SHERIFFDOM OF LOTHIAN AND BORDERS AT LIVINGSTON

[2024] FAI 13

LIV-B543-22

DETERMINATION

BY

SHERIFF PETER G L HAMMOND, Advocate

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

into the death of

ANN MARGARET DRUMMOND

LIVINGSTON, 26 February 2024

The sheriff, having considered the information presented at the inquiry, determines in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, (hereinafter referred to as "the 2016 Act"):

In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred)

The late Ann Drummond died at 02.08 hours on 27 June 2019 at Glasgow Royal Infirmary.

In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in the death occurred)

Ann Drummond did not die as a result of an accident.

In terms of section 26(2)(c) of the 2016 Act (the cause or causes of the death)

The cause of the death of said Ann Drummond was: Complications of extensive burns

In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in the death)

Ann Drummond did not die as a result of an accident.

In terms of section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided)

1. The effective sharing of potentially relevant information held by the police, within the police service itself and with NHS staff, about concerns over the mental state of Mr Marks based on recent contacts with him, the nature of the threat he made against Ms Drummond and his previous history of domestic incidents.
2. The carrying out of a thorough and effective risk assessment for the safety of Ms Drummond and warning her of the potential danger posed by Mr Marks.

In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death)

1. The inadequate sharing of information held by Police Scotland, as referred to under section 26(2)(e) above.
2. The failure to undertake an effective risk assessment in relation to Ms Drummond as referred to under section 26(2)(e) above.

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

There are no other facts, beyond the foregoing findings set out in this Determination, which are relevant to the circumstances of the death of said Ann Drummond.

Recommendations

In terms of sections 26(1)(b) of the 2016 Act (recommendations (if any) as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances)

Having considered the information presented at the Inquiry and the changes implemented by Police Scotland since June 2019, no recommendations are made.

NOTE

The legal framework

[1] This inquiry was held in terms of section 4(1) of the 2016 Act, and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the 2017 Rules"). This was a discretionary inquiry in terms of section 4(1) of the 2016 Act, as the Lord Advocate considered that the death occurred in circumstances giving rise to serious public concern, and that it was in the public interest for a public inquiry to be heard into the circumstances of the death.

[2] The purpose of the inquiry is set out in section 3 of the 2016 Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. The inquiry is an exercise in fact finding, not fault finding. The inquiry is an inquisitorial process. The Procurator Fiscal represents the public interest on behalf of the Crown.

[3] In terms of section 26 of the 2016 Act the inquiry must determine certain matters, namely; where and when the death occurred; when any accident resulting in the death occurred; the cause or causes of the death; the cause or causes of any accident resulting in the death; any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death; any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the Sheriff to make

recommendations in relation to matters set out in subsection 4 of section 1 of the 2016 Act.

Introduction

[4] This inquiry was held into the death of Ann Drummond. Ms Drummond died on 27 June 2019, aged 47, as a result of being assaulted by Kevin Marks or McFaulds (hereinafter referred to as "Kevin Marks"), who was not criminally responsible for his conduct due to mental disorder at the time of the incident. Kevin Marks had had a number of contacts with Police Scotland and NHS Lothian in the lead up to the assault which led to Ms Drummond's death. Despite these interactions, his presentation was not noted by NHS Lothian as psychotic, and he was not considered to be a risk to himself or others; to the extent that no emergency action (such as detention in hospital or referral to mental health crisis services) was deemed appropriate. This inquiry was convened to examine these contacts with Police Scotland and NHS Lothian prior to the incident, and to establish whether there were missed opportunities to intervene whereby steps might have been taken to avoid the death.

[5] The death of Ms Drummond was reported to the Procurator Fiscal (hereinafter referred to as "the Crown"). The First Notice intimating the Crown's intention to hold this Fatal Accident Inquiry was lodged with the Sheriff Clerk on 14 September 2022.

[6] A number of preliminary hearings were held to focus the issues for inquiry and discuss preparations for the evidential hearing. The Hearing of evidence in the inquiry

took place over a number of days, commencing on 6 September 2023 and concluded on with a Hearing on submissions on 27 November 2023.

[7] Throughout the proceedings, Ms Sun, Procurator Fiscal Depute, represented the Crown. Ms Bennett, counsel, represented NHS Lothian Health Board, and Ms Toner, counsel, represented Police Scotland. The family of Ms Drummond were not legally represented and elected not participate in the inquiry, although they did attend as observers.

[8] The inquiry heard from a number of witnesses, whose statements and reports were lodged and referred to in the course of their oral evidence. In addition, the Inquiry considered a number of other documentary productions lodged by the parties. These included extracts from medical and police records, and NHS documentation reflecting on the incident. Helpfully, the parties had entered into a significant joint minute of agreement covering the chronology of events, the post mortem findings, the criminal proceedings and the status of the productions. It was agreed that all documents, including medical records, were to be admitted into evidence without the need to be spoken to by their author.

[9] The witnesses examined were:

For the Crown:

a. PC Ross Walker, Police Scotland

b. Dr James Carr, (formerly FY 2 Trainee in A & E; now GP)

c. Dr Elizabeth Walsh (formerly ST6 Trainee; now A & E Consultant)

d. PC Graeme Rodgers, Police Scotland

e. DC Lynn Myles, Police Scotland

f. Mrs Gillian Currie, Advanced Nurse Practitioner

g. Dr Alastair Morris, Consultant Forensic Psychiatrist

h. Dr Gary Stevenson, Consultant Psychiatrist

For NHS Lothian:

i. Dr Steven Hearns, Consultant Physician in Accident and Emergency

[10] Affidavits by a number of further witnesses, who did not appear in person at the inquiry, were also lodged. It was agreed by joint minute that these witness' affidavits should be admitted in evidence and treated as the equivalent of their parole evidence. The witnesses whose evidence was received by affidavit were:

a. Mr Dzidzai Chipuriro, Clinical Services Manager, NHS Lothian

b. Temporary Chief Inspector Stephen Grimason, Police Scotland

c. Detective Chief Inspector Natalie Cook, Police Scotland

In addition, a number of statements by witnesses who did not appear at the inquiry were produced. In particular, it was agreed by joint minute that two police statements provided by Lindsay Saint, Clinical Forensic Nurse, should be admitted in evidence as equivalent to parole evidence by her.

[11] The joint minutes cover a number of facts which were not in dispute. In addition to various formal matters, the substantive joint minute includes a helpful narration of the background, Mr Marks' medical and domestic history and the chronology leading up to the tragic events of 25 June 2019. In terms of the joint minutes, it was agreed that:

[12] Ms Drummond was born on 11 April 1972. She was 47 years old at the time of her death. She lived at her home address in Livingston, and had her own dog walking business.

[13] Kevin Marks was born on 19 May 1972. He was single and, prior to his remand in the State Hospital, was unemployed, although had been assisting Ms Drummond with her dog walking business.

[14] Kevin Marks had been in a relationship with Ms Drummond for around 2½ years, which ended one week before her death in June 2019. Kevin Marks had been living with Ms Drummond at her home address, but moved out on 19 June 2019 following the breakdown of their relationship. Thereafter he stayed with his mother, MD at Bathgate on a temporary basis.

Kevin Marks' psychiatric history

[15] Kevin Marks has a history consistent with physiological alcohol and drug dependence syndrome. He underwent psychiatric assessment at St John's Hospital ("SJH") on three occasions in 2015. On each occasion he had been conveyed to hospital by police/ambulance having threatened or attempted suicide at Bathgate station, whilst under the influence of alcohol.

[16] On 8 April 2015 Kevin Marks underwent a full mental state examination (psychiatric assessment) by an FY1 doctor in Liaison Psychiatry under supervision of, and discussion with, a psychiatric consultant. It was concluded following his assessment that there was no evidence of psychiatric disorder. Kevin Marks was

provided information about, and advised to contact, alcohol services in Edinburgh. The details of this assessment, including the risk assessment, mental state examination, diagnosis and treatment plan are contained in Crown production 4, pages 14 to 23. A summary of this assessment was notified to his GP, Dr Bennison at Mill Lane Surgery, Edinburgh by letter (Crown production 13, pages 17 – 19).

[17] On 1 May 2015 Kevin Marks underwent a further psychiatric assessment by the same FY1 doctor who assessed him on 8 April 2015. This assessment was also under supervision of a psychiatric Registrar in Liaison Psychiatry. Following the assessment, he was diagnosed as presenting with no obvious mental illness apart from severe alcohol dependence. He was assessed as psychiatrically fit for discharge once medically fit. The management plan on discharge noted that he had been assessed by the West Lothian Drug and Alcohol Service team, and was given advice on Alcohol Breakaway Clinics. It was recorded that West Lothian Social Work were aware of him via the Police Adult Protection Team. The details of this assessment including the mental state examination, diagnosis and treatment plan are contained in Crown production 4, pages 24 to 35. A summary of this assessment was notified to Dr Bennison by letter (Crown production 13, pages 23 – 26).

[18] On 25 September 2015 at SJH, Kevin Marks underwent psychiatric assessment by a CT2 (a qualified doctor and junior psychiatric trainee) under supervision. The psychiatrist considered that his "presentation is somewhat bizarre" with some features of possible hypomania, but she did not think he met the criteria for detention, and noted that he would be unwilling to remain in hospital. Mr Marks was deemed fit to be

discharged to his mother's address (noted to be his temporary address) and agreeable to outpatient follow-up and to register with a GP. The details of this assessment including the mental state examination, diagnosis and treatment plan are contained in Crown production 4, pages 37 to 42.

[19] Kevin Marks failed to attend an out-patient psychiatric clinic appointment at SJH on 26 February 2016 and again on 30 May 2016. (Crown production 4, pages 42 – 44).

Kevin Marks' previous domestic history 1991 – 2018

(LB 1991- 2005)

[20] Kevin Marks was in a relationship with LB from 1991 until the end of 2005. On 22 January 2006, Lothian and Borders Police were contacted by LB's father and advised by him that Kevin Marks had made threatening phone calls to him and to LB and had stated that he would "get" them. On 8 May 2006, LB contacted Lothian and Borders Police to advise that Kevin Marks had made several phone calls to her in which he threatened to kill her and her family. Police officers attended at LB's home on both occasions in response. On both occasions, LB advised that she did not wish to make a complaint but preferred for police to warn Kevin Marks about his behaviour. On both occasions, police officers thereafter traced Kevin Marks and warned him regarding his behaviour towards LB.

[21] On 23 April 2013, LB reported to Police Scotland that, between 7 March 2013 and 21 April 2013, Kevin Marks had repeatedly made phone calls to her and sent her text messages and in one text message had threatened to shoot her. A statement was noted

from LB. A Domestic Abuse Incident Form was completed on the STORM system which triggered an entry to be logged on the Information Networking for Family Protection Unit officers (INFO). Police officers traced Kevin Marks and, on 29 April 2013, he was detained and interviewed under caution and thereafter released without charge pending further inquiry. A record was created on the interim Vulnerable Persons Database (iVPD) under the Domestic Abuse and Child Concern categories and shared with partner agencies.

(CS 2006- 2008)

[22] Kevin Marks was in a relationship with CS between 2006 and 2008. On 10 July 2010, CS reported to Lothian and Borders Police that she had received a number of threatening text messages from Kevin Marks, which included threats to kill her and her child by shooting them. A statement was taken from CS and a domestic incident was raised on the STORM system. Kevin Marks was thereafter detained, interviewed under caution and released without charge. On 24 April 2012, CS reported to Lothian and Borders Police that, in the course of a car journey, Kevin Marks had assaulted her and had threatened to kill her and her child. Police officers noted a statement from CS, a Domestic Abuse Incident Form was submitted and a record was logged on the INFO system. Kevin Marks was thereafter detained and interviewed under caution and released without charge.

(CM 2009- 2010)

[23] Kevin Marks was in a relationship with CM between 2009 and 2010. On 9 December 2010, Lothian and Borders Police were contacted by neighbours of CM to report that Kevin Marks had smashed a window at CM's property whilst she was not at home. Kevin Marks was subsequently convicted of a breach of the peace with a domestic aggravator in respect of the incident. On 16 August 2012, Lothian and Borders Police were contacted by a neighbour of Mr Marks in respect of a disturbance. Police attended and Mr Marks was charged with assault upon CM and breach of the peace. The reporting officer submitted a Domestic Abuse Supplementary Data Form which triggered a record being logged on the INFO system. CM advised police officers she did not wish to pursue any complaint. Kevin Marks was not convicted of any offence in respect of the incident.

Prior domestic history with Ann Drummond

[24] On the evening of 8 July 2018, Kevin Marks contacted Police Scotland and reported that Ann Drummond had been driving her car under the influence of alcohol. He advised he had mental health issues and asked for help. Police officers attended his home address immediately and found Ann Drummond in the garden. Mr Marks was noted to be under the influence of alcohol whilst Ann Drummond was observed to be sober. Police officers did not identify any concern in relation to Kevin Marks in terms of self-harm or suicide. An entry was logged on the iVPD in relation to his mental health.

[25] Later the same evening, Ann Drummond contacted Police Scotland to report that Kevin Marks had climbed out of a window and was suicidal. Police officers attended immediately at the home address of Kevin Marks and at Bathgate train station, where Kevin Marks was known to police to have attempted suicide on prior occasions. Kevin Marks subsequently returned to his home and made no threats of self-harm or suicide. The previously submitted iVPD entry was updated with information regarding the incident.

[26] Whilst police officers were in attendance, Ann Drummond advised that she suffered from mental health problems and required support. An Adult Concern entry in relation to Ann Drummond was placed on the same iVPD that had previously been generated. No domestic aggravator was input on to the iVPD.

[27] The information was then shared with Social Work services, as a result of which both Kevin Marks and Ann Drummond were offered support and separate appointments with Social Work services. Ann Drummond failed to attend for her appointment with Social Work services on 1 October 2018 and, on 16 October 2018, Social Work services closed their case and informed them in writing.

Circumstances of death

[28] On 20 June 2019, at around 17.15, Kevin Marks contacted police via 999 telephone call to report allegations that he had been sexually assaulted two days previously by Ms Drummond and a male. Further calls were made to the police by Kevin Marks at 17.45, and his mother at 18.21 and 18.50 for the same reason. At 19.59

Kevin Marks contacted the police again and stated that he had an internal injury and needed a medical examination. He made a further call to the police at 20.18 complaining that he was not being taken seriously. In the course of that call, Kevin Marks stated:

> "I've been that much abused I want to go up and put a knife right up under her chin…. This is how serious the insult and the abuse that I'm saying to you and I want an examination so you can get the pieces. My insides are fucking falling out."

The police call handler upgraded the incident to a priority, prompting immediate police response and an ambulance was requested.

[29] At about 2100 hours on 20 June 2019, witnesses Police Constables Nadia Munro and Ross Walker attended at Kevin Marks' mother's address at Bathgate.

[30] At about 2130 hours, same day, paramedics Wendy Taylor and Janice Laing attended at the same address and carried out routine observations on Kevin Marks which were normal. The paramedics noted his allegations, that he had been the victim of a sexual assault, and that he reported having taken 9 lines of cocaine that day and alcohol. He was asked if he wanted to go to hospital, which he did. Thereafter Kevin Marks was conveyed to SJH Livingston by the paramedics with police officers in attendance. Kevin Marks' mother, MD, also accompanied the journey. The paramedics' record of their attendance is contained in NHS Lothian production 3, pages 1-2.

[31] On arrival at SJH, and once the handover process was completed, Constables Nadia Munro and Ross Walker were relieved by witnesses Police Constables Nicole Banks and Graeme Rodgers. Thereafter, in presence of Constable Rodgers, Kevin Marks was assessed and triaged by witness Tina Jones, staff nurse from SJH

A & E department at 22.20 on 20 June 2019. Tina Jones' triage notes recorded the following:

> "sexual assault/? drugged
>
> PRESENTING COMPLAINT: biba bibp - and over from crew. Patient states he has been drugged by partner, takes cocaine regularly, however states that he has been drugged by partners own medication. Unsure of what it is. ongoing for the past 4 weeks? Believes he has been sexually assaulted. States he has 6/10 abdo pain. refused analgesia. news 1 gcs 15. Mum present.
>
> HISTORY OF PRESENTING COMPLAINT:
>
> URINALYSIS REQUIRED/DONE?:
> PAIN SCORE:
> FAST SCORE:
> SEPSIS SCORE:
> TRIAGED BY: t jones
> TIME OF TRIAGE: 2220"

Kevin Marks was referred to senior doctors.

[32] Following the triage process, Kevin Marks was left in the care of his mother who was content to remain at hospital with him. Constables Banks and Rodgers thereafter left SJH.

[33] Kevin Marks was assessed by Dr James Carr, a junior doctor working as part of the A & E team. Dr Carr took a history from, and carried out a full examination of, Kevin Marks. Dr Carr's documented record of his assessment is recorded at Crown production 14, pages 1-3. Following assessment, Dr Carr's impression was that Kevin Marks had non-specific abdominal pain and that he was currently not at immediate risk of suicide or self-harm. Dr Carr discussed his assessment and plan with Dr Elizabeth Walsh. Mr Marks was advised to register with a GP and to have his bloods

repeated. He was also given signposting to support services and advised to engage with support. He was given worsening advice regarding his abdominal pain and advised to liaise with the police. Kevin Marks was then discharged from SJH into the care of his mother.

[34] At about 0400 hours on Friday 21 June 2019, whilst on routine mobile patrol, Constables Banks and Rodgers saw Kevin Marks and his mother getting out of a car on Livery Street, Bathgate. Kevin Marks stated to the officers that he had been deemed fit for discharge after being assessed by a psychiatric doctor and was to remain at his mother's address.

[35] At about 1400 hours on 21 June 2019, witnesses Detective Constables Kenneth Alexander and Lynn Myles attended at Kevin Marks' mother's home address in order to obtain a statement from him in connection with the alleged sexual assault. Due to his presentation, an entry into vulnerable person database (VPD) was submitted.

[36] DC Myles sought guidance from senior police officers in relation to whether Kevin Marks should be conveyed to hospital for psychiatric assessment. She was advised that no further assessment was deemed necessary, due to the fact that he had already been psychiatrically assessed a few hours prior with a follow up appointment being arranged, and that he was not displaying any suicidal thoughts or tendencies. DC Myles was further advised that the Police Public Protection Unit (PPU) were making arrangements with health and social work to carry out a visit to see Kevin Marks prior to police obtaining a statement from him.

[37] During the evening of 21 June 2019, Kevin Marks contacted Police Scotland and made an allegation that his ex-partner was about to harm his dog. At around 2004 hours that evening, Police Constables Mark Kerr and Fraser McEwan attended at Kevin Marks' mother's address in response to this allegation. At that time, Constables Kerr and McEwan found Kevin Marks to be under the influence of alcohol. During conversation with the officers, it was established that the dog to which Mr Marks referred had died some months previously. The officers had no concerns for Mr Marks' wellbeing and were content to leave him in his own care.

[38] On 24 June 2019, Detective Constables Alexander and Myles were made aware that Kevin Marks had made contact with police requesting an update on the investigation into his sexual assault complaint. DC Myles updated the iVPD system and reported the matter to senior officers. DC Myles was advised that PPU would make another approach to health and social work to advise them of this further information.

[39] In the evening on 24 June 2019, Kevin Marks was arrested by the police and held in Livingston Police Station overnight due to offences he committed earlier on the same day.

[40] Whilst at the Livingston Police Station, Kevin Marks was assessed twice by community forensic nurses. At 11.30pm on 24 June 2019 he was seen by Lindsey Saint. At 8.15am on 25 June 2019 he was seen by Gillian Currie. Crown production 7 contains Lindsey Saint's documented record of her assessment. Crown production 8 contains Gillian Currie's documented record of her assessment. On both occasions Kevin Marks

was assessed as having no acute mental health disorder, and was deemed to be fit for custody release and court appearance.

[41] On 25 June 2019 Kevin Marks appeared at Livingston Sheriff Court and was released on bail.

[42] Ms Drummond planned to pick up Kevin Marks from court. She met with him around 1620 hours on 25 June 2019 at Livingston Sheriff Court. They left together in her car. Shortly after, at an unclassified road in the countryside near to Bathgate, Kevin Marks assaulted Ms Drummond by setting her on fire. She was so severely injured that she died on 27 June 2019 at Glasgow Royal Infirmary as a result of complications of her burn injuries.

Post mortem

[43] Ms Drummond's body was subsequently conveyed to the Edinburgh City Mortuary, and on 29 June 2019 was examined by Doctors Ralph BouHaidar and Kerryanne Shearer, both Consultant Forensic Pathologists. Crown production number 1 is the Autopsy Report. This records that the cause of death was: 1(a) Complications of Extensive Burns.

Criminal investigation and disposal

[44] Kevin Marks was subsequently indicted in the High Court of Justiciary at Edinburgh for the murder of Ann Drummond. In September 2020, following receipt of medical evidence, the Crown accepted a plea of Not Guilty on the basis that, in terms of

section 51A of the Criminal Procedure (Scotland) Act 1995, he was not criminally responsible for his conduct due to mental disorder. He was made subject to a restriction and treatment order, compelling his detention at the State Hospital, Carstairs, where he remains.

The evidence and submissions thereon

[45] The live questions for the Inquiry were whether there were precautions which might reasonably have been taken which might have realistically avoided the death, and whether there were any defects in any system of working which contributed to the death. Only the Crown proposed substantive findings in relation to those matters. Quite appropriately, NHS Lothian and Police Scotland both addressed the issues only insofar as these affected their own particular organisation. Both challenged the substantive findings proposed by the Crown and submitted that the court should only make formal findings.

Findings sought by the Crown

[46] The Crown invited me to make findings:

Under section 26(2)(e) that the following were reasonable precautions whereby the death might have been avoided:

(1) Patients' collateral information should be communicated to NHS staff by police officers.

(2) Mr Marks should have been referred to mental health professionals following the mental health assessments on 21 and 25 June 2019.

(3) Police should have engaged with Ms Drummond following their repeated interactions with Mr Marks between 20 and 24 June 2019.

(4) Mr Marks' threats toward Ms Drummond should have been acted on.

(5) Mr Marks previous domestic history should have been taken into consideration by Police Scotland when dealing with the new incident.

And

Under section 26(2)(f), that the following were defects in a system of working which contributed to the death

(1) The NHS Lothian emergency department and custody nursing staff's mental health assessment training was inadequate in June 2019.

(2) The communication between NHS Lothian and Police Scotland in the leading up to the offence was poor.

Crown's proposed findings under section 26(2)(e) (reasonable precautions)

Communication of collateral information about patients by police to NHS staff

Crown submissions

[47] The Crown noted that when Mr Marks was brought to the A & E Department at SJH on 20 June by police officers and paramedics, PC Walker had concerns about his mental welfare. However, PC Walker "didn't speak to any medical staff" before being relieved by his colleagues.

[48] On arrival at A & E, Mr Marks was triaged by Nurse Tina Jones in the presence of witness PC Graeme Rogers. Mr Marks was thereafter seen in the early hours on 21 June 2019 by a junior doctor, Dr James Carr, who was on a 4 month rotation in the A & E department. Dr Carr's previous mental health assessment training was limited to his undergraduate studies and as part of a non-specialist psychiatry block undertaken by all medical students in their progress towards qualification.

[49] The information available to Dr Carr at the time of the assessment was restricted to Mr Marks' potential physical injuries as a result of the alleged sexual assault, but did not include concerns that police officers had about his mental health. Witness PC Walker's evidence was that during his encounter with Mr Marks at his address that evening, he did have concerns about his mental welfare. These concerns were due to his agitated presentation, and the inconsistent way he made his disclosure. These concerns were later recorded on the police iVPD system, but the details of the police concerns were not communicated to Dr Carr prior to the assessment. No information in relation to Kevin Marks' mental health concerns were recorded in the triage sheet.

[50] The account given by Mr Marks during the course of his assessment did prompt Dr Carr to consider whether his mental health was affected. However, the primary focus at that time was on the clinical aspects of his physical presentation. A history of suicidal attempts, as well as drug and alcohol misuse, were noted but Kevin Marks was not thought to be an immediate risk to himself or other people. His sexual assault allegation was treated as genuine. Consequently, a referral to ACAST (Acute Care and Support Team) was deemed by Dr Carr to be unnecessary.

[51] The Crown commended the evidence of Dr Alistair Morris. In his view, "Gold dust" information was held by police, such as the details contained in the transcript of the 999 calls on 20 June (which transcript was not made available to the Inquiry). This demonstrated to Dr Morris that he was psychotic. Confidentiality of police and NHS databases creates challenges for information sharing, but in practice this happens informally from time to time. Dr Gary Stevenson had noted that the police were in possession of a lot of information that was not shared with NHS staff, and suggested that there was a need to look for viable ways to do this. The existing Information Sharing Protocol (NHS Lothian production No 8, referred to in Mr Chipurio's affidavit) between NHS and the police only related to information about people in police custody.

[52] Dr Carr and Dr Walsh might not have reached different conclusions had they been made aware of the contents of the 999 calls (which were not known to the attending police officers at the time). However the police officers' observations and concerns about Marks' mental welfare might have been of assistance to the clinicians in

interpreting what they were dealing with, and so assisted with any subsequent assessment and treatment.

Police Scotland submissions

[53] It was unreasonable and unrealistic to expect the police officers to have articulated any particular concern for Kevin Marks' physical or mental health at and around the time of his admission to hospital on 20 June, beyond that which they discussed with ambulance and hospital personnel. At the time of medical assessment, Mr Marks was categorised by Police Scotland as a complainer in a serious sexual matter. It was the understanding of police officers that Mr Marks was to be psychiatrically assessed at hospital, as well as assessed for physical injury. PC Ross Walker stated in evidence that he had concerns for Mr Marks' mental welfare based on his presentation, and that those concerns were communicated by him to the paramedics on their arrival.

[54] Mr Marks was categorised by paramedics as a Grade II urgency patient. PC Graham Rodgers gave evidence that he presented as "clammy, sweaty, agitated and fidgety" and that he made repeated and detailed reference to sexual practices and cocaine use, all whilst within the triage room at SJH. Mr Marks was subsequently examined by Dr Carr, who carried out a mental health assessment prior to him being deemed fit to be discharged.

[55] It was not reasonably practicable for police officers to have communicated any thoughts they might have had about Mr Marks' presentation to the treating clinician. The assessment of Mr Marks' presentation by medical professionals was a matter for the

exercise of their clinical judgment, and it was not for police officers to discern what information may be clinically relevant to any treating doctor. It was the understanding of police officers that Mr Marks was to be psychiatrically assessed at SJH. Even had police officers appraised Dr Carr of their thoughts on Mr Marks' presentation, it was a matter of speculation as to what weight Dr Carr might have attached to any of that in arriving at his clinical assessment.

[56] In relation to the content of the 999 call, the attending police officers were not aware that during the call by Mr Marks, he had talked about holding a knife under Ms Drummond's chin. Even had they known this, it would not have been reasonable or practicable to communicate that to the clinician treating Mr Marks.

[57] It was submitted that the passing of "collateral information" by Police Scotland to NHS staff, beyond the information which was communicated by them, was therefore not a reasonable precaution, nor was it one which, realistically on the evidence, could have resulted in Ms Drummond's death being avoided. Police Scotland invited me to make no finding under section 26(2)(e) in relation to this matter.

Adequacy of mental health assessments at SJH (21 June 2019) and Livingston Police Station (25 June 2019) - Should Mr Marks should have been referred to mental health professionals following these mental health assessments?

Crown submissions

[58] The Crown commended to me the evidence of Dr Gary Stevenson, whose evidence was that he would have referred Mr Marks to psychiatric services on 21 June

2019. Although Dr Stevenson had the benefit of access to information which was not available to Dr Carr at the time, his opinion was that a more embedded approach in assessment would have been better. There was always a risk that "unless you make enquiries, the patient may not disclose". In his opinion, there were red flags which should have alerted Dr Carr. Mr Marks had previous documented suicidal attempts and a history of drug use. There was also a disparity between Mr Marks' sexual assault related physical findings and his account. These were all indicators that a more robust mental health assessment would have been beneficial. Dr Stevenson acknowledged Dr Carr's lesser experience in mental health assessment, but he would have wanted to find out why the sexual allegation was being at that particular time if it had been ongoing for a period of time. Context and content were important. Simple questioning, as carried out by Dr Carr, might give a "snapshot" but not result in an adequate picture. Due to Dr Carr's lack of enquiry of Mr Marks in the assessment, this aspect was not explored with him.

[59] Dr Stevenson was also critical of Dr Walsh's handling of the situation presented to her by Dr Carr. In his view, it was of concern that the senior doctor was basing her decision and advice on the inexperienced doctor's representations without her seeing the patient herself.

[60] In relation to the assessment carried out by Gillian Currie at Livingston Police station on 25 June, Dr Stevenson thought that, on one view, it could be considered adequate on the information she had at the time, but he would have expected an experienced nurse to probe further given Mr Marks' history.

[61] Dr Morris stated that the A & E assessment was reasonable, but he also commented that Kevin Marks had said odd things which would have led him to explore in more depth. He would have referred Mr Marks to ACAST on 21 June 2019. In relation to Gillian Currie's assessment on 25 June 2019, Dr Morris stated that a "carry forward error" had occurred, in that the records noted that Mr Marks had been "seen by psychiatry" (page 7, Crown production number 8); whereas he had only been seen by the junior A & E doctor, Dr Carr. This error may have set the tone for subsequent assessments by nursing staff, whereby Dr Carr's assessment was given undue weight, and the "suicide" comment made by Kevin Marks when had his fingerprints taken shortly beforehand was noted but disregarded by Gillian Currie. The decision not to probe this aspect further was a significant missed opportunity an experienced psychiatrist would have picked up on.

[62] The Crown submitted that it was clear from the evidence of Dr Morris and Dr Stevenson that, admittedly with the benefit of hindsight, Mr Marks was presenting with psychotic symptoms on 21 and 25 June 2019 and should have been referred to ACAST for further assessment.

[63] As noted at page 10 of the NHS Lothian Adverse Event review (Crown production number 9), it is of concern that:

> "clinical staff were repeatedly unable to identify the psych.otic and risk relevant nature of Mr C's delusional statements. In part this appears to reflect the mental health training that assessing nursing and medical staff had had, as well as their relatively junior position. As well as leading to a failure to identify psychotic symptoms it led to a failure to consider risk to others."

[64] The Crown submitted that Kevin Marks should have been referred to mental health professionals following the assessments on 21 June 2019 at the A & E department at SJH and on 25 June 2019 at Livingston Police Station. The evidence established that more experienced medical staff would have enquired more, and explored the issues further with Mr Marks. Dr Stevenson indicated that perhaps there should be more psychiatrists available to the A & E department, so that a more joined up approach could be taken. Furthermore, in Dr Stevenson's view, there should be automatic referral to, and consideration or assessment by, an appropriately trained mental health clinician for patients presenting to A & E with disparity between presenting physical symptoms/findings, and expressed causation. The Crown did accept however that to give effect to these suggestions might present considerable difficulties to all services involved.

NHS submissions

[65] On behalf of NHS Lothian, counsel reminded me of the context in which Mr Marks presented to NHS services with his allegations. Police officers had attended Mr Marks at his mother's home, in response to his report that he had been the victim of a sexual assault, that he had been drugged by his partner (Ann Drummond) and had an associated physical injury. An Initial Briefing Report (IBR) was completed by the police and passed on to CID for further investigation.

[66] Although the attending officer, PC Walker, had concerns about Mr Marks' mental health, these concerns were not communicated to the nurses/doctors at SJH. In

any event, these concerns related to Mr Marks' demeanour, and not to the content of the allegations he had made. The allegations were taken at face value, and not considered untrue or delusional.

[67] When police took Mr Marks to SJH, this was on a voluntary basis, to follow up his allegations of abuse and examine him for signs of physical injury; in particular the abdominal pain he was describing. No mental health concerns or symptoms were noted by the ambulance paramedics, and there is nothing to indicate that the allegations were considered by the attending paramedics to be untrue. Neither were any mental health concerns or symptoms noted when Mr Marks was triaged at SJH. Again, no doubts were raised at that stage regarding the allegations being considered untrue.

[68] Therefore, by the time Mr Marks was assessed by Dr Carr, in A & E at around 01.23 on 21 June, there was no information to alert him that Mr Marks required a mental health assessment.

[69] Dr Carr took a full history from Mr Marks. He noted his allegations and his complaint of abdominal pain. He carried out a physical examination which included an abdominal examination. On advice from Dr Walsh, he did not specifically look for evidence of sexual assault; this being the remit of a forensic examiner/specialist.

[70] Dr Carr explored with Mr Marks how he felt about the allegations, and Mr Marks referred to suicidal thoughts. This prompted Dr Carr to carry out a mental health assessment, asking Mr Marks about his feelings and intentions, and whether he had any active thoughts of self-harm or suicide at that time. Dr Carr also noted that

Mr Marks had a history of previous alcohol dependence, and of previous suicide attempts in 2015, which was recorded in his medical records on the clinical portal.

[71] Dr Carr could not recall if he had accessed the portal and seen what was recorded about Mr Marks' mental health history at the time of his assessment, but it was important to note that: (i) Dr Carr was alive to Mr Marks' history at the time of his assessment; (ii) that his usual practice was to look at the records on the clinical portal at the time of assessment; (iii) if he did not follow his usual practice on this occasion, he did so at some point because he recorded the history in the A & E records (CP14); and (iv) he was aware of Mr Marks' history by the time he discussed his case with Dr Walsh.

[72] His assessment took in Mr Marks' mood, appearance, speech, behaviour, perception, and insight. He noted that Mr Marks presented in a calm manner and he was appropriately dressed. He was guarded, but understandably so. He was structured in his responses to questions. His narrative was clear and easy to follow, and he showed insight. Dr Carr's assessment took a half hour or so, during which he explored whether Mr Marks had active suicidal ideation, which was denied. He made no threatening remarks towards Ms Drummond and expressed no thoughts of hurting her. Although not documented, Dr Carr's position was that it would be his usual practice to ask about intentions to harm others.

[73] Dr Carr noted Mr Marks had protective factors, which gave him reassurance. He was to be discharged into the care of his mother. He was to register with a GP, and he had an appointment booked with the police in relation to the allegations. He was

provided signposting to further professional support services. He understood the plan, and was receptive to it.

[74] In the submission of NHS Lothian, there was therefore no basis upon which Dr Carr would or should have known that Mr Marks' allegations were delusional beliefs.

[75] Dr Carr discussed his assessment and his plan with the senior/supervising doctor, Dr Walsh, then ST6 Speciality in Emergency Medicine (now Consultant in Emergency Medicine). In her evidence, Dr Walsh described Dr Carr as a very thoughtful and thorough doctor. She had worked closely with him for about 6 weeks, during which time she had had lots of patient consultations with him, and she noted he had good acumen. Dr Walsh did not review Mr Marks, explaining that it is not possible for the senior doctor on duty to see every patient. She considered the information provided by Dr Carr was adequate for her to form a view, and she did not doubt his assessment. She was aware of Mr Marks previous suicide attempts in 2015. She explained in evidence that that history in itself would not alter her decision and advice to Dr Carr, and would not point to the need for a specialist psychiatric assessment. Mr Marks did not present with active plans or intentions for self-harm, suicide or harm to others. He was assessed as not presenting with an acute psychiatric problem.

[76] Dr Carr was also clear in his evidence that if his assessment indicated an increased risk of suicide or an acute psychiatric illness, he would have requested he stay for psychiatric assessment and made a referral.

[77] Accordingly, it was decided that Mr Marks' presentation did not warrant referral to ACAST/on-call mental health team. Dr Walsh also made the point that it was unlikely that the on-call psychiatrist would have agreed to see Mr Marks , even if a referral had been made, because there was nothing in his presentation to indicate he was having a mental health crisis.

[78] Counsel invited me to accept Dr Walsh's evidence that it was not clear at the time that Mr Marks' allegations were delusional. The last thing A & E medical staff want to do is put people off coming to them with allegations of sexual assault. They had no basis for dismissing Mr Marks' allegations as delusional given that those allegations had already been accepted at face value by the police and the ambulance service/paramedics. Taking the delusional allegations out of the picture, there were no other factors that pointed to Mr Marks having a mental health crisis requiring further intervention.

[79] Dr Stephen Hearns, Consultant in Emergency & Retrieval Medicine, was the only independent expert in Accident & Emergency medicine from whom the Inquiry heard evidence. He adopted his report (LHB1) as his evidence to the Inquiry, supplemented by his oral testimony. Counsel commended his expertise and testimony and invited the court to accept his report, oral evidence, and his conclusions. Dr Hearns was well qualified to speak to the training, duties and responsibilities of A & E medical staff, and was unable to find any shortcomings with the involvement of Dr Carr or Dr Walsh in Mr Marks's mental state examination at SJH.

[80] Counsel invited me to accept the conclusions of Dr Hearns and prefer them to the opinions of Dr Stevenson. No competing expert evidence was led from an A & E specialist. Dr Hearns was eminently qualified to give expert evidence and the court should have no hesitation in accepting his testimony on that basis.

[81] The court could place little, if any, reliance on the testimony of Dr Stevenson about the assessment and management of Mr Marks' at SJH. It was of no utility to the court and ought to be disregarded. At the time of preparing his report (January 2022), Dr Stevenson had not had sight of the SJH A & E records relative to Mr Marks' attendance on 20 and 21 June 2019. He had not had sight of the ambulance record, nor seen the triage nurse's note. These documents were not made available to Dr Stevenson until a much later stage - before he gave evidence. He had subsequently been provided with the statements of Dr Carr, Dr Walsh, Dr Morris, and Clinical Forensic Nurses Gillian Currie and Lindsay Saint. By the time he came to give evidence, he had also seen Dr Hearns' report. However, he did not seek to reflect on or revise his report to take into account the new information now available. Dr Stevenson accepted in cross-examination that his report and his underlying opinion was largely influenced by the content of the Death Report - which was not available to this Inquiry - and NHS Lothian's Significant Adverse Event Review ("SAER") (CP9).

[82] Counsel submitted that Dr Stevenson's opinion proceeded on the basis of a number of misunderstandings.

[83] Dr Stevenson took from the Death Report that when the police attended Mr Marks on 21 June 2019 "it was evident to attending officers that Marks appeared to

have significant mental health issues and no evidence to substantiate any crimes". This did not properly represent the evidence before the Inquiry.

[84] Dr Stevenson wrongly referred to concerns raised and recorded in the previous few days from police during their repeat encounters with Mr Marks. However, in the previous few days before 20 June 2019, there were no repeat encounters with the police.

[85] Dr Stevenson was critical of Dr Carr for failing to ask Mr Marks why he believed he had been sexually abused and why, if it had occurred over a "number of years" he was only realising it now. However this was incorrect. The evidence was that Mr Marks first report of the alleged sexual assault was made to the police on the evening of 20 June 2019, at which time, he reported that the assault had occurred two days previously. This was clearly noted and documented by Dr Carr.

[86] Dr Stevenson's conclusions that Mr Marks was "clearly and consistently presenting with psychotic symptoms" is not borne out by the evidence before the Inquiry. Dr Stevenson explained that his conclusions were based on information from Mr Marks' mother regarding a change in presentation in the week before attending SJH, and the Death Report. Mr Marks' mother's evidence was not before the Inquiry. It was submitted that Dr Stevenson's conclusions are based on hindsight and his material misunderstandings of the facts.

[87] In counsel's submission, the most significant point about Dr Stevenson's evidence is that he fell short of meeting his obligations to the court as an expert witness. I was referred to judicial dicta on what is expected of expert witnesses. Despite not being an expert in A & E practice, Dr Stevenson's evidence strayed into this area. He insisted

on offering his opinion on both Dr Carr and Dr Walsh. Ultimately, he did concede however, that he would have to defer to Dr Hearns' opinion on A & E practices, and the role and decision making of Dr Carr and Dr Walsh.

[88] Turning to the evidence of Dr Morris about the review which produced the SAER, although the review team had available a significant body of documentation, they only interviewed Dr Carr and CFN Currie.

[89] Dr Morris had reached his views in the SAER as an experienced psychiatrist with the benefit of hindsight. He had seen "gold dust" information held by the police database, such as the 999 transcripts. He was under the impression that Mr Marks presented with beliefs that people had been "switched". However, that did not represent the evidence before this Inquiry. The only reference to "switching" spoken to by witnesses was in relation to Mr Marks' claim that his partner was switching his medication. Dr Morris described this as odd, but "potentially plausible".

[90] Dr Morris deferred to Dr Hearns' opinion on matters of A & E practice, and the clinical decisions made by Dr Carr and Dr Walsh. He agreed that when Dr Carr assessed Mr Marks, he was presenting with a physical complaint; having reported a potential sexual assault crime to the police, and that there was no basis for Dr Carr to question this. He accepted that the decision not to refer Mr Marks to psychiatry was not unreasonable. With the benefit of hindsight, Dr Morris was able to say that Mr Marks was presenting with psychotic symptoms, but at the relevant time, he came across "as very plausible" and that he "didn't clearly present as being psychotic, even though he is saying bizarre things." This was in direct contrast to the view of Dr Stevenson.

[91] At the time of Mr Marks' assessments at Livingston Police Station on 24 and 25 June 2019, his allegations remained subject to an ongoing police investigation, and his interactions with the police relating to that investigation between 21 and 24 June were not known to the two CFNs that carried out the assessments.

[92] Counsel submitted that the suggestion of a "carry forward" error, referred to by Dr Morris, was based on the assumption that the two CFNs were influenced by the misunderstanding that Mr Marks had undergone a psychiatric assessment at SJH. However, the court should accept the evidence of the CFNs that their assessment of Mr Marks was based on their own independent observations rather than any earlier assessments.

[93] Commenting on the evidence of both CFNs Saint and Currie, Dr Morris considered it "not unreasonable in the circumstances" that Mr Marks' allegations were taken at face value. Although Dr Morris considered Mr Marks was psychotic when seen by CFN Currie, he said it was only in hindsight after he committed the fatal act that psychosis would have become the obvious diagnosis. He could not say conclusively that CFN Currie's assessment and clinical decision making was incorrect.

[94] Dr Morris was also under the impression that CFN Currie had not asked Mr Marks if he had any thoughts of harming others. However, counsel invited the court to prefer the evidence of CFN Currie herself that she did pose this question. That has been her consistent position since providing her statement to the police in July 2019.

[95] Dr Stevenson considered it was reasonable for CFN Currie to be reassured from her own assessment of suicide risk that Mr Marks' earlier comments about suicide did

not suggest an imminent risk of that. In his professional experience people often say one thing which they contradict moments later. He thought it was reasonable for her to take Mr Marks' allegations at face value subject to some further exploration/enquiry.

[96] It was submitted that the court should accept Dr Hearns' evidence. He was unable to find any basis upon which the clinical decision making of Dr Carr and Dr Walsh, or the practice and procedure at SJH could be criticised. He could identify no reasonable precautions which could reasonably have been taken which might have avoided the death. Nor could he find any defects in the system of working at SJH. For these reasons, counsel submitted that the findings proposed by the Crown under section 26(2)(e) and (f) of the Act in respect of NHS Lothian should be rejected, and only formal findings should be made by the court.

Lack of police engagement with Ms Drummond about risk, following their interactions with Mr Marks between 20 and 24 June 2019.

Crown submissions

[97] The Crown highlighted a number of incidents with mental health implications involving Kevin Marks in the days between 20 June and the fatal attack on Ms Drummond on 25 June 2019.

[98] On 20 June 2019 Mr Marks reported having been sexually assaulted by Ms Drummond and a neighbour. In the course of his numbers of phone calls to the police, he stated to the call handler "I've been that much abused I want to go up and put

a knife right up under her chin". On police attendance Kevin Marks was conveyed for a physical and psychiatric assessment at SJH.

[99] The following day, 21 June 2019, Mr Marks again contacted police, stating that Ms Drummond had arranged for his dog to be shot. Police responded and established the dog in question had died some months previously. The matter resolved with the attending officers deciding not to intervene as they had no concerns for Mr Marks' wellbeing.

[100] On the same day, police CID officers made attempts to note the details of the sexual assault allegation. They tried to explore Mr Marks' account, but the account was incoherent. DC Lynne Myles stated in evidence that Mr Marks told officers that he wanted to be a snake, and that Ms Drummond was using invisibility to control him. As such, no substantive crimes were able to be identified at the time. Mr Marks further contacted police on 24 June 2019 requesting an update.

[101] Following these incidents, police updated their databases. In particular, iVPD was updated. Extensive engagement between Police Public Protection Unit (PPU) and partner agencies followed. However, in responding to these incidents on consecutive days, the police did not fully appreciate the seriousness of Mr Marks' apparently deteriorating metal health condition and his fixation on Ms Drummond, whom he was blaming for both perpetrating sexual offences against him and for killing his dog.

[102] In the Crown's submission, the situation required the police to engage with Ms Drummond in order to highlight this apparent fixation and to offer her personal safety advice and police assistance. There is no record of any police engagement with

Ms Drummond resulting from the police interactions with Mr Marks. If she had been made aware of his stated desire to threaten her with a knife, she would have had the opportunity to make informed decision about her interaction with him.

[103] This aspect was recognised by DCI Natalie Cook, who noted in her affidavit that:

> "A broader, more intrusive risk assessment in response to the incidents of 20/21 June 2019 could have identified [Mr Marks'] growing fixation on and hostility towards Ms Drummond, and allowed for proactive engagement with Drummond and necessary safety planning."

[104] The Crown accepted that risk assessment and safety planning might not have altered the outcome for Ms Drummond, as she might have still chosen to keep the company of Mr Marks. However the Crown submitted that, on a balance of probabilities, if the police had contacted Ms Drummond and made her aware of his allegations and threats against her, this may have reasonably resulted in her death being avoided.

Police Scotland submissions

[105] It was important to note that, on 20 June 2019, Mr Marks was considered by police to be a complainer in a sexual matter and also a person in need of medical attention. In their interactions with him over these days, including the hours spent with him at hospital, officers at no stage considered him to present a risk to Ms Drummond or any member of the public. There being no basis, on their evidence, for them to have done so.

[106] From 21 June 2019 onwards, officers of Police Scotland were aware that Mr Marks had been discharged from hospital, having seen him in the street, and were given to understand from him that he had been psychiatrically assessed. Officers had no basis to do other than accept this information at face value. Further, officers had no basis upon which to contact Ms Drummond to advise her of the complaint being made against her, which was under investigation. Ms Drummond was, at that time a suspect. Suspects are not typically given updates on the progress of the investigation into a complaint against them, until such times as a formal accusation might be made, whether through arrest or detention. It was submitted that it was neither desirable nor appropriate for police officers to have engaged with her on the detail of the complaint under investigation at that stage.

[107] Contrary to the Crown submissions, it was not reasonable to expect Police Scotland to recognise Kevin Marks' apparently deteriorating mental health condition and his fixation on Ms Drummond, because they were aware that he had been assessed and discharged from hospital.

[108] In any event, as acknowledged by the Crown, what Ms Drummond might have done with any information passed to her about Mr Marks' complaint against her is entirely a matter of speculation. There was therefore no evidence to support any finding that police engagement with Ms Drummond might realistically have resulted in her death being avoided.

Failure of police to act on Mr Marks' threats toward Ms Drummond

Crown submissions

[109] In his phone call to the police at 20.18 hours on 20 June 2019, Kevin Marks stated to the call handler that "I've been that much abused I want to go up and put a knife right up under her chin". This threat was recorded on the Police STORM system but was not passed onto the officers who would subsequently have had interactions with Mr Marks. It would appear when Ms Drummond collected Kevin Marks from Livingston Civic Centre on 25 June 2019, she was unaware of Kevin Marks' contact with police on 20 and 21 June 2019, when he made threats against her during a call to police, blamed her for sexually assaulting him and latterly for harming his dog.

[110] DCI Cook provided an excerpt from the Police Domestic Abuse Standard Operational Procedure (SOP) which provides roles and responsibilities as follows:

> "ACR (Area Control Room) – Instigate an appropriate police response and ensure the officers attending are aware of all available and relevant background information."

[111] There was a lack of action in response to the threat made by Kevin Marks to hold a knife to Ms Drummond. The attending police officers, witness PC Ross Walker, DC Lynne Myles, PC Graeme Rogers all confirmed that they were not made aware of this threat when dealing with Mr Marks.

[112] DCI Cook expressed the view at paragraph 67 of her affidavit, that:

> "this may be attributed to human error, or could be indicative of the call operator not fully appreciating the potential risk to Ann Drummond, particularly given [Mr Marks'] non-recent history of making such threats to previous domestic partners, captured on legacy systems that are not routinely researched by call handlers."

[113] DCI Cook also noted at paragraph 40 of her affidavit that:

> "Reference to the threat to harm Ms Drummond by [Mr Marks] was captured on the STORM incident. This was not shared with attending officers by the call dispatcher, nor was it picked up by the first responders or supervisor post-incident when reviewing systems or providing supervisory footprint on STORM. The Domestic Abuse SOP clearly outlines the roles and responsibilities for first responders and supervisors."

[114] In cross-examination by Police Scotland, PC Rogers was asked whether his actions at SJH would have been different had he known about the threat at that time. PC Rogers responded: "yes, I'd probably have remained at hospital until the physical and mental health assessments were finished. We'd then investigate the threats."

Police Scotland submissions

[115] In counsel's submission, the statement made by Kevin Marks in the course of his 999 call had to be considered in the context in which it was made. Further, the evidence of the attending officers reflected that, even had the content of the 999 call been known to them, the priority would nonetheless have been for Mr Marks to have been conveyed to hospital for assessment and treatment, if indicated.

[116] The affidavit of DCI Cook referred to the Disclosure Scheme Domestic Abuse Scotland (DSDAS) database, and the "power to tell" decision making forum. This process allows police officers to consider the need to make a disclosure on the basis of information known to them about a potential victim's partner. The process is a staged process, initiated by an application from police officers to disclose information. On the evidence of DC Myles, even had that process been initiated from any point in the

evening of 20 June 2019, it was unlikely to have been completed to allow disclosure to Ms Drummond to be effected by 25 June 2019.

[117] In any event, counsel submitted that there was no evidence at all as to Ms Drummond's actual state of knowledge or recent communication, if any, with Kevin Marks. Even assuming she had no knowledge of the threat and allegation, it was unknown how she would react to this information on being advised. It was mere speculation to consider what, if anything, she might have done differently.

Mr Marks previous domestic history - should this have been taken into consideration by Police Scotland when dealing with the new incident?

Crown submissions

[118] Mr Marks had previously come to the notice of the police for historical abuse of his previous partners. These incidents were recorded by Lothian and Borders Police, as predecessors of Police Scotland, on their legacy computer systems. DCI Cook indicates in paragraph 49 of her affidavit that:

> "Were these incidents to be reported to police now, a different course of action would be adhered to as standard, including routine consideration of previously reported domestic incidents and opportunities to revisit undetected domestic crimes and safety planning".

[119] All the attending police officers confirmed that they were not aware of these previous domestic incidents involving Kevin Marks.

[120] PC Walker stated that once he returned to the police station, he checked on iVPD and a crime recording system called UNIF, but did not identify anything significant. He

did not search for any previous domestic incident when submitting the iVPD entry. PC Walker did however accept that, with hindsight, if he had had knowledge of the recent threats and the previous domestic history, he would have approached the matter of a risk assessment for Ms Drummond differently.

[121] Police Temporary DCI Stephen Grimason stated in paragraph 11 of his affidavit that:

> "Regarding the concern itself, the submitting officer should check Police systems to see information that would factor into their real time decision making on how to protect and safeguard that individual at that time. In particular the systems that would be checked would be the CHS (Criminal History System) System, PNC (Police National Computer) System, the SID (Scottish Intelligence Database) System and the IVPD System, but would be very much dependent on the type of incident the officer is dealing with. There would be expectation that the Control Room would tell officers in relation to any incident anything that was relevant from the STORM System, and as such, officers would not routinely themselves research STORM whilst dealing with an incident. The STORM system would be researched as part of the Concern Hub subsequent risk assessment following submission of the Concern Report."

[122] The Crown submitted that perhaps the first concern report raised on IVPD by PC Walker had not been properly assessed and actioned. Despite the PPU involvement and their action with partner agencies, DCI Cook identified that the Police Supervisor "did not pick up" the "threat" (paragraph 40 of her affidavit). She further stated in paragraph 62 of her affidavit that:

> "In the circumstances of [Mr Marks], it may be that reliance on the Concern Report meant that the previously recorded domestic incidents involving [Mr Marks] and other partners would not be looked into and would not be taken into account in informing any risk assessment or action taken."

[123] DCI Cook continues her views in paragraphs 71, 72 and 74 that:

> "Had police been made aware of [Mr Marks'] previous domestic history and placed that with the threat he made towards Ann Drummond on 20 June 2019, it is possible that officers may have recorded same as a domestic incident, with [Mr Marks] as the perpetrator and Ann Drummond as the victim."
>
> "Victim safety consideration would then have been applicable in respect of Ann Drummond, though given [Mr Marks'] apparent poor mental health, it is unlikely that he would have been held in police custody, but rather routed to hospital for assessment and subsequent report to COPFS via Police Undertaking for a later date."
>
> "Safety was considered in respect of [Mr Marks] and it is stated that on both 20 June 2019 and 21 June 2019 he was left in his mother's care but nil is recorded regarding considerations re the safety of the now deceased and male neighbour".

Police Scotland submissions

[124] Counsel submitted that the information held on police legacy systems about domestic abuse by Mr Marks was very limited. It noted relationships with three women, other than Ms Drummond, between 1991 and 2018. Over that period, Mr Marks was convicted of one charge of breach of the peace, with a domestic aggravation, prior to his relationship with Ms Drummond. Counsel stressed that the Inquiry was not concerned with whether any previous allegations against Kevin Marks might or ought to have been dealt with differently. At the time of her death, Ms Drummond had made no complaint to Police Scotland (or its local predecessors). The "new incident" was one in which Mr Marks was a complainer as opposed to a suspect.

[125] The only potential relevance to the Inquiry of previous allegations made against Kevin Marks, prior to his relationship with Ann Drummond, would appear to be in relation to his statement to the 999 call handler, as quoted in paragraph 17 of the Joint

Minute of agreement of evidence. Attending officers were not aware of that statement having been made. Officers at that time had no access to the STORM system whilst on mobile patrol. Officers stated in evidence that, even if they had had access to STORM on handheld devices at that time, as they do now, it is not always practicable to search systems when attending incidents, particularly in situations of urgency.

[126] Counsel therefore submitted that it was not reasonably practicable, or relevant, for the attending officers to have made any inquiry into Mr Marks' prior domestic history, particularly in circumstances in which no complaint had been made against him.

[127] I was reminded that PC Rodgers had stated in evidence that, with the benefit of hindsight, had he been made aware of the statement made in the course of the 999 call, it may have called for further police investigation. However, although this might have led to further research of his domestic history, the priority on 20 June 2019 would nonetheless have still been for Mr Marks to be taken to hospital, given the nature of his complaint and presentation. In any event, the outcome of any police investigation, and the time frame in which that could move forward, were matters of speculation.

[128] In these circumstances, it was submitted that consideration of Mr Marks' prior domestic history, such as was recorded on police legacy systems, would not have been a reasonable precaution which, realistically on the evidence, might have avoided Ms Drummond's death.

[129] Counsel submitted that the findings proposed by the Crown under section 26(2)(e) were not precautions which would have been reasonable for Police

Scotland to have taken. Further, and in any event, there was no evidence of any causative or contributory link of any of the proposed precautions, had they been taken, to Ms Drummond's death, such as would properly amount to a reasonable precaution in terms of the Act. Accordingly, counsel proposed that no findings in terms of section 26(2)(e) should be made in relation to Police Scotland.

Crown's proposed findings under section 26(2)(f) (Defects in any system of working which contributed to the death)

[130] The Crown submitted that, on the evidence of Dr Morris and Dr Stevenson, together with the affidavits from Temporary DCI Grimason and DCI Cook, there were two defects in systems of working, which failures contributed to Ms Drummond's death:

Adequacy of mental health assessment training of NHS Lothian emergency department and custody nursing in June 2019

Crown submissions

[131] With regard to the mental health assessments carried out by Dr Carr and Gillian Currie, both Dr Morris and Dr Stevenson commented on the clinicians' lack of enquiry with Mr Marks during the assessments and the apparent lack of consideration of his previous suicidal attempts and history. Furthermore, the NHS Lothian internal review board noted that:

> "Clinical staff were repeatedly unable to identify the psychotic and risk relevant nature of Kevin Marks' delusional statements. In part this appears to reflect the mental health training that assessing nurse and medical staff had had."

[132] Since the NHS Lothian adverse event review, recommendations on mental health assessment training for the relevant staff have been made and implemented. Mr Dzidzai Chipurio, the Clinical Services Manager for NHS Lothian confirmed in his affidavit that "New to Forensic" training course, recommended by Dr Morris was now in place. It is a national 12-months training course, provided by experienced senior staff working in Police Custody healthcare. The course is designed to get novice staff up to speed with relevant knowledge and management procedures involved in providing care for secure psychiatric patient care. All staff who work within custody units have now received "New to Forensic" training or are due to be enrolled on the next course.

NHS Lothian submissions

[133] Counsel submitted that, on the evidence, it could not be said that the training of Dr Carr or the CFN's was inadequate at the time and having regard to the tasks expected of them in their respective roles. In my discussion of the evidence on this point, I will deal in detail with the specific issues raised.

Poor communication between NHS Lothian and Police Scotland in the days before the fatal incident

Crown submissions

[134] The Crown submitted that the principal issue identified in this Inquiry was that information of a potentially highly relevant clinical value was not shared with the

relevant personnel within a reasonable time frame. The threat made by Mr Marks was not shared with the attending police officers on 20 and 21 June 2019. The content of the 999 call made by Mr Marks and the police concerns in relation to his mental welfare were not shared with the triage nurse and Dr Carr. Dr Morris regarded these pieces of information as "gold dust", but they were not passed onto the relevant staff at the right time. It was submitted that had the NHS staff and police communicated better, and the information were made available to clinicians, it would be highly likely to lead to further clinical assessment and consideration of further treatment and or admission of Kevin Marks.

[135] This view is supported by the findings of the SAER (Crown production 9), at page 9) that:

> "information viewed by the authors (death report from Police Scotland and Police emergency call transcript etc) suggests that Police Scotland were in possession of a significant amount of highly risk relevant information about Kevin Marks which, had it been available to assessing NHS Lothian staff is likely to have resulted in a different outcome."

Police Scotland submissions

[136] Counsel submitted that findings in terms of section 26(2)(f) require to have a causal nexus. There were no defects in the system of work within Police Scotland as an organisation, such as could be considered causative of, or contributory to, Ms Drummond's death. In counsel's submission, no finding should be made under this subsection in relation to Police Scotland.

[137] In relation to internal information sharing across police resources and staff, the Crown raised the question of the content of the 999 call being shared with attending officers. The evidence reflected that, had police officers been aware of this statement, Mr Marks would still have been conveyed to hospital for treatment. Knowledge of this statement would have made no difference to that course of action being followed.

[138] In relation to police officers sharing that information with clinicians is concerned, this was explored in evidence with Dr Morris. However, when asked about possible improvements to any joint working between police and NHS, and whether any system could improve that, Dr Morris said that he could not envisage how this would genuinely work in practice. He recognised that information sharing between NHS and police happens on an informal basis, but it was not something which happened all the time. He explained that "nowhere in the UK is there formal joint NHS/police information sharing," due to the highly confidential databases within the respective organisations. Thus, not only was there an absence of evidence to demonstrate a defect in the system of work in relation to information sharing, the available expert evidence indicated the contrary to be the case.

Discussion and conclusions

[139] Generally, I found all the witnesses to the Inquiry to be credible and reliable. There was little, if any, dispute about the facts spoken to in evidence. The controversy was rather about the inferences which could be drawn from those facts; and in

particular the thoroughness and appropriateness of the various agencies' and witnesses' responses to their interactions with Mr Marks and Ms Drummond.

[140] In considering these matters, there was available to the court evidence of police resources, practices and responsibilities; and expert opinion evidence as to whether medical and health professionals ought to have picked up signs of mental health disturbance and followed these up according to how Mr Marks presented at the time he was seen and the information they had at that time. I have also had regard to the internal Significant Adverse Events Review (SAER) commissioned by NHS Lothian (Crown production 9) and the SAER implementation report (production 10). In terms of the joint minute, these documents were agreed to be true and accurate copies and received in evidence without the need to be spoken to by their authors. Police Scotland also carried out a Domestic Homicide Review reflecting on the incident from the police perspective, and this is referred to in the affidavit of Detective Chief Inspector Natalie Cook, which is to be treated as her parole evidence in term of the joint minute.

[141] When considering the meaning of "reasonable precautions" in the context of section 26(2) (e), I agree with the Crown that the standard to be applied is that outlined in Sheriff Kearney's determination dated 17 January 1986, in the death of James McAlpine, (referred to at paragraphs 8-99 of the 3rd edition of *Sudden Deaths and Fatal Accident Inquiries* by Iain Carmichael). Sheriff Kearney observed that:

> "In relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided, it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might

> have prevented the accident or death, be satisfied that the precaution was a reasonable one"

[142] In that case, it was also observed that:

> "The phrase 'might have been avoided' is a wide one…… It means less than 'would, on the probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities."

[143] The court heard differing credible professional opinions from medical experts, from different standpoints, about Mr Marks' mental health and what might reasonably have been picked up and acted on by the NHS staff concerned on the basis of the information they were given and their own assessments.

[144] NHS Lothian submitted that the court should prefer the evidence of Dr Hearns to that of the other medical experts, Dr Morris and Dr Stevenson. Dr Hearns was an A & E specialist whereas Dr Morris was a Forensic Psychiatrist; as was Dr Morris. NHS Lothian suggested that it was appropriate for an A & E expert, rather than a psychiatrist, to comment on the adequacy or otherwise of health staff involvement in carrying out mental health assessments in the custody or A & E setting. Criticisms were made of Dr Stevenson's evidence, but although some misunderstandings were apparent, I did not accept the submission that Dr Stevenson had failed in his duties as an expert witness. He addressed the issues asked of him. He is a psychiatrist of many years standing and his evidence covered matters at the intersection of psychiatric and A & E practice. It is true that Dr Stevenson was not an expert in A & E practice, but he did concede that this was the case, and accepted that he would have to defer to Dr Hearns' opinion on matters of A & E practice and the appropriateness of the actions taken by

Dr Carr and Dr Walsh at SJH. He was candid and detailed in his evidence. He made concessions where appropriate. In my view it is a question of the weight to be attached to his evidence, and that is a matter for the court in the light of its assessment of the issues. Albeit that I have preferred the evidence of Dr Hearns in relation to specific matters of A & E practice, Dr Stevenson has raised important questions. I do not accept that Dr Stevenson's evidence fell short of the duties expected of an expert witness; or that it was of no utility in assisting the court to understand the background.

[145] Pinpointing reasonable precautions which might have led to a different eventual outcome is complicated because the matters considered at the Inquiry were wide ranging and involved different agencies and their different processes, and the operational constraints and pressures their staff were under at the time; together with a number of variables or unknowns.

[146] It would be wrong to confuse the tests to be applied in this Inquiry to the issues for the court in, for example, a civil action seeking damages for negligence. There is no requirement to establish blame or fault. There is no requirement of foreseeability of harm. Indeed the object of the Inquiry is to identify what may have gone wrong for the purposes of avoiding deaths arising in similar circumstances in the future. Thus the court is entitled to have regard to hindsight where that is instructive.

[147] The submissions of both Police Scotland and NHS Lothian understandably tended to focus on justifying their own organisation's involvement. The approach was to look at each stage of involvement to argue that findings suggesting fault should not

be made having regard to the state of knowledge of those concerned at the material time and their adherence to procedures.

[148] The problem with that approach is that it fails to acknowledge the larger picture. A man with a previous psychiatric history, exhibiting psychotic symptoms and hostility towards the deceased and with an, albeit limited, domestic history had repeated contacts with police and NHS services in the days before the fatal act, and yet his condition and the risks that it posed to him and others was not recognised or acted on. Individual pieces of information were processed, passed on and retained separately, without being drawn together so that decision makers in the police and NHS were alerted to the development of a worrying bigger picture of risk.

[149] In considering the Crown's criticisms of NHS Lothian, it must be recognised that there were a number of significant patient related complications which, in the words of the SAER, "hindered a straightforward assessment" of Mr Marks. He had a major and current poly-substance use disorder, involving misuse of cocaine and alcohol. Also, according to the evidence, Mr Marks was apparently able to describe what in hindsight were psychotic symptoms, in a plausible and coherent way that a number of professionals including health and police staff who were investigating his allegations tended to accept. This led to professionals being satisfied that he was not mentally unwell, and that he was safe to be discharged home with no immediate risks.

[150] There was some discussion in the evidence about the difficulties of services accessing information held across a number of different IT systems. The SAER noted that there were at least 4 separate IT systems in use by the police and NHS, and had the

information been available to all parties this would have increased the likelihood of concerning information being recognised and acted upon. However, there are understandable issues of operational sensitivity, data protection and patient confidentiality which necessarily make sharing of information on police/NHS systems between the respective organisations difficult. The evidence was that there are no formal reciprocal arrangements anywhere in the country for automatic or routine information sharing, although there is informal information sharing from time to time. Such protocols as there are apply to persons in custody, and the circumstances here are different. The issues around this are not straightforward, and no practical suggestions were made about how information on independent databases could be shared between agencies in this way. The Crown and the expert witnesses acknowledged the difficulty in this regard.

[151] The Crown's two specific criticisms of NHS Lothian were that Mr Marks should have been referred for review by specialist mental health professionals after the mental health assessments undertaken on 21 and 25 June 2019; and that these assessments were not effective because the staff were not adequately trained. In my view, these issues are linked and the former would follow on from the latter. In other words, if the court accepted the Crown submission that the mental health examinations were ineffective due to inadequate staff training, that would be the reason that Mr Marks was not referred to ACAST.

[152] In relation to the adequacy of staff training in mental health assessments, Mr Marks was not being seen by specialists as a psychiatric admission. He was being

seen in the A & E Department of a busy General Hospital by non-specialist staff, and later in the police custody suite.

[153] CFN Saint was not trained as a mental health nurse (RMH) but, at the time of her assessment of Mr Marks, she had undergone training including on the "New to Forensic Medicine" and "New to Forensic Mental Health" courses. She had around 11 years' experience of carrying out mental health assessments within police custody and in the prison system. She explained the guidance and factors she had regard to when assessing a custody in 2019 and was adamant that if she had concerns about a custody's mental health, she would refer them on for psychiatric assessment.

[154] She took his allegations at face value. She was aware of Mr Marks' prior history of suicide attempts and carried out a suicide risk assessment. This included asking about suicidal thoughts, and thoughts of harming others. Nothing of concern arose from that. He was not exhibiting any of the signs she would expect to see as evidence of psychosis. She had noted erroneously in her record that Mr Marks was being seen by "psychiatry", but I accepted her evidence that her own independent assessment had not been unduly derailed by that, and that she had carried out her assessment objectively.

[155] In relation to the assessment by CFN Currie on 25 June, she was not a trained mental health nurse. However, she had also previously undertaken the "New to Forensic Medicine" and "New to Forensic Mental Health" courses. I accepted she had a clear understanding of what was required in terms of a mental health/state examination, and the correct procedures for mental health assessment and the circumstances in which referrals for further psychiatric assessment would be required.

[156] CFN Currie was asked to see Mr Marks after he made a comment, while having his fingerprints taken, about committing suicide. She reviewed CFN Saint's notes and then carried out a mental state examination. She did not review the SJH records, but relied instead on her colleague's notes which had been made approximately 8 hours earlier. She was asked to reassess him before he was released to court because he had made a subsequent remark about suicide. This remark was the only new factor since the earlier assessment.

[157] CFN Currie's mental state assessment seems to have been thorough. In addition to standard questions, she explored whether he had any intentions of self-harm or suicide, or harm to others. She challenged him about whether the allegations had been put to the police, and about the allegation that his partner was drugging him. I am inclined to accept her evidence that she did not ignore the remark about suicide but took that into account in her assessment. Mr Marks did not present to her as having paranoid or delusional thoughts.

[158] CFN Currie stated that her assessment was not based on a misunderstanding that Mr Marks had undergone a psychiatric assessment at SJH, nor was it influenced by the entry noted by CFN Saint. She was also adamant that her assessment was independent of CFN Saint's assessment and independent of any assessment Mr Marks may have undergone at SJH.

[159] CFN Currie had undertaken further training since June 2019. She said that even with the benefit of further training, it would not have made any difference to how she

assessed Mr Marks if he had presented in similar circumstances and she had the same information at the time.

[160] The SAER had recommended that all CFNs should be dual qualified (RGN and RMN). However, Dr Morris recognised that was not practicable. At the time of the review, he had not recognised that CFN Saint had undergone the "New to Forensic Medicine" and "New to Mental Health" training courses. He observed that, if that was so, that was exactly the background training he would expect, as recommended by the SAER. He described CFN Saint's training as "excellent". Dr Stevenson accepted that he was unable to comment on the training of the CFN's.

[161] Dr Morris ultimately was not critical of the assessments carried out by the CFN's, and I have come to the view that this is correct having regard to their training and experience. I do not accept that the training of the CFN's was inadequate or that any further training has been identified which would represent reasonable precautions whereby the death of Ms Drummond might been avoided.

[162] Turning to the training of Dr Carr, Dr Hearns gave expert opinion evidence on training of A & E doctors at both junior and at specialist/consultant level. He explained the relevant Royal College of Emergency Medicine ("RCEM") guidance and standards relating to mental health assessment in the emergency department setting, and related these to the assessment and management of Mr Marks attendance at SJH on 20/21 June 2019.

[163] Dr Hearns' evidence was that the great majority of patients who attend A & E with mental health issues are discharged without referral to psychiatric services. Only

around 4% of patients that present to A & E present with a mental health issue as their primary complaint. Of significance, he emphasised that Mr Marks' presenting complaint was not in relation to self-harm/suicide or a primary mental health issue. I accept his evidence that according to RCEM guidance, there was no requirement for Dr Carr to undertake a mental state examination.

[164] In relation to Mr Marks' prior history of suicide attempts in 2015, Dr Hearns explained that he would place little weight on this when the current presenting complaint was not in relation to a suicide attempt. There was a discussion about whether Dr Carr checked the records/clinical portal. Dr Carr frankly accepted that he could not now remember whether he did so, but that would have been his practice. His note recording the year of the prior suicide would strongly suggest that he did. However, Dr Hearns' convincing expert evidence was that, in the circumstances, it would not have been unreasonable for him simply to have relied on the history provided to him by Mr Marks, without further research. In his report, Dr Hearns concluded that Dr Carr's assessment was reasonable. He described it as a very thorough and comprehensive assessment. Dr Carr had discussed Mr Marks' case with a senior colleague, Dr Walsh. He noted that the appropriate seeking of advice from a senior colleague represents evidence of good practice and further demonstrated that there was appropriate supervision.

[165] On the question of supervision, I also accept Dr Hearns' evidence that it was acceptable, and entirely reasonable, for Dr Walsh not to assess Mr Marks' herself. Given the considerable burden on an A & E team, particularly overnight, I have little hesitation

in accepting that it would not be practicable for senior supervising doctors to assess all of the patients personally whenever a junior doctor sought advice. It appears to be a normal way of working for junior doctors to consult with senior colleagues by way of informal discussions. In such instances, it must in my view be left to the professional discretion of senior clinicians in hospital as to whether they have sufficient reliable information from the scenario presented to them by the junior doctor; or whether they need to see the patient themselves.

[166] On the question of whether Mr Marks should have been referred by A & E to a specialist psychiatrist, I also accept Dr Hearns' expert opinion that having regard to Mr Marks' presentation, the clinical decision made by Dr Carr and Dr Walsh to take his allegations at face value and not to refer him for psychiatric assessment was reasonable. Dr Hearns made the point, as did Dr Walsh, that it would be dangerous for an A & E doctor to dismiss a report of sexual assault as untrue or delusional. He agreed that, on the basis of Mr Marks' presentation and the allegations being taken at face value, it was unlikely that the on-call psychiatrist would have seen Mr Marks.

[167] Counsel addressed the issue of whether there should have been an automatic referral for psychiatric assessment if there was no physical injury to substantiate Mr Marks' allegations. In my view, Dr Hearns' evidence was clear and should be accepted. He explained that a large majority of patients that present to A & E report physical symptoms which cannot be explained with physical examination or other tests. It would therefore be disproportionate to refer all these patients to psychiatry given the number involved. There was no guidance mandating this. In any event, Dr Hearns

pointed out, firstly, that a person could be sexually assaulted in the manner described without leaving any physical evidence; and secondly, Dr Carr did note that Mr Marks had tenderness in his abdomen. A specialist forensic examination was outwith the expertise or remit of Dr Carr. Therefore I accept Dr Hearns' view that, on the basis of Mr Marks' presentation, together with such information as was available to Dr Carr at the time, there were no apparent grounds for either detaining him under the Mental Health (Care and Treatment) (Scotland) Act 2003 or referring him to ACAST for specialist review.

[168] Dr Hearns told the court most trainee doctors working in A & E receive their only formal mental health training during a brief teaching session during their induction as a medical student. This is what happened in Dr Carr's case. I am satisfied from the evidence of Dr Hearns that Dr Carr's training did not fall short of that received by the majority of junior doctors in A & E, and could not be considered inadequate.

[169] Dr Carr decided to carry out a mental health assessment after Mr Marks attended as a complainer in a sexual case, which was apparently being investigated by the police, and made reference to suicidal thoughts. He explored that issue. The examination was lengthy; and uneventful from a mental health perspective. Mr Marks denied thoughts of suicide at that time. Although the allegations could be considered lurid and unusual, that had to be balanced against Mr Marks' calm demeanour and the absence of any unusual pattern of speech, appearance or behaviour during the examination. Dr Carr was reassured by the police involvement and a number of protective factors. Dr Hearns' opinion was that the examination was reasonable on the basis of Mr Marks' presentation

and the state of background knowledge about him which was available to Dr Carr at that time.

[170] For these reasons, I have determined that the mental health assessment training of the NHS staff concerned was not inadequate. Furthermore, in the particular circumstances, and on the basis of the information available to NHS staff at the time of their interactions with Mr Marks, it was reasonable for the CFN's and Dr Carr not to have referred him for specialist psychiatric review by the ACAST team. I am not prepared to find that a decision to refer Mr Marks to mental health professionals would have been a reasonable precaution whereby Ms Drummond's death might have been avoided. Neither am I able to find, in relation to the decision making process around referral or the standard of mental health assessment training, that the evidence disclosed defects in any system of working within NHS Lothian A & E or custody nursing arrangements which contributed to the death.

[171] Turning to Police Scotland and their communication and information sharing, confidentiality, Data Protection, operational considerations and respect for the dignity of victims of alleged crimes are all valid concerns. I accept that NHS and Police Scotland simply opening their databases to each other is neither desirable nor feasible. However, both Dr Morris and Dr Stevenson noted in their evidence that there appears to have been potentially relevant information known to police or held in police resources, and which never made its way to the CFN's or Dr Carr and Dr Walsh at the time of their assessments. This is addressed by the parties at length in their submissions, which I will not repeat in full here.

[172] With hindsight, the police did have information with a potential bearing on the detection of Mr Mark's psychotic state and the assessment of the risk that he posed to Ms Drummond, but this was not communicated to those who needed to know. Had this information been passed on to front line police officers and to NHS staff, then individually or cumulatively, that might have helped to inform the clinicians' mental health assessments and influenced the eventual outcome. It might also have informed the police approach to risk assessment in relation to Ms Drummond. In my view, the Crown's submissions about the police have validity.

[173] When Mr Marks first contacted the police on 20 June 2019 to make a report that he had been sexually assaulted, he referred to wanting to threaten Ms Drummond with a knife. DCI Cook's evidence was that the operational procedure for control room staff featured a requirement that the controller should ensure officers attending an incident were aware of "all available and relevant background information". Although this was recorded on the police STORM system, it was not passed on to the attending officers who accompanied him to SJH for examination. They were unaware of the threat. Neither were the attending officers made aware of previous domestic incidents involving Mr Marks. According to DCI Cook, this suggested human error; or that the call operator may not have fully appreciated the potential risk to Ann Drummond because Mr Marks' domestic history, such as it was, was contained in older databases which the call handler would not have routinely consulted. PC Rogers did state that if he had known about the threats, he would probably have taken a more proactive interest in the outcome of the hospital assessments and investigated accordingly.

[174] Temporary Chief Inspector Grimason emphasised the need for officers to check police systems for information that would factor into their decision making. He confirmed that Control Room staff would be expected to tell officers attending an incident anything that as relevant from the STORM system.

[175] Those officers did have some concerns about Mr Marks' presentation, but these concerns were not passed on to NHS staff. In particular, Dr Carr was unaware of the background. Neither was anything bearing on risk or potential threat picked up by supervisory grade officers.

[176] When DC Myles attended on the afternoon of 21 June to take a statement from Mr Marks about his sexual assault complaint, she was understandably concerned about his presentation and what he was saying. He was not making sense, "erratic" and rambling. For example, he kept asking her, "what animal would you be?" He did not appear to her to be under the influence of drink or drugs, and did not smell of alcohol. She thought that he had some sort of mental issue. It was at this meeting that Mr Marks made the particularly concerning remarks that he wanted to be a snake, to be invisible like Ms Drummond, who was using her invisibility to control him. He also said that he believed Ms Drummond was having an affair with a former neighbour, and that they used tunnels between their houses and made themselves invisible to go through.

[177] The following day, Mr Marks contacted the police again and said that Ms Drummond was about to harm his dog. The police officers who attended ascertained that the dog had died some months previously, but did not raise any concerns for Mr Marks' wellbeing at that time.

[178] In my view, having regard to the evidence of the psychiatric witnesses, these statements were examples of the sort of information held by Police Scotland and described by Dr Morris as "Gold Dust" information. They were clearly at least suggestive of psychotic delusions meriting serious concern and further expert investigation. Yet these were not passed on to the CFN's who carried out the mental health assessments.

[179] Had the police passed on to NHS staff the information that Mr Marks was making these statements, it seems unlikely that he would have been repeatedly assessed as fit for court/release; without at any rate being seen by ACAST for specialist input. Of course, it is not known what would have happened had NHS been so aware. It is accepted that Mr Marks was plausible when being assessed, and did not display at that time the red flags which would have led to referral. However, if NHS staff had the information about the threats and delusional statements, it would have enabled his allegation to be put in context. That might well have then led to specialist intervention of the kind that would have detected what has subsequently been realised were psychotic symptoms, and to the exercise of power to detain him under the mental health legislation for treatment for his own protection and/or the protection of others.

[180] In considering what findings to make, I have borne in mind the judicial definitions referred to in the submissions. It is clearly not necessary that any proposed precaution would in fact have avoided the death; only that it might have done. A precaution which might have resulted in the death being avoided is not tied to

probabilities, but in the words of Sheriff Kearney "rather directs one's mind in the direction of lively possibilities."

[181] I have therefore concluded that the effective sharing of potentially relevant information held by the police, within the police service itself and with NHS staff, about the mental health of Mr Marks, based on recent contacts with him, might have led to the detection of his psychosis and the taking of protective steps. As such, that was a precaution which could reasonably have been taken, which might realistically have resulted in the death of Ms Drummond being avoided.

[182] The other matter which arises from the ineffective sharing of information held by the police is that no adequate risk assessment was carried out in relation to the risks posed to Ms Drummond by Mr Marks' recent threats and his persecutory beliefs about her. DCI Cook deals with this in detail in her affidavit. She recognises the nature of the problem in relation to risk assessment. She observes that, had police been made aware of Mr Marks' previous domestic history and connected it to the threat he made, it is possible that officers may have recorded this as a domestic incident with Mr Marks as the perpetrator and Ms Drummond as the victim. If that connection was made, victim safety considerations would then have come into play. As DCI Cook notes, safety was considered in respect of Mr Marks to the extent that it was considered safe to leave him in his mother's care; but nothing was recorded about consideration of the safety of either Ms Drummond or the neighbour mentioned. There is no evidence that Ms Drummond was aware of any risk of danger. DCI Cook states in her affidavit that a broader and more intrusive risk assessment in response to the incidents of 20 and

21 June 2019 could have identified Mr Marks' growing fixation on, and hostility towards, Ms Drummond, and allowed for proactive engagement with her around necessary safety planning. Her observation that more robust investigation into the threats may have provided enforcement opportunities or influenced the outcome of Mr Marks' appearance at court on 25 June 2019.

[183] I accept that there are a number of sensitive issues. It is a legitimate concern that persons reporting that they have been victims of a crime have a right to dignity and fair consideration without premature judgment or dismissal of their complaint. I also accept that there are good operational reasons why the police do not ordinarily "tip off" suspects that they are being investigated in connection with a criminal allegation before such time as they have carried out enquiries and are ready to put an allegation to the suspect. However, it seems to me that where a serious potential risk to someone's safety has been identified, then operational considerations should yield to safety considerations, and protective measures taken according to a proper risk assessment; even if that required alerting the suspect. Of course it is not known what Ms Drummond would have done had she been warned of Mr Marks' threat. She may have ignored any warning and continued to meet up with Mr Marks. Nevertheless, she would have been given the opportunity to consider her safety and be alert to the risks.

[184] For these reasons, I have concluded that carrying out a thorough risk assessment for the safety of Ms Drummond and warning her of the potential danger posed by Mr Marks was a precaution which could reasonably have been taken which might realistically have resulted in the death being avoided.

[185] The court may also make findings under section 26(2)(f) of the Act if it concludes that any defects in any system of working contributed to the death. I have made findings above that effective information sharing by the police within the police service and with NHS Lothian, and the carrying out of an effective risk assessment of harm to Ms Drummond, including warning her of the potential threat, were reasonable precautions whereby, had they been taken, the death might have been avoided. I also consider that both of these failures were systemic and arose from haphazard processes which meant that information was not collated from various police sources and passed on to those who needed to know.

[186] I have therefore determined in terms of section 26(2)(f) of the Act that the inadequate sharing of information which I have identified, and the failure to undertake an effective risk assessment in relation to Ms Drummond, were both defects in systems of working within the police which can be fairly said to have contributed to her death.

[187] In considering steps taken by Police Scotland since June 2019 to strengthen risk assessment practices and protocols, DCI Cook makes reference to a number of changes. However, it is clear that Police Scotland have demonstrated awareness of the issues raised, and a commitment to delivering prevention and early intervention approaches towards vulnerable witnesses in domestic situations. Training to improve awareness of the Disclosure scheme for Domestic Abuse Scotland has been undertaken. In October 2019, a "Please think DSDAS" internal campaign was launched. In December 2019, the DSDAS National Review was completed and recommendations included immediate changes to the functionality of the police databases to streamline

common "user challenges". Procedures are subject to regular review, resulting in refreshed user guidance being updated from time to time. Training has included sessions to ensure that senior officers with supervisory roles are professionally equipped to oversee these activities operationally and share good practice. In particular, the use of markers for possible domestic abuse have been clarified and strengthened. It was also recognised that the manual undertaking of these functions could be negatively impacted by human error, and automated upgrades to systems and quality assurance measures have been built in.

[188] In July 2020, a new "contact assessment model" was introduced to police control rooms to grade calls to the police in terms of urgency and risk. Under that model, a "Threat, Harm, Risk, Investigation, Vulnerability, Engage" (THRIVE) assessment is conducted and appended to the STORM Incident Report to allow the call to be properly routed and resolved. This details the assessed level of risk, the action proposed and the level of system checks which have been carried out.

[189] In 2021, a "Contact, Engagement and Resolution Project" (CERP) was introduced to improve standards of service through Police Scotland's response to vulnerability, risk and public need. This is a rolling programme of continuous improvement work. Now, any domestic STORM incident raised has to be signed off by a supervisory officer before closing the case on police systems as a "No Crime" report. There have also been numerous version upgrades to the iVPD system to give supervisors proper oversight and enable risks to be identified and addressed at the point of contact.

[190] In view of the measures put in place by Police Scotland since June 2019, I have no further recommendations to make in that regard.

[191] In closing this Determination, may I join the representatives of the parties at this Inquiry in expressing my condolences to the family of Ms Drummond for their sad loss as a result of this tragic incident.