SHERIFFDOM OF GLASGOW AND STRATHKELVIN

[2024] FAI 32

GLW-B1210-22

DETERMINATION

BY

SUMMARY SHERIFF DIANNA McCONNELL

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

into the death of

ELIZABETH McCREADY

Glasgow, 20 August 2024

The sheriff, having resumed consideration of the cause, Finds and Determines that in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") the following:

(1) In terms of section 26(2)(a) of the 2016 Act (when and where the death occurred) that the death of Elizabeth McCready, born 22 October 1968, occurred at 2040 hours on 30 June 2018 at Glasgow Royal Infirmary, Glasgow.

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

1(a) Multi-organ failure.

1(b) Paracetamol intoxication (clinical diagnosis).

(3) In term of section 26(2)(e) of the 2016 Act, a precaution which could reasonably have been taken that might realistically have resulted in the death being avoided;

A possessions check should have been carried out in respect of Ms McCready when she was admitted to Munro Ward, Stobhill Hospital, Glasgow on 23 June 2018.

(4) In terms of section 26(2)(f) of the 2016 Act, there was no defect in any system of working which contributed to the death.

(5) In terms of section 26(2)(b) and (d) of the 2016 Act, there was no accident on which to base any findings.

(6) In terms of section 26(2)(g) of the 2016 Act (any other facts which are relevant to the circumstances of the death:

The entry in the medical records dated 25 June 2018 at 16:20 hours is inadequate to the extent that it is ambiguous and inconclusive as to whether Ms McCready did in fact accept going to the shops on 25 June 2018. This was potentially important information and the entry in the records should have been fully detailed and unambiguous.

(7) In terms of section 26(1)(b) of the 2016 Act I have no recommendations which might realistically prevent other deaths in similar circumstances arising from the evidence.

NOTE:

Introduction

[1] This is a discretionary Inquiry held under section 4 of the 2016 Act the death having occurred in Scotland in circumstances which give rise to serious public concern and it

appeared to the Lord Advocate to be expedient and in the public interest for an Inquiry to be held into the circumstances of the death.

The proceedings and the parties

[2] Preliminary hearings took place at Glasgow Sheriff Court on a number of occasions before a brother Sheriff, the Inquiry itself was held from 11 September 2023 to 14 September 2023; from 14 November 2023 to 16 November 2023 and on 5 and 14 December 2023 concluding with a hearing on submissions on 27 March 2024. Ms A Doran, procurator fiscal depute, represented the Crown. Ms L Doyle represented the next of kin Mrs Elizabeth Bendoris. Mr A Rodgers represented Nurse Claire Fitzsimmons. Ms N McCartney represented Dr R McCaffery and Dr N Gajree and Mr Fitzpatrick, counsel, represented Greater Glasgow Health Board.

The sources of evidence

[3] Three joint minutes of agreement were entered into by the parties. I heard evidence from 13 witnesses, 12 of whom who gave evidence at Glasgow Sheriff Court and one gave evidence by Webex. I also had the benefit of affidavit evidence from four additional witnesses. A large number of productions were submitted in advance of the hearing. Several productions were lodged in the course of the hearing. At the conclusion of the evidence all parties submitted full and detailed written submissions which were supplemented by oral submissions on 27 March 2024. I am grateful to parties for their assistance in the preparation and conduct of the Inquiry.

The Legal framework

[4] The Inquiry is held under section 1 of the 2016 Act and is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 rules"). The purpose of such an Inquiry is set out in section 1(3) of the 2016 Act and is to:

(a) establish the circumstances of the death, and;

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

[5] In cases where the circumstances of the death do not give rise to a mandatory inquiry, an inquiry may nonetheless be held on a discretionary basis in terms of Section 4 of the 2016 Act, where to do so appears to the Lord Advocate to be expedient in the public interest on the ground that the death was sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern. This Inquiry is accordingly a discretionary Inquiry, the death having occurred in Scotland in circumstances which give rise to serious public concern.

[6] Section 26 of the 2016 Act requires the sheriff to make a determination and section 26(2) sets out the factors relevant to the circumstances of death insofar as they have been established to the satisfaction of the sheriff. These are:

(a) when and where the death occurred;

(b) when and where any accident resulting on the death occurred;

(c) the cause or causes of the death;

(d) the cause or causes of any accident resulting in the death;

(e) any precautions which –

(i) could reasonably have been taken, and

(ii) had they been taken might realistically have resulted in the death or any accident resulting in the death, being avoided;

(f) any defects in any system of working which contributed to the death or any accident resulting in the death;

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

[7] For the purposes of subsection 2(e) and (f) it does not matter whether it was foreseeable before the death or accident that the death or accident might occur –

(a) if the precautions were not taken, or;

(b) as the case may be, as a result of the defects

[8] With regard to any recommendations, the matters referred to in Section 26(1)(b) are as follows:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working

(d) the taking of any other steps which might realistically prevent other deaths in similar circumstances.

[9] The scope of inquiry therefore extends beyond simply establishing the facts relevant to the death of Ms McCready, but to establish whether if future deaths occurring in similar circumstances could be prevented and to restore public confidence and allay public anxiety arising from the circumstances of the death of Ms McCready.

[10] The standard of proof at any Inquiry under the 2016 Act is the civil standard of proof on the balance of probabilities. It is not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability. An Inquiry is an exercise in fact-finding; not fault-finding. An Inquiry is an inquisitorial process; the purpose being to bring out in public the facts and circumstances of the death. It is not a trial of anyone, nor is it a proper forum for determining fault; it is not an exercise in pillorying or stigmatising any individual or individuals or apportioning blame amongst them.[1] The examination and analysis of the evidence is conducted with a view only to setting out in the Determination the circumstances which section 26 of the 2016 Act refers, in so far as it can be done.

The Issues

Ms McCready, was an informal psychiatric patient with suicidal ideation and was able surreptitiously to consume a fatal overdose of paracetamol whilst receiving inpatient care in a hospital ward. Paracetamol was neither prescribed nor administered as part of her inpatient management. She therefore either brought it with her into the hospital, or acquired it while on the ward or during an unauthorised absence or absences from the ward. The issue of public concern is how the circumstances giving rise to her death can have happened while she was in hospital care.

[1] *Low* [2007] FAI (under Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976)

A Summary of issues to be addressed by the Inquiry

- The possessions check on admission to Munro ward
- Risk assessment and observation level
- Leaving the ward without permission or supervision
- Ward check logs missing
- Inadequate record keeping
- Named nurse on leave when assigned
- The 72 hour assessment not completed
- Half hourly observations
- Failure to document family concerns
- Failure to obtain a corroborative account from family
- Failure to escalate certain information to medical staff
- Absence of electronic medical records
- Switchboard fault
- Participation in and dissemination of the outcome of the significant Clinical Investigation

[11] There was substantial agreement between parties in relation to the factual background in relation to Ms McCready's medical history and treatment she received in the period leading up to her death. In addition, a substantial number of productions lodged and referred to by witnesses to the Inquiry were agreed as true and accurate copies.

[12] The factual circumstances agreed by the parties were incorporated in three joint minutes:

Background in terms of the three joint minutes

[13] Elizabeth McCready (hereinafter referred to as "Ms McCready") was born on 22 October 1968 and was 49 years of age at the date of her death on 30 June 2018. She was unemployed and lived at home in the east end of Glasgow with her son, who was 18 years of age at the date of her death. She also had an adult son and daughter. She had a non-cohabiting partner. She had six brothers, two of whom pre-deceased her. Her father died when she was 13 years old. Her mother is alive.

[14] Ms McCready's past had been punctuated by trauma. She had been in a long-term abusive relationship with a partner who subsequently died. She had been addicted to heroin and suffered from mental illness, including depression and anxiety. She had attempted suicide on several occasions. One of her siblings who pre-deceased her had taken his own life, the other died in a road traffic collision. There was a family history of Schizophrenia. Ms McCready had previously reported a difficult relationship with some members of her family, including the relationships she had with her mother, her daughter - from whom she was estranged - and her grandson, whom she did not have access to.

History of psychiatric ill health and overdose

Overdose 1987

[15] On 8 May 1987, when she was 18 years old, Ms McCready was admitted to Glasgow Royal Infirmary (hereinafter referred to as "GRI"), Alexandra Parade, Glasgow, G31 2ER. She had taken an overdose of Amitriptyline (a tricyclic antidepressant). She recovered and was discharged with no follow-up.

Overdose 1994

[16] On 27 September 1994, Ms McCready was admitted as an emergency to Crosshouse Hospital, Kilmarnock, for a deliberate overdose. She had taken 25 tablets of Tegretol (an antiepileptic medicine), 4 tablets of Ibuprofen, plus other unknown tablets. She was referred for psychiatric assessment prior to discharge. No medication was prescribed on discharge from the psychiatric assessment and no out-patient follow up was arranged.

Overdose 1997

[17] On 19 November 1997, Ms McCready was admitted to the Victoria Hospital, Blackpool, England, following a deliberate overdose of Prothiaden (a tricyclic antidepressant) following an episode of domestic violence. She was discharged home and did not wish to attend a domestic violence refuge.

Overdose 2017

[18] On 14 September 2017, Ms McCready was admitted to GRI. She presented as having taken an overdose of an unknown quantity of antidepressants, antipsychotics, and alcohol. She was admitted to hospital for further monitoring and assessment. She reported low mood and vague suicidal ideas.

[19] On 15 September 2017, Ms McCready was referred to the Northeast Area Crisis Team by liaison psychiatry at GRI. It concluded that whilst she presented with low mood and was flat in affect, this was because of her social situation and the breakdown of her family relationships. The Northeast Crisis Team did not consider they could offer a role to support Ms McCready and she was transferred back to the care of her General Practitioner.

May 2018

[20] On 14 May 2018, Ms McCready attended her General Practitioner stating her current medication was not positively helping the symptoms she was experiencing. She admitted to experiencing anxiety and low mood with flashbacks. She was assessed as having no thoughts of self-harm or any suicidal ideation. Ms McCready was referred to the Community Mental Health Team (hereinafter referred to as 'CMHT') on 14 May 2018 by her General practitioner, Dr Allan McNeill. The urgency of the referral was marked "routine".

Psychiatric ill-health and overdose 2018

19 June 2018

[21] Ms McCready was assessed at Auchinlea CMHT by a community psychiatric nurse ("CPN"). She described experiencing low mood and anxiety. She denied any current suicidal ideation, plans or intent. Ms McCready indicated that she felt her medication was not effective. The issue with her medication was to be discussed at the next Multidisciplinary team meeting (hereinafter referred to as "MDT"). A Clinical Risk Screen and Management Tool (hereinafter referred to as "CRSMT") was completed. Ms McCready was awaiting a follow-up appointment with CMHT but was admitted to hospital before that appointment could be scheduled.

[22] A Specialist Shared Assessment relating to Elizabeth McCready (hereinafter referred to as "SSA") was completed by a student nurse Karleen Burke, and counter signed by Lorna McCann, Charge Nurse (now Community Psychiatric Nurse) on 20 June 2018.[2] This was completed following an assessment of Ms McCready at Auchinlea Community Mental Health Team (hereinafter referred to as "CMHT").

[23] The SSA was completed following a routine referral by General Practitioner, Dr Allan McNeill on 14 May 2018 due to Ms McCready experiencing anxiety and low mood.[3] During the SSA, Ms McCready was said to be concordant

[2] Crown Production 39, page 1040 – 1050.
[3] Crown Production 39, page 1040.

with all of her prescribed medication, but she reported that they were ineffective.[4] She reported, amongst other matters, that she had frequent flashbacks; that domestic abuse had been perpetrated against her; and suggested that she had been sexually abused. She reported low mood and anxiety. She reported a volatile relationship with her children.[5] Ms McCready described memories "haunting" her.[6] She reported hearing her ex-partner's voice but identified this as a memory as opposed to hallucinations.[7] She also reported that she feels her ex-partner touching her. She reported her concentration to be poor and her sleep to be poor for months. She reported thoughts of suicide, however denied any plans or intent to act on those thoughts.[8] Nursing staff commented that she had insight to her mental health and was able to rationalise her thoughts regarding hearing her ex-husband's voice.[9] She reported her son to be a protective factor, however she stated she had to look after him as he was experiencing difficulties with his own mental health. She reported that she had had previous suicide attempts and had stockpiled medication. She stated she had done this when her youngest son was in hospital and said she was under the influence of alcohol at the time. She reported that she did not think talking therapy would help her and she asked for a medication review as she felt her current medication was not effective.[10]

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[4] Crown Production 39, page 1043.
[5] *Ibid,* 1044
[6] *Ibid*, 1047
[7] *Ibid,* 1046
[8] *Ibid*, 1047
[9] *Ibid,* 1047
[10] *Ibid*, 1047

[24] A summary of the SSA was completed by the same nurse on 27 June 2018. Said summary reports that Ms McCready rated her mood as 1/10 however this could improve to a 4/10 when she was with her partner as she "feels safe with him".[11] She denied any suicidal ideation or thoughts of self-harm and at that time identified her son as a strong protective factor. She reported further suicide attempts, the most recent of which was 15 September 2017. She reported to be under the influence of alcohol at the time and was able to identify alcohol to be the drive behind this.[12] No thought disorder was noted or observed.

21 and 22 June 2018

[25] Ms McCready was brought to GRI in an ambulance at 00:49 hours on 22 June 2018 following an intentional mixed overdose, having been consumed at approximately 22:30 hours on 21 June 2018. She presented as having taken 20 diazepam tablets (2 milligram dose), 20 mirtazapine (an antidepressant) (45 milligram dose), 20 sertraline tablets (an antidepressant) and an unknown quantity of aripiprazole (an antipsychotic drug) and terazosin (an alpha-blocker). Some of these medicines had been prescribed to Ms McCready and some were prescription medications prescribed to another. After taking the tablets, she contacted her youngest son by telephone, informing him of her actions and asking him to care for her dogs. Her son contacted the emergency services.

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[11] *Ibid*, 1050
[12] *Ibid,* 1049

23 June 2018

[26] Carol Gardner, Liaison Mental Health Nurse from Glasgow Liaison Psychiatry Service assessed Ms McCready within GRI. Carrying out a mental health assessment and management plan in respect of Mrs McCready on 23 June 2018 at ward 4, Glasgow Royal Infirmary.[13] She wrote to Mrs McCready's GP on the same day.[14] Nurse Gardner discussed her assessment with the duty doctor at Mackinnon House, Stobhill Hospital, who was in agreement with Ms McCready being admitted to Munro Ward as an informal patient. Following assessment, Ms McCready was considered actively suicidal with no identifiable safety plan. Her circumstances were discussed with the duty doctor at Munro ward (hereinafter referred to as 'the ward') at The New Stobhill Hospital (hereinafter referred to as 'Stobhill').

Admission to Stobhill

Admission process

[27] Stobhill is located at 133 Balornock Road, Glasgow, G21 3UW. Stobhill contains acute adult mental health inpatient admissions wards. The ward is a 20-bedded, mixed-sex adult acute mental health ward. Thirty nurses cover the ward, 24 hours per day, 7 days a week. The ward has six ensuite bedrooms and three

[13] Crown Production 14
[14] Crown Production 14

dormitories with separate toilet and showering facilities. The ward is an unlocked ward.

[28] The ward receives both formal and informal patients. A formal patient is someone who has been detained under the relevant Mental Health Act. An informal patient is one who has agreed voluntarily to go to the ward for treatment.

[29] Following an intentional mixed drug overdose on 21 June 2018, Ms McCready was admitted to ward 4 of Glasgow Royal Infirmary on 22 June 2018.[15] Following assessment, she was then admitted to Munro Ward, McKinnon House, Stobhill Hospital on 23 June 2018 for further inpatient psychiatric help. Her admission was informal, and she was not detained. She was placed under general observations. Dr Hannah Crockett carried out Ms McCready's medical assessment upon admission to Stobhill.[16] Nurse Claire Fitzsimmons admitted Ms McCready to the ward, carried out a nursing assessment and completed admissions paperwork.[17]

[30] When Ms McCready was admitted to Stobhill hospital, the normal possessions check was not documented as having been carried out. She had been transferred there by taxi with a nurse escort from Glasgow Royal Infirmary, with "N/A" noted on the discharge form in a box headed "own medication returned to patient".[18] The Significant Clinical Incident Investigation which took place after

[15] *Ibid,* 964
[16] *Ibid,* 1282
[17] *Ibid,* 1271
[18] Crown production 3, page 191

Ms McCready's death concluded that it is possible that she brought paracetamol into the ward with her, and concluded that the lack of a possessions check may have significantly contributed to the incident which led to Ms McCready's death.[19]

[31] Ms McCready's care plan assessment was to be completed within 72 hours of admission to Stobhill Hospital. The 72-hour admission assessment was started on 26 June 2018 but according to the findings of the Significant Clinical Incident investigation was not completed.[20] The Significant Clinical Investigation concluded this was unlikely to have had a significant impact on the incident.

[32] When admitted to Stobhill hospital, Ms McCready was allocated a named nurse, Hugh McGregor who was on "annual leave" (having finished his shift just before Ms McCready was admitted on 23 June, and not being back on shift until 25 June). This allocation was completed by Senior Charge Nurse Catherine McCauley. Allocating a patient, a named nurse who is on annual leave is contrary to policy.[21]

[33] On 24 June 2018, Ms McCready was reported to be responding to unseen stimuli and hearing the voice of her ex-partner.[22] She was offered and accepted 2mg of lorazepam for agitation. On the same date, she left the ward without consulting staff. The time that Ms McCready was off the ward on 24 June 2018 was not documented in any nursing notes. There are four nursing entries in

[19] Crown Production 16, page 693.
[20] *Ibid,* page 691.
[21] *Ibid,* 692.
[22] Crown Production 12, page 633.

Ms McCready's records on 24 June 2018. The entry at 1928 hours on 24 June 2018 notes that she slept for a few hours in the afternoon and the entry recorded at 1940 hours recorded she had returned to ward with family.[23]

[34] On 25 June 2018 a multidisciplinary team review (hereinafter referred to as an "MDT") took place.[24] Ms McCready told staff that she was experiencing suicidal ideation. During the MDT meeting, Ms McCready stated to staff that, "death was the only thing that could make things better" for her.[25] No delusions were noted or abnormal interpretation of voices. Suicidal thoughts were noted however no plans or intent. It was considered that the diagnosis was not immediately clear, but that Ms McCready was presenting with symptoms of PTSD, and that her "voices" were likely related to this. Ms McCready's observation level remained unchanged from "general".[26] A plan was set to ask a psychologist to provide literature to Ms McCready on techniques to use when experiencing symptoms of PTSD and for therapeutic activity to be offered to manage her stress and anxiety. A plan was also made to review her past psychiatric history, review past medications, discuss with her GP, refer to TAN for stress coping techniques and anxiety management and to start discussions about trauma work. Zopiclone was prescribed as required to assist with sleeping.[27]

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[23] *Ibid,* 634, 635.
[24] *Ibid,* 635
[2525] *Ibid,* 637
[26] *Ibid,* 638
[27] *Ibid,* 638

[35] On 28 June 2018 Ms McCready attended a ward review with Dr Neera Gajree but did not engage.[28] She sat with her head in her hands looking at the floor and responded to questions by saying, "I don't know what you mean".[29] She was wearing her dressing gown and was described as dishevelled, sullen and irritable, staring at the floor and demonstrating nil eye contact.[30] She was noted to have no formal thought disorder ("NFTD").

[36] Ward check logs are missing.[31] It is unclear how often or for how long Ms McCready may have left the ward. The time that Ms McCready was absent from the ward on 24 June 2018, is not documented in nursing notes. It is unclear whether Ms McCready left the ward on 25 June 2018, as it is not documented in nursing notes.

[37] Ward check logs may have been destroyed, contrary to Greater Glasgow and Clyde Policy.[32]

[38] Local ward practice of "half hourly welfare checks" on all patients was inconsistent with the practice across the Inpatient Mental Health campus and the NHS Greater Glasgow and Clyde Safe and Supportive Observation Policy and Practice Guidance.[33] The Guidance was for hourly checks to be carried out for patients under general observation with variation where perceived risks dictate.

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[28] *Ibid,* 645
[29] *Ibid,* 645
[30] *Ibid,* 645
[31] Crown Production 22, page 733.
[32] Crown Production 16, page 692.
[33] Crown Production 29, page 807.

The Significant Clinical Investigation concluded this had no bearing on the incident. However, the Significant Clinical Investigation did conclude that there were differences in nurses' accounts of what the checks meant meaning it is possible that the level of reliance placed on the half hourly checks could be misleading.[34]

[39] The Significant Clinical Investigation concluded that there was no "safety net" of checks for admission routine processes and had there been, it is possible that lapses such as failure to carry out a possession check could have been rectified timeously.[35]

[40] The standard practice by nursing staff on the Munro ward was to make nursing entries once at the end of a shift.[36] The Significant Clinical Investigation concluded that nursing documentation was "light".[37]

[41] In the 24 hours prior to Ms McCready being discovered unresponsive on the ward at Stobhill hospital on 29 June 2018, there were only two entries in her notes. One entry was at 1926 hours the evening prior (28 June 2018), and one entry at 0600 hours on the morning of 29 June 2018.[38] The entry at 0600 hours on 29 June 2018 reads: "Eliz [sic] in bed at start of duty. Irritable + short tempered at times. Refused all 10pm medication. Slept well".[39] Nurse Claire Fitzsimmons was the

[34] Crown Production 15, page 692
[35] *Ibid*, 692
[36] *Ibid,* 692.
[37] *Ibid,* 692
[38] *Ibid*, 692
[39] Crown Production 12, page 646.

author of the entry at 1926 hours where she noted: "Slept for most for the vast majority of the day. Refused morning medication – would not get up. Up for brief periods to smoke. Muttering at times, shouting at others. Not appearing distressed".[40]

[42] The NHS Greater Glasgow and Clyde Safe and Supportive Observation Practice Guidance states at page 742, paragraph 1.3. that, "it is *expected* that patients on general observation will not leave the ward without advising staff". Within the same document at page 742, paragraph 1.4 it states, "patients *must* advise staff when they plan to leave the ward".[41]

[43] All discussions with the patient regarding observation levels should be documented in the patient record and reflected in the care plan.[42]

[44] When Ms McCready was found unresponsive on the ward on 29 June 2018, a "2222" call was made. However, there was a delay in response. An error on the switchboard resulted in the general medical arrest team at the main hospital being called initially and in error. Following Ms McCready's death on 30 June 2018, this was rectified.[43]

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[40] *Ibid, page* 646
[41] Emphasis added by PFD.
[42] Crown Production 25, page 764.
[43] Crown Production 15, 692.

29 – 30 June 2018

[45] Ms McCready was conveyed to hospital by paramedics and subsequently admitted to the emergency department of GRI. She was hypoglycaemic, presenting with evidence of liver necrosis and profound metabolic acidosis (a condition in which there is excess acid in the body fluids) and a Glasgow Coma Scale of 11.

[46] Ms McCready was assessed by Trainee Psychiatrist, Ben Chetcuti, on 29 June 2018 whilst on the ward at Glasgow Royal Infirmary. He was asked to see Ms McCready by colleagues in Accident and Emergency to provide a psychiatric opinion of her. He described Ms McCready as, "confused and apparently disorientated. Not answering questions. Just shouting incomprehensibly".[44] He concluded that she had likely ongoing suicidal ideation. Ms McCready was placed on an Emergency Detention Certificate. She was placed on constant observation.[45]

[47] Ms McCready was transferred to the Intensive Care Unit. Her blood pressure deteriorated, and she required vasopressor support (a form of life support and a group of medicines that contract blood vessels and raise blood pressure). She received three cardioversion shocks but did not improve. She had an acute kidney injury but did not require dialysis. A discussion took place with the liver unit in Edinburgh regarding her suitability for transfer for transplant, however, due to her psychiatric history and multiple overdoses, Ms McCready

[44] Ibid, 680
[45] *Ibid*, page 680.

was not deemed a suitable candidate for transplant treatment and a conservative management plan was preferred. She was stable for 24 hours.

30 June 2018

[48] Ms McCready's condition continued to deteriorate progressively, consistent with paracetamol overdose. She had multi-organ failure including liver failure, her kidneys were not working, and her brain was affected by liver failure. She experienced increasing cardiovascular instability, rapidly worsening acute respiratory distress syndrome and worsening conscious levels which required intubation and ventilation. She had very low oxygen levels due to lung injury and bruising throughout her body due to liver damage. She was diagnosed with acute liver failure secondary to significant paracetamol overdose with hepatic encephalopathy (a loss of brain function as a result of failure in the removal of toxins from the blood due to liver damage), coagulopathy (the blood's ability to coagulate/form clots is impaired) and acute kidney injury. Ms McCready became increasingly unstable, despite maximal therapy. She rapidly developed malignant arrhythmias and cardiac arrest. Cardiopulmonary resuscitation (CPR) was not attempted due to the irreversibility of her condition.

[49] Following discussion between medical personnel, it was agreed that care would be withdrawn. Life was pronounced extinct at 20:40 hours, 30 June 2018.

Post mortem and toxicology

[50] Post mortem examination was carried out on 4 July 2018 at the Queen Elizabeth University Hospital, Glasgow by Dr Sharon Melmore, Forensic Pathologist, University of Glasgow. Cause of death was listed as:-

1a. Multi organ failure, due to

1b. Paracetamol intoxication (clinical diagnosis)

[51] Dr Melmore confirmed multi organ failure was in the form of an accumulation of fluid in the lungs (pulmonary oedema), jaundice of the skin and sclera (the part of the eye commonly known as the white) and bruising. There was also microscopic evidence of infection and inflammation in the lungs.

[52] Toxicological analysis of samples retained at the time of the post mortem examination and of hospital bloods revealed Ms McCready had levels of both antipyretic and analgesic paracetamol.

[53] Ms McCready had many bruises which Dr Melmore concluded were consistent with the effects of liver failure. No significant injury was identified which could have caused or contributed to death.

[54] Following the death of Elizabeth McCready a significant clinical incident investigation was commissioned by Greater Glasgow Health Board on 24 July 2018 and Crown production 16 is the report of that investigation.

[55] An action plan [46]was developed in response to the six recommendations made at section 6 of the CSCI.

[56] The action plan was input on datix[47]. It also appears in a tabular format[48].

[57] Janice Naven prepared the documentation outlining what has been done in response to the SCI recommendations after assuming her role as inpatient services manager[49].

[58] Audits of the general observation charts for all wards within Stobhill Hospital were completed in March and April 2021 (Greater Glasgow Health Board productions 1 – 9) and in July 2022 (Greater Glasgow Health Board productions 10 – 18) and reports on those audits have been prepared and are contained within Greater Glasgow Health Board productions 19-21.

[59] An audit was undertaken in July 2022 at Stobhill Hospital relevant to checking and documenting patient belongings. The audit report is dated August 2022 (Greater Glasgow Health Board production 23). The audit identified that checks of shopping and deliveries were performed on an individual basis usually influenced by patient safety concerns.

[60] An audit of practice in terms of care planning and named nurse allocation was performed on the mental health wards at Stobhill Hospital and Greater Glasgow Health Board production 24 is the report of that audit dated December 2022.

[61] In terms of the standard operating procedure that has been introduced, the inpatient observation charts are to be retained within the ward for a minimum of 18 months[50]. Audits

[46] Crown production 17 and Crown production 18
[47] Crown production 17
[48] Crown production 18
[49] Crown production 31
[50] Crown production 25, page 763, paragraph 4

have confirmed that staff are aware the check sheets are retained for 18 months (Greater Glasgow Health Board productions 1 – 18).

Summary of witnesses' evidence to the Inquiry

Witness – Elizabeth Bendoris

[62] Elizabeth Bendoris is 89 years old. She is the mother of the deceased Elizabeth McCready who was her only daughter. Mrs Bendoris has six other children, all sons.

[63] Mrs Bendoris gave evidence that Ms McCready had three children, two boys and one girl, namely David, Catherine and William. Her evidence was that she thought that Ms McCready had been quite unwell with mental health problems prior to her death but that she did not really know the extent of those. Mrs Bendoris knew that Ms McCready took paracetamol and other medication, as she suffered from headaches. Mrs Bendoris was told by her granddaughter Catherine that Ms McCready had been admitted to Stobhill Hospital just before she went on holiday. She was not particularly concerned before she went on holiday but had noticed that Ms McCready had been a bit quieter than usual when she visited her. She gave evidence that Ms McCready had come to help paint her house before she went on holiday. She commented that Ms McCready's son William took a lot of drugs and Ms McCready came to her mother's to get away from him. She said that Ms McCready was terrified of her son and it caused her a lot of stress. Mrs Bendoris agreed that she had lost two of her children, one in a car accident and the other who had schizophrenia had committed suicide. She agreed that Ms McCready would not always tell her about all her worries as she did not want to cause her further upset.

[64] She recalled that Ms McCready phoned her from Stobhill Hospital and asked how her holiday had been and asked how her brother, who has dementia was doing. Ms McCready then told her, "I don't feel too good". Ms McCready said "I don't know what's wrong but something's wrong with me" and Mrs Bendoris told her that she needed to tell the doctor. The phone just went dead. Mrs Bendoris said that she phoned the hospital right away to report the phone call from Ms McCready. Their response was that Ms McCready was sleeping. Mrs Bendoris questioned that because she had just been talking to her. The call then ended abruptly. She was not sure who she spoke to at the hospital.

[65] Nobody at Stobhill spoke to her about Ms McCready's health, her marriage or her medical history. She did not think there was anything wrong with Ms McCready but acknowledged that she had taken an overdose before. She did not have much awareness of Ms McCready's mental health difficulties. She felt Ms McCready was not happy because of her son and his problems.

[66] After Ms McCready died Mrs Bendoris and her granddaughter Catherine met with Dr McCaffery and a nurse. She could not recall the date and could not really recall what she had been told about what was wrong with Ms McCready. Mrs Bendoris knew that Ms McCready had taken drugs in the past and her belief was that James Gray had influenced her negatively. She acknowledged that she did not really know James Gray very well. She recollected that Ms McCready had been beaten by her ex-husband.

[67] They had told the doctor at the meeting that Ms McCready had said that she had suicidal thoughts before she was admitted to Stobhill. Despite that, she believed that

Ms McCready did have plans to live – she had a wee grandson (Catherine's son) and although she and Catherine had fallen out, Ms McCready would come to Mrs Bendoris' house to see her grandson. The day before Ms McCready took the overdose she had spoken to her on the phone and she seemed fine. Mrs Bendoris was shocked to find out Ms McCready was in Stobhill and was unable to go and visit her there because of her own health.

[68] Mrs Bendoris conceded that she did not like James Gray.

[69] Mrs Bendoris confirmed that just before she had gone on holiday Ms McCready was back to visiting her almost every day.

Witness - James Gray

[70] James (also known as Jamie) Gray is 59 years old. He is unemployed and he was in a relationship with the deceased Elizabeth McCready at the time of her death. They had been in a relationship for around 16 months. He said he was "slightly aware" that Ms McCready had mental health problems at the time of her death.

[71] Mr Gray had attended with Ms McCready at Auchinlea Community Health Centre in Easterhouse around 19 June 2018. His evidence was that just before Ms McCready was admitted to hospital she had been waiting for a community psychiatric nurse to come and see her following upon a visit to the community health centre on 19 June2018. Mr Gray recalled that Ms McCready had started using headphones to block out voices. This was just before she was admitted to Stobhill Hospital. She told him that the voice she was hearing

was that of her ex-partner. Ms McCready's ex-partner had passed away about 2 years prior to June 2018.

[72] Mr Gray and Ms McCready did not live together but she visited regularly and she loved staying with Mr Gray because she felt safe. Ms McCready's son (William) suffered from mental health issues and she found William quite challenging. On 22 June 2018 it was Mr Gray's birthday and Ms McCready came round and had a cup of tea but she was "ratty". She started shouting which was unlike her. Words were exchanged and she left. They were still in contact via Facebook and Mr Gray became aware that she was in Glasgow Royal Infirmary having taken an overdose of pills. Ms McCready took the overdose the day of his birthday on 22 June 2018. He was shocked but thought she was going to be okay. She had told Mr Gray months before that she was suicidal but she promised him that she would not commit suicide.

[73] Mr Gray's evidence was that Ms McCready loved her family but there were issues. He tried to get on with Ms McCready's family but he did not think that they liked him. When he spoke to her when she was in Glasgow Royal Infirmary she sounded alright, according to Mr Gray, but said that she needed a break and that was why she was going to Stobhill Hospital.

[74] He visited her on the Munro Ward in Stobhill and took some things to her for her use, including underwear and other various items, he thought that was on the Sunday or Monday after she had been admitted.

[75] When he entered the Munro Ward he thought he pressed a buzzer but he formed the impression that there was not a lot of security.

[76] He thought that on his first visit Ms McCready came to fetch him and took him to the garden area. He could not remember whether he spoke to any members of staff on that occasion.

[77] When asked what he and Ms McCready talked about on this occasion he said that Ms McCready told him she loved him and apologised for shouting. His recollection was that he had visited her about two or three times and on the second occasion they went to Springburn Park accompanied by his daughter. He said he was not aware of any formalities or rules that had to be followed to leave the ward.

[78] Mr Gray could not remember whose idea it was to leave the ward. He was not made aware of whether Ms McCready was permitted to be off the ward at any specific times. He could not remember whether she took a mobile phone with her. The park was about a 10 or 15 minutes' walk from the Munro Ward but they went for chips first and said variously that they were way for about half an hour or about an hour in total. He took Ms McCready back to the hospital and said that they buzzed the door again and a staff member let them in. He said that no members of staff spoke to them at that point and nobody asked where they had been.

[79] He said that either the next day after the visit to Springburn Park or the day after that Ms McCready told him that she was hearing voices. She said it was her ex-partner and he told her to throw herself under a bus. He was concerned about this and phoned the ward and spoke to a male staff member telling him "don't let her out she's hearing voices to throw herself under a bus". He did not recognise the voice and he did not ask for any details.

[80] He thought that he must have visited her on the Sunday (24 June) and took her possessions and visited Springburn Park. He thought the conversation about her hearing voices was either the Monday, 25 or Tuesday, 26 June. He phoned the staff straight away. He recollected that he and his daughter then attended on the Wednesday and that they stayed in the garden. He picked William up in a taxi and took him to visit Ms McCready. His recollection was that Ms McCready argued with William. Mr Gray thought he had spoken to nursing staff a few times and on one occasion when he was visiting, he was concerned about her presentation.

[81] On the Wednesday he described Ms McCready as being sprawled out lying on a bench "as if she was possessed". She looked "sparkled" when she lay down on the bench. She was then up dancing and singing which was very unlike her because she was a quiet person. His recollection was that he must have spoken to someone about his concerns. He recollected that Ms McCready told him that she was arguing with a nurse and asked him to get her out of the hospital. He tried to reassure her. He was also aware that she visited an ice cream van, because she phoned him twice whilst she was at the van.

[82] He thought that Ms McCready was going to the shops. She did not tell him she was going to buy paracetamol. She did not ask him for paracetamol because he did not have it and he was not aware that she had asked anyone else to bring in paracetamol.

[83] Mr Gray confirmed that he was not searched when he brought items in for Ms McCready and was not searched when he returned from the park with her.

[84] He said that Elizabeth was a heavy smoker and his impression was that she perhaps got cigarettes from another patient because his understanding was that "the patients

swapped stuff". He said that her mood got worse and worse. She told him to tell William not to phone her because he was making her mental health worse.

[85] She was taken to Glasgow Royal Infirmary and he thought that she was then taken to the Queen Elizabeth where she died. Mr Gray said that he was extremely upset and remembered her dying at the Queen Elizabeth because he was there. It was suggested to him that he was mistaken but he was adamant.

[86] Mr Gray's recollection was that he was with her before she died and that he was "bawling and screaming".

[87] In cross-examination Mr Gray was asked whether Ms McCready told him what drove her to take an overdose during 2018 and he said that Ms McCready's daughter Catherine found out that she was talking to her son and grandson in England, she tried to keep this from her daughter but she found out and this caused an issue

[88] He said that he had a very good relationship with Ms McCready. She had talked about her future with him and he was shocked and heartbroken when she died.

Witness – Catherine McCready

[89] Catherine McCready is 28 years old. She is the daughter of Elizabeth McCready.

[90] She has two brothers, William and David.

[91] The witness described Ms McCready as a lovely lady who was very family orientated and was respectful and polite. She did however have a background of depression and was unwell. She last saw her in March 2018 and they had a falling out. They were not on speaking terms when Ms McCready was admitted to Stobhill

Hospital. When she last saw her mother she was quite different having lost a lot of weight and did not seem herself.

[92] She felt that her mother hid a lot of her emotions and did not let on how she was feeling to her and her siblings. She was very shocked when she heard that her mother was in hospital having taken an overdose. Her mother found living with William difficult, he had problems with drink and drugs and had mental health issues. He could be violent in the house.

[93] She recalled speaking to her mother on the Tuesday of the week she was in hospital. She phoned her mother's mobile phone and Ms McCready told her that she was starting to hear voice of Catherine's deceased father. She wanted Catherine to come to the hospital to visit her but the witness could not do that because of her son. She also told Catherine that she was dancing with people up and down the ward which was not like her. James Gray then told her that Ms McCready did not like Catherine phoning her. She phoned her mother on Wednesday to ask her why she had said that and Ms McCready said "stop phoning me, leave me alone". In the same phone call Ms McCready told Catherine that she was going to a shop nearby and to an ice cream van. She said she was buying washing up liquid and soap powder at the ice cream van. She said she was going to the shop to buy paracetamol. This concerned her and she phoned her brother to discuss.

[94] Catherine asked her why she was buying paracetamol. It made Catherine feel really panicky but she could not go to the hospital because she had no child support in place, she had interpreted what her mother told her about buying Paracetamol as an

intention to harm herself. Ms McCready told Catherine that she was walking to the shop and was not supervised.

[95] She confirmed that she had not told medical staff that Ms McCready was planning to buy paracetamol.

[96] She felt that Ms McCready should have been on a more rigorous level of supervision.

[97] When Ms McCready's belongings were returned to her there were five packets of foreign brand cigarettes in her belongings whereas her mother was in the habit of smoking menthol cigarettes and a mixture of clothing some of which were not Ms McCready's.

Witness – Carol Gardner

[98] Mrs Gardner is 51 years old and is a qualified mental health nurse. She is an approved mental health practitioner.

[99] She worked in Glasgow Royal Infirmary from January 2018 until November 2020 as a liaison psychiatric nurse. Her role was to work in mental health services in GRI so typically she would be asked to see people who presented on admission to GRI with mental health needs, for example those who had self-harmed or patients in accident and emergency whom she was asked to assess. She performed the role of liaison between general medicine and psychiatric services.

[100] Mrs Gardner first encountered Ms McCready when she presented at Glasgow Royal Infirmary having taken a mixed intentional overdose. Ms McCready had been brought to Glasgow Royal Infirmary by ambulance in the early hours of 22 June 2018.

[101] She carried out a risk assessment using a clinical risk screening and management tool. It includes an assessment of historical alcohol use, trauma, vulnerability and domestic abuse. It is a tool used to give services a view of what the possible risks to the patient are taking account of historical risk. Part of the document used is hand written and there is a part which is typed later. Ms McCready was not detained under the Mental Health Act. Her status was informal. She obtained some information from Ms McCready and other information specifically from EMUS, which meant accessing Ms McCready's previous mental health records, from which she was able to see any previous mental health issues and history.

[102] Ms McCready had previously self-harmed. She had ticked the box for impulsivity (which means prone to quick change of mood which may result in self-harm or suicide) but was not sure whether this was self-reported by Ms McCready or was on record. The management plan for Ms McCready is included at page 609 of the records. It is documented that Ms McCready continued to voice suicidal ideation with a plan and intent. She denied any protective factors, refused to safe plan, refused crisis referral and after discussion with the duty doctor, it was agreed that she would be admitted to Munro Ward. Ms McCready reported a previous history of trauma and abuse and a denied any protective factors. In relation to the question of protective factors Ms McCready would have been asked whether there was anything that would stop her from attempting suicide, for

example family members, pets etc. In relation to her refusal to safe plan, the patient would have to have guaranteed and committed to a plan to manage any risk in the community and Ms McCready refused to do this.

[103] Mrs Gardener was asked whether this was "as bad as it gets regarding possible suicidal ideation and self-harm?" and her answer was that, it could be, but patients who voice these thoughts and who are assessed in this way do not always go on to commit suicide. It indicated that Ms McCready was a vulnerable individual.

[104] The box detailing Acute Psychosis is not ticked. In the course of the assessment, Ms McCready said she "wants to be dead". The record contains a copy of a letter sent to Ms McCready's GP, Dr Walker to update him in the community. It is very detailed and informs of the plan for her to go to Stobhill. Details of the mixed overdose are included in the letter and also records that Ms McCready reported that she took the overdose because she could no longer take it. She had been thinking of taking the overdose for some time and "had just had a right bad day". After taking the tablets she messaged her son asking him to look after her dogs and informed him of her actions. She reported that she had been stockpiling her medication for the purpose of overdose and reported that she took the overdose because she could not cope with life anymore. Her assessment was discussed with the duty doctor at MacKinnon House who was in agreement that Ms McCready be admitted to the Munro Ward. Ms McCready appeared keen for admission and was agreeable to be admitted informally. The letter also states that there is no evidence of any thought disorder and Ms McCready appeared to show good insight into her current mental health but continued to voice ongoing suicidal ideation with a plan and intent.

[105] Ms McCready could not go back to the community without support at that point. Mrs Gardener's impression was that Ms McCready had difficulty engaging and did not want to give too much away, but her speech was clear and she had no problem understanding questions.

[106] Ms McCready reported her mood as zero out of ten on the LIKCART scale with zero being the lowest ever felt. It is the standard scale for mental health assessments.

[107] The witness also noted that Ms McCready reported lack of sleep which can be an issue and can promote poor mental health and Ms McCready appeared to be in that cycle.

[108] Ms McCready took, lorazepam, sleeping tablets on alternate nights and reported that she took two to three to try to sleep. She felt that the dose was not enough and so she was not taking them in accordance with her prescription. Ms McCready did not seem to be responding to voices or unseen stimuli and did not seem thought disordered. She had good insight into her mental health, in that she could acknowledge what was happening and why and knew that she felt low. Ms Gardener denied that in 2018 mental health services were under pressure and denied that it was difficult to access services. In her experience if a patient was vulnerable and unwell a bed would be found if required.

[109] Informal status means that the patient consents to admission and has the capacity to consent. If she had concerns she could have discussed it with a doctor at Glasgow Royal Infirmary or she could have asked the duty doctor to come in and assess the patient. If she had felt that the Mental Health Act had to be invoked she would have requested that Ms McCready be assessed by a doctor and she did not do that.

[110] It was not unusual for the liaison psychiatry nurse to complete the admissions paperwork but the receiving doctor would also complete admissions paperwork. Regarding transfer to Stobhill, a member of staff would take her to Stobhill and it would be for Stobhill to determine observation levels when Ms McCready was admitted because the doctor needed to do their own assessment on Munro Ward. The usual situation was that Ms McCready would be taken by taxi with a nurse escort. She was unable to say whether Ms McCready had come into hospital with paracetamol in her possession. She was asked whether Ms McCready was at the very serious end of the spectrum of patients assessed and she said that it was a "fairly typical" assessment and she saw a lot of patients like this.

Witness – Dr Hannah Crockett

[111] Dr Hannah Crockett is 38 years old and is a general practitioner.

[112] She graduated from Edinburgh University in 2010 with an MBCHB and she has been a member of the Royal College of Physicians (GP) from 2019 when she completed her training.

[113] She is not currently resident in the United Kingdom having lived in Azerbaijan for the last 1½ years. She presently works as a locum GP and is accordingly self-employed.

[114] Following upon her foundation year and ST2 training she started her GP training scheme.

[115] In 2019 she took up a fellowship post for 6 months while working as a locum GP.

[116] Dr Crockett last worked for the NHS in 2019. During her GP training she trained on a number of specialties at a number of hospital placements.

[117] Her training included psychiatric placements and she worked in a psychiatric placement at Stobhill Hospital in February 2018 until the end of July 2018. Whilst at Stobhill she worked under the supervision of a consultant psychiatrist on a ward and performed the role of duty doctor. She worked on the Munro Ward at Stobhill Hospital. This was a hybrid role meaning that she spent some time working in the hospital setting and some in Auchinlea Health Centre, Easterhouse. Whilst at Stobhill in 2018 she worked alongside Dr Gajree who was a trainee in psychiatric training. She also worked with Dr Abigail Parkins who was an ST2 which was the same level as herself. She described her role as having two elements, namely, looking after her consultant (Dr McLaughlin's) patients from day to day on the ward and carrying out the role of duty doctor which meant that she would see anyone who needed to be seen and would prescribe medication including psychiatric medication. She also attended multi-disciplinary meetings.

[118] On 23 June 2018 she was duty doctor at Stobhill. She was referred to medical records and confirmed that she had completed the admission document in respect of Ms McCready. She dealt with the physical side of admission and also a psychiatric assessment of Ms McCready.

[119] Dr Crockett did not remember getting a call about Ms McCready or meeting her. She did not recall completing the admission document. With reference to the notes she could see that Ms McCready had taken an overdose of tablets. She did not carry out the psychiatric assessment in respect of Ms McCready, it was carried out by the liaison team at GRI. However had she not being privy to the liaison team's assessment she would have carried out a full psychiatric assessment herself.

[120] It was put to her that the receiving doctor at Stobhill would also be expected to carry out a full psychiatric assessment and she said that there was a very short period of time available to repeat paperwork which had already been done.

[121] The psychiatric assessment was composed of pre-populated sections with spaces for freehand notes. She did not recall carrying out a risk assessment on Ms McCready. She said that if a patient was admitted on a Saturday they would normally see their named psychiatrist on the Monday. In the interim the on-call team at the weekend would be responsible for the care of that patient. She confirmed that she had checked Ms McCready's medication electronically but there was an issue with the electronic records in that the last prescribed medication was in 2015. This was strange and could only be checked by phoning Ms McCready's GP during working hours on Monday.

[122] In relation to her mental state examination (MSC), Dr Crockett had noted "poverty of speech so hard to assess". Ms McCready was not saying very much so it was hard to know what her thoughts were.

[123] She confirmed that she was sufficiently qualified at that time to carry out an MSC and had carried out such examinations before. An MSC as an observation and documentation of a person's mental state and presentation. Although this is an examination that is specific to psychiatry any medical doctor would have an awareness of MSC. From the records she confirmed that Ms McCready's observation level was noted as garden and time out. She confirmed that the garden was at the back of the ward and was completely fenced off.

[124] She could not remember what documents she had during the assessment but she thought it was handwritten notes. Under the heading "risk to self and others" she confirmed that the risk assessment had been completed by someone else. She confirmed that she had ticked it and assumed that she had checked that it was complete or she would have completed it.

[125] She did not complete the interventions section. She should have circled no.

[126] She could not recall whether she discussed with Ms McCready what general observations entailed and she could not recall whether any paperwork would be given to a patient to tell them about general observations.

[127] She assumed that this would be part of an introduction to the ward and she thought that the nursing staff would do that.

[128] She confirmed that she would not have accepted Ms McCready without notes. If there had been no notes she would have made phone calls to speak to whoever had seen her already and she would have sought senior advice. She confirmed she could receive a patient if the risk assessment had been carried out by a colleague and confirmed that she would not have cut any corners. She confirmed that she would look at the risk assessment and in this case she did not speak to a senior Doctor. She was satisfied that she had sufficient information to put Ms McCready on general observations from the paperwork she had available and the information in the assessment. She said that if a person was admitted informally it would be unreasonable to require special observations because the idea is to have the least intrusive observation as possible. Dr Crockett confirmed that the fact that Ms McCready had suicidal intent would not necessarily mean that she required special

observations and confirmed that if she had been very concerned about Ms McCready she would have spoken to a senior colleague.

Witness – Dr Rosemary McCaffery

[129] Dr McCaffery adopted the terms of her affidavit. She described in some detail her qualifications and experience.

[130] In summary Dr McCaffery has been a consultant in general adult psychiatry since September 2003. She is a registered member of the Royal College of Psychiatrists and is an approved medical practitioner as defined under the Mental Health (Scotland) Act 2003. From 2015 until October 2020 she worked within Stobhill Hospital in Glasgow managing in-patients within an affiliated role managing out-patients. In general the in-patients she worked with were severely unwell and of significant risk to self, others and/or with marked functional impairment meaning that they were unable to care for themselves. Generally, such patients had high levels of psychiatric and physical co-morbidity and had often experienced high levels of trauma making their illnesses more resistant to treatment.

[131] As well as her clinical duties and experience Dr McCaffery was responsible from 2012 to 2021 for the psychiatric training programme in Parkhead and Stobhill Hospitals in her role as educational supervisor. She served in several regional training committees affiliated to the West of Scotland Deanery. She continues to have responsibility for the training of psychiatric and GP trainees and medical students.

[132] Dr McCaffery recollected first meeting Ms McCready on 25 June 2018.

[133] With reference to the medical records Dr McCaffery confirmed that Ms McCready was admitted on 23 June 2018 and between that date and 25 June 2018 she was assessed by

a junior duty doctor, which assessment would be continued by nursing staff. If the junior doctor had any concerns they could contact Dr McCaffery or Dr Gajree. In addition over the weekend there was a consultant psychiatrist on call at all times.

[134] Dr Crockett was the junior doctor in this case. She did not speak to Dr McCaffery about Ms McCready before 25 June 2018. There is a general requirement that a patient be seen within 72 hours of admission by a consultant. With reference to Ms McCready, she explained that her multidisciplinary team meeting (MDT) on Munro ward always took place on a Monday morning. In advance of the MDT she would have access to the admission notes from liaison services and Dr Crockett's notes. She did not recall reading notes made by Carol Gardner. Her evidence was that Dr Gajree would have read these case notes as part of her role (which is common practice) and would summarise the points to Dr McCaffery. A discussion would also take place with the nurses regarding how Ms McCready had been since she was admitted. She said that a treatment plan would have been discussed then Ms McCready would be invited to come in.

[135] Her evidence was that the nursing staff said that Ms McCready had initially settled well into the ward but seemed at times upset and was sometimes responding to voices, especially after contact with her family. She seemed to be particularly worried about her son.

[136] The diagnosis at the point she was admitted was not clear cut. She had low mood, social stressors and suicidal thoughts and stated to the liaison services that she was having flashbacks and nightmares but did not mention voices at that point. At that point there were a number of differential diagnoses in relation to Ms McCready but Dr McCaffery did

not have all of the information at that time. Generally in the early stages of admission (the first week) the focus is on assessment of the patient which requires to be thorough and can take some time. It is often necessary to see the patient medically a few times to get as clear a picture as possible together with a review of past case notes and a corroborative history from family if the patient consents to this. This will be considered along with the patient's ongoing presentation and observations from the nursing staff.

[137] Ms McCready's diagnosis was not immediately obvious and although PTSD was a likely diagnosis (because of her flashbacks and nightmares) further assessment was required in terms of her potential drug use and her personality functioning.

[138] While further assessment is ongoing the patient requires to be given any medication required.

[139] Her evidence was that observation of a patient involves observing how she is interacting, her levels of distress and her wellbeing.

[140] On admission Ms McCready was assigned to general observations. This meant that the nursing staff on duty at the time would check on her every half hour. General was thought to the appropriate level of observations at that time because she was speaking about suicide <u>if</u> she was sent home and also taking account of how she was presenting on the ward. Some patients will discuss their plan for suicide. They often will reveal what those plans are and personally she assesses a large number of patients with suicidal ideation.

[141] She was referred to the record completed by the liaison nurse which said that Ms McCready refused to divulge a plan. She commented that it is not uncommon for

patients who have just taken an overdose to say they want to be dead. Ms McCready often presented as very angry on the ward and very frustrated and it is not unusual for someone who is angry to refuse to discuss. She said that generally staff have to balance information a patients discloses with other aspects of what is going on. It was later revealed that Ms McCready had had suicidal thoughts for some time. She took an overdose because she was having a bad day but she then contacted her son, went to hospital and agreed to be admitted to hospital, all of which suggested that she wanted to get better and to continue living. Dr McCaffery was aware that Ms McCready had made a previous suicide attempt in 2017 and when Dr Gajree reviewed her medical history on Wednesday (27 June) this revealed that there were three previous suicide attempts. It was put to Dr McCaffery that in fact there were five suicide attempts by overdose and she was asked whether that would have changed the complexity of things. She said it would not because the three suicide attempts she was aware of were historical, and her mental health issues 20 years ago were possibly linked to addiction issues at the time. She confirmed that such historical information would not be transferred to the digital system.

[142] Dr McCaffery could not recall which nurse would be in attendance at the MDT meeting on 25 June 2018 but thought that it would be one of the experienced staff nurses or charge nurses as opposed to the assigned nurse.

[143] She saw no benefit in having a named or assigned nurse present because if additional input was required they could be called upon to attend.

[144] With reference to the medical records, she confirmed that the notes at 25/6/18 were her notes. She recalled Ms McCready disclosing to her that she had been hearing voices.

She was having flashbacks and nightmares. She was experiencing auditory phenomenon that was causing her embarrassment. She found the voices quite alarming and she recognised it was unusual to be hearing voices so she had a level of awareness and insight. She had the ability to say whether the voices were real or not. This is in contrast to a psychotic illness when a patient can no longer say what is real and what is unreal. As a consequence it was not considered that she had a psychotic illness at that point and what she was experiencing could be characterised as pseudo-hallucinations. Dr McCaffery noted from the records that Ms McCready said, "Death is the only thing that would make things better for her". Dr McCaffery's view was that this was not a clear indication of suicidal intent because what she was saying did not necessarily align with what she was doing. For example she was looking to have her medication sorted out, and to having ongoing contact with her eldest son from whom she had been estranged. The day before she had been trying to help her other son, so there were clear signs of ambivalence. At the end of the meeting an action plan was devised for her treatment which included a review of her past psychiatric history and past medication in order to understand which medication for anxiety and low mood had been prescribed before and what had worked. Dr McCaffery's position was that this required to be done before making any changes to her medication. She had a history of drug addiction so antidepressants could be helpful but needed to be managed as they are not always successful. Further, Ms McCready had possibly been buying additional diazepam. She changed her prescription from Nitrazepam on alternate nights to Zopiclone, which is a sleeping tablet, as required because her sleep had been poor. She had not considered prescribing an antipsychotic at a low dose because if she did and

Ms McCready got better they would have to continue the prescription and even at low dose there can be side effects. In her view an antipsychotic at this point was a sledgehammer and not warranted because it is also difficult to give up. She also wished to obtain information on managing symptoms of PTSD from psychology and for nursing staff to start working with Ms McCready on this. This would involve the nursing staff helping her to disengage from any distressing PTSD flashbacks and nightmares, and to tell her she was safe and to let her know that she could be helped and could get better. She also wanted to start discussions about trauma work and to refer Ms McCready to TAN nurses for stress coping techniques and anxiety management. The plan was that the nursing staff would do this with Ms McCready when she was able to engage. Trauma work is the optimal treatment for PTSD but can be very difficult for patients because of the distress it causes when recalling and talking about past traumas during therapy.

[145] It was put to Dr McCaffery that Ms McCready was quite acutely unwell. She disagreed stating that she had a different perspective and that Ms McCready was not as unwell as other patients because she could be calm and focused. The plan was that when Ms McCready had these voices and nightmares staff would intervene to discuss and assist and also she had been prescribed medication which would calm her when required. Diazepam for example is a quick acting benzodiazepine. The plan was to manage her distress and have discussions with her about trauma treatment.

[146] Dr McCaffery confirmed that the MDT was the last time she dealt with Ms McCready face to face but she was involved in a review of progress in relation to her treatment plan with Dr Gajree and nursing staff on 28 July 2018. There were discussions

about Ms McCready's diagnosis and the aim was to have discussions with her family to discuss her usual personality functioning. On 28 July Dr Gajree made three attempts to meet with Ms McCready. She was referred to the nursing notes on 26 June and agreed that although she could not recall the specifics it was clear Ms McCready was not really engaging with nursing staff and she and Dr Gajree would have discussed that.

[147] She was referred to a note made by Dr Gajree about her clinical view of Ms McCready's presentation. She confirmed that she and Dr Gajree had started to think that Ms McCready may have an emotionally unstable personality disorder (EUPD) due in part to the way she was relating to Dr Gajree and the nurses. She was angry and not participating in interviews. This fitted with a diagnosis of EUPD, and patients often present as aggressive and angry, although it can be transitory and can change. She did not believe Ms McCready was guarded about her thoughts, explaining that the term refers specifically to someone who is psychotic and will not share their thoughts. In Dr McCaffery's opinion Mc McCready was not guarded, she was angry. The hope was that the nursing staff would form a relationship with her and help her. Ms McCready was angry with her family and she was angry with the staff. The plan was to continue to monitor her and stay with the current plan so there was no change to the current plan. They were continuing to observe and assess and speak to the family with her permission. The possible diagnosis at this point was EUPD and PTSD. She was asked whether in her view a person with EUPD was at increased risk of suicide throughout their lifespan compared with the general population.

[148] Dr McCaffery's answer was that it was important that those with the condition can manage their state because it generally will not resolve. Ms McCready had a complicated

range of conditions which required to be managed which is common both in and out of a ward. The failure of Ms McCready to engage with the treatment plan was a manifestation of her frustration and EUPD.

[149] She was not aware of members of Ms McCready's family telephoning the ward with concerns about her. She commented that they already had information from the meeting with Ms McCready on 25 June, that she was hearing her ex-partner's voice telling her to do things.

[150] Dr McCaffery could not recall being aware that Ms McCready had left the ward on one occasion without telling staff and potentially on another occasion reported by her partner. She said it would be unusual for staff to report it to her unless it meant that the person wanted to leave permanently which might mean that the Mental Health Act would have to be invoked. Dr McCaffery pointed out that Ms McCready left the ward very early in her admission. She was an informal patient so she technically had the right to discharge herself. She may not have fulfilled all of the criteria for detention. In any event after 26 June there is no indication she tried to leave.

[151] Dr McCaffery disagreed that Ms McCready's observation levels should have been raised from general. She did not think that there were indicators to raise her levels bearing in mind that on the ward the staff were dealing with multiple patients with similar symptoms and she could not see any indication to raise her level. General observation was the least restrictive management for her and in Dr McCaffery's opinion it would have been distressing for Ms McCready to be followed around given that she was a traumatised individual. It would have been difficult for her and could potentially have made her worse.

Dr McCaffery was asked whether with the benefit of hindsight there was anything which could have been done to have reduced the risk of suicide. Dr McCaffery had thought a great deal about it and spent a significant amount of time in interview, enquiry and discussion and her difficulty was that she could not differentiate the risk factors Ms McCready was showing with what many patients with the same condition show. Her evidence was that it is extremely difficult to differentiate the factors in mental health and so it is extremely difficult for doctors and nurses to make accurate predictions to try to reduce the risk and make a patient better. It is always a complex balancing act, between allowing a patient autonomy and placing someone under constant observation levels. They are always trying to balance that.

[152] Dr McCaffery confirmed that she became aware of the fact that a possessions check was not recorded as having been carried out when Ms McCready was admitted. She, personally thought it would be possible for Ms McCready to have brought paracetamol into the ward. Dr McCaffery's understanding about the policy relating to possessions checks was that an informal patient had to agree to any possessions check, which is part of the admissions protocol. If suspicions were aroused the search policy would be invoked. She confirmed that a voluntary patient who wanted to bring in paracetamol and hid it in their underwear, for example, and said that they had no medication then unless they had a basis to suspect the nursing staff would not have any power to search such a patient. She agreed that there was a lot of trust placed on the patient so if a patient is determined to conceal something there is very little that nursing staff could do unless the nursing staff had additional information. Dr McCaffery confirmed that all medication should be with the

nursing staff as a matter of policy. A patient could bring in their own medication. She agreed that Ms McCready could have obtained paracetamol from another patient or from visitors coming in because generally they would not be subject to a possessions check. She was asked whether she thought that it would be beneficial for patients to be routinely engaged in a possessions check when they returned to the ward after being off the ward. In her view, it might be difficult on a practical level because people were in and out of the ward on such a regular basis. It would be a question better put to nurses.

[153] It was put to Dr McCaffery in cross-examination that when Dr Gajree tried to interview Ms McCready three times it could be characterised as not co-operating with treatment of any kind. Dr McCaffery said it would be rare to make that decision on the basis of one interview. Regarding notes that she refused medication and was leaving the ward. She pointed out that a patient has a right to refuse medication and that engagement can be variable. For example in this case - Lorazepam was as and when required. Regarding Ms McCready wanting to leave the ward, a decision would have to be made at that point.

[154] Dr McCaffery pointed out that patients are adults so it would be explained to them what is required of them. There is no punitive element to time outs or possessions checks. For example because she had left the ward once without asking for permission it would not trigger constant observations. In cross-examination she reiterated that having given some thought to Ms McCready's case over the last 5 years, she had not been able to find anything which made Ms McCready stand out from other patients. Knowing everything that is known now she is still unable to say what drove her suicide. Her PTSD and substantial

social stressors had a part to play but she had all of that for a while. She was very worried about her son's mental health and was struggling with that because she herself was unwell and her son needed her. Her current problems had been precipitated by a series of arguments with her daughter and she was agitated with her family. Dr McCaffery confirmed that EUPD is potentially a mental illness and it is a lifelong condition. It is partially treatable in the sense that patients can be offered help to manage their fluctuating moods and suicidal thoughts but it is recognised that it is difficult for them to engage by nature of the condition. Retrospectively, the differential diagnosis was correct in relation to the PTSD and EUPD was likely but further investigation was needed to be certain because it was too early in the assessment process. When asked whether it can be said that Ms McCready's suicide arose because of untreated mental illness or under diagnosis, Dr McCaffery's answer was that Ms McCready <u>was</u> diagnosed and in very early stages of treatment. She commented that the majority of suicides have mental illness underlying but there are people who commit suicide because of extreme stress and they are merely unhappy.

[155] Treatment for EUPD and PTSD takes months if not years. The treatment plan in Ms McCready's case was to alleviate distress while starting treatment.

[156] In cross-examination it was suggested to Dr McCaffery that on Wednesday, 27 June Ms McCready told her daughter that she was buying paracetamol and her daughter took that to have a sinister purpose but did not tell anyone at Stobhill, her youngest son William was also aware. Dr McCaffery pointed out that William visited on the Wednesday. She confirmed that had that information been passed on to the nursing staff she would have

expected to have a discussion with Ms McCready about this and for her to be asked for a look at her belongings and if she had refused it would have been thought that there was a clear risk and one option would have been to have placed her under constant observation by the nursing staff based on the risk at the time. If the nursing staff had discovered a quantity of paracetamol there would have been a reassessment of risk, an intervention and a decision about constant observation would have been made given that Ms McCready had taken an overdose. She pointed out that if somebody went on to constant observation the aim would be to keep them on that level of observation for as little a time as possible because it is so intrusive. Had she known that Ms McCready had been buying paracetamol she would have been placed on constant observations. Ms McCready's death was not predicted. If an overdose had been predicted they would have taken precautions. She reiterated that what the aim is was to try to mitigate risk because it was not possible to eliminate all risk. So that is usually done by helping to reduce stressors. She reiterated that most of the patients on Munro Ward at the time were so unwell as to present a risk to themselves or others and unable to exist in the community. However Ms McCready was not as serious as most of the others. Dr McCaffery was very shocked and upset about the death of Ms McCready.

[157] She referred to certain things said in the report by Julia Wells and in particular a comment that Ms McCready's level of suicide risk was dismissed by all medical staff involved in her care. She thought it was a misleading statement because they were treating her and trying to care for her. She denied that there was a patient safety issue caused by the workload on Munro Ward at that time .The staff were experienced, she herself was very

experienced and some of the people looking after Ms McCready had been qualified for years. The charge nurses and staff nurses were very experienced and very good and she was confident that if they had concerns they would have no problems coming to speak to her. They were good at managing things themselves but they knew how to get in contact with Dr McCaffery or her replacement if on annual leave if need be.

[158] With regard to record keeping, Dr McCaffery confirmed that she recorded as much as possible but could not write everything because of constraints of time.

[159] Dr McCaffery confirmed that she would have been concerned about Ms McCready if her illness deteriorated to the extent that she could not rationalise her voices, if she thought the voices were real and if she was struggling to see a future where she could get better. The long-term plan for Ms McCready was trauma- based therapy. She would be discharged from the ward when she was less distressed or the voices were at a manageable level. She would have estimated this in terms of months rather than weeks, for example 3 to 6 months or up to a year.

[160] Dr McCaffery would have expected to have been told about Ms McCready leaving the ward if she was doing it repetitively or at any risk when she was out. She reiterated that her reading of Ms McCready leaving was that she had simply left in error forgetting to say to the nursing staff because she was not used to the rules.

[161] Dr McCaffery confirmed that at her meeting with the family Mr Grey said she had seemed fine and her usual self. She was referred to Julia Wells' report and confirmed that Ms McCready was <u>not</u> thought disordered. She reiterated that she did not agree with Ms Wells' assessment that the level of observation was inadequate and amounted to a defect in

the system. She said that in her view Ms Wells' risk assessment was incomplete and does not take into account certain of Ms McCready's actions. She misunderstood Ms McCready as psychotic. If a person is thought disordered they likely have schizophrenia, a severe level of psychosis. In her view, Ms Wells' has misunderstood the nursing staff's notes. A person who can have normal conversation with her family is not extremely distressed so Ms Wells' is portraying a level of illness which does not exist. Dr McCaffery's position is that Ms McCready did engage at times. Ms Well's rationale for concluding that Ms McCready should have been placed on enhanced observations is based on an incomplete picture. It is necessary also to look at how the patient is acting, the severity of illness, and how interested they are in getting better. Dr McCaffery did not agree that Ms McCready's observation level should have been altered.

[162] Dr McCaffery's opinion was that Ms McCready did not have delusional beliefs. She may have appeared quite jumbled and, quite distressed and in Dr McCaffery's experience it is not uncommon for the nursing staff to be less accurate than the medical staff.

[163] She was asked whether she would have expected Dr Gajree to review the notes made by the nursing staff and her answer was no. In 2018 they would have relied on the nursing staff speaking to them. Now, in 2023 they would read the notes and she confirmed that she would challenge the nursing staff regarding the language used.

[164] Her evidence was that the MDT forms a significant part of the assessment. Dr McCaffery also said that she had had full discussions with Dr Gajree about Ms McCready and she had discussed her with the nursing staff. It was suggest to her that Ms McCready was no longer engaging and Dr McCaffery said there were certainly periods

for example after the argument with her son when her mood was angry and her behaviour was very typical of someone who was angry. It is not unusual for staff to have to manage volatile patients, the nursing staff are very skilled at that .The expectation is that her anger would change in time so Dr McCaffery really would have expected by the following Monday she would have changed but it was not unusual to struggle in this way during treatment.

Witness – Dr Neera Gajree

[165] Dr Gajree adopted the terms of her affidavit, which largely detailed her qualifications and experience. She commenced her consultant post in January 2021 having completed her specialist training in psychiatry.

[166] Dr Gajree now deals primarily with out-patients and having previously worked at Stobhill Hospital in Glasgow she stopped working there in August 2018. She worked there for a year from 2017 to 2018 under the supervision of Dr Rosemary McCaffery. In 2018 she recalled that Ms McCready was Dr McCaffery's patient but that she was leading on her case under Dr McCaffery's supervision. She first met Ms McCready on 25 June 2018 at the MDT.

[167] With reference to records she confirmed that Ms McCready was admitted on Saturday, 23 June 2018. Her understanding was that none of the on-call consultant psychiatrists were contacted about Ms McCready over the weekend which was not unusual.

[168] The practice at the MDT was that doctors and nurses would discuss Ms McCready's case before meeting with her. At the meeting Dr Gajree would have been the person asking questions and she would have had access to liaison psychiatry notes and Dr Crockett's clerking notes.

[169] Dr Gajree confirmed that she had access to the liaison form. Her recollection was that it was available to her in hard copy.

[170] Her evidence was that this document would have been read by the nursing staff and other doctors involved in Ms McCready's care. She confirmed that she would have been responsible for giving Dr McCaffery a synopsis of what was in the liaison form and would not be surprised if Dr McCaffery had not read it in its entirety herself. There would have been a discussion about the information contained in the document before the meeting. Ms McCready agreed to an informal admission but refused crisis referral. She was admitted because of a risk of self-harm. She had ongoing suicidal thoughts but was not expressing any active intention of acting on thoughts of suicide. She was also saying that she wanted to find out things regarding her family and her medication. These were all things which would indicate that Ms McCready wanted to continue living. Dr Gajree's evidence was that she had no prior knowledge of Ms McCready's previous psychiatric history on 25 June but found out some information later.

[171] Dr Gajree was referred to the statement made by Ms McCready and documented in the records that, "The only thing to make things better would be death" and confirmed that although this is suicidal ideation, many who express suicidal ideation would not be admitted to hospital. Medical staff would try to assess the risk that patients will go on to complete suicide. This is a complicated exercise because lots of psychiatric patients say that they wish they were dead and do not want to go on living when in fact completed suicide is relatively rare in contrast to the large number of patients who express suicidal ideation. It was suggested to her that Ms McCready told the liaison nurse that she had plans to end her

life which she was not willing to divulge, however Dr Gajree commented that at the meeting with her, Ms McCready expressed plans that indicated she wanted to live rather than die. The outcome of the MDT meeting was to continue to monitor Ms McCready's mental state and to speak to her GP to get more background information and to review her psychiatric history. Initially the thought was that she had PTSD and should be managed and given techniques to manage trauma via psychology. Her medication was changed because of her history of drug addiction.

[172] Ms McCready's observation levels were general observation. Her recollection was that she had the notes from 23 and 24 June available on the 25th. The nursing staff would also give a verbal handover but the doctors would have access to the notes. Her recollection was that the nursing staff and the medical staff would write in the same notes which were paper at that time.

[173] Dr Gajree's evidence was that most patients were put on general observation on admission which was considered in Ms McCready's case to be the most appropriate level.

[174] Dr Gajree could not recall whether she was made aware that Ms McCready had left the ward prior to the MDT meeting.

[175] Dr Gajree's understanding was that when Ms McCready left the ward she was told she was not supposed to do that and she was agreeable to staying on the ward. She denied that would have impacted the observation level. She was asked whether she formed the impression that Ms McCready had been off the ward on two occasions. She was unable to say. She was asked whether if it was twice that would have changed her mind regarding observation levels and her answer was not necessarily. She did not believe that the

observation levels would have been changed based on this as Ms McCready was spoken to, it was a misunderstanding, she was not saying she wanted to leave. It was her view that absconding from the ward is different.

[176] She got access to Ms McCready's past psychiatric history on 27 June 2018 and last saw her on 28 June.

[177] Dr Gajree was unable to recall how she got all the past history but thought she would have had access to the electronic system (EMUS), which was a fairly new electronic system at that time.

[178] Her position was that previous psychiatric history from the 80s and 90s would not have necessarily been available to her and she could not recall if it was. She believed that she did later document Ms McCready's previous suicide attempts in the notes and reiterated that a lot of information comes from the patient themselves and the notes effectively corroborate the patient's position.

[179] She did not believe she was aware of previous overdose attempts in 1987 and 1997. She was asked whether that would have been relevant, she said that she would have taken it into account but decisions about Ms McCready's presentation at the time would not have been influenced by historical matters. On 28 June 2018 she asked the nursing staff to ask Ms McCready to come to an interview room and she was told by staff that she did not want to attend. Ms McCready was eventually persuaded to come and see her but when she arrived her engagement was very poor. She had been in bed and was wearing her dressing gown. She looked dishevelled with little eye contact and she would not answer questions. Her presentation was different from what it had been on 25 June and she had noted in the

records that Ms McCready did not engage but commented that her presentation was changeable so she was to stay in hospital to be monitored. The witness recalled discussing Ms McCready with Dr McCaffery at that time. She was asked whether the change in "clinical presentation" resulted in a review of her level of observation. Dr Gajree said that she felt that general observations were still appropriate despite the change in her presentation. She could not recall directly speaking to Dr McCaffery about that but did speak to her about Ms McCready in general. At page 646 of the records there is a note saying "nil change to treatment plan". The witness commented that Ms McCready's presentation had been quite changeable in hospital but they needed her to co-operate and they required her consent to speak to her family. Part of the plan was to monitor her mental state as she was in a very early stage of admission. She discussed Ms McCready's presentation with Dr McCaffery and they thought about the possibility that she had EUPD but they could not diagnose at that point. It was put to the witness that Ms McCready failed to engage, was refusing to take medication and was angry because she was not getting time out from the ward and these were all triggers or markers that the treatment plan was not working. She disagreed and pointed out that it was very early in her admission. She was due to be seen in the following week on 1 July.

[180] She said that she was now aware that there was not a possessions check when Ms McCready was admitted to the ward so it is possible that she brought paracetamol with her into Stobhill.

[181] She confirmed that she was not on the ward on 29 June but phoned to see how Ms McCready was. She believed that Ms McCready was more settled and had been in bed

and Dr Gajree did not find out that she had died until Monday, 1 July. She was shocked and incredibly saddened. She was asked if on reflection there was anything that could have been done to prevent Ms McCready's death and she said that on reflection they did not know Ms McCready well. She was very unwell but her view was that everything was thought through very carefully and nothing could have been done medically to prevent her overdose and death. In cross-examination she was asked about the period between 25 and 28 June and asked "did you forget about her or were you getting updates"? Dr Gajree commented that in the community patients would not be getting two reviews a week. Staff were aware that she was back on 28 June and the nursing staff who were based on the ward would be observing. If they needed to talk to one of the doctors about a patient they could. She did not recall it happening in this case.

[182] Dr Gajree was asked about voices telling Ms McCready to take drugs and Dr Gajree's understanding was that it was illicit drugs particularly heroin. On 25 June for example Ms McCready described hearing her ex-partner's voice but she did not believe he was still alive. She felt this was abnormal and she was not compelled to act on it. The witness said that the doctors were aware that Ms McCready was hearing voices telling her to harm herself which is common. They knew about the voices and the broad nature of the voices. In her view the information from her partner was not an urgent issue and they would not expect the staff to get in touch before the 28 June. She was referred to the nursing staff documentation that Ms McCready was thought disordered. Dr Gajree disagreed with that diagnosis as did Dr McCaffery. She did not think she was delusional.

[183] With regard to observation levels, Dr Gajree said that Ms McCready was a voluntary patient who left the ward and then returned on a voluntary basis which indicated to her that she was willing to accept informal admission and to engage. She did not regard it as absconding, it was not a locked ward. She could have walked out and not come back if she had chosen to. She said that it was not common to impose enhanced observations on a patient who was choosing to be in hospital.

[184] If she had been told that Ms McCready was buying paracetamol she would have asked Ms McCready about it. It would have been discussed with the nursing staff how to manage that situation and it would have been discussed with Dr McCaffery. It is not clear what the outcome would have been but she would not have ignored that information. If they had known she was stockpiling paracetamol it might have changed her management plan. Dr Gajree was unable to say that if she had been made aware of this on 27 June it would have been possible to save Ms McCready's life. She said she was not an expert. On 25 June Ms McCready was keen to have a medication review and talked about stresses with her family situation which she wanted to find out more about - so she had future plans and specific things she wanted to achieve. She had taken an overdose, disclosed it, been admitted to GRI and then she was willing to come into Stobhill to get care and treatment. Suicide can be very unpredictable but decisions had to be made with the information available at the time.

[185] In cross-examination she said that there were no issues with workload when she was working on the Munro Ward and she had a good working relationship with Dr McCaffery who was experienced and always available for advice. She also had a good

relationship with the nursing staff and in her view the nursing staff never hesitated to raise concerns regarding patients on the ward with the doctors when appropriate. Also they were able to contact Auchinlea Health Centre if they could not get a hold of the doctors but they were very experienced psychiatric nurses on the whole and they could manage a lot themselves. She also confirmed that an alternative to being in hospital for Ms McCready was to be managed or assisted at home by the liaison team and the crisis team who were also very experienced psychiatric nurses who are based at Auchinlea. This was an option which was discussed by the liaison team with Ms McCready and she declined this. In fact it was more common that failed overdoses would be managed at home as there can be more benefit in the long term to manage such a patient in their own environment. In relation to the information available at the time of the MDT, Dr Gajree said there was a danger in trying to assess somebody's condition from notes alone. It is important to observe how they objectively present as part of the assessment in mental illness because a patient could say anything but psychiatric staff are trained to assess their mental health and their presentation as well. It can be challenging to make a diagnosis.

[186] Dr Gajree was asked what she would have done if Ms McCready had continued not to engage and she said it was not clear but they may have had to consider detention under the Mental Health Act depending on her mental state. They had also intended to try and get more information from her family but they needed her consent. She was asked why there was no change made to Ms McCready's observation level. She said that they wanted to continue monitoring her. It was not a huge increase in risk as far as they were concerned. She was agitated, so having someone around all the time could have been more difficult for

her and not beneficial. She did not present as having disordered thoughts. She was not presenting as psychotic. She knew the voices were not real. She agreed that what she was experiencing was pseudo-hallucinations. They therefore did not want to prescribe antipsychotics as it was very early days and also they would have to discuss with the patient to make sure they gave informed consent. On 28 June 2018 they could not discuss it with Ms McCready and did not feel it was necessary to compel her at that stage.

[187] She was sent a copy of the outcome of the significant clinical incident review. She was not involved in the review but saw the report. She did not take any issue with it.

[188] When shown the report by Julia Wells she disagreed with it in several respects. For example, it is incorrect that they did not discuss risk at the MDT. To suggest that the level of suicidal risk was dismissed by all disciplines involved was completely unfounded. To say that it was absent in documentation is also unfounded. The assessment of risk was documented in the MDT. It was ridiculous to suggest that no-one cared .After Ms McCready's death Dr Gajree spent a lot of time reflecting. It was personally very upsetting to her. With the benefit of her increased expertise and knowledge she genuinely believed things were managed as best they could be at the time and there was nothing that she would have done differently.

Witness -Dr Khan

[189] The witness is Dr Khuram Khan. He is a consultant forensic psychiatrist presently working in the State Hospital Carstairs which is a high secure hospital.

[190] He is approved under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as having expertise in the care and treatment of mental health issues. He is registered with the GMC and he is an Associate of the Royal College of Physicians.

[191] He graduated with a Bachelor of Medicine and Bachelor of Surgery degree in Karachi, Pakistan in 1997.

[192] His first psychiatric placement following graduation was in the West Midlands where he worked in 2006 in Rampton High Security Hospital. He completed 4 years basic training in Inverness in 2006. Thereafter he worked at Rampton High Security Hospital in 2009 to 2010 as a speciality doctor.

[193] He then worked as a specialist registrar (SP4) at Arnold Lodge in Leicester for one year specialising in personality disorders.

[194] From 2010 until 2012 the witness completed his specialist registrar (SP5 and SP6) posts at Orchard Clinic in Edinburgh. This is a medium secure clinic. As part of his training he worked in prisons. In February 2012 the witness worked in NHS Tayside as an SP6 (acting up consultant) until August 2012 in a low security service. He was then appointed to a consultant post in the State Hospital Carstairs. This was a hybrid role working also in the IPCU which is the low security unit in Bellside. He worked between the State Hospital Carstairs and Bellside Hospital in Forth Valley until 2016/17. Thereafter he worked for a brief period managing female offenders for a year in Cornton Vale Prison. He is now solely based in Carstairs as a consultant forensic psychiatrist and he primarily diagnoses, treats and manages patients there. He describes himself as a general psychiatrist

[195] He spoke to the various branches of Psychiatry. General psychiatry deals with the general population, in addition there is old age psychiatry, child psychiatry, learning disability psychiatry and forensic psychiatry. All psychiatrists who specialise have basic general training and exposure to all branches and it is not until later in their careers or training that they specialise. His view was that mental disorders are the same for each group so the approach to assessment and management is the same.

[196] The forensic aspect of his job is the interface with psychiatry and the law and includes assessing matters such as fitness to attend trial and criminal responsibility.

[197] All patients at the State Hospital are detained so they are all in Carstairs by way of legislative means. He has experience of treating informal patients.

[198] He has given evidence before as an expert witness in an FAI and in criminal and civil proceedings. He has prepared several reports for parties involved in litigation on a number of occasions and has prepared two to four medico- legal reports per month since becoming a consultant. He understood his role as an expert witness and understood his duty to the court.

He prepared two expert reports at the request of the Crown regarding the death of Elizabeth McCready

[199] He was referred to Crown production 32 and adopted this report as evidence. This is a supplementary report he prepared when he received further information to supplement the initial information he was provided with. He confirmed that the additional information which had not been available to him when he prepared his initial report (Crown production 30) changed his opinion. He confirmed that he was given the statement of Dr Rosemary

McCaffery who was one of the doctors who cared for Ms McCready. This led to a better insight into the clinical decision-making at the time of Ms McCready's treatment.

[200] Dr Khan was asked whether he would expect an informal patient to be subject to a search of their person or possessions on admission to hospital, and whether the NHS have a policy regarding "search in psychiatric wards" and his evidence was that it is not universal, it varies across wards and across health boards. He was referred to production No 26, Greater Glasgow Health Board productions, Volume 1, page 13, which contains Guidance for staff when a patient refuses to be searched. The guidance says that a patient can refuse to be searched but that there are tools at staff disposal and if the tools fail it should be referred to the principal medical officer who could make the decision to refuse to admit the patient as an informal patient. The police could become involved and the question would be should the patient continue with informal status or should the powers given by the Mental Health Act be used? He would expect all searches to be recorded in the records

[201] Dr Khan's understanding from the records was that Ms McCready was suffering from PTSD (Post Traumatic Stress Disorder). He also referred to associative disorders where a patient temporarily loses touch with reality because of anxiety or PTSD and because of that they experience psychotic symptoms. He explained that psychotic illnesses are a group of mental health disorders and that a patient can display psychotic behaviour but not be suffering from a psychotic illness. From the records it was his impression that Ms McCready's condition was deteriorating. She was prescribed lorazepam which can be used at any time to relieve anxiety.

[202] Dr Khan noted that there was a MDT meeting on 25 June 2018 and explained that a multi-disciplinary team typically consisted of a psychiatrist or psychologist, social worker, occupational therapist and nursing staff who look after the patient. The gold standard is that the patient is also involved.

[203] At the MDT meeting on 25 June 2018, Ms McCready's symptoms were not suggestive of frank psychosis but rather neurotic symptoms. It is not always clear cut and is dependent upon the patient's history, symptoms and observations of the patient. From the notes Dr McCaffery thought that the symptoms were indicative of PTSD and a plan was set which in his opinion was very robust. Dr McCaffery decided against anti-psychotic medication to manage Ms McCready's anxiety. She was to have lorazepam as required. He agreed with Dr McCaffery's diagnosis that a frank psychotic illness or a major depressive disorder could not be assigned due to lack of convincing evidence. However his opinion was that a prescription of a low dose of an anti-psychotic such as quetiapine could have been useful to reduce arousal and to help her think clearly alongside the planned interventions such as psychological management of PTSD and anxiety. His opinion was that an anti-psychotic and a benzo diazepam prescription under supervision could have been useful. He was not critical of Dr McCaffery's plan however because it is a matter of personal choice. In relation to the benzo- diazepam there was a reason for not prescribing this due to Ms McCready's history of drug misuse and Dr McCaffery was trying to avoid Ms McCready suffering a dependence on medication. It was the least prescriptive option.

[204] Dr Khan's evidence was that although the medical records were detailed the further information from the two doctor gave him greater insight into the therapeutic positive risk taking in relation to observation levels.

[205] He noted from the records that Dr Gajree assessed Ms McCready on the ward on 28/6/18. She spoke with Dr McCaffery on 28/6/18 as part of the ward review and when she was conducting that review Dr Gajree had sight of reports of Ms McCready shouting at family members and staff. Dr Gajree tried to speak to Ms McCready. She discussed with Dr McCaffery and following that discussion it was thought useful to get information about pre-admission behaviours from her family. The plan was to continue to monitor Ms McCready's mental state and continue with the original plan with no change

[206] Notwithstanding the fact that Ms McCready was displaying heightened behaviours since entering Stobhill there was noted to be no change in the plan to manage her. It was suggested to him that by 28 June 2018 Ms McCready was not engaging meaningfully. He pointed out that by then the team had started to think about personality deficit disorder and wanted to speak to the family about her personality. They had not been able to speak to her family. The plan was to discuss with her GP and there was an ongoing plan to review her psychiatric history and medication but she was not engaging so it was a difficult situation. In addition to Ms McCready's mental health problems there were behaviour issues as well. In Dr Khan's opinion Ms McCready knew she was not supposed to leave the ward. She was pushing the boundaries and breaching protocols leaving the ward sometimes which is typical of a patient with personality deficit.

[207] In his opinion, allowing a patient to have a degree of independence and to use the least restrictive levels of observation is an accepted treatment strategy for a person who has emotionally unstable personality disorder (EUPD). He pointed out that EUPD had been considered as a diagnosis in respect of Ms McCready but not formally or firmly diagnosed. His evidence was that a personality disorder of any kind is not diagnosed after one interview. Indeed careful consideration requires to be given when making that diagnosis because of the social stigma attributed to such a diagnosis. He pointed out that a patient could be disadvantaged because the personality disorder diagnosis is about who they are and patients can become frustrated and feel trapped with that condition. He confirmed that it was possible, indeed it is a common comorbidity for a patient to have post-traumatic stress disorder (PTSD) and EUPD.

[208] Dr Khan's opinion was that Ms McCready was experiencing pseudo-hallucinations related to the PTSD, which were not psychotic.

[209] His opinion was that patients with EUPD are at greater risk of suicide because of their impulsivity, emotion dysregulation and mood swings. All of this together with a lack of coping skills in dealing with anger, for example, mean that those with such a diagnosis find it difficult to cope. He spoke to the difficulty in trying to assess how genuine suicidal ideation is in such a patient, as opposed to just a cry for help and inability to deal with mood swings and anger or in order to get some secondary gain, for example to influence the doctor to prescribe drugs. His evidence was that there are no hard and fast rules and in general, when a suicidal ideation is assessed a number of factors have to be looked at but even after a detailed assessment it can be difficult to prevent suicide in some patients.

Dr Khan gave an example of one of his own patients who committed suicide after being in Dr Khan's care for 2 years in a ward much like Munro ward

[210] He said that overall management, including observation of patients with EUPD is difficult because doctors struggle to have a relationship with such patients. He said that sometimes the patients like the doctor and sometimes they hate them and that can happen in the course of a day. He also said that the risk of accidental death is high in such patients because of the impulsivity. He said it was very difficult to say whether the taking of a staggered overdose over 48 to 72 hours was accidental or intentional and pointed out that 72 hours is an insignificant period of time for relationship building with a patient with EUPD He said that there was always chaos in the lives of such patients and it tends to be a very challenging fast moving situation However, if such a patient is not given sufficient autonomy it will hinder recovery also it is not just about medication. With EUPD doctors can manage symptoms such as mood swings with medication. There is also psychology to be worked on and he confirmed that it was likely he would have made the same decisions as Dr McCaffery.

[211] Dr Khan's evidence was that he does not now stand by the opinion given in his first report. His opinion now is that the decision to place Ms McCready on general observations was appropriate but with the benefit of hindsight not sufficient. He clarified that what he meant by that was, because she has done what she has done and because she is no longer with us

[212] Further, with hindsight, Ms McCready's guarded behaviour was an important sign, in that she did not say anything about paracetamol to the medical staff.

[213] In cross-examination the witness agreed that it was inevitable that an unpredictable patient with EUPD should be more closely observed at least in the early stages but it was patient specific because a blanket approach or a restrictive approach would create problems in the future. He also pointed out that many patients with EUPD are managed in the community and are often not admitted to hospital because the ultimate goal is to manage these patients in the community. He confirmed that he would have expected information from family members, for example that she had said to them that her voices told her to jump in front of a bus to be passed on to doctors. Although that piece of information alone would not change his judgement. He was asked whether there were any changes to practice which he would suggest which would prevent the death of a patient like Ms McCready in the future and he said that the searching of possessions on admission should have been done properly and also information that the family was providing seemingly did not go to the clinicians responsible for her care. In cross-examination he confirmed that information from the family that Ms McCready had told them she was leaving the ward and purchasing paracetamol would have been useful information and would have prompted him to speak to the patient directly and also request a search of her possessions for paracetamol. He also said that he would ask questions about <u>why</u> she was leaving and purchasing paracetamol.

[214] Dr Khan was asked whether her leaving would be an automatic reason for detention in terms of the Mental Health Act and he said that if she had not come back then it would be a strong argument for detention in terms of the Mental Health Act but because she came

back and gave a positive response when spoken to he probably would not have detained her in terms of the Mental Health Act.

[215] In relation to future intervention in cases like Ms McCready's, searching possessions on admission would be appropriate and also he would expect it to be repeated depending on the information available**.**

[216] Dr Khan noted that the serious clinical incident report suggested reviewing the ward practice of half hourly checks. He commented that the half hourly check which was in place in Munro Ward was more than required.

[217] He acknowledged that initially he had been critical of the decision not to increase her level of observations but after receiving the additional information his conclusion was that the observation level of general observation was appropriate. In his opinion Ms McCready was not psychotic. In his opinion the MDT was conservative about treating Ms McCready and the plan was designed to help her cope. In a patient with PTSD constant observation could be counterproductive and produce adverse therapeutic effect, further, patients can become dependent on being constantly observed.

[218] His evidence was that it is a complicated exercise judging risk and keeping the long game in sight to achieve treatment. As stated in his second report, he was now of the opinion that Dr McCaffery's approach in using observation as a therapeutic intervention was appropriate. It was clear to him that Dr McCaffery's clinical thinking and judgement about Ms McCready's mental health difficulties and management of risk was robust. He understood her rationale for balancing the risk that Ms McCready posed and using the least restrictive management option to manage Ms McCready's care and risk.

Witness - Abigail Parkins

[219] Dr Parkins gave evidence by way of affidavit. She graduated in 2013 with a medical degree and commenced specialty general practice training in 2015. This was completed in August 2019 when she qualified as a GP. Between February 2018 and August 2018 Dr Parkins was on a 6 month rotation in psychiatry working at the Arran Mental Health Resource Centre in Glasgow. She also worked as an "on-call" hospital doctor covering evenings and weekends initially at Parkhead Hospital and then at Stobhill Hospital in Glasgow. She was a third year GP trainee at this point and her job was to attend to patients on wards who require urgent acute medical care. She was working on Friday, 29 June 2018 within Stobhill Hospital and was asked to attend at the Munro Ward to carry out an assessment. The initial information was that a patient's blood sugar was low. She and a colleague ran across the car park to the Munro Ward which was very close and arrived there within 2 minutes. She was shown to the room that Ms McCready was in and she provided care to Ms McCready as detailed in the medical notes (Crown production 12, page 647 – 648).

[220] Dr Parkins was told by nursing staff that Ms McCready was found unresponsive and her blood sugar level was less than one despite her not being diabetic.

[221] There were BM strips at the end of Ms McCready's bed. These are used to measure blood sugar levels. She was also told that an empty paracetamol packet had been found with 48 tablets missing. Ms McCready was unresponsive and it was apparent that she required to go to Glasgow Royal Infirmary for treatment. Dr Parkins

instructed the nurses to call an immediate threat to life ambulance to take Ms McCready to hospital. Dr Parkins commenced emergency medical care following the ABCDE protocol. Notably her BM scored below one when normal BM is four or more and this was concerning. Further Ms McCready's Glasgow Coma Scale score which measures consciousness scored 4 out of 15 which was very low. Generally 3 out of 15 is considered coma level.

[222] A paracetamol overdose seemed likely to Dr Parkins. She considered that there may have been a staggered paracetamol overdose as it was unlikely that her presentation was an immediate response to taking paracetamol. The ambulance arrived and Dr Parkins stayed with Ms McCready until that point.

Witness – Dr Alex Puxty

[223] Dr Puxty gave evidence by way of affidavit.

[224] Dr Alex Puxty FRCA, MRCP, DRCM, FFICM qualified as MBCHB from the University of Dundee in 2001.

[225] He was placed on the GMC specialist register for anaesthetics and intensive care medicine in February 2011.

[226] He currently works as a consultant in anaesthesia and intensive care medicine at Glasgow Royal Infirmary, Glasgow. Dr Puxty was an intensive care unit consultant when Ms McCready was admitted to Glasgow Royal Infirmary from Stobhill Hospital on 29 June 2018. He had overall responsibility for her care.

[227] Ms McCready was admitted to the emergency department initially at 1404 hours and triaged as category 1.

[228] Dr Puxty reviewed Ms McCready's notes and was provided with a copy of Dr Abigail Parkin's notes made when Ms McCready was found at Stobhill Hospital on 29 June 2018.

[229] Dr Puxty noted that Ms McCready's glucose level was less than one and commented that it would be very unusual for a patient to present with a blood glucose level of less than one after immediately taking an overdose. His evidence was that Ms McCready had a low blood glucose level because her liver was failing.

[230] His interpretation of Dr Parkins' notes is that Ms McCready's presentation, particularly the blood glucose level of less than one, was not consistent with an overdose within the last 12 to 18 hours. He made reference to the fact that a blister packet of paracetamol was discovered next Ms McCready. She was found in Stobhill on 29 June 2018 and that 48 tablets were missing from the packet. Hypothetically in his view Ms McCready may have taken the 48 tablets just before she was discovered however even if she had taken all 48 tablets shortly before she discovered it is his opinion that she must also have taken paracetamol before this. Even if she had taken 48 tablets shortly before she was discovered that is not what caused her to present with liver failure when she was admitted to Glasgow Royal Infirmary. It was his opinion that she had certainly taken paracetamol in the days prior to 29 June. She would not have presented at hospital with liver failure had she only just taken the paracetamol that morning,

whether it was 48 tablets or not. He described the symptoms and signs of paracetamol overdose.

[231] Initially there would be mild abdominal pain or mild nausea and vomiting. The victim would be vague.

[232] After 24 hours the patient may display right upper quadrant pain and within 24 to 72 hours of untreated overdose there may be evidence of hepatic necrosis (liver cell death) and following this confusion and agitation which again could be evidence of the liver failing.

[233] After 3 to 5 days recovery may begin or the patient may develop acute liver failure, coagulopathy (which is a bleeding disorder), glycaemia (which is low blood glucose) and patients in acute liver failure might develop cerebral oedema and hepatic encephalopathy.

[234] Dr Puxty's opinion is that Ms McCready had likely taken what is known as a staggered overdose (an overdose can be described as staggered if all the tablets or capsules were not taken simultaneously within one hour). The level of paracetamol in Ms McCready's system would be consistent with a toxic dose if taken more than 10 hours prior to admission to Glasgow Royal Infirmary. Unfortunately the potential for staggered overdose further complicates the interpretation of the level. When Ms McCready attended at Glasgow Royal Infirmary she was in established liver failure suggesting that the overdose was significantly greater than 10 hours previously. Ms McCready's level of Paracetamol was 37 mg per litre. Dr Puxty was unable to tell the time of ingestion because it may represent a small overdose taken relatively recently

or a much larger dose taken much earlier because the liver metabolises drugs and toxins in the body therefore the concentration in the blood will depend not only on the dose but also when it was taken. He was unable to say the time of ingestion as there were too many unknowns in the case of Ms McCready.

[235] In conclusion he suggested that the time of overdose in Ms McCready's case was likely 48 to 72 hours before she was discovered on 29 June. On the general presentation of paracetamol overdose his suggestion was that she had been ingesting Paracetamol from 2 to 4 days before 29 June 2018. His evidence was that with a patient who had been consuming paracetamol in the days before 29 June 2018 there is a possibility that the patient would present as sleepy and drowsy.

Witness – Catherine McCauley

[236] Catherine McCauley is a retired nurse. She retired in January 2022 but she is still a registered nurse and works as a bank nurse.

[237] She has been a registered mental health nurse for around 35 years. She worked at Stobhill Hospital from March 2018 to January 2022. Prior to that she worked at Parkhead Hospital for around 30 years until it closed and was amalgamated with Stobhill Hospital. The majority of her career has been in psychiatric nursing. She has been a senior charge nurse for nearly 20 years. A senior charge nurse is responsible for leadership and guidance to nursing staff, supervising and teaching, managing in--patients on Munro Ward and attendance at MDTs. During 2018 she was the only senior

charge nurse on Munro Ward. Morris Smart and Avril Maxwell were both charge nurses.

[238] She was not working on 23 June 2018 when Ms McCready was admitted to the ward. She believed Claire Fitzsimmons was the admitting nurse and Ms McCready was on general observations. The level of observation is decided by the nurse or doctor who admits the patient and if an informal patient is to have enhanced observations they must consent to that because it is very intrusive. Regarding the level of observation, a nurse will go round and check on all patients to make sure they are safe, whether they need anything, if they are sleeping they would check that they are breathing. Staff engage with them and offer help and advice. In June 2018 observation would be a minimum of every half hour but this has now changed to every hour. There were leaflets explaining general observations on a notice board, at the entrance in the patients' day room and at the nurses' station.

[239] Time out, was decided at the MDT and could be, for example, one hour with family, two hours to the shops, one hour to the park and is regularly revised at each MDT. It is determined on a risk basis and done continuously. Every time a patient goes out of the ward a risk assessment would be carried out. Information about time out was contained in leaflets which were placed throughout Munro Ward. Sometimes leaflets were given to some carers. The implementation of the observation policy was the responsibility of the nurse in charge so it was the witness' responsibility to designate and make sure it was carried out. Ultimately, though it is everybody's responsibility.

[240] It is possible for a nurse in charge to introduce an enhanced level of observation but it would require to be referred to a MDT and a nurse would have to be designated to carry out the enhanced observations. It would then have to be followed up the next working day. The duty doctor could be asked to review it. Ms McCauley said that she felt supported in her role by the medical staff and the nursing team.

[241] She described the duties of a named nurse. They would communicate with the patient and relatives and co-ordinate the care. There should be a minimum of three one-to-one talks with the patient per week. The named nurse for Ms McCready was Hugh McGregor. She could not recall allocating him. It was pointed out to her that Hugh McGregor was on leave when he was allocated to Ms McCready, which was contrary to policy. She accepted that but pointed out that a named nurse is not with a patient constantly and other staff would be involved in the care of the patient also.

[242] The 72 hour assessment is where things that have not been done in the initial assessment are carried out.

[243] A patient's possessions should be logged. She described that when a patient is admitted a possessions check is carried out at their bedside with screens around. Generally staff would ask the patient to take their bags out and show what they have in their handbags, and in their pockets. The purpose is to check for items of value and to check that that they do not have items which could harm themselves or others. All prescribed and over the counter medication must be handed in. In the course of the possessions check they would ask patients to turn out their pockets. . The possession check is about getting the patient to consent and to co-operate. There was a lot of trust

placed on the patient and she agreed that if a patient had something concealed and wanted to keep it concealed that would be possible. She stated that staff do not search. She confirmed that there is a search policy but it is not readily invoked as it creates mistrust. It disturbs the therapeutic relationship. Her understanding was that there was no power to search an informal patient without consent. If an informal patient refused and staff were suspicious they would phone the police. She would not necessarily expect the nurse who was conducting the admission procedure to do the possession check. It might be delegated to another member of staff. The initial assessment is carried out in an interview room and when they are moved to the bedside their bags go with them and that is when the possessions check takes place. Claire Fitzsimmons was the admitting nurse for Ms McCready. It was not normal practice at that time to record the possessions check in the notes. It was recorded in the clothing book which is kept on the ward. It was put to her that there was no record of a possessions check being carried out for Ms McCready and she said it was not completed. Her understanding was that when they went to get the clothing book it was not there. She also pointed out that patients swap items and give things to each other like tobacco and shampoo. Nurses tried to discourage it but it does happen

[244] When a patient left on time-out staff would ask them questions when they returned. They might ask how they were, were they anxious, where had they gone and what did they have (in their possession). Staff are trying to develop trust but have to risk assess all the time and part of that is getting to know the patient. It is very challenging. She was aware that the serious clinical incident review thought that a lack

of possessions check could have contributed to Ms McCready's death. She disagreed, because she may not have had the paracetamol when she arrived. In Ms McCauley's 38 year nursing career this is the first paracetamol overdose of a patient in hospital she has experienced.

[245] She was only aware of Ms McCready leaving the ward once. Walking through the park it would take 10 to 15 minutes to get to the local shops where there was a Chinese takeaway, chip- shop and a general store. She also referred to an ice cream van which has been on the site for about 20 years and stops outside all of the wards at 11.30 and 4.30 every day. When the ice cream van is there a nurse stands in the car park and observes the patients at the van.

[246] She explained that she did not consider a trip to the ice cream van to be an unauthorised absence. It is not considered to be off ward. It is the only place that patients can go to buy supplies such as toiletries as well as ice cream.

[247] It was suggested that Ms McCready was angry at the lack of time out and she indicated that if a patient wanted to leave a doctor would have to assess them before they could sign out. If there was information that somebody had left the ward she would expect the nurse who had received that information to go to the patient and ask them, did they leave, how they were feeling, any plans, were they suicidal? She also confirmed that if a family member had phoned up concerned there was something wrong with the patient she would have expected the nurse who took the call to go and check on the patient, say to the family member that the person was sleeping but if she

woke up they would get her to call the family member back and also ask the patient if they were okay.

[248] She emphasised that the purpose of a psychiatric nurse's job is to have a therapeutic relationship. A high percentage of patients have trauma backgrounds and if nurses were to say "you must" it would not work. An informal patient who is on the ward on a voluntary basis is assumed to want help.

[249] She explained that enhanced observations would be used with a very distressed patient who wants to take their own life and a designated nurse would be with the patient at all times. They would go to the bathroom with them. It is very intrusive. She explained that a patient's suicide risk varies sometimes in the course of a day. Some need help for a couple of hours but there is a big difference between thoughts of suicide and planning to do it. There is a risk that a period with enhanced or special observations is so intrusive that the patient reacts badly. It is a difficult balance. Special observations are there to support patients but may only be for a matter of hours. A relationship of trust between staff and patients is very important.

[250] Entry to the ward was controlled by a buzzer system. The code was on the wall. Visitors would buzz and a nurse would go down and let the visitor in. It was not possible to just wander in but a patient could go and let them in themselves. She agreed that the doctors and nursing staff worked well together on Munro Ward and trusted each other. They could approach Dr McCaffery or Dr Gajree if need be. She pointed out that the fact that Ms McCready left the ward would not automatically mean that she should be "searched" or put on enhanced observations. It would assessed at the time

and staff would do everything in their power to avoid calling the police. Patients were discouraged from going into other people's rooms. She said that if a patient left the ward but then came back willingly it would be discussed at the MDT. She said Ms McCready did not seem thought disordered. She had family issues and the witness felt very shocked and upset when she died. In cross-examination she confirmed that the garden in Munro ward is not secure. Patients have access to it if they have time out.

[251] She was asked whether the ice cream van sold paracetamol. Her answer was that as far as she was aware it was not available. She was not personally aware of anyone ever buying medication and had never heard of items such as non-prescription medication being sold. She had never seen it displayed for sale. Her understanding was that management had asked the ice cream van after Ms McCready died not to sell any medication. She conceded that possibly the nurse who was supervising could miss what someone was purchasing because two people were served at one time.

[252] The witness was directed to the serious clinical incident review in relation to the criticisms contained therein in relation to the named Hugh McGregor being on annual leave. Her position was that care did not stop just because one nurse was not available. In her view there was no prejudice to Ms McCready's care or adverse impact as a consequence.

[253] It was also suggested to her that Ms McCready's care plan was not completed within 72 hours. She said Ms McCready's care plan was done on her treatment plan. Some parts of that are more important than others. In her view only the possessions

check was missing. She had been seen by a doctor, the assessment had been done and the care plan was developed.

[254] She was asked whether there was anything that could reasonably have been done to prevent the overdose and she said there was nothing reasonable because there has to be reasons to detain somebody. Looking back, she was unable to think of anything. If staff had been told that Elizabeth was going to harm herself with paracetamol or was buying paracetamol at the shop or they suspected she had paracetamol, they would have spoken to her and probably have had her assessed by a doctor. There may have been compulsory detention but they did not get the opportunity to do anything. If a patient and the family do not communicate it can be very difficult. The staff try to gather information. They try to observe then communicate. The policies are there to assist the staff who try to learn when something bad happens.

Witness – Claire Fitzsimmons

[255] Ms Fitzsimmons is 33 years old and is now a civil servant.

[256] She was previously a charge nurse working with in-patients until 2 years ago thereafter she worked with out-patients for a year. She graduated with a Bachelor's degree in nursing in 2010

[257] She worked on Munro Ward at Stobhill Hospital as a band 6 charge nurse in 2018 and was the admitting nurse on 23 June 2018 when Ms McCready was admitted to Munro Ward.

[258] As admissions nurse she oversaw the admissions process. There are several components to the admissions process which involves orientating the patient to the ward. There would also be a risk assessment of the patient.

[259] The witness confirmed that when a patient was admitted to Munro Ward a possessions check would be carried out. She confirmed that the possessions check would be carried out at a patient's bedside. A triplicate clothing book was kept in a filing cabinet in the nurses' station and was used to record possessions. One page went with the patient's notes and one went to the patient as a receipt for their possessions. It would include a log of items of high value such as jewellery as well as hazardous items such as glass or sharps and clothing so it could be all be accounted for. There was a two-fold purpose to the possessions check, namely to keep track of the patient's property and to take concerning items away from them. Such items would be taken for safe-keeping and placed in a locked cabinet.

[260] Her evidence was that many patients would bring in medication and that it would be taken from them and locked in a treatment room on the ward for safe storage. She confirmed that paracetamol would be removed regardless of whether the patient was informal or formal. She confirmed that although she admitted Ms McCready she did not personally carry out the possessions check. She could not say if it did or did not happen. Further she was not aware who did the possessions check. She was asked whether she was working with a colleague and said not necessarily.

[261] In general the admission was done as a team because the ward was busy and there were lots of admissions so some staff would do the orientation, some would liaise

with the family and some would do the possessions check. It should be possible to identify who carried out the possessions check by looking at the triplicate receipts in the possessions book. She emphasised that the check is not a search.

[262] Her practice was to ask patients whether they had anything on them, or in a bag, in their pockets or on their person that would be dangerous. If they denied having any such items she would have to take their word for it. As far as she was concerned she did not have any powers to search an informal patient. She said she could not speculate as to why there was no copy of a receipt or record of a possessions check having been carried out. Her position was that it still could have been done. She said that ordinarily she would assign the possessions check or patient's orientation to another member of staff but did not recall doing that specifically in this case. Her evidence was that it was likely she delegated it and it would not be her usual practice to record who she delegated a possessions check to. She agreed however that it would be good practice to do that. She denied forgetting to do the possessions check in Ms McCready's case. She denied forgetting to delegate the check. She was involved in the significant clinical incident review after Ms McCready's death. She was aware that the review concluded that the lack of a possessions check may have significantly contributed to Ms McCready's death.

[263] It was her practice to discuss observation levels with a patient on admission, although she could not recall having discussions with Ms McCready. Normally she would ask a patient to repeat back to her the terms of the assigned observation level. There is also written literature regarding observation levels on the ward. She confirmed

that Ms McCready had time out to the garden only. She was a smoker and the garden is where she could smoke. She described the garden as a courtyard where the gates are closed over but not padlocked.

[264] She did not recall Ms McCready's admission process. She could recall that Ms McCready was talking to herself, she was animated, shouting and talking on the phone and seemed distressed. She recalled offering Lorazepam to Ms McCready, which she accepted. She could not recall if she was able to engage with Ms McCready on a therapeutic level.

[265] Patients "absconding" from the ward, was not uncommon. She was would have reported Ms McCready's absence from the ward to the medical staff if it was prolonged or sustained She confirmed that there had been an issue with the phone call for emergency assistance and said that the call was accidentally diverted to the hospital response team. She thought that was a switchboard issue.

[266] With reference to the records , on 29 June 2018 she heard Ms McCready making a persistent groaning noise when walking past her room. She confirmed that she had found blood sugar monitoring strips near Ms McCready's bedside. She was not a diabetic so this was out of place. The witness had never experienced any other patient who had completed suicide while on the ward. She was asked specifically whether a possessions check should be carried out if a patient left a ward and then returned. She was not sure that patients would tolerate this in a mental health ward saying that they do come and go a lot and it would be a lot of manage. It would be challenging. She made the point that Munro Ward was very busy, with a fast turnover of patients,

frequent admissions and discharges and changes in status. There was a lot going on at any one time. It was not unusual for patients to go off the ward and it was not necessary to call a doctor in most circumstances

[267] She commented that it was a good team on the ward and a positive place to work. Dr McCaffery and Dr Gajree were very approachable. Staff were devastated that Ms McCready had come to harm. It was very difficult in the aftermath. She commented that in any suicide a very many factors come into play. She could not suggest anything which might have prevented Ms McCready's death including observations levels. In her view the general observation level was reasonable at the time.

[268] She denied that the ward being very busy impacted on patients' care at the time. She said it was a good experienced team and the situation was managed.

[269] She was definitely not dismissive of any risk to Ms McCready. She did not know that there was information that Ms McCready was going to the shop and buying paracetamol, if she had been told then she would have had a conversation with her. She would have tried to retrieve the paracetamol and it would have been escalated.

[270] She could recall any calls from Ms McCready's family.

Witness – Morris Smart

[271] Morris Smart gave evidence by way of affidavit which he adopted and also parole evidence. He has been a registered mental health nurse since July 1993. He worked initially at Parkhead Hospital until around June 2018 when he started work at Stobhill Hospital initially based in Munro Ward. He still works at Stobhill Hospital. He

has been a charge nurse since 2001. He recalled Ms McCready as a patient on Munro Ward and referred to her as Liz.

[272] He did not recall many interactions with Ms McCready. He was able to speak to the entry in the medical records of 25 June 2018 just before 4.20 pm. He received a phone call from Ms McCready's partner Jamie. He said that he had received a phone call from Ms McCready who told him that she was hearing the voice of her ex-partner and that the voice was telling her to do things.

[273] Mr Gray also told Mr Smart that he was concerned that Liz was going to the shop despite having no time out. Mr Smart gave evidence that he had not been aware of her being off the ward on 25 June. He was asked whether in the course of the telephone call Mr Gray told him that Ms McCready said the voices were telling her to throw herself under a bus and he said he was not told that. His recollection was that after the phone call he immediately went to find Liz and he recalled her being in the garden area sitting on one of the benches. He did not remember the interaction but noted from an entry in the medical records that he reiterated to her that time out is only for the garden which she seemed to have taken on board.

[274] He recalled having two other interactions with Ms McCready on 29 June 2018. He started at 7.30 am that day and he received a handover from a nurse on the night shift. He conducted two 30 minutes checks on Ms McCready that morning. He could not say exactly when those checks took place but they would have been between 7.30 am and midday.

[275] There were also other staff conducting observation checks during this period. The checks were not solely his responsibility. There was a chart for completing observation checks kept at the nursing station or in the duty room. Two observation checks for Ms McCready were whilst she was in her allocated bed space and she did not want to engage with him. On one of the checks she was lying in her bed and facing away from him. He was asking her how she was feeling and she told him to fuck off. He did not consider that there was an immediate safety concern.

[276] He gave evidence that a patient's property is checked on admission and a receipt is produced for items they have been admitted with. There is also a search policy which can be followed for patients who cause staff a degree of concern for the patient's own safety or the safety of others. When the witness completed possessions checks on Munro Ward his practice was to ask patients what possessions they had and request that they hand over anything that might harm themselves or others. The possessions are then recorded in a book (the witness believes that each ward in Stobhill now has two books whereas in June 2018 there was only one possessions book on Munro Ward) and the patient is given a receipt.

[277] An informal patient who has paracetamol in their possessions could get that into the Munro Ward on admission. For example when completing a possessions check the witness said that nurses might ask to look in a patient's bag but if permission is refused then it is difficult to escalate the matter beyond cajoling the patient to show staff what items they have. He also said he would record in the care plan that a possessions check had been carried out either by himself or another nurse to satisfy himself that it was

done. He was asked about there being no record of a possessions check in relation to Ms McCready and he said that he would expect that it did not happen. He was asked whether it was possible Ms McCready could have brought paracetamol in and he said it was impossible to say that that she did not. The witness confirmed that he had seen a copy of the serious clinical incident review report. His evidence was that he did not speak with Ms McCready's mother on 28 June. He said if he had done he would have documented it. He confirmed that had he been told that Ms McCready had told her partner that the voices were telling her to thrown herself under a bus, he would have documented that specifically.

[278] With regard to possessions checks he emphasised that nurses were trying to build a rapport with patients and trying not to be authority figures. However they do have to ask a patient what have you go on you. His comment was that some people do not always tell the truth. . If someone is refusing a possessions check it can be escalated to police if nurses have a concern. Regarding Ms McCready leaving the ward, the witness believed that she took his advice on board that she should not go out. His position was that he would not always be required to tell a doctor right away. He was unable to recollect exactly what Ms McCready said in relation to his conversation about going to the shop.

Witness - Hugh McGregor

[279] Hugh McGregor is a retired mental health nurse. He qualified in 2001 and latterly worked in Stobhill Hospital prior to retiring around 3 years ago.

[280] The witness recalled the death of Ms McCready, he was her named nurse when she was admitted to the Munro Ward in Stobhill Hospital. He was on days off when she was admitted on 23 June 2018.

[281] The witness was referred to the medical records of 25 June 2018 at page 639 when he met Ms McCready.

[282] It was not entirely unknown that a patient would be allocated to a nurse on days off as other nurses would be responsible for looking after the patient until his return. He pointed out that all nursing staff on the ward would look after patients.

[283] The named nurse would make sure that the care plan and paperwork was up to date for a patient. They would have more input with a patient's family and they would try to have regular one-to-ones with the patient as part of the therapeutic approach. They would try to build a relationship and build trust with a patient. He was unaware that the allocation of a named nurse who was on leave was contrary to policy as pointed out by the critical incident review carried out by the health board.

[284] He was aware that when a patient was admitted there would be a check of their possessions or a listing of their possessions done by a member of the nursing staff. His understanding was that normally there would a record of that in the notes.

[285] He knew that there was no record of a possessions check being carried out in the case of Ms McCready. His inference was that it had not been done. He confirmed that he had not completed the 72 hour assessment for Ms McCready because the ward was very busy and hectic and she was agitated and it was difficult to get information from her. His evidence was that Ms McCready became more agitated and upset when he or

other members of staff tried to speak to her. He was unsure whether she was entitled to time out of the ward but felt that it would be inadvisable "given the state she was in". He said he was not aware that she had left the ward on at least one occasion. He could not recall whether he attended the MDT meeting for Ms McCready. He said he did not recall speaking to the family on the phone about Ms McCready. He was questioned regarding his description of Ms McCready as having delusional thoughts. He said that it seems that the family had told him that she was expressing thoughts about her deceased ex-husband which were not true but she held to be true. He had no recollection of taking a call and passing on information to the medical staff. He commented that if there were any particular concerns about a patient nurses could always contact a member of the consultant team to express concerns.

[286] With reference to the medical records and particularly the entry that said she "remained disordered", he could not remember the entry but could only surmise that she appeared to be talking to someone who was not there. Although he could remember very little about Ms McCready his evidence was that she was not deteriorating. She seemed the same every time he spoke with her. She was agitated and incoherent but there was the odd time that she said something which made it easier to understand.

[287] He was not on duty the day she became very unwell and he heard of her death when he returned after days off. He was asked whether he had any idea how Ms McCready came to be in possession of paracetamol and his answer was that Munro was not a locked ward and there are a lot of patients and visitors in and out all the time. If a patient came in with a bag or someone brought things in for them he said that he

was not in the habit of asking them every time. He was referred in cross-examination again to his entry about Ms McCready being thought disordered. He said he meant that she was expressing things which did not make sense. His recollection now was not clear and he commented that he should have recorded things better at the time. He did not remember speaking to her mother on the phone. He was asked in cross-examination whether he felt the need to escalate her care to Dr Gajree or Dr McCaffery and accepted that he did not do that at the time nor did he seek to increase her observation levels even though he had the power to do that temporarily. He suggested that perhaps observation levels could have been looked at due to the acute level of stress she was experiencing but it was put to him that he did not suggest that at the time and his answer was that he must not have thought it necessary at the time.

Witness – Lorraine Cribbin

[288] Lorraine Cribbin gave evidence by way of affidavit. She is the chief nurse for adult services employed by NHS Greater Glasgow & Clyde. She has been in this post for over 3½ years and services consist of mental health, addiction, prison health care, police custody and sexual health service. She spoke to the fact that implementation of the principles of the Healthcare Improvement Scotland: Scottish Patient Safety Programme (SPSP) paper from observation to intervention "has been delayed in NHS Greater Glasgow & Clyde Mental Health Services mainly due to the impact of covid-19 from March 2020".

[289] Pending implementation of the policy across all mental health wards, the health board put pre-implementation training back on track however this was affected by challenges in relation to the recruitment and retention of mental health nurses which is a national challenge. In her affidavit she stated that the NHS GGC Safe & Supportive Observation Policy and Practice Guidance that is in place is safe and effective and is not to the detriment of patient care albeit the newer practice will represent quality improvement once implemented.

Witness – Katrina Phillips

[290] The evidence of Katrina Phillips was given by way of affidavit.

[291] Ms Phillips has been a registered mental health nurse since 1988 and has worked exclusively within NHS services since then.

[292] The majority of her direct nursing care experience has been in a mental health in-patient setting.

[293] She retired in May 2021 but returned to NHS GGC in January 2022 as adult services incident investigation lead. She remains in this position chairing and taking the lead on complex Significant Adverse Event Reviews. (SAER)

[294] Significant Clinical Incident (SCI) investigations and SAERs are materially the same thing with the terminology changing from SCI to SAER in 2020/2021.

[295] The witness spoke to the purpose of an SCI/SAER, which is to identify the root cause or causes that may have contributed to an incident and key learning both in terms of what the service could do better but also to learn from and to share good practice to

reduce the likelihood of a similar incident occurring and reduce the risk of future harm to patients.

[296] She spoke to the process that was completed for the SCI investigation in relation to Ms McCready's death.

[297] Following Ms McCready's death on Munro Ward the decision was taken that a full SCI was to be commissioned on 24 July 2018.

[298] The Incident Review Group (IRG) then considered appropriate terms of reference for the review. The IRG is a multi-disciplinary group consisting of representatives across adult services including psychiatrists, nurses (including a professional nurse advisor), occupational therapist, psychologist, community mental health staff, addiction staff and service managers. This group meets fortnightly to consider all incidents, completed reports and briefing notes. In Ms McCready's case the IRG decided it would be appropriate to appoint an external chair taking into account that the incident was an in-patient suicide. Dr Adam Burnell, consultant of liaison psychiatry at Glasgow Royal Infirmary was appointed as external chair and lead investigator. Esther Milligan, in-patient services manager at Leverndale Hospital and a registered mental health nurse was also appointed as an investigator because the IRG recognised that it was important that the review team included someone with nursing experience who had an understanding and knowledge of in-patient systems. Finally Dr Russell Hosey who is a consultant in general adult psychiatry at Stobhill was appointed to the group. The terms of reference were set out in section 1 of the SCI (Crown production 16, page 688). The SCI was completed in September 2019 and was

submitted to Dr Alex Thom, clinical director and Isabel Paterson who was then head of adult services for health and social care in North East Glasgow for review prior to sharing with the IRG for comment.

[299] The SCI recommendations and plan of action would then be agreed and recorded on DATIX which is the incident management system together with target dates for completion.

[300] The SCI would also be sent to the significant clinical incident review executive group which the witness described as a quality assurance group consisting of senior nursing and medical staff who meet monthly and review all completed reports and consider things like whether the SCI has covered the terms of reference and if its conclusions are supported by evidence and if the review team have spoken to the appropriate people. If content that all matters had been addressed the group closed the SCI and at that point the next of kin is written to and invited to a meeting to discuss the report and its recommendations.

[301] The witness spoke to the action plan contained in Crown productions 17 and 18 and to the six recommendations made at section 6 of the SCI.

[302] Responsibility for implementing the action plan was assigned to Hazel Thomson, in-patient services manager.

[303] At Crown production 31 Janice Naven commented on what has been done in response to the SCI recommendations.

[304] Recommendation one, was to review the ward practice of half hourly checks. Recommendation two, if continuing with half hourly checks clarify the standard

expected. In summary the witness spoke to the fact that although the half hourly checks on the Munro Ward were not considered to be inconsistent with the policy it was suggested that less frequent hourly checks may provide a better opportunity to provide patients with meaningful therapeutic engagement and that there was a danger of half hourly observations being a tick box exercise. It was decided that patients on general observations should be observed as a minimum hourly. More frequent observations may still be followed where a patient's assessed risk dictates that to be suitable. A new format for the general observation check chart was agreed and put to use in Munro Ward on 20 July 2020. (Munro Ward is now named Struan Ward).

[305] Crown production 23 is a copy of the chart used. The time of the check now requires to be entered by an allocated nurse when completing the check who is also required to insert their initials and signature which promotes accountability. An escalation box has been introduced on the chart which prompts staff to confirm they have informed the nurse in charge of an unauthorised patient absence in terms of the standard operating procedure and the use of the chart is to be reviewed by the nurse in charge daily, periodically by the senior charge nurse.

[306] Audits of the general observation charts for all wards within Stobhill Hospital were completed in March and April 2021, July 2022. The audit report of 15 July 2022 noting various examples of good practice such as all wards demonstrating consistent completion of hourly checks, the staff clearly initialling those and wards using the escalation box where unauthorised patient absences have occurred. There are ongoing audits regarding general observation checks.

[307] SCI recommendation three was to review compliance with professional standards for record keeping policy to ensure a good minimum standard of frequency and detail of nurse documentation throughout the 24 hour period. The SCI concluded that the standard practice of making nursing entries once at the end of a shift meant documentation was light. However compliance with the NHS GGC professional standards for record keeping policy was reviewed and it was determined that there is nothing wrong with staff making one entry in a patient's record per shift as a minimum. If there is a significant care event then staff should document that as soon as possible. Record keeping is audited as part of the ongoing nursing care core audit schedule by the professional nurse advisor and by the senior charge nurse as part of routine nurse line management supervision and they will take matters forward with any nurse who has not made entries in the notes as is to be expected.

[308] SCI recommendation 4 was to review the ward processes regarding admissions paperwork and practice to facilitate the opportunity to detect errors such as not recording belongings and this should be audited.

[309] The SCI concluded that Ms McCready's possessions had not been recorded on her admission to Munro Ward as they should have been. Catherine McCauley discussed this with the nursing team on the Munro Ward and highlighted the omission. The SCI found that there had been an indication that the book for recording possessions had gone missing so new books were ordered. An audit was undertaken in July 2022 at Stobhill Hospital in relation to the checking and documenting of patient belongings. The audit report found that all wards reported patient belongings are always checked on

admission and an itemised list of belongings are recorded in the clothing book. Staff are also recording instances where items have been removed from a patient due to having been identified as a safety risk.

[310] There is also a process for staff to update a patient's possessions log if they are returning to the ward from time out or if they have received a delivery. The audit identified that checks of shopping and deliveries were performed on an individual basis usually influenced by patient safety concerns. Audits relevant to the completion of possessions checks are ongoing.

[311] SCI recommendation 5 was to review processes in relation to completion of care plan documentation within 72 hours of admission.

[312] This arose from the SCI determination that Ms McCready had been allocated a named nurse, Hugh McGregor, who was on annual leave contrary to policy and that this likely negatively impacted his ability to complete the 72 hour assessment on time.

[313] In her opinion there was not very much significance to Mr McGregor being on annual leave when Ms McCready was admitted on 23 June 2018. He returned to work on 25 June and appropriate care had been provided while he was absent. It was also her view that in any event all material information had been documented within 72 hours of her admission so she was confused by the SCI conclusion regarding this.

[314] The witness later discovered that the identified needs and risks which had been documented in Ms McCready's care plan should have been completed within another section of her admission documentation. It was not in fact absent but documented within a different part of the paperwork.

[315] Nevertheless an audit of practice in terms of care planning and named nurse allocation was carried out on the mental health wards at Stobhill Hospital and the results were contained in a report dated December 2022. (GGHB production 24). The conclusion of the audit was that care plans for new admissions tended to be completed within the first 72 hours on most wards. A senior charge nurse now requires the nurse in charge of shift to audit admission paperwork to ensure that all admission documentation is completed within 72 hours. If required the nurse in charge should allocated any outstanding tasks to support the named nurse complete the 72 hour assessment. In addition to this planned annual leave will be checked prior to allocating a named nurse to a patient to help ensure that admission paperwork is completed within 72 hours. There are ongoing audits relevant to this matter.

[316] SCI recommendation six was to review the process of disposal of ward check logs.

[317] This arose because the SCI noted that ward check charts were retained for up to 3 months prior to being destroyed. The new procedure which has been introduced is that the charts are to be retained within the ward for a minimum of 18 months. (Crown production 25, page 763, paragraph 4). All staff are advised of this requirement and all wards have been appropriately retaining check sheets. Audits have been carried out that confirm that staff are aware the check sheets are to be retained for 18 months. The record of these checks are kept either at the nursing station or in the office and are then filed in the ward filing system.

[318] It is a single document that covers every patient on the ward so it is not kept in individual patient records. Audits are ongoing.

Witness – Julia Wells

[319] Ms Wells produced two reports lodged by the Crown (Crown productions 33 and 34 report and appendix which ran to some 83 pages and Crown productions 37 and 38 which ran in total to some 44 pages).

[320] Regarding her qualifications and experience, she adopted the terms of her affidavit and gave parole evidence about those qualifications and relevant experience.

[321] Ms Wells is currently the chief nurse for mental health and learning disability services with NHS Grampian.

[322] Within this role Ms Wells has professional accountability for all mental health and learning disability nurses working within NHS Grampian. She is also the chair of the mental health learning disabilities Scottish patient safety programme and she regularly undertake and leads adverse event reviews, engages in complaints management and acts as professional advisor to nursing panels for disciplinary hearings.

[323] She confirmed when questioned that she had never given evidence as an expert witness in court prior to the present matter.

[324] There was some preliminary confusion regarding whether she understood her duties to the court as an expert witness. Having initially appeared to misunderstand she confirmed in evidence that she was aware of her duties to the court as an expert witness

and was aware of those duties at the time of writing her report. Indeed there is a statement in her supplementary report in this regard which she adopted

[325] There were objections to the admissibility of her evidence by Ms McCartney for Drs McCaffery and Gajree and by Mr Fitzpatrick for the Health Board. This was on the basis generally, that she did not have the requisite knowledge or expertise to assist the court with any of the issues arising for determination.

[326] It was suggested that she lacked any clinical experience in acute general adult psychiatric nursing at a sufficiently senior level or for sufficient duration to enable her to give expert evidence.

[327] It was also suggested that there were a number of factual errors and errors in terminology in her report and it was suggested that if permitted to give evidence as an expert certain aspects of her evidence would give cause for concern and should be treated with caution.

[328] I do not intend to rehearse the submissions made in any further detail. Having heard evidence regarding her expertise and experience and the submissions in respect of that, I formed the view that on balance I was satisfied that she had sufficient expertise to give opinion evidence in relation to certain aspects of her report. Ultimately, it would be a matter of what weight the court gave to her evidence. I proceeded on that basis.

[329] Ms Wells adopted the terms of her report with the exception of the final paragraph on page 835 which makes reference to the SCI report's action plan.

[330] Initially she was directed to paragraph three of page 828 of her report, specifically to her use of the word "search" when commenting that "it appears on

admission that Ms McCready's belongings were not searched". Her position was that in NHS Grampian that is what it was called but explained that it might be "nursing jargon". She was asked whether the descriptor "possessions check" would be more appropriate for an informal patient and her position was that the process involved going through a patient's belongings and checking these. In her view that process should then be documented in the nursing notes and having examined the records in relation to Ms McCready she could see no record of this having been carried out. She was asked what such a check would entail and asked specifically whether bags would be opened and pockets gone through. She said that if there was a risk of a patient carrying a weapon then yes, but if it was nothing like that a nurse probably would not put hands into somebody's pockets. She also commented that if a patient said no to this process then that should be escalated to the nursing manager RMO to try to understand why and ultimately it could lead to a change in their status.

[331] She criticised the lack of detail in certain entries in the records. For example, she would have expected that information from her partner that the voice of her ex-partner was telling her to throw herself in front of a bus would be recorded specifically in the records.

[332] If she had taken that phone call from Mr Gray she would have recorded it in the notes and escalated to the medical staff because ultimately the medical staff are responsible.

[333] Her evidence was that it was not clear to her from the records who made the decision regarding observation levels. She also conceded that it was not clear from the

records whether Ms McCready left the ward and gave evidence that she has had to draw an inference that this was the case. In her view it would be important to know that Ms McCready was going off the ward and she would expect nurses to communicate with medical staff regarding that.

[334] In her view there was a lack of documented one-to-one time with nursing staff. However she conceded that one entry per shift is reasonable.

[335] It was her view that nursing staff should have increased the observation levels in respect of Ms McCready and that there had been a disconnect between the nurses and medical staff. She referenced the fact that some of Ms McCready's behaviour on the ward was described as bizarre. Ms McCready was throwing things and in Ms Wells' view it was still her opinion that Ms McCready should have been placed on enhanced observations. In cross-examination she reiterated that as a consequence of the documented conduct of Ms McCready her case should have been escalated to the medical staff. Ultimately it was her opinion that the observation level was not sufficient.

[336] She was referred to the SCI report. The opinion of the review was that the team was highly cohesive and there was good communication between the team. Ms Wells noted that she had considered that statement.

[337] She was questioned about accuracy in her report and was asked whether she accepted that it is a possessions check and not a search which is carried out on admission in relation to an informal patient. She said that she did not have the policy regarding possessions checks in Stobhill. She was asked whether she made an error in her report when she made reference to Ms McCready being thought disordered. She

was referred to page 834 of her report where she said her opinion from reading the notes was that there was a sense that the level of suicidal risk was dismissed by all disciplines involved in her care. Her evidence to the Inquiry was that she withdrew that statement. It was put to her that the Inquiry had heard evidence that there was incredible thought and care put into Ms McCready's management on the ward and her answer was that she did not disagree with that. Her attention was drawn to certain errors in her report, for example she has added the word "thought" to certain descriptions in the records noting Ms McCready was disordered. She accepted this was an error and she accepted that the medical use of that term is significant that but her evidence was that the word disordered is worrying in itself.

[338] She did not accept that she cherry picked certain factors and ignored others. She confirmed that it was now apparent to her who had made the original decision regarding observation levels for Ms McCready. She thought that Dr Crocket's decision was "unusual" although she accepted that she did not have the requisite expertise to criticise the clinical decision-making of medical staff.

[339] Her evidence was in a similar ward in NHS Grampian it would be common for multiple patients to be off the ward at any given time of the day and they would not be searched on return. She accepted in evidence that if a patient wanted to keep an item concealed there was a good chance that a possessions check would not find the item. Regarding the possessions check in this case, her evidence was that "if it is not documented it did not happen".

[340] She was asked about a one-to-one therapeutic relationship in relation to Ms McCready and her evidence was that on balance she thought she was getting that although it was not documented or labelled in the records as a one-to-one. She explained that there were occasions at MDT meetings attended by doctors, nurses, occupational therapists and psychologists where there may be divergences of opinion in relation to matters including observation levels. This would not stop her sharing her opinion. Her position was that the observation levels in this case should have been increased.

[341] In her supplementary report she stated "no comment or opinion has been offered about medical practice" – and said in evidence, "I am very clear it is out with my expertise to comment on medical practice".

[342] Her position was that the determination of observation levels is multi-disciplinary and explained that her comments regarding observation levels are from a nursing view point. Nurses have the gift to increase observation levels and this was not done in the present case.

[343] She went on to say as highlighted from the nursing documentation there are five nursing entries over a period of 4 days that highlight that Ms McCready appeared "thought disordered". There is no evidence to suggest this was escalated or highlighted to medical staff. I Note that unfortunately She persisted to use this terminology even after it was pointed out to her (which she appeared to accept) that she had added the word "thought" to the nurses' description).

[344] She also persisted in making reference to the RMO for decision-making despite the fact that Ms McCready was an informal patient. An RMO has responsibility for patients detained in terms of the Mental Health Act.

Discussion and conclusions:

[345] The parties to the Inquiry submitted lengthy and detailed written submissions. These were supplemented by oral submissions. Broadly, on behalf of Drs McCaffery and Gajree and Nurse Fitzsimons it was submitted that only formal findings should be made on the basis of the evidence. On behalf of Greater Glasgow health board it was submitted that a reasonable precaution could have been for Catherine McCready to have advised staff about the telephone conversation she had with her mother informing her that she was going to the shops to buy paracetamol.

[346] On behalf of the Crown and next of kin the Inquiry was invited to make a significant number of findings and recommendations which I will discuss below. I am grateful for all submissions and I have considered them carefully. I do not however intend to rehearse the entirety of submissions in detail.

[347] It was submitted on behalf of the Crown and next of kin that there were a number of precautions which could reasonably have been taken and had they been taken might realistically have resulted in the death being avoided: Further It was submitted by Ms Doyle on behalf of the next of kin that there were nine failures which contributed to the death of Ms McCready in terms of section 26(2)(f). The Crown submission was that if I was not persuaded in this regard then comment could be made in terms of section 26(2)(g).

Observation levels:

[348] Ms Doran on behalf of the Crown and Ms Doyle on behalf of the next of kin were critical both of the observation level assigned to Ms McCready and the quality of observations throughout her stay in hospital. Accordingly, it was submitted on behalf of the next of kin that a precaution which could reasonably have been taken was:

> "Increased and meaningful observations of the deceased which may have allowed staff to recognise that she was planning to commit suicide".

[349] An associated submission was that in terms of section 26(2)(f) - failure to conduct frequent and meaningful observations of the deceased; failure to review the care plan and observation status by nursing staff and psychiatry following disengagement by the deceased; failure by nursing staff to escalate to psychiatry following her running up and down the corridor and failure by nursing staff to record and accurately record salient information, including information by family members, all amounted to defects in a system of working which contributed to the death .

[350] In this respect, I was invited therefor to make a number of recommendations, which included *inter alia*:

> (1) To recommend improvements to the quality and standard expected on observations of patients, including half hour one to one time which should all be recorded.

(2) To recommend that nurses must report any concerning behaviours in presentation to medical staff.

[351] On behalf of the Crown it was submitted that a precaution which could reasonably have been taken and had it been taken might realistically have resulted in the death being avoided was to:

> "Ensure information obtained during observations is acted upon which may have given staff greater insight about suicidal intent or influenced a change in observation levels**".**

[352] The remaining parties to the Inquiry invited me to reject the proposition that the observation level assigned to Ms McCready and maintained without change during her time on Munro ward was insufficient or inadequate in terms of level , quality or frequency.

[353] In support of this proposed finding the Crown submitted that there was a marked decline in Ms McCready's presentation whilst she was an inpatient at Stobhill. This submission was based in part on the evidence of James Gray, who described her during a visit as being, "…sparkled out. Like she was possessed". Further, he said she was acting out of character and asked him to get her off the ward. Catherine McCready told the Inquiry that upon telephoning her mother she noticed that she "…sounded like a different person…edgy".

[354] It was submitted that the medical records also demonstrated a decline in Ms McCready's presentation; in particular a nursing entry of 25 June 2018 recorded that

it was: "not possible to have an in-depth conversation with her due to her current mental state"; a nursing entry on 27 June 2018, recorded that she was "quite disordered and irate in presentation…talks incessantly…walks up and down corridors…agitated, shouting and swearing". Psychologist Fiona Scott provided information on post-traumatic stress disorder and grounding techniques "not possible to even attempt [to work through these] given current presentation"; a nursing entry 27 June 2018 recorded that "Elizabeth became very agitated again…screaming abuse very loudly…offered as required Lorazepam 1mg but unwilling to accept this. Continuing to shout abuse at staff."

[355] It was pointed out that on the morning of 28 June Doctor Gajree attempted to speak with her and recorded, "…high levels of agitation, screaming abuse loudly, required Lorazepam yesterday…attempted to speak with Elizabeth. Initially refused to get out of bed for 20 minutes, told nursing staff to 'fuck off', was eventually brought down by a nursing assistant… sat with her head in her hands, looking at floor, replying 'I don't know what you mean' to every question asked, told me to, 'get me out this fucking hospital', stormed out the room…wearing dressing gown, dishevelled, sullen and irritable in manner, staring at the floor, refusing to engage in conversation, nil eye contact."

[356] The Crown submitted that, notwithstanding, that Doctor Gajree accepted in evidence that there was a change in presentation of Ms McCready on 28 June 2018.and that the care plan was be reviewed if there was a change in clinical presentation, Doctor Gajree did <u>not</u> change Ms McCready's observation levels.

[357] Dr Gajree was due to meet with Ms McCready again on 1 July. However, following 28 June, the Crown submitted there was a continued decline in Ms McCready's presentation making reference to nursing entries on 28 and 29 June which record; "Slept for the vast majority of the day. Refused morning medication – would not get up…muttering at times, shouting at others, not appearing distressed" and that she was "…irritable and short tempered…refused 10 pm medication." It was submitted by the Crown that observations carried out by nursing staff were a vital part of the management of a patient's risk on the ward and any changes to presentation should have been escalated to Dr Gajree and Dr McCaffery as should any unauthorised absence from the ward and that did not happen in this case.

[358] Reference was made to the evidence of Nurses Smart and McGregor; Morris Smart confirmed that he carried out two checks on Ms McCready and that she was not engaging but did not feel the need to tell the doctors.

[359] Hugh McGregor confirmed that Ms McCready was not engaging with him and that she was, "incoherent and upset and becoming more so". He did not recall whether he passed this information onto the doctors. When exploring his entry in the medical records on 26 June he stated to the Inquiry that Ms McCready seemed not to be in a state where she could engage therapeutically and that it wasn't possible to even attempt working with Ms McCready on the material provided by the psychologist, given her presentation. He described Ms McCready as, "…quite disordered and irate in presentation…talking incessantly, becoming more agitated". [360]When it was explored with Nurse McGregor what he meant by "disordered" in his entries of 26 and 27 June he

explained that, "…she was saying things that didn't seem to make a lot of sense." It was submitted by the Crown that Nurse McGregor was a very experienced mental health practitioner and that the definition given by him accorded with the psychiatric definition provided throughout the Inquiry. However, the Crown's submission was that his observation on Ms McCready presenting in this way was dismissed by the treating medical team.

[361] Regarding the system of observation on the ward, The Crown submitted that it cannot be verified whether half- hourly observation checks were taking place or not. Referring to the evidence of Nurse Fitzsimmons who said that it was "very ad-hoc" and that whoever happened to be passing the nursing station on the hour or half-past the hour would pick up the observation check sheet and carry out the thirty-minute observation. Given that observation is a therapeutic tool to keep patients safe this was inadequate.

[362] The Crown submitted that although Dr Khan stated that he understood the clinical reasoning for Dr McCaffery and Dr Gajree's approach concerning general observation and that he believed the use of observation as a therapeutic intervention by the treating medical team was "appropriate". He also stated that with the benefit of hindsight (in light of Ms McCready's completed suicide), that general observations were "not sufficient". The Crown further referenced Dr Khan's evidence regarding the difficulties of managing patients with Emotionally Unstable Personality Disorder ("EUPD") - "…in female patients with EUPD there is always chaos and that is how it manifests and how it becomes dangerous." Suggesting that "guarded behaviours" ought

to have been taken into account, particularly if the patient is suspected of suffering from EUPD.

[363] The Crown referred to the opinion of Julia Wells whose opinion was that in the present case there had been a disconnect between nursing and medical staff and the information shared between them.

[364] Ms Doyle on behalf of the next of kin confirmed in submissions that she took no issue with the Crown submissions aligned her position with that of the Crown.

[365] On behalf of Drs McCaffery and Gajree it was submitted generally, that risk management is an ongoing dynamic process involving service users, carers and the MDT team working collaboratively to identify and manage potential risks to patient, staff or public. It is not an attempt to predict the future and it is not possible to eliminate all risks for any service user. The aim of the risk management plan is to minimise and manage risks where possible. The concept of positive risk taking and the least restrictive alternative must be the central aim of all clinicians in the assessment and management of risk and this was the evidence of both Drs McCaffery and Gajree and the expert witness Dr Khan.

[366] There was evidence before the Inquiry that overly restrictive approaches to the management of risk can be disempowering and diminish the capacity to take responsibility for self and self-management- each of which are central to the principles of recovery. Specifically I was asked to reject the suggestion by the Crown that Nurse McGregor's observations were dismissed by the treating medical team as being without

any foundation based on the evidence. Indeed Nurse McGregor himself did not suggest there should have been enhanced observations at any time.

[367] Further, it was submitted that there was no clinical justification for constant or enhanced observations at any time Ms McCready was on Munro ward and there was no evidence from any of the nurses or the doctors caring for Ms McCready to support this assertion.

[368] The opinion evidence of Julia wells ought to be rejected in favour of the evidence from the nurses and doctors caring for Ms McCready, who had sight of her and who carried out the risk assessment. It was a very experienced team and the Inquiry was urged to reject any suggestion there was a dismissive approach to Ms McCready's care.

[369] Finally, it was submitted that even if observations levels had been increased, it could not be said this would have prevented her death, as arguably Ms McCready would still have had opportunity to execute her plan.

[370] It was submitted by both Mr Fitzpatrick on behalf of Greater Glasgow Health Board and Mr Rodgers on behalf of nurse Fitzsimons that the Inquiry should reject any suggestion that Ms McCready's condition was declining to the extent that nursing staff should have reported to medical staff and if they did so this would have inevitably resulted in Ms McCready's observation status being changed at some point which could have prevented the death.

[371] The evidence of Drs McCaffery and Gajree regarding the risk assessment which resulted in general observations being continued should be accepted. As should the supportive opinion of Dr Khan. The evidence of Julia Wells and the Crown and Next of

Kin submissions in this regard should be rejected. It was submitted that there was no substance in the Crown's suggestion that some vital new information about the deceased's presentation during the period in question, if only it had been passed to medical staff, was apt to have led to a decision at some unspecified point in time to introduce constant observations, which somehow would have prevented her death.

[372] With regard to the observation level assigned to Ms McCready and maintained throughout the duration of her stay in Munro ward, I have carefully considered the evidence led in the course of the Inquiry together with the submissions made.

[373] Dr Rosemary McCaffery gave evidence that she was the Psychiatric consultant with overall responsibility for Ms McCready's care. At the relevant time she was assisted by Dr Gajree who was then an experienced specialist trainee in psychiatry and is now a consultant Psychiatrist.

[374] Both gave evidence that on admission Ms McCready was assigned to general observations. This meant that the nursing staff on duty at the time would check on her every half hour. General was thought to the appropriate level of observations at that time because she was speaking about suicide <u>if</u> she was sent home and also taking account of how she was presenting on the ward.

[375] Dr McCaffery's evidence was that it is not uncommon for patients who have just taken an overdose to say they want to be dead. It was later revealed that Ms McCready had had suicidal thoughts for some time. In June 2018 she took an overdose because she was having a bad day but she then contacted her son, went to hospital and agreed to be admitted to hospital, all of which suggested that she wanted to get better and to continue

living. Dr McCaffery gave evidence at some length regarding the clinical decision making process with regard to the assessment of risk and consequent observation levels (see the summary of her evidence above)

[376] She disagreed that Ms McCready's observation levels should have been raised from general to enhanced. She did not think that there were indicators to raise her levels bearing in mind that on the ward the staff were dealing with multiple patients with similar symptoms and she could not see any indication to raise her level. General observation was the least restrictive management for her and in Dr McCaffery's opinion it would have been distressing for Ms McCready to be followed around given that she was a traumatised individual – indeed it was contra-indicated insofar as it could potentially have made her worse.

[377] Dr McCaffery was asked whether, with the benefit of hindsight, there was anything which could have been done to have reduced the risk of suicide.

Dr McCaffery's evidence was that she had thought a great deal about it and spent a significant amount of time in interview, enquiry and discussion and her difficulty was that she could not differentiate the risk factors Ms McCready was showing with what many patients with the same condition show. Her evidence was that it is extremely difficult to differentiate the factors in mental health and so it is extremely difficult for doctors and nurses to make accurate predictions to try to reduce the risk and make a patient better. It is always a complex balancing act, between allowing a patient autonomy and placing someone under constant observation levels.

[378] Her evidence was that the MDT forms a significant part of the assessment. Dr McCaffery said that she had full discussions with Dr Gajree about Ms McCready and she had discussed her with the nursing staff. Although Ms McCready had periods when she was not engaging, for example after the argument with her son when her mood was angry and her behaviour was very typical of someone who was angry. It was not unusual for patients to struggle in this way during treatment.

[379] Dr McCaffery's opinion was that Ms McCready did not have delusional beliefs and was not thought disordered. She was not psychotic.

[380] She profoundly disagreed with Ms Wells' assessment that the level of observation was inadequate and amounted to a defect in the system. In her view, Ms Wells, in her report, portrayed a level of illness which did not exist and her rationale for concluding that Ms McCready should have been placed on enhanced observations was based on an incomplete picture.

[381] In evidence, Dr Gajree's concurred with Dr McCaffery regarding risk assessment and observation level. She spoke to her meeting with Ms McCready on 28 June when a reluctant Ms McCready was eventually persuaded to come and see her. Her engagement was very poor. She had been in bed and was wearing her dressing gown. She looked dishevelled with little eye contact and she would not answer questions. Her presentation was different from what it had been on 25 June and she had noted in the records that Ms McCready did not engage but commented that her presentation was changeable so she was to stay in hospital to be monitored. She discussed Ms McCready

with Dr McCaffery at that time. Her evidence was that general observations were still appropriate despite the change in her presentation.

[382] It was accepted by both doctors that her presentation had been quite changeable in hospital but they needed her to co-operate and they required her consent to speak to her family. Dr Gajree discussed Ms McCready's presentation with Dr McCaffery and they thought about the possibility that she had EUPD but they could not diagnose at that point because she was in a very early stage of admission and she was due to be seen in the following week on 1 July 2018.

[383] Both Doctors denied that information about very historical suicide attempts would have altered the decision regarding observation levels.

[384] With regard to information about her going off the ward not being relayed to them , both Doctors gave evidence that this information would have been unlikely to result in a change of observation level. Dr Gajree said that Ms McCready was a voluntary patient who left the ward and then returned on a voluntary basis which indicated to her that she was willing to accept informal admission and to engage. It could not be regarded as absconding. It was not a locked ward. She could have walked out and not come back if she had chosen to.

[385] The evidence of both doctors was that whilst it would be generally appropriate to document and convey information from the family regarding concerns about a patient to medical staff. In this case they were already aware that Ms McCready was hearing the voice of her ex-partner telling her to do things to harm herself.

[386] Dr McCaffery confirmed that she would have been concerned about Ms McCready if her illness deteriorated to the extent that she could not rationalise her voices, if she thought the voices were real and if she was struggling to see a future where she could get better.

[387] The long-term plan for Ms McCready was trauma- based therapy. She would be discharged from the ward when she was less distressed or the voices were at a manageable level. She would have estimated this in terms of months rather than weeks, possibly up to a year.

[388] She denied that there was a patient safety issue caused by the workload on Munro ward.

[389] With regard to record keeping, Dr McCaffery confirmed that she recorded as much as possible but could not write everything because of constraints of time. It was the same for nursing staff.

[390] Dr McCaffery said that she was very shocked and upset about the death of Ms McCready. She referred to a comment in the report by Julia Wells that Ms McCready's level of suicide risk was dismissed by all medical staff involved in her care. This was a misleading statement because they were treating her and trying to care for her.

[391] Dr Khan gave evidence as an expert witness. His opinion was that Dr McCaffery's approach in using observation as a therapeutic intervention was appropriate. It was clear to him that Dr McCaffery's clinical thinking and judgement about Ms McCready's mental health difficulties and management of risk was robust. He

understood her rationale for balancing the risk that Ms McCready posed and using the least restrictive management option to manage Ms McCready's care and risk hence the level of general observation at the time was appropriate. He explained that when he said in evidence that, with hindsight it was not sufficient he meant "because she has done what she has done and is no longer with us ".

[392] I found both Dr McCaffery and Dr Gajree to be credible and reliable witnesses. I accepted their evidence summarised above and detailed in each of the individual summaries of evidence regarding the rational for their clinical decision making in relation to Ms McCready. In my view Dr McCaffery was an impressive witness who presented as caring and compassionate. Both she and Dr Gajree gave detailed evidence about the various factors taken into account which they required to balance in assessing Ms McCready and devising her treatment plan. I accepted that evidence. Further, I accepted their evidence regarding the rationale underpinning the decision to maintain Ms McCready on general observation level notwithstanding her fluctuating presentation which was recorded in some detail in the medical records having been clearly observed by nursing and medical staff.

[393] Dr Khan's evidence regarding that clinical decision making assisted the Inquiry and in my view was entirely supportive of the approach taken by Doctors McCaffery and Gajree. I accepted his evidence.

[394] I prefer the evidence of these three witnesses to the evidence given by Julia Wells.

[395] Ms Wells gave evidence as an expert witness. Her position was that the observation levels in this case should have been increased.

[396] In her supplementary report she stated "no comment or opinion has been offered about medical practice" – and said in evidence, "I am very clear it is out with my expertise to comment on medical practice".

[397] Her evidence was that the determination of observation levels is multi-disciplinary and explained that her comments regarding observation levels are from a nursing view point. Nurses have the gift to increase observation levels and this was not done in the present case.

[398] Her opinion was that there was a disconnect between nursing and medical staff and that certain crucial information should have been escalated- for example the information that Ms McCready was running up and down the ward and acting in a somewhat volatile manner.

[399] I reject her opinion that there was such a disconnect. Both doctors gave evidence that they were aware of Ms McCready's presentation. Indeed Dr Gajree experienced this personally on the 28 June and both were aware that she was presenting as angry and volatile. I accepted their evidence in this regard.

[400] Unfortunately, I considered that Ms Wells evidence was somewhat undermined by certain errors in her report and a worryingly sweeping statement in her report (which she retracted in evidence) that there was a sense that the level of suicidal risk was dismissed by all disciplines involved in (Ms McCready's) care.

[401] Accordingly I am not satisfied on the evidence led that findings should be made in terms of section 26(2)(e) that precautions which could reasonably have been taken were;

- "Increased and meaningful observations of the deceased which may have allowed staff to recognise that she was planning to commit suicide".
- "Ensure information obtained during observations is acted upon which may have given staff greater insight about suicidal intent or influenced a change in observation levels"

[402] I am not satisfied on the evidence led that findings should be made in terms of section 26(2)(f) – namely that

- failure to conduct frequent and meaningful observations of the deceased;
- failure to review the care plan and observation status by nursing staff and psychiatry following disengagement by the deceased and
- failure by nursing staff to escalate to psychiatry following her running up and down the corridor
- failure by nursing staff to record and accurately record salient information, including information by family members

All amounted to defects in a system of working which contributed to the death.

[403] It follows therefor that I have no recommendations to make in this regard.

Named nurse on leave:

[404] It was submitted by the Crown that this was a factor relevant to the circumstances of Ms McCready's death.

[405] It was submitted on behalf of the next of kin that this was a defect in a system of working which contributed to the death.

[406] Evidence was led and indeed it was a matter of agreement that Hugh McGregor was Ms McCready's named nurse. He was on annual leave when he was appointed which was contrary to policy, as concluded by the SCI.

[407] Ms McCartney for both doctors submitted this had no relevance to the death at all and that it did not affect Ms McCready's care in any way.

[408] Mr Fitzpatrick, counsel for GGHB, submitted that no witness suggested in evidence that this had any impact whatever on the deceased's care indeed Catherine McCauley stated in evidence that if the named nurse was on annual leave the rest of the staff would provide the care and there would be no adverse consequence because the nursing staff do not stop care just because the named nurse is unavailable..

[409] I considered the evidence and submissions. I found Catherine McCauley to be a credible and reliable witness. She was an impressive witness in many respects and was a thoughtful and measured witness who in my view was doing her best to assist the Inquiry. I accepted her evidence in this regard.

[410] In my view, based on the evidence available to the Inquiry, I do not consider that the fact that the named nurse Mr McGregor was on leave when appointed had any relevance to the circumstances of the death insofar as the issue had no significant or demonstrable bearing on the circumstances of the death. I therefor make no findings in this regard, in terms of section 26(2)(f) or indeed any alternative section nor do I make any comment in terms of section 26(2)(g). I make no recommendations.

72 hour assessment:

[411] It was submitted by the Crown that this was a factor relevant to the circumstances of Ms McCready's death.

[412] It was submitted by the Crown that Ms McCready's care plan assessment was to be completed within 72 hours of admission by her named nurse. The 72 hour admission assessment was started but was not completed. Hugh McGregor said, "The ward was so busy and hectic…when I met with her, she was very agitated and incoherent in every conversation so that was very difficult". Agreeing that the allocation of Ms McCready as his named patient when he was not on the ward had an impact upon his ability to complete the care plan assessment within the 72 hour window. Further, the SCI concluded that nurse McGregor being assigned as Ms McCready's named nurse whilst he was on leave likely had a negative impact on his ability to complete the 72 hour assessment on time.

[413] Ms McCartney for both doctors submitted that this resulted in no impact/relevance to the death.

[414] Mr Fitzpatrick Counsel for GGHB submitted, that no witnesses suggested in evidence that this had any impact whatever on the deceased's care.

[415] Catherine McCauley's evidence was that she was unable to *identify anything that was missing in relation to the 72 hour assessment*, saying that *the basics were all there, the initial assessment was carried out ,the risk screen was done, and the information had been received from GRI.* Just the possessions check was missing. I accepted her evidence in this regard.

[416] Katrina Phillips gave evidence by affidavit. It was also her view that all material information had been documented within 72 hours of Ms McCready's admission so she was confused by the SCI conclusion regarding this.

[417] The issue of the missing possessions check is dealt with below.

[418] On the basis of the evidence available to the Inquiry, I do not consider that this issue is a fact relevant to the circumstances of the death, insofar as the issue had no significant or demonstrable bearing on the circumstances of the death. I therefor make no findings in this regard, in terms of section 26(2)(g) or any alternative section. I make no recommendations.

Half hourly observations:

[419] It was submitted by the Crown that this was a factor relevant to the circumstances of Ms McCready's death.

[420] It was submitted by the Crown that the Munro ward operated an additional observation policy of half hourly checks, which the SCI concluded was contrary to the NHS policy of general observation which was in place on the ward at the time

[421] Mr Fitzpatrick, Counsel for GGHB, submitted that no witness suggested in evidence that this had any impact whatever on the deceased's care and so there is no relevance to the circumstances of the death.

[422] Catherine McCauley gave evidence that half -hourly checks were in excess of what was required. She gave evidence that a nurse would go round and check on all patients to make sure they were safe and to ask whether they needed anything. If they

were sleeping they would check that they were breathing. Staff engage with patients and offer help and advice. I accepted her evidence in this regard.

[423] According to the evidence of Ms Phillips, half hourly checks were not inconsistent with the policy but the usual practice in other Stobhill wards was in fact for less frequent observations, namely hourly. Following the SCI, the level on Munro ward is now a minimum of hourly.

[424] On the basis of the evidence available to the Inquiry, I do not consider that this issue is a fact relevant to the circumstances of Ms McCready's death, insofar as the issue had no significant or demonstrable bearing on the circumstances of her death. I therefor make no findings in this regard, in terms of section 26(2)(g) or any alternative section. I make no recommendations.

Switchboard fault:

[425] It was submitted by the Crown and the next of kin that this was a factor relevant to the circumstances of Ms McCready's death.

[426] It was submitted that when Ms McCready was found unresponsive on Munro ward, there was an error with the switchboard which failed to alert the correct emergency response team. This resulted in the general medical team from the main hospital being called initially, which caused some delay. This was rectified following Ms McCready's death.

[427] On the basis of the evidence available to the Inquiry, I do not consider that this issue is a fact relevant to the circumstances of Ms McCready's death, insofar as the issue

had no significant or demonstrable bearing on the circumstances of her death. I therefor make no findings in this regard, in terms of section 26(2)(g) or any alternative section. I make no recommendations.

Ward check logs:

[428] It was submitted by the Crown that this was a factor relevant to the circumstances of Ms McCready's death.

[429] Ward check logs were shredded after three months contrary to Greater Glasgow and Clyde Policy.

[430] The absence of these records was unfortunate as production and examination of the records might well have assisted the Inquiry.

[431] Katrina Phillips gave evidence that following the SCI a new procedure has been introduced so that charts are to be retained within the ward for a minimum of 18 months. All staff are advised of this requirement and all wards have been appropriately retaining check sheets. Audits have been carried out that confirm that staff are aware the check sheets are to be retained for 18 months. The record of these checks are kept either at the nursing station or in the office and are then filed in the ward filing system.

[432] It is a single document that covers every patient on the ward so it is not kept in individual patient records.

[433] On the basis of the evidence available to the Inquiry, although unfortunate, I do not consider that this issue is a fact relevant to the circumstances of Ms McCready's death, insofar as the issue had no significant or demonstrable bearing on the

circumstances of her death. I make no findings in this regard, in terms of section 26(2)(g) or any alternative section. I make no recommendations in light of the evidence given by Ms Phillips regarding the changes, which have been implemented as above.

No corroborative account of Ms McCready's presentation was obtained from her family: [434] The Crown submit that there was a failure by staff to attempt to gain the consent of Ms McCready to authorise staff to communicate with Ms McCready's family with a view to obtaining a corroborative account.

[435] On behalf of the next of kin it was submitted that this was a defect in a system of working which contributed to her death.

[436] It was submitted by the Crown that gaining a corroborative account of Ms McCready was part of her treatment plan, following the MDT on 25 June 2018.

[437] Dr McCaffery confirmed in evidence that staff were to try and obtain consent from Ms McCready to speak with her family when she was calmer. It was the Crown's submission that there is no evidence that this was followed up throughout the period of Ms McCready's admission. For example, there are no notes which indicate that attempts were made to obtain this consent and that attempt failed.

[438] Further, Catherine McCready gave evidence that she spoke to her mother on the Tuesday and Wednesday before she died. She told the Inquiry that her mother, "…sounded like a different person…edgy'. Further, she told the Inquiry that the way

her mother was whilst in the ward was quite different to how she was in the community.

[439] James Gray gave evidence that he visited Ms McCready on the ward, and they sat in the garden. He described her as being, "…sparkled out. Like she was possessed". He said she was acting out of character and asked him to get her off the ward. He said he reported this to nursing staff. This is not recorded in the nursing notes.

[440] Mrs Bendoris expressed concern about her daughter, the day before she died, to nursing staff. This is not recorded in nursing notes.

[441] Dr Rosemary McCaffery was asked about the concerns raised by the family. She was unaware that the family had reported concerns to the ward. No staff had communicated this to her.

[442] The Crown submit that had the notes reflected the families concerns and observations about Ms McCready, "some corroborative evidence from the family would already have been available for Doctor McCaffery and Doctor Gajree to assess and changes in Ms McCready's appearance might have been garnered by the treating medical team, even in the absence of gaining consent from Ms McCready to contact family members directly for the purpose of this exercise." Dr Gajree was asked: "Is that information of significance and would you have wanted to know that?" The answer was: "All collateral information we get is taken into account. If we had that information, we would have considered it in addition to everything else".

[443] I accepted the evidence of both Doctors, that there was a plan to seek Ms McCready's consent to seek information from her family. There was evidence that she was in the very early stages of treatment and her presentation was changeable. The plan was to seek her consent when she was more settled. Further, there was evidence before the Inquiry that she had ongoing issues with her family. She did not wish her son to visit her and she did not wish her daughter to call her. She was heard arguing with her family both in the ward and on the phone.

[444] There was evidence from nursing staff and Dr Gajree that they had tried to engage with Ms McCready and been rebuffed. I accepted that evidence. It was recorded in the records and spoken to in evidence.

[445] Regarding the evidence of Mrs Bendoris, she recalled that Ms McCready phoned her from Stobhill Hospital and asked how her holiday had been and asked how her brother, who has dementia was doing. Ms McCready then told her, "I don't feel too good". Ms McCready said "I don't know what's wrong but something's wrong with me" and Mrs Bendoris told her that she needed to tell the doctor. The phone just went dead. Mrs Bendoris said that she phoned the hospital right away to report the phone call from Ms McCready. Their response was that Ms McCready was sleeping. Mrs Bendoris questioned that because she had just been talking to her. The call then ended abruptly. She was not sure who she spoke to at the hospital.

[446] Nobody at Stobhill spoke to her about Ms McCready's health, her marriage or her medical history. She did not think there was anything wrong with Ms McCready but acknowledged that she had taken an overdose before. She did not have much awareness of

Ms McCready's mental health difficulties. She felt Ms McCready was not happy because of her son and his problems.

[447] She believed that Ms McCready did have plans to live. She had a grandson (Catherine's son) and although she and Catherine had fallen out, Ms McCready would come to Mrs Bendoris' house to see her grandson. The day before Ms McCready took the overdose she had spoken to her on the phone and she seemed fine

[448] I have no reason to doubt the evidence of Mrs Bendoris and while her phone call should have been recorded and dealt with less abruptly, I am unable to conclude that taking her evidence as a whole, she would have been able to contribute additional crucial information which would have changed the treatment plan or altered the observation level at that time.

[449] Regarding the evidence of Mr Gray, he was adamant that he told a nurse in a phone call about a voice telling Ms McCready to "throw herself under a bus", and I have no reason to doubt him in this regard - it is very specific and the general tenor of the call was recorded. However, in my view his evidence regarding the reporting of other concerns was less persuasive. His recollection was that, "he must have spoken to someone about his concerns (regarding her presentation)" but could give no clear details. Unfortunately, his evidence was further undermined by virtue of the fact that he was adamant that Ms McCready was taken to the Queen Elizabeth hospital where she died. Mr Gray said that he was extremely upset and vividly remembered her dying at the Queen Elizabeth because he was there. It was suggested to him that he was mistaken but he was adamant and regrettably, I conclude that the reliability of sections of his evidence is questionable.

[450] Accordingly, on the evidence available I am unable to accept either the proposition by the Crown or next of kin that I should make findings in terms of section 26(2)(g) or (f) respectively in this regard . I make no recommendations.

Participation in and Dissemination of the Significant Clinical Investigation:

[451] The question of whether criticisms of the SCI review and report, contained in the report and supplementary report by Julia Wells, were relevant and within the scope of this Inquiry was considered during the Inquiry, in the context of objections to the admissibility of her evidence generally. I note that Julie wells adopted her reports in evidence with the express exception of the section about the SCI. Nevertheless, having considered all submissions, including written submissions it is my view that a review of the NHS's internal Inquiry in relation to its constitution, independence and conduct is not relevant to the circumstances of the death. It is out with the scope of this Inquiry to assess the adequacy of the SCI review into the circumstances of Ms McCready's death. I therefor do not propose to make any determination or recommendation in this regard.

Absence of electronic medical records:

[452] The Crown submit that this may have had an impact on the assessment of the risk Ms McCready's posed to herself and how to manage that risk.

[453] The next of kin submitted that the unavailability of a full medical history in the form of electronic records amounted to a defect in the system of working which

contributed to Ms McCready's death – specifically because those treating her were not aware of the number of prior suicide attempts which may have had an impact on risk assessment .

[454] I reject these propositions. The evidence does not support them. Both Dr McCaffery and Dr Gajree gave evidence that, had they known about all of the historical suicide attempts this would not have changed the risk assessment.

[455] Dr McCaffery gave evidence that she was aware that Ms McCready had made a previous suicide attempt in 2017 and when Dr Gajree reviewed her medical history on Wednesday (27 June) this revealed that there were three previous suicide attempts. It was put to Dr McCaffery that in fact there were five suicide attempts by overdose and she was asked whether that would have changed the complexity of things. She said it would not because the three suicide attempts she was aware of were historical, and mental health issues 20 years ago were possibly linked to addiction issues at the time.

[456] I accept Dr McCaffery's evidence in this regard and consequently, on the basis of the evidence available to the Inquiry, I do not consider that this issue is a fact relevant to the circumstances of Ms McCready's death, insofar as the issue had no significant or demonstrable bearing on the circumstances of her death. I therefor make no findings in this regard, in terms of section 26(2)(g) nor do I find that this amounts to a defect in a system of working which contributed to Ms McCready's death – specifically because those treating her were not aware of the number of prior suicide attempts. I make no recommendations.

Medical records: The medical record keeping (and recording) was deficient (nursing and medical).

[457] It was submitted that instances of poor record keeping include inter alia;

[458] The nursing documentation for the inpatient period was light as per the SCI conclusions.

[459] The Crown's submission is that absence of any mention of observation status in the MDT notes is not only significant but contrary to the NHS record keeping policy.

[460] Dr Gajree gave evidence that she spoke with Dr McCaffery about the review of Ms McCready. However, this is not recorded in the medical notes.

[461] Dr Gajree gave evidence that she telephoned the ward on 29 June to make a check on Ms McCready. The Crown submit that an entry should have been made to evidence that the telephone call happened in line with the NHS Greater Glasgow and Clyde Professional Standards for Record Keeping.

[462] The medical entry relating to Ms McCready's ex-partner telephoning the ward to express concern over Ms McCready hearing voices of her ex-partner does not accurately record or detail the information which Mr Gray said he gave to the nurse which included that the voice was instructing Ms McCready to throw herself in front of a bus.

[463] The medical records do not record Mrs Bendoris' telephoning the ward the day before Ms McCready died, contrary to the evidence that Mrs Bendoris' gave the Inquiry.

[464] Several of the examples highlighted by the Crown have been considered and addressed in terms of consequential impact in other sections of this determination.

[465] Whilst I accept and concur with the NHS professional record keeping and communication good practice policy namely that "Good records promote high standards of clinical care and ensure continuity of care and evidence patient… involvement in care planning and review… record-keeping is an integral component of clinical supervision for registered and non-registered staff." I also accepted generally the evidence of Dr McCaffery and Dr Gajree and Catherine McCauley, that whilst efforts are made to document as much as possible it is impossible to document everything that happens on a busy ward . I accepted the evidence of Dr Gajree when she said in evidence that, "It is incorrect that we did not discuss risk at the MDT. To suggest that the level of suicidal risk was dismissed by all disciplines involved is completely unfounded. To say that it is absent in documentation is also unfounded…the assessment of risk was documented in the MDT". In my view the evidence given by both doctors in relation to the assessment of risk and designation of observation level with reference to the medical records, was clear and comprehensive. The medical records, notwithstanding the perceived deficiencies outlined above were adequate and allowed the SCI review to conclude that the two medical assessments following admission were of a high standard, being very thorough and demonstrating clear thinking about Ms McCready's presentation. Further despite commenting that the process was poorly documented the SCI review was able to conclude that observation level was generated by a well-functioning MDT and communication within the team.

[466] In relation to the nursing records there was evidence before the Inquiry that it was standard practice and sometimes inevitable that nursing entries were made once at the end of the shift. This resulted in the nursing records being described as "light" by the SCI. The evidence of Katrina Phillips was that the SCI reviewed this practice with reference to the relevant professional standards for record keeping policy and determined that there was nothing amiss with staff making one entry in a patient's records per shift as a minimum provided any significant care events are documented as soon as possible. Presently, record keeping is audited by the professional nurse adviser and senior charge nurse.

[467] I am satisfied on the basis of the evidence that none of the above omissions (with the exception of the entry of 25 June 2018 at 16:20 hours) in respect of the records, although unfortunate had any significant or demonstrable bearing on the circumstances of Ms McCready's death. I therefor make no findings in this regard and no recommendations.

Note: I deal with the entry of 25 June 2018 below.

Time off the ward

[468] There is a difficulty in establishing whether Ms McCready was in-fact off ward on 25 June 2018. I note that it is in fact a matter of agreement in terms of the joint minute that it is unclear <u>whether</u> Ms McCready left the ward on 25 June 2018 as it is not documented in the nursing notes. The matter was explored with several witnesses at

the Inquiry. The Crown submit that this should be information which is readily ascertainable from reading the records and should not be ambiguous.

[469] Nurse Morris Smart spoke to the entry in the medical records of 25 June. He received a phone call from Ms McCready's partner Jamie. Mr Gray told him that he had received a phone call from Ms McCready who told him that she was hearing the voice of her ex-partner and that the voice was telling her to do things.

[470] Mr Gray also told Mr Smart that he was concerned that Liz was going to the shop despite having no time out. Mr Smart gave evidence that he had not been aware of her being off the ward on 25 June. He was asked whether in the course of the telephone call Mr Gray told him that Ms McCready said the voices were telling her to throw herself in front of a bus and he denied this. His recollection was that after the phone call he immediately went to find Liz and he recalled her being in the garden area sitting on one of the benches. He did not remember the interaction but noted from the entry in the medical records that he reiterated to her that time out is only for the garden which she seemed to have taken on board.

[471] I found this evidence to be unsatisfactory in a number of respects. I agree that the entry in the record is ambiguous and regrettably, as a consequence of the passage of time and the paucity of the record Nurse Smart was unable to clarify exactly what had been said in the course of this interaction with Ms McCready. It is not clear for example whether he asked her if she had in fact been to the shops. It is not clear whether she accepted that she had been to the shops. I considered that this information from Mr Gray should have prompted several basic questions. For example, have you been to the

shops? If so when? For what purpose – what did you require to buy? Regrettably the entry in the records is inadequate to the extent that it is not conclusive as to whether Ms McCready did in fact accept going to the shops on 25 June 2018. In my view this was potentially important information and unfortunately Nurse Smart was unable to assist further given the passage of time. In my view this particular inadequacy in the records is concerning and is a factor relevant to the circumstances of the death in terms of Section 26(2)(g) . I note that there is an NHS policy in place regarding standards of record keeping, Compliance with the professional standards for record keeping policy is audited on an ongoing basis. (see the summary of evidence of Ms Phillips) I therefore make no recommendation in this regard.

Prevent the patient from leaving the ward without knowledge of staff and remove confusion regarding where the patient was allowed to go:

[472] It is the Crown's submission that Ms McCready left the ward without the knowledge of staff and therefore she possibly brought paracetamol into the ward following her unauthorised absence(s). The Crown suggest that there was confusion regarding <u>where</u> she was allowed to go.

[473] Mr Fitzpatrick for GGHB invited me to reject that proposition on the basis that it was not possible on the available evidence to draw an inference that Ms McCready left the ward on 25 June 2018.

[474] Ms McCartney for both Doctors agreed and suggested that over and above the documented absence on 24 June 2018 the Inquiry would be required to speculate in relation to additional absences.

[475] She also submitted that it should be borne in mind that as an informal patient Ms McCready could leave at any time. If she decided to leave permanently then a decision would have to be made regarding escalation and possible review of her status.

[476] Dealing firstly with the suggestion that there was confusion regarding where she was allowed to go - I am unable, on the evidence, to agree with that proposition.

[477] Within her Mental Health Care Plan, which was completed by Doctor Crockett, it states that Ms McCready was only permitted to have time out in the garden with the corresponding code given, of "5" which states, 'Unaccompanied (grounds only)"

[478] This was not altered at the MDT on 25 June 2018.

[479] It appears that only the witness McGregor was confused (when giving evidence) regarding where she was allowed to go which is indeed unfortunate given that he was her named nurse. It is not clear however whether he was confused in June 2018 or simply confused now as a consequence of the passage of time. Regrettably on the whole, I did not find his evidence to be particularly helpful. He had very little recollection of his interaction with Ms McCready and was not a particularly impressive witness overall, perhaps due to the passage of time.

[480] Nurses Fitzsimmons, McCauley and Smart were aware, (see the summary of their evidence) and I accepted their evidence in that regard.

[481] Both commented that unauthorised absence would not necessarily require escalation to medical staff.

[482] Nurse McCauley's evidence was that she was only aware of Ms McCready leaving the ward once. Walking through the park it would take 10 to 15 minutes to get to the local shops where there was a Chinese takeaway, chip shop and a general store. She also referred to an ice cream van which has been on the site for about 20 years and stops outside all of the wards at 11.30 and 4.30 every day. When the ice cream van is there a nurse stands in the car park and observes the patients at the van. She explained that she did not consider a trip to the ice cream van to be an unauthorised absence. It is not considered to be off ward. It is the only place that patients can go to buy supplies such as toiletries as well as ice cream.

[483] There was evidence that Ms McCready was visiting the ice cream van. Ms McCauley was asked whether it sold paracetamol. Her answer was that as far as she was aware it was not available. She was not personally aware of anyone ever buying medication and had never heard of items such as non-prescription medication being sold. She had never seen it displayed for sale. Her understanding was that management had asked the ice cream van after Ms McCready died not to sell any medication. I accepted this evidence as credible and reliable. There was no further evidence before the Inquiry to suggest that the van sold paracetamol therefor I am unable, on the available evidence, to find that paracetamol could have been purchased at the van.

[484] It is a matter of agreement that Ms McCready was off the ward on 24 June 2018 (without consulting staff) and that the time she was off ward was not documented in any nursing notes. However there was evidence from several witnesses to the Inquiry that this could be considered to be a simple oversight on her part and indeed it was potentially therapeutic.

[485] Although the time was not documented – the fact of the absence was and she was spoken to about this by Nurse Fitzsimmons. I am satisfied on the basis of this evidence that Ms McCready knew she was not to leave the ward without consulting staff.

[486] There was some confusion as to whether Ms McCready was as a matter of fact off the ward on 25 June 2018. In fact it is a matter of agreement in terms of one of the joint minutes that it is unclear whether Ms McCready left the ward on 25 June 2018 as it is not documented in the nursing notes. The confusion emanates from the nursing entry on 25 June 2018 described above.

[487] Despite agreeing that it is unclear, the Crown submit that it is more likely that Ms McCready was absent from the ward on two occasions: 24 June 2018 and 25 June 2018 and that I am entitled to infer that the entry on 25 June 2018 relates to an event taking place on 25 June 2018. In other words, that Mr Gray has telephoned and reported Ms McCready's absence from the ward contemporaneously with that event occurring. In addition Catherine McCready gave evidence to the Inquiry that her mother was going to the ice cream van regularly and that she had been walking to the shops unsupervised.

[488] I have already commented on the evidence regarding the entry on 25 June 2018. In my view the evidence available to the Inquiry regarding this is unsatisfactory in a number of respects. I agree that the entry in the record is ambiguous. As a consequence of the passage of time and the paucity of the record Nurse Smart was unable to clarify exactly what had been said in the course of this interaction with Ms McCready. Crucially, it is not clear for example if he asked her whether she had in fact been to the shops. It is not clear whether she accepted that she had been to the shops.

[489] There were no further entries regarding unauthorised absences from the ward recorded in the medical records. There was no evidence led from any of the nursing or medical staff about any absences they witnessed or suspected over and above the absence on 24 June 2018.

[490] It is of course possible that Ms McCready left the ward unnoticed and returned unnoticed but I am not prepared or indeed permitted to speculate regarding the number and nature of any such absences.

[491] I am satisfied that Ms McCready left the ward unauthorised on 24 June 2018. I am also satisfied on a balance of probabilities that she did not purchase paracetamol during this outing (see the evidence of Mr Gray). In contrast, while it cannot be excluded and is therefore possible that she left the ward on 25 June 2018(and purchased paracetamol), I cannot be satisfied on a balance of probabilities on the evidence available to the Inquiry that she did so. Accordingly, I am unable to find on the evidence available that it is more likely than not that she left the ward on 25 June 2018 or other unspecified date and purchased paracetamol. That being so I am not prepared to make the any

findings in the terms proposed by the Crown or next of Kin in respect of this matter, nor am I prepared to make the finding, in terms of section 26(2)(e), proposed by Counsel for GGHB in respect of Catherine McCready's failure to inform staff about the telephone call with her mother on 27 June 2018.

Carry out possessions check at the point of admission to Stobhill:

[492] On behalf of the Crown it was submitted that a reasonable precaution would have been to have carried out a possessions check at the point of Ms Macready's admission to Stobhill Hospital.

[493] On behalf of the next of kin it was submitted that a possessions check of the deceased both upon her admission to Munro ward and upon her returning to the ward on the occasions she left the ward which may have allowed staff to discover she had paracetamol on her possession were reasonable precautions. It was submitted that this amounted to a defect in a system of working which contributed to the death. Both Crown and next of kin submitted that it was agreed that when Ms McCready was admitted to Stobhill hospital on 23 June 2018, that a normal possessions check was not documented as having been carried out.

[494] The Crown submitted that it was Claire Fitzsimmons, the admitting nurse when Ms McCready was admitted to Stobhill, who was responsible for the admission process including completing admission paperwork.

[495] A possessions book was kept on the ward and anything of value or potentially dangerous was to be clerked in, recorded in the book and thereafter the patient would be given a receipt for this.

[496] Nurse Fitzsimmons gave evidence about the normal procedure, stating: "Basically, we take them to the bed area, decant [their] bag with their consent they would bring out what is in their bag ask them if they have anything on them that is concerning to us…with their consent…it's challenging we need to know there is nothing dangerous within the environment, we need to know there is nothing that was contraband…I would ask if they had anything in their pockets, concealed on their person that would be considered dangerous…that would cause harm to someone. I would have to take that as their word I would not have any powers to take that any further."

[497] She confirmed that the possessions book, was kept in a filing cabinet in the nurse's station. This was a triplicate book, allowing any material in the patient's possession to be recorded and thereafter two extra copies of that document were generated. Ordinarily, once the possessions had been clerked in a copy would remain with the clothing book, one of the copies would be put with the patient's notes and the final copy was given to the patient.

[498] The Crown submitted that as well as any concerning items, such as glass, sharps, or razors, medication would ordinarily be taken in for safe storage, given it was commonplace for patients to bring medication onto the ward with them at the time of admission.

[499] Whilst, that was the normal procedure, Nurse Fitzsimmons was said to be at best ambiguous as to whether it had taken place or not, stating that she did not personally carry out the process or recall whether she delegated that task. Even if she had delegated the task, it was the Crown submissions that it ought to have been documented per the NHS Professional Record Keeping and Communication: Good Practice policy.

[500] It was submitted by the Crown that it was unlikely that the check took place. The evidence of Catherine McCauley, was that the possessions book was not available when Ms McCready was admitted, she said "I believe they were on order…we didn't have a book". The Crown submitted that it was a reasonable inference that the possession check had not been carried out, given Nurse Fitzsimmons' admission that she did not carry out the possessions check herself and her lack of recollection of delegating the possessions check, especially given that she was working alone at the time of Ms McCready's admission. In addition there was evidence that the book was "on order".

[501] Further, Catherine McCready's evidence was that items were returned to the family which did not belong to her mother.

[502] Reference was also made by the Crown to the evidence of the witness Hugh McGregor who had agreed that the fact that the possessions check did not feature in the notes led to an inference on his part that it had not been carried out.

[503] The Crown also referred to the findings of the SCI which had accepted the possibility that Ms McCready had brought paracetamol into the ward with her and had ultimately concluded that the lack of a possessions check may have significantly contributed to the incident which led to Ms McCready's death.

[504] The Crown submitted that had a possessions check been carried out, this would have been a reasonable precaution which might realistically have prevented Ms McCready's death, given that it was reasonable and indeed the usual practice to carry out a possessions check. Had Ms McCready had paracetamol in her possession, this would have been removed from her by the nurse carrying out the check. If Ms McCready did not have access to paracetamol, she would not have been able to take excessive quantities of it with fatal consequences.

[505] On behalf of Drs Gajree and McCaffery the possibility was accepted that in the absence of a possessions check, Ms McCready may have brought paracetamol into the ward with her. It was accepted that it was possible no possessions check was carried out.

[506] It was however, submitted that speculation must be avoided, and that the Inquiry could not be sure, on balance, whether a possessions check was carried out or not.

[507] It was submitted that it was a relevant consideration that patients are not searched and can refuse to comply, meaning a possessions check would not necessarily have discovered paracetamol. Further, Ms McCready could also have bought the medication when off the ward, or obtained it from a visitor or a patient, and in light of these possibilities it would be speculation as to where Ms McCready sourced the paracetamol and therefore, the effectiveness or otherwise of a possessions check upon her admission remains unknown.

[508] It was however also recognised that in her evidence Dr McCaffery had accepted that it was likely that a possessions check, had not been undertaken in respect of Ms McCready.

[509] On behalf of Nurse Fitzsimmons it was accepted that as a matter of fact there was no record of a possessions check being carried out.

[510] Given the lack of any witness who confirmed carrying out the check, and in the absence of any record of same, it was conceded that it was also possible that no possessions check was carried out, leading to the possibility that Ms McCready could smuggle in paracetamol to the ward in sufficient quantity to ultimately consume , causing her death.

[511] The lack of a record of the possessions check, did not necessarily mean a check had not been carried out, and it remained possible that a possessions check was carried out when Ms McCready entered the ward, but nothing untoward was found.

[512] It was also submitted that the nature of the possessions check for informal patients meant that they were not patted-down, stripped, or otherwise probed. Patients would simply be asked directly if they were holding any items that may pose a risk including medication. At all times patients could refuse to comply. They could refuse to allow a bag to be searched, or simply deny they were in possession of anything hazardous. In that scenario the staff could only trust the patient's word and as a matter of generality, a patient who refused a possessions check would still be admitted onto the ward.

[513] Even if Ms McCready had entered Munro Ward in possession of paracetamol, any possessions check would not necessarily have discovered it. It was accepted that on the inarguable basis that carrying out a possessions check would have been "reasonable" it was submitted it could not be said to represent a precaution which, if taken, would have prevented the death, simply because it was unknowable if Ms McCready had any paracetamol at the point of her admission, and if she did, if it would have been discovered during the possessions check. Accordingly, it was submitted that the suggestion that a possessions check would have revealed paracetamol was a matter of speculations which was to be avoided.

[514] On behalf of the Health Board, it was conceded that whilst a possessions check should have been carried out, carrying it out in the deceased's case could not be characterised as a precaution which realistically might have prevented her death, because it was submitted that it was implausible that Ms McCready could have brought the paracetamol into Munro Ward with her. In this regard it was submitted that on Thursday, 21 June 2018 that Ms McCready had taken an intentional mixed drug overdose at home. The drugs ingested at that time had not included paracetamol. She had been found unresponsive and admitted by ambulance to Glasgow Royal Infirmary at 0049 hours on Friday 22nd June 2018. There she had been medically assessed and none of her family had accompanied her to Glasgow Royal Infirmary in the ambulance, nor did any of them visit her while she was in Glasgow Royal Infirmary. She was not prescribed or given paracetamol while she was in Glasgow Royal Infirmary. She was transferred to Munro Ward at Stobhill Hospital on Saturday 23rd June by taxi with a

nurse escort, and "N/A" was noted on the discharge form in a box headed "own medication returned to patient."

[515] It was therefore submitted that it appeared to be extremely unlikely that she had a significant quantity of paracetamol on her person at the point of admission to Glasgow Royal Infirmary, and given that she was significantly unwell there, and given she had no visitors, it was unlikely that she could have acquired paracetamol while there. Accordingly, it was intrinsically unlikely and implausible that she can have had a significant quantity of paracetamol on her person at the point of admission to Stobhill.

[516] In terms of Section 26(2)(e) therefore there were no precautions which could reasonably have been taken by any employee of Greater Glasgow Health Board which, if taken, might realistically have resulted in the death being avoided.

[517] On behalf of the next of kin it was submitted that the evidence supported a finding that a possessions check had not been done, and therefore that a finding in terms of section 26(2)(e) to the effect that a precaution which could realistically have been taken and which had it been take might realistically have resulted in the death being avoided should be made on the basis that a possessions check of the deceased upon her admission to Munro ward may have allowed staff to discover she had paracetamol on her possession.

[518] Having considered the evidence and the relevant submissions I accepted the Crown and next of kin submissions to the extent that it was a matter of agreement between all parties that when Ms McCready was admitted to Stobhill hospital on 23

June 2018, she should have been subjected to what was referred to as the normal possessions check.

[519] It was also agreed and I accept as a matter of fact that any such check was never documented as having been carried out.

[520] In my view a possessions check when she was admitted to Munro ward was a precaution which could reasonably have been taken.

[521] For the following reasons I find on a balance of probabilities that a possessions check was not carried out and as a result I accept that this reasonable precaution was not taken.

[522] The Inquiry heard evidence regarding the process and the purpose of a possessions check in the case of an informal patient from several witnesses, including Nurses Fitzsimmons and McCauley.

[523] The admitting nurse was the person responsible for the entire admission process which included a possessions check. During the course of this check the relevant nurse was required in the words of Nurse Fitzsimmons to identify: "items of high value, jewellery…hazardous items, glass or sharps…check in the clothing they had brought in so if anything goes missing we can account for it".

[524] Any concerning items in the possession of the patient, would normally be removed for safe storage or disposal. This is, to ensure that any items which are an actual or potential danger to the patient, to fellow patients, or to staff would be removed.

[525] The possessions check was also designed to ascertain whether the patient had attended at the hospital with any existing medication, either prescription or non-

prescription. The Inquiry heard evidence from several witnesses that all medication would be removed and stored safely and securely pending the patient's discharge from hospital.

[526] The witnesses Fitzsimmons and McCauley said that a "possessions or clothing book" was maintained on the ward and anything of value, or potentially dangerous would be checked in, with the patient being given a receipt for any items removed. This process also applied to any medication in the patient's possession.

[527] The record of this process was to be completed and maintained within a triplicate book kept in a filing cabinet in the nurse's station. The format of this book allowed all records to be maintained in triplicate, producing three copies of the record, with one copy remaining within the book. A further copy was given to the patient and the final copy was placed with the patient's notes.

[528] Nurse Fitzsimmons told the Inquiry that when a patient was admitted to the Munro Ward at Stobhill , that: "routinely we would carry out a belongings check...basically, we take them to the bed area, decant [their] bag with their consent they would bring out what is in their bag ask them if they have anything on them that is concerning to us…with their consent…it's challenging we need to know there is nothing dangerous within the environment, we need to know there is nothing that was contraband… I would ask if they had anything in their pockets, concealed on their person that would be considered dangerous…that would cause harm to someone. I would have to take that as their word I would not have any powers to take that any further."

[529] I accepted the evidence of several witnesses including Nurses Fitzsimons and McCauley that this process very much depended on the co-operation and goodwill of the patient and relied to a great extent on the candour and truthfulness of the patient. Accordingly the process was not capable of addressing the situation where a determined patient decided to mislead staff regarding possession of any forbidden items, nor could it deal with a determined patient who sought to actively conceal any such items.

[530] Accordingly, whilst an important process, in the absence of any degree of active searching, it was not capable of preventing a determined individual from introducing forbidden items into the hospital at the time of their admission.

[531] I accept that it was a matter of agreement that there was no documentation of any kind pertaining to a possessions check within Ms McCready's medical records, nor was a centralised record maintained. There was also no evidence that any record or receipt had been provided to Ms McCready.

[532] Nurse Fitzsimmons was questioned closely as to whether in fact a possessions check had been carried out for Ms McCready. I found her evidence on this issue to be ambiguous and unsatisfactory. For example she stated: "I did not personally carry out the process so I cannot say whether it happened or did not happen…I am not aware of who did the possessions check…I could not speculate to be honest; it has either been done and mislaid or it could potentially not have been done…we could speculate for as long as you wanted, I could not answer that specifically."

[533] This was clearly unsatisfactory, especially as she had also confirmed that she had *"not necessarily"* been assisted by anyone else, saying: "I am not aware of who carried it

out…Ordinarily I would delegate that task….I do not recall doing that. I would assign possessions check and patient orientation whilst I did the admission procedure."

[534] Accordingly, whilst Nurse Fitzsimmons was able to give evidence to the effect that she had not actually personally undertaken the possessions check, notwithstanding that she remained responsible for the possession check procedure, she could not confirm whether the check was carried out by any other individual.

[535] She suggested that the possessions check might have been delegated by her to another unnamed individual, given her comment that ordinarily she would delegate that task but could not confirm whether this process of delegation had in fact taken place in relation to Ms McCready.

[536] Even if this had been delegated by her,(and her evidence about this was at best ambiguous), then this process should properly have been documented in terms of existing policy and indeed the NHS Professional Record Keeping and Communication: Good Practice policy.

[537] Whilst it was accepted by Nurse Fitzsimmons that it was possible that no possessions check had in fact been carried out, it was also submitted on her behalf that the lack of any record of the possessions check did not necessarily mean that a check was not carried out.

[538] Notwithstanding the suggestion that an absence of evidence did not necessarily equate to evidence of absence, the fact remained that no witnesses could actually confirm that the check had been carried out. Whilst Nurse Fitzsimmons suggested that she may have delegated the task to a colleague, she was unable to identify any such colleague,

and her suggestion in this regard appeared to me to be simply predicated upon her typical practice rather than any particular memory of the practice adopted in this particular case.

[539] Whether or not the check was carried out, it was submitted that in any event because any such check could never constitute a "search" and as it was necessarily reliant upon the consent and co-operation of the patient, it followed that had Ms McCready entered Munro Ward in possession of paracetamol, any possessions "check" might not *necessarily* have discovered it, especially if Ms McCready had been set upon concealing said items.

[540] A check was not a search and as staff were not permitted to conduct a search then there would have been no way of staff knowing about any items such as paracetamol unless Ms McCready told them about it or suspicions were aroused. In the absence of the physical aspect of a search any check was at best an incomplete manner of ascertaining whether a prospective patient had any forbidden items with them at the point of admission.

[541] Having considered the evidence and submissions I accept that there would inevitably be limitations as to what might be recovered in the course of any possessions check, particularly if the admitting nurse was faced with a recalcitrant patient who wished to secrete items about their person or indeed a forgetful patient, unaware of items carried by them. I note however the evidence of Nurse McCauley who spoke to the skills employed by experienced staff, to persuade, cajole and secure co-operation. I accepted that evidence. Further I accepted her evidence that if a patient seemed

reluctant or evasive, there were other tools at the disposal of staff. This included escalating the matter by perhaps calling the police, involving medical staff and ultimately changing the patient's status.

[542] I reject the submission that a possessions check had been carried out either by Nurse Fitzsimmons or by someone delegated by her and recorded in a log, which was subsequently misplaced. I accept instead the evidence of Catherine McCauley, who said her understanding at the relevant time was that the possessions book was not available and was on order.

[543] Given this evidence and in the absence of any evidence to the contrary I conclude that it was unlikely that any records had been entered and maintained. This was consistent with the fact that there was no triplicate copy of the possessions check in any of the medical records pertaining to Ms McCready or with the items which were purported to have belonged to Ms McCready which were returned to her family.

[544] I was satisfied therefore that there had been no record maintained of any possession check, and therefore there was no indication as to who, if anyone had actually undertaken this task.

[545] Having considered the evidence, I find on a balance of probabilities that no possessions check was carried out at the point of Ms McCready's admission. In coming to this conclusion, I have taken cognisance of the following factors:

- Nurse Fitzsimons' admission that she did not personally carry out the possessions check herself.

- Nurse Fitzsimons' lack of recollection about whether that she had in fact delegated the possessions check to anyone else.
- The absence of any witnesses indicating that this task had been delegated to them;
- The fact that no triplicate copy from the possessions book was contained within Ms McCready's medical notes, in breach of the protocol requiring that a copy of the possessions check be maintained on the patients records.
- Catherine McCready's evidence that items were returned to the family which did not belong to her mother.
- Doctor McCaffery's acceptance that it was likely that a possessions check, had not been undertaken with Ms McCready.
- Hugh McGregor's evidence that the absence of any reference to a possessions check in the clinical notes meant that it could be inferred that it had not been carried out.
- The Significant Clinical Investigation's conclusion that when Ms McCready was admitted to the ward the normal possessions check was not carried out and it is possible that Ms McCready brought paracetamol into the ward with her.

- I note that the SCI also concluded that there was no "safety net" of checks for admission whereby lapses such as a failure to carry out possessions check could be rectified.

[546] On the basis of the evidence I find that a reasonable precaution would have been to carry out a possessions check on admission which was the usual practice on the ward.

[547] On the basis of the evidence I find that there was a system in place at the relevant time to record that a possessions check had taken place. This was the triplicate recording which included placing one copy of the possessions record with the patient's notes. Regrettably no member of staff noticed that this was not included with Ms McCready's notes.

[548] Unfortunately, I am unable to conclude, categorically, how Ms McCready came to be in possession of paracetamol on Munro ward, however I find that it is at the very least a realistic possibility that she may have had a quantity of paracetamol in her possession upon admission. I reject the proposition that it would have been inherently unlikely that she would have been transferred from GRI to Munro ward in possession of paracetamol. I note that there was no evidence led of a possessions check when she was admitted to GRI. I accepted the evidence of Ms Gardener, the liaison nurse at GRI as credible and reliable – she was unable to speak to such a check. The record which she spoke to in relation to the return of medication as N/A was neutral in my view. For example if medication had never been taken from her it could not be returned. Further, I accepted the evidence of Drs McCaffery and Gajree who both thought it was possible for Ms McCready to have brought paracetamol into the ward.

[549] In my view, there was a realistic possibility that a proper possessions check, adequately recorded, (notwithstanding its inherent limitations) would have been able to discover any such medication in Ms McCready's possession, leading to it being removed and stored securely. I accept that another possibility is that she acquired paracetamol while she was on the ward. There were a number of ways in which she could have done so; she could have bought it at the shops, she could have obtained it from a visitor or another patient. There were adminicles of evidence both supportive of and contra-indicating some of these possibilities. In my view whilst it was a possibility that she had acquired the paracetamol whilst on the ward it would require speculation to determine how she had come to acquire paracetamol.

[550] In considering the question of whether a possessions check was a reasonable precaution which if carried out, might realistically have resulted in Ms McCready's death being avoided. I note that it is a matter of agreement between the parties that the undertaking of a possessions check was a precaution, which might reasonably have been taken. Further I note that what is required in relation to a finding in terms of section 26(2)(e) namely that a precaution might realistically have prevented a death is to determine whether there was a real or lively possibility rather than a remote chance that it might have done.

[551] Accordingly It is my finding that the failure to carry out a possessions check was a precaution which could reasonably have been taken and had it been taken might realistically have resulted in the death of Ms McCready being avoided in terms of section 26(2)(e).

[552] I note the findings of the SCI which followed upon the death of Ms McCready and I note the steps which have been taken by Greater Glasgow Health board in response. In relation to possessions checks the recommendation was to review the ward processes regarding admissions paperwork and practice to facilitate the opportunity to detect errors such as not recording belongings and this should be audited.

[553] An audit was undertaken in July 2022 at Stobhill in relation to the checking of patient belongings which found that all wards reported that patient belongings are always checked on admission and an itemised list recorded in the possessions book.

[554] Importantly, staff are also recording instances where items have been removed as a safety risk. There is also a process for staff to update a patient's log if they are returning to the ward from time out or if they have received a delivery. The Audit identified that checks of shopping and deliveries were performed on an individual basis usually influenced by patient safety concerns and audits are ongoing.

[555] In light of the steps taken by Greater Glasgow Health Board- which have already been implemented, I make no recommendations in terms of section 26(1) (b) of the Act.

[556] Finally, I join with all parties in offering my sincere condolences to the family and partner of Ms McCready.