising from Dr Browne’s interview with Josephine (para. 344). Moreover, notwithstanding certain ‘*misgivings*’ he had about the way that Dr Browne testified,<sup>205</sup> the judge accepted that he was a truthful witness (para. 280). In the light of both findings—Dr Browne’s accuracy in note-taking and his truthfulness as a witness—the judge’s subsequent finding that the notes, solely on the issue of inpatient admission, ‘*give an inaccurate picture*’ flies in the face of his earlier appraisal of Dr Browne’s truthfulness and the court’s repeated findings that the notes he made were accurate.

**151.** In reaching his decision, the trial judge failed to consider the inevitable consequence which it had for Dr Browne’s credibility as a whole, and he further failed to reconcile such a consequence with his earlier finding that Dr Browne was a truthful witness. The appellants are correct in their submission that the judge’s finding on the offer of inpatient care can have no other interpretation, but that Dr Browne dishonestly fabricated the content of the contemporaneous assessment notes and his entries in to the A & E Chart. Of necessity, such a finding means that Dr Browne falsely recorded that he had discussed inpatient care as an option

---

<sup>204</sup> Paragraph 344 of the High Court judgment.

<sup>205</sup> The judge considered Dr Browne’s account, with reference to his statement to the coroner, to be ‘*somewhat rehearsed*’ (para. 338) and was critical of Dr Browne’s habit of wandering from the direct tense to the subjunctive (para. 277).

with both Josephine and the plaintiff, that he falsely recorded that he had offered it and that it was declined, that he falsely recorded that both were happy with day hospital referral and agreed to it, and that he had falsely recorded that both were happy to go home once medically fit and cleared. It means that he also falsely recorded in the A & E Chart that he had obtained a collateral from the plaintiff and, again, that the plaintiff had agreed for his wife to come home once medically fit. Such dishonestly fabricated entries could not have been '*made in good faith*'<sup>206</sup> The trial judge made no effort to confront the inevitable consequence of his finding on inpatient admission. The serious and inescapable implication that flows from his finding has significant reputational implications for Dr Browne. If the finding were based on credible evidence and accompanied by a reasoned explanation, then it would be a finding by which this court is bound. However, the paucity of *any* evidence in support of the finding has already been noted. The finding is also vitiated by a want of reasoned analysis. The lack of any explanation as to how the judge could reconcile his finding on inpatient care (which carried the inevitable implication of a dishonest fabrication not only of the Psychiatry Department's records but also of those retained in A & E), with his earlier findings as to Dr Browne's truthfulness as a witness and accuracy as a note taker, amounts to a significant deficiency in the judgment. The failure to consider the obvious implication of his finding on inpatient care and its irreconcilability with his earlier findings renders the judgment so flawed as to be not properly reasoned at all.

### **Engagement with Expert Evidence**

**152.** In reaching the two critical findings of fact that grounded the court's decision on negligence, the appellants claim, as a distinct ground of appeal, that there was a failure on the part of the trial judge to engage, appropriately, with the expert evidence at trial. They

---

<sup>206</sup> The judge had earlier stated (at para. 281) that he was satisfied that insofar as any dispute arose as to the observations recorded by Dr Browne, these were made '*in good faith*'.



characterised this as an essential '*disregard*' for the '*credible and consistent*' evidence given by Professor Sheehan and Professor Thakore, coupled with a reliance on Professor Casey's evidence which they say was '*inconsistent and devoid of credibility*'.

**153.** It is, of course, incumbent upon a claimant in clinical negligence litigation not only to establish a duty of care and a breach thereof, but also to demonstrate that the breach in question caused the damage complained of and that the particular damage was foreseeable. I propose to review the trial judge's engagement with the expert evidence on two issues that were critical to his finding of negligence: (i) the evidence on the predictability of suicide (foreseeability); and (ii) the evidence on the consequence of Dr Browne's alleged failure to conduct a more detailed collateral with the plaintiff (causation). Before doing so, however, a brief word might be said about the legal framework within which this Court may review a trial court's assessment of expert evidence.

### ***The Legal Framework***

**154.** The function which the courts can and must perform when resolving disputes between experts '*is to apply common sense and a careful understanding of the logic and likelihood of events to conflicting opinions and conflicting theories*' in order to achieve a just result (*per* Finlay C.J. in *Best v. Wellcome Foundation Ltd* [1993] 3 IR 421 at p. 462). When there are contradictions in the evidence of expert witnesses, a trial judge will generally provide an explanation as to why the evidence of one expert is preferred over that of another. The depth of the explanation required will depend on the significance of the discrepancy to the proceedings. In *Morgan*, Collins J. noted (at para. 21) that:

*"As regards expert evidence, it is difficult to conceive of any circumstance in which it might be sufficient to resolve conflicts of evidence on the basis of a bare statement that the court 'preferred' the evidence of expert A to the evidence of expert B. Of course, as Clarke CJ emphasised in Danbywiske, the choice 'may not require a great deal of explanation in a judgment'. Again, the context will be key."*

**155.** It is well established that an appellate court may have greater scope when reviewing findings made on the basis of expert evidence than when doing so on non-expert oral testimony. Guidance on the scope of an appellate court’s review of a trial court’s approach to expert evidence is to be found in *Donegal Investment Group plc v. Danbywiske* [2017] IESC 14. The High Court had delivered a judgment which fixed the price at which shares in a company might be bought. The Court of Appeal allowed the appeal and remitted the matter to the High Court, with directions as to how the valuation should be calculated. The appellants sought to challenge the Court of Appeal decision. In the Supreme Court, Clarke J. (as he then was) confirmed that the *Hay v. O’Grady* principles apply to the role of an appellate court in assessing findings made with the assistance of expert testimony.<sup>207</sup> However, he added, there may be more scope for an appellate court to assess whether the reasons stated by the trial judge for preferring one piece of expert evidence over another stand up to scrutiny. Clarke J. explained that this is because a trial judge’s decision to prefer the evidence of one expert over another is influenced by the *rationale* put forward by the competing experts, more so than would be the case as regards factual evidence. He observed (at para. 5.6):

*“While it is true [...] that the assessment of all evidence, whether expert or factual, requires both the application of logic and common sense, on the one hand, and an assessment of the reliability or credibility of the witness gleaned from having been in the courtroom, on the other, it may be fair to say that it is likely that a decision based on expert evidence will be significantly more amenable to analysis on the basis of the logic of the positions adopted by the competing witnesses and the assessment of the trial judge of their evidence on that basis.”*

**156.** The Supreme Court held that the Court of Appeal had been correct to find that no sufficient reason could be gleaned from the judgment or the run of the case, as regards the

---

<sup>207</sup> *Donegal Investment* at para 5.4. See also Chapter 23-226 of *Delaney and McGrath on Civil Procedure* (4<sup>th</sup> Edition, Round Hall, 2018).

methodology applied in the valuation of a company. It stressed the importance of a trial court giving a clear statement of the reasons for its decision. Clarke J. stated (at para. 8.9):

*“Where a finding of fact is of significant materiality to the overall conclusion of the case and where the reasons of the trial judge are neither set out in the judgment or can safely be inferred from the run of the case and the structure of the judgment itself, then an appellate court is unable properly to carry out its task of scrutinising the judgment to see whether the findings of fact are sustainable in the light of the principles set out in cases such as Hay v. O’Grady and Doyle v. Banville. In such circumstances an appellate court will have no option but to allow an appeal to the extent appropriate [...].”*

On this point, Clarke J. relied on *James Elliott Construction Limited v. Irish Asphalt Limited* [2011] IEHC 269, wherein Charleton J. had noted that an important part of the trial judge’s assessment of expert evidence is the application of common sense and logic to the views of that expert.

**157.** In *Nemeth v. Topaz Energy Group Limited* [2021] IECA 252, this Court overturned a High Court finding of negligence. The lower court had found the appellant responsible for the respondent’s knee injury sustained whilst checking magazines stored at a low level. The trial court found that the injury was reasonably foreseeable, and that the employer failed to take reasonable care. The trial judge found that the training undertaken by the respondent was lacking in measures to address lower limb injuries and that the appellant’s risk assessment did not address injuries likely to be caused by squatting or kneeling.

**158.** For the Court of Appeal, Noonan J. recalled several recent judgments of this court commenting on expert evidence, of consulting engineers, in particular, which suggested that where the evidence of such experts deals with ordinary everyday matters with which most people would be expected to be familiar, the court may, to an extent, and should, where appropriate, bring its own common sense to bear on the issue. The judge stated at para. 40 *‘[t]hat is not to say that a court is simply free to disregard expert evidence with which it might*

*not agree but where ordinary everyday matters are being considered, some rational analysis should be brought to bear on what might be described as more extravagant theories about such commonplace things.’* He observed that different considerations apply where highly specialised areas of medical or scientific expertise are concerned.

**159.** In *Topaz*, Noonan J. referred to the lack of credible evidence in support of the trial judge’s findings, stating that the judge had made a number of speculative leaps which the evidence did not support. He set out why it was that the appellate court could overturn the findings made by the trial judge in the circumstances, stating (at paras. 50 and 51):

*“[...] as the authorities emphasise, it is not sufficient for a trial judge to simply prefer the evidence of one witness over the other without at least a brief explanation why he or she does so. Otherwise, the parties, and an appellate court, are left in the dark as to why one side won and the other lost. [...]*

*The same rationale applies to conflicts of expert evidence involving matters of expert opinion. Here again, some explanation, however brief, is required to show why one opinion is preferred over another and this necessarily involves engagement with, and analysis of, the competing views of the experts. This is absent in the present case. [...]*”

**160.** The relevant principles on the scope of appellate review in respect of findings based on expert evidence may be summarised thus: (i) that an important part of the trial court’s assessment of expert evidence is the application of logic and common sense to the views of the expert; (ii) that, on review, such assessment may be significantly more amenable to analysis based on the logic of the positions adopted by the competing experts; (iii) that where a finding of fact is of *significant materiality* to the overall conclusion of a case, it must be accompanied by reasons which set out, clearly, the basis for the finding without which an appellate court will be unable to determine whether the finding is sustainable; (iv) that ‘speculative leaps’ unsupported by credible evidence are not sustainable; (v) that a bare statement by the trial court that it prefers the evidence of one expert over another will not be sufficient; (vi) that some

explanation, however brief, is required to show the basis for such preference; and (vii) that this necessarily involves engagement with an analysis of the competing views of the experts.

### ***Expert Evidence on the Predictability of Suicide***

**161.** One feature of Professor Casey’s oral evidence was her testimony that Josephine’s death was predictable because she was a ‘high risk’ for suicide, going so far as to say that, if necessary, the involuntary detention of Josephine should have been considered. The appellants say that Professor Casey’s evidence was not credible. At the outset, they say, it was informed by and based upon the plaintiff’s own false narrative. Additionally, they submit, her opinion regarding the predictability of Josephine’s suicide contradicted her own writings (and those of others) on the issue of predicting suicide; the other two experts agreed with her position as published in her academic work and strenuously disagreed with her oral evidence on this issue. Moreover, given that the judge (at para. 165) did not accept Professor Casey’s evidence that the deceased should have been admitted involuntarily, if necessary, it must follow that Josephine could not have been considered an ‘*immediate*’ risk to herself—that being a criterion for involuntary admission.

**162.** In reply, the plaintiff points out that the trial judge preferred Professor Casey’s evidence having regard to her extensive knowledge and expertise in the area. He refers to the five areas of concern identified by her in relation to the standard of care offered by Dr Browne, describing them as ‘*red flags*’ which ought to have been identified.

**163.** The ability of psychiatrists to predict suicide was addressed at some length by the experts on both sides in the case. Experts on both sides gave evidence on the relationship between the level of suicide risk following an episode of self-harm (‘*immediate*’, ‘*moderate*’ or ‘*high*’) and the eventual outcome in terms of actual follow through to suicide, particularly, for those in the high risk category. It was put to Professor Casey that it was ‘*a startling proposition*’ for her to make *a causative connection* between the areas of concern she had identified in this case and

the actual suicide that occurred, particularly when her own academic publications had confirmed the unpredictable nature of suicide.<sup>208</sup> In this context, certain sections from a chapter she had published in *Psychiatry and the Law* were quoted. For example, she had written:

*“One of the issues arising in law from deliberate self-harm and suicide is the possibility of litigation against doctors when a patient dies by suicide, and especially when the person has had a previous experience of self-harm or suicidal thoughts. In such circumstances, understandably, there is often surprise and anger that the suicide was not foreseen and therefore prevented. From the legal perspective, a primary issue in assessing clinical or administrative decisions taken in such cases in respect of the management of an individual patient’s care is whether the suicide was predictable and/or preventible (sic).”*<sup>209</sup>

**164.** Professor Casey had also described the type of patient considered to be a high risk of suicide. She had written:

*“When the patient can describe such thoughts (suicidal thoughts) and/or provide the details of plans to ends one’s life in a cold and unemotional manner, then the risk of suicide is very high and admission to hospital, compulsory if necessary, is usually required for further assessment and appropriate treatment.”*<sup>210</sup>

**165.** Professor Casey disagreed with the proposition that based on the above indication of what constituted ‘a high risk of suicide’, Josephine did not fall within this category.<sup>211</sup> When pressed as to how she equated Josephine’s remorse and regret and unwillingness to hurt her children with ‘a cold and unemotional description of an intention to commit suicide’, she replied that counsel was ‘extrapolating from a theoretical chapter to an individual case’.<sup>212</sup> She accepted that, in the long term, suicide is unpredictable, but in the short term one can

---

<sup>208</sup> Transcript, Day 4, page 42, lines 1-9.

<sup>209</sup> Transcript, Day 4, page 44, lines 1-12.

<sup>210</sup> Transcript, Day 4, page 46, lines 4-10.

<sup>211</sup> Transcript, Day 4, page 46, line 13.

<sup>212</sup> Transcript, Day 4, page 46, lines 20-21.

‘*identify the people who may be at high risk*’.<sup>213</sup> She accepted that the outcome of studies indicate that in many cases of patients who would not be considered to be at risk of suicide, they proceed to kill themselves whereas in cases where they are considered a high risk, most of them do not.<sup>214</sup> In fact, the vast majority of patients considered as high risk do not actually take their own lives by suicide.<sup>215</sup>

**166.** On the relationship between suicide and deliberate self-harm, Professor Casey agreed that ‘*[d]uring a one year follow up roughly one per cent of deliberate self-harm patients will progress to suicide.*’<sup>216</sup> Another extract from her chapter was read into the Court record:

*“[E]ven in high risk groups, suicide is a rare event, leading to problems in prediction that are manifold, especially in excessively high false positive rates (i.e. those who would be predicted to commit suicide but who in fact do not). If an intervention were tailored to prevent suicide in this high-risk group, then the input would far exceed the necessity and would be unmanageable and unresourceable. This problem is illustrated by the classic study [referenced] [i]n which 4,800 in-patients were examined . . . In summary, for every 100 cases predicted, the forecast was wrong 97 times.”<sup>217</sup>*

**167.** Professor Casey acknowledged that such a figure represented ‘*a stark illustration of how utterly unpredictable suicide really is*’. She pointed out that of those who actually did die by suicide in that study, half were correctly predicted.<sup>218</sup> She confirmed her published conclusion that ‘*even in a high-risk group . . . only a tiny minority (3.3 per cent) expressed suicidal ideas or threats at the final consultation, demonstrating the problem of preventing suicide*’.<sup>219</sup> When it was put to her that Josephine was not a patient who had expressed suicidal ideation at her last meeting with Dr Browne and, on the contrary, had said that she was not going to end her

---

<sup>213</sup> Transcript, Day 4, page 47, lines 11-14.

<sup>214</sup> Transcript, Day 4, page 57, line 29 – page 58, line 2.

<sup>215</sup> Transcript, Day 4, page 61, line 25.

<sup>216</sup> Transcript, Day 4, page 61, lines 14-19.

<sup>217</sup> Transcript, Day 4, page 63, lines 8-27.

<sup>218</sup> Transcript, Day 4, page 64, lines 2-6.

<sup>219</sup> Transcript, Day 4, page 65, lines 3-7.

life by suicide and was sorry for the attempt, Professor Casey agreed but said that Josephine's overall history should have raised concerns and alerted the doctor.<sup>220</sup>

**168.** Professor Casey saw no discrepancy between her conclusion that Dr Browne was negligent in his care of the deceased and her published material. While the long term predictability of suicide borders on the impossible, in the near term, she considered that a risk assessment properly conducted had the potential to save lives. The combination of risk factors in this case, she said, should have resulted in inpatient care which, most likely, would have prevented Josephine's suicide by enabling her to develop a different perspective on her situation and providing access to psychological therapy.<sup>221</sup>

**169.** Professor Thakore testified that trying to foretell who will and who will not die by suicide was '*fraught with difficulties*'. It was '*incredibly difficult to predict those people who commit deliberate self-harm and who will then actually commit suicide.*'<sup>222</sup> Asked whether it would have made any difference even if '*concealment*' were known to be an issue in this case, he testified that '*[A]s Professor Casey has said in her own chapter, there is no evidence that any individual risk factor or collection of risk factors or a risk assessment will allow one to predict confidently that somebody will end up completing the act.*'<sup>223</sup> Professor Casey's own written word and his professional experience of the data does not support the contention that Josephine's suicide was predictable.<sup>224</sup>

**170.** Suicide was a complicated issue, according to Professor Thakore, and he sought to explain the conundrum in which practising clinicians find themselves, citing research that was consistent with the same findings as those cited by Professor Casey in her publication (see para. 166 above). He stated:

---

<sup>220</sup> Transcript, Day 4, page 65, lines 19-23.

<sup>221</sup> Transcript, Day 4, page 67, lines 1-28.

<sup>222</sup> Transcript, Day 11, page 97, lines 20-22.

<sup>223</sup> Transcript, Day 13, page 7, lines 19-23.

<sup>224</sup> Transcript, Day 13, page 9, line 29 – page 10, line 1.



*“People who are deemed ‘high risk’ of committing suicide almost never commit suicide and roughly half of the people that do commit suicidal (sic) are deemed to be ‘low risk’, which puts you in a position to say, well, there’s no individual risk factor with respect to suicide 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. So if you were to look at a sample of people that you believe that were high risk of committing suicide, 97 out of 100 of those people would not commit suicide. So it’s exceedingly difficult to predict who will and who won’t.”<sup>225</sup>*

**171.** Professor Thakore had testified that Dr Browne’s treatment plan reflected the fact he had taken Josephine’s previous episode of self-harm seriously.<sup>226</sup> When questioned further on the importance of suicide risk assessment, he testified:

*“Well, as I’ve said countless times, it’s of little or no value whatsoever. You can’t use a scale that is going to help you to determine who will and who will not commit suicide. This is what all the evidence over the past 40 years has stated time and time again. We wish there was something that we could use but there simply isn’t. And the most recent paper in the British Medical Journal of October 2017 reiterates that when it looked at seven studies, six of which were deemed as high quality by Prizma standards. It stated the same thing, which was that there’s no individual or collective number of risk factors that allow us to predict suicide in any meaningful or accurate way or with any confidence whatsoever.”<sup>227</sup>*

*“Unfortunately we’re just practising in this terrible vacuum where we’re expected to be able to determine who is a high risk and who is a low risk and none of the data allows us to do so with any degree of confidence. And that is a huge problem for us as practising clinicians. And the idea of introducing risk assessment [papers] . . . [is] really not useful and the use of ‘low, medium and high’ is meaningless in terms of who actually completes it.”<sup>228</sup>*

---

<sup>225</sup> Transcript, Day 11, page 99, lines 1-19.

<sup>226</sup> Transcript, Day 13, page 11, lines 1-2.

<sup>227</sup> Transcript, Day 13, page 39, lines 16-29.

<sup>228</sup> Transcript, Day 13, page 40, lines 7-16.

**172.** When it was put to Professor Thakore that the assessment forms were designed, to some extent, at least, to decide whether or not there was a risk of suicide, he answered:

*“They’re not designed to predict suicide unfortunately. There’s no reliable or credible risk assessment questionnaire that will, with any confidence, predict suicide unfortunately. This has been shown time and time again. The best one, which is called CASA, is equally bad at predicting suicide, simply because the data is based upon a group of people who commit deliberate self-harm and then may commit suicide, but those people unfortunately do not represent fully the clinical characteristics of those people who actually commit suicide. And it’s a huge difficulty for us because we are inundated with people who commit self-harm on a day-to-day basis, and to try and sieve through that and see who is going to be committing suicide in the future is, at the moment, impossible.”<sup>229</sup>*

Professor Thakore’s evidence was that it is ‘*almost impossible to predict suicide, even in people that are high risk, and in fact most of the suicides occur in people that we would determine to be low risk*’.<sup>230</sup>

**173.** Finally, expert testimony was also given on the long-term outcome for those patients who are, in fact, admitted to hospital following an episode of self-harm. Professor Casey had testified that if Josephine had been admitted to hospital by Dr Browne, ‘*the chances are that she would still be alive*’.<sup>231</sup> Nevertheless, she went on to accept as ‘*absolutely true*’ the statement in her chapter to the effect that there was very little evidence that psychiatric assessment and intervention (which she agreed referred to admission) following an act of self-harm, had any long term impact on suicide.<sup>232</sup> She had written that: ‘*[t]his is because of the low predictability of suicide even in a high risk group such as those who have a history of self-harm.*’<sup>233</sup> On the basis of the logic of that passage, it was put to her that there was very little

---

<sup>229</sup> Transcript, Day 13, page 40, line 23 – page 41, line 8.

<sup>230</sup> Transcript, Day 11, page 118, lines 7-16.

<sup>231</sup> Transcript, Day 2, page 126, lines, 13-14.

<sup>232</sup> Transcript, Day 4, page 56 lines 26-29; page 57, line 1.

<sup>233</sup> Transcript, Day 4, page 57, line 29 – page 58, lines 1-2.

evidence that an intervention would have made any difference in this case. She utterly disagreed stating, again, that counsel was ‘*extrapolating from a theoretical chapter on suicide to a very specific case*’—one that involved a lady with a depressive illness who had made a prior attempt and was now making another attempt.<sup>234</sup> She did agree that most of those who took their lives after discharge from hospital were thought at the time to be at no or no immediate risk.<sup>235</sup>

#### *The Court’s assessment*

**174.** A troubling aspect of the High Court judgment in this case involving allegations of clinical negligence was the absence of any appropriate consideration of the question of the foreseeability of damage in the light of the expert evidence, and specifically, the evidence on the low predictability of suicide even in high risk groups. It is implicit in the trial judge’s conclusion that Josephine’s suicide was foreseeable and that, on balance, it would have been avoided *but for* the course of action or treatment plan adopted by Dr Browne. Such a conclusion could only have been reached, safely, if it had resulted from a reasoned analysis of the foreseeability of Josephine’s death in the light of the expert evidence on this issue. In my view, it was necessary for the trial judge to explain how he arrived at the conclusion that Josephine’s death was foreseeable in the face of the overwhelming expert evidence that suicide, even in high risk patients, was ‘*utterly unpredictable*’ (as *per* Professor Casey, see para. 167 above) or ‘*almost impossible to predict*’ (as *per* Professor Thakore, see para. 172 above).

**175.** Before proceeding to review the trial court’s assessment of the expert evidence, I pause to point out, for the avoidance of any doubt, that I do not accept, nor should it be inferred from this judgment, that the difficulties inherent in predicting suicide could ever relieve a psychiatrist of the duty to carry out a risk assessment and to offer appropriate treatment in

---

<sup>234</sup> Transcript, Day 4, page 58, lines 25-29.

<sup>235</sup> Transcript, Day 4, page 66, lines 1-3.

accordance with the results thereof. A risk assessment, in some cases, may well indicate that inpatient treatment is warranted, and it would be negligent if an assessing doctor, in such cases, failed to discuss this treatment option and failed to offer it to the patient. The challenge facing a psychiatrist whose patient, in such circumstances, refuses admission to a psychiatric facility and has the capacity so to do, will be considered in the next section. For now, suffice it to say that risk assessment remains a vital component of the day-to-day work of psychiatrists who routinely see significant numbers of patients in Accident and Emergency Departments following episodes of self-harm.

**176.** The High Court judgment does not address in any considered way the expert evidence on the difficulties psychiatrists face in trying to predict the likelihood of suicide in patients who present following an incident of self-harm. Whilst the judge acknowledged the extensive debate that arose during Professor Casey's cross-examination on the unpredictability of suicide, he did not consider it necessary '*to engage to any great degree with this debate*' (para. 397). He noted that, judged statistically, predictors can be '*immensely unreliable*', but considered risk assessment to be '*a useful tool*'. Passing over the question of whether it was predictable or foreseeable that Josephine would end her life by suicide, the judge proceeded to conclude that had she been admitted to hospital, it was '*probable that she would have survived*' (para. 399).

**177.** With respect, the expert evidence on the important issue of foreseeability in this case required a more considered and sophisticated analysis than the one found in the judgment of the trial court. It was not sufficient, in my view, for the judge to bypass an analysis of the extensive expert evidence on the issue with a mere observation that whereas '*suicide can be unpredictable it was not inevitable*' (para. 400). Clearly, the judge preferred Professor Casey's evidence that Josephine's death was foreseeable. Whilst he was entitled to prefer the evidence of one expert over another, he could not properly do so without addressing, even briefly, the inconsistency between Professor Casey's oral testimony and her published work and

explaining why that was not problematic. In addition, he could not, in my view, properly ignore the evidence of the appellants' expert on the near impossibility of predicting suicide without, at least, saying why, or without indicating what it was about that evidence he found wanting or unconvincing (*Donegal Investment*).

**178.** Although psychiatry is, undoubtedly, a specialised area of clinical practice, the expert evidence in this case was amenable to analysis on the basis of the logic of the positions adopted by the competing witnesses (see *Donegal Investment*). For example, when tested against the facts of this case, the appellants' experts' testimony that the assessment notes indicated that Josephine was seriously distressed because of significant life stressors which triggered a feeling of 'helplessness', as distinct from being clinically depressed with a sense of 'hopelessness', was more convincing than Professor Casey's testimony that Josephine was suffering from a depressive illness which Dr Browne had failed to diagnose. Additionally, Professor Thakore's evidence on the distinction in the profession that is drawn between an aborted suicide attempt and an actual suicide attempt made sense.

**179.** Equally, on the application of logic and common sense, Professor Thakore's evidence on the foreseeability that Josephine would take her own life which was articulated in the light of research findings in the area of suicide prediction, was more convincing than Professor Casey's evidence on point, which was marked by distinct inconsistencies between her oral testimony to the court and her written publication on predicting suicide. The views expressed in her academic publication relied upon the same research that Professor Thakore relied on for his views.<sup>236</sup> However, the fact that she relied on this research in her writings (see para. 166 above) in order to demonstrate the problem of preventing suicide obliged her, at the very least, to explain, clearly and convincingly, why it did not apply to the facts of this case. This, to my mind, she failed to do.

---

<sup>236</sup> That Professor Thakore was addressing the same research as Professor Casey is evident from his testimony. See: Transcript, Day 13, page 7, lines 19-23.

**180.** Professor Casey's repeated refrain that counsel was '*extrapolating*' from a theoretical chapter to a specific case was not persuasive. It did not address the essential contradiction between what she had published about unsuccessful attempts at predicting suicide based on known risk factors even in high risk groups,<sup>237</sup> and what she had stated in her oral evidence on the predictability of Josephine's suicide because she was '*high risk*'. Moreover, her refrain ignored the fact that, as a general proposition, the findings and principles articulated in the '*theoretical chapter*'<sup>238</sup> were based upon empirical studies of real people and specific cases. Her reply was all the more unimpressive in circumstances where her published work on the issue of predicting suicide stated, expressly, that it focuses on '*the relevant psychiatric data which should inform the courts' consideration of the questions of legal liability*'.<sup>239</sup> The problematic aspects of Professor Casey's testimony ought to have addressed and resolved by the judge before deciding that he preferred her evidence over the testimony of the other expert in the case.

**181.** Moreover, an explanation by the trial judge as to why Professor Thakore's evidence was to be rejected was all the more necessary in circumstances where his views concurred entirely with Professor Casey's published work on the predictability of suicide but diverged only from her oral evidence on predicting Josephine's death. The judge's observation (at para. 397) that Professor Thakore's views on risk assessments appeared to be '*out of kilter*' with those of his colleagues required substantiation, particularly, where those views were based upon research which was entirely consistent with Professor Casey's published work. If anything, it was Professor Casey's views that appeared to be '*out of kilter*', not just with the views of Professor Thakore and Professor Sheehan but, indeed, with her own published views. None of the experts took issue with the fact that there are, of course, '*risk factors and indicators*' that a psychiatrist

---

<sup>237</sup> See Casey, Brady, Craven & Dillon, *Psychiatry and the Law*, (2<sup>nd</sup> Ed. Blackhall, 2010), Chapter 8 (Patricia Casey) '*Suicidal Thoughts and Behaviours*' p. 125.

<sup>238</sup> Transcript, Day 4, page 46, lines 20-24.

<sup>239</sup> Casey *et al.*, *Psychiatry and the Law*, Chapter 8 (Patricia Casey) '*Suicidal Thoughts and Behaviours*' p. 121.

must bear in mind in adopting a course of treatment, but that fact did not detract from the extensive expert testimony that, even in high risk groups, the probability of correctly predicting suicide in people who self-harm is low. That was an essential part of the evidence with which the trial judge failed to engage.

**182.** Applying logic and common sense to the expert evidence on the foreseeability of Josephine's suicide and reviewing the trial judge's approach to that evidence, it seems to me that Professor Thakore's views—supported as they were by Professor Casey's published work—were eminently more persuasive. To the extent that the trial judge rejected his evidence, *without explanation*, in preference for the problematic testimony of Professor Casey, I am satisfied that he fell into error.

**183.** There were other aspects of the High Court's findings that were also unsatisfactory in that they demonstrated a failure to engage with the expert evidence in the case. For example, the trial judge found that the risk of suicide in this case was '*significant*' (although clearly not '*immediate*' given his rejection of Professor Casey's evidence on involuntary detention). Professor Sheehan had categorised the risk as '*moderate*'. He did so by referring to several factors, including, that Josephine had regretted the '*impulsive*' nature of her action, that she had denied any thoughts of self-harm (which, incidentally, she repeated twice after she had left Dr Browne) and that she had agreed to accept the '*significant intervention*' of treatment in hospital as a day patient. The judge's failure to engage with any of this evidence makes it difficult for this Court to know how he arrived at his own classification of the risk as '*significant*', thus rejecting the persuasive explanation Professor Sheehan had given for classifying the risk as '*moderate*'. This, too, was a deficiency in his judgment.

**184.** Moreover, I could find little, if any, basis in the expert evidence for the trial judge's conclusion that it was probable that Josephine '*would have survived*' had she been admitted to hospital. Even Professor Casey, whose testimony he preferred, confirmed that it was '*absolutely true*' that there was very little evidence that psychiatric assessment and intervention

*in the form of hospital admission*, following an act of self-harm, had any long term impact on suicide.<sup>240</sup>

**185.** The trial court's finding of liability in this case was premised on the proposition that Josephine's suicide was predictable, that Dr Browne ought to have foreseen the probability of it occurring and that he ought to have adopted a different course of action to prevent that foreseeable suicidal act from happening. The overwhelming weight of the expert evidence—supported as it was by Professor Casey's published work—did not support this view. The difficulty in predicting suicide with any degree of accuracy ought not to have been ignored by the trial court when reviewing the reasonableness of Dr Browne's core psychiatric assessment which inevitably involved an evaluation of several factors. The risk assessment he performed included an evaluation of Josephine's testimony wherein she had expressed remorse, had been fully transparent about a previous incident of self-harm, had denied current suicidal ideation, and had accepted admission to hospital to receive treatment as a day patient. Moreover, factored in to that evaluation was the consideration that, having declined inpatient admission, Josephine was not returning to an empty house, but was going home to the care of her family.

**186.** It would be quite wrong, in my view, if, armed with the benefit of hindsight, the 'reasonableness' of an assessment were to be viewed through the prism of whether a self-harming patient ultimately went on to die by suicide. The temptation to determine, retrospectively, the reasonableness of a psychiatric assessment on the basis of eventual outcome must be avoided. In this regard, I find the judgment in *Orpen v. HSE* [2010] IEHC 410 of particular assistance in reviewing the trial judge's approach to liability and causation in this case. In *Orpen*, O'Neill J. at para. 59 stressed the importance of the multiplicity of factors which must be weighed by a treating psychiatrist when engaging in a risk assessment. A trial court, to my mind, is obliged to have some regard to the inherent complexities that confront

---

<sup>240</sup> Transcript, Day 4, page 56, lines 25-29; page 57, line 1.



psychiatrists when conducting risk assessments, particularly, where the predictability of suicide, even in high risk groups, is low. The expert evidence on this issue was an important consideration in determining the question of foreseeability of damage in this case. Having regard to the foregoing analysis, I am satisfied that the trial judge did not engage in any meaningful way with the extensive expert evidence on the predictability of suicide.

### ***Evidence on the Consequences of a Brief Collateral***

**187.** The crux of the trial judge's findings of negligence hinged on what he considered to be the inadequacy of collateral inquiries which, in his view, flowed from Dr Browne's restricted view of confidentiality. Put another way, he found that Dr Browne's views caused him to gather insufficient information which, had it been gathered, would have led him to alter the treatment plan that was put in place for Josephine and thus would not have resulted in Josephine taking her own life. Before examining the expert evidence on the clinical consequences that flowed from Dr Browne's approach, it is necessary to examine, firstly, the evidential basis for the finding that Dr Browne had shut himself off from a potentially rich harvest of information.

### ***Sources of missed information***

**188.** Broadly speaking, the trial judge identified three sources of potential information which Dr Browne had failed to 'tap', and which, if he had tapped or paid heed to, would have guided him to what the judge considered the 'appropriate' treatment plan. The first source was the plaintiff, the second was Dr Brennan (Josephine's GP), and the third was the plaintiff's son. As noted, the judge found that the failure to harvest information from these sources was based, at least in the case of the plaintiff and his son, on Dr Browne's self-imposed restraint concerning patient confidentiality. That is a matter to which I shall return. For now, it is

necessary to consider each of the potential sources in turn in order to examine whether the trial judge's finding is sustainable in the light of the evidence that was before the court.

**189.** The trial judge found (at para. 349) that it was probable that had Dr Browne followed the appropriate practice and enquired about Josephine in greater detail over a longer period of time from the plaintiff '*he would have obtained information which would have contradicted certain elements of the deceased's narrative*'. He then set out to consider which elements of Josephine's narrative would have been contradicted by the plaintiff. On the question of the marriage breakdown, the issue of alcohol misuse, and the report of financial stress, the judge was satisfied that no contradiction would have emerged in relation thereto. On his own analysis, at para. 362, the '*potentially rich harvest of information*' from which Dr Browne had shut himself off was somewhat depleted in that it was reduced to just two issues. Those two issues were (i) the plaintiff's own alleged history of child abuse and (ii) the previous attempt with the hosepipe. If these issues had been explored in greater detail, the judge found that this would have signalled to Dr Browne a difference between the what the plaintiff would have said and what the patient had told him.

**190.** The judge found that the plaintiff would probably have denied Josephine's account of his own alleged history of child abuse. Nevertheless, he held (at para. 365) that this was an issue which Dr Browne ought to have raised: '*[i]t might have been a "false flag" but, to a medical practitioner acting appropriately, it would have spurred further enquiry, or, at least, consideration.*' This was an extraordinary observation to make and the most immediate question that arises is 'To what end?' Had further inquiry on this issue been '*spurred*', it could only have been detrimental to Dr Browne's efforts to verify what Josephine had said. The plaintiff's probable answer—being untruthful—could not but have hampered the psychiatric assessment in that it would have then led Dr Browne to question or to doubt Josephine's reliability notwithstanding the fact that she had been perfectly truthful.

**191.** The other ‘*red flag*’ which would have been uncovered had a more detailed inquiry been made was, according to the trial judge, the plaintiff’s ‘unawareness’ of the attempt at self-harm in relation to the hosepipe incident. I have already identified the several deficiencies inherent in his finding of fact regarding the plaintiff’s implausible version of the hosepipe incident. It is not necessary to repeat those deficiencies. Suffice it to say that, when it came to the plaintiff, the contention that Dr Browne had shut himself off from a ‘*potentially rich harvest of information*’, which could have informed his view and guided him towards the appropriate course of treatment, collapses under scrutiny. With its collapse, the other finding which flowed from it, namely, that a longer collateral with the plaintiff would have uncovered ‘*concealment*’, must also fall.

**192.** The trial judge found that Josephine’s General Practitioner was the second source of information which Dr Browne had failed to ‘*tap*’. The absence of a telephone call with Dr Brennan was criticised by the court. Professor Casey had testified that a call to the GP should have been made as a matter of course, and that the failure to do so in this case was a ‘*grave*’ error.<sup>241</sup> Professor Sheehan did not agree. He said that the family doctor should be called if the psychiatrist considers that there is a shortfall in the information obtained on assessment.<sup>242</sup>

**193.** The judge arrived at his finding that Dr Brennan ought to have been called by a somewhat circuitous, but ultimately flawed route that merits scrutiny. According to the court below, had a fuller inquiry with the plaintiff been made, Dr Browne would have discovered his ‘unawareness’ of the prior attempt and this should have raised a ‘*red flag*’. The material errors made in reaching that finding have already been noted. The judge went on to say (at paras. 380-381) that:

---

<sup>241</sup> Transcript, Day 2, page 89, lines 12-13.

<sup>242</sup> Transcript, Day 12, page 38, line 22 – page 39, line 14.

“*[O]ther issues may well have been raised challenging the veracity of [Josephine’s] account of matters. 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 [Josephine’s] narrative.*”

In the alternative, the judge found (at para. 382) that a medical practitioner acting appropriately would have considered the information gleaned from the curtailed collateral to have been so limited as to require that contact be made with the GP.

**194.** As to what the judge meant by the ‘*other issues*’ that may have been raised that would challenge the veracity of Josephine’s account, is not at all clear. The judge had already found that, apart from the prior attempt with the hosepipe, the only other issue where Josephine’s truthfulness would have been challenged by the plaintiff was in respect of his alleged history of child sexual abuse (para. 367). We know that, despite the plaintiff’s repeated attempts to undermine Josephine’s credibility in this respect, she was ultimately vindicated as being the one telling the truth. Any query on this front, as already noted, could only have impeded Dr Browne’s assessment of Josephine insofar as he may then have suspected that Josephine was mistaken or delusional, when, in fact, she was not.

**195.** The judge’s reference to the plaintiff’s son probably confirming the plaintiff’s information about Josephine’s narrative is also problematic. There was nothing in the evidence to suggest that anyone other than the plaintiff knew about the hosepipe incident, and it is inconceivable that the judge seriously believed (at para. 381), that the son would, in all likelihood, have been in a position to confirm his father’s denial of child sexual abuse. Remarkably, he had earlier found it probable that a collateral from Mr. Stephen Cloonan (hereinafter ‘Stephen’) would have raised question marks about ‘*these matters*’ (para.

356)—that is, about the hosepipe incident and his father’s alleged history of child sexual abuse!<sup>243</sup>

**196.** Thus, the trial judge’s finding (para. 381) that ‘*at that point*’, a medical practitioner acting appropriately would have called the family doctor, with particular reference to the prior attempt and its potential concealment, is entirely unsound since the reasoning by which the judge arrived at that point was significantly flawed.

**197.** The judge found (at para. 383) that if a call had been made to Dr Brennan, Dr Browne would have learned three things: that the GP was ‘*wholly unaware*’ of any suicide attempt or intent to self-harm; that he had made a diagnosis of depression when he last saw Josephine; and, that he would have recommended admission to hospital. In the judge’s view, Dr Brennan’s opinion ought to have weighed heavily with the doctor receiving it and ‘*would probably have influenced his view*’ on treating Josephine.

**198.** Taking each factor in turn, I have already observed that there was nothing on the record to show that Josephine’s previous attempt at self-harm had occurred prior to her visit to Dr Brennan (see para. 134 above). Consequently, the notion that a call to Dr Brennan would have uncovered ‘*potential concealment*’ (he being ‘*totally unaware*’ of the prior attempt) which would then have alerted Dr Browne, and influenced his treatment plan, is misplaced. Second, the ‘*diagnosis*’ (para. 104) of depression which Dr Browne would have discovered was, according to Dr Brennan, one which he had made when he last saw Josephine. There was no note of this diagnosis in his consultation notes. The notes contained only a reference to Josephine’s ‘*distress*’.<sup>244</sup> Moreover, there was nothing to suggest that Dr Brennan considered

---

<sup>243</sup> The judge had accepted (at para. 356) that there was no evidence to suggest that Stephen was aware of any of ‘*other matters*’ referred to in Dr Browne’s notes. Nevertheless, he considered that a significant potential source of information was there and was not ‘*tap[ped]*’.

<sup>244</sup> Transcript, Day 1, page 65, lines 21-23.

that Josephine's condition was serious enough to warrant a referral to psychiatric support services to help her cope with the 'depression' which he claimed to have diagnosed.<sup>245</sup>

**199.** An undocumented diagnosis of depression made by a patient's GP some four weeks prior to an attempted suicide may well be considered a significant factor. However, even if this were known as a result of a telephone call made on the day, it would not have absolved Dr Browne of the duty to form his own opinion of the patient. He, as the psychiatrist assessing Josephine at the time of her admission to hospital, was entitled, indeed obliged, to make up his own mind, to come to his own view of the patient as she presented during the course of his lengthy interview with her. Dr Browne had been practising psychiatry for twelve years and, in his professional view, Josephine did not present with a depressive illness but, rather, with very significant stressors in her life which necessitated urgent psychiatric intervention and support. That, the record indicates, is what he offered to Josephine. When the offer of admission was rejected, he noted that an urgent referral to the day hospital was required. His sworn testimony was that he knew that the matter was serious and that was the reason why he offered her inpatient admission to hospital. Moreover, his oral testimony is corroborated by the entry he made in the medical records which confirms that, following her refusal of admission, Dr Browne had noted 'urgent referral' to the day hospital.

**200.** Thus, had Dr Brennan been called and had he recommended inpatient care (as he says he would have done), this would not have added anything to Dr Browne's own assessment of what was appropriate in the circumstances that presented. Dr Browne had also considered that inpatient care was appropriate and that, he said, was why he discussed it with Josephine and offered it to her—and his evidence in this regard was accepted by the trial judge.

---

<sup>245</sup> This, it seems to me, was the point that Professor Thakore was making when he testified that the GP could have contacted the psychiatric services if he had been concerned whereas the trial judge seems to have understood him to say that the GP could have called A & E during the course of Josephine's admission thereto.

**201.** Dr Brennan also testified that if he had been called, Dr Browne would not have received any more factual information than he already had. An analysis of the evidence before the trial court demonstrates that the judge's finding that the failure to call or to 'tap' Dr Brennan was a missed opportunity to garner a potential '*harvest of information*' which would have influenced Dr Browne in his treatment of Josephine was ill-founded and misconceived. This finding does not stand up to scrutiny.

**202.** The third possible missed source of information, according to the trial judge, was the plaintiff's son, Stephen. The judge was satisfied that Dr Browne was aware that Stephen was upset and concerned that his mother was coming home and that he remonstrated with him. He found that Dr Browne '*paid no heed*' to this, constrained by his erroneous views of patient confidentiality and by the fact that the decision had already been made about the treatment plan (para. 391). Although the judge refers (at para. 395) to '*the additional information*' that would have been harvested from discussing the situation with Stephen, it is unclear what precise additional information the judge had in mind. I have already observed the paucity of truthful information that could have been gleaned from a longer collateral with the plaintiff. Apart from accepting that Stephen was upset about his mother going home, the judge does not indicate what further information he would or could have provided to Dr Browne, which would have altered the treatment plan or guided him towards the 'appropriate' one

**203.** Reviewing the transcript with a view to ascertaining what, if any, was the additional information which the judge had in mind when it came to Stephen, the principal areas of his testimony related to his mother's overdose and condition, and his encounter with Dr Browne. It is clear from the High Court judgment that the trial judge did not accept Stephen's evidence on Josephine's condition in A & E. He had stated that she was '*disorientated*' and '*confused*'

and *'was off her head.'*<sup>246</sup> In finding that Josephine did not lack capacity, this somewhat exaggerated evidence was, necessarily, rejected by the trial judge.

**204.** The other issue on which Stephen testified concerned his encounter with Dr Browne. The record shows that Dr Browne clearly recalled meeting Stephen and having a brief exchange with him. The judge, erroneously, in my view, described Dr Browne as having *'purported'* to give an account of this encounter in a manner *'which suggested that he had a clear recollection'* and then subsequently saying *'that he did not actually remember the exchange'* (para. 278). A careful reading of the transcript indicates that the trial judge erred in his synopsis of Dr Browne's evidence on this issue. Dr Browne testified that he did remember the encounter but what he denied was Stephen's evidence that he had asked *'Are you not keeping her in, like?'*<sup>247</sup> It was that specific aspect of the encounter which Dr Browne denied.<sup>248</sup> Thus, the trial judge's inference that Dr Browne had somehow given contradictory evidence in respect of this encounter was misconceived. That aside, it remains unclear what additional information Dr Browne could have obtained from Stephen which would have caused him to alter the treatment plan—a plan which, as noted, reflected the fact that he considered inpatient treatment to be appropriate and, in default thereof, by reason of refusal by the patient, urgent referral for treatment at the day hospital (see para. 200 above).

**205.** The High Court judge considered that a medical practitioner in Dr Browne's situation, if acting appropriately, would have spoken to the patient, held a longer collateral with her husband, then called the patient's General Practitioner and then, either before or after so doing, had a discussion of the matter with the patient's son (paras. 392 and 393). I would leave to another day the question of whether a hospital psychiatrist in an A & E department is under a duty to speak, individually, to every family member who is present in the

---

<sup>246</sup> Transcript, Day 3, page 11, line 27.

<sup>247</sup> Transcript, Day 3, page 11, lines 17-18.

<sup>248</sup> Transcript, Day 5, page 94 lines 5 and 25.



aftermath of an attempted suicide and who wishes to discuss the situation with the doctor. In any given case and having regard to the distressing nature of such an event, it is conceivable that several concerned family members could be present, each with differing views as to what should be done. The judge, in this case, accepted that an appropriately lengthy interview with the patient had taken place, lasting probably an hour and fifteen minutes, and that this was followed by a discussion of some five to seven minutes with the patient's next-of-kin. He further accepted that following this collateral, a joint consultation involving the patient and her next-of-kin took place. In these circumstances and recognising that every case will turn on its own particular facts, I would caution only against imposing unrealistic expectations on liaison psychiatrists consulted in respect of emergency admissions to A & E departments following self-harming incidents.

### **Patient Confidentiality**

**206.** Dr Browne testified that in the collateral he obtained from the plaintiff, he did not go into detail about issues which Josephine had discussed with him, believing that he owed her, as his patient, a duty of confidentiality. He also testified that having discussed the situation with her nominated next-of-kin, he did not consider it appropriate to discuss it further with her son.<sup>249</sup> In oral and written submissions, the plaintiff criticises Dr Browne, sharply, for his restrictive view and points to that as the source of several alleged failings on his part.

**207.** There is no doubt that the trial judge's criticism of Dr Browne's restricted understanding of patient confidentiality was material to his finding of negligence.<sup>250</sup> He observed that doctors in a situation such as the one that confronted Dr Browne are free to enquire from family members with a view to obtaining collateral information confirming or contradicting material that has been garnered from the patient. He found that Dr Browne's views were out of keeping

---

<sup>249</sup> Transcript, Day 10, page 47, lines 19-21.

<sup>250</sup> Paragraph 348 of the High Court judgment.

with the views of medical practitioners of similar standing. He considered that it was this restrictive view which impeded Dr Browne from having sufficient regard to ‘*the previous suicide attempt and its concealment*’,<sup>251</sup> and which prevented him from paying heed to the plaintiff’s son’s remonstrations.

**208.** I have already observed that, because of significant and material errors, the judge’s finding in respect of the plaintiff’s unawareness of the previous suicide attempt with the hosepipe was not sustainable. I have also noted that, with its collapse, fell his finding of a failure to uncover ‘*concealment*’ or ‘*potential concealment*’.<sup>252</sup> Moreover, Professor Sheehan testified that the assessment notes demonstrate that Josephine was forthcoming in discussion and readily disclosed details of her previous attempt at self-harm, indicating no element of concealment on her part. The weight of the evidence indicated that it was more likely than not that she was speaking the truth when she told Dr Browne that she had forgotten to remove the hosepipe and that her husband had found it later. Notwithstanding the plaintiff’s several attempts to undermine her truthfulness on other issues, she was vindicated as having been the one who spoke the truth.

**209.** Some criticism of Dr Browne’s evidence on the duty of patient confidentiality was justified, in my view. His distinction between ‘talking’ and ‘disclosing’ led to a certain fuzziness in his evidence.<sup>253</sup> He accepted that he had obtained Josephine’s consent *to talk* to her next-of-kin, yet felt obliged *not to disclose* too much detail of what she had told him so as not to trespass on her right to patient confidentiality.<sup>254</sup> His evidence was that he wanted to ‘fact check’ what she had told him about having made a prior attempt. The plaintiff’s

---

<sup>251</sup> Paragraph 355 of the High Court judgment.

<sup>252</sup> In the judgment, the judge’s findings shift between ‘*concealment*’ and ‘*potential concealment*’. See paragraph 381.

<sup>253</sup> Transcript, Day 8, page 14, lines 21-23; and page 15, lines 5-9.

<sup>254</sup> Transcript, Day 8, page 16, lines 18-20.

answering of his question about finding the hose with ‘—[y]eah, he had found the hose’ was the corroboration for which he was looking.<sup>255</sup>

**210.** It should be observed that his testimony showed that Dr Browne was not ignorant of the Medical Council Guidelines on the disclosure of information both with and without patient consent.<sup>256</sup> He was familiar with the provisions of Section C (26.1) and Section C (28.1) of those Guidelines both of which were read into the record. Those provisions stipulate, *inter alia*, that while the concern of the patient’s relatives and close friends is understandable, a doctor must not disclose information to anyone without the patient’s consent. Moreover, they provide that disclosure of patient information without the patient’s consent may be justifiable ‘*in exceptional circumstances*’ where it is necessary to protect the patient from serious risk.<sup>257</sup> In Dr Browne’s view, however, he was satisfied that *full* disclosure was not required in the circumstances that presented as he had received sufficient information from Josephine, who had given a coherent and a comprehensive account of the reason for her attempted suicide and the stressors under which she operated. Without going into detail, he had verified her account with the plaintiff. She had told Dr Browne that she regretted her ‘*impulsive action*’. That being so, he did not consider that there were ‘*exceptional circumstances*’ warranting further disclosure since the purpose of the collateral was to ascertain whether Josephine was telling the truth. Having interviewed the plaintiff, he was satisfied that she was. The implausibility of the plaintiff not asking what a random question about finding a hose had to do with his wife’s attempted suicide has already been noted (see para. 137 above).

**211.** That observation aside, and even accepting that criticism of Dr Browne’s views is justified, the judge was obliged, as a matter of law, to be satisfied that the plaintiff had established, on the balance of probability, a causal link between Dr Browne’s restricted view

---

<sup>255</sup> Transcript, Day 8, page 16, lines 8-10.

<sup>256</sup> Transcript, Day 8, page 18, lines 2-15.

<sup>257</sup> Para. 28 of the Medical Council Guidelines at Number 26 and Transcript, Day 8, page 19, line 3.

of patient confidentiality and the damage in respect of which he complained. In other words, the question that was required to be considered was whether Dr Browne's view of patient confidentiality was the cause of Josephine being discharged which, in turn, led to—not only the risk but the essential likelihood—that she would decide to end her life by suicide. Could it be said that 'but for' his view on patient confidentiality, Dr Browne would have acted differently by recommending a different treatment plan which, in turn, would have led to a different outcome? Here, with due respect to the trial judge, the High Court judgment runs into considerable difficulty.

**212.** The trial judge was entitled to find that Dr Browne's view on patient confidentiality was not in keeping with the view of medical practitioners of similar standing. However, such a finding, on its own, is insufficient to establish clinical negligence (*Dunne*).<sup>258</sup> Causation is a critical factor and the plaintiff had the burden of establishing, on the balance of probability, a causative connection between Dr Browne's restricted view of patient confidentiality and the damage of which he complained. In this regard, it should be noted that Professor Casey acknowledged the distinct possibility that nothing would have changed in terms of Dr Browne's treatment plan for Josephine, had he contacted her General Practitioner and obtained more by way of a longer collateral from the plaintiff. She stated that, had her suggested course of action been taken, this '*might*' have unearthed new information and consequently a different treatment plan.<sup>259</sup> In order to find clinical negligence, of course, it is not sufficient to show that a different course of action *might* have led to a different outcome. One is obliged to establish that on the balance of probability that the course of action actually adopted was the cause of the reasonably foreseeable damage that ensued.

---

<sup>258</sup> All experts agreed that Dr Browne would not have been constrained by the Medical Council Guidelines to discuss the details of Josephine's case with the plaintiff.

<sup>259</sup> See the penultimate paragraph of Professor Casey's supplemental report, dated 16 June 2016.

**213.** Having found Dr Browne’s view on patient confidentiality to be out of keeping with those of medical practitioners of similar standing, the trial judge held (at para. 349) that it was probable that had Dr Browne followed the appropriate practice and enquired in greater detail over a longer period of time from the plaintiff: *‘he would have obtained information which would have contradicted certain elements of the deceased’s narrative.’* The judge (at para. 362) went on to find that:

*“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.”*

**214.** From the analysis conducted thus far, I am satisfied that the only elements of Josephine’s narrative which would have been contradicted by the plaintiff were either not credible (his unawareness of the hosepipe) or not truthful (his own alleged history of abuse). I am also satisfied that the finding that Dr Brennan and Stephen were missed sources of additional information about Josephine which would have altered Dr Browne’s treatment plan (or ‘guided’<sup>260</sup> him towards the appropriate one) was not supported by the evidence. That being so, the trial judge’s finding that the consequence of Dr Browne not conducting a longer collateral or making more detailed inquiries was that he had shut himself off from a potentially rich harvest of information is untenable. It was not established by the evidence that anything which the identified sources could or would or might have offered in the course of further inquiries, would have altered the treatment plan which Dr Browne had considered as appropriate in the circumstances that prevailed. To a consideration of that treatment plan, I shall now turn.

---

<sup>260</sup> Paragraph 347 of the High Court judgment.

## The Treatment Plan

**215.** The trial judge's finding (at para. 362) that the '*potentially rich harvest*' could have informed Dr Browne's view and guided him to the appropriate treatment for Josephine requires analysis. Apart from the fact that the substance of the '*harvest*' was not identified, the treatment plan that Dr Browne considered appropriate for Josephine—as indicated in his contemporaneous notes—involved, as the primary option, inpatient admission and care. Whatever about the judge's hypotheses (at para. 381) about Josephine's '*concealment*' from the plaintiff or Dr Brennan, there is no dispute about the fact that she did not conceal her previous attempt at self-harm from Dr Browne. She gave considerable detail about the stressors in her life that led to the previous attempt. She described what she did with the hosepipe but that she could not go through with it because she could not hurt her children. The record shows that Dr Browne's evidence was that he appreciated that the situation that presented was serious. He testified that he did recognise the '*red flag*' of the previous attempt and, in his own words, that that was the reason why he offered inpatient care to Josephine.<sup>261</sup> The importance of what presented was not lost on him. Several times throughout his testimony he repeated that he did offer inpatient care and treatment.<sup>262</sup> All experts agreed that inpatient care was appropriate as treatment in this case.

**216.** It was open to the trial judge to take the view that Professor Casey's criticisms of the brief nature of the collateral should be accepted. However, in my opinion, the judge could not rightly ignore Professor Sheehan's evidence as to what difference a longer collateral would have made in terms of changing the treatment plan. As this testimony pertained to causation of damage, it was a crucial part of the expert evidence. Professor Sheehan was very clear that Dr Browne had chosen the most appropriate course of treatment in the circumstances, namely,

---

<sup>261</sup> Transcript, Day 8, page 17, lines 18-19.

<sup>262</sup> Transcript, Day 5, page 85, lines 15-26; page 86, lines 9-11 and 29 – page 87, line 1.

inpatient admission.<sup>263</sup> The judge accepted that Josephine was offered inpatient admission, noting that her rejection of this option was understandable given the stigma still associated with psychiatric illness (para. 390). Thus, the treatment plan offered—and noted in writing as having been offered—by Dr Browne was precisely the treatment plan to which (in the judge’s view) Dr Browne would have been ‘*guided*’ had he but held a less restricted view of patient confidentiality and conducted a more detailed collateral. It was Josephine’s decision to decline the offer of inpatient care—a decision she made with capacity—that was the cause of her being discharged and not Dr Browne’s view of patient confidentiality. It follows that the finding that Dr Browne’s view on patient confidentiality prevented or impeded him from offering ‘*the appropriate course of treatment*’<sup>264</sup> is untenable and misconceived. It is unsatisfactory to the point that it must be set aside.

*‘Accommodating’ the risk of suicide*

**217.** This brings us to the heart of the issue that is presented in this appeal, namely, what a psychiatrist in an emergency department is obliged to do where a patient with capacity to decide on treatment rejects inpatient care as ‘*the appropriate course of treatment*’ but does not meet the statutory criteria for involuntary detention as a psychiatric patient.<sup>265</sup>

**218.** In coming to his finding of negligence on the part of Dr Browne, the trial judge found (at para. 389) that it was ‘*necessary*’ that the ‘*significant suicide risk*’ be ‘*accommodated in the advice and treatment of [Josephine]*’ and that ‘*[b]oth the risk and the treatment should be guided by the principle of the least restrictive option*’. What, precisely, the judge meant by the term ‘*accommodated*’ and how such ‘accommodation’ was to be achieved in the circumstances that prevailed, requires to be unpacked. The judge had accepted that the involuntary detention

---

<sup>263</sup> Transcript, Day 12, page 41, lines 23-27.

<sup>264</sup> Paragraph 362 of the High Court judgment.

<sup>265</sup> Paragraph 362 of the High Court judgment

of Josephine was not appropriate.<sup>266</sup> He also accepted that inpatient care had been offered to and declined by Josephine.<sup>267</sup> That being so, the judge was obliged, in my view, to say how such a risk of suicide is to be ‘*accommodated*’ in circumstances where a patient with capacity to decide upon her own medical treatment, agrees to being treated in a day hospital and, as an autonomous adult, rejects the option of voluntary inpatient care.

**219.** This critical issue had been raised, specifically, by Professor Sheehan. He testified that inpatient care should be offered to a patient in Josephine’s position but that little could be done in circumstances where the patient declines to accept it and refuses voluntary admission. He was asked, specifically, what he would have done had he been called as the consultant in this case. He said that the first thing he would have said is: ‘*This lady should be offered admission to hospital*’ and he testified ‘*[T]hat’s actually what Dr Browne did.*’<sup>268</sup> He went on to state that ‘*[b]ased upon the information there, I couldn’t have detained her.*’<sup>269</sup> He then summarised the clinical reality confronting practitioners in rather stark terms:

*“It often comes down to like a core decision, which is this lady has a second attempt, it clearly is serious, can you detain her? She doesn’t want to come in but can you detain her? That’s what it clinically boils down to. With the information provided, that I’ve seen, my view is she doesn’t meet the criteria of the Act. So your hands are tied.”*<sup>270</sup>

**220.** There is nothing in the judgment of the High Court to indicate that the trial judge engaged in any way with this critical part of the expert evidence. Instead of grappling with the reality that Josephine, as a patient with capacity, had autonomously declined inpatient admission, the judge proceeded to embark upon a series of assumptions that led him (at para. 345) to ‘*feel it probable*’ that Josephine would have accepted inpatient admission had greater persuasive force

---

<sup>266</sup> Paragraph 389 of the High Court judgment.

<sup>267</sup> See para. 390 of the High Court judgment. He found her attitude ‘*not surprising*’ because of the stigma still attaching to mental illness in this country.

<sup>268</sup> Transcript, Day 12, page 40, lines 27-29.

<sup>269</sup> Transcript, Day 12, page 42, lines 15-16.

<sup>270</sup> Transcript, Day 13, page 82, lines 6-12.



been exerted by Dr Browne, armed with the support of her family and the advice of Dr Brennan (para. 395). The judge found (at para. 402) that a medical practitioner, appropriately informed, would have persuaded Josephine to remain as an inpatient in hospital. He found that had this approach been followed, she would not have taken her life. He was therefore satisfied, at para. 403, that a case of negligence had been made out against Dr Browne.

**221.** With respect, the approach adopted by the trial judge was vitiated by error in that it was based, entirely, on speculation. The earlier analysis has already shown that there was nothing in terms of additional or new information which the plaintiff, his son, or Dr Brennan could have offered which would have '*altered*' (para. 162) the proposed treatment plan, which, the record shows, recorded '*inpatient care*' as the first option that was discussed with and offered to the patient and her husband (see para. 34 above). Moreover, I can find no basis in the evidence for the judge's '*feel[ing]*' that it was probable that Josephine would have changed her mind had Dr Browne joined forces with her husband to encourage her to stay in hospital. The marriage breakdown was cited by Josephine as the second significant stressor in her life and the judge recognised (at para. 354) that the plaintiff, at that time, would not have contradicted her claim of marriage breakdown. In these circumstances, the idea that, having left the marital home, the patient's husband from whom she had recently separated, could have, somehow, persuaded her to accept admission to a psychiatric facility is speculative if not somewhat naïve.

**222.** It is also important to note, as the appellants point out, that 'the obligation to persuade' which the trial judge appears to have read into the duty of care (at para. 338) was never put to Dr Browne at any time during his evidence. He was cross-examined about the plaintiff's claim that he had refused a request to admit Josephine as an inpatient.<sup>271</sup> It was never put to him that he had failed to persuade her to accept voluntary admission. He was, thus, deprived of procedural justice in that he never had any opportunity to address such a proposition. In

---

<sup>271</sup> Transcript, Day 5, page 44, lines 22-25.

permitting that untested proposition to translate into a finding of negligence against Dr Browne, the trial judge erred in law.

## **Conclusions on Issue 2**

**223.** The significant and material errors in the way the trial judge reached his findings on the on the two critical finding of fact constitute serious deficiencies in the High Court judgment (see *a contrario* this Court’s judgment (Faherty J.) in *Kildare County Council v. Morrin* [2021] IECA 341). The errors identified above led to an erroneous determination on the part of the judge. His finding on the hosepipe incident was *unsupported* by credible evidence, ran contrary to the objective evidence and was against the weight of that evidence. It was also based upon the implausible and ‘*hopelessly unreliable*’ evidence of the plaintiff (*Whelan v. Allied Irish Banks plc* [2014] 2 IR 199).

**224.** Additionally, I am satisfied that the High Court’s finding (para. 339) that Dr Browne had ‘*set his mind*’ on day care as the appropriate treatment prior to his collateral interview with the plaintiff, and that the plaintiff was, effectively, presented with a *fait accompli*, was also vitiated by a number of material errors in the way in which it was reached. These errors included the fact (i) that the finding was not supported by any of the evidence given at trial; (ii) that it constituted speculation on the part of the trial judge; (iii) that it was against the evidence and against the weight of the evidence; (iv) that it was inconsistent with the corroborative contemporaneous records of a witness whom the judge had earlier found to be truthful and whose note taking, in several respects, he found to have been accurate; and (v) that it was vitiated by a want of reasoned analysis insofar as there was a failure to reconcile its inevitable consequence—namely, that Dr Browne had falsely and deliberately fabricated both his own assessment notes and the A & E chart—with an earlier finding that Dr Browne was a truthful witness.

**225.** Moreover, I am satisfied that the trial judge’s findings of a failure on the part of Dr Browne to tap a potential ‘*harvest of information*’ was not borne out by the evidence. Equally, his finding that such a ‘*harvest*’, if tapped, could have guided Dr Browne towards ‘*the appropriate course of treatment*’ was entirely misconceived, in circumstances where he accepted that Josephine had been offered inpatient care—the course of treatment which all experts agreed was the appropriate treatment in this case.

**226.** The errors identified above were compounded by the fact that the judge’s findings were reached without any proper or meaningful engagement with essential parts of the expert evidence. Those parts of that evidence concerned issues of foreseeability and causation and included (i) the inherent difficulties psychiatrists face in predicting suicide even in high risk groups, and (ii) the absence of any *material* consequences, in terms of the treatment plan, that flowed from the brief nature of the collateral taken from the plaintiff or the failure to make further inquiries. The judge also failed to engage with the clinical reality confronting psychiatrists where competent patients who are at risk, decline inpatient care but do not meet the statutory criteria for involuntary admission. The judge’s failure to engage with such critical parts of the evidence, in my view, meets the criterion laid down by the Supreme Court in *Leopardstown Club Ltd*, in that the omission went to the very core, or the essential validity, of the trial judge’s findings on negligence.

**227.** In my view, the trial judge further fell into error in proceeding to speculate about probable outcomes if Dr Browne had exerted greater persuasive force to encourage Josephine to change her mind and to accept inpatient care in a psychiatric hospital. His speculative finding was all the more flawed in circumstances where Dr Browne had not been afforded an opportunity to address the alleged failure to persuade.

**228.** Recalling what O’Donnell J. (as he then was) said in *Whelan* (at p. 238), I am satisfied that this is a case that falls within the category of cases contemplated by Henchy J. in *Northern Bank Finance v. Charleton* [1979] IR 149 when he had stated (at p. 191) that:

*“The court of appeal will only set aside a finding of fact based on one version of the evidence when, on **taking a conspectus of the evidence as a whole**, oral and otherwise, it appears to the court that, notwithstanding the advantages which the tribunal of fact had in seeing and hearing the witnesses, the version of the evidence which was acted on could not reasonably be correct.”*

**229.** In coming to my decision on the second issue in the appeal, I am cognisant of the high degree of deference that an appellate court must show to the trial judge. I am also mindful of the obligation ‘*to avoid applying any exaggerated or unrealistic standard*’ of review by this Court to the High Court judgment (*McDonald*, para. 34). That said, I am satisfied that the lower court’s findings on the hosepipe issue and on the issue of inpatient admission fell clearly within the boundaries of findings that could not, reasonably, be correct and it would be unjust, in my view, for the appellants to be bound by those findings.

**230.** None of the deficiencies identified above were minor or technical in nature. The significant and material errors in how the trial judge reached the findings of fact, necessarily impacted upon his overall assessment of what had transpired on the morning of 18 April 2011, and his unsupported findings were, undoubtedly, foundational to his conclusion that Dr Browne was to be faulted for having breached his duty of care. Those errors constitute an unequivocal justification for this Court to interfere, in the interests of justice, with the judge’s findings of fact, upon which he grounded his conclusion of clinical negligence. Those findings cannot stand and require to be set aside.

### **Issue 3: On Discharging the Burden of Proof**

**231.** The onus was on the plaintiff to discharge the burden of proof and to establish that, on the balance of probability, Dr Browne failed in his duty of care. The appellants submit that, as a matter of law, the plaintiff failed to discharge the burden of proof in two separate but related

respects. First, they say that he failed to discharge the onus of establishing a breach of duty in accordance with the *Dunne* principles; and second, they say that the extent of plaintiff's untruthful evidence was such that the claim should be disallowed because of his failure to discharge the burden in a truthful and straightforward way.

### **The *Dunne* Principles**

**232.** Insofar as the alleged failure to establish a breach of duty under the *Dunne* principles is concerned, the appellants rely on a number of cases in which the courts have considered the management of psychiatric patients. These include *C v. North Western Health Board* [1997] Ir. L. Log Weekly 133 (Circuit Court Judge White); *Orpen v. Health Service Executive* [2010] IEHC 410; and *Corrigan v. Health Service Executive* [2011] IEHC 305. On the evidence that was before the trial court, the appellants contend that there were no grounds for the judge's finding that Dr Browne's actions met the test for establishing negligence as set out in *Dunne*. In their view, the plaintiff's narrative collapsed under the weight of his own untruthful evidence and, as such, he failed to discharge the burden of proof. On any view of the plaintiff's evidence, they say that there could not have been a finding that Dr Browne was proven 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*'.<sup>272</sup> They say that the plaintiff's '*fatally flawed claim*' was rescued only by the unsupported findings made by the trial judge.

**233.** In *C*, the plaintiff claimed damages for assault by a patient who had been admitted, voluntarily, to hospital in circumstances where close supervision was not deemed necessary by the consultant psychiatrist in charge. Having been admitted to a day room, the patient escaped and assaulted the plaintiffs. They argued that closer supervision should have been prescribed for the protection of others. White J. held that there was a duty owed to the plaintiff but, on

---

<sup>272</sup> *Dunne* at p. 109

the application of the *Dunne* principles, he found that there had been no breach of that duty and he refused to impose liability. The case focussed on whether the psychiatrist's decision not to place the patient in a special unit with closer supervision was in breach of duty. The court in *C* held that it was not for a judge or jury to decide which one of two possible choices was the correct one. The doctor had examined the patient for thirty minutes and no propensity for violence was indicated in the GP's referral letter. The regime ordered was reasonable in the circumstances. There being no failure to discharge the duty of care, the plaintiff's claim was dismissed.

**234.** Applying the approach adopted by the High Court in *Orpen*, the appellants submit that there is no basis for the finding that Dr Browne was in breach of duty in not admitting the deceased to hospital. The patient in *Orpen* was a young and single man, named Michael, who had employment difficulties and moderate depression. He took an overdose of pills and, having previously contemplated driving his car off a pier, he presented himself to Letterkenny General Hospital. A Dr McGrory conducted a psychiatric assessment lasting an hour and ten minutes. The assessment included a mental state examination in which the patient was noted as being '*unkempt*' and '*unshaven*'. There was no eye-to-eye contact, his head was down, he was hunched over and sad-looking. Subjectively and objectively, his mood was low, although his memory and insight were intact. She had developed a good rapport with him and had discussed hospital admission. The patient felt that he did not need to be admitted. She agreed and did not pressure him into accepting admission. He said that he was depressed, had dropped out of college and could not cope with life's pressures, but also said that he regretted his actions and would not attempt suicide again. Dr McGrory diagnosed the patient as suffering from depression. His sister was called and when she arrived, she found her brother, to whom she was close, lying in a despondent state. She joined the consultation with him and Dr McGrory. The plan was that he would go home and stay with his sister and that he would attend the following day at a day hospital for counselling.

**235.** Although Dr McGrory considered that the patient was at risk of suicide, she did not consider that he was at risk at that time on the basis that he had attended the hospital, voluntarily, for help, had assured her that he did not have any intention of committing suicide and had repeatedly expressed his remorse. Dr McGrory discussed her findings, diagnosis and plan with the Consultant Psychiatrist by telephone and he had agreed with her assessment and proposed treatment plan. Both doctors were reassured by the fact that the patient could be discharged to a caring relative in a non-threatening and comfortable environment.

**236.** The patient did attend hospital the next day and was examined by a senior psychiatric nurse who asked him to attend again the following day. The patient asked to rearrange that appointment as he was due to work in Malin and considered that this would be a distraction from his troubles. The following day, the patient took his own life by driving his car off a pier. The plaintiff's mother brought proceedings for damages arising from her son's suicide.

**237.** The plaintiff's expert, Dr Cookson, said the patient was a '*high risk*' for suicide and that the doctors did not carry out a sufficient risk assessment. Whereas he agreed it was not an appropriate case for involuntary admission, the expert said that the patient should have been persuaded, with the assistance of his sister, to agree to voluntary admission. Failing such agreement, the patient should only have been released on a regime of close supervision. Rejecting that evidence, the Court considered that, in assessing the suicide risk, neither doctor had failed in the duty of care they owed to Michael. As to the decision not to admit the patient to hospital and to discharge him into the care of his sister, O'Neill J. stated (at para. 67) :

*"[...] 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."*

**238.** In light of the decision in *Orpen*, the appellants say that there was no basis for the High Court's finding, in this case, that Dr Browne was in breach of his duty of care. Josephine had described her overdose as '*impulsive*' and did not think it was a suicidal attempt. She had explained why she did not go through with the previous attempt involving the hosepipe attempt, namely, that she could not hurt her children. Dr Browne had recorded that Josephine had denied any thoughts of self-harm or intent and that she was '*very remorseful*' and regretted the attempt. In contrast to the deceased in *Orpen*, Josephine was noted as being '*pleasant*' and '*chatty*', a patient who '*came willingly to the review*' and who, in Dr Browne's view, was not suffering from depressive illness. As in *Orpen*, the patient was being discharged into the care of a family she loved and had agreed to accept treatment as a day patient.

**239.** The appellants submit that Dr Browne's management plan was entirely in accordance with the principle of managing psychiatric patients in the least restrictive environment. Professor Sheehan gave evidence that he saw many people to whom he would strongly recommend admission to hospital, but that '*we still live in a world where there is a major stigma about admission to a psychiatric ward*'. The least restrictive environment, he testified, is what most people want.<sup>273</sup>

**240.** The appellants also rely upon the observations of Irvine J. (as she then was) in the case of *Corrigan*. The patient in that case was a voluntary patient suffering bipolar depression and was in a manic state on her admission to Roscommon County Hospital. She fell several times and, on one occasion, suffered an orthopaedic injury to her shoulder. She sued the HSE on the basis that she should have been provided with a regime of constant supervision. The HSE

---

<sup>273</sup> Transcript, Day 13, page 59, lines 21-26.



defended its decision not to provide such a regime on the basis that it was in accordance with the principle of using the least restrictive option. Irvine J. stated (at para. 35):

*“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...”*

**241.** The plaintiff does not reply in any detail to the appellants’ submissions on the case law that was opened to the Court. He submits that Josephine’s death ‘*came about*’ as a result of the failure to effect a proper standard of medical care having regard to the deceased’s medical history. The requisite standard, he says, was breached in failing to offer inpatient care and/or failing to ensure that the deceased was admitted to hospital in order to receive the care she needed, having regard to the serious nature of her admission.

**242.** It was also breached in failing to diagnose a depressive illness, which failure, it is said, arose from a failure to interview the plaintiff, independently, and to make contact with the GP. The plaintiff’s submission then sets out an extract from *Dunne* on the principles applicable to the standard of care owed by a medical practitioner.

**243.** The plaintiff contends that the Dr Browne failed in a number of aspects in the standard of care provided and he refers to the aforesaid ‘five failings’ or criticisms made by Professor Casey (see para. 41), which he claims resulted in the deceased ‘*not being offered/adequately offered inpatient care*’. The trial judge, he says, correctly found that admission ‘*was not offered in a manner that could have been accepted by the deceased and her family*’. Admission ought to have been offered when the plaintiff was present so that the deceased could have been encouraged to accept it.<sup>274</sup>

**244.** The plaintiff submits that the failings, which were contrary to generally accepted practice, meant that Dr Browne was not in a position to assess the seriousness of the deceased’s

---

<sup>274</sup> Paragraph 54 of the plaintiff’s submissions to this Court.

condition. These failings, he says, were largely a consequence of his erroneous views on doctor/patient confidentiality. Whilst submitting that there was a failure to interview the plaintiff independently,<sup>275</sup> the plaintiff also contends that in the light of the brief discussion that Dr Browne had with him, it is clear that he had already decided that the deceased should and would attend the day hospital.<sup>276</sup>

### **The Court's Assessment**

**245.** I have already observed that it was on the basis of the two unsupported findings discussed above that the trial judge proceeded to find Dr Browne guilty of negligence. In reaching this finding, the judge, obviously, considered that the onus of establishing a breach of the duty of care had been discharged. With the substance of plaintiff's narrative having been rejected by the High Court and with the two unsupported findings set aside, it is difficult to see what, if anything, is left of the plaintiff's case such as could come close to discharging the burden of proof.

**246.** Whilst the trial judge held (at para. 379) that Dr Browne had left himself in a position of possessing '*inadequate detail*' to properly assess the scope of the risk of Josephine's suicide, I have already identified the dearth of evidence to support that finding and the flawed reasoning by which the trial judge arrived at his view. Apart from Dr Brennan's view that she was depressed (a view which the experienced psychiatrist did not share) there is an obvious paucity in the judgment as to which precise details or what specific (and truthful) information about Josephine's presentation Dr Browne had failed to obtain. The trial judge's working hypothesis that Dr Browne had somehow missed an element of '*concealment*'<sup>277</sup> which, had it been known, would have altered his treatment plan is simply not borne out by the evidence that was

---

<sup>275</sup> Paragraph 51 of the plaintiff's submission to this Court.

<sup>276</sup> Paragraph 54 of the plaintiff's submissions to this Court.

<sup>277</sup> Paragraph 381 of the High Court judgment

before the court. Moreover, as already noted, Dr Browne's restrictive view of the duty of patient confidentiality was not sufficient, in itself, to establish negligence in the absence of causation.

**247.** The test for clinical negligence is a high one. It must be proven that the course which the doctor adopted was one which no professional practitioner of ordinary skill would have adopted, if acting with ordinary care.<sup>278</sup> On the facts of this case, it means that no such practitioner would have acted as Dr Browne did. The landmark ruling in *Dunne* is marked by a preference for assessing professional negligence by reference to the consistency or not of a practitioner's adherence to general and approved practices. Whereas *Dunne* permits a finding of negligence where a practice that is followed is '*inherently defective*', importantly, no negligence will be found where a practitioner who did not adhere to '*general and approved practice*' nevertheless conducted himself, reasonably, having regard to other like practitioners.<sup>279</sup>

**248.** Dr Browne was found by the trial judge to have been a truthful, if imperfect, witness. His testimony was that he had conducted a lengthy interview in which he listened to Josephine's history and took a detailed note of what she said; he assessed her mood and mental state and noted her remorse and regret; she denied suicidal ideation and was forthcoming in what she told him. He formed the impression that her deliberate self-harm had occurred against a background of significant stressors and recent alcohol misuse. He was aware of a previous aborted attempt where her inability to hurt her children prevented her from proceeding. He discussed and offered inpatient care which, as the trial judge noted, she had, understandably, declined. He had taken a brief collateral from her husband sufficient to verify the veracity of what his patient had told him. His evidence was that he then held a further joint consultation

---

<sup>278</sup> *Dunne* at p. 109.

<sup>279</sup> See Mills, *Medical Law in Ireland* (23<sup>rd</sup> Edition, Bloomsbury, 2017), chapter 8.59, citing Healy's '*elegant summary of Dunne*' in Healy, *Medical Malpractice Law* (1<sup>st</sup> Edition, Round Hall, 2009), chapter 5.48.

with the patient and her husband and discussed the various treatment options, offering again the opportunity to be admitted to hospital which, again, was declined. It simply cannot be said that in discharging Josephine home to the care of a family she loved, with contact details for 24/7 support in the event of any emergency or deterioration in her condition, and on the understanding that she would return, voluntarily, for treatment following an urgent referral to the day hospital, that Dr Browne took a course of action which no other practitioner of like skill and specialisation would have followed. The weight of the expert evidence did not support such a view.

**249.** Although Dr Browne may be criticised for his particular interpretation or view of the duty of patient confidentiality, it has not been established that it was this view which led him to adopt a course of treatment that departed from standard and approved practice. All experts agreed that standard and approved practice would dictate that inpatient admission was appropriate in this case. Professor Casey testified that, in the absence of consent, the detention of Josephine, against her will, if necessary, should have been considered. Professor Thakore and Professor Sheehan were adamant that this would have been inappropriate as Josephine did not meet the statutory criteria for involuntary detention. The trial judge did not accept Professor Casey's testimony, there being '*no evidence that the issue would have arisen*' (para. 338). Moreover, the judge accepted (at para. 390) that Dr Browne *had* offered inpatient care to Josephine and that she had refused to accept it. Instead of engaging with the evidence of Professor Sheehan on the stark reality that confronts a psychiatrist '*whose hands are tied*' in such a situation, the trial judge proceeded, on the only basis that he could, to find negligence against Dr Browne by postulating a speculative scenario in respect of which there was *no evidence at all* tendered at trial. This speculative scenario was one wherein Dr Browne had decided, in the course of assessing the patient and before verifying anything of what she had said with her husband, to discharge Josephine home. He simply informed the plaintiff of this and the plaintiff simply accepted it, demurely. This was not the plaintiff's evidence. This was

not Dr Browne's evidence. This was no one's evidence. It was entirely the judge's own speculation. Thus, whilst accepting that inpatient hospital admission had been offered to Josephine, the judge decided, essentially, that it had not been offered enough or offered in the presence of the plaintiff.

**250.** As to it being not offered enough, it was never put to Dr Browne that he had a duty, having offered inpatient care, to persuade Josephine to change her mind and to accept it. Nor was he questioned about the extent of the conversation that he had with Josephine when they discussed inpatient care. In such circumstances, there was no basis for finding that a further discussion with her would probably have caused her to change her mind.

**251.** As to inpatient care not being offered or advocated in the presence of the plaintiff (para. 394), the combined weight of the credible evidence and the corroborative documentary evidence pointed to the fact that it was. Dr Browne's sworn testimony to the Inquest and to the court was that inpatient care had been discussed with and offered to Josephine who did not want to accept it, and that it was discussed again and offered again in the presence of the plaintiff, and that they had declined it but did so having agreed that if either of them felt it necessary or if the situation deteriorated they would contact the emergency psychiatric ward (Station B) which was open 24 hours.<sup>280</sup> Moreover, Dr Browne's testimony that inpatient care had been offered in the presence of the plaintiff was corroborated in the contemporaneous record created at the time. Without any explanation as to why he rejected the corroborative contemporaneous record of a witness whom he had found to be truthful—and whilst, of necessity, recognising the untruthfulness of the plaintiff's repeated requests for inpatient care—the trial judge decided, against the weight of the credible evidence, that inpatient care had not been offered in the presence of the plaintiff. His decision in this regard was perplexing and

---

<sup>280</sup> Whereas the judge found Dr Browne's statement to the Inquest somewhat '*rehearsed*', the evidence he gave at trial was consistent with that statement. That evidence was the subject of examination, rigorous cross-examination, re-examination and questions put by the trial judge.

bizarre. There was no basis in the evidence to suspect or imply that Dr Browne had falsely ‘doctored’ his notes, each page of which he had signed as he proceeded through the assessment.

**252.** In the absence of any expert evidence to the effect that standard and approved practice in psychiatry requires the discharge of a ‘duty to persuade’ a patient (with capacity) to come into a psychiatric hospital in circumstances where that patient does not wish to do so, I am satisfied that the trial judge’s finding of a breach of duty on the part of Dr Browne was wrong in law.

**253.** Having regard to the extent of the plaintiff’s inconsistencies and untruthfulness, and, in particular, to his initial and repeated insistence that Dr Browne never spoke to him alone and refused his request for inpatient admission, it is clear that he sought to paint a picture of Dr Browne that was far from the truth and was not supported by the objective evidence in the case. It must also be observed that much of Professor Casey’s testimony rested upon the presumption that the plaintiff was telling the truth not only about the absence of any collateral interview and his unawareness of the prior attempt,<sup>281</sup> but also about his wife’s state of mind.<sup>282</sup> Although the trial judge recognised the impact which the plaintiff’s untruthfulness must have upon Professor Casey’s consideration, she was not recalled to the witness box after mid-trial discovery (and what it uncovered) had been made. To the extent that the trial judge relied on the evidence of Professor Casey (which was not without its own inconsistencies) I am satisfied that he failed to take sufficient account of the impact of the plaintiff’s false narrative on the reliability of her evidence.

**254.** In coming to his decision on negligence, the trial judge criticised Dr Browne for the ‘*over-reliance*’<sup>283</sup> he placed upon what Josephine had told him. A word of caution is merited here. The evidence established that Josephine had been forthright and forthcoming in providing relevant and truthful information *at that time*. Dr Browne’s reliance on her

---

<sup>281</sup> As noted above, her evidence as to the plaintiff’s state of knowledge on this point was ambiguous.

<sup>282</sup> She pointed to her making up accounts of his own sexual abuse as an example of Josephine not being right.

<sup>283</sup> Paragraph 339 of the High Court judgment.

statements as to her current state of mind on the question of self-harm was an important part of his overall assessment, having satisfied himself that she was telling the truth about the significant stressors in her life and her prior aborted attempt. Given her capacity and lucidity (as evidenced in the detail she provided) Dr Browne was entitled to attach importance to what Josephine told him about the absence of thoughts of self-harm and her regret and remorse at her impulsive action, in terms of his overall assessment. As O’Neill J. observed (at para. 64) in *Orpen*:

*“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.”*

**255.** The statements made by Josephine to Dr Browne were also crucial to *his* assessment of suicide risk in the immediate future—which was also the timescale in issue in this case. He was entitled to weigh them in the balance. Dr Browne’s evidence of her denial of suicidal ideation was supported by the evidence of her daughter and the plaintiff. She reassured her daughter, Stephanie, that she would get help and that everything would be okay.<sup>284</sup> She promised the plaintiff that it would not happen ever again after he had given out to her about what had happened.<sup>285</sup>

**256.** Moreover, if little or no weight were to be given to what competent patients say in the assessment of suicide risks and the selection of treatment options, then, as the trial judge in *Orpen* observed ‘*[t]he 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*’ (at para. 62). Professor Casey’s evidence was that even in a

---

<sup>284</sup> Transcript, Day 2, page 10, lines 24-28.

<sup>285</sup> Transcript, Day 1, page 46, lines 6-8.

high risk category as few as one per cent of this group actually go on to die by suicide and that ‘[i]f an intervention were tailored to prevent suicide in this high-risk group, then the input would far exceed the necessity and would be unmanageable and unresourceable.’<sup>286</sup> It would not be appropriate, in my view, if psychiatrists in clinical practice felt obliged to adopt a defensive policy of admitting patients to hospital ‘just in case’ an unpredictable suicide were to occur. Promoting the defensive detention of patients could seriously undermine the advances made in recent years to protect the rights of people who suffer with mental health problems.<sup>287</sup> Apart from its adverse societal implications, such a practice would violate the principle of the least restrictive option in terms of treatment and care.

**257.** In view of the facts of this case and the principles established in the relevant jurisprudence and taking into account the expert evidence on the unpredictability of suicide even in high risk patients, I am satisfied that the approach taken by the court in *Orpen* was the appropriate one and that it ought to have been applied to this case. Moreover, it was not for the trial court nor for this Court to determine, with the benefit of hindsight, whether the decision made by Dr Browne was ‘*the correct one*’ (see White J. in *C*), but rather whether the decision he made was reasonable in all the prevailing circumstances.

**258.** The trial judge’s finding of negligence, of necessity, rejected the reasonableness of Dr Browne’s decision. In his view, reasonableness required that Dr Browne, having already spent an hour and fifteen minutes with Josephine in the context of a process that took almost two hours in total, ought to have engaged in yet further consultation and advice. Notwithstanding Professor Casey’s testimony about the effect of family in persuading a patient to accept admission, I do not consider that such an approach can be followed, blindly, as a matter of course. Every family has its own dynamic. I am not convinced that the trial judge was correct in his speculation about what would, probably, have happened if Josephine’s husband had been

---

<sup>286</sup> Transcript, Day 4, page 63, lines 12-15.

<sup>287</sup> Healy, *Medical Malpractice Law* (1<sup>st</sup> Edition, Round Hall, 2009), chapter 4.102.



called upon to join forces with Dr Browne in the persuasive endeavour envisaged by the trial judge. For a doctor to try to pressure or persuade a patient into accepting admission to a psychiatric facility when she does not want to do so, and for him to join forces with her husband in the process thereof, in circumstances where the breakup of her marriage was already a significant source of distress for the patient, may not only cause further harm to the patient but could seriously militate against facilitating trust in the doctor/patient relationship—a trust which must be regarded as fundamental in the context of psychiatry. Every case will, of course, turn on its own facts, but there was nothing in the evidence to suggest that, on the facts of this case, the judge’s (impermissible) speculative scenario would have yielded the results he envisaged.

**259.** In my view, and, particularly, where inpatient care had been offered to and rejected by Josephine, and where detaining her involuntarily was simply not an option, Dr Browne’s plan under which Josephine was to be treated, urgently, in the next (or second) most restrictive environment cannot be impugned as being unreasonable. That management plan had been agreed by Josephine in the light of her rejection of inpatient admission to a psychiatric hospital and her denial of suicidal intent. The plan, which involved discharging Josephine into the care of her family, with emergency 24/7 back up support and with arrangements for urgent admission to the day hospital, was also consistent with the guiding principle of managing patients with mental health problems in the least restrictive environment consistent with their safety and the safety of others. It cannot, in my view, be impugned, even though the outcome was not one which Dr Browne either expected or could have predicted. The observation of Griffin J. for the Ontario High Court is apposite and worth recalling: *‘Psychology and psychiatry are inexact sciences and the practice thereof should not be fettered with rules so*

*strict as to exact an infallibility on the part of the practitioners which they could not humanly possess.*<sup>288</sup>

**260.** Whereas much was made of Dr Browne’s restrictive understanding of the duty of patient confidentiality, it was not demonstrated that such views caused him to adopt a treatment plan that departed from a general and approved practice. All experts agreed that inpatient admission, in the circumstances of the case, should have been offered. The evidence established, and the trial judge accepted, that inpatient care *was* offered to Josephine with the judge noting that it was understandable why she declined it.<sup>289</sup> His finding that she would probably have changed her mind and agreed to inpatient admission if greater persuasive force had been exerted was not only impermissibly speculative but may have had damaging consequences for the doctor patient relationship.

**261.** A court must review a decision in the context in which it was made and not in the light of what subsequently transpired. It must consider whether the decision that was actually made was a reasonable one in all the prevailing circumstances. To my mind, the trial judge erred when, instead of identifying any unreasonableness in the decision that was actually made in this case, he substituted what he considered would have been a better decision.

**262.** Whereas O’Neill J. in *Orpen* had carefully reviewed all the factors that fell to be considered by the psychiatrist in conducting a suicide risk assessment, the trial judge in the instant case focussed almost exclusively upon one aspect of Dr Browne’s approach which was his view of patient confidentiality and from there he decided that this had led to a failure to ‘tap’ additional sources of information. Instead of identifying the factually true information which Dr Browne purportedly failed to obtain, the judge proceeded to find that if such

---

<sup>288</sup> See Healy, *Medical Malpractice Law* (1<sup>st</sup> Edition, Round Hall, 2009), chapter 4.102, citing *Haines v. Bellissimo* (1977) 82 DLR (3d) 215 at 229 (Can.).

<sup>289</sup> Paragraph 390 of the High Court judgment.

*'potential'* information had been garnered, it would have altered his treatment plan or guided him towards the appropriate one.

**263.** In focussing almost exclusively on Dr Browne's approach to patient confidentiality, the trial judge paid little or no attention to several important issues in relation to Josephine's presentation which Dr Browne had identified during his long discussion with her and which he was obliged to bear in mind in coming to an agreed treatment plan with his patient. The evidence at trial was that, in making his risk assessment, Dr Browne was conscious of several factors that were required to be weighed in the balance. Primary among those, on one side of the equation, was Josephine's previous aborted attempt at suicide, a serious 'flag' which he recognised as such<sup>290</sup> plus her recent attempted overdose, following the consumption of alcohol that morning, wherein she ingested several medications, including anti-depressants, which she said she had commenced two weeks earlier. Other important factors were the significant stressors in Josephine's life which she identified as the criminal proceedings in respect of historical child sexual abuse, the breakdown of her marriage to the plaintiff and some unspecified financial concerns—stressors which in Dr Browne's clinical judgment were the source of Josephine's sense of *'helplessness'* and distress, not hopelessness and depression. Against these, on the other side of the equation, Dr Browne had to weigh additional relevant factors which included Josephine's stated remorse and regret over what she described as an *'impulsive'* act, her stated inability to hurt her children, her denial of suicidal ideation, her open and forthcoming disclosure of her problems, including, her prior attempt, her wish not to be admitted to a psychiatric hospital, her agreement to receive treatment as a patient in the day hospital, and the fact that she had a family she loved and to whom she could go home. There was nothing at all to indicate to Dr Browne that Josephine would be left *'alone and unaided'* as the trial judge described her prior to her suicide.

---

<sup>290</sup> Dr Browne referred to this as *'serious'* and *'it did raise a flag'* and that was why he recommended inpatient care. Transcript, Day 13, page 11, lines 1-2.

**264.** Certain important factors in the assessment conducted in *Orpen* were not present in this case, such as, a history of family suicide and a diagnosis of depression. That said, both cases included a history of contemplating suicide (whether by carbon monoxide poisoning or driving off a cliff) and a decision not to proceed, several life stressors, an overdosing on pills, regret at having made the attempt, a denial of suicidal ideation, a refusal of inpatient care, an agreement to accept treatment as a day patient and discharge into the care of the patient’s family. Seen in that light, it cannot be the case, in my view, that there was no breach of duty on the part of the doctor who assessed Michael and discharged him home, and yet there *was* such a breach on the part of Dr Browne who assessed Josephine and also discharged her home—with the added ‘safety net’ of an emergency number that was available around the clock.<sup>291</sup> Having regard to the legal test of clinical negligence as set out in *Dunne* and applied by the High Court in *Orpen*, I am bound to conclude that the trial judge erred in finding that Dr Browne was negligent in all the prevailing circumstances.

**265.** The observations of O’Neill J. in *Orpen* apply with equal force to this case. Faced with a choice between admission to a psychiatric ward, which, itself, could be traumatic for an already vulnerable woman or a discharge home into the care of her family, and bearing in mind that she was to come back to the psychiatric services by way of urgent day hospital referral and that she had been given, as an additional ‘safety net’ or layer of protection, the contact telephone number of the emergency ward that could be called at any time in the short

---

<sup>291</sup> Much ado was made by the judge about the fact that this emergency number was written on a piece of paper that was taken from a note pad. I found the judge’s criticisms around this fact were unduly immoderate and somewhat excessive. In any event, he appears to have misunderstood that what was written on this piece of paper was the address and number of the day hospital (see Transcript, Day 1, page 39, lines 19-21). The evidence did not support this view. It clearly supported the view that it was an emergency contact number for the psychiatric ward that was available at all times should a deterioration in the situation should arise. Moreover, the Nursing Notes confirm that the arrangement for the ‘urgent referral’ to the day hospital was to be made, not by the plaintiff or the patient, but rather that it was the Outpatients Psychiatric Services (Ballybane) that would contact Josephine for an appointment ‘*this week*’.

intervening period,<sup>292</sup> it simply cannot be said, in my opinion, that the trial judge was correct to find that Dr Browne failed in his duty of care to Josephine.

**266.** In summary, the plaintiff's account of what transpired on the morning of 18 April 2011 was, unfortunately, marred by inconsistencies and untruthfulness. His sworn evidence was built upon a false narrative that contradicted many aspects of his own case on the pleadings. Important parts of his account changed only when compelling evidence showed that he was not telling the truth. Most of his narrative was rejected by the trial judge. In these circumstances it cannot be said that he discharged, in a truthful and straightforward manner, the burden of proof that was his. The trial judge, therefore, erred in finding that the plaintiff had discharged the onus that was on him to establish a breach of duty on the part of Dr Browne, in accordance with the *Dunne* principles.

### **The Impact of Untruthful Testimony**

**267.** In support of their submissions on the impact of untruthful evidence on the obligation to discharge the burden of proof, the appellants rely upon several cases, including *Vesey*, *Shelly-Morris* and *Ahern*. The effect of giving false evidence was considered by the Supreme Court in *Vesey* and in *Shelly-Morris*. Whereas both cases were concerned with exaggerated evidence in respect of injuries sustained, the appellants contend that the principles enunciated therein have general application to the potential consequences attendant upon giving false evidence. The appellants submit that, at common law, it is open to a court to dismiss a claim where a plaintiff gives false or misleading evidence. They say that, as a matter of law, the plaintiff had failed to discharge the burden of proof in a truthful and straightforward manner and that, because of the extent of his untruthful evidence, his claim should be disallowed.

---

<sup>292</sup> The evidence was clear that the telephone number was not the number of the day hospital but was the number of the emergency ward and that it was the day hospital that was going to contact Josephine on Dr Browne's instigation. (Transcript, Day 5, page 49, lines 11-14).

**268.** The appellants point to several aspects of the plaintiff's evidence in support of this claim. For example, they point to his testimony as to the deceased's state of mind, the duration of the meeting, the time the meeting started, the alcohol misuse issue, the financial stressors, the sexual abuse of the plaintiff himself as a child, the absence of any collateral discussion, and, importantly, the breakdown of his marriage. They say that the plaintiff's testimony on all of these issues was, effectively, rejected by the trial judge. Although the judge nuanced his rejection, in some respects, and was reluctant to find that the plaintiff had perjured himself, he nevertheless did not accept the plaintiff's evidence that there was no breakdown of marriage. He did so, they say, in a non-accusatorial manner and in a way which completely ignored the fact that there was no innocent explanation for the untruthful evidence given by the plaintiff, other than that it was an attempt to discredit Dr Browne by undermining the reliability of what he had recorded. Effectively, they say, the plaintiff claimed that Dr Browne had recorded things that did not happen, had failed to record things that did happen and had recorded an action plan that had not, in fact, been agreed either with himself or with the deceased.

**269.** The appellants ask how, having not accepted most of the evidence which the plaintiff gave on these issues, we have arrived at a situation where the judge made a finding of negligence against Dr Browne. In the appellants' submissions, the trial judge did exactly what the Supreme Court in *Shelly-Morris* said a judge should not do, namely, he rescued the plaintiff from the consequences of his own untruthful evidence. The appellants point, in particular, to the judgment of Hardiman J. therein where he stated (at p. 257) that the onus of proof in these cases lies on the plaintiff and that a court is not entitled to speculate in the absence of credible evidence. He continued:

*“To do so would be unfair to the defendant. Moreover, a plaintiff who engages in falsehoods may expose himself or herself to adverse orders on costs. Furthermore, as I observed in Vesey (...) ‘there is plainly a point where dishonesty in the prosecution of a claim can amount to an abuse of the judicial process as well as an attempt to impose on the other party’”*

**270.** In *Shelly-Morris*, Hardiman J. had referred to the fact that the defendant had not, in that case, sought the ‘*drastic relief*’ (p. 258) of staying or striking out the plaintiff’s proceedings. That was not to say that such relief would be inappropriate in a similar case in the future. It appeared to Hardiman J. that a plaintiff who was found to have engaged in deliberate falsehood must face the fact that a number of corollaries arise from such a finding. These include that his or her credibility in general, and not simply on a particular issue, is undermined to a greater or lesser extent. Further, in a case or an aspect of a case that is heavily dependent on the plaintiff’s own account, the combined effects of the falsehood and the consequent diminution in credibility mean that the plaintiff may have failed to discharge the onus on him or her either generally or in relation to a particular aspect of the case. Moreover, ‘*if this occurs, it is not appropriate for a court to engage in speculation or benevolent guess work in an attempt to rescue the claim, or a particular aspect of it, from the unsatisfactory state in which the plaintiff’s falsehoods have left it.*’<sup>293</sup>

**271.** The appellants claim that this is precisely what happened in this case. The trial judge has rescued the claim by making findings that involved ‘*speculation or benevolent guess work*’. In this regard, they point to his acceptance of the plaintiff’s claim that he was unaware of the hosepipe incident, in preference to the account of this incident that was given by the deceased. The appellants also refer to the trial judge’s observations as to what Dr Browne might have elicited had he interviewed the plaintiff for longer, observations which, they say, were comprised, largely, of speculation.

**272.** Finally, the appellants refer the Court to the observations of Feeney J. in *Ahern*, wherein he noted that the courts clearly accept that the telling of deliberate falsehoods in respect of one aspect of a claim might have implications for a plaintiff’s credibility, generally, and might

---

<sup>293</sup> *Shelly-Morris*, p. 258.

mean that the plaintiff has failed to discharge the required burden of proof. Feeney J. also made reference to the judgment of Hardiman J. in *Vesey* (at p. 197) where he made it clear that it is not the responsibility of the judge to '*disentangle the plaintiff's case*' where it had become entangled as a result of lies and misrepresentations systematically made by the plaintiff. In *Ahern*, the court also pointed out that a plaintiff in an action is personally responsible for the factual content of the Replies to Particulars and cannot, and must not, be allowed to hide behind professional advisors in relation to the claim. Feeney J. also confirmed that a plaintiff has an unquestioned responsibility that an affidavit sworn by him or her is factually accurate, irrespective of the position under s. 26(2) of the Civil Liability and Courts Act 2004.

**273.** By way of reply, the plaintiff submits that given the '*minor and insignificant nature of the issues with his evidence,*' the facts of this case can be distinguished from the facts in *Vesey*, *Shelly-Morris* and *Ahern*. He also contends that his case had not become '*entangled as a result of lies and misrepresentations*' and that the trial judge was not required to '*disentangle*' his case and that there had been no failure to discharge the burden of proof.

**274.** The plaintiff also relies on the Supreme Court decision of *Hay v. O'Grady* and cites from the passage of McCarthy J. where he articulated the well-known principles regarding an appellate court's jurisdiction in assessing the findings made by a trial judge who has heard all the evidence: '*It may be that the demeanour of a witness in giving evidence will, itself, lead to an appropriate inference which an appellate court would not draw*'. The plaintiff submits that the trial judge found that there were some '*inconsistencies*' but that he approached the plaintiff's evidence with due caution and consideration. The judge, he says, also had regard to the subjective lens through which the family viewed their wife and mother in contrast to how Dr Browne viewed her in the hospital. The plaintiff submits that Dr Browne's evidence contained its own difficulties. He says that the trial judge weighed up all the evidence before him, placed particular reliance on the '*blemish free*' evidence of his children and made findings



of fact as a result. He was best placed to evaluate the evidence having had the benefit of observing the demeanour of the witnesses.

**275.** In the plaintiff's view, the trial judge was correct to hold that inpatient care was not offered adequately to the deceased or her family. The evidence that Josephine was not herself and was not fit to leave the hospital, he submits, was correctly preferred by the trial judge over that of Dr Browne, given the family's intimate knowledge of the deceased. The plaintiff contends that having failed to gather all the relevant information concerning the deceased's history and condition, the clinical decision made by Dr Browne to allow her to be released from hospital which led to the deceased taking her own life, meant that she was not afforded the appropriate standard of care by the appellants.

#### *The legal framework*

**276.** In *Vesey*, the plaintiff exaggerated the extent of his injuries resulting from a road traffic accident. Acknowledging the plaintiff's dishonesty, the trial judge had commented (at p. 194):

*"The plaintiff has lied to me. He has lied to his own doctors and he has lied to the defendant's doctors in a manner, which has rendered the opinions of the doctors almost useless, because, they admit themselves, they depend on the veracity of the history given to them by the plaintiff to form their opinions."*

**277.** On appeal, it was submitted that the award of damages was excessive and unmerited given the trial judge's finding concerning the plaintiff's lack of credibility. It was argued that the negative character of the plaintiff's evidence had a knock-on effect on his ability to discharge the burden of proof.

**278.** The Supreme Court allowed the appeal and reduced the award of damages because of the dishonesty of the plaintiff. Central to its reasoning was the principle (expressed at p. 198) that it is not the *'responsibility of a trial judge to 'disentangle' the plaintiff's case when it has become entangled as a result of lies and misrepresentation systematically made by the plaintiff*

himself'. The failure on the part of the plaintiff to adduce credible evidence resulted in the reduction of damages. Additionally, Hardiman J. expressly rejected (at p. 198) the attempt by the plaintiff's counsel to distance the plaintiff's testimony from the content of the particulars sworn:

*"The fact that particulars of injuries or breach of statutory duty are necessarily expressed in legal terms and particulars of injuries or prognosis in medical terms, in no way exempts the plaintiff from ensuring, with the assistance of his solicitor, that the underlying facts are correctly stated."*

**279.** What a trial court may and may not do in the face of dishonest evidence was addressed with particular acuity by Hardiman J. in *Shelly-Morris*. In that case, an exaggerated claim was in issue but what Hardiman J. said applies, with equal validity, to untruthful evidence regardless of its purpose. Reiterating his own earlier observations in *Vesey*, he stated (at p. 257):

*"that the onus of proof in these cases lies on the plaintiff who is, of course, obliged to discharge it in a truthful and straightforward manner. Where this has not been done 'a court is not obliged, or entitled, to speculate in the absence of credible evidence' (per Hardiman J. at p. 199). To do so would be unfair to the defendant."*

He continued (at p. 258):

*"a plaintiff who is found to have engaged in deliberate falsehood must face the fact that a number of corollaries arise from such finding:-*

*(a) the plaintiff's credibility in general, and not simply on a particular issue, is undermined to a greater or lesser degree;*

*(b) in a case, or an aspect of a case, heavily dependant (sic) on the plaintiff's own account, the combined effects of the falsehoods and the consequent diminution in credibility mean that the plaintiff may have failed to discharge the onus on him or her either generally or in relation to a particular aspect of the case; and*

*(c) if this occurs, it is not appropriate for a court to engage in speculation or benevolent guess work in an attempt to rescue the claim, or a particular aspect of it, from the unsatisfactory state in which the plaintiff's falsehoods have left it."*

**280.** The *ex tempore* judgment of Feeney J. in *Ahern* was decided in the context of an application for dismissal within the terms of s. 26 of the Civil Liability and Courts Act 2004, which sets out clear criteria for the dismissal of a fraudulent claim. It was argued that the plaintiff's claim for the cost of continued care was unjustified and was supported by false and misleading evidence, including a false and misleading affidavit of verification. Feeney J. cited *Vesey* and *Shelly-Morris* as authorities, first, for the legal principle that a plaintiff's lack of credibility could result in a failure to meet the burden of proof and, secondly, that it is not the judge's role to disentangle the plaintiff's lies from the truth. Ultimately, Feeney J. found (at para. 33) the plaintiff to be '*overall a truthful witness even if every detail of her narrative was not necessarily precise*' and thus, he found that s. 26 did not apply. While the plaintiff's evidence did constitute an exaggeration of her damages, she had not knowingly misled the court, a specific statutory criterion for establishing a fraudulently false or misleading claim.

### **The Court's Assessment**

**281.** There is, of course, a distinction to be made between the context in which the untruthful exaggerated evidence was given in *Vesey* and *Shelly-Morris* and the giving of untruthful evidence, generally. That said, there is no reason why, as a matter of law or of logic, the principles enunciated by the Supreme Court in those cases should not apply with equal force to cases where untruthful evidence is given on factual issues relevant to the question of liability. Either way, to my mind, a court is entitled and, indeed, *obliged* to have regard to the fact that significantly untruthful evidence was given by a plaintiff and to recognise that serious consequences may follow therefrom (*mutatis mutandis*, *Vesey* and *Shelly-Morris*).

**282.** Of course, not every rejection by a trial court of evidence given by a witness necessarily means that such a witness has wilfully lied to or misled the court. An individual's recollection may be impaired, perceptions of a particular event may differ, and minor discrepancies may arise. However, on no analysis of the evidence in this case could it be said that the

inconsistencies in the plaintiff's testimony were attributable to his flawed recollection of detail or his particular perception of events. For example, it was established, unequivocally, that he swore that several important matters asserted in his pleadings were true. He also swore that his testimony, which contradicted those matters, was also true. He testified that he had no idea what Josephine was talking about when she told Dr Browne of his alleged history of sexual abuse and yet the evidence established that he had discussed this very matter in considerable detail with Josephine and had gone to the Rape Crisis Centre about it. He swore, repeatedly, that his marriage was not in any difficulty (despite having pleaded marital separation) and only later, under cross-examination in the light of mid-trial discovery, was he compelled to admit that Josephine had gone for marriage counselling and that he was aware that she had done so. When questioned about the inconsistencies in his case, he offered no plausible explanation<sup>294</sup> apart from an indirect attempt to blame his lawyers for the contents of his pleadings—something which the Supreme Court in *Vesey* deemed impermissible.

**283.** Whereas '*an arid transcript*' will seldom convey the full atmosphere of a trial, I am satisfied, that the transcripts in this case, disclose, unequivocally, that the plaintiff's evidence was marked by a series of falsehoods and/or inconsistencies and/or misrepresentations, and by a high degree of implausibility in respect of several important issues. These issues included the state of the marriage, Josephine's capacity and reliability, his not finding the hosepipe contrary to what Josephine had said, and his alleged repeated requests for inpatient care. In such circumstances, I do not accept the plaintiff's submissions that the inconsistencies in his evidence on these issues were of a '*minor or insignificant nature*'.<sup>295</sup> In the absence of any or any innocent explanation for the untruths in the plaintiff's case, I am bound to conclude that the purpose of his untruthful testimony was for no other reason than to undermine the competence and to attack the professionalism and character of Dr Browne.

---

<sup>294</sup> See his purported reply at the end of his final cross-examination.

<sup>295</sup> Paragraph 55 of the plaintiff's submissions to this Court.

**284.** It hardly needs to be said that the swearing of an oath or an affidavit, or the furnishing of a solemn affirmation, is not a matter that is to be taken lightly. Such solemn declarations are made for the singular and fundamental purpose of assisting the court in the administration of justice. Where, as in this case, the evidence establishes a high degree of dishonesty in the prosecution of a claim, the Court, in my view, is not entitled to gloss over it or to excuse it or to downplay its harmful and adverse impact upon the other party. To do so would be unfair to a defendant.

**285.** Despite the serious level of untruthfulness in the plaintiff's evidence, no adverse consequences would appear to have flowed therefrom. It is clear, as already noted, that during the course of the trial, the judge appeared to appreciate the significance of the plaintiff's untruths. For example, upon recall and when cross-examined on the question of the marriage breakdown, the judge observed that the plaintiff seemed to be avoiding the '*central issue*',<sup>296</sup> and made it clear to him that, with abundant clarity, he had pleaded that there were financial stressors and there was a breakdown of his marriage, matters which the plaintiff had sworn on oath to be true.<sup>297</sup> The judge said that the plaintiff did not appear '*to grasp the significance*' of providing two sworn statements of facts, each of which contradicted the other. Observing that the plaintiff was trying to '*explain it away*', the judge said that he needed to find an explanation because the burden of proof was on the plaintiff and that he, the judge, had to make a finding based on credible evidence.<sup>298</sup> Moreover, the judge recognised that what he was dealing with were issues '*of no small significance and indeed of statutory significance*'.<sup>299</sup> Despite such a clear recognition of the importance of what was in issue, the judge, nevertheless, when it came to the judgment, made no attempt to confront or resolve those issues of no small significance or to draw any adverse consequences from the plaintiff's obviously contradictory sworn

---

<sup>296</sup> Transcript, Day 10, page 51, line 16.

<sup>297</sup> Transcript, Day 10, page 51, line 21 – page 52, line 1.

<sup>298</sup> Transcript, Day 10, page 52, lines 3-10.

<sup>299</sup> Transcript, Day 10, page 60 lines 3-6.

evidence. In some instances, the judge seemed to excuse it, and in others, he viewed it, benignly.<sup>300</sup>

**286.** The trial judge's findings on several issues can have no other meaning but that the plaintiff gave untruthful evidence. Of particular significance, to my mind, was his untruthful evidence in relation to his repeated demand for inpatient care and Dr Browne's refusal to accede to his request. If, in proceedings for clinical negligence, a plaintiff is prepared to make such an astoundingly untruthful claim against a doctor—one which the trial judge rejected—a question must, inevitably, arise as to the motivation therefor. There was no attempt made by the trial court to consider why the plaintiff had lied on this important issue or to comment on the implication which this had for Dr Browne's standing and reputation.

**287.** Although the judge stated (at para. 351) that he must '*approach the plaintiff's credibility*' with '*caution*', the record of the High Court judgment does not support the view that any such caution was exercised or applied in practice. Thus, for example, when it came to a choice between the plaintiff's and Josephine's account of the hosepipe incident, the judge chose to accept the plaintiff's version, even though he was aware that the plaintiff had tried, unsuccessfully, and on more than one occasion, to undermine Josephine's credibility on important issues and was shown to have been the one who was telling lies. How, in such circumstances, and whilst purportedly exercising '*caution*', the trial judge could prefer the plaintiff's account over that of the deceased is altogether unfathomable and the '*rationale*' he provides for so doing fails, entirely, on the application of logic and common sense (see paras. 131, 132 above).

**288.** I am satisfied that where, as the appellants submit, the substance of the plaintiff's narrative had collapsed under the weight of his untruthful evidence, the only way that this claim

---

<sup>300</sup> See, for example, the trial judge's reference to the '*awful matters*' at para. 317 which lay behind the plaintiff's unsuccessful attempt to attack Josephine's reliability and Dr Browne's accuracy as a note-taker. See also the judge's reference '*to be fair to the plaintiff*' at para. 302 in circumstances where the evidence demonstrated that the plaintiff had been untruthful and that he only acknowledged the truth when confronted with compelling evidence

could succeed was for the judge to ‘*disentangle*’ the plaintiff’s ‘*story*’ about the hosepipe incident from the rest of his untruthful evidence on several important issues (*Ahern*). Instead of drawing the appropriate adverse implications from the plaintiff’s systematically untruthful testimony, the trial judge, inexplicably, accepted his implausible ‘*story*’ against the weight of the credible evidence. He then proceeded to speculate that, had a further inquiry been held, this ‘*story*’ would have emerged which would, in turn, have uncovered the concealment or potential concealment of a prior attempted but abandoned incident of self-harm (of which, incidentally, the doctor was fully aware) and that this, in turn, would have altered the treatment plan or guided Dr Browne towards an appropriate one. The treatment plan actually devised involved medical care being administered in the most restrictive environment possible next to inpatient admission, which had been offered and declined. With respect, I find that not only did the trial judge’s ‘construct’ involve considerable speculation and benevolent guesswork, but it also lacked plausibility as a matter of common sense.

**289.** The trial court’s ‘*rescue*’ (*Shelly-Morris*) was underpinned by the judge’s hypothetical conjecture. As already observed, there was no basis in the evidence for his speculative scenario and no legal authority for his finding that there was, essentially, a duty to persuade a patient, with capacity, to accept an offer of admission to a psychiatric facility in the face of her refusal of such offer. The judge, in my view, was not entitled to salvage the plaintiff’s claim in the manner that he did. In mounting such an endeavour, I am satisfied that he fell into error and did precisely what the Supreme Court in *Vesey* had said that a trial judge ought not to do. Having rejected almost the entirety of the plaintiff’s narrative, he impermissibly rescued it through a process of ‘disentanglement’ and by a replacement of the plaintiff’s actual case with a case that was never made.

**290.** To my mind, this was a case where the plaintiff’s credibility was so undermined that it was open to the court to find that the burden of proof had not been discharged and that the case could be dismissed. On the basis of *Vesey*, the trial court was obliged, at the very least, to hold

the plaintiff personally responsible for the factual content of replies to particulars he had given about his marriage breakdown. This was all the more so in the context of a significant claim for loss of consortium.

**291.** The trial judge, in my view, was obliged to consider why the plaintiff gave utterly contradictory sworn testimony at trial and was further obliged to subject to greater scrutiny the purpose of the plaintiff's wrongful allegations against Dr Browne. In circumstances where no explanation was given by the plaintiff for his entirely contradictory evidence, nor any inquiry made into the purpose of his untruthful allegations, the trial judge erred in overlooking the fact that the degree of the plaintiff's untruthfulness was such as to impede him in the discharge of the burden of proof.

**292.** Moreover, bearing in mind the remove at which this Court reviews the trial judge's findings, there would appear to have been nothing highlighted in the demeanour of the plaintiff which could possibly justify the trial judge's overly benign approach to such untruthful evidence. Insofar as the judge commented on his demeanour, it was to say that he was 'evasive', lacked 'candour', was 'almost in denial', and made a backhanded concession 'if not outright falsehood' on an important aspect of his evidence.<sup>301</sup>

**293.** I do not underestimate the significant trauma that is caused by suicide nor, indeed, the myriad of emotions generated thereby. It may also be the case that, at times, people may tell themselves stories in order to cope with or process certain traumas in life. Even bearing that in mind, it cannot and does not relieve those who choose to litigate in the aftermath of a suicide of the duty to tell the truth. That duty is recognised in the solemnity attendant upon the swearing of an oath or the making of a solemn declaration and the discharge of that duty is fundamental to the administration of justice. I stop short of concluding that the dishonesty in

---

<sup>301</sup> See paragraphs 52 and 274 of the High Court judgment.



this case amounted to an abuse of judicial process—but, in my view, it certainly came very close thereto.

**294.** With that in mind it would be remiss of me not to observe that the benign attitude adopted by the judge towards an untruthful plaintiff stood in rather sharp contrast to his severe criticism of Dr Browne who, notwithstanding his imperfections, was found to be a truthful witness. During the course of the trial, the judge queried a discrepancy between what Dr Browne had claimed was his usual practice and certain entries in the Log Book which appeared, on its face, to indicate, that such practice was not always followed. He wanted Dr Browne to return to the court to explain such discrepancy. When it emerged, after various fixings of dates and times for the taking of evidence, remotely, that Dr Browne was not present when the court was ready to take up his testimony, the judge protested profusely about this and made disturbing remarks about calling the Gardaí to compel Dr Browne’s attendance.<sup>302</sup> Dr Browne’s non-attendance on that particular day was altogether inadvertent and arose not from any disrespect to the court, but rather from an innocent miscommunication to him from his solicitor.

**295.** Although it was appropriate for the judge to preface his consideration of the issue of credibility with an acknowledgement of the trauma that was visited upon the family (para. 266), it was, nevertheless, remarkable, to find that little or no criticism was made of the plaintiff, whose repeatedly untruthful evidence on a range of important matters was devoid of innocent explanation and whose casual attitude to the swearing of an oath cannot but be regarded as a disrespect to the court in its administration of justice. His disregard for the legal process was evident in the fact his affidavit of verification was sworn *after* he had given his initial sworn testimony. One might reasonably have expected, in those circumstances, that the plaintiff

---

<sup>302</sup> The trial judge stated: “*Dr. Browne is in the witness box under direction of this Court, Mr. Hanratty, and if he does not appreciate the seriousness of that situation, I can make it abundantly clear to him and, very quickly, if he has members of An Garda Síochána going to where he is at present and taking him here forcibly. It is not within his gift to decide when he is available. If there was a difficulty, there was ample time for him to instruct you and to instruct his solicitors to make an application and of course I would have facilitated him. It is not within his gift to decide he is not available today.*” (Transcript Day 10, page 6, lines 12-23.)

would have been at pains to ensure the veracity of what he had pleaded. If any contradictions were noted, it might also have been expected that such a matter would have been brought to the attention of the Court and an application made to amend the pleadings, if necessary. No such application was made. The judge's warning to the plaintiff that an explanation had to be found (which never was) for such blatant discrepancies was considerably more gentle than his harsh rebuke of Dr Browne for his non-culpable absence from court.

**296.** I have already indicated my rejection of the plaintiff's submission that the issues in respect of which he gave false and misleading evidence were '*minor and insignificant*'. In a claim for loss of consortium, there was nothing minor or insignificant about swearing that the marriage was not in difficulty in circumstances where: (i) the verified pleadings referred, expressly, to marital separation as a background stressor for the deceased; (ii) Josephine had told Dr Browne that she and the plaintiff had broken up and that this was a source of significant distress; and (ii) there was independent corroborative documentary evidence in the form of the counsellor's notes confirming that the marriage was in difficulty. Moreover, making blatantly untruthful denials of his own alleged history of childhood sexual abuse was not minor in nature in circumstances where they were made by the plaintiff with the clear intent to undermine the deceased's capacity and the doctor's competence.

**297.** I am aware of the role which the trial court plays in the finding of facts and of this Court's reluctance to interfere with such findings where they are based on credible evidence. The difficulty, of course, in this case, was that the trial judge's findings of fact upon which he based his conclusion as to negligence were reached on the basis of accepting non-credible evidence which was against the weight of the truthful evidence and then further substantiated by speculation. Nor do I accept the plaintiff's submission that the trial judge's findings were based on the '*blemish free*' evidence of his children. I have already noted the judge's non-acceptance of Stephen's somewhat exaggerated evidence as to the capacity of the deceased. I have also observed that an important aspect of Stephanie's evidence corroborated Dr Browne's testimony

that Josephine had denied any thoughts of suicide or self-harm in the immediate time before her death.

### **Miscellaneous Matters**

**298.** There are many other matters upon which comment might be made. The trial judge’s reference (at para. 31) to Josephine’s ‘*psychosis*’ was clearly incorrect as there was no evidence of any illness of this nature given at trial. Equally erroneous, in my view, was his finding (at para. 295) that the interview started at 10:30 or shortly thereafter, a finding made in the face of a clear entry on the first page of the assessment form that the interview commenced at 10:00. The judge’s finding, it seems to me, was based on his clear misunderstanding of a 10:45 entry in the A & E Nursing Notes and, in particular, his reading into that entry the presumption that ‘*psychiatry present*’ meant that the psychiatrist was present and *about to start*.<sup>303</sup>

### **Conclusion**

**299.** In the Supreme Court judgment in *Wright v. AIB Finance and Leasing Ltd*, Clarke J. (as he then was) noted (at para. 7.10) that:

*“... findings of fact of the trial judge can, in accordance with Hay v. O’Grady [1992] 1 I.R. 210, only be disturbed if there was no evidential basis for them or if the reasoning of the trial judge in reaching those conclusions of fact does not stand up. [...] It is also clear that findings of fact can be disturbed where there is a material and significant error in the assessment of the evidence or a failure to engage with a significant element of the evidence put forward (see for example Doyle v. Banville [2012] IESC 25).”*

**300.** I am satisfied that, in this case, all three reasons identified by the Supreme Court in *Wright* were present such as would justify this Court in disturbing the trial judge’s findings of fact. There was no credible evidential basis for the first finding in respect of the hosepipe and

---

<sup>303</sup> Transcript, Day 11, page 67, lines 1-2.

no evidential basis at all for the second finding which concerned the *fait accompli* decision to discharge. The judge's rationale for reaching both findings did not stand up to scrutiny and the findings were vitiated by material and significant errors in the manner in which they were reached. Moreover, there was a manifest failure on the part of the trial judge to engage with significant elements of the expert evidence put forward on the unpredictability of suicide and the absence of any material consequences, in terms of the appropriate treatment plan, that flowed from Dr Browne's failure to conduct more searching inquiries. In view of the foregoing and without straying beyond the principled boundaries governing an appellate court's review of a trial court's findings, I am satisfied that the findings of the trial judge that were material to his finding of negligence on the part of Dr Browne were so flawed as to require that they be set aside. Moreover, the plaintiff had failed to discharge the onus of establishing a breach of duty, in accordance with the *Dunne* principles, in a truthful and straightforward manner.

#### *Ordering a retrial or allowing an appeal*

**301.** In certain circumstances, an appellate court's identification of material errors in a trial court's findings may result in an order for a retrial (see, for example, *McDonald v. Conroy*).<sup>304</sup>

Order 86A(3) of the Rules of the Superior Courts provides that:

*“(1) Following the hearing of an appeal, the Court of Appeal may remit proceedings to the High Court with such directions as it considers just.*

*(2) If on the hearing of an appeal, it appears to the Court of Appeal that a new trial ought to be had, it may set aside the original decision or order and direct a new trial, which may be confined to a particular question or issue, without interfering with the original finding or decision on any other question or issue.”*

**302.** This is, clearly, a discretionary issue. Though it is open to the Court of Appeal to remit proceedings to the High Court, it is not required to do so. In *Holohan v. Donohoe* [1986] IR

---

<sup>304</sup> See also Collins and O'Reilly, *Civil Proceedings and the State*, 3rd Ed. 2019 8-78

45, the Supreme Court found that, in lieu of ordering a retrial, it could bring proceedings to an end and substitute its own assessment of damages for that of a jury. It held that this discretion would only be used where the justice of the case so required. In *Topaz*, this Court found that there was no credible evidence to support the trial judge's finding that the appellant was liable for the respondent's injury. Noonan J. did not order a re-hearing; instead, he allowed the appeal and dismissed the plaintiff's claim.

**303.** To my mind, given my view that there was no credible evidence to support the trial judge's findings and that the plaintiff has failed to discharge the onus of proof, both in accordance with the *Dunne* principles and in a truthful and straightforward manner, the appropriate course for this Court to follow is the one it adopted in *Topaz* and to allow the appeal *simpliciter*.

### **Decision**

**304.** The appeal is allowed. The proceedings are dismissed.

**305.** As the appellants were wholly successful in their appeal, I would propose, provisionally, to make an order for the costs of this appeal and for the costs of the High Court proceedings. I would also propose to make an order directing the plaintiff to repay to the appellants the sum of €70,000 that, by order of the High Court made on 3 October 2018 and perfected on 19 October 2018, was paid on account, pending this appeal.

**306.** If the parties wish to argue for alternative orders to the ones proposed, provisionally, herein, then they should notify the Court of Appeal Office, accordingly, within twenty-one days of the date of this judgment. Thereafter, the parties will be notified of a date for a brief hearing on costs and the Court, on that date, will also hear submissions as to the appropriate time frame within which the repayment of sums paid out on account, pending appeal, should be made.

**307.** As this judgment is delivered electronically, Faherty J. and Ní Raifeartaigh J. have indicated their agreement with its conclusion and the reasoning upon which it is based.