SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNDEE

[2018] FAI 23

B845-16

DETERMINATION

BY

SHERIFF G A WAY

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND) ACT 1976

into the death of

DALE THOMSON

Dundee, 27 June 2018

The Sheriff having resumed consideration of the Inquiry, in terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 finds as follows:

Section 6(1)(a)

Dale Thomson died at his flat in Dundee, at some time before 8.55pm on 27 January 2015. This is confirmed by the post-mortem report and agreed in the Joint Minute.

Section 6(1)(b)

The cause of death was hanging. There was no accident. This is confirmed by the post-mortem report and agreed in the Joint Minute.

Section 6(1)(c)

There were no reasonable precautions whereby the death of Dale Thomson might have been avoided.

Section 6(1)(d)

There were no defects in the system of working that contributed to his death.

Section 6(1)(e)

Facts relevant to the circumstances of the death were:

Mr Thomson should have had a full mental state examination and assessment carried out by an Approved Medical Practitioner, between 8 and 10 January 2015, when he was in Carseview on a voluntary basis. In particular there was no formal system in place for ensuring that the Consultant Psychiatrist responsible for his care and treatment had been notified of Mr Thomson's admission.

There was no system in place to allow communication from Carseview to Mr Thomson's GP when he left in-patient care abruptly against medical advice.

There was insufficient consideration given to the use of the power of detention in terms of section 36 of the Mental Health (Care and Treatment)(Scotland) Act 2003 on 10 January 2015 prior to allowing Mr Thomson to discharge himself from Carseview.

Sheriff

NOTE

Act:

Mr Steven Quither PF for the Crown

Mr Mark Fitzpatrick Advocate for NHS

Ms Laura Donald Solicitor for Dr Mattias Feile

Mr Gary Burton Solicitor for Nurses Petrie, Rundle, Taylor and Hamilton

Ms Gillian Merchant Solicitor for Nurses Drurie, O'Keefe and Borch

Ms Claire Rafferty Solicitor for Drs Howson and Gunput

Ms Isla Craig or Bowen Solicitor for Dr Kao

Mr Daniel Devine for the family of the late Dale Thomson

INTRODUCTION

[1] This is a voluntary enquiry into the death of a young man who had, prior to his demise, sought medical assistance and who had been an in-patient at Carseview Clinic; part of the Ninewells Hospital campus at Dundee. It falls to be determined by reference to the, now superseded, Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Section 6 of which requires the presiding Sheriff to make a determination regarding:-

(a) where and when the death and any accident resulting in the death took place;

(b) the cause or causes of such death and any accident resulting in the death;

(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the deaths; and

(e) any other facts which are relevant to the circumstances of the death.

THE ESSENTIAL CHRONOLOGY

[2] Dale Thomson attended his GP on 8 January 2015 where he reported thoughts of hanging himself, described low mood and appeared angry. His GP, Dr MacMillan, referred himself to the Mental Health Services at Carseview Mental Health Facility for an emergency assessment.

[3] Dr David and mental health nurse, Jill Drurie, undertook the emergency assessment of Mr Thomson on 8 January 2015 and decided to admit him as an in-patient. Mr Thomson remained an in-patient on 8, 9, and 10 January 2015. In the afternoon of 10 January 2015, Mr Thomson wished to leave Carseview. He was assessed by Dr Feile and discharged himself against medical advice. He was collected by his grandmother who took him back to his house where he lives alone.

[4] Mr Thomson's sister telephoned the ward to report that Mr Thomson had made threats to burn down people's houses once out of Carseview. Staff at Carseview informed the police about this threat.

[5] Mr Thomson was returned to Carseview by the police during the evening of 10 January 2015. Mr Thomson was assessed by Dr Kao and mental health nurse, John Hamilton. Dr Kao contacted Dr Howson, senior doctor on call, for advice following her assessment of Mr Thomson. At the outcome of the assessment, Mr Thomson was released back into police custody.

[6] Mr Thomson did not return to his own flat but stayed with his mother until 22 January 2015. He had sole care of his daughter on a number of occasions overnight

with the agreement of the child's mother.

[7] Mr Thomson attended his GP on 22 January 2015 who, on reviewing Mr Thomson, requested an urgent assessment at Carseview. This was carried out on 23 January 2015 by Dr Gunput and Jill Drurie. An action plan was put in place which included a trial prescription of an antidepressant, a referral to a substance misuse service, and advice to return to his GP if Mr Thomson's mental health deteriorated. Mr Thomson committed suicide on 27 January 2015.

THE EVIDENCE

[8] I had before me a substantial body of productions and heard oral testimony over a number of days. I have divided the evidence in this sequence: the events prior to death; the post mortem investigations and the independent expert review.

[9] Dr MacMillan was Mr Thomson's GP. Dr MacMillan did not recall much engagement with him at an appointment on 8 January 2015. He had been a practice patient since 1986. The GP notes disclosed that from around 2009 onwards there were entries referring to some aspects of depression. In 2010 there had been in the region of four young male suicides, three of whom were connected to the patient. Between 2012 -2014 there had been treatment by way of anti-depressants. The last recorded prescription for such medication was in January 2014. Dr MacMillan accepted that there appeared to be some benefit to the patient derived from the medication but he could not have had access to this for a year. The notes revealed a third party report by telephone that the patient had been self-harming and had attempted suicide and the

police had been involved.

[10] When Mr Thomson arrived, accompanied by his grandmother and girlfriend, his mood was low and angry. He was fidgety and looking for some kind of help. Dr MacMillan assessed him as potentially suicidal. He was sufficiently worried about his patient to refer him to the Carseview Centre for emergency psychiatric assessment. This requires action within 24 hours. He confirmed that this was not a course of action he took often or lightly. Dr MacMillan phoned the duty worker at Carseview and provided what information he could. He noted in the GP records "suicidal symptoms; tried to hang himself; cuts up both forearms. Referred to psychiatric assessment today at 5.30pm at Carseview with his gran and girlfriend". Dr MacMillan described himself as pretty much locked out of the process at this point. There was a further entry in the notes on 9 January 2015. "Third party attendance from gran, Eleanor McLaren, she let me know Dale was admitted to Carseview yesterday". He then learned from the family that Mr Thomson had discharged himself against medical advice on Saturday 10 January. It was reported to Dr MacMillan that Mr Thomson had become frustrated that nothing was happening over the weekend. Dr MacMillan understood that his patient would have been seen by a consultant on Monday 12th but was disappointed that Mr Thomson had not had senior assessment and had been discharged with no other follow up.

[11] His family booked an appointment for 13 January but Mr Thomson did not attend. On 15 January Dr MacMillan was informed by the family that Mr Thomson had been taken into police custody on 10 January and was taken by them to Carseview, but

was uncooperative and refused re-admission. Dr MacMillan confirmed that he had access to the "Vision" system (which he described as a kind of "front page" of clinical event recording) and would have received information from Carseview electronically but dates of transmission are not reliable and his recollection was that he was acting, largely, on updates from the family.

[12] On 22 January Dr MacMillan saw Mr Thomson with his mother. He noted his general presentation was agitated much as he had seen him before. He was, however, visibly upset by his time in Carseview. He was crying and complained that he had just been ignored from Thursday to Saturday. Patients began to get on his nerves; one in particular kept shuffling his feet and talking. He just could not take it. Dr MacMillan again assessed that the patient would benefit from formal psychiatric intervention but on a critical "same day" basis as at the last appointment. He referred Mr Thomson to Carseview again, but this time Dr MacMillan classed this as an urgent psychiatric assessment at Carseview: this would mean an appointment within 72 hours, i.e. by Friday 23 January 2015. He also prescribed five doses of Zopiclone, a sleeping tablet, to aid rest before the psychiatric team saw and assessed him again.

[13] On 23 January his grandmother telephoned to say he had been told to see his GP for antidepressants and she was extremely concerned he would take his own life. His mother also phoned that day, dissatisfied he was not admitted to Carseview and the family were beside themselves with worry. The family was clearly of the view that Carseview was not doing enough. Dr MacMillan noted that the family complained that Carseview were more concerned about cannabis use and pending criminal matters but

that Mr Thomson was very unstable, depressed and needed treatment, so he made an appointment to see Mr Thomson that day. Mr Thomson did not attend. Dr MacMillan offered another appointment on 27 January but, again, Mr Thomson did not attend. On 28 January Dr MacMillan was advised by the police of Mr Thomson's death. He was saddened but also surprised by the news. Prior to January 2015 Mr Thomson had not been to the GP in a year, and he had not been taking his prescribed antidepressant medication during that time. He was asked, in cross examination, whether he was surprised that Mr Thomson had not been detained at any time when he was taken back after he discharged himself by Carseview. Dr MacMillan was only able to offer his opinion that overall he was surprised that Carseview had not been able to offer Mr Thomson any further help.

[14] Dr Ranjeeta David was a Speciality Registrar working at Carseview in January 2015. She was, at that time, midway through the standard 6 years' psychiatry training. She made her own assessments but could call on more senior colleagues when she thought that support was appropriate. She confirmed that there is always a consultant psychiatrist on call. In cross examination she conceded that, out of hours, it was rare for a consultant to physically come in but there was a middle grade doctor on call who might come in.

[15] Mr Thomson was seen by her as an emergency GP referral on 8 January 2015. Prior to seeing Mr Thomson for her face to face assessment she had sight of the initial triage assessment from the crisis management team, who would have spoken to the referring GP: from this she learned of symptoms of low mood and recent self-harming,

which she understood to be superficially lacerated forearms. She was also aware that the police had taken Mr Thomson into custody overnight but no charges followed. It was reported that Mr Thomson had attempted to hang himself but the rope snapped.

[16] She then saw Mr Thomson to carry out a generic mental health assessment. She was accompanied at the assessment by a Community Mental Health Nurse, Jill Drurie. Mr Thomson told Dr David he felt it was not worth being in hospital. His low mood and thoughts of self-harm had persisted for at least the past 2 months. She ascertained that his family was very concerned for his safety and he had made repeated attempts to hurt himself. There was a history of domestic abuse from his father and other family mental health issues: an uncle with schizophrenia and 2 bipolar sisters. She discovered that when his best friend had hanged himself he had taken an overdose of ibuprofen. He had been referred for psychiatric intervention some two years before but was deemed ineligible due to cannabis use. He continued to use cannabis daily and had a criminal case pending for growing cannabis. Dr David observed that cannabis can induce symptoms of psychosis. Mr Thomson tested positive for cannabinoids the next day. He had taken cocaine in the past. He used to binge drink, but had not misused alcohol for the past two years. He had stopped taking antidepressants many months ago. She confirmed that the prescription was for the maximum dose (45mgs) of Mirtazapine.

[17] Mr Thomson's physical presentation was agitated, eye contact was difficult to establish and he fidgeted throughout the consultation. There was, however, no evidence of self-neglect; he was socially appropriate and generally cooperative. His

overall cognitive function, movement and speech were normal. Suicidal thoughts were articulated but he did not refer to any specific or immediate plans. He presented as having vague paranoid ideas. Dr David asked about what she described as possible pseudo hallucinations, as he mentioned hearing voices of people wanting to hurt him. She noted that Mr Thomson described ongoing but unfocused thoughts of hanging himself as he wanted to die. He seemed to think he had never been given adequate or correctly focused support. She was aware the GP had referred Mr Thomson to Mental Health Services as an emergency assessment. The clinical risk assessment was discussed with Nurse Drurie before a management plan was completed. The conclusion was identified as a risk arising from ongoing suicidal ideation in the context of a history of previous impulsive behaviours. She noted her impression that Mr Thomson was suffering a possible drug induced psychosis. Mr Thomson was offered and accepted voluntary hospital admission. This was communicated to his GP electronically. She confirmed the report to the GP was:

> "Following assessment Dale was offered CRHTT referral to provide intensive home treatment and support. However, Dale was ambivalent about being able to safely plan and keep himself safe, therefore, he was offered in-patient care which he accepted and he was admitted formally to ward 2, Carseview Centre and I am sure that in-patient services will keep you informed of his progress."

[18] She did not recall any reluctance to admit Mr Thomson. She did discuss with the family members present whether there were options for care that would keep him within the family. The issue, with any patient, is to review options to in-patient treatment, which she did, but she was clear that such an option was not indicated in this case. Indeed she accepted that had Mr Thomson not voluntarily agreed to be admitted,

she might have used Mental Health Act detention powers. She had no further involvement with Mr Thomson.

[19] Nurse Jill Drurie is a mental health nurse based at Carseview. She is highly experienced and estimated that she participated in patient assessment perhaps ten times a week and will have done hundreds over her career. She first encountered Mr Thomson on 8 January 2015 when she assisted Dr David after his GP emergency assessment referral. She confirmed that this meant an assessment within 4 hours of GP referral. An urgent referral allowed for a window of 72 hours. The concern was low mood and suicidal ideation.

[20] She would assemble the triage information and accessed the electronic "Midas" records. Mr Thomson did not have a general adult psychiatric history. She explained that a reference to the police in the notes referred to the need to ask police to carry out a welfare check if the patient failed to attend. Her role was to complete the assessment form. The concern was whether he had an ongoing plan or purpose to harm himself. He had vague ideas that people were speaking about him with malicious intent. He was a regular cannabis user, consuming two "joints" a day. He had self-harmed both forearms superficially on 5 January. He reported witnessing domestic abuse towards his mother growing up, and had discontinued his prescribed anti-depressant medication months ago. The identified risk was of acting on suicidal ideation, acting upon impulse. He had done this before. She noted important historical details such as an attempted overdose when the patient's best friend had committed suicide some ten years before. He also seemed to have some vague paranoid thoughts and referred to people speaking

against him. He was not uncooperative but it required patience to get information from him. She did learn of his trial for attempted murder and also charges for cultivating cannabis. He also talked about his daughter.

[21] Community based treatment was considered as an option by Dr David and was discussed with the two family members who had come with Mr Thomson. The family did not feel able to keep the patient safe and Mr Thomson was clear that he was unable to work with the crisis resolution home treatment team (CRHTT). He was equally ambivalent about his own ability to action a safety plan. He was to be admitted on a voluntary basis for general observations and to gather more assessment information. Dr David's preliminary assessment was that Mr Thomson was suffering from a drug induced psychosis. Nurse Drurie could not form her own clear opinion on psychosis but observed signs of risk and vulnerabilities that required further assessment. She did not work on the wards but would have expected he would be seen by a ward doctor next day. The suicidal ideation risk was rated amber which would indicate face to face interaction with a named nurse. She had no further involvement in the admission, beyond taking the patient and the family with him to the ward area and passing him to an attending nurse.

[22] On 22 January Mr Thomson was referred to Carseview again by his GP. The referral was urgent rather than emergency, i.e. seen within 72 hours. She noted that the GP was concerned that the patient continued to present with low mood and agitation. He was expressing suicidal ideation, but was not considered by the GP to be actively suicidal at the time of referral. An appointment was arranged for 0930 on 23 January.

She again accompanied the doctor (Dr Gunput) for the assessment. Mr Thomson's mother was present. She provided background information on Mr Thomson since he had last been in the unit. She mentioned issues such as her son dwelling on the breakdown of his parents' marriage. Dr Gunput as the clinician led the consultation. He asked questions. Nurse Drurie noted that Mr Thomson was less open to discussion and engagement with the doctor than when she had seen him last. The consultation was very similar to that with Dr David but the main process difference was that Dr Gunput did not break off for a discussion with Nurse Drurie in private. Dr Gunput made a diagnosis and his assessment was that any suicidal ideation was transitory and that there was no evidence of any firm plan or actual intent. The patient was in a state of increased agitation but there was no evidence of severe and enduring mental illness. He was noted to be continuing to use cannabis and was advised to refrain or reduce use. Mr Thomson acknowledged that and was offered advice on referral to the Addaction addiction service in Dundee. He declined the referral and was clear he could handle the cannabis issue in his own way. Mr Thomson was discharged back to his GP to commence the anti-depressant citalopram at 200mgs. The GP should offer monitoring appointments to the patient and be referred back if there were further concerns. Mr Thomson was advised to reduce cannabis use and offered a referral to the drug counselling service, Addaction, but he was not interested. Nurse Drurie felt that Mr Thomson still presented as in need of treatment but he appeared fed up with everything going on. He was sullen and uncooperative and she did not disagree with the doctor's decision. He and his mother were quite vocal and expressed discontent at

the outcome but Mr Thomson did confirm he would see his GP for the medication. His mother said she would hold Dr Gunput and Nurse Drurie responsible should anything happen to her son.

[23] Sometime later that day the community mental health team received a phone call from Mr Thomson's grandmother, who also expressed concern that Mr Thomson was not admitted as an in-patient. She discussed this with Dr Gunput and with Dr Bheemaraddi, the locum consultant at the crisis team, to review matters. Dr Bheemaraddi could have disagreed and Mr Thomson would have been invited back for a further assessment. Nurse Drurie could not say what Mr Thomson's reaction might have been standing his reluctance to engage but this was moot because the consultant did not disagree with Dr Gunput. She was asked about patients being referred to the CRHTT on discharge and offered her general observation that this might happen in some cases and not in others. There was no rule and decisions would be patient specific.

[24] She learned of Mr Thomson's death after the event and was saddened and surprised by it because she did not anticipate such an action. She believed there had been evidence of positive future thoughts rather than any active plan for suicide. She was clear in her own mind that there was nothing clinically that should have been done differently either by her or Dr Gunput.

[25] Dr Jennifer Kao is now practising as a qualified GP. On the evening of 10 January 2015 she was the junior doctor within the wards at Carseview, where she had worked for about 5 months. She had, at that time, completed her medical degrees

and two years' foundation training. She was on a six month training placement but she was not seeking speciality training in psychiatry. Psychiatry training is part of the undergraduate syllabus but she also underwent an induction course and on the job training at Carseview. She was attached to a consultant and followed his ward work, clinics and on call duties.

[26] Dr Kao's recollection of Mr Thomson was somewhat hazy. He had been brought to Carseview by the police after some kind of incident. She spoke to the police to obtain some background details of that evening and considered the documents that she had available to her. She consulted Dr David's assessment and read the MIDAS computer notes, including Dr Feile's assessment. She did not remember seeing Nurse Drurie's hand written notes. She was unaware of the fact that Mr Thomson had not been seen by a consultant during his admission and she had no way of knowing that, given how those records were held. She also did not have access to his GP records and these could not be obtained out of hours. She was not aware of the references to depression within Mr Thomson's GP records. Her evidence was that she would have considered Dr David's assessment; from which she knew that Mr Thomson had had suicidal ideation, was not assessed as having any active plans and that the preliminary or working diagnosis was a drug induced psychosis. Mr Thomson had been on general observation and there had been no obvious difficulties recorded by the nurses.

[27] Dr Feile's records showed that Mr Thomson had discharged himself against medical advice. She was clear that she approached the patient assessment free from preconceptions but conceded that she was, at least to a degree, reassured by the fact

that Dr Feile had recorded "no overt signs of mental illness", that the admission had been due to a possible drug induced psychosis, that Mr Thomson was on general observations only and that he was not detained against his will. Dr Kao was clear that she did not feel in any way constrained by the assessments of either Dr David or Dr Feile. They were evidential factors but it was her duty to use her own judgement in the assessment. Dr Kao confirmed that the purpose of her assessment was to determine whether the risk was such that Mr Thomson needed to be admitted or detained. She assessed Mr Thomson along with Nurse Hamilton. There were no family or friends present. The police waited outside. She explained her approach to the generic mental health assessment. She was unable to complete that process because Mr Thomson would not engage, he was hostile and uncooperative but he was not shaking or agitated. He was not asking for help and he was not asking to be admitted. This was all reflected in her contemporaneous notes.

[28] The court heard that Dr Kao considered Mr Thomson's mental state, his appearance, his behaviour and his speech. She noted that Mr Thomson was casually dressed in heavily stained jogging bottoms with his hood up. He did not appear to be under the influence of alcohol. He was hostile and brittle. He was focused on his phone throughout and avoided eye contact with her. Dr Kao found it impossible to establish rapport. She noted, however, that his speech was spontaneous and coherent. He was not crying, shaking or begging her help but he did raise his voice, at times and he was swearing. His mood was angry. There was no obvious formal thought disorder and he was not noted to be responding to external stimuli, like hearing voices.

He did not have any delusions or paranoid ideas. Her observations were very similar to those recorded by others. He gave no signs of confusion or cognitive impairment due to drugs or alcohol. He had normal thought patterns and capacity to make decisions.

[29] Dr Kao required to consider all of the information available to her, which included the records, information from the police, Mr Thomson's answers to her questions and how he was presenting at the time. She concluded, taking all the data into account, that it was not likely that Mr Thomson had a mental disorder at the time. He was certainly angry and frustrated but equally he was in police custody and had been brought to Carseview under duress. She saw no ongoing symptoms or other evidence to support Dr David's working hypothesis of drug-induced psychosis. Dr Kao concluded that it was not necessary to admit Mr Thomson because he did not have a mental disorder and had derived no benefit from his previous admission. He was not a patient representing after discharge against advice having had a change of heart; he was only there because he was in police custody and patently against his will. He seemed capable of accessing support in the community from his GP and family. Mr Thomson was not asking for admission nor did Dr Kao consider that she could have persuaded Mr Thomson to stay at the hospital at that juncture, particularly as she had not developed a rapport with him.

[30] In her clinical judgment the mere fact of Mr Thomson's previous suicidal thoughts was not enough to deem it necessary to admit him to hospital. She explained that having suicidal thoughts or making threats against people does not mean there is

necessarily depression or a significant mental illness. Rather, it is one factor to take into account when assessing the level of risk. She accepted that NHS Tayside had introduced a new protocol with a presumption towards re-admission when someone who had discharged against medical advice came back. No such protocol or presumption existed in January 2015.

[31] She accepted that the Significant Clinical Event Analysis Review (SCEAR) did not agree with her assessment on the question of detention. She found that upsetting but simply did not agree with the criticism. She had a real patient in front of her, not just sets of records and reports, and she stood by her assessment. She confirmed that there were beds available and that there was no physical or resource bar to admission. The earlier admission had been voluntary and now Mr Thomson was presented because of alleged criminal acts and threats against his family. Dr Kao, however, saw no evidence of real intent or active plans. Risk of anti-social behaviour is not grounds for detention under the Mental Health Act: Mr Thomson was in police custody and remained so when he left Carseview so the criminal matters were for them to deal with.

[32] She accepted that she did not know why Mr Thomson had decided to leave Carseview beyond what was recorded by Dr Feile. The patient was uncooperative and she could not establish rapport. She agreed that it was difficult to assess Mr Thomson but did not interpret his evasive and non-communicative behaviour as masking his true presentation or symptoms. She did her best to satisfy herself that her diagnosis was correct. She consulted Dr Howson, the senior psychiatrist on duty, and he agreed with her assessment. She stood by it.

[33] Dr Mattias Feile was a junior doctor, designated as a "service psychiatrist", which he explained meant that he was the equivalent of a core trainee. In 2015 he mostly worked at the Kingsway psycho-geriatric unit in Dundee but had duties at Carseview when on call. Dr Feile was on call on 10 January 2015. He was called by nursing staff at Carseview because a voluntary patient Mr Dale Thomson wanted to discharge himself. He could not attend immediately as he was with patients at Kingsway but left as soon as possible: he estimated he was there within an hour or so. He stated that on arrival he would have examined all the available patient records. He quite honestly could not remember details such as whether he saw the Triage contact assessment or Dr David's assessment. He spoke to nursing staff in the Duty room to get the history, with their views and observations. The information put to him from the records matched his recollection of the patient's history; he was, for example, aware that Dr David's working diagnosis was drug induced psychosis.

[34] He also recalled a telephone call from the patient's sister and he spoke to her; she said she did not want him in her house, he was violent, and there was a threat to burn someone's house down. Dr Feile believed he had that information before he saw Mr Thomson. It was suggested to him that this call was after he had seen Mr Thomson but he stuck to his recollection. He saw Mr Thomson in his own room for around 10 minutes. He simply did not want to engage with the doctor. Mr Thomson refused to be interviewed, remained lying on his bed with his hood over his face. All he would confirm was said he wanted out: a demand he presented with an angry and brittle demeanour. Dr Feile did, however, manage to speak to the patient for a brief period and

observed no overt sign of any psychiatric illness. He could not detect any auditory or hallucinatory symptoms. There was, for example, no obvious rapid eye movement.

[35] Dr Feile was aware of the suggestion that the patient's symptoms were induced by illicit drug misuse. He explained that as the last time Mr Thomson could have ingested illicit drugs was the 8 January 2015 it was quite possible that any previous drug induced psychosis had resolved. The fact that the patient had tested positive for cannabinoids the next day was explained by the way cannabis is absorbed into the body. It was quite possible that he was no longer being affected by earlier cannabis consumption.

[36] Mr Thomson was making some eye contact and was listening. Dr Feile told him that it was his clear advice that Mr Thomson stay in the Ward. He was aware that Mr Thomson had not seen a consultant and seemed to recall that he agreed with the patient that waiting until Monday to see one was not ideal. There was no evidence, beyond frustration and dissatisfaction with a perceived lack of progress, to indicate that Mr Thomson would have been caused any inconvenience by remaining in Carseview till the Monday to be seen. He told Mr Thomson he was quite willing to carry out a full mental state assessment and that he could not medically discharge him without one.

[37] He had to explain to Mr Thomson the option to discharge himself against medical advice. Mr Thomson declined any further assessment and stated he would leave against advice. Dr Feile could still detect no loss of reality, decision making capacity or overt signs of mental disorder. He made it clear to Mr Thomson that it was his opinion that he should stay in hospital to wait for senior assessment and that he

recommended he should not leave. Mr Thomson simply refused to engage. Dr Feile made it clear that he considered the question of engaging the emergency detention powers available to him under the 2003 Mental Health Act: indeed that was one of the primary reasons he had been called out by the nurses on duty. Nurses have a very limited power to detain patients and the function of that power is to allow a doctor to attend. Dr Feile confirmed that he considered detention to be a very serious step. You are depriving someone of their free will and liberty. It was akin to arrest by the police. He said he was obliged to try persuasion first, to make the patient realise staying was for the best and only if that failed should detention be contemplated.

[38] He did not detain him because he did not believe, at that time, that the statutory criteria were met. He observed a patient who seemed to have insight into his condition and whose judgment was not impaired. He agreed that he was aware that Mr Thomson had been an in-patient since the 8th and had not seen a senior psychiatrist. He knew that Mr Thomson had had a family visit earlier in the day and to the best of his recollection he knew, at that time, that he had made threats against his sister. If he had thought his threats were driven by psychosis or that he had otherwise lost touch with reality that would have been an important reason to detain him. He did not reach that conclusion and frankly, based on the evidence available to him the behaviour seemed more likely a result of other social stressors and to be a police matter. It was, in fact, the nurses who phoned the police about the threats. Mr Thomson simply did not present to Dr Feile as a patient with mental disorder or even in a depressive state and he most certainly did not leave any impression he would go out and kill himself.

[39] In cross examination Dr Feile confirmed that he was interviewed by one of the hospital managers for the Local Adverse Event Review (LAER) and provided a written statement but he was not directly involved in the SCEAR. He acknowledged that that report observes that there was no reference to consideration by him of Mental Health Act detention. He agreed that he had not noted it but, at the time, it seemed self-evident that he had, as it was a primary reason why the nurses had to call him out when Mr Thomson sought discharge. His evidence was clear: he did consider it, although did not note it.

[40] He had received training on the use of detention both from induction courses and through practical experience. He had observed Mental Welfare Tribunal hearings reviewing patients already detained. He had assisted senior colleagues in their assessments. All psychiatrists had to have detention powers in mind as they are used quite regularly.

[41] He discussed the SCEAR conclusion that the detention criteria may have been met and that two consultants formed the view that he should have done so. He accepted that he wished he had but this was based upon the known fate of Mr Thomson. Clinical judgment is not a mechanical process and none of the reviewing senior psychiatrists actually saw Mr Thomson. Dr Fiele was with 3 or 4 of his seniors afterwards, and none of them thought he had erred.

[42] He agreed with the expert opinion of Dr Scott that a mental state examination is an essential part of the diagnostic process; and he referred back to his evidence about the patient's mood, eye contact and general demeanour. He, however, accepted, with the

benefit of hindsight that he may not have had as complete a picture of the patient as he should have wanted. He still believed that he had all the essential elements of a mental state examination but perhaps did not have adequate responses from Mr Thomson. It would have been better to try to obtain better patient engagement.

[43] If Mr Thomson had stayed or been detained Dr Feile accepted that a whole different chain of events would have been triggered. This was, however, speculation. He would have had a senior assessment and perhaps treatment following that would have a positive outcome. He *may* have evaluated differently the fact that the patient would not talk to him and, on that basis, would prefer to have detained him. At the time he felt he had to give him the benefit of the doubt. He did not accept he necessarily took the wrong view at the time.

[44] He did accept that on reflection he perhaps did not know enough about Mr Thomson and should have persevered in trying to engage him and might have learned enough to have detained him. He felt he might evaluate matters differently and thought he might express it thus: "I will probably have to detain you, you don't give me enough information…. You have tried to take your own life…there is depression and drug abuse".

[45] He accepted that with hindsight he lacked specific knowledge, for example an understanding of precisely what had triggered Mr Thomson's decision to leave, and his decision not to detain was affected by that lack. He accepted that was the SCEAR's conclusion. He accepted that was a possible view but he rejected the suggestion that this proved his decision at the time was flawed.

[46] Nurse Louise Rundle was originally cited to attend the Inquiry but was not called to give evidence. However for the sake of completeness she was Mr Thomson's "named" nurse. It would have been Nurse Rundle's responsibility to conduct a 1:1 assessment if Mr Thomson had been an in-patient for a period of 72 hours. Mr Thomson discharged against medical advice on 10 January 2015, therefore the assessment did not take place. She was not on duty when he discharged against medical advice and had no other involvement with his care.

[47] Nurse Donna Petrie has nursing degree in mental health. She is a staff nurse and considered herself middle management grade. She was the nurse in charge on 9 January 2015 during the backshift. She remembered Mr Thomson on the ward and that he was being visited by family members. Her specific involvement related to bag checks. All visitor bags are checked for prohibited items such as alcohol, drugs, other stimulants or items that could be used for self-harm. She checked one of Mr Thomson's visitor's bags; she believed it was a sister. She found one or more cans of energy type drinks. This could not be allowed on two grounds. Energy drinks are high stimulants and cans have ring pulls with sharp edges. The items were not allowed to be given to Mr Thomson. She did not have much recollection of any other involvement with the patient that day. Nurse Petrie was not on shift on 10 January 2015 when he discharged against medical advice. Ms Petrie had no other involvement in Mr Thomson's care.

[48] Nurse Violet Taylor qualified in 1982 and was acting senior charge nurse at Carseview. She has a B.Sc. and M.Sc. in nursing studies. She has always specialised in mental health nursing. She was not on duty when Mr Thomson was admitted but was

aware of him when she came on duty around lunchtime on the 10 January 2015. She was engaged on largely administrative duties. Mr Thomson was a voluntary patient and not noted as an enhanced engagement patient and indeed seemed settled and quiet. There was nothing of special note. She was then told by colleagues that Mr Thomson wanted to leave. She was aware that he was a voluntary admission and so they had to alert the on call doctor because the others had gone off duty. It seemed best to try and persuade him to stay rather than confront him with attempts to exert authority. Dr Howson was there but dealing with another patient who was an emergency detention. He was on his computer doing the paperwork and said he was unable to help. However, as Nurse Taylor recalled Mr Thomson was not actually trying to leave. He was demanding attention but seemed, even if grudgingly, content to wait in his room for the duty doctor to see him. There was, therefore no need to use the nurses' holding power.

[49] Nurse Taylor had no personal knowledge of Mr Thomson's history or in-patient observations and so could not do much to assist Dr Feile when he arrived from the Kingsway geriatric unit. She could not recall if Dr Feile spoke to anyone else in the unit before he saw the patient. He certainly accessed the patient's electronic record and may have looked at printed records as well. He saw Mr Thomson and decided he be allowed to leave against medical advice. Later she received a phone call from Mr Thomson's mum asking her to confirm he had left, which she did. She was hostile and angry that he had been allowed to go, so she tried to explain about him taking his own discharge, which was against the doctor's advice. There was also a call from Mr Thomson's sister

saying he had made threats to burn down her house with her and her children in it. Her recollection was that Mr Thomson had already left Carseview when the call was received.

[50] Nurse Taylor confirmed that despite all her years of specialist experience the decision taken by Dr Feile was his to take. She would, however, have spoken up if she did not agree with such a decision. This was because she had to assist where possible a junior doctor and it was part of her professional development. Detention, in her view, was a serious infringement of a person's right to liberty and self-determination. Any decision to detain must be fully justified and the overall approach would be cautious.

[51] She was asked about the policy on mobile phones and confirmed that it was not policy to require them to be surrendered unless there are specific clinical reasons to do so. She knew that something had disturbed Mr Thomson but whether this related to mobile phone calls or texts she could not say. She was told of family visits earlier in the day and that could be the trigger. She also confirmed that the system of admission that had led to Mr Thomson being overlooked during the Friday consultant rounds had been reformed to prevent a repetition of that error.

[52] Nurse John Hamilton is a senior mental health nurse, with a degree in psychology, and has worked in the field since 1989. He was on duty on 10 January 2015 at Carseview. He was quite candid that his recollection was hazy. He has attended at hundreds of assessments. He recalled that there was a doctor in the unit that evening and that a male was brought in, who he accepted was Mr Thomson. The police had arranged for Mr Thomson, who was in their custody, to be assessed. He first saw the

patient in the waiting area and he was then taken into the assessment room. He had some food with him but was not at all pleased to be at Carseview. He seemed reluctant to answer any questions. Nurse Hamilton's impression was that Mr Thomson felt the whole process was pointless. He was fairly relaxed; kept eating his takeaway. He was described as more disgruntled than agitated. Nurse Hamilton accessed the patient records and learned of the discharge against advice earlier that day. He noted that Mr Thomson had made some threats against his family before he left the unit.

[53] The doctor (Kao) tried to engage with Mr Thomson to establish a clinical rapport but he was just totally unwilling to engage and, when asked by Dr Kao if he wanted to come into hospital, he said it would be a waste of time, and that the whole process was useless. He swore repeatedly. He was fully orientated to everything that was happening. There was nothing to indicate he was delusional or hallucinating. He emphasised that what he observed was a risk assessment. This was a police request not a GP referral admission assessment. He agreed with Dr Kao's assessment that the patient did not come close to meeting emergency detention criteria, but a more in-depth assessment would have had to take place to be sure. Mr Thomson left, still in the custody of the police.

[54] Nurse Craig Borch is a psychiatric nurse. He was on duty in Carseview on 9 January 2015. He noted Mr Thomson was relaxed and settled around the ward. This accorded with the observations of other staff.

[55] Nurse Gail Taylor is a senior staff nurse who was on duty in Carseview on the evening of Mr Thomson's admission on 8 January 2015. She has specialist psychiatric

nursing training at University level. She carried out a general nursing assessment two hours after admission. He was graded green (low risk) for suicidal ideation and low mood. A named nurse is assigned for a face to face private session. Louise Rundle was assigned to this role and she would have completed this by 12 January. Nurse Taylor explained the system of allocating patients between the two open wards (there is a closed security ward) at Carseview. This was no more sophisticated than using the postcode of the referring GP practice. Mr Thomson was admitted under a senior psychiatrist, Dr Singh, and should have been allocated to Ward 1 under the GP postcode system, but as there was not a bed available at the time he was, in fact, admitted to Ward 2. This admission leads to a serious administrative error. Dr Singh would have seen Mr Thomson doing his rounds on Ward 1 on Friday 9 January but he was not in this ward at the relevant time. The consultant with responsibility for Ward 2 did not know of Mr Thomson and so he did not pick him up on his ward round. She explained that a new protocol, with emails and an audit trail, has since been implemented to prevent this type of error.

[56] Mr Thomson had several visitors on Saturday 10 January. Mr Thomson had presented no issues of any significance over the past two days but it was noticeable that his mood changed after his visitors left. The nurses could not fathom what any trigger or flashpoint might have been. He was observed to have become ill-tempered, hostile and vocal in complaint. He became quite disruptive. He started saying he wanted to leave the ward. He demanded to see a doctor because he could not be kept at Carseview against his will. Nurse Taylor tried to engage with his issues but he just barged past her,

swearing, and went to his room. He put his belongings out on the corridor floor. Nurse Taylor asked him to go back to his room. She said it was all rather scary but the nursing staff were more concerned about the patient. They did not want to patronise or otherwise antagonise him but Nurse Taylor apologised for any delay and explained that they had summoned a doctor who was on his way from the Kingsway Care Centre. Mr Thomson could see him as soon as he arrived.

[57] She decided to ask Dr Howson, a senior psychiatric practitioner who was, by sheer coincidence, in the nurses' office on other business, if he could see Mr Thomson but he said this was within the province of the junior doctor on call and he had other responsibilities. Nurse Taylor recalled that he was phoning his wife at the time. Dr Howson reminded the nurses that they had a legal holding power and could detain Mr Thomson if he tried to leave before the duty doctor arrived. Nurse Taylor and her colleagues were reluctant to go down that path. Mr Thomson was a voluntary patient and threats seemed unlikely to build trust or create any better rapport with him. They resolved to keep trying to persuade him to remain. The nursing staff, who had known doctors of all ranks deal with requests to leave against medical advice, again tried to engage the assistance of Dr Howson but he again declined and then left the unit. In the end the issue of the nurses' holding power was irrelevant because Mr Thomson was still there when the duty doctor, Dr Feile arrived.

[58] The doctor then saw the patient. Nurse Taylor was not present at the assessment but was told by Dr Feile that Mr Thomson had taken discharge against medical advice. She knew that information came from Mr Thomson's sister concerning alleged threats to

burn down her house. She was sure that Dr Feile received the phone call from the sister complaining that her brother was making serious threats, after it was agreed he could leave against medical advice. She was sure that he recalled Dr Feile remarking that "that's him gone" and then Mr Thomson's sister phoned. Nurse Taylor heard Dr Feile say it was a police matter. She had no other involvement with Mr Thomson.

[59] Nurse Sonya O'Keefe was a staff nurse who was on duty at Carseview Ward 2 on 8 and 9 January. She observed and checked upon Mr Thomson regularly. He was a bit agitated on first admission but he settled in. He asked for something to help him sleep on 8 January and he was given lorazepam. He slept well enough over the two days with the help of the medication. Nurse O'Keefe noticed nothing untoward with the patient at all.

[60] Dr George Howson now holds the rank of consultant but was, in January 2015, a senior registrar: otherwise called a psychiatric practitioner graded ST5. His main duties were in the field of the area addiction service, but he was also part of the on call rota. He was in Carseview on 10 January 2015 specifically to assess another patient to review a short term detention order under the Mental Health Act. He can't remember fully being asked by two nurses about Mr Thomson but knew he wanted to leave the ward, and he advised them they should ask the junior doctor to see him. It was not easy for him to see Mr Thomson because he was second on call and had responsibility for providing advice to 3 sites across the whole of Tayside. He was not aware of any crisis. He would have dealt with a critical patient. A voluntary patient asking to leave is quite commonplace and would be dealt with by the doctor covering the site at that time. He was already

covering three other sites over Tayside. The work he was doing could not have been done by a junior doctor.

[61] He was at home, later that evening, when he was called by Dr Kao, the doctor on call, for advice. Mr Thomson had, apparently, been brought back to the ward in police custody. Dr Howson was aware of the circumstances of the patient's discharge against medical advice. He had been told of threats made by Mr Thomson to harm his family and that was why the police had intervened. He knew the working diagnosis at admission had been drug induced psychosis. Dr Kao reported to him that there had been no evidence of symptoms to suggest the patient was psychotic when she saw him; nor had he shown such evidence during his 48 hours on the ward. The information from nursing staff was that there had been no concerns about ongoing suicidal thoughts after his admission. In terms of low mood and possible depressive symptoms, again the report from staff was he had been quite settled during his admission. He had become upset after a visit from family members and it was only after that event that the patient wanted to leave.

[62] He learned from Dr Kao that Mr Thomson had been angry and irritable when interviewed, not wanting to engage, but that she had asked him specifically whether he had ongoing thoughts of harming himself or others, and he denied those thoughts. So the plan was agreed between himself and Dr Kao. He had discharged himself against advice. Dr Howson agreed that if a patient, in those circumstances, re-presented of their own volition that might indicate a change of heart or different thought processes and that was a factor that could be taken into account. Mr Thomson, however, had been

brought back under duress by police and was not asking for admission or engaging in any meaningful way. The reasonable inference was that the patient's decision as to whether he wanted to be in hospital or not was unchanged. This would mean admission would have to be by way of detention under the Mental Health Act. Dr Howson agreed with Dr Kao's assessment that admission was not necessary so would not consider detention.

[63] Dr Howson explained that for a detention certificate, the patient firstly needs to be assessed as requiring to be admitted because of their mental state and then they must refuse to do so voluntarily; only then would a doctor need to consider invoking section 36 of the Mental Health Act. In Dr Howson's opinion Mr Thomson was not close to meeting the criteria for detention. He acknowledged that Dr Kao has said she did not complete a formal assessment. He did not accept that although perhaps with hindsight she might feel that her assessment was not as detailed as she would have liked. The mental state examination is harder with a patient who is not cooperating, but it will still reflect their presentation objectively: the way they say things; how they are in the waiting room, etc. You add to that the background information you have from other sources, such as how he had been presenting in the last 48 hours.

[64] Dr Howson was not concerned that Mr Thomson had not seen a consultant or other advanced medical practitioner (AMP) because he had been seen by other qualified professionals and had been observed on the ward. He acknowledged the different opinion offered by the Crown's expert Dr Scott, but disagreed, and observed that not having the patient in front of him puts any expert carrying out a paper analysis at a

considerable disadvantage. Dr Howson remained of the opinion that Dr Kao had no basis to detain Mr Thomson against his will and that he supported her decision.

[65] Dr Arvind Gunput qualified as a doctor in 1993 but has worked in the field of mental health since 2001. He is not of consultant grade but is classed as a speciality doctor in psychiatry. In January 2015 he was a staff grade locum, not in permanent employment by NHS Tayside. He was on duty at Carseview, as part of the crisis team, on 23 January 2015. Mr Thomson had an appointment on a GP referral with concerns about self-harm and suicidal ideation. He was assisted by Nurse Drurie. She had previously assisted Dr David when the patient was seen on 8 January and she informed Dr Gunput about this. He had access to the patient records and was able to establish a basic history. He carried out a generic mental health assessment. He explained that psychiatric assessment depends upon face to face engagement. Mental health was fluid and changeable: quite unlike other more predictable conditions like say diabetes or a broken leg.

[66] Dr Gunput saw the patient for about 30-45 minutes. He asked the patient about symptoms and noted that he reported being depressed for years. There was a history of substance misuse and problems with alcohol. Mr Thomson said that, at this time, he was not abusing alcohol. He was using cannabis: perhaps two or three joints a day. He had experienced a violent childhood and other family members had mental health issues: a sister with depression and a schizophrenic brother. Immediate issues were noted as depressive thoughts, lack of sleep and appetite. He confirmed that he was

involved with the criminal justice system and was due to be seen on 28 January for an assessment by a social worker for a restriction of liberty tag following a criminal conviction.

[67] The focus for Dr Gunput was the risk of harm. He recalled that the patient seemed stable. Mr Thomson was anxious at first and had a habit of repeatedly rubbing his eyes. However, he was not reluctant to engage and was prepared to make eye contact. His speech pattern appeared settled, calm and rational. He was presenting facts logically and seemed to have insight into his situation. What he said remained relevant and Dr Gunput believed that a level of rapport was established. They discussed how he saw things and there were no hallucinations, delusions or obvious formal thought disorder. There was no evidence of any current depression and he laughed a couple of times during the interview. Mr Thomson did not express any active plans for self-harm or make threats against others. Dr Gunput was unable to form a clear impression of what the patient or indeed his mother wanted from him. He was clear that they did not demand that Mr Thomson be admitted.

[68] Dr Gunput was satisfied that he had been able to confront the critical risks identified in the GP referral: self-harm, suicide and psychosis. His diagnosis excluded these risk factors and he believed the patient did not need to be admitted. The plan was to start citalopram, an anti-depressant, for self-referral to Addaction to address cannabis use, and for the GP to monitor progress. There could be a further referral if other issues emerged.

[69] Nurse Drurie was preparing notes for the Addaction referral when Mr Thomson and his mother just abruptly walked out. Dr Gunput noted comments which indicated they were not satisfied with his assessment but they refused to re-engage and left the unit. Dr Gunput mentioned the patient informally to the consultant Dr Bheemaraddi. He reviewed the plan and did not disagree.

[70] Dr Gunput did not consider specific community mental health follow up was indicated for the patient. He identified social stressors such as his criminal justice issues as being at the forefront of Mr Thomson's mind. He believed that his action plan would address this. He could not see any immediate reason to involve the community crisis team. The doctors' diagnosis did not include clinical depression at all. He had suggested citalopram because the patient had reported that he had previously benefited from an antidepressant which he had taken for a few months. Dr Gunput was suggesting a trial to see if it was of benefit, rather than a treatment. He elected to recommend a weekly supply simply as a precaution because of the previous reference to self-harm; although he did not exhibit any suicidal ideation at the interview.

[71] He was asked in cross examination to reflect upon the evidence that had been given by Mr Thomson's mother to the effect that he had been distant throughout the consultation and that it was led by Nurse Drurie. Mrs McLaren also said her son was highly agitated, shaking, and saying that he was in a black hole of despair. His mother was equally sure that she had said that Mr Thomson needed to be kept in Carseview to protect him from himself. Dr Gunput said these allegations did not accord with his recollection of the events. He had noted that the patient had expressed suicidal ideas

and indicated that he did not want to be here but this was expressed passively with no indication of active suicidal intent.

[72] The patient did say that he had experienced what he described as voices outside his window that he believed were family members. He got a taxi to his mother's house to ask what was going on. His mother confirmed the family had not been at Mr Thomson's home. He was clear that what he was being asked to do was recommend ongoing treatment for Mr Thomson. There was no shortage of bed space or any other resource issue militating against admission. Dr Gunput expressed his clear diagnosis that there was no evidence that the patient was suffering from a severe or enduring mental illness and that what he observed would not have been addressed by admission as an in-patient. In his view he needed help with his heavy cannabis use and other lifestyle stressors. This was why he was discussing addiction services and a trial of medication that might help him sleep and be calmer, when Mr Thomson and his mother walked out.

[73] Dr Gunput accepted that certain criticisms had been levied at him both by the LEAR and the SCEAR and he was aware of the expert opinion of Dr Scott. He stood by his diagnosis which was based on an actual face to face consultation not an after the event paper analysis. He acknowledged that Dr Scott was of the opinion that Mr Thomson may have been suffering from agitated depressive disorder but Dr Gunput saw no symptoms to confirm that. In his view the patient was able to express positive thoughts indicative of forward planning. He spoke about seeing a criminal justice social worker, as a way forward in his life. Far from the "black hole" Mr Thomson's mother

referred to, Dr Gunput saw no bleak outlook in the patient's presentation. He confirmed that had there been any sign of active risks of self-harm or to others he would have noted that and acted upon it. He was asked whether he might have detained Mr Thomson just to be on the safe side. Dr Gunput was resolute that the mental health legislation offered no such test. There was no reason or grounds for compulsory detention in his opinion.

[74] He accepted that he had been referred to the General Medical Council. The investigation had concluded that he was not at fault. The independent expert report prepared by Dr DG Goodhead, consultant psychiatrist, for Dr Gunput in connection with the GMC investigation was lodged in process. This was not spoken to or the author subject to cross examination. However, Dr Goodhead offered his insight, of course as with all the other experts based upon a paper analysis, that Dr Gunput could not be criticised for any alleged failure to seek to detain Mr Thomson under the Mental Health Act. Firstly, there was no refusal by the patient to accept admission: he was not offered this option because of Dr Gunput's diagnosis of his mental state. Dr Goodhead did not see any clear evidence of delusional thinking suggestive of a major mental health condition. In his expert opinion, the decision not to admit was probably based, inevitably, upon the failure of the previous attempt at hospitalisation and the further assessment when the patient was brought back by the police which had not resulted in re-admission. Dr Goodhead expressed his general opinion that, in his experience, patients with such problems as irritability and impulsivity tend not to gain great benefit from hospitalisation unless there was a co-morbid psychiatric condition.

[75] Mrs Amanda McLaren is the late Mr Thomson's mother. She filled in the background and history of her son as well as what she experienced as events unfolded in January 2015. Mr Thomson had two brothers (one his twin) and two younger sisters. She recalled her sons' struggle with depression over a number of years. Mr Thomson had been prescribed anti-depressant medication called Mirtazapine but had stopped taking it in early 2014 because, in her opinion, he decided he just wanted to do without drugs and would live and cope with things without it. She recalled that her son had become quite down in January 2015. Her perception was that he was perhaps overly ruminating on or reliving his own childhood because he was now the father of an 18 month old daughter. He did not live with his girlfriend or the child but he remained part of their lives. Mrs McLaren believes he was seeking help because of this new family dynamic. This was, however, not all positive because he expressed the view that he was not a good enough dad. This seemed to hark back to his concerns for his own childhood distress. He started talking about the domestic abuse Mrs McLaren had suffered and that he should have protected her. He said that he had made a mess of his life and that nothing was working. She described him as feeling he had been fighting demons for years and was in a black hole with no escape.

[76] On 4 January she went with his sister to see Mr Thomson. At first he would not let them in. They prevailed on him to open the door and he was patently not well. He had cut himself. He became agitated and upset. He demanded to know if this was what they wanted; to see him self-harming. He ordered them out of his house. They left but were sufficiently concerned to call the police. The police responded but Mr Thomson

would not let them in. He was ultimately seen by the police but after a time they released him without charge. Mr Thomson was, however, angry at being reported to the police and became estranged from his mother at this point.

[77] She was not involved with the GP appointment on 8 January but was told that her son had been admitted as a voluntary patient. She was phoned by her daughter saying that Mr Thomson had been phoning her from Carseview. He was saying wild things and threatening to blow up her house and Mrs McLaren because they had got the police onto him. Mrs McLaren did not go up to Carseview but her mother and Mr Thomson's girlfriend did. She had no idea that he would walk out or she would have gone and tried to stop him. She was told that he had got annoyed when told a doctor would not see him until Monday and he left. Mr Thomson also told her he heard staff discussing him and they did not believe his threats were real. The police told her they took him back to Carseview the same day because he was making threats. He was not admitted to hospital and the police took him back to his flat in the Charleston area of Dundee.

[78] Mr Thomson seemed to overcome his dispute with his mother because he came to see her. She managed to get him to stay over. He had disturbed sleep and Mrs McLaren described staying up to be sure he did not leave and disappear on her. Appointments were made to see the GP but she did not succeed in getting her son to attend until 23 January 2015. She thought that her son was having hallucinations as he complained that she and his brother were standing outside his house speaking with police when they hadn't left her house. She explained that it took until the 23rd because,

although Mr Thomson said he would see the doctor he needed to actually be willing to go. She had to wear him down by stressing his relationship with his new daughter and how much she needed him.

[79] She was with him when he saw Dr MacMillan. The doctor wanted to make another referral to Carseview. Mr Thomson was resistant, at first; she was able to persuade him to go. She went with him when the appointment was arranged at Carseview. She recalls that only the nurse (Drurie) spoke, and that the doctor (Dr Gunput) did not do so. The diagnosis was depression. He would be prescribed anti-depressants and weekly follow up. Her son became extremely agitated and protested that it was not depression but something far worse. He needed to be admitted but as they wouldn't do it he walked out. She asked about follow up psychiatric treatment and was told he did not need it. She said if anything happened to her son she would hold them responsible. She told them he needed to be kept in, to protect him from himself. When she caught up with her son in the corridor he said to her "even thae dinnae think I'm worth saving". It was put to her in cross examination that the medical records make it clear that the doctor was actively involved in the consultation and that Mr Thomson did not ask for admission before he walked out, but she stoutly denied this.

[80] Mr Thomson came home with her but on the following Monday ended up going to his own house so he could exercise contact with his daughter. The last time she spoke to him was about 11 am on 27 January and she told him she had got him a GP appointment. Later she phoned his twin and they went looking for him. She feels guilty

every day for trusting he would go to his appointment. If he had still been saying he was going to hang himself she would not have left him. In re-examination it was put to her that as she had said herself about getting her son to go to the GP, he himself had to buy into any clinical programme or treatment and that after the initial admission he seemed hostile and uncooperative. She believed that was because he had lost confidence. The doctors just did not know what her son was like before so couldn't see the state he was really in. She accepted that she had received an apology from the Health Board in a letter in May 2016, for failings in Mr Thomson's care.

[81] Mrs Eleanor McLaren was the grandmother of the late Mr Thomson; she too was able to assist the court with some background and life history. She agreed he would confide in her and that his relationship with both parents had issues. His father often worked offshore but had a tendency to be over strict. His father drank a lot and there was domestic strife, including violence, that Mr Thomson and his siblings witnessed. His relationship with his siblings and indeed his girlfriend, the mother of his daughter, could be stormy.

[82] She was aware that January 2015 had been difficult for her grandson. She had been told of self-harming and attempted suicide. She agreed to go with him and his girlfriend, Ms Jodie McMulkin, to see his GP on 8 January. His mother could not go as Mr Thomson was angry with her because of an earlier police matter. Jodie went because she was the mother of Mr Thomson's child who was about 15 months old at the time. His daughter was an important part of his life and although they did not live in family he saw her a lot. The GP agreed that her grandson needed to be seen as an emergency at

Carseview. She and Jodie took him up to the clinic. Mr Thomson was seen by a male and a female and although not entirely sure who they were one was a nurse and the other a doctor. It was later put to her that it was a female nurse and a female doctor but she continued to recall that one was male. Mrs McLaren recalled that the medical staff were reluctant to offer admission and seemed to want to know what she thought. She said that such a thing could not be her decision.

[83] The medical staff were suggesting that he might be able to get psychiatric help but stay with family. They were told that neither Mrs McLaren nor Ms McMulkin could provide such security. They could not keep him against his will. The other members of the family were equally ruled out. It was put to Mrs McLaren that the evidence of the doctor as recorded in the hospital notes indicated that her grandson had no immediate or active plans for suicide. She denied this and said the notes were just wrong. She recalled his words: "I've already tried to do it, if you don't help me I'm going to do it again." The notes recorded only that Mr Thomson was saying he did not want to live but she was clear that she told the interviewers that her grandson had a noose ready and had plans. She was certain that it was obvious that he was an active suicide risk. In any event, Carseview did admit him and she and Jodie then left.

[84] She and Ms McMulkin willingly undertook the task of hospital visiting, but again partly because Mr Thomson was not on good terms with other members of the family. They visited on Saturday 10 January and her grandson told her that he had still not seen a doctor since admission. She enquired of the nurses on duty and was told he would see a consultant on Monday. This made her grandson angry. He said he was too

ill to wait until Monday. He threw a can of juice away and lay on his bed crying. She and Ms McMulkin did not see what more they could do and left.

[85] Mr Thomson phoned his grandmother, later that day and said he was leaving the hospital. She said she would pick him up in her car. When she got there he was already outside the unit with his bag. He said to her "no one came – no one helped me" and was upset and distressed. She also recalled phrases like "they had their chance". She took him back to his flat in Charleston and left him there.

[86] She later learned that there had been a major incident after she had dropped him off at his flat, involving a two hour standoff between her grandson and the police which culminated with him being taken, in police custody, back to Carseview. She was told that he was not re-admitted and the police let him go home. She did speak to the GP once more over the telephone but left for a visit to Ireland on 17 January and did not return until the day her grandson died.

[87] Mrs Jacqueline Hawes is a family friend. She had known Mrs Amanda McLaren for over 30 years. She had her own children but the two families were like glue. Mr Thomson was the closest friend that her two middle children had. She looked on Mr Thomson like another son. She described Mr Thomson growing up and how he would come to her house so frequently it was his second home. She confirmed that his behaviour had been problematic. She referred to some really scary moments and that she had taken him to hospital before.

[88] She was aware that Mr Thomson had psychological problems that he was blotting out. He would drink heavily and take illicit drugs. She would see him face to

face but they also kept in touch by social media including text messages and Facebook. She was aware that he had attempted suicide and lesser self-harm incidents. She did not see Mr Thomson at Christmas 2014 but specifically recalled text messages around the 6 January 2015 that referred to "demons in his head".

[89] On 10 January 2015 she received a call from Mr Thomson's sister asking her to get to his flat in Charleston as there was an incident. She went as fast as she could and when she arrived she met Mr Thomson's mother Amanda and his twin brother, Billy. There was a heavy police presence. Mr Thomson had apparently made some kind of threats and the police had been called. He would not let them into his flat. The police accepted that Mrs Hawes might have influence over Mr Thomson and that he trusted and would not harm her. She was able to persuade him to let her in. He locked the door behind her. He told her that he was going to slit his throat. He said he needed help but no-one was listening to him. Mrs Hawes was able to persuade Mr Thomson to surrender to the police. She agreed to take his dog, a Japanese Akiha, which helped calm Mr Thomson as he had threatened the police with the dog and he feared his pet might be harmed. Mr Thomson surrendered to the police. Mrs Hawes could not assist with events after that night but offered her opinion that Mr Thomson was in such a state she would have thought that Carseview was bound to have "sectioned" him for his own safety.

[90] Jodie McMulkin was the girlfriend of Mr Thomson and the mother of his daughter. She explained that they had shared a flat in Dundee from 2010 to 2012 but

had not lived together since then, except perhaps for a few months in 2014. His daughter was born on 30 November 2013.

[91] She described Mr Thomson as often moody but never aggressive towards her. She was aware that he had been charged with attempted murder and acquitted but this was before she knew him. He was not a regular drinker but was a persistent user of cannabis. He had emotional ups and downs and she accepted that she found socialising with Mr Thomson challenging. She explained that he would provoke confrontation sometimes leading to fights with other men, where he seemed invariably to get hurt. She gradually realised this was a form of self-harm. These incidents could be as frequent as once a month.

[92] She perceived his real problem was that he found it hard to accept that he had psychological difficulties that he could not just shake off on his own. He was not readily willing to seek help. He would go to the doctor and was prescribed medication but he then decided whether to take it or not. Ms McMulkin saw a significant change for the good when their daughter was born. He seemed more positive but accepted he needed support and wanted to go to the doctor for help. He asked her to go with him to the GP. She went and Mr Thomson's grandmother Eleanor McLaren came too. Mr Thomson had not told her about suicidal attempts but at the GP consultation he told the doctor he was going to try and kill himself. She described him as fidgety and upset throughout. The doctor made an emergency appointment at Carseview and she and Mrs McLaren went with him.

[93] She could not be clear about the sequence of events at Carseview. She accepted that Mr Thomson may have been seen in private but there were also discussions with her and Mrs McLaren. The question of giving him help in the community was discussed. They were asked if family could look after Mr Thomson at home. Ms McMulkin and Mrs McLaren confirmed that they could not do so. Mr Thomson needed help and protection they just could not offer. The doctors seemed to accept that and Mr Thomson was admitted as a patient. She and Mrs McLaren left at that point.

[94] Ms McMulkin visited Mr Thomson in Carseview the next day. He seemed agitated. She and Mrs McLaren visited, again, on 10 January. Mrs Eleanor McLaren went to speak to the nurses because Mr Thomson said he had not seen a doctor since he was admitted. She came back and although Ms McMulkin could not recall what exactly was said he became upset. She recalled him throwing away a can of juice. A nurse intervened and told him to go back to his room and Mrs McLaren and Ms McMulkin had to leave. She only heard about the incident later that day involving the police after the event.

[95] She assisted the court considerably by describing her interaction with Mr Thomson after he left Carseview until 23 January 2015. She saw him a lot. He came to see his daughter almost every day and sometimes took her out. He seemed happy when with his daughter and Ms McMulkin agreed to let him babysit her overnight at his own flat. She was asked what made her trust Mr Thomson with his daughter overnight after all that had happened in the past few days but she said she just did. The only time Mr Thomson seemed happy was when he was with his daughter and Ms McMulkin just

thought this would help. She was distraught when she learned that Mr Thomson had killed himself. She really did not think that he would do that.

[96] Ms Raegan Thomson is the youngest sister of the late Mr Thomson. She saw her brother on 5 January when she and her brother Billy went to his flat in Charleston after her mother had raised concerns for him. He was not immediately cooperative and it took them half an hour to persuade him to let them in. He was agitated and kept swearing and telling them to fuck off. He had a Stanley craft blade at his arm. They went out and phoned the police, or perhaps someone else had already done so. She phoned Jackie Hawes, the mother of one of her brother's closest friends, to come and help calm him. The police came. They let Jackie go up and she persuaded him to come out. The police arrested him and he was put in handcuffs to be taken away. He was angry at her and her mum because he thought they had phoned the police. He said he guaranteed he would not be here for his birthday. He was taken to the cells for his own safety. She thinks he was not taken to Carseview because he had been drinking. The next day when he was released he went to her sister's (Raegan's) and pulled the sheet over his head in the bedroom. He continued to send text messages but would not answer his phone, at least not to her. That was the last time she saw him.

[97] Mr Piers McGregor is the in-patient service manage for NHS in Angus and Dundee based at Carseview. This is a clinical management role. He has clinical standing but does not carry any caseload. He was formerly a mental health nurse but progressed through the ranks to management status. He had no clinical involvement with Mr Thomson of any kind but chaired the Local Adverse Event Review (LAER)

following his death. The LAER can be invoked for a number of reasons and not just for fatalities. It is to consider any poor or unexpected clinical outcome. He explained that the next level of enquiry is for it to escalate to a Significant Clinical Event Analysis Review (SCEAR). The conclusions of a LAER may trigger a SCEAR. This happened in the enquiry into the death of Mr Thomson. The LAER is local, whereas a SCEAR is organisational and service-wide, with a possibly greater impact on a number of services, and so involves more senior review. He described in some detail how the LAER goes about its work and gathers information. This was informative but narrating it would be of limited relevance to this process. Equally, as will become clearer later when considering the submissions, it is clear that all parties considered that the SCEAR effectively superseded the LAER and so narrating how it reached its conclusions in any detail is unnecessary. The critical issue here is that the LAER concluded that Mr Thomson's death was not avoidable.

[98] The LAER panel reflected on why Mr Thomson was overlooked by the consultant during the first regular ward round after his admission. The error was acknowledged and this led to a recommendation for change in the way consultants are notified of admissions. Consultants now receive email notification and moreover care for all the patients physically within their ward, regardless of any formal allocation based upon the GP practice of the patient. They recommended and Mr McGregor confirmed have now created a general adult psychiatry policy, available to all clinicians, relating to the process of discharge against medical advice. There would, for the future, be a focus on consideration of the option of a presumption of automatic re-admission

following discharge against advice. Mr McGregor confirmed, by reference to the Action Tracker lodged in process, that there is now such a presumption provided the patient re-presents within 48 hours. However, the LAER concluded that this change would not actually have made a difference to the situation that confronted Dr Kao when Mr Thomson was brought back to the unit in police custody.

[99] Mr McGregor also contributed to the SCEAR, whose principal authors were two senior clinicians Linda Graham and Dr Stuart Doig, whose evidence will be considered below. He referred to the recommendations set out in the SCEAR report. Some actions related only to review of the LAER and SCEAR process and were not relevant to this inquiry, however the following are:

- 1 Better standardised assessment for emergency and urgent referrals. The patient should receive equivalent care and communication regardless of the time of day or professionals involved.
- 2 A formalised system be put in place to notify consultants that a patient has been admitted under their care whatever ward that patient is accommodated.
- 3 All new patients should be reviewed by a consultant psychiatrist or experienced higher level clinician effectively fulfilling the same function for a specified area within a time scale set by senior clinical management. The standard set will require to take account of service provision and the current evidence available around patient safety. This standard should be regularly audited and results made available to the Associate Medical Director for mental health.

- 4 Review of the recording of information gathered and noted on in-patients and any improvement plan that may be required reported and implemented.
- 5a SCEAR report to be circulated to appropriate clinical and educational supervisors.
- 5b Review of the induction training with regard to the use of the Mental Health Act.
- 6 There should be presumption towards automatic re-admission of a patient who re-presents within 48 hours of leaving against medical advice provided they are medically fit (not intoxicated or requiring other acute hospital treatment).
- 7 Where a person has had an admission as an in-patient and has no established mental health care in place, there should be automatic referral for community mental health team review, unless sanctioned as unnecessary by a consultant psychiatrist or equivalent.
- 8 Where patients leave in-patient care abruptly, whether against medical advice or not, this information should be communicated quickly to those that need to know, primarily GPs and the community mental health team.

[100] He concluded his evidence by identifying those elements of the SCEAR Action Tracker for which he had undertaken implementation responsibility but also confirmed that all the above recommendations had been implemented.

[101] Dr Stuart Doig is a consultant forensic psychiatrist and clinical director for mental health in Tayside. He is based at Murray Royal Hospital in Perth but has also

worked at Carstairs State Hospital. He explained that there are 60 consultants in the psychiatric service and 10 of those have opted to be on the on call rota. There will be one on call consultant, out of hours and at weekends along with a middle grade doctor. At weekends, no consultant will be present in Carseview or at Murray Royal but will be on call and may come into the hospitals, but more commonly will give advice by telephone. They may also give advice regarding patients in Ninewells and Perth Royal Infirmary. The Stracathro unit has relocated temporarily to Carseview because of difficulties managing the out of hours medical cover at a distance. He has considered Dr Scott's reports and understands his position to be (i) that Mr Thomson may have been suffering from a major depressive episode, and that it was relevant to the reasons for him taking his own life; and (ii) that the arrangements in place at the time for review of patients admitted out of hours were not what he understood to be the standard set out in a report by the Royal College of Psychiatrists. The latter report had in fact been withdrawn.

[102] Dr Doig had made inquiry and learned that 50% of health boards have 24 hour review by an AMP. Fife, Ayrshire & Arran, and Lanarkshire do not have such arrangements, but have similar arrangements to those in place at Tayside in January 2015. He also looked at a report in England which did not contain any recommendation for a 24 hour AMP review; nor did the National Confidential Inquiry into homicide and suicide, just published. When the Royal College guidance was current, it was not mandatory. Currently there would be practical resource and logistical implications for Tayside to have such provision. It is easier where service provision is concentrated at

one site, an issue which is out for consultation in Tayside. Tayside have introduced "safety huddles" on a Saturday and Sunday morning, which is, in his view, an adequate substitute for routine 24 AMP review. A safety huddle is a multi staff review and a senior psychiatrist will be involved. This may be by conference call link.

[103] He addressed the question of weekend cover by consultants or other senior psychiatrists. He told the court that what might be called "the weekend issue" was very much a non-psychiatric problem. Recent research has suggested that mental health patients do better if admitted over weekends. Indeed NHS Lothian, who presently have a 24 hour AMP consultation protocol are also looking at the safety huddle model as a substitute. Dr Doig was clear he believed it was safe for a patient admitted on a Friday night to await senior review on Monday unless a junior doctor or nursing staff identify a emerging need for senior review. He has had no negative feedback.

[104] In relation to Dr Scott's suggestion that Mr Thomson's presentations in January 2015 are explained by agitated depression, he has reviewed the records and saw a number of features which, with the benefit of hindsight, could suggest mental illness needing further assessment. He, however, stressed the complicated presentation of the patient. There was a clear history of illicit use of psychoactive substances and also the problems caused by poor engagement. He agreed with the proposition that where there was assessed to be no evidence of mental illness, referral to other services such as Addaction, a local addiction service, was quite appropriate. He stressed that treatment of substance abuse was accepted to be predicated upon patient cooperation and desire to

be free of addiction. This is why such problems are excluded for compulsory treatment under the Mental Health Act.

[105] The question whether a patient needs to be detained to be treated for mental illness is a matter for clinical judgment. Dr Doig considered the statutory tests to be a relatively low bar. It is a question of the clinician having a reasonable belief that there may be a significant mental illness. This is risk assessment and Dr Doig considered that the statutory provision for intervention by an independent Mental Health Officer in the detention process was an important protection both for the patient and the clinician. Equally an AMP must be involved within the shortest possible timeframe and various persons and authorities notified. These were significant checks and balances.

[106] Dr Scott's concerns about discharge documentation, discharge against medical advice policy with improved training and supervision, have all been met. Dr Doig actively contributed to the SCEAR Action Tracker and Tayside Health Board have sought to implement all of its recommendations. The SCEAR certainly concluded that the criteria for detention under section 36 of the Mental Health Act were made out for Mr Thomson on 10 January. Under cross examination Dr Doig suggested that he would prefer to say that detention should have been considered. He was, however, of the opinion that the statutory criteria could have been met. He would take the same stance for subsequent re-presentation at the unit that same day.

[107] He was asked if he thought Dr Gunput should have invoked section 36 powers when he assessed Mr Thomson. He did not see any grounds for detention of the patient at that point but conceded that it was possible that the whole plan for Mr Thomson's

treatment would have been different had he been detained at any time on 10 January and then been seen by a senior psychiatrist and a Mental Health Officer. He accepted that the SCEAR had concluded that major systems failures had contributed to Mr Thomson's tragic death.

[108] Ms Linda Graham is not a psychiatrist. She is a consultant clinical psychologist in Tayside. She is a Deputy Director but still has a clinical caseload. She co-chaired the SCEAR and prepared the consequential Action Tracker. The SCEAR concluded that there were identifiable systems failures in Mr Thomson's care, for which Tayside Health Board had issued to his family an unreserved apology.

[109] The SCEAR formally concluded that there were three root causes that were pivotal in the death of Mr Thomson: Firstly, there was no robust system in place to ensure that the patient was subject to consultant review. This meant that a number of important clinical decisions were taken by a series of junior doctors and doctors in training without oversight from a senior consultant colleague. Had this oversight taken place there may have been a more robust examination of the clinical diagnosis, the need to invoke detention under the Mental Health Act and the need for assertive follow up by the community mental health services. Similarly there was no robust system in place for a presumption of community follow up for all cases where patients leave in-patient care without a consultant being involved the discharge process.

[110] Secondly, there was no system in place that positively encouraged re-admission when a patient re-presents following discharge against medical advice. Had this taken place, the consultant review is likely to have been triggered.

[111] Thirdly, there was a false but building assumption that adequate mental health assessments were being obtained each time the patient was being seen by the mental health service. This appears to have led to a situation where clinicians used the fact that no follow up had been arranged for the patient as evidence that a "no mental illness" diagnosis and "no immediate suicide risk" judgement had been made and were valid. Such judgements were not in keeping with the history offered by the GP, information offered by the family or the fact that he was repeatedly presenting to services when he had no history of doing so. This was especially true of the in-patient admission where the extremely limited nature of the assessment that took place in ward was not recognised by subsequent clinicians. Again, there was no oversight of this process by one key individual and limited pockets of knowledge were passed on through records (which at times were very limited) for yet another new person to make decisions around the case. Had there been a more longitudinal view or wider oversight there may have been a more robust view of the working diagnosis, differential diagnosis and an associated plan for care and treatment.

[112] The SCEAR also concluded that proximal causes that should be recognised were the human errors outlined in the root causes and in particular the human error in the decision making process on 10 January 2015 when detention under the Mental Health Act was deemed appropriate.

[113] She spoke to most of the remedial issues set out in the Action Tracker items and understood that additional evidence was given by her colleagues Piers McGregor and Dr Doig, addressing the implementation of its recommendations. These have all been

met; and Dr Scott's concerns have also all been met, with the exception of routine 24 hour AMP review out of hours.

[114] Dr Singaravelu Thiyagarajan has worked in the field of psychiatric medicine since 2005. He became a consultant in 2014. He described a pattern of ward rounds every Tuesday and Friday. He is the ward 1 consultant who would have seen Mr Thomson had his presence been brought to his attention but, regrettably, that did not happen. He simply did not know of his existence. The present system has been reformed so that there is now a checklist for the admitting nurses and as part of that they send immediately an email to the consultant. Dr Thiyagarajan confirmed that had that system been in place then he would have seen Mr Thomson on Friday 9 January, fully assessed him and formed a management plan. He agreed that, as the patient was voluntary, any management plan would have touched on the question of request for discharge against medical advice and that would be available to on call or duty junior doctors.

[115] Dr Alan Scott was an independent expert instructed by the Crown for this inquiry. His published CV discloses an extensive and eminent career. He is a very experienced psychiatrist, who was in full time practice from 1991 to 2012. He is a Fellow of the Royal College of Psychiatrists and has held a number of appointments including to the Mental Welfare Commission. He has, over his career, developed a special interest in the fields of depression and schizophrenia. He has extensive experience in peer review of colleagues' work but this was his first experience of testifying before an inquiry or court. He provided two reports (July 2015 and June 2016) that are lodged in

process; a principal and then a supplementary commenting upon the SCEAR recommendations.

[116] Dr Scott observed that in general, he found the records of Carseview to be above average in his experience. Doctors cannot record everything or they would be swamped with administration. He would have specific criticisms of note keeping but there was no systemic problem with the records. He would later, however, highlight specific issues of concern arising from the lack of any face to face consultation with Mr Thomson by a consultant or senior psychiatrist (an AMP) and the discharge of Mr Thomson against medical advice or DAMA. He was also of the opinion that a brief letter to the GP was vital after DAMA. This was for two main reasons. The first was to alert the GP that his or her patient was not in hospital and that they had not been discharged by a clinician. The GP could then take such action as seemed appropriate. Secondly, the GP would know what happened (or not) in hospital and would not be dependent upon anecdotal report from the patient or family.

[117] He then turned to the sequence of events in Mr Thomson's interaction with Carseview. He made it clear that a mental state examination was a core skill set in psychiatry. He could not accept, from the notes of Dr David, that meaningful assessment had been carried out at the emergency admission stage. However, what she did achieve might suffice to deal with a situation where the examining clinician suspected that illicit drugs were an important factor and it was necessary to observe the patient for some time to obtain a clear picture. He also accepted that Dr David expected the patient to be seen by a consultant or other senior AMP and more thoroughly

reviewed thereafter. In response to questioning from me, he accepted that Dr David put her position as no higher than an impression rather than a firm diagnosis. The fact was Dr David did admit Mr Thomson and she could not be criticised for that. She did not see the patient thereafter.

[118] He explained that what Dr David expected was that the patient would be seen by an AMP, someone in higher training who would assess him in the ward. She was seeing the patient as an emergency admission and admitted him so that he became a patient under full medical observation in a psychiatric unit. Psychiatry was a field of medicine where, unlike more physical problems, such as a broken leg, there were no x-rays etc. to assist the clinician. A great deal rested upon the years of experience, training and knowledge that senior practitioners acquire. Clinical observation is important but it must be tested in the context of any other known facts from the patient history. This patient had close relatives with mental health issues, had reported suicidal ideation and made threats to harm himself and others.

[119] Dr Scott concluded that, from all the evidence available to him, it was probable that Mr Thomson suffered from a serious mental disorder, agitated depressive disorder or an even more serious psychiatric illness. Such illness, if appropriately treated, can have very positive outcomes. The improvement for the patient can lead to far more effective coping strategies and would significantly reduce the risk of harm or at the extreme, suicide. The totality of the examinations and observations recorded by Carseview between 8 to 10 January simply did not, in his opinion, justify the conclusion that Mr Thomson did not have a mental illness.

[120] Conditions such as agitated depressive disorder are uncommon and can involve subtle and differential diagnosis. A junior doctor might well miss such a condition. There was no documented evidence that a diagnosis of a disorder such as agitated depressive illness was considered during the admission. Someone with experience would realise the differential diagnosis needed to be cast quite wide. Assessment required to be repeated in a much more systematic way.

[121] In 2012 and 2014 the Royal College of Psychiatrists said that an examination by an AMP should take place within 24 hours of admission. The absence of an assessment by an AMP or consultant was unreasonable and would probably have led to a more appropriate diagnosis. An AMP would certainly have created an action plan which would have assisted junior doctors who saw the patient thereafter and might be confronted with issues such as requests for discharge.

[122] He concluded that Mr Thomson continued to suffer from a depressive illness after his discharge and was probably still ill at the time of his death. Had he been seen by an AMP after admission or detained under the Mental Health Act rather than discharged against advice, which would also have triggered an examination by an AMP, there might have been a different and more positive outcome. At the time of Dr Kao's assessment, although he cannot say what the outcome would have been, consideration should again have been given to detention. The symptoms he identified would be consistent with such a diagnosis: agitation, depression, loss of appetite. Mr Thomson had suicidal ideation and seemed disinterested in his life. He would say he was at least depressed. The patient could have had a much more serious illness such as

schizophrenia or manic depression. He had a brother with schizophrenia and a sister with bipolar disorder.

[123] Dr Scott found it difficult, without knowing the reasoning, to understand why those who saw Mr Thomson on 10 and 23 January did not think the detention criteria were met. Dr Scott could say with some certainty that consideration to the use of those powers ought to have been given. He could not say whether detention would have been necessary or not from the evidence available to him.

[124] When Mr Thomson was brought back on 10 January the question in Dr Scott's mind was why not just re-admit; why not invite the patient to come back and wait for the senior assessment that had not taken place. On 23 January an assessment was undertaken but Dr Scott could not judge its depth or quality. There was no documented evidence of questions Dr Scott would expect to have been covered. He saw no note of the patient being asked whether he was having any strange experiences, or seeing or hearing things. The anti-depressant prescription was puzzling. Why was he prescribed an antidepressant, if there were no symptoms of depression? Why was the medication on short weekly prescription, which might imply concern for harmful misuse? Dr Scott summed up his opinion that, on the balance of probabilities, Mr Thomson had at least a depressive illness, and perhaps a more severe illness, and that there was no documented evidence to argue against that diagnosis.

[125] In cross examination Dr Scott agreed he had not observed Mr Thomson as the attending clinicians had done. He was not a witness as to fact. He had already conceded that everything that happens may not be written down in medical records,

otherwise doctors would spend all day writing and not treating patients. He did not know all the questions that might have been asked. Mr Thomson could have been sufficiently calm and appropriately engaged on occasions to convince clinicians to discount the evidence of how agitated and distressed he had been at other times. In his opinion, however, such matters were before the NHS internal enquiries and he considered that the conclusions and required actions in the SCEAR were comprehensive and appropriate. He remained concerned that there was no provision in Tayside for AMP review within 24 hours of admission, seven days a week.

[126] He stressed the importance of AMP assessment which should include a plan for the possibility of the patient seeking early discharge, with some advance consideration of the issue whether and how the Mental Health Act might be applied in that event. An AMP is not necessarily a consultant, but is a senior doctor with special knowledge of the workings of the mental health legislation. He considered it is probable that an AMP may have advised that detention be considered if the patient insisted on leaving hospital, as Mr Thomson did on 10 January. In Dr Scott's view the documented evidence did not justify the statement that Mr Thomson had no mental illness. Detention, rather than DAMA on 10 January was, therefore, a reasonable precaution which might have prevented the death. Dr Scott accepted that when Mr Thomson was brought back to the unit by the police on the evening of 10 January his opinion on detention was more speculative.

[127] Dr Scott also agreed that he had not been shown a transcript of the evidence of individual clinicians before coming to give his opinion evidence. He had not been asked

to update his reports from 2015 and 2016. He also accepted that he was working with an element of hindsight and had access to the full records, including all the GP records, and therefore had more material available to him than was available to the clinicians at the time. He agreed that patients who present to psychiatry with potential mental illness may have other dynamics and stressors in their lives which could explain their presentation, other than serious mental disorders. The diagnosis of agitated depression disorder or other serious mental health conditions was a desktop exercise, without seeing the patient. He examined records but did not know what the various clinicians actually said, did or observed face to face. He conceded that the diagnosis of agitated depressive illness was raised as a possibility but he was more confident that Mr Thomson had a depressive illness. This was still serious.

[128] Dr Scott also accepted that he could not ignore the fact that he knew the tragic outcome for Mr Thomson was death by suicide. He agreed that the attending clinicians would have to consider, as did he, that suicidal ideation is not always driven by mental illness. The vast majority of suicides have mental disorder factors but that can include alcohol and drug abuse. Some people kill themselves because they are unhappy about their lives in some respect, and have no treatable mental illness. He accepted that any of the symptoms described could be attributed to factors in the patient's life other than depression or other mental illness. However, Dr Scott stressed that if a clinician is presented with prima facie evidence of depression, he would expect documented reasoning setting out why a diagnosis of a depressive illness was being discounted. So far as Dr Scott could ascertain the only psychosocial stressors recorded relate to cannabis

use. The fact remained that Mr Thomson merited further senior assessment. On the hypothesis that Mr Thomson had a mental illness, there is a good evidence base, which he considered beyond speculation, that there were treatments available that could have been of benefit to him. Outcomes from such treatments are often positive and lead to improved coping strategies for life stressors and reduce the risk of harm.

[129] He was asked about 24 hour AMP assessment in other parts of Scotland. He was unaware, but now accepted that the 2014 Royal College guidance, to which he had referred, had been withdrawn. However, in practice, many hospitals currently operate senior review within 24 hours. This would be, where ever possible, face to face and not by telephone. He, however, conceded that there are major resource implications. The Royal College recommendation, whatever its current status, was never mandatory, and he recognises there may be difficulty in implementing a 7 day consultancy service. He also agreed that the service with which he was most associated in Glasgow, operated with a centralised urban patient base and NHS Tayside was more rural. He also acknowledged that Glasgow had an emphasis on specialist nurse triage which freed up doctors for other tasks. This of course had its own resource implications recruiting, training and retaining specialist nurses in appropriate numbers. He accepted that other areas used different review systems such as the safety huddle and varying forms of consultant review including conference call links. There were dynamic national policy and strategic issues in play and it was not a simple case of comparing one area against another and arguing one system was better than another. The important thing was to secure early and ongoing review of patients at senior level.

[130] Dr Douglas Patience was an independent expert instructed on behalf of Dr Kao. He is a consultant psychiatrist but retired from full time practice in January 2017. He is experienced in providing expert reports and reviewing other clinician's cases. His full report was lodged in process and was available to the court. However, put short, he adopted his report and principally disagreed with Dr Scott's diagnosis that Mr Thomson was, over the relevant period, suffering from a significant mental illness. In his opinion Mr Thomson presented as suffering from a personality disorder. Dr Patience explained that he considered the clinical factors that must be examined sets the bar for concluding that a significant mental illness exists quite high. The threshold was not met in this case.

[131] On the question of whether a patient, who was allowed to discharge themselves against medical advice, should have follow up psychiatric care of some kind entirely depended upon whether or not the relevant clinician was clear that there was no sign of significant mental illness. In his experience it was quite a common occurrence for voluntary patients to be discharged against medical advice and follow up care would depend upon the circumstances of each individual patient. He considered the evidence of Nurse Drurie that on Thursday 8 January Mr Thomson was offered a referral to the community health team to provide intensive home treatment and support. Dr Patience accepted at that time the medical team must have considered that there was a need for mental health follow up.

[132] He, equally, had concluded that on the balance of probabilities the criteria for emergency detention under the Mental Health Act, when Mr Thomson was brought back to Carseview and seen by Dr Kao, were not met. He agreed with Dr Kao's

conclusion that, as Mr Thomson was not seeking re-admission to his voluntary status and was refusing to engage with her, the only option was to detain. He confirmed her conclusion that she would have been wrong to do so as the statutory tests were simply not established. There were no relevant symptoms nor was there evidence of impaired capacity to reason or take decisions. He had reviewed the GP records and accepted that there was a record of depressive symptoms but he saw nothing there that would provide the basis for a clinical diagnosis of a significant mental illness such as atypical depressive disorder. He, however, accepted that depression was a mental disorder and could indeed meet the first criteria of emergency detention. He, however, taking all the evidence available to him remained of the opinion that Dr Kao did not have the right to detain Mr Thomson.

[133] Dr Patience accepted that Dr Kao was quite inexperienced and that could raise a question as to whether or not she should have been assessing at all. She was presented with a complex scenario. Agitated depression, if Mr Thomson was so affected, is not common. The notes also reveal concerns about possible ADHD and PTSD from the death of a friend in unhappy circumstances. He also accepted that Mr Thomson threatening to harm his family, burn down a house and the like was concerning but it was still, not in his opinion, determinative of a mental disorder. Anger at family members or people like the police was commonplace. Dr Kao had, however, consulted a senior psychiatrist on call who had confirmed her assessment and agreed with her decisions.

[134] Dr Patience was asked to comment of the conclusion of the SCEAR that there was a false but building assumption that a proper assessment had been undertaken and that more was known about Mr Thomson than was actually the case. He accepted that was their conclusion but he saw no evidence of such assumptions in the actions of Dr Kao.

[135] He was examined in some detail on the diagnosis offered by Dr Scott. His conclusion was that Dr Scott's opinion was speculative. He could not, however entirely rule it out. In his view there were significant social stressors in the patient's life and that such adverse life events may have been responsible. Suicide is not restricted to those with significant mental health issues. Mr Thomson may have had a depressive illness or indeed some other serious mental health disorder but to make such a diagnosis there must be evidence of symptoms. He found no such symptoms in the GP records or in any of the Carseview in-patient records. He was clear that this was his opinion, even with the benefit of hindsight, and knowing the tragic outcome. He noted factors and stressors such as significant and persistent substance misuse, evidence of personality disorder with mood instability and self-harm. Mr Thomson had criminal justice problems and seemed to have increasingly low self-esteem. Dr Scott, in Dr Patience's opinion, did not give due weight to these factors. The behaviours recorded, including impulsive action without plans, irritability and anger arising from domestic disputes is more indicative of personality disorder rather than mental illness or disorder. A patient abusing alcohol or illicit drugs is not necessarily responding to any form of mental disorder.

[136] Mental health was really a laymen's concept of the medical issues that confront psychiatrists. The clinician's approach is to consider the patient presentation and try to discern whether the substance abuse preceded or followed from the behaviour and any other symptoms reported or observed. Dr Patience accepted, as a general proposition, that he could not exclude the possibility that Mr Thomson was suffering from mental illness, but on the balance of possibilities, he would not be confident to express that view and therefore could not. He did not have sufficient information as to the patient's history after he saw Dr Kao to his tragic suicide to say whether other interventions might have helped. Some patients respond to treatment; others do not.

[137] Dr Patience also assisted the court by setting out his experience of the differences of clinical practice that might be relevant between Tayside and his home ground of Glasgow. He explained that Glasgow used to be divided into four units, effectively covering the north, south, east and west districts of the City. They used to use the postcode type referral scheme as in Tayside but now they were rationalised into two centres with an emergency triage centre. An acute admission on a Friday night would be seen and assessed by a specialist psychiatric nurse. They have the power to escalate to a senior psychiatrist. In Glasgow, a patient admitted on a Friday night may not have consultant review until Monday, although there is greater access to middle grade doctors, who are likely to rank as senior psychiatrists (AMP). The systems are different but neither system would have guaranteed an assessment of a patient by a senior psychiatrist within 24 hours of admission at the weekend without other interventions. There were resource implications and each system has advantages and disadvantages.

Centralisation is generally a feature of large urban catchment areas and different criteria must be considered when looking at rural and multi-district needs.

SUBMISSIONS

[138] The submissions in this case were in writing and these are lodged in process. The representatives spoke briefly to their written submissions. The submissions, especially those for the various medical personnel represented, for obvious reasons tend to cover the same ground, but from slightly different perspectives. The legal test submissions are similarly overlapping. I will, for the sake of the narrative, precis both the legal test and general submissions but it must be understood that I have considered the full submissions and all case-law or other authorities cited to me whether I expressly mention any element or not in my summary.

[139] The legal submissions can be summed up, collectively, as follows. It was submitted that, in considering whether it is appropriate to determine that there were "any reasonable precautions … whereby the death might have been avoided", the court has to have careful regard to the language employed in the statutory provision. The court may only make such a finding where the precaution would have carried a realistic prospect, or a real or lively possibility of avoiding the death (see IHB Carmichael, "Sudden Deaths and Fatal Accident Inquiries", 3rd edition, 2005, p174, para 5-75).

[140] The exercise of considering whether reasonable precautions were available which might have prevented the death differs from the resolution of an action of

damages for negligence. In *Black* v *Scott Lithgow Ltd* 1990 SLT 612, the Lord President (Hope) said at p 615:

> "There is no power in [section 6(1)] to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident [or death] … This is in contrast to … the 1895 Act which gave power to the jury to set out in its verdict the person or persons, if any, to whose fault or negligence the accident [or death] was attributable. It is plain that the function of the Sheriff at a Fatal Accident Inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is concluded with a view only to setting out in his determination the circumstances to which the sub-section refers, insofar as this can be done to his satisfaction. He has before him no record or other written pleadings; there is no claim of damages and there are no grounds of fault upon which his decision is required."

[141] I was also referred to the words of Sheriff Principal Mowat in the Lockerbie plane bombing Inquiry, Sheriff Principal Mowat said:

> "It was inevitable that some of the submissions in relation to subparagraph (c) … proposed findings which would, in my view, have constituted a determination that certain persons … had been negligent in some respect. I have therefore had to consider how far it is proper for the presiding Sheriff to make such findings in a fatal accident inquiry. It is generally recognised that such an inquiry is not the proper forum for the determination of questions of civil or criminal liability. This was reaffirmed in the case of **Black -v- Scott Lithgow Ltd**. The reasons for such a decision are clear. In a criminal case, or in a civil action based on delict, the accused or the defender is given full notice of the allegations made against him either in the form of an indictment or by the written pleadings. In the vast majority of cases he is entitled to hear all the evidence against him before putting forward his defence. In a fatal accident inquiry no such notice is given and the bulk of the evidence … is led by the Crown with a view to eliciting the facts of the situation surrounding the death … It is true that one of the purposes of the inquiry is to ascertain the facts in such a way as to enable the relatives of the deceased to consider whether they provide the basis for a civil action but it is not for the presiding Sheriff to make a judgment on that question in his determination … It is clear that in some cases a statement that a reasonable precaution might have prevented the death carries with it the implication that a certain person … owed a duty to take that precaution and so was negligent. The same situation applies even more clearly to a finding under paragraph (d). It is for that reason, it seems to me, that Section 6(5) of the Act provides that the

> Sheriff's determination in a fatal accident inquiry may not be founded on in any other judicial proceedings. In that situation I have come to the view that any finding under Section 6(1)(c) should avoid, so far as possible, any connotation of negligence. Accordingly it should not contain any indication as to whether any person was under a duty either at common law or under statute, to take the precaution identified in the finding."

[142] It was suggested that the essential purposes of a fatal accident inquiry included the enlightenment of those legitimately interested in the death, such as relatives, as to the cause of death, and the enlightenment of the public at large whether any reasonable steps could or should have been taken whereby the death might have been avoided so that lessons may be learned or practices improved. The court has to be cautious of drawing sweeping conclusions from evidence which may be incomplete. The judicial exercise is fact-finding, not fault-finding.

[143] It was conceded that there has been more doubt expressed concerning the question whether or to what extent foreseeability should be a factor in the court's determination whether there were reasonable precautions which might have prevented the death. Many sheriffs appear to have followed the views expressed by Sheriff Reith in the *Sharman Weir FAI 23/01/03* as could be seen in Sheriff IHL Miller's determination in the *Margaret Gill FAI 30/09/09*, who said :

> "in my opinion a Fatal Accident Inquiry is very much an exercise in applying the wisdom of hindsight. It is for the Sheriff to identify the reasonable precautions, if any, whereby the death might have been avoided. A Sheriff is required to proceed on the basis of the evidence adduced without regard to any question of the state of knowledge at the time of the death. The statutory provisions are concerned with the existence of reasonable precautions at the time of death and are not concerned with where they could or should have been recognised. They do not relate to the question of foreseeability of risk at the time of death which would be a concept relevant to the context of our fault-finding exercise, which this is not. The statutory provisions are widely drawn and are intended to

> permit retrospective consideration of the matters with the benefit of hindsight and on the basis of the information and evidence available at the time of the Inquiry. There is no question of the reasonableness of any precaution depending upon the foreseeability of risk. In my opinion, the reference to reasonableness relates to the question of availability and suitability or practicality of the precautions concerned….In my opinion, the purpose of a Fatal Accident Inquiry is to look back, as at the date of the inquiry, to determine what can now be seen as no reasonable precautions, if any, whereby the death might have been avoided, and any other facts which are relevant to the circumstances of the death…The purpose of any conclusions drawn is to assist those legitimately interested in their circumstances of the death to look to the future. They, armed with the benefit of hindsight, the evidence led at the Inquiry, and the Determination of the Inquiry, may be persuaded to take steps to prevent any recurrence of such a death in the future."

[144] In addition there is helpful guidance on the interpretation of the test set out in Sheriff Kearney's determination of 17 January 1986, in the death of James McAlpine:

> "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 (section 6(1)(c)) 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. The phrase 'might have been avoided' is a wide one which has not, so far as I am aware, been made the subject of judicial interpretation. It means less than 'would, on the probabilities have been avoided' and rather directs one's mind in the direction of the lively possibilities."

[145] Further guidance can be found in Sheriff Holligan's determination arising out of the death of John Kelly of 3 September 2014 where he states:

> "Causation does have a role. In particular the provisions of section 6(1)(c) and (d) seem to me to proceed on the basis there will be, in most cases, a process or event which falls to be examined in order to see what led to an accident. Having established such process or event, it is then possible to see what steps might have been taken to avoid the outcome or what defects there were. In my opinion, the provisions of Section 6(1)(c) and (d) fall to be applied objectively and with the benefit of hindsight. Section 6(1)(e) gives some support to this

> interpretation. There might be circumstances that might be relevant to the death but might not have been established to have a causal link".

[146] I was, fairly, presented with a somewhat different approach, perhaps particular to medical Fatal Accident Inquiries taken by Sheriff Stephen, as she then was, in the *Lynsey Miles FAI 27/02/04* and by Sheriff Braid in the *Marion Bellfield Inquiry 28/04/11*. The latter determination raised questions whether the death might have been avoided by different exercises of clinical judgment. The sheriff declined to characterise these as precautions which might have prevented the death, on the view that to do so would sit uneasily with the natural meaning and use of the word precaution. In *Lynsey Miles* (2004), at page 23, Sheriff Stephen noted that:

> "The key word must be 'reasonable' - in judging what is reasonable and particularly whether the actings of medical professionals or indeed any other professional achieves a certain standard of care must be taken by lawyers before we embark on a critique of the treatment carried out by doctors. As lawyers we are no more than tutored laymen who can apply normal analytical skills and common sense. Whereas we may question and indeed criticise medical professionals, lawyers cannot be the arbiters of what is reasonable based upon our examination alone. There is always a risk in Inquiries such as this that emotive issues arise, perfectly understandably."

Her Ladyship went on to state, at page 25:

> "Again lawyers should be slow to comment upon medical practice, far less criticise medical practice, unless there is clear appropriate testimony which challenges the treatment a patient receives. The view I take of this matter is that for precautions to be reasonable they have to be reasonable given the whole circumstances surrounding the patient and treatment of the patient with particular reference to the treating physician and if appropriate his junior medical staff. Before I can find a precaution to be reasonable in the context of a medical issue, there must either be an admission by the treating doctor that he failed to take a precaution or course of action which he clearly ought to have taken or took the course of action which, in the exercise of ordinary care, ought not to have been taken. Failing that, there would require to be established by independent evidence, the manner in which the doctor in a particular area of

> expertise, and with the particular experience, ought to have acted. This clearly requires there to be a standard by which the actings of doctors are judged. As I have said it is wrong for lawyers to be quick to criticise doctors without such justification and reflecting the jurisprudence surrounding medical negligence issues it must avoid the situation whereby medical professionals become hamstrung in their treatment of patients because of concern that their view and their clinical judgement may be called into question by a colleague who takes a differing view."

[147] Sheriff Braid also considered what a reasonable precaution might involve in *Marion Bellfield*:

> "…that is not to say that every single thing which might have been done and which might have avoided the death should, if it was a reasonable step to have taken, make its way into a finding under section 6(1)(c). Not only would that not be helpful in avoiding future deaths, but it would involve placing unjustifiably wide construction on the word 'precaution'. Whatever that word means, it must place a limit on the sort of acts or events which should be included in a section 6(1)(c) finding. The natural meaning of 'precaution' is an action or measure taken beforehand against a possible danger or risk… since one purpose of a fatal accident inquiry is to inform those with an interest of what actions should be taken in future, a finding under section 6(1)(c) must carry with it the implication that the precaution ought, with the benefit of hindsight, to have been taken in the case which resulted in death, albeit without the necessary implication that the failure to take it was negligent."

[148] The same issue has now been the subject of more recent judicial determination in the Outer House of the Court of Session, in an application for judicial review of a sheriff's determination, in the case of *Sutherland* v *Lord Advocate* [2017] CSOH 32, which was heard by Lord Armstrong in December 2016. Lord Armstrong opined *inter alia* that:

> "in determining whether the death might have been avoided by a reasonable precaution, the appropriate test has been described as that of a lively possibility. Such a description is entirely apt and is consistent with the language of section 6(1)(c). According the provision its ordinary meaning, certainty or probability are not relevant considerations in determining whether the death might have been avoided. Further, given the nature of the process as I have described it, in considering whether a precaution is reasonable, foreseeability has no part to play. That question falls to be determined with the benefit of hindsight, and a

> finding that the death might have been avoided by the application of a reasonable precaution carries no implication that the failure to take the precaution was negligent or unreasonable. Whether or not a precaution was reasonable does not depend on foreseeability of risk, or whether at the time the precaution could or should have been recognised."

Lord Armstrong went on to opine further that:

> "it was submitted that it would be possible to envisage a situation, involving the exercise of clinical judgement, whereby a doctor was presented with two or more options and could not know which was in the patient's best interests. I accept that in such a situation where the optimal course was not taken, it would not be appropriate to determine that the selection of another of the available options would have been a reasonable precaution. I accept that to do so would distort the ordinary meaning of 'reasonable precaution' and would in any event be of no assistance for the future".

[149] In the context of a medical FAI, the court should therefore avoid determining that a different decision taken in an exercise of clinical judgment would be a "precaution" within the meaning of the legislation.

[150] The submissions on the facts were as follows. The Procurator Fiscal, for the Crown, accepted that there was no dispute on the cause of death all as per the Joint Minute. He, however, for the Crown invited me to make findings under section 6(1)(c) and determine such a precaution to have been for Mr Thomson to have had a full mental state examination and assessment carried out by an Approved Medical Practitioner, either between 8 and 10 January, when he was in Carseview on a voluntary basis or as a result of his being made the subject of an emergency detention under section 36 of the Mental Health (Care and Treatment)(Scotland) Act 2003 ("MHA") following either of the occasions on 10 January when he was seen firstly by Dr Feile and then later on by Dr Kao. In addition, there was evidence from Dr Scott and Dr Doig that

the nurses' holding power could also have been used to physically prevent Mr Thomson leaving the ward and to facilitate such an examination on 10 January, when he was insistent he wished to leave the ward against medical advice.

[151] Similarly, on 23 January when he saw Mr Thomson, Dr Gunput should have considered further assessment, since if the symptoms and history were not as a result of mental illness, there was no confirmation as to what was causing them.

[152] Equally in terms of Section 6(1)(d) there seemed to have been a systemic failure which resulted in Mr Thomson not being seen by a Consultant or other Approved Medical Practitioner between 8 and 10 January, following upon his agreement with Dr David to stay in Carseview on a voluntary basis. The reason for this was that as a patient of Dr MacMillan's practice, he would ordinarily have been admitted to Ward 1, but since it was full, he was admitted instead to Ward 2. At the time of his admission due to what was described by him as a "miscommunication" the consultant for Ward 1, Dr Thiyagarajan, was not alerted to Mr Thomson's admission and advised that the first he was aware Mr Thomson had even been on Ward 2 was when he signed Mr Thomson's discharge letter (p349), round about 28 January, the day after Mr Thomson's death. Having not been told about Mr Thomson being in Ward 2, he had no reason to seek him out to assess him, which he could and would have done on Friday 9 January, when he did his ward round for Ward 1. The Inquiry didn't hear from any Ward 2 consultant but, on the basis there was no assessment done, that consultant presumably didn't see Mr Thomson either. Steps were later taken to address this *lacuna* but these were obviously not in place between 8 and 10 January; if they had been the full

assessment which Dr David had in mind for Mr Thomson when she persuaded him to stay on a voluntary basis on 8 January would have taken place and the purpose of that admission would not have been frustrated.

[153] So far as the section 6(1)(c) finding is concerned it was the clear purpose of the initial voluntary admission for Mr Thomson to be seen by an AMP or similar. Dr David did not purport to do anything other than seek to facilitate that. Dr Thiyagarajan identified that such an assessment would have resulted in a management plan for Mr Thomson's care and Dr Scott felt such an assessment would have anticipated a DAMA, which would have informed and assisted Dr Feile. The SCEAR (p50) agreed with this being likely put in place in any such assessment. With reference to whether this "might" have avoided or prevented Mr Thomson's death, the court need look no further than whether it would give rise to a lively possibility that it would do so and in the Crown's submission that it would have.

[154] Dr Scott had no doubt whatsoever that Mr Thomson suffered from mental disorder and if his symptoms were not as a result of that he was concerned that no alternative explanation for them was identified. Even if a full assessment by an AMP concluded he did not actually have a mental disorder, the symptoms indicated the likelihood that he did, *ergo* the initial requirement for section 36 was met. Dr Doig was of the view there were features suggestive of mental illness and, perhaps, psychosis worthy of further assessment. Dr Patience also conceded the possibility, if no more than that, that Mr Thomson's suicidal ideation was caused by treatable mental illness, which such an assessment might have confirmed. Such an assessment should have been

carried out somewhere in this whole sequence of events. Had any of Drs Feile, Kao or Gunput detained Mr Thomson under section 36, a full assessment of the nature contemplated by Drs Thiyagarajan and Scott would then have taken place and a management plan put in place to address Mr Thomson's mental health issues by treatment.

[155] Dr Scott stated that in his extensive experience in general depressive illness, even severe depressive illness, is "eminently treatable in the sense that the vast majority of patients would experience, in the general case, …. improvement and a significant portion would achieve….remission from illness". This view about a possibly successful outcome potential for treatment was supported by Dr Patience, certainly insofar as addressing suicidal ideation. The Crown argued that Mr Thomson would fall into this category of "vast majority". The fact that he would and treatment would be expected to have this effect must raise the "lively possibility" that an AMP assessment and all that would flow from it, whether by providing for a contingency in the event of Mr Thomson seeking to take DAMA, management and treatment "might" have led to a different outcome and went further than mere speculation.

[156] This, he argued, tied in with the question of a section 36 detention. Such action would have triggered review not only by a consultant or equivalent but also a Mental Health Officer. Dr Scott and, indeed, the SCEAR report reviewing Dr Feile's and Dr Kao's assessments, considered that detention criteria were met. The inquiry also heard from Dr Doig, who chaired the SCEAR and was one of the consultants who were of the view that, contrary to what Drs Feile and Kao concluded, the criteria for a section

36 detention would have been met. The Crown submitted that regard should be had to Dr Scott's evidence that Dr Gunput should have facilitated a far more thorough assessment. Accordingly, for all of these reasons, the court could safely make this finding under section 6(1)(c).

[157] So far as the section 6(1)(d) finding is concerned it was submitted that the clear purpose of the initial voluntary admission was for Mr Thomson to be seen by an AMP or similar. Dr David did not purport to do anything other than seek to facilitate that. There was evidence that his failure to be seen was identified as having occurred due to a miscommunication issue, which could not happen now since the system has changed. Now, the Ward 1 consultant would be notified by email about a Ward 1 patient being in Ward 2 and in the meantime, if I understood the evidence correctly, he would be attended to by the Ward 2 consultant. With hindsight, the "old" system seems to be one ripe for just such an issue as arose with Mr Thomson's care to occur and it might have been simpler to simply allocate patients to available beds in available wards, to be seen by the consultant for that ward. Indeed, Piers McGregor advised this was now the case.

[158] The Crown accepted that NHS Tayside took steps to address the admission error which occurred in this case, perhaps even in consequence of this case and had no reason to doubt that they will continue to seek improvement in this and all other aspects of patient care. The LAER and SCEAR previously referred to both identified systemic failures. The LAER identified a different outcome might have resulted, although Mr McGregor said this was not definite and the SCEAR identified "Required Actions" arising out of the circumstances of Mr Thomson's death. Of these, some related to

"governance" but it was submitted that Required Actions 1, 2, 3, 5(a) & (b), 6 and 8 reflect concerns arising from the circumstances of this fatality and led to a "full and unconditional apology for the failings in Dale's care" which "fell below the standard (NHS Tayside) would expect" being tendered to his family by the Medical Director of NHS Tayside. Dr Doig and Ms Linda Graham also, very fairly, conceded systemic failure.

[159] It was submitted therefore that the system in place broke down, resulting in Mr Thomson not being fully assessed, as previously referred to and which was of considerable significance. In these circumstances the Crown sought the findings indicated. The Crown, however, made it clear that it did not seek as such to criticise decisions made by individual doctors. The Crown accepted that these were very difficult circumstances and required very difficult evaluation of evidence and symptoms, taking into account many nuances of presentation of symptoms. The Crown did not suggest that any of the doctors who dealt with Mr Thomson were doing anything other than trying their very best to make the best decisions for him. On 2 such occasions, when he was seen by Dr Feile and Dr Kao he was truculent and unco-cooperative.

[160] Nonetheless, it was suggested that with the benefit of hindsight some decisions might have been made differently and there might have been a different outcome. The most crucial of these was the missed opportunity between 8 and 10 January for a full mental health assessment to be carried out by an AMP, which seems to have left Mr Thomson disillusioned about just what help he could get from Carseview, although

that view had softened somewhat by the time he saw Dr Gunput on 23 January, in that Dr Gunput said he engaged with him on that occasion, albeit that the consultation ended disharmoniously.

[161] The purely factual result of Mr Thomson's disenchantment with Carseview was that when he had the opportunity with Drs Feile and Kao to confirm his wish to remain there, he did not take it, indeed seeking a DAMA from Dr Feile. In such circumstances the Crown did not seek to minimise the difficulties which those doctors must have faced in trying to carry out a meaningful assessment and the undoubted advantage they had over anyone else carrying out a "desktop" review of Mr Thomson's care. However, both from Dr Scott and NHS Tayside's own review**s** there is clear evidence that certain things could and should have been done differently and, furthermore, that there might have been a different outcome.

[162] Mr Fitzpatrick, counsel for the NHS, submitted that before the court can find that there were any reasonable precautions that might have prevented Mr Thomson's death, or that there were any systems' failures which *did* contribute to the death, the court first has to address the questions whether, at the material times (a) he was suffering from a mental illness (b) it was treatable (c) treatment would have alleviated the illness and prevented his suicide, and (d) his suicide was driven by untreated mental illness.

[163] He argued that unlike the question of whether there were any reasonable precautions that might have avoided the death (for which a lively possibility will suffice), these *a priori* questions fall to be determined by the court on the balance of probabilities. Unless the court can first be satisfied that Mr Thomson probably was

mentally ill, and that he probably did not commit suicide for some unrelated reason or reasons, it is not possible to say that there was a lively possibility that different decisions or actions by clinicians might have prevented it. What the court should not do is pile one layer of possibility upon another. The court should not embark upon an exercise of looking for reasonable precautions which might have prevented the death (or for systems failures which contributed to the death) based only upon a *possibility* that Mr Thomson's death at his own hand by hanging *might* have been driven by a mental illness which *might* have been treatable. The court should first determine whether it has been established on the evidence as a matter of probability that these conditions were met.

[164] The court has to decide if facts have been established on the basis of credible and reliable evidence, and whether it can draw reasonable inferences from those facts. The standard of proof as regards the circumstances surrounding the death is the balance of probabilities. The court cannot hold facts established on the basis of speculation. Counsel accepted that there was opinion evidence before the court from Dr Scott which, if accepted in its entirety, could justify the court in reaching the conclusion on the balance of probabilities that all four of the above questions set out above can be answered affirmatively. Dr Scott's hypothesis is that Mr Thomson was suffering at least from depression, and possibly a more serious underlying mental illness, such as agitated depression, or schizophrenia. The answers he ventured in his reports to the questions put to him for his reports by the Crown under reference to the Fatal Accidents

legislation, and which he amplified in his evidence, are all expressly founded upon his hypothesis.

[165] Counsel submitted that a major problem for Dr Scott's hypothesis is that it was not shared by Dr Patience, who viewed these matters differently, and who considered that Dr Scott had engaged upon a speculative exercise. Dr Patience considered that Mr Thomson may have had a personality disorder, associated with his early and later adverse life events, his history and alcohol misuse, his ongoing drug misuse, his impulsivity and irritability, and his history of self-harming behaviours, such as the picking fights seemingly inviting injury, as described in evidence by Mr Thomson's former partner Jodie McMulkin. It is also known from the evidence that he had expressed regrets about family relationships; that he felt he was not a good father to his child; and that he had an appointment with the criminal justice system, concerning assessment for a tag in connection with a restriction of liberty order, scheduled for 28 January, the day after he took his own life. One or more of these factors may have driven his suicide, rather than mental illness. It might be speculative to associate these matters, or any of them, with his decision to end his own life; but, on Dr Patience's approach, it would be no more speculative than Dr Scott's view that his suicide was driven by mental illness instead. Counsel also adopted the submissions on these issues for Drs Kao, Howson and Gunput.

[166] The court should conclude that the reason or reasons for which Mr Thomson committed suicide remain unknown and, indeed, cannot now be known. There is an insufficient basis in evidence to conclude that he committed suicide by reason of mental

illness. Counsel submitted that if the court agreed with the foregoing, it would be illogical, unnecessary, and superfluous to go on to consider whether in his clinical management there were any precautions which might have prevented his death, or that there were any systems failures which did contribute to his death.

[167] However, as findings by way of determination under this head have been proposed both on behalf of the Crown by the procurator fiscal, and by Mr Devine on behalf of the family, counsel argued that all of their proposed findings would offend against Lord Armstrong's guidance in the *Fraser Sutherland* case, *supra,* and should not be entertained by the court, for that reason. The submissions made on behalf of the individual clinicians in the case were again adopted. The court must be satisfied that any defective system probably *did* contribute to the death, and not merely that it might have done so. The same considerations apply as in the foregoing paragraph.

[168] Counsel argued that the evidence yielded no rational basis for concluding that any defective system probably *did* contribute to Mr Thomson's death. Findings by the court concerning any defects in systems of working are not therefore going to belong under this head (although the court could make any such findings under section 6(i)(e) instead, if so minded). The Board has acknowledged that there were systems failures around Mr Thomson's management, which they believe they have addressed (under reference to the evidence of Piers McGregor, Dr Doig, and Linda Graham). But unless Dr Scott's hypothesis is to be accepted, it cannot be said that any of them (or any of those now postulated by the procurator fiscal or by Mr Devine) did contribute to the death.

[169] Ms Donald, agent for Dr Feile, submitted that the criticism levelled at her client with regard to the failure to detain Mr Thomson when he sought discharge was unjustified. All the clinicians who saw Mr Thomson over the period of 10–23 January on three occasions formed the view that he was not suffering from a mental disorder which would allow him to be legally detained. Each of the clinicians formed their own views based on the information to hand and the presentation in front of them. Importantly, Dr Kao and Dr Gunput were clear that they made their own assessment of the patient.

[170] Dr Feile was a locum psychiatrist (a Locum Appointment for Service or LAS) with NHS Tayside. He graduated in 2010, with three years of foundation training followed by specific training in psychiatry. All of his experience and training was with NHS Tayside. At that time of his examination of Mr Thomson he had one further examination to sit.

[171] Dr Feile had explained that he assessed Mr Thomson on the day he saw him, as best he could and without the benefit of detailed further information. He was aware that Mr Thomson had not seen a consultant yet but other than that had little information on why the patient wanted to leave when he was summoned from other duties to attend at Carseview as duty doctor. He thought he had the triage information and Dr David's assessment and he was clear he spoke to the nursing staff on duty to establish the history and to hear their views. There was also the disturbing telephone call to the ward by Mr Thomson's sister, which Dr Feile recalled was before he saw Mr Thomson, but which a nursing colleague said was received after Dr Feile had seen and assessed

Mr Thomson. In Ms Donald's submission the timing of that call is not something which required to be fixed in terms of the evidence.

[172] Dr Feile was clear in his evidence that detention under the Mental Health Act was the primary purpose for his call out to see Mr Thomson. The nurses did not have to use their two hour holding powers because, as he understood matters, the patient was willing to wait to see him. He was met with a patient who was not prepared to be assessed, who would not engage with him and who wanted to depart the Centre. He declined to be formally assessed by Dr Feile. In Dr Feile's clinical judgement Mr Thomson showed no signs of psychosis, he felt he demonstrated insight and that his judgement was not impaired. In short Dr Feile took the view that Mr Thomson was not suffering from the mental illness he required to suffer from to allow Dr Feile to detain him in terms of the Mental Health Act. In giving his evidence on that point, Dr Feile was clear that he did not consider Mr Thomson to be depressed and did not think he would commit suicide.

[173] Dr Feile plainly wished he had detained Mr Thomson but that of course was with the benefit of hindsight. He accepted that on reflection he probably did not know enough about the patient and he could, perhaps, have tried to learn more before taking his decision. He could have called a more senior colleague but at the time, he took the view that the essential component of the mental disorder was absent and senior review was not called for.

[174] Dr Feile only had that one interaction with Mr Thomson. After he discharged himself against medical advice, Mr Thomson had several other opportunities for

medical intervention none of which resulted in any action. Dr Feile met with his educational supervisor (as part of the SCEAR follow up) so that his supervisor might be clear that Dr Feile was not lacking sufficient knowledge and skills in the application of the Mental Health Act. There appeared to be no further training on that required and his educational supervisor was satisfied that Dr Feile was not lacking.

[175] With regard to his decision not to detain on 10 January, Dr Feile felt that at the time Mr Thomson did not meet the criteria for detention. He did not agree that he had erred at the time although he very fairly accepted in evidence that with hindsight given Mr Thomson would not engage he might have assessed him differently.

[176] Counsel reminded me that none of the nursing staff (and they all appeared to be experienced nursing staff) who gave evidence disagreed with the approaches taken by any of the medical staff at Carseview. Had the nurses disagreed or had concerns they were able to raise those concerns and if necessary ask for a consultant review.

[177] She addressed the submissions of the other representatives. Those submissions made on behalf of the individual clinicians were adopted. She touched on the critical comparison of the two expert witnesses Dr Scott and Dr Patience. Dr Scott has not worked full time as a consultant psychiatrist since 2012 and in particular has not undertaken out of hours work since then. He had not previously given evidence in court in either an Inquiry or in respect of a claim. Of note, Dr Scott was not prepared to move from the conclusions contained in his report when asked to do so based on evidence given before the Inquiry. He had prepared his report based on the medical records (including the GP records which were not available to the clinicians who saw

Mr Thomson) and he accepted that he used all of the records to form his view – a view which was formed knowing the final outcome and working backwards.

[178] The clinicians involved in assessing Mr Thomson did not have those full records, and could not have had them. Dr Scott had made assumptions in writing his report – and he seemed to accept that anything which he had assumed wrongly would cause his report to be wrong. On occasion he indicated that if information was not written in the records then it was not available, although he did accept that doctors cannot take the time to write everything in the records. Dr Scott's view was that Mr Thomson had a depressive illness and that there was no documented evidence in the records to contradict that. Dr Scott's view was that detaining Mr Thomson under the Mental Health Act would have been a reasonable precaution which might have prevented death in light of all the evidence. He did not see the patient on any of the four times he was seen by clinicians whilst Mr Thomson was in hospital – he was basing his view on the papers alone and knowing the outcome. Dr Scott, paradoxically, considered the Carseview records to have been good records.

[179] Dr Patience was an experienced and well known expert witness. His view was that Dr Scott's opinion that Mr Thomson suffered from a depressive illness was speculative; he commented on the dearth of depressive symptoms recorded in the GP records. He accepted that Dr Scott's observations might reasonably be included in an analysis testing for a differential diagnosis. Dr Patience conceded points put to him in cross examination. He was not bound by his written report and he accepted that he was disadvantaged in not having seen Mr Thomson. Dr Patience gave evidence to the effect

that the threats Mr Thomson was said to have made, and his unruly behaviour in Carseview on 10 December, were not necessarily attributable to a mental disorder.

[180] Ms Donald challenged the Crown submission as it does not take Dr Patience's evidence into consideration at all and has therefore failed to balance the two. Indeed she highlighted the reference to Dr Scott's evidence that in patients suffering from general depressive illness that is, "eminently treatable……the vast majority would experience…….improvement and a significant portion would achieve …..remission from illness"; the suggestion being that Mr Thomson fell into this category of "vast majority". She argued that the Crown assertion from that quotation: "the fact that he would and treatment would be expected to have this effect raises, surely, the "lively possibility" that an AMP assessment……"might" have led to a different outcome and goes further than mere speculation." Was just that, an exercise in speculation? She, however, reminded me that the Crown very fairly sets out that it does not wish to criticise decisions made by individual doctors.

[181] She turned to the submissions for the family. In general she pointed out that many of the criticisms levelled are imprecise and do not address how many of them "might" have avoided the death of Mr Thomson; for example the suggested finding that there was a failure to provide a timely discharge letter? This appears to be linked to an alleged systems defect which contributed to the death of Mr Thomson in that there was no system in place to allow communication from Carseview to Mr Thomson's GP when he left in-patient care abruptly against medical advice. There is no explanation as to what would follow from such communication and how this would have affected

Mr Thomson's subsequent actions? Mr Devine is unclear with his proposed findings, listing most of them twice when considering section 6(1)(d).

[182] She submitted that although much is made of the SCEAR findings, those findings were reached without further discussion with clinicians involved and without the patient in front of them. Those involved in the SCEAR report did not have the benefit of hearing all the evidence that was before the Inquiry. The court should consider all the evidence and reach its conclusions.

[183] Mrs Bowen, the agent for Dr Kao, submitted that there had been insufficient evidence led to support a finding that a reasonable precaution by Dr Kao would have been to admit Mr Thomson to hospital or utilise an emergency detention certificate. She pointed out that Dr Kao was a junior doctor in training, she carried out a careful assessment on the information that she had available to her, taking into account the patient's presentation, having been brought to Carseview in police custody. In the proper exercise of her clinical judgment, she concluded that Mr Thomson did not meet the criteria for an emergency detention certificate. That was a reasonable conclusion on the basis of her assessment that it was not likely that Mr Thomson had a mental disorder at the time and he retained capacity to make decisions. She, however, did not act alone: she sought guidance from her senior colleague on her assessment, as she was required to do. The senior, Dr Howson, agreed a management plan to discharge Mr Thomson with advice to contact his GP or NHS should his condition deteriorate. Mr Thomson did return to his GP two weeks later and was referred back to Carseview. He did not see Dr Kao then.

[184] She argued that the evidence of Dr Patience should be preferred to the evidence of Dr Scott and the conclusions of the SCEAR. The SCEAR conclusions are based on incorrect assumptions and additional information that was not available to Dr Kao. Comparatively Dr Patience specifically assessed the actions of Dr Kao taking into account her experience, the information she had available to her and her evidence to the court. In Mrs Bowen's submission his report and his evidence to the court support the conclusion that it would not have been a reasonable precaution for Dr Kao to admit or detain Mr Thomson in hospital at the time of her assessment.

[185] So far as the question of reasonable precautions and the real or lively possibility that the death might have been avoided, Mrs Bowen submitted that it was relevant that Mr Thomson did not take his life for another two weeks after the assessment by Dr Kao. There is little known about what happened during that time. There is even less known about what would have happened had Dr Kao admitted him. There is a lack of evidence before the court to satisfy that test and such a conclusion would be speculative.

[186] Her secondary submissions, if the court ruled against her on causation, were to the effect that, following the dicta of Lord Armstrong, a reasonable precaution carries no implication that the failure to take the precaution was negligent or unreasonable. She respectfully submitted that any finding of a reasonable precaution by the court need not be critical of Dr Kao and can be framed in such a way as to reflect that, for the reasons Mrs Bowen had already advanced. Equally, there had been no criticisms of Dr Kao's personal system of working. There were no issues with Dr Kao's personal system of working. She was medically trained, suitably experienced and appropriately

supervised. She is a conscientious doctor. She applied her training and clinical judgement. She liaised with her senior colleague. They came to a decision together.

[187] Mrs Bowen commented upon the submissions of others. She accepted and adopted what was said for the other doctors and nurses represented at the Inquiry. She, however, commented on the Crown submissions by agreeing with the Procurator Fiscal's observation that "these were very difficult circumstances and requiring very difficult evaluation of evidence and symptoms, requiring to take into account many "nuances" of presentation of symptoms" and reiterated the reference to the comments of Lord Armstrong narrated above. In her submission the Procurator Fiscal's stance was quite consistent with the scenario that confronted Dr Kao: a situation involving the exercise of clinical judgement where there were more than two options and it was not possible to know which was in the patient's best interests, even now with the benefit of hindsight. Mr Thomson was not asking for re-admission and detention against his will could have made him resentful and resistant. Dr Doig, an experienced consultant made it clear in his evidence that this was a matter of clinical judgement and different conclusions may be reached. As Lord Armstrong has stated "in such a situation where the optimal course was not taken, it would not be appropriate to determine that the selection of another of the available options would have been a reasonable precaution".

[188] Finally, Mrs Bowen addressed the submissions for the family. She was critical of the general lack of clarity in the submissions. It was, for example, not clear which of the doctors to whom the proposed reasonable precautions were directed. She highlighted a significant issue of factual accuracy. It was suggested in the family

submissions that Dr Patience had accepted that Mr Thomson's suicide was driven by a mental illness when in fact, he had put it no higher than that it was possible that his suicide was driven by mental illness, however he would not be confident to say one way or the other, even on the balance of probabilities. She also challenged the assertion that Mr Thomson discharged himself on the Saturday solely due to not being able to see a doctor until Monday as sheer speculation and there is insufficient evidence to support that conclusion.

[189] Equally she rejected the contention that the SCEAR was undoubtedly in a better position to ascertain and conclude the likely diagnosis and submitted that throughout the Inquiry medical witnesses had been clear a face to face assessment of the patient is fundamental to a diagnosis. Those undertaking the SCEAR did not see the patient. Dr Kao did see him and evaluated the various elements of his presentation relevant to a mental state examination. Mrs Bowen invited me to make no findings under any head.

[190] Ms Rafferty, agent for Drs Gunput and Howson, lodged submissions that were very much in line with those of the other clinicians; in essence there were no reasonable precautions that might have been taken by either of her clients, whereby the tragic death of Mr Thomson might have been avoided, or any defects in their systemic approach. She argued that considering the whole circumstances surrounding Mr Thomson's death, it remains uncertain whether he was in fact suffering from a mental illness. Extensive evidence was heard to the effect that those who commit suicide do not always have a mental illness. It is common for individuals to commit

suicide due to adverse life events. It is clear that Mr Thomson was experiencing a number of life stressors both in his personal life and having regard to external factors such as ongoing court cases.

[191] In addition, Mr Thomson's long seated and persistent drug use was another risk factor for suicide and a likely contributing factor to his emotional difficulties. The court should note that four doctors and a number of nurses were involved in the assessment of Mr Thomson at various points in January 2015, none of whom came to the conclusive conclusion that Mr Thomson was suffering from a mental illness. The SCEAR and the independent expert Dr Patience could not reach such a conclusion: the highest assessment was that it was possible. To set against all this Dr Scott was confident that he could say with certainty that Mr Thomson was suffering from a mental illness. In her submission the evidence of Dr Patience should be preferred. He provided a more measured approach and concluded that while it was possible Mr Thomson was suffering from depression he could not say with any certainty and not to meet the balance of probability test. Significant weight should be placed on the evidence of those who assessed Mr Thomson as the treating physicians. She reiterated the importance of viewing the patient face to face cannot be underestimated. A number of signs and symptoms can be gathered from seeing the patient whether they engage with the assessment or not. Suicidal ideation is a dynamic symptom which can change rapidly and is hard to predict. It would be neither feasible nor practicable to admit as an in-patient every person who presented with suicidal ideation, but equally it could cause the patient detriment and be of limited benefit to them. Both doctors

used their extensive psychiatric experience when providing an input into Mr Thomson's care. They exercised their clinical judgement based on the circumstances of the case. Neither doctor concluded that Mr Thomson was suffering from a mental illness and steps were taken to address Mr Thomson's social stressors. There was no reasonable precaution which either ought to have taken, even with the benefit of hindsight.

[192] The Inquiry heard divergent evidence as to whether Mr Thomson should have been admitted or treated differently by the practitioners in this case. There was a range of options available to Dr Howson and Dr Gunput and they applied their experience and clinical judgment to choose a course of action. They could, of course, have decided to follow a different course of action but that cannot be translated into that course being a reasonable precaution, as to do so would prescribe how doctors or nurses should exercise their judgment, something which should be avoided. There is simply no evidence to show that the death might have been avoided had Mr Thomson been admitted to hospital by either doctor.

[193] She also submitted that, for the same reasons as she had already advanced, the Inquiry ought not to make a determination under section 6(1)(d). She reiterated the stricture of Sheriff Scott in his determination following the FAI into the death of James Bell Stephen (quoted by Carmichael at 11-06) "If he [the sheriff] detects a defect in a system it must be one which contributed to the death or accident." So although she urged me to accept that there was no defect in her clients' system of working, even if there were any such defect it did not contribute to the death.

[194] Ms Merchant, the agent for Nurses Drurie, O'Keefe and Borch, submitted that there were no reasonable precautions Jill Drurie, Sonya O'Keefe or Craig Borch could have taken where the death of Mr Thomson may have been avoided. No evidence before the court indicated that there was a real and lively possibility that the death may have been avoided. Equally there were no defects in any system of working used by the nursing staff which contributed to the death.

[195] For the sake of brevity I would add that Mr Burton, agent for Nurses Petrie, Taylor, Hamilton and Rundle, did lodge submissions but aside from emphasising that the nurses' holding power was never engaged here, either because the patient agreed to wait to see or a doctor or that a clinician was present whose authority and powers ousted those of the nurses, he adopted the submissions made for their medical colleagues. I will therefore not narrate them separately.

[196] There was some criticism made of the nursing staff, primarily by the family but perhaps by implication in the opinion of Dr Scott. These criticisms were unfounded. It was alleged that there were deficiencies in the assessment of Mr Thomson on Ward 2 between 8 and 10 January. There was a failure to provide adequate assessments of Mr Thomson and properly document the assessments during the period 8-10 January 2015. Nursing staff are said to have failed to engage with the patient to explore and assess any potential mental illness. Again it was said that there was little evidence of proactive attempts to engage with Mr Thomson when he started asking for discharge. They had found out no more about him than at the point of admission and did not attempt to build a therapeutic relationship".

[197] However, it was submitted that was no specification of what these alleged "deficiencies in the assessment" were. No "deficiencies" were put to Ms Drurie, Ms O'Keefe or Mr Borch in evidence to allow them to respond accordingly. Similarly no questions were asked of these witnesses regarding their assessments during their shifts, their documentation or their engagement with Mr Thomson. Equally, the generic allegation by the family that nursing staff were unsympathetic and uncaring was not put to any of them for comment.

[198] The failure to pursue such a line of questioning meant that the court was deprived of any explanations of the nursing interaction and critically their understanding of their professional duties and expectations during the period of 8-10 January 2015. However these matters were not raised and therefore it is unfair for findings now to be sought upon matters that were not put to these witnesses in cross examination. There is no evidence before the court to credibly state that had these matters taken place, as is now suggested they should have, that this may have prevented Mr Thomson's death. Equally, there is simply no evidence to suggest that there were systems failures that were the fault of or even contributed to by nursing staff. The nurses at all times in the care of Mr Thomson acted under the systems established by and at the direction of doctors.

[199] Mr Devine, the agent for the family, submitted that there were, in terms of section 6(1)(c) reasonable precautions whereby the death of Mr Thomson might have been avoided as follows. The failure by Carseview Staff to have Mr Thomson examined by an Approved Medical Practitioner (AMP) during the initial admission to Carseview

between 8 and 10 January 2015. Specifically, there was no formal system in place for documenting that the Consultant Psychiatrist responsible for the patient's care and treatment had been notified of Mr Thomson's admission. There were deficiencies in the assessment of Mr Thomson while an in-patient on ward 2 of Carseview between 8 and 10 January 2015.

[200] The failure to provide adequate assessments of Mr Thomson and properly document the assessments during the period 8 to 10 January 2015. Failure to provide Mr Thomson with a named nurse as stated in the risk management plan. The failure by nursing staff during Mr Thomson's in-patient admission between 8 and 10 January 2015 to engage with him and explore and assess any potential mental illness. The failure to carry out a comprehensive mental state examination and record the same.

[201] A failure to accurately diagnose Mr Thomson and whether or not he was suffering from a mental disorder. A failure to consider treatment subject to section 36 of the Mental Health (Care and Treatment) (Scotland) Act 2003. This is known as treatment subject to an emergency detention on the evening of 10 January 2015. A failure to diagnose that Mr Thomson met the criteria for emergency detention.

[202] A failure by a junior doctor to seek involvement of a Medical Practitioner with special experience in the diagnosis and treatment of mental disorder prior to allowing Mr Thomson to seek a discharge against medical advice on the evening of 10 January 2015. A failure by Carseview staff to enquire or ascertain what triggered Mr Thomson's behaviour to suddenly change and seek discharge against medical advice when he had previously apparently been calm and relaxed.

[203] A failure to provide a robust assessment to ascertain whether Mr Thomson was suffering from a formal mental illness or not and specifically a failure to consider when formulating a diagnosis that this should be based on the wider information that was available as opposed to the limited information obtained at interview. A failure to provide a timely discharge letter. A failure to offer re-admission to Mr Thomson when he presented at Carseview on the evening of 10 January 2015 after earlier that evening taking discharge against medical advice. A failure to provide follow up care by Mental Health Services such as the Community Mental Health Team. A failure to accurately determine the risk assessment of Mr Thomson and in particular, on 23 January 2015 when Mr Thomson had his last assessment.

[204] He also submitted that in terms of section 6(1)(d) there were defects in the systems of working which contributed to the death as follows. The failure by Carseview Staff to have Mr Thomson examined by an Approved Medical Practitioner (AMP) during the initial admission to Carseview between 8 and 10 January 2015. Specifically, there was no formal system in place for documenting that the Consultant Psychiatrist responsible for the patient's care and treatment had been notified of Mr Thomson's admission. The absence of an assessment by an Approved Medical Practitioner (AMP) or a Consultant Psychiatrist was a major deficiency which contributed to the death of Mr Thomson.

[205] There were deficiencies in the assessment of Mr Thomson while an in-patient on Ward 2 of Carseview between 8 and 10 January 2015. These deficiencies were a result of defects in the system of working. The deficiencies in the assessment contributed to the

death by suicide of Mr Thomson on 27 January 2015. A further systems defect which contributed to the death of Mr Thomson was that there was no system in place to allow communication from Carseview to Mr Thomson's GP when he left in-patient care abruptly against medical advice. This contributed to his death. There was also a false but building assumption that adequate mental health assessments had been obtained which led to clinicians using the fact that no follow up had been arranged as evidence that Mr Thomson had no mental illness diagnosis and no immediate suicide risk. The totality of Carseview staff involved in Mr Thomson's care, therefore, would also be classed as human error and contributed to Mr Thomson's death.

[206] He then reviewed the investigations into Mr Thomson's tragic death. This has a two tier system, namely the Local Adverse Event Review (LAER) and the Significant Clinical Event Analysis Review (SCEAR). The primary purpose of the Adverse Event Management Framework is to improve systems, practice and care and not to apportion blame. The Crown instructed Dr Allan Scott, Consultant Psychiatrist, to compile a report concerning the care and treatment of Mr Thomson. Dr Scott completed a report on 30 July 2015. He concluded there were defects in the system of working that contributed to the death of Mr Thomson. He also concluded there were reasonable precautions whereby the death might have been avoided. Dr Scott's report was provided to the SCEAR. The LAER was completed on 2 February 2016 and the SCEAR final report was completed on 9 March 2016. The Crown instructed Dr Scott to consider the conclusions and proposed actions that resulted from the LAER and SCEAR and Dr Scott completed his report on 8 June 2016. Dr Scott found that the process of the LAER

was subsumed in the process of the SCEAR. The investigation outcome of the LAER was not endorsed by the SCEAR. His main concern were the conclusions and required actions of the SCEAR that revolved around the assessment of all patients admitted to hospital within twenty four hours of admission should be seen by an approved medical practitioner (AMP). He would return to this issue later on in his submissions.

[207] He conceded that there was significant amount of overlap between the issues he raised between sections 6(1)(c) and (d) of the 1976 Act. He had listed some sixteen reasonable precautions whereby the death of Mr Thomson might have been avoided but he would, for the sake of brevity deal with them collectively. The cumulative effect of the failings identified by the SCEAR meant there was a false but building assumption that adequate mental health assessments were being obtained each time Mr Thomson was seen by the staff at Carseview. The SCEAR identified that these accumulative failings were the root cause in the death of Mr Thomson. Thereafter, the SCEAR recognised a proximal cause of human error.

[208] He submitted that, in terms of section 6(1)(c), the crucial singular reasonable precaution which might have avoided the death of Mr Thomson was the failure to have Mr Thomson examined or assessed by an Approved Medical Practitioner between 8 and 10 January 2015. The next specific reasonable precaution whereby the death of Mr Thomson might have been avoided was the specific human error by Dr Feile when he failed to consider or adequately address whether Mr Thomson met the criteria to be detained under the Mental Health Act. This was noted by the SCEAR when reviewing Mr Thomson's care. A further reasonable precaution which might have avoided the

death of Mr Thomson was surrounding events when he re-presented at Carseview on 10 January 2015 when he was assessed by Dr Kao and Dr Howson.

[209] He further argued that, in terms of section 6(1)(d) that the defects in the system of work which contributed to the death were the systems failure which led to Mr Thomson not being seen by a Consultant Psychiatrist whilst an in-patient between 8 and 10 January. Such an assessment was likely to have resulted in a diagnosis of a mental disorder and the patient treated in some way. The failure by Dr Feile to diagnose that Mr Thomson was suffering from a mental disorder and indeed the other factors whereby Mr Thomson would have met the criteria to be detained subject to section 36 of the Mental Health (Care & Treatment) (Scotland) Act 2003 on the evening of 10 January 2015. The SCEAR concluded Mr Thomson *would* meet the criteria for the MHA to be invoked. He argued that it follows the SCEAR must have concluded Mr Thomson to be suffering from a mental disorder given that this is one of the criteria for emergency detention.

[210] Equally the failure by both Drs Kao and Howson to offer re-admission to Mr Thomson when he re-presented on 10 January 2015 is a further serious failure which contributed to the death of Mr Thomson. The two Consultant level Psychiatrists involved in the SCEAR process considered that Mr Thomson should have been offered re-admission without prejudice and if he would not accept this the use of the MHA would have been just as appropriate at this juncture as it would at the point of going against medical advice earlier in the night.

[211] A further major contributor to Mr Thomson's death was the failure to arrange follow up care. Carseview Staff had three opportunities to arrange follow up care by Mental Health Services (CMHT referral). Had Mr Thomson been provided with CMHT follow up, it is likely he would have received the appropriate treatment.

[212] He urged me to accept the family evidence of the growing struggle of Mr Thomson to cope with his mental health problems. He was reluctant to seek help as he did not think it was worth it. The family was clear that Mr Thomson was exhibiting symptoms such as hallucinations, hearing voices and the like. The doctors were told this. He was threatening suicide and had active plans. He invited me to prefer the evidence of the family of the consultation with Dr Gunput and accept that Mr Thomson, far from being unable to articulate the help he sought, was asking for admission. In any event the significant outcome of that consultation was Mr Thomson feeling despair and commenting that, "even they dinnae think I am worth saving".

[213] He reminded the court of the evidence that during the period shortly before his death when he had reconciled and was staying with his mother, neither were sleeping and the only time he was leaving the house was when he was to visit his daughter. His mother believed that had her son received proper treatment and care his death would have been avoided.

[214] Mr Thomson's grandmother was able to speak to the demeanour of her grandson, at the GP appointment of 8 January and also during the first assessment at Carseview. When Mrs McLaren visited on Saturday 10 January she explained that Mr Thomson's demeanour changed after he found out he would not be assessed by a

doctor until the following Monday. She collected him from Carseview and noted his comment that nobody came to help him. He had asked for and needed help but nobody helped him. He submitted that this is the likely trigger for the discharge against medical advice.

[215] He submitted that Ms McMulkin was able to confirm Mr Thomson had changed after the birth of his daughter, and he realised he needed help. She informed that he was a good dad although Mr Thomson himself didn't think that. Mr Thomson felt worthless. Ms McMulkin confirmed that during the two week period after Mr Thomson had taken DAMA he was very agitated and the only time that she ever seen him happy during that period was when Mr Thomson was with his daughter. Ms McMulkin was of the view that if Carseview had detained Mr Thomson and he received the proper help, he would still be alive today.

[216] It was submitted that the totality of the GP and family evidence over the period from 5 January up until the time Mr Thomson died tends to support that he was suffering from a mental disorder, and in particular, the disorder is getting worse and not better. It does not support the fact that this is a person who was calm and relaxed. Moreover, this gives credence to Dr Scott's opinion. Mr Thomson continued to suffer with a depressive illness after his discharge and was probably still doing so at the time of his death.

[217] He pointed to inconsistencies in the approach to follow up care in the community. On 8 January, it was discussed that appropriate treatment was referral to the crisis response and home treatment team (CRHTT) had that been possible, working

with Mr Thomson's family. However, there was no such consideration of using the CRHTT on the 23 January assessment. At the very least, Mr Thomson should have been offered a further assessment. There is no reason why CRHTT would not have been offered as Mr Thomson was now staying with his mother. He was also critical of Dr Gunput's failure to consult nurse Drurie during his consultation. Nurse Drurie could have had had valuable insight through her previous involvement.

[218] He turned to the question of detention by Dr Mattias Feile. He pointed out that although the doctor was clear he did consider an emergency detention there were no notes to reflect that he had. Clearly, at the time when Dr Feile was attempting to ingather information, Mr Thomson was in no mood to engage or co-operate. The assessment lasted barely ten minutes. Dr Feile was not able to ask Mr Thomson whether he had delusions or hallucinations. Dr Scott was of the view that Mr Thomson would probably have met the criteria to be detained under section 36 of the Mental Health Act. The SCEAR concluded that the criteria for the use of an emergency detention certificate would have been met. If Dr Feile was in any doubt, he could have contacted a senior or even a Consultant, but he did neither. The SCEAR concluded that Dr Feile's specific human error in his decision making around the use of the Mental Health Act was one of the proximal causes of Mr Thomson's death. The critical issue is that detention would have triggered review by an AMP and a Mental Health Officer. The senior clinicians who reviewed the case all agreed that a diagnosis or at least a differential diagnosis of an illness such as agitated depressive disorder would be something that an experienced clinician might have detected. Experience was at a premium in the field of mental

health. If Dr Feile had considered the Mental Health Act then it is likely Mr Thomson would have been detained and, in all probability, he would have been seen by an AMP and received the proper treatment, which would have avoided his death.

[219] The agent submitted that, of course, we know that there was a senior psychiatrist in the unit who could have intervened or aided Dr Feile. The first issue that arises with Dr Howson is whether or not he had actually seen Mr Thomson when he was banging on windows, kicking doors and shouting to be released. His recollection was vague, whereas Gail Taylor's recollection was clear. Dr Howson's evidence was that he would have intervened if there had been an emergency or crisis. He was clear that there was not. The nurses had matters in hand and the patient was waiting for Dr Feile to arrive. Mr Devine invited me to consider that Dr Howson's evidence on this point was unreliable. In terms of Dr Howson's second involvement with Mr Thomson, this was simply his discussion with Dr Kao by telephone. Dr Howson was aware of the DAMA and the recent threats, and he should have given more weight to these factors. This is supported by the fact that NHS policy was changed to include a presumption towards re-admission. The SCEAR also concluded the use of considering the Mental Health Act would have been just as appropriate prior to Mr Thomson's DAMA as at the juncture of his re-presentation.

[220] Mr Devine argued that the basic rationale of the SCEAR was not challenged. He accepted that criticisms were raised because many of the attending clinicians were not actively engaged in the process. He acknowledged that questions were raised of how the SCEAR could come to its conclusions when the Review Team had not seen the

patient. He pointed out that Dr Doig advised the threshold for emergency detention certificate is reasonable grounds for believing that they have a mental disorder not actual clinical certainty. That was not challenged. The SCEAR, in his submission, with the vast experience of three Consultants, the LAER, which was also assisted by a Consultant Psychiatrist, and the independent report by another consultant, Dr Scott, must be set against the fact that Mr Thomson was seen by a series of junior doctors, undoubtedly placed the SCEAR in a better position to ascertain and conclude the likely diagnosis and the actions which should have been taken in relation to Mr Thomson's mental condition, particularly so the events of 10 January. The conclusions and findings of the SCEAR should be adopted by the court. He would review the issue of 24 hour AMP cover hereafter.

[221] Mr Devine addressed the issue that only Dr Scott was prepared to say that, on the balance of probabilities, Mr Thomson was suffering from agitated depression or similar mental illness. Dr Scott was very clear in his thinking and provided more than sufficient information to justify both of his reports. For example, he was able to say that there were sufficient symptoms documented in the medical records to say the position that he had no mental illness is not consistent with them. He argued that Dr Doig and the SCEAR had concluded that at the point of admission that Mr Thomson was suffering from a depressive illness. It is notable that Dr Doig in his evidence indicated a similar diagnosis when Mr Thomson was admitted and that is referred to in the SCEAR. Dr Scott was prepared to allow the possibility that his suggested diagnosis of agitated depression may well be wrong. He had greater confidence to suggest that he had

depressive illness. Dr Scott conceded that whether further assessments would have revealed that he actually had an agitated depressive illness was something that he could not say with any certainty.

[222] Mr Devine submitted Dr Scott's evidence fully supported his views in the substantive report of 30 July where he concluded that the absence by an AMP was a major deficiency and unreasonable. Dr Scott was clear that there should have been a full mental state examination. Mr Thomson should have had this on Friday 9 January. Dr Scott was clear that emergency detention, at any time during the process, would have triggered such an examination by an AMP.

[223] The failure to diagnose any psychiatric illness and the resulting failure to provide any psychiatric treatment contributed to Mr Thomson's death. Dr Scott concluded that Mr Thomson continued to suffer from a depressive illness after his discharge and probably still was at the time of his death.

[224] Dr Scott had expressed a view that Mr Thomson may be suffering from a more severe illness in his initial substantive report. At that time, he only had the benefit of the various medical psychiatric records. However, in the course of his oral testimony, he was advised of the family's evidence, particularly of his actings since his discharge and how Mr Thomson had reacted to the lack of treatment he received in Carseview, and this reinforced his opinion. In his opinion Mr Thomson was getting worse and the psychotic symptoms more pronounced.

[225] Mr Devine accepted that, as with all the other reviewing clinicians, Dr Scott did not meet Mr Thomson face to face, but argued that he had more information than that

before the SCEAR. Dr Scott did concede many matters but did not retract his opinion that his diagnosis did pass the threshold of the balance of probabilities. This was not mere speculation. He pointed out that there other disagreements between the clinicians. Dr Doig gave evidence that the threshold for detention, as regards mental disorder, was low based on a reasonable belief, whereas Dr Patience viewed the threshold for reaching a mental disorder was high. Dr Patience viewed that he could not conclude, on the balance of probabilities, that Mr Thomson's suicide was driven by a mental illness. He would need to know more of what was happening to the patient in the proceedings up to the final event. He did not rule it out entirely. Dr Scott's opinion should be preferred.

[226] Mr Devine addressed the issues arising from the legal tests examined above. He accepted that it was clear from case law that a Fatal Accident Inquiry should use the wisdom of hindsight and to look back at the date of the Inquiry to determine what can be seen as a reasonable precaution. The test for identifying reasonable precautions under section 6(1)(c) is not that the reasonable precaution would have avoided the death, but only that it might have done. It means less than probability and directs the court's mind in the direction of lively possibilities, as per Sheriff Kearney (re the Inquiry of James McAlpine).

[227] He submitted that with regard to the opinion of Lord Armstrong, Sheriff Pieri had determined that a reasonable precaution whereby the accident resulting in the death might have been avoided would have been for a Mr Sutherland who was a Cardiologist to have sought experienced consultant radiology opinion. It was later submitted that the Sheriff had misdirected himself in consideration of hindsight, reasonable

foreseeability and the meaning of "reasonable precaution" for the purposes of section 6 of the 1976 Act and in the context of a case involving clinical judgment; the available evidence was insufficient to justify the finding in relation to the precaution identified.

[228] Lord Armstrong refused the petition and held the Sheriff had not erred in law. Sheriff Pieri had approved the approaches set out in the determinations made in the cases of Sharmaine Weir and Kieran Nichol. Lord Armstrong specifically refers to the Sheriff's determination at paragraphs 90 to 93 and concluded that he did not err in approaching his determination under section 6(1)(c) in the way he did. Mr Devine submitted that the opinion of Lord Armstrong is therefore authoritative in the correct approach to be taken in Fatal Accident Inquiries namely the Sharmaine Weir and Kieran Nichol approach as opposed to the approaches in Fatal Accident Inquiries of Lynsey Miles and Marion Bellfield. Mr Devine suggested the submissions for the NHS on this point are taken out of context. Lord Armstrong is merely observing that in such a situation he would accept that when the optimal course was not taken it would not be appropriate to determine the selection of another of available options would have been a reasonable precaution. However, Lord Armstrong was satisfied that in the

> circumstances of the Petitioners' decision, not to operate, were not of that type. Dr Fiele was aware he could have sought advice from someone with more expertise (such as a speciality registrar or a consultant on call). This is similar to the Sheriff's determination that Mr Sutherland should have sought a further opinion.

[229] Mr Devine argued that in Mr Thomson's case the context of criticisms against individual clinicians are completely different from those that faced the medical staff in

the Sutherland case. In the Sutherland case, there were competing views from the various witnesses and experts as to whether or not Mr Sutherland should have sought more expertise opinion. In Mr Thomson's case, there were different clinicians/doctors seeing Mr Thomson at different times, with different presentations and indeed with different information.

[230] Mr Devine submitted that the court does not have to find that Mr Thomson was suffering from a mental illness to determine whether there were any reasonable precautions that might have prevented Mr Thomson's death. For example, the systems failure which led to the miscommunication whereby Mr Thomson was not seen by his consultant, does not depend upon whether Mr Thomson had a mental illness or not. However, the court should be aware that Mr Thomson was admitted with a working diagnosis of drug induced psychosis. Dr Doig and the SCEAR panel was also of the view that Mr Thomson was suffering from a mental illness at least as regards the power of detention.

[231] The agent for the family however made it clear that he was not submitting that any blame should be placed on any individual nurse, doctor or clinician in relation to Mr Thomson's treatment. His intention was merely to highlight the findings of the SCEAR as part of his submission that the court should adopt the findings of the SCEAR. He accepted, as a matter of law, that any precaution if reasonable does not involve an exercise of foreseeability. It does not involve any consideration of negligence. It is a decision arrived with the benefit of hindsight. There is no implication in such a finding that a failure to take a precaution is negligent or unreasonable.

[232] He also accepted the analysis of counsel for the NHS concerning the process of establishing causation. He adopted the same cascade: (a) was Mr Thomson suffering from a mental illness, (b) was it treatable (c) would treatment have alleviated the illness and prevented his suicide (d) was his suicide driven by untreated mental illness. However, he reminded the court of counsel's concession that if the court accepted Dr Scott's evidence in its entirety, it could justify the court in reaching a conclusion on the balance of probabilities that all four of the above questions set out can be answered affirmatively. The SCEAR had certainly adopted Dr Scott's reports and have made numerous changes as a result of Dr Scott's report.

[233] The NHS have made numerous admissions, accepted various errors and system failures contributed to the death of Mr Thomson. They have issued apologies. This is difficult to reconcile with their submissions in this process that we are dealing with sheer speculation.

[234] Finally Mr Devine addressed the issue of AMP assessment within 24 hours of admission. Dr Scott made it clear that he considered this a critical issue and this was the reason he added that to the proximal causes in his supplementary report of 8 June. It is clear from the evidence of Dr Thiyagarajan he would have seen Mr Thomson when he did his Ward round on Friday morning 9 January 2015. Dr Thiyagarajan confirmed he did do the Ward round but Mr Thomson was overlooked as he did not know Mr Thomson was admitted to the Ward.

[235] Dr Doig spoke to the various services across the Health Board region, namely Murray Royal in Perth, Carseview Centre in Dundee and Stracathro Hospital in Brechin.

In general, Dr Doig spoke about the psychiatry services in Tayside and how they compared with other services in Scotland and in particular, the reason why other Health Boards in geographical areas across Scotland are able to operate a system whereby a patient is seen within 24 hours of being admitted to the Psychiatric Unit by an AMP, where in Tayside that would be extremely difficult. The critical difference in those areas that can operate 24 hours to be seen by an AMP are their psychiatry services are centralised into one site whereas in Tayside there are three sites dispersed over Perth, Brechin and Dundee. He advised there appears to be a 50/50 split currently across Scotland, with some Health Boards such as Lothian and Grampian setting the standard for 24 hour review 7 days a week, for an Approved Medical Practitioner to review within 24 hours, whereas other Boards such as Fife, Ayrshire & Arran and Lanarkshire where they do not have such arrangements and they have arrangements currently that are similar to those arrangements that were in place at Tayside at the time of Mr Thomson's death. Tayside had to disperse psychiatric services over these three sites and 24 hour cover would be unworkable.

[236] Dr Doig advised the court that the Royal College of Psychiatrists had now removed the Report which gives guidance to members about when patients should see a Psychiatrist. This report had been, possibly, more appropriate for acute admissions rather than mental health units. He was told of Dr Scott's view that a patient should be seen by an AMP within 24 hours. Dr Doig believed that the safety hurdles which he advised the court about were seen as an adequate substitute to the 24 hours AMP. Dr Doig agreed that in terms of the safety hurdle that that would involve discussions about

a patient without seeing them face to face. Dr Doig agreed that the ideal situation would be if someone could see an AMP within 24 hours.

[237] The agent then informed the court that he had been instructed that there have been high level consultations regarding centralisation of Tayside's Psychiatric Care. Standing that the proposition discussed by Dr Doig is predicated on the basis that patients should be seen by am AMP only at one central site, this would make their argument redundant, if indeed centralisation of all services is transferred to Carseview.

[238] There had also been evidence from Dr Patience on this point from his experience elsewhere but the agent accepted that the Glasgow area operates a completely different system to Tayside at the point of admission where they have specialised psychiatric nurses. Mr Devine, for the family, still submitted, however, that it would be reasonable to conclude, subject to resource and logistical issues, that a patient should see an AMP within 24 hours of admission, seven days a week.

DISCUSSION AND OPINION

[239] All the legal representatives, including Mr Devine for the family, were agreed that the first and indeed primary exercise that the court, in this Inquiry, must perform is to consider four questions. These are whether, at the material times: 1. Mr Thomson was suffering from a mental illness; 2. it was treatable; 3. treatment would have alleviated the illness and prevented his suicide and 4. his suicide was driven by untreated mental illness. Logically, questions 2, 3, and 4 are predicated upon an affirmative answer to question 1. I also accept the general submission that if I am not

persuaded, on balance, that I can answer question 1 in the affirmative then there can be no evidential basis for any finding in terms of section 6(1)(c). Equally, I would require to find some alternative basis for any contributory factors in terms of section 6(1)(d). Matters are more at large for me, in terms of section 6(1)(e).

[240] I have concluded that I cannot, on balance, answer question 1 in the affirmative. The diagnosis, to the full extent of the balance of probabilities, of a mental illness that might have driven Mr Thomson to his death came solely from Dr Scott, the expert retained by the Crown. This was, by his own admission, a diagnosis which might be wrong and one which he had, of necessity, to base upon a desk top examination of the records available to him. He did not hear any of the other evidence before the Inquiry or consider any transcripts. This was his first appearance as an expert giving evidence before a court and he was criticised by some of the representatives for a failure to reflect sufficiently when it was put to him that factors he had taken into account had not been borne out in evidence. In particular he founded, quite heavily, upon the absence of certain details in notes from clinicians but those clinicians had given evidence which filled those gaps. Dr Scott did appear to consider the points made but in fact did not significantly modify his position and in particular his diagnosis of agitated depressive disorder or worse, even in the face of that evidence. I found this difficult to square and it diminished the persuasiveness of his evidence.

[241] In any event, I must balance all the evidence in this case and set against Dr Scott's opinion all that appears to me to have been otherwise established. I had before me the evidence of four, albeit junior, doctors who had all examined, to some

extent, Mr Thomson face to face. All the medical witnesses, including Dr Scott, were very clear that psychiatric assessment was based upon face to face examination. The court was left in no doubt that this field, as yet, does not benefit from objective scientific assistance such as X-rays or body scans. There is little equivalence between mental illness and a broken leg. Dr David, on the evening of 8 January, made a preliminary, indeed quite speculative, diagnosis of drug induced psychosis. None of the doctors who actually saw Mr Thomson, thereafter, detected any serious or treatable psychiatric illness. I will return to this.

[242] I also considered reports and heard testimony from a number of other senior consultant grade psychiatrists, who reviewed the records and other evidence available to them. None of these experts was able to say, beyond the level of a possibility, that they could diagnose the kind of illness, such as agitated depressive disorder, suggested by Dr Scott. I accept that the SCEAR made certain findings but that process applies different tests and gathers evidence in ways not available to a court. Their fact finding is collegiate and is not based upon sworn testimony subject to cross examination. Moreover, it was clear from the evidence that attending clinicians, who were able to assist the court in person, had not actively participated in the SCEAR process. This is not a criticism of the SCEAR, as it has a specific function to perform within the NHS review structure; I merely observe that it is not a simple matter for a court to accept or adopt a SCEAR report without setting it in the context of all the evidence the Inquiry actually considered.

[243] I now return to those clinicians who actually saw Mr Thomson. The evidence of Dr Howson is relevant. He is the only senior psychiatrist who had some interaction with Mr Thomson and was involved in front line decision making. He was perfectly well aware of the circumstances surrounding Mr Thomson's discharge against medical advice. He was in Carseview at the time. He made it clear, and I accept, that if he had considered Mr Thomson to be in crisis or that matters were beyond the control of nurses, he would have stepped in. He did not and explained his reasons for this. He was then consulted by Dr Kao on the evening of 10 January. He, against the backdrop of his knowledge of the events of earlier that day, agreed with the assessment of Dr Kao. He saw nothing to suggest her diagnosis was wrong or that Mr Thomson should be detained against his will.

[244] Dr Feile gave evidence to the effect that he did not detect symptoms of mental illness. He assessed Mr Thomson as stable and with insight into his situation. He accepted that he could not fully assess the patient because he would not engage. He, however, saw no reason to revise the working diagnosis of drug induced psychosis made by Dr David. He could not persuade the patient to either be fully assessed by him or wait until Monday to see a more senior doctor. The patient was voluntary and wanted to go home. This, he considered, was consistent with the impact of illicit drugs on the patient having diminished over the past 48 hours or more. He freely conceded, with the benefit of hindsight, that he should have been more concerned about Mr Thomson's lack of engagement and that he did not truly know enough about the patient. However, this was against the background of questions concerning his

consideration, or lack thereof, of compulsory detention. All the senior psychiatrists who gave evidence were of the same opinion: the test for detention does not require a diagnosis of mental illness to the balance of probabilities; it requires a lesser standard. The fact that Dr Feile now believes he could have detained Mr Thomson under the Mental Health Act, does not detract from his primary evidence that he did not, in fact, diagnose a mental illness.

[245] I accept that Dr Kao was in a somewhat different and very difficult position when she saw Mr Thomson. He was in police custody, after what could only be described as a siege. He had threatened police with his dog and had only surrendered thanks to the intervention of a close family friend, Mrs Hawes, who he trusted and respected. It is interesting to note from her evidence that Mr Thomson showed what the psychiatrists would refer to as forward planning as he was not prepared to surrender until he had assurances that his dog would be properly cared for. I accept Dr Kao's evidence that Mr Thomson did not ask for re-admission. I also accept that she saw no evidence of a mental illness interfering with the patient's thought processes or reasoning such that she would require to detain him under the Mental Health Act.

[246] There is also the evidence of Dr MacMillan, the GP. He saw Mr Thomson after he left Carseview. I accept that he did re-refer him for psychiatric assessment but I consider it significant that he did not see the need to do so on an emergency basis, as he had done on 8 January. It is reasonable to infer from this that he did not see Mr Thomson as worse than when he presented before but rather that he was, at least to some degree, a little better.

[247] The last clinician to see Mr Thomson was Dr Gunput. I accept his evidence that he carried out, to the best of his ability, a mental state examination. Dr Scott accepted that this was so; his concern was the extent and quality of that process. I am satisfied that Dr Gunput did lead the consultation. I also accept that he could not ascertain, with any clarity, what assistance Mr Thomson was seeking. Dr Gunput was clear that there was no demand for an in-patient admission. He was exploring options with the patient. There was no challenge to his evidence that there were no resource issues that night. There were beds available and if he believed that Mr Thomson required and would benefit from admission that is what would have been offered. Dr Scott queried why anti-depressants were prescribed by Dr Gunput if he did not diagnose a depressive condition. I accept Dr Gunput's explanation that this was simply a trial because the records disclosed that the patient had gained benefit from such medication in the past. The patient's mother, in her evidence, described nights without sleep that she shared with her son, before seeing Dr Gunput. The prescription was only for one week. Dr Gunput hoped that Mr Thomson might get some rest and then be reviewed by his GP.

[248] Dr Patience was struck by the lack of evidence pointing to symptoms of mental illness which was why he disagreed with the diagnosis of Dr Scott. In his evidence Dr Scott argued that the lack of records relating to adequate investigation by the attending clinicians of such symptoms reinforced his diagnosis or as he put it, there was nothing to argue against it. Dr Scott, however, readily accepted that doctors cannot record everything or they would become administrators not clinicians attending

patients. Both independent experts make reference to a desire, indeed a diagnostic need, to know more about Mr Thomson and what was happening in his life both before and after he was in Carseview. I accept that the SCEAR was critical of the lack of any greater accumulation of knowledge about Mr Thomson, when he was an in-patient. The court has, however, the benefit of a substantial body of evidence, which was not available to the experts and fills in many of the gaps perceived by Dr Scott. It is that evidence which has led me to the conclusion that I cannot, on balance, accept the diagnosis of Dr Scott.

[249] The family witnesses were very helpful and quite candid in their description of the life of Mr Thomson. There was no doubt that he had a difficult personality, at times, and that he had abused alcohol and illicit drugs for many years. There was no challenge to the evidence that he was a heavy cannabis user in January 2015. Indeed, one of the criminal justice issues he faced related to growing cannabis. He was, the day before his death, expecting to see a social worker for a report into a Restriction of Liberty Order (popularly called "a tag") and this would have seen him kept in his home for a period; usually, in Dundee, between the hours of 7pm to 7am.

[250] The evidence of Ms McMulkin was particularly revealing. She described Mr Thomson as often moody. He was not a regular drinker but was a persistent user of cannabis. He had emotional ups and downs. She perceived his real problem was that he found it hard to accept that he had psychological difficulties that he could not just shake off on his own. He was not readily willing to seek help. She accepted that she found socialising with Mr Thomson challenging. He was never aggressive towards her but would frequently provoke confrontation with other men. This would lead to

fighting, where he seemed invariably to get hurt. The violence could be extreme; Mr Thomson stood trial for attempted murder before she was involved with her. He was acquitted but she described violent incidents that she witnessed that could be as often as once a month. She gradually realised this was a form of self-harm. Self-harm, in one form or another, was clearly a feature of Mr Thomson's life for many years.

[251] The medical records disclosed that Mr Thomson reported that he was prone to act on impulse or react to situations as he found them. He is noted as saying that he did not make plans, he just did things. This chimes with the undisputed evidence that Mr Thomson took his own decisions on whether to accept medical advice or not. We know that he had some positive benefits from anti-depressants, for a time, but that he simply stopped taking his medication without consulting his GP. He did this because he felt he could cope without them. This was in line with the evidence of Mrs Hawes, who had known Mr Thomson since birth. She confirmed that his behaviour had been problematic. She referred to some really scary moments and that she had taken him to hospital before. She was aware that Mr Thomson had psychological problems that he was blotting out.

[252] There can be no doubt that something changed in Mr Thomson's life leading up to January 2015. The evidence from the family makes it apparent that neither Mr Thomson nor indeed, other members of his family had much faith in psychiatrists. His sister said that they ask a lot of stupid questions. He had not seen his GP in more than a year. He continued to act impulsively and was self-harming. When his mother and sister, in understandable concern for his safety, called the police Mr Thomson

blamed them and cut himself off from his mother. Yet, as we will see, he was, at the same time, thinking of his mother and her past life with some care and concern. It is not easy to reconcile these competing emotions but they seem to fit with the general description of mood swings and impulsive reaction to any attempt by others to help him.

[253] He was, however, persuaded not only to consult his GP but to accept the referral to Carseview on 8 January. He was also willing to be admitted as a voluntary patient. The evidence suggests that he settled in the unit. He needed help to sleep but he accepted the prescribed medication and it worked. He was visited by some members of the family and he had contact with the outside world as he had his mobile phone. Yet, by the afternoon of 10 January he was demanding to be discharged. We cannot say, with any certainty, what caused this change of attitude. The family are convinced there was a single trigger: being told that he would not see a consultant until Monday. There was however, other evidence from Dr MacMillan that Mr Thomson complained to him that he was becoming annoyed at other patients. One was talking a lot and shuffling his feet. Mr Thomson feared he might hit him.

[254] One curious aspect of the evidence is that although Mr Thomson became quite loud and difficult with the nurses, he did not actually try to leave on his own accord. He complained but packed his belongings and did wait to see Dr Feile. It must also be noted that if his disquiet was directed at his perceived failures by Carseview, why were the threats he made directed against his sister? Equally, if his concern was to see a doctor why did he refuse to engage with Dr Feile. I was favourably impressed by

Dr Feile's manner and presentation. He is not a newly qualified junior doctor and struck me as having a demeanour that could have satisfied Mr Thomson that he was being taken seriously.

[255] I cannot possibly know what truly motivated Mr Thomson but it is clear he had decided to leave and was not to be deflected from his chosen course of action. This is consonant with all the other available evidence describing his tendency to self-determine his coping strategies in his own way. I accept that it is possible that he was responding to an illness, such as agitated depression disorder, but I just cannot, on the evidence, elevate that possibility to probability. He may, as Dr David speculated, have been in the grip of drug induced psychosis when admitted and, as Dr Feile observed, this had passed for the time being.

[256] Mr Thomson's mother described the days after her son's discharge. She was not involved in his return to Carseview and his consultation with Dr Kao but she learned of it. Events then took another paradigm shift. Mr Thomson was so angry with his mother, over her decision to call the police after the earlier self-harm attempt, that she did not feel able to visit him in Carseview. He had made very serious threats against his sister but the evidence suggests that his mother was included. Yet, he went to stay with her. She describes several sleepless nights. She made appointments for him to see his GP. He failed to go. She then describes wearing him down by pointing out his duty to his daughter, who needed him to be well. Ms McMulkin had confirmed that being with his daughter was the only thing that made him happy. Mr Thomson agreed to see his

GP, Dr MacMillan, once again. This, once, again contradicts his normal pattern of self-determination of his need for medical or indeed any other assistance.

[257] This, in my judgment, is more consistent with the evidence of Dr Patience that there were no symptoms of a treatable mental illness, than the views of Dr Scott. I accept that there was evidence that Mr Thomson continued to complain that people were talking about him, who were not physically present. I did not, however, detect any suggestion of auditory hallucinations. These voices were not inside his head or directing him to do things against his will. There was also a patent inconsistency with regard to what the family perceived as his mental state and what they actually allowed him to do. Mr Thomson was not only trusted to be with his infant daughter, but he was allowed to baby-sit her at his flat and on his own. This seems a remarkable level of trust to extend to someone who was believed to be at risk of self-harm of whatever magnitude.

[258] Indeed, whilst it cannot be more than speculation, I suspect that Mr Thomson's time with his daughter, prior to his death, could hold the key to his actions.

[259] The expert psychiatrists and indeed all the representatives, including Mr Devine, accepted that not all suicides are driven by treatable mental health problems. People commit suicide for complex social and economic reasons. It can be a response to severe stress and a way to avoid the perceived consequences of some act which the person may be about to confront. The evidence of Mr Thomson's mother set out a very specific issue that had, recently, come to the fore in discussions with her son. He was ruminating over the domestic abuse that his mother had endured at the hands of his father. He seemed

concerned that he should have taken action and that he failed to protect her. This seemed to weigh very heavily upon his mind.

[260] He coupled these thoughts with serious concerns for his own child. He told Ms McMulkin and other members of his family, that he was a bad father. He was told this was not true but he did not seem to accept those assurances. There is little doubt that Mr Thomson had issues with his place in society over many years. His sense of low esteem and self-worth seem reflected in the acts of self-harm, including picking pointless fights, that were laid before the court. None of this evidence was contradicted in any way. Equally, his recorded statements about Carseview to the effect that no-one cared about him or thought he was even worth saving are potentially important windows into his state of mind. I think it is possible that Mr Thomson was ruminating about past domestic abuse by fathers and his failure to protect his own mother from it, to the extent that it created in his mind the fear that he would fail his daughter badly. He might not just be a poor father but far worse, that he might actually prove to be a force of detriment to his own child. She might not thrive and he would be to blame.

[261] I, however, accept the submission of Mr Fitzpatrick that on the evidence available to me I cannot know, to level of the legal test I must apply, why Mr Thomson took his own life. We will never know and that is a personal tragedy for all concerned.

[262] I have, however, recorded that there were serious systemic failures in the care of Mr Thomson and whilst I cannot establish a causal link to his death, they are indisputably relevant facts. There is no doubt that, for whatever reason, Mr Thomson was experiencing an increasing sense of self-loathing and worthlessness. He had,

hitherto, been quite content to take or leave medical advice as he thought fit. He reached out for medical help on 8 January 2015 and accepted Dr David's invitation of voluntary admission. He should have seen a senior consultant the next day. I have no doubt that this was a vital window of opportunity for him to see that he was regarded as a person and being taken seriously. The consultant would have carried out a thorough mental state examination and devised a treatment plan. We cannot know what that might have been but it would have been a planned way forward. Mr Thomson would know this and not simply have been aimlessly waiting around the ward all weekend in ignorance. This doubtless left him with unproductive time to ruminate on his life and the problems to be solved that, I suspect, were going through his mind.

[263] This was a young man with a long history of psychological distress, personality problems and mood swings. He had always found taking advice from others difficult. It seems to me that a window of opportunity closed when Mr Thomson realised nothing was actually happening. This should not have occurred and at least cannot have been of assistance to this very troubled young man. Equally, Dr Feile could have detained him and with hindsight he wished he had. This, again, would have triggered senior review. Such attention from senior people might have persuaded Mr Thomson to persevere with medical help.

[264] Dr Kao was in a very difficult position but, had there been a presumption in favour of re-admission, then she might have been able to address matters differently and persuade Mr Thomson to come back to the unit. The policy, at the time, left her only with the option of compulsory detention. I accept why she did not do so.

[265] I have also recorded that the failures in procedure following unplanned discharge were also detrimental to the patient. His growing sense of worthlessness might have diminished if the GP had been able to intervene in some way. Again, he knew his GP and it would have been a sign of ongoing care and concern. Dr MacMillan did not learn of his patient's abrupt departure from Carseview until told by the family.

[266] I, for the reasons set out above, have rejected the submissions of both the Crown and Mr Devine for the family with regard to findings in terms of sections 6(1)(c) or 6(1)(d). There is, accordingly, no purpose in my addressing further, the other submissions either on the law or the facts. There was common cause on that from all the representatives. However, the failures of Carseview are perfectly clear and set out in both the LAER and SCEAR reports. They should not have occurred. I, however, accept the unchallenged evidence that all these issues have been addressed and corrected. I have, therefore, no recommendations to make for the future. The attending doctors all acted in good faith and to the best of their abilities in challenging circumstances, but I trust the corrections and adjustments to the system will help them with their difficult clinical duties in the future.

[267] There is one issue that was raised by Mr Devine that I feel I must, at least, touch upon. This is the question of assessment of patients by senior psychiatrists within 24 hours of admission, seven days a week. Mr Devine, whose submission it was, very fairly conceded that this was likely to be an issue where this inquiry might not express an opinion as it involves assessment of NHS resources and higher strategic policy. The evidence before me, from all the clinicians, was that such an assessment was desirable

but that it could be achieved in different ways. In particular there are systemic issues which will vary between urban sites and rural areas. I have decided that I can reach no conclusion on this point. I am fortified in this view by the announcement on 5 May 2018 that the Scottish Ministers have launched a full Inquiry into mental health provision in Tayside. I have no doubt the family will make an important contribution to that process. Such an inquiry will have scope and powers far beyond the limited extent of a Fatal Accident Inquiry. I will, therefore, say no more on the question of extended consultant out of hours cover.

[268] Finally I must extend my sincere condolences to the family of Mr Thomson: his grandmother, mother, siblings, wider family and friends, for their loss. The tragic death of a young man in circumstances that cannot be considered anything other than untimely and very sad must be keenly felt by all who knew and loved him. However, Mr Thomson lives on, not only in hearts and memories but vitally in the person of his daughter and I know that the family will rally round her to ensure that she does not forget her father and that she has a secure future. The past cannot be undone but I hope that lessons can be learned for the future here, by all who have been touched by the late Mr Dale Thomson's life.