SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES & GALLOWAY
AT HAMILTON

[2023] FAI 20

B350-20

DETERMINATION

BY

SHERIFF T S MILLAR

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

YVONNE ANNE ROBSON

Hamilton, 13 April 2023

The sheriff having considered the information presented at the inquiry determines in terms of section 26(2) of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") that:

(a) In terms of section 26(2)(a):

The death of Yvonne Anne Robson, born 28 October 1963, occurred on 23 May 2015 at Carrick Hills Road, near Dunure. The precise time of death is unknown.

(b) In terms of section 26(2)(b) (when and where any accident resulting in death occurred):

No accident occurred resulting in the death of Yvonne Anne Robson.

(c) In terms of section 26(2)(c) (cause or causes of death):

The cause of death of Yvonne Anne Robson is unascertained.

(d) In terms of section 26(2)(d) (cause or causes of any accident resulting in death):

No accident resulted in the death of Yvonne Anne Robson.

(e) In terms of section 26(2)(e) (any precautions which (i) could reasonably have been taken and (ii) had it been taken might realistically have resulted in the death or the accident resulting in the death being avoided):

[i] Following the overdose taken by Ms Robson on 21 May 2015, a full assessment of her physical and mental state should have been undertaken at a Multi Disciplinary Team chaired by her consultant, or other trained and competent clinician, along with nursing staff and other professionals involved in her care, before any pass for a period outwith the hospital grounds was granted.

[ii] Full notes of concerns raised by family members should be retained, incorporated into medical records and considered at any such MDT.

[iii] Communication with family members should be encouraged throughout any period of admission and reviewed regularly, provided same is not assessed as detrimental to the health and wellbeing of a patient.

[iv] Where a pass for a period outwith hospital grounds is granted, where appropriate, a relevant family member should be advised of such to enable the family to render assistance during the pass or to raise concerns in connection therewith.

[v] Clinicians should be trained in and be fully conversant with requirements of any guidance regarding fitness to drive as a result of any illness, including DVLA and SEAN (Scottish ECT Accreditation Network) guidelines, and should apply said guidelines. Details of advice given to a patient following thereon should be clearly noted in the medical records.

[vi] The decision to allow a pass should be clearly documented by the responsible clinician with full details of the pass recorded in medical records.

[vii] Where a course of action post a suicide attempt is determined by a consultant at an MDT, that course should be followed after any further similar incident unless specifically countermanded by the consultant or similarly qualified clinician and the reasons therefor should be documented.

(f) In terms of section 26(2)(f) (any defects in the system of working which contributed to the death or accident resulting in death):

[i] The medical record keeping was poor throughout the admission. Forms or assessments to be completed at or following admission were not

completed fully or were not updated appropriately after a significant event, such as a suicide attempt.

[ii] There was no system of working whereby guidance as set out in the Suicide Assessment and Treatment Pathway was to be followed, and documented, particularly in respect of involvement of family members.

[iii] There was no system of working whereby a Safety Plan should be discussed with the patient, regularly reviewed, written and handed to the patient for use while on any pass.

[iv] Locum staff with no clear understanding of the MIDAS (Medical Information Data Analysis System) completed ward records on 23 May 2015 and no proper assessment of the patient's physical or mental state, nor review of the risk assessment, were carried out by nursing staff prior to the patient leaving on pass on 23 May 2015.

[v] DVLA guidelines on fitness to drive were not followed.

[vi} SEAN guidelines on fitness to drive following ECT were not followed.

(g) In terms of section 26(2)(g) (any other facts relevant to the circumstances of death):

[i] The delay in obtaining psychological services between 21 January and 23 March both 2015, as a result of the request being sent to the wrong section, was unacceptable and may have contributed to the patient's mental state.

[ii] The delay in prescribing medication following the wash out period from phenalzine was unacceptable, particularly post ECT when a relapse into depression is common, and may have contributed to the patient's mental state.

[iii] The patient's dietary requirement were not fully met and, along with the effect of medication, led to significant weight loss which may have contributed to her mental state.

[iv] Reliance on an assessment by a junior locum doctor who had not started a psychiatric training post should not be encouraged.

[v] Where consultants are contacted while not on duty, they should have the capability of accessing patient records.

Matters raised above were, in the main, identified in the Significant Adverse Event Review in their Key findings and Recommendations. No further Recommendations are required.

Legal framework

[1] This was a discretionary inquiry held under section 4 of the Act, the death having occurred in Scotland in circumstances which give rise to serious public concern and the Lord Advocate had decided it to be in the public interests for an inquiry to be held into the circumstances of the death. The procedure to be followed in such inquiries is governed by provisions of the Act and the Act of Sederunt (Fatal Accident Inquiries Rules) 2017. The purpose of such an inquiry is to establish the circumstances of the

death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances (section 1(3) of the Act). Section 26 requires the sheriff to make a determination and section 26(2) sets out the factors relevant to the circumstances of death insofar as they have been established to the satisfaction of the sheriff These are: (i) when and where the death occurred; (ii) the cause or causes of such death; (iii) any precautions that could have reasonably been taken, and if so might realistically have avoided the death; (iv) any defects in any system of working which contributed to the death; (v) any other facts which are relevant to the circumstances of the death. The sheriff has to be satisfied on the balance of probabilities that there are precautions or defects in the system of working which, had they been taken, might realistically have avoided the death or defects in the system of working which contributed to the death and there is a reasonable possibility that any recommendations made may prevent deaths in similar circumstances in the future. The scope of inquiry therefore extends beyond simply establishing the facts relevant to the death of Yvonne Anne Robson, whether it was to see if future deaths occurring in the circumstances or similar circumstances could be prevented and to restore public confidence and allay public anxiety arising from the circumstances of the death of Yvonne Anne Robson. The determination is limited to the matters defined in section 26 of the Act which also provides that the determination shall not be admissible in evidence nor be founded on in any judicial proceedings of any nature, thus encouraging full and open exploration of the circumstances of a death.

Participants and representation

[2] The Procurator Fiscal represents the public interest in a fatal accident inquiry. Mr Stuart Faure, Procurator Fiscal Depute appeared and the relatives of Ms Robson were represented by her brother, Mr Damien Robson. Lanarkshire Health Board were represented by Mr Donald Davidson, Counsel and Ms Ritchie, solicitor for the Board.

[3] I am grateful to all those appearing at the inquiry for their professionalism and assistance in the conduct of the inquiry and for their assistance in particular in agreement on uncontentious matters by joint minute which greatly assisted the inquiry. Notice of an inquiry dated 30 July 2020 was received by the court and a first order was made on 13 August 2020 assigning a preliminary hearing on 1 October 2020. Further preliminary hearings were held on 29 October, 5 November 2020 and 4 February 2021. A hearing was assigned for 22 February to 5 March 2021 but said hearing was discharged on the motion of Mr Davidson, Advocate for the Health Board, opposed by the Crown and by Mr Robson. A further preliminary hearing was assigned for 7 April 2021. On that date the parties had not been able to identify days and a further preliminary hearing was assigned for 17 September 2021 when it called for the first time before myself. A joint minute had been prepared and lodged and a further joint minute was being considered. A list of witnesses to be called was lodged with the court, witnesses to adopt written witness statements as part of their evidence and a binder containing all statements from all witnesses to be lodged in advance of the next calling of the case along with a running order for witnesses. Mr Davidson advised the only witness for the Board was to be an occupational therapist and a copy of her statement

and report would be lodged by the next calling of the case along with medical records of the deceased. It was agreed that the hearing would be conducted in person and a further preliminary hearing assigned for 14 October 2021 to confirm progress. On that date a second joint minute had been lodged and sent to all parties for consideration and agreement. Electronic copies of statements and running order had been electronically emailed to the court and a full binder containing all statements forwarded to the court. A further preliminary hearing was assigned for 2 November 2021 to allow the court time to read through the statements and running order only received on that date from the Crown.

[4] In regard to the fact that the response from the Board had indicated they did not accept conclusions made by experts on the Crown list of witnesses, and that the locality lead occupational therapist in mental health, now retired, was the only witness to be led by the Board, I enquired whether an expert witness for the Board should be considered. As a result the Board did instruct an expert report from Nabila Muzaffar, consultant psychiatrist with NHS Forth Valley who produced a report, supplementary report and gave evidence to the inquiry. A final preliminary hearing was held on 2 November 2021 when the inquiry into the death was ordered to be held commencing 4 November 2021. The inquiry thereafter heard evidence on 4, 5, 8, 9, 10, 11, 15, 29, 30 November, 1 December 2021. The evidence had not been completed by that date and was continued to dates to be further assigned. On 2 March further dates were assigned for 20 April 2022 thereafter 25 May, and 25 August 2022 when evidence concluded and a hearing on submissions assigned for 21 November 2022. Parties were directed to draft written

submissions and exchange same 20 days prior to said hearing with final written submissions to be lodged 14 days prior to said hearing. Written submissions were lodged timeously by all parties.

[5] While witnesses had provided written statements, read by them at the start of their evidence, or in the form of written reports to the inquiry, each witness was then examined at length and cross examined, again at length, by Mr Davidson and Mr Robson. In terms of the joint minutes entered into, Crown Production 1, being the notification to the Register of Births, Marriages and Deaths, was agreed to be an accurate record, the fire investigation report, Crown Production 3, compiled by watch manager Gary Love dated 7 December 2015, Crown Production 8, forensic archaeology report compiled by Dr Jennifer Miller signed by her dated 30 July 2015, Crown Production 9, a joint DNA analysis report compiled by Fiona McMahon and Lee Cowie signed by them both dated 16 June 2015. Crown Production 12, a post mortem report by Dr Gemma Kemp dated 9 June 2015, Crown Production 12a, toxicology report compiled by Parks, trainee forensic toxicologist and Denise McKeowan, forensic toxicologist dated 29 June 2015 were all accepted as true and accurate copies and these witnesses did not require to give oral evidence to the inquiry. In addition Crown label 1, album 1 taken by Anne Hunter, scenes of crime officer on 23 May 2015, Crown label 2, albums 2, 3 and 4 taken by Shona Blacklock, scenes of crime officer on 24 May 2015, Crown label 3, albums 5, 6, 7 and 8 taken by Althea Joseph, scenes of crime officer on 26 May 2015 all at Carrick Hills Road near Dunure and Barry Devlins Recovery Yard, McColl Avenue, Ayr

were accepted as true and accurate and had not been retouched and no witnesses were required to speak to these productions.

[6] In respect of the witnesses they gave evidence on dates as follows:

4 November 2021: Karen Wood, Damien Robson, Staff Nurse E

5 November 2021: Staff Nurse E (continued); Dr A

8 November 2021: Dr A (continued); Dr D

9 November 2021: Dr D (continued); Dr C

10 November 2021: Dr C (continued); Nurse F

11 November 2021: Nurse F (continued); Nurse G

15 November 2021: Procurator Fiscal Depute read Crown Production 13, SAER report dated 21 January 2016 into the death of Ms Robson and responses which were raised by her family by Dr Alistair Cook, L Lawson and Karen McIntyre

29 November 2021: Dr Cook

30 November 2021: Dr Ruth Ward

1 December 2021: Dr Ruth Ward (continued)

20 April 2022: Nurse H (retired); Dr Alan Scott

25 May 2022: Dr Alan Scott (continued)

1 August 2022: Dr Nabila Muzaffar

25 August 2022: Dr Nabila Muzaffar (continued); Dr Jenkins

Summary

[7] Yvonne Anne Robson was 51 years old at time of her death. She was a qualified physiotherapist who lived alone in East Kilbride. She had five siblings, three brothers and two sisters. Her father pre-deceased her in September 2013. Ms Robson did not cope well with his death. Her mother at the time of Ms Robson's death was suffering from dementia.

[8] Ms Robson's past was punctuated by extensive periods suffering from mental illness. This impacted on her personal relationships and her ability to work and function independently in the community. Her first admission to hospital was in 1989 with a diagnosis of manic depression or bi-polar affective disorder. She had attempted suicide on several occasions including by walking into the sea, injecting mercury into her body, or by taking overdoses of medication including paracetamol. There were also periods when Ms Robson was able to maintain both employment and relationships.

[9] Between 9 October 2014 and 26 November 2014 Ms Robson had been admitted to hospital following an attempted suicide by paracetamol overdose. Ms Robson had driven to Largs with the intention of committing suicide by drowning. She had disposed of her phone so no one could contact her. Ms Robson had sat by the waterside all night, fallen asleep on a bench then made her way to a train station where she sought assistance. On admission to hospital she admitted to having taken an overdose of paracetamol. She was discharged into the care of a community based psychiatric team including consultant psychiatrist Dr A.

[10] Her illness escalated and there were further fears that Ms Robson would self-harm. She was re-admitted as a voluntary patient to Ward 20, Hairmyres Hospital on 23 December 2014 under the care of Dr A. Ward 20 is an inpatient psychiatric ward accommodating 25 or 26 patients. It generally operates at 100% capacity. Ms Robson was the only inpatient seen by Dr A at this time and was seen by her from admission to 20 April 2015, with a gap from 8 February 2015 to 9 March 2015 when Dr A was on extended leave. During that period Dr B attended ward rounds and saw Ms Robson. On 20 April Ms Robson came under the care of Dr D, consultant psychiatrist, until the date of her death on 23 May 2015. Dr D had just returned to duty after a period of maternity leave. Drs A and D both worked part-time. During the period of admission, Dr C, a Locum Appointed for Service, a junior doctor appointment, was involved in Ms Robson's care and treatment. Dr C had completed a four month post in Psychiatry during her Foundation training. She took no part in diagnosis of patients, or prescribing medication unless under supervision. Her role was predominantly as scribe at Multi Discipline Team meetings and drawing bloods.

[11] At the time of her admission in December 2014, Ms Robson diagnosis was Bipolar Affective Disorder with severe depression and suicidal ideation. Ms Robson did drive a car at the time of her admission. NHS Lanarkshire's Inpatient Assessment and Treatment form at admission has a section relating to this and states:

> "If yes, patient advised if appropriate, of DVLA guidance that people with psychiatric conditions which are causing or are felt likely to cause symptoms affecting safe driving should report it to the DVLA"

A link to that guidance is attached to that paragraph. And the appropriate section of the guidance is set out under "MORE SEVERE ANXIETY STATES OR DEPRESSIVE ILLNESSES" requiring notification to DVLA. The guidance sets out: "driving should cease pending the outcome of medical enquiry. A period of stability will be required before driving can be resumed".

Nothing was completed for this section in respect of Ms Robson nor was she advised of the guidance at that time.

[12] During her time as a voluntary inpatient, Ms Robson's underwent a course of Electro Convulsive Therapy (ECT) with 12 treatments (the maximum amount) between 5 January and 12 February 2015. Prior to treatment, Dr A assessed Ms Robson on the Montgomery Asberg Depression Rating Scale (MADRS), with 10 criteria ranging 0-6 for each, with scoring therefore from 0 to 60, 60 indicating the most severe condition. At that time Ms Robson scored 42, markedly ill. Dr A completed SEAN Electroconvulsive Therapy Audit Reviews (T5 audits) on 9, 15, 22, 29 January and 5 February 2015, after which Dr A was on leave. A sixth audit should have been carried out on completion of the ECT course but there is no record of that. Dr A recorded the CGI (Clinical Global Impression) as "no change" on 9 and 15 January with "minimally improved "on all other reviews. Dr C carried out the MADRS assessment after ECT finished recording a score of 23, which would indicate much improved. Dr C had omitted to mark a score on one of the criteria relating to suicidal thoughts. There is no record of Dr C having been supervised at that assessment, and, at that time, Dr C would not have had sufficient

experience to do so without supervision. No Mental State Examination was carried out for Ms Robson after completion of the course of ECT.

[13] SEAN have issued guidance on "**Depression, ECT and fitness to drive**" in place in February 2015. In the "Conclusions and Recommendations" section it states:

> "Most patients who are depressed enough to have ECT should be advised not to drive for 3 months after recovery because this is the law. They may be advised that this is because of the nature of their depression not because of ECT. Given that ECT may bring about a more rapid remission they may be driving again more quickly if they have ECT than if they don't".

Dr A was unaware of this guidance. Ms Robson was not told of the guidance.

[14] Towards the end of the course of ECT, Ms Robson's drug regime was changed. This had been discussed with Ms Robson prior to admission in December 2014, at which point she was on a high dose of Phenalzine, an anti-depressant medication. Phenalzine was reduced from 6 February and stopped on 23 February. A ten day wash-out period should follow but a new anti-depressant drug was not prescribed until 16 March 2015, following the return to duty of Dr A. No explanation for the delay was given. Phenalzine can cause weight gain. Ms Robson had lost 9% of her body weight in the three months to 12 March, some of which could have been attributed to stoppage of that drug use.

[15] During her course of ECT treatments, on or around 21 January 2015, Ms Robson was referred for psychological assessment. The referral was directed to the incorrect section and there was a delay in input until 23 March 2015 after enquiry from her family members and the return of Dr A. Ms Robson was therefore deprived of assistance from

a psychologist for a period of up to two months. Ms Robson had up to six sessions with a psychologist prior to 25 May 2015.

[16] On her return from leave on 9 March, Dr A formed the view that ECT had been reasonably successful and depressive symptoms were in remission, based partly on the reduced MADRS score of 23, indicating a marked improvement of symptoms. Subjectively, Ms Robson did not feel the ECT had been as effective as a previous course of ECT. Nevertheless, her diagnosis thereafter was of anxiety predominately, with moderate depression. As stated above, the referral to Psychology and new drug regime were implemented after the return of Dr A.

[17] Dr A reviewed Ms Robson on a regular basis after her return from leave, meeting her on 12, 16, 19, 31 March and 2, 10 and 13 April all 2015. It was noted that Ms Robson still had signs of depression, a reduction in suicidal thoughts, difficulties with medication but increased anxiety, with anxiety escalating. Nursing notes indicate Ms Robson was generally of low mood, facially flat, diet variable from poor to good, fleeting thoughts of suicide with no plan, anxious about going on passes but working towards a discharge. Ms Robson also continued to lose weight. At a MDT meeting on 10 April 2015 Ms Robson requested an overnight pass which was agreed. She stated she found her anxiety to be "debilitating/incapacitating". It was agreed services would be explored to replicate support being offered to Ms Robson by her sister, Karen Wood. Ms Robson was advised by Dr A that it was safe to drive. About this time Dr A also advised Ms Robson to report her condition to DVLA, which she did.

[18] Throughout the period of Dr A being the responsible consultant for Ms Robson, Ms Robson's family had been supportive of their sister. In particular Damien Robson had visited regularly in the evening and Karen Wood during the day. Mrs Wood had also regularly attended MDT meetings and provided insight into her sister's thoughts, worries and concerns. At no time did Ms Robson suggest to Dr A or other staff that she did not wish her family involved in her care. Ms Robson reported to nursing staff that she regularly met family members while on a pass from the ward

[19] On 20 April 2015 Dr D became the consultant in charge of Ms Robson's care. In addition to that consultant, Ms Robson was also having input from a psychologist, occupational therapist and a dietician. There was a verbal handover from Dr A to Dr D. Dr A explained Ms Robson had been admitted with depression, treated by ECT after which her mood had significantly improved but now had residual anxiety and that should be the focus of moving forward. After observation of Ms Robson, Dr D also was of the view that Ms Robson was principally suffering from anxiety with mild underlying depression. There are no written notes in respect of this handover.

[20] Dr D made some changes to Ms Robson's drug regime. She increased the doses of sertraline (an anti-depressant medication) and quetiapine (an anti-psychotic medication) and prescribed pregabilin (for treatment of anxiety).

[21] Dr D was aware Dr A had evaluated Ms Robson as fit to drive. Dr D did not, at that or any later stage, reconsider Ms Robson's fitness to drive. At no stage did she have regard to DVLA guidance, nor to SEAN guidance post ECT.

[22] According to the medical records, Dr D met Ms Robson on 20, 27 and 30 April, 7, 11 ,13, and 18 May all 2015. Dr D also visited the ward on 23 April and 21 May but did not meet with Ms Robson who was on a pass each of these days. Karen Wood was present at the meeting of 30 April 2015. At that meeting Dr D discussed with both Ms Robson and her sister, Karen, difficulties in family relationships secondary to her illness. Karen expressed some frustration in Ms Robson not taking full responsibility for her recovery and dismissing ideas which might assist. Ms Robson continued to experience extreme anxiety with suicidal thoughts at times but was reluctant to discuss ways she thought about to harm herself.

[23] At some point after the meeting of 30 April, Ms Robson requested that Dr D not contact her sister Karen, explaining that Karen was ill. She also requested that her brother, Brian, a GP, not be called as he was busy. There is no written record of any such meeting or request. This resulted in a lack of communication thereafter with any family member. It was never explored further, nor reviewed, at any later stage.

[24] To assist in a discharge strategy there was a discharge date of 10 June 2015. Ms Robson had a number of "passes" (arranged absence from the ward for a predetermined length of time). These were sometimes day passes when she would leave the ward, sometimes supervised, sometimes unsupervised and thereafter extended for longer periods including overnight passes. Passes are referred to within the nursing notes. There is no separate document which would easily assist in recording such passes, whether day passes or overnight passes, nor how Ms Robson coped during any

such periods. There was no written safety plan in place prior to any such pass. No checks were carried out following any such pass.

[25] Whilst on pass from the ward Ms Robson attempted suicide. Ward staff were first made aware of this on 6 May 2015, 17 days prior to the date of her death. Ms Robson outlined a staggered overdose whereby she drank a solution made up of water and 60 paracetamol over a 3 day period being 1, 3 and 4 May 2015. The ward records indicate Ms Robson went for a walk outwith the hospital on 1 May, on 2 May she had a day pass and said she was meeting her sister, on 3 May had a further day pass. Ms Robson had indicated her mood was low with suicidal thoughts but would not act on these. She expressed no concerns on return to the ward after each pass. On 4 May she was sick in the morning so a meeting with OT had to be postponed to the afternoon. She then met the occupational therapist and spoke of suicidal ideation and that she had chosen not to discuss any such plan when asked by Dr D. She did ask what would happen if she had made an attempt on her life but refused to discuss details. The therapist encouraged her speak to someone and give detail of what she had done but that advice was not taken up by Ms Robson. The Late Shift report of 4 May sets out that Ms Robson had had thoughts of suicide since entering the ward but appreciated the difference between thinking about and planning to harm herself. She denied any current plan to self-harm but did state she was unwilling to share any plan with staff as they would be able to stop her if she wanted to act on the plan. Ms Robson had a further day pass on 5 May, the ward records indicating she left shortly after noon and was due to return about 20:00. She also met with a psychologist that day.

[26] In the early hours of 6 May Mrs Wood received a telephone call from Ms Robson who revealed that she had taken an overdose of paracetamol while on pass. Mrs Wood alerted ward staff to this but there is no record of her call. Ms Robson also followed Mrs Wood's advice and told ward staff of the staggered overdose taken on the Friday (16 tablets), Sunday (20 tablets) and Monday (26 tablets) of her passes. This is recorded in the ward notes. Ms Robson was transferred to a medical ward for observation and treatment. Mrs Wood attended at the hospital and was present when Ms Robson was visited by Dr C in the medical ward. Mrs Wood waited outwith the room where Dr C met Ms Robson. Dr C made no attempt to gain information from Mrs Wood regarding the overdoses taken albeit the she was first person spoken to by Ms Robson. Dr C made no attempt to discuss matters with Mrs Wood after her examination. Mrs Wood resumed her visit with Ms Robson and Ms Robson shared the information given to Dr C.

[27] At that meeting Ms Robson disclosed to Dr C that she had had suicidal thoughts for weeks, feeling no better from admittance. She had had thoughts of jumping in front of trains, crashing her car but mainly of taking an overdose. She had read that a staggered overdose might be more effective than single episode, had bought capsules over a period and stored in her car, taking powder from capsules and dissolving in water. This was done in a carpark. When she woke in the ward on 6 May, she felt unwell, phoned her sister, Karen, and advised her of her actions. She followed Karen's advice to tell staff of her overdose. Ms Robson was disappointed the overdose had not worked. She accepted she had been "devious and sneaky". Ms Robson felt hopeless

with ongoing desire to end it all but denied any intent or future plan to harm herself. Dr C recommended no further passes until reviewed by Dr D

[28] The review by Dr D took place on 7 May, with Dr C present. Although Ms Robson had first reached out to a family member, no family member was present at that meeting. Ms Robson confirmed that she had planned and hoped that the overdose "would be effective". She worried that relationships with both her consultant and sister had been harmed but was pleased her sister had acknowledged that the difficulties were as a result of her "illness". Significantly, it was agreed that "immediately after such events we reduce passes". Home passes were cancelled over that weekend, along with other measures.

[29] Prior to Ms Robson's next consultation with Dr D, ward records indicate Ms Robson felt no improvement in mood since admission and she continued to have thoughts of suicide. Ms Robson was also noted to have had time with a brother and her sister. No home passes were issued in this period.

[30] Dr D, Dr C and a staff nurse met Ms Robson on 11 May. Staff had noted her to gag or vomit when attempting to take medication, denied by Ms Robson. Her medication was adjusted and she was advised not to take a day pass pending a further MDT on 13 May.

[31] Ms Robson met with both her occupational therapist and psychologist in advance of the MDT of 13 May. She discussed her staggered overdose with each. She denied having further suicidal plans but also felt low and unable to cope with living with the level of anxiety then felt.

[32] Both the psychologist and occupational therapist were present at the MDT on 13 May, along with Drs D and C and nursing staff. Objectively it was felt that Ms Robson's mood had lifted from admission but she was still struggling with identity and future ability to cope. Ms Robson was still anxious and experiencing suicidal thoughts but denied any active plan. To move forward Ms Robson was to devise a plan and set goals for herself to achieve for a discharge date. It was recorded that "further self-harming behaviour would not change or delay this discharge date". Although Ms Robson stated "I don't think I can do it", the date was set for 10 June 2015 or the day after.

[33] Over the next few days Ms Robson expressed optimism for her future discharge, planning to prepare herself for this, or anxiety leading to panic attacks when she stated she was scared of being discharged. Ms Robson also requested passes for 21 to 22 May and 24 to 25 May 2015.

[34] On 17 May Ms Robson spent most of the morning in bed before going home on a day pass. On return she appeared anxious and upset and said she had thoughts of jumping in her car and driving away. While she did not want to have thoughts of suicide or self-harm, she did want to get rid of her "churning" thoughts and feeling so low. She handed her house and car keys to staff to stop her acting on these thoughts. She advised her brother, Damien, of this. He advised she should consider moving the car to her mother's house and Ms Robson was considering this. He advised staff in the ward of this suggestion. That is not recorded in any ward notes.

[35] At the ward round on 18 May, Ms Robson confirmed to Dr D that she had had ideas of getting in her car and driving away but denied suicidal plans. However she did state that she thought the handing over of the keys was safer for her at that moment. Ms Robson also met with her psychologist, occupational therapist and staff nurse during that day. Ms Robson confirmed she still felt anxious and unable to keep herself safe. It was discussed that Ms Robson should have responsibility for her own safety and that by handing over her car keys, she had shifted responsibility from herself. It is agreed that the following day, Ms Robson received back her keys. There is no record of any discussion with Ms Robson at this time of any change in her mood or anxiety or about thoughts of driving away previously expressed. It is known that she received her keys only as a result of a check of the safe book (a book kept to record items placed in or removed from a safe held in the ward) retained on the ward.

[36] Ms Robson had a day pass on 20 May and an overnight pass on 21 May. On both dates she was seen by her occupational therapist within her home. Ms Robson showed signs of anxiety and expressed suicidal ideation. The level of anxiety expressed did not match her observed behaviour and coping strategies were discussed.

[37] On 21 May 2015, after the visit with her occupational therapist, sometime after 20:00, Ms Robson phoned Damien Robson in a distressed state. She was crying and had difficulty communicating. She explained she had taken another overdose of paracetamol but had been sick. Due to his circumstances he could not drive to meet her. Having ascertained she did not need an ambulance and felt she could drive, he told her to drive back to the hospital. He remained on the phone call throughout the journey and

her return to the ward. He heard her explain about the overdose and then her phone was passed to a person who said he was the nurse in charge at that time. Although requested, the nurse did not give a name. Mr Robson introduced himself and requested forcefully that his sister not be allowed out on a further pass, this being her second overdose in a fortnight, and that he be given updates on Ms Robson's condition. He left his own mobile number. He was assured Ms Robson would be taken care of by staff. That was his last contact with his sister. He received no return call from the hospital. There is no record of these events in the medical records which merely set out that Ms Robson returned from pass, asked to speak to staff and advised of her overdose. Ms Robson was medically assessed but no treatment was required in relation to the physical consequences of taking an overdose.

[38] On 22 May 2015 Dr C met with Ms Robson along with Staff Nurse L. At that time Dr C was a junior doctor and a locum appointment for service, with four months of psychiatric study during her Foundation course. She had not started her formal psychiatric placement. She had not previously made any diagnosis. She had not made any decisions in respect of Ms Robson's care or medication. Dr D, the consultant for Ms Robson, was not on duty that day. There was no direct verbal communication between Dr D and Dr C, nor is there any written record of communication between them. Dr D was in attendance at another hospital in connection with her young child. Dr D telephoned the ward in regard to another patient and was advised of the overdose taken by Ms Robson the previous evening by a nurse. Details were not given as they referred only to the nursing notes. A nurse advised Dr D of her opinion of Ms Robson's

current state. Dr D had no access to nursing notes, not having a laptop which had been requested by her on several previous occasions. Dr D requested that Dr C carry out a mental state examination and risk assessment and, if there was no change in her condition, a pass could be maintained after Ms Robson's physical and mental state were assessed on the ward prior to leaving on the pass. Dr C met with Ms Robson. Ms Robson confirmed having met her occupational therapist and discussed suicidal thoughts with her. They had discussed Ms Robson taking responsibility for not acting on such thoughts. After the occupational therapist left her home, Ms Robson felt anxious and "had had enough". She dissolved paracetamol in water and drank same but not as much as she wished as she felt nauseous. Ms Robson believed this would be a fatal dose. That discussion with Dr C omits any contact with Damien Robson including his discussion with a nurse and the requests made by him. Ms Robson yet again denied any future plan to self-harm. Ms Robson asked if this would affect her discharge date and was told it would not. It was suggested that she prepare a written safety plan before next going on pass but this did not happen. Dr C assessed that there was no change to Ms Robson's mental state examination and Ms Robson could go on a pass if she wished. There was no reference to the decision taken and recorded at the MDT of 7 May when it was noted that, "immediately after such events we reduce passes" and when passes were suspended for a period.

[39] Ms Robson left the ward on a pass on 23 May 2015 sometime around midday, in possession of her car keys. Before leaving she had sent a text message to her brother Damien and to her sister. She advised that she had dropped her phone, smashing the

screen so could not safely use it and not to worry if they could not get hold of her. Mr Robson believed Ms Robson to be in Ward 20 and to be remaining there at this time. The nursing notes for that day are brief. The final entry was by a bank nurse with no knowledge of Ms Robson, no clear understanding of the MIDAS system and who did not consult any current risk assessment. The risk assessment had not been updated despite a note on the medical records that it needed to be updated following the overdose taken by her. They do not indicate any assessment of Ms Robson's mood prior to leaving the ward. No safety plan had been prepared as suggested by Dr C. No details of her pass were recorded. Ms Robson did speak to Staff Nurse H during social interaction but no assessment was properly carried out. Although not seen to have done so, no other party being involved, it is a reasonable inference that Ms Robson drove away from the hospital.

[40] On Saturday 23 May 2015 at about 8.30pm, witnesses were driving towards Maybole when they came across a motorcar on fire. An emergency phone call was made to the fire service. The car was positioned some 40 yards from the road on grassland beside a row of bushes. The road was an unclassified road close to Dunure Road, Ayr leading over to Carrick Hills to Maybole in South Ayrshire.

[41] Fire fighters responded to the call and arrived on the scene at approximately 8.52pm. The car was still alight. Human remains were recognised within the driver's seat of the motorcar. The flames were extinguished and the police were called. Police attended at the scene and preserved the scene and arranged for photographs to be taken. The motorcar was identified as a Honda Jazz registration

number NH55 2XX, belonging to Ms Robson. On 24 May 2015 the vehicle, with the human remains in situ, were taken to a secure storage facility in Kilmarnock to be forensically examined.

[42] A fire investigation officer conducted an investigation into the fire and concluded that deliberate ignition was the most probable cause but given the extent of the fire damage to the motorcar he was unable to substantiate this opinion and classified the cause of fire as "undetermined". He did confirm that the handbrake was pulled up in the engaged position and the driver's seat had been pushed back as far as the rules would allow having maximum legroom. The human remains were in the driver's seat leaning over to the front passenger cabin area.

[43] On 26 May 2015 a forensic archaeologist attended with a police officer at the secure facility and conducted a further investigation (Crown Production 8).

[44] The human remains were identified after a DNA analysis was that of Ms Robson Anne Robson (Crown Production 9).

[45] On 2 June 2015 a post mortem examination was conducted at Sothern General Hospital and the primary cause of death was listed as 1a unascertained (Crown Production 12). A forensic toxicologist report dated 29 June 2015 confirmed the presence of pregabalin following analysis of a urine sample. Pregabalin had been prescribed whilst Ms Robson was an inpatient at Hairmyres Hospital (Crown Production 12a). It was not possible to obtain blood samples.

[46] Ms Robson's death was registered in the register on 15 June 2015 showing her death occurred on 23 May 2015 and the cause of death was recorded as 1a unascertained (Crown Production 1).

Discussion

[47] To assist in assessing whether there was any matters arising from the care and treatment of Ms Robson from admission in December 2014 and her death on 23 May 2015, the Court had the benefit of evidence from Doctors Cook, Scott, Ward and Muzaffar as well as Dr Jenkins from DVLA, and I am grateful for the contribution of each. Dr Cook spoke to the Significant Adverse Event Review and some of the recommendations are reflected in my recommendations here. In some respects, I was unable to follow conclusions reached when the evidence in the Inquiry did not match the information obtained for the Review. One example of this is in respect to the meeting of 22 May with Dr C and Staff Nurse L. The Review proceeded on the basis of a telephone discussion between Dr D and Dr C when the evidence shows no such discussion took place. Further it does not reflect that Dr D was off duty, had no access to medical records and was attending hospital with her young child. The Review sets out that the meeting had been a MDT but I cannot accept it as such. As Dr Cook stated, his was a review, not an inquiry so was based on records and statements. Other experts spoke to their reports with supplementary information. I have taken their evidence, including all reports lodged, and will refer to significant areas, if required.

[48] All parties lodged written and detailed submissions, again for which I am grateful and have taken into full consideration.

[49] There arose six principal areas of discussion:

[i] Relevance of guidance on driving having regard to guidelines from DVLA and SEAN post ECT

[ii] Involvement of family members

[iii] Diagnosis and treatment

[iv] Hospital records, including notes and assessments

[v] Safety Plan

[vi] Management of passes.

I will deal with each in turn

Guidance on driving.

[50] As noted in paragraph [11] above, the DVLA Guidance is specifically referred to within admission forms to be completed but was left blank in relation to this admission. Neither Dr A nor Dr D had any detailed knowledge of the Guidance, nor did either refer to it during Ms Robson's admission. Dr A had advised Ms Robson to make a referral to DVLA but without herself having detailed knowledge of the advice given in the Guidance. While she advised Ms Robson that Ms Robson was fit to drive, at that time this was not by reference to any part of the Guidance. Dr D did not consider the DVLA guidance at any time, accepting the position prior to her engagement with Ms Robson. She did not assess the position after Ms Robson revealed she felt like crashing her car or

after Ms Robson handed over her car keys to staff. Neither Dr A nor Dr D were aware of the SEAN Guidance post ECT. In accordance with those recommendations, Ms Robson should have been advised not to drive for a period of three months following ECT. While this issue was subject of lengthy examination and cross examination, it was clear that those responsible for Ms Robson's care had little knowledge of either guidance and consequently could not, and did not, provide advice in line with either Guidance. At the MDT on 18 May 2015, it is noted Ms Robson had handed in her car keys "which she feels is safer for her at the moment". The reasons for that were not explored with her. The universal opinion was that Ms Robson cooperated with all advice given to her by the medical staff. It follows that, had she been advised not to drive, she would not have done so. It also follows that, after handing in her car keys, had she been advised not to take them back, she would have followed that advice. I accept the DVLA Guidance does make provision for a clinician to advise that a person may continue to drive pending a decision from DVLA. However I do not consider that applicable here as Dr A had not sufficient knowledge of the guidance to make that determination in relation to Ms Robson. Nor do I accept the opinion of Dr Muzaffar that Ms Robson's condition was mild or moderate depression. On admission her depression was severe with ideas of suicide. Her depression had been less pronounced after ECT but she still had severe anxiety with depressive symptoms and suicidal ideation. It was accepted by Dr A that, post suicide attempts and revealing she had thoughts of crashing her car, Dr A would have advised Ms Robson not to drive.

Involvement of family members.

[51] While there had been difficulties in family relations prior to her admissions in late 2014, following Ms Robson's admission in December of that year, her family were closely involved in her care. Her sister, Mrs Wood, phoned nightly and attended regularly, including at MDTs. Her brothers were in frequent phone contact and visited regularly. When on pass, this was usually to meet and be in the company of a family member, as she reported to ward staff right up to 23 May 2015. It was to family members she turned, not medical staff, after both suicide attempts in May 2015. Dr D believed it was about that time Ms Robson told her she did not want family members informed of her care. No note was made of any such meeting or request by Ms Robson. Having regard to the previous welcomed assistance from her family, it is more probable that Dr D misinterpreted the views expressed by Ms Robson at the MDTs on 7 and 11 May. The notes do not set out in explicit terms that Ms Robson did not wish family involvement, but did mention illness of Mrs Wood and how busy her brother might be. In any event, Dr D should have clarified Ms Robson's wishes, discussed the basis of any change in Ms Robson's relationship with her family and kept this under review. It was accepted by all expert witnesses that such a request from a patient should be documented, shared and discussed with other clinicians but that did not happen. The importance of involving family members is highlighted in the Suicide Assessment and Treatment Pathway, Supporting Guidance, compiled by the Suicide Prevention Working Group which includes NHS Lanarkshire. Little or no regard appears to have been paid to this by the medical staff involved in the care of Ms Robson. As part of recommended

actions for those of medium suicide risk, it states "Family cohesion and support act as buffers and protective factors against suicide across cultures". While there is reference to family involvement throughout the ward records and at early MDTs, there is no record of any formal involvement after the MDT of 20 April which appears to be the first and only meeting of any family member with the consultant in charge of Ms Robson's care, and indeed the last with any medical professional. As a result of failure to involve family in her treatment and of passes, coupled with the failure to note Mr Robson's role and comments on Ms Robson's return to hospital on 21 May, no medical staff were aware of the phone messages to Mrs Wood or Damien Robson regarding lack of ability to communicate while on pass on 23 May. Those messages should have caused concern, and, if known, should have prompted a review of that pass.

Diagnosis and Treatment

[52] Ms Robson had suffered from poor mental health for many years. On her admission to Ward 20 on 23 December 2014, her diagnosis was of a severe relapse of depressive illness. Such was the severity of her depression, she underwent the maximum course of ECT, being 12 sessions between 5 January and 12 February 2015. Ms Robson had undergone ECT previously so was able to subjectively note any improvement in her illness. Dr A carried out Audit Reviews on 5 occasions between 9 January and 5 February (each after two sessions) but was on leave when ECT sessions were completed. Dr A noted "no improvement" following the first two Audit Reviews and "minimal improvement" on the later Audit Reviews. As noted above the MADRS

scoring was carried out by a locum, Dr C, and omitted one of the scoring criteria. This does not appear to have been noticed by any medical staff during Ms Robson's period of admission. Post ECT, medical staff were of the view that Ms Robson's depressive illness was much improved, based partly on that MADRS score but also on observation and assessment of Ms Robson. It was assessed that Ms Robson's predominant condition was now of severe anxiety, with moderate depression. Her medication was changed resulting in a period with no anti-depressant medication. Dr Scott highlighted the advice regarding medication and high relapse rates post ECT, together with the lack of recording of a formal comprehensive mental state examination. The consultants in charge advised such an examination would be incorporated into the MDTs carried out regularly. Dr Scott also cited her low moods, suicidal ideation and weight loss as indicative of a relapse into a more serious depressive state. While these are all factors to be considered, I cannot say that the diagnosis by both consultants, along with the input from the psychologist and occupational therapist, was incorrect. They had the benefit of the ward notes as well as regular meetings with Ms Robson. While a record particular to a mental state examination would have been helpful, I accept that the equivalent was carried out at MDTs. Accordingly I do not accept that any deficiency in the diagnosis or treatment contributed to the death of Ms Robson.

Hospital records, including notes and assessment.

[53] It is common ground that the medical records and notes are not of good quality. On dietary issues the SAER noted "there is evidence of poor recording and a 'laissez-

faire' attitude to dietary issues that were clearly having an impact on YR's physical health and psychological well-being". There is no record of formal mental state examinations having taken place, concerns raised by family members omitted, constant reference to "risk assessment and safety plan remains relevant" despite neither having been reviewed on a regular basis. The Mental Health Risk Assessment was described as a "box ticking exercise" but it is an important document and reflects the issues set out in the Suicide Assessment and Treatment Pathway, Supporting Guidance. It should have been updated regularly. Of concern is the lack of recording of involvement of family members following the staggered overdose (Mrs Wood contacting the ward) and the overdose of 21 May when Damien Robson spoke with a staff members and vociferously stated his opinion on future passes. Omission of their involvement allowed an assessment that Ms Robson had returned to the ward and reported these incidents voluntarily and independent of advice, leading to these being protective factors when in fact she had contacted family and acted on their advice. The omission of the latter in particular meant that staff were unaware of the particular circumstances of the overdose on 21 May and family concerns over future passes, matters which should have been considered by Dr D, Dr C and Staff Nurse L. The record of the meeting of Ms Robson with Dr C is full but was not followed up and does not reflect accurately the involvement of Dr D. Dr D did not speak directly with Dr C, had no access to medical records and, as set out above, had no knowledge of the involvement of Damien Robson. No safety plan, as suggested by Dr C, was produced. Dr C did not note that Ms Robson's physical or mental state be assessed prior to leaving on pass. Dr D in

evidence stated she wished Ms Robson to remain on the ward for twenty four hours and that she be assessed by staff prior to any further pass. There is no record of any assessment of Ms Robson's mental state on 23 May prior to leaving the ward. Charge Nurse H gave evidence that she was in charge of the ward that day but was not formally involved with Ms Robson. She had not read any of the recent notes regarding Ms Robson and was unaware of the overdose recently taken. She stated she had had a relatively lengthy discussion with Ms Robson while receiving a massage from Ms Robson and that Ms Robson was happy, talking about the future and gave her no cause for concern. She did not provide a statement to police at that time, nor take part in the SAER, the first statement appearing to have been taken some six years after Ms Robson's death. I cannot put any weight on any such conversation. It took place without knowledge of recent events, in a social setting which was inappropriate and did not cover many matters which would be covered in a formal assessment. Yet again the notes reflect "risk assessment and safety plan remains relevant" although the appropriate Assessment was not completed and the nurse who noted that had no knowledge of Ms Robson. That note also set out "Client left today for pass until Tuesday" which was incorrect. The paucity of the notes and omissions of family involvement and concerns were relevant factors in whether the particular suicide could have been avoided.

Safety plan.

[54] As described by Dr Muzaffar, a safety plan is generally a document in which a number of skills are identified which a patient can utilise when they are distressed as an alternative to self-harm or suicide. As set out in the Suicide Assessment and Treatment Pathway, strategies and actions should be appropriate to the person and may include distraction and utilisation of problem solving techniques. Although referred to often in nursing notes ("safety plan remains relevant"), there was no written safety plan for Ms Robson. She was repeatedly advised she could contact the ward if an issue arose while on pass, and she was seeing a psychologist and occupational therapist, but these measures to not comply with the definition given by Dr Muzaffar and referred to by other witnesses. In effect, there was no safety plan devised in conjunction with discussion with Ms Robson. Distraction techniques are referenced, but mainly by the patient saying these were not working. That does not appear to have been explored further with her. Given that a safety plan is to be utilised to reduce the risk of self-harm or suicide, it follows the lack of same was relevant to the ultimate outcome in this case.

Management of passes.

[55] It was very difficult, if not impossible, to find any management or recording of passes. At MDTs it is stated that Ms Robson should be allowed a pass but the extent of such, whether day or overnight, in or outwith hospital grounds, is not recorded. Details seem to have been left to nursing staff once the principal was established by the consultant. The issue of recording of passes is taken up within the SAER with the

recommendation that these be clearly recorded. After the meeting with Dr C on 22 May, Ms Robson was allowed to continue with an overnight pass. No regard appears to have been taken to the decision after a MDT of 7 May, noted above, that "immediately after such events we reduce passes". At that time passes were cancelled. Dr D did not have access to hospital records at that time and it would be too much to expect her to remember that detail when she was off duty and at a hospital with her young child. It could, and should, have been noticed by Dr C and taken into consideration and discussed with a consultant. The failure to involve family, again as noted above, meant they were not aware of the detail of any pass and, crucially, unaware of the overnight pass for Ms Robson on 23 May. Had they been aware, concerns would have been raised with nursing staff. Failure in these regards led to Ms Robson being out on a pass with no definite date for return, no awareness by her family and no effective support.

Conclusions

[56] The Inquiry is concerned with the death of Yvonne Anne Robson on 23 May 2015 and the particular circumstances around that death, Some recommendations may be particular to that death, some more generic but based on the facts of this incident. Several witnesses were asked about the difficulties in developing a strategy to prevent future suicides in patients with suicidal ideation. That is outwith the scope of this Inquiry.

[57] There were several instances where care of Ms Robson following her admission to Ward 20 at Hairmyres Hospital on 23 December 2014 were less than ideal. Examples

of these are the delay in obtaining psychological input, failure to attend to dietary requirements, the extended period following wash-out before new medication was prescribed and failure to record family concerns about these matters, all of which are referred to in the SAER. None of these, however, were directly relevant to Ms Robson's death on 23 May 2015. Ward 20 was a very busy psychiatric ward operating at 100% capacity. The consultants involved both worked part time and, in normal circumstances, Ms Robson would not have come under their care. It is perhaps unfortunate that the first consultant had an extended period of leave at conclusion of the ECT sessions and that the second consultant was just returning from a period of maternity leave. Nonetheless both acted in the best interest of Ms Robson during her period in the ward. While criticism of their diagnosis was made by Dr Scott, as set out above, I can find no grounds to fault their diagnosis of improving depressive condition and of severe anxiety following ECT. They reviewed Ms Robson regularly at MDTs and had input from a psychologist, occupational therapist and nursing staff. The proposed treatment plan was in alignment with that diagnosis. The deficiencies however were manifest from the time of her admission on 23 December 2014. DVLA guidelines were not followed from admission notwithstanding there is a question in the admission forms specifically directed to those guidelines. SEAN guidelines following ECT were not followed. While a clinician can advise that a person is safe to drive following a referral to DVLA on fitness to drive, this should have been kept under review, Dr A stating she would have changed her view on fitness after the events and disclosures by Ms Robson in May 2015. Dr D did not consider the position afresh at any stage. Failures to keep the

family involved throughout, despite Mrs Wood being present at early MDTs, and failing to record concerns raised or to take histories from them after incidents, minimised the information available to clinicians when determining plans for discharge. In particular, had family members been involved in passes, the phone messages to her brother and sister in the morning of 23 May should have raised serious concerns. Dr Muzaffar considered the lack of a suicide note or similar prior to the pass that morning to be significant but these messages were an indication of her intent, reflecting as they did Ms Robson's action in disposing of her phone to prevent family contact when she travelled to Largs with the intention of drowning herself. This is noted in Dr C's letter to Ms Robson's General Practitioner of 27 November 2014, the day following her discharge on 26 November 2014. Clinicians should also have considered the statement by Ms Robson to staff on 4 May 2015 when she stated she would not tell staff of plans (to commit suicide) in case they tried to stop her. The circumstances of 22 May were described as a perfect storm: the consultant was not working that day, she had no access to medical records, she was advised of the overdose when phoning about another patient and while at hospital with her own child, Ms Robson was seen by a junior locum doctor who had not started her psychiatric training and who described her prior involvement as a scribe, not diagnosing patients, not even prescribing medication without supervision, accompanied by a staff nurse not experienced in that ward and confusion over the actual communication and advise given. At the MDT following the staggered overdose, action following any further similar event was clearly set out but was not followed on this occasion. Any advice actually given by the consultant was not

recorded. According to her evidence, that was that Ms Robson to be kept in overnight, physically and mentally assessed the following day, and allowed to go on pass if she wished. There was no such assessment properly carried out. In summary, the pass should have been cancelled and, if not, the family should have been advised in advance, and Ms Robson should not have been driving. These would have been reasonable precautions.

[58] Finally, I join with the others in offering the condolence of the Court to the family of Ms Robson. I appreciate it is likely to have been difficult to be reminded of the circumstances of her death so long after the event.