**SHERIFFDOM OF LOTHIAN AND BORDERS AT SELKIRK**

**[2025] FAI 27**

SEL-B82-24

DETERMINATION

BY

SHERIFF P PATERSON

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

into the death of

HARRIS JAMES MACDONELL

Selkirk, June 2025

**Determination**

The Sheriff having considered the evidence and submissions of the parties; determines that in terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the Act") as follows:-

1. In terms of Section 26(a) of the Act, that Harris James Macdonell's death took place at an electric pylon located in a field across the road from his home in Lilliesleaf, Scottish Borders at 03:39 hours on 19 August 2020.

2. In terms of Section 26(2)(b) of the Act Harris James Macdonell took his own life as a result of deliberately coming into contact with or coming close to an 11 KV power line located in a field across from his home at Lilliesleaf, Scottish Borders.

3. In terms of Section 26(c) of the Act the cause of Harris James Macdonell's death was electrocution.

4. In terms of Section 26(d) of the Act the cause of the accident was Harris James Macdonell deliberately taking his own life.

5. In terms of Section 26(e) there were no precautions which could have reasonably been taken that would have prevented Harris James Macdonell's death.

6. In terms of Section 26(f) of the Act there were no defects in the system of working which contributed to the death of Harris James Macdonell.

7. In terms of Section 26(g) of the Act there are two matters that are relevant in relation to the death of Harris James Macdonell. The first is the lack of residential psychiatric beds for children and adolescents. The second matter is the lack of any control over entry and exit to Huntlyburn Ward.

**Recommendations**

1. In terms of Section 26(1)(b) of the Act the court has one recommendation to make, namely that entry and exit to Huntlyburn Ward should be controlled.

**NOTE**

**Introduction**

**Legal Framework**

[1] The purpose of an inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths in similar circumstances.

[2] Section 26 of the Act requires the sheriff to make a determination which in terms of Section 26(2), is to set out factors relevant to the circumstances of the death, in so far as they have been established to his satisfaction. These are (a) when and where the death occurred; (b) when and where any accident resulting in 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 could reasonably have been taken and if they had been taken might realistically have resulted in the death being avoided; (f) any defect in any system of working which contributed to the death or to the accident; and (g) any other facts which are relevant to the circumstances of the death. In terms of section 26(1)(b) and 26(4), the inquiry is to make such recommendations (if any) as the sheriff considers appropriate as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a system of working, and (d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances. The crown represents the public interest. An inquiry is an inquisitorial process and the manner in which evidence is presented is not restricted.

The determination must be based on the evidence presented at the inquiry. It is not the purpose of an inquiry to establish criminal or civil liability.

**Summary**

[3] The inquiry has had the very considerable benefit of a very detailed Joint Minute which summarises the factual background to the sad events leading to Harris's death and set these out below for ease of reference. I have made certain very minor amendments to the same to correct what appear to me to be minor grammatical or typographical errors. I have shown the amendments in square brackets.

1. Harris James Macdonell was born on 14 June 2001. He died in the early hours of 19 August 2020, when he was 19 years old.

2. At the time of his death Harris resided with his family – namely his parents, Dr Jane Macdonell and David Macdonell, his older sister (Katie) and his two younger brothers (Robbie and Patrick) – at the family home in the Scottish Borders.

3. Harris attended Lilliesleaf Primary School and then, from S1 to S4, Selkirk High School. He transferred to Loretto School for the 2017/2018 academic year and was a boarder there. He returned to Selkirk High School to complete his secondary education in 2019.

*Circumstances of Harris's Death*

4. After attending rugby practice on 18 August 2020, Harris returned home and had dinner at about 9pm. His parents saw him in the kitchen at 9.30pm, at which point they went to bed.

5. The following morning Dr Macdonell realised that Harris was not at home. At about 11.53am she reported him to police as a missing person. A search of the home and the surrounding area was commenced.

6. At about 5.20pm on 19 August 2020 Mr Macdonell noticed a set of ladders leaning against an electricity pylon in a field opposite the family home. He found Harris, unresponsive, lying in the field next to the pylon. Emergency services attended, but Harris's life was pronounced extinct at 6.05pm.

7. Harris had used the set of ladders to climb the pylon in the early hours of 19 August 2020 and been electrocuted as a result of coming into contact with, or coming into close proximity to, an 11[K]V power line.

8. On 26 August 2020 a post-mortem examination was carried out by Dr Thomas Prickett and Dr Ian Wilkinson. In their final post-mortem report dated 31 March 2021 they recorded the cause of death as being electrocution, noting that there [were] burns characteristic of electrocution on the limbs and left chest (CP 2, p 8).

9. Crown production 2 is the final post-mortem report, the contents of which are agreed.

***January 2018***

10. On 22 January 2018, when he was 16 years old, Harris consulted with Dr Angus McVean, General Practitioner, at Selkirk Medical Practice. Dr McVean recorded that Harris was 'feeling flat and at times suicidal' and 'feeling low and down all [the] time'. He recorded that the previous weekend Harris had taken a knife 'and thought about harming / killing himself but couldn't go through with it'. He recorded that Harris was 'not sure he would continue and do it again but might' (CP 34, p 1001). Dr McVean referred Harris to NHS Borders's Child and Adolescent Mental Health Service ('CAMHS') the same day (CP 5, p 300).

11. On 23 January 2018 Harris attended a consultation with Dr Ruth Ashman, Consultant Psychiatrist, and Julie McLaughlin, Community Psychiatric Nurse (CPN). They recorded his mood as appearing 'low and objectively flat'. They agreed a diagnosis of depression and prescribed fluoxetine. It was arranged for Harris to meet with Dr Helen Wilson, Consultant Clinical Psychologist, to assess his suitability for psychological therapy (CP 5, p 297). A Clinical Risk Screen and Crisis Card were completed (CP 5, pp 38-41).

12. On 24 January 2018 Dr McVean prescribed Harris 20mg fluoxetine, one capsule to be taken each morning (CP 34, p1001).

13. By letter dated 26 January 2018 Dr Ashman and CPN McLaughlin wrote to Dr McVean. The letter set out the background to the consultation and under 'Summary/plan' stated: 'Harris [presents] as a young man with a moderate to severe depressive illness on a background of possible social relationship

difficulties, as well as organisation and concentration difficulties'. It stated that a trial of fluoxetine should be commenced at 10mg for one week, increasing to 20mg after one week, and that they had organised for Dr Wilson to meet Harris and assess his suitability for psychological therapy (CP 5, p 46).

14. On 29 January 2018 Dr McVean saw Harris and noted that Harris was experiencing no problems with the fluoxetine, but that his mood was still very variable (CP34, p 1001). At 2.46pm that day Dr McVean emailed Dr Ashman, stating that there were no side effects from the fluoxetine, but that Harris remained 'very flat, low' and some ideas of self-harm persisted (CP 5, p 50).

15. On 31 January 2018 Dr Ashman and CPN McLaughlin attended a consultation with Harris and his mother. Dr Macdonell had phoned the previous day, concerned about Harris, who had climbed onto the roof of the family home. When seen independently on 31 January 2018, Harris reported still feeling very 'empty' and low at times. It was noted that Harris would continue to be managed at home, that appointments for him to see CAMHS staff had been arranged and that he would continue on 20mg fluoxetine for the time being (CP 5, pp 296-297). Dr Ashman emailed Dr McVean with a summary of the consultation (CP 5, p 48).

***February 2018***

*Admission to Huntlyburn Ward, Borders General Hospital*

16. On 1 February 2018 Dr Macdonell called CAMHS. She spoke to CPN McLaughlin. Dr Macdonell reported a difficult morning. While she had been getting ready to go out with Harris, Harris had gone out of his bedroom window and onto the roof. She reported that, increasingly, she was 'increasingly feeling unsafe managing Harris at home'.

17. In February 2018 there were three Young Peoples Inpatient Units (YPUs), providing inpatient mental health care for people under 18, in Scotland, located in Edinburgh, Glasgow and Dundee.

18. CPN McLaughlin and Dr Macdonell discussed the potential admission of Harris as an inpatient. CPN McLaughlin contacted the YPUs in Edinburgh, Glasgow and Dundee. She was informed that there were no beds available at that time in those YPUs. She contacted Huntlyburn Ward, an acute adult inpatient unit operated by NHS Borders. She was informed that a bed was available, but that they were 'busy at present'. It is recorded as follows: 'Mum agrees admission feels necessary as risk does not feel manageable at home.' CPN McLaughlin told Dr Macdonell that she would speak to Huntlyburn Ward re admission and get back to her re logistics (CP 5, p 52).

19. On 1 February 2018 Dr Ashman spoke to Dr Kevin Brown, Consultant Psychiatrist. Dr Brown agreed with Dr Ashman that admission sounded appropriate. There were no beds available at Edinburgh YPU. Harris was put

on a list for the next available bed at Edinburgh YPU (CP 5, p 52). Dr Brown agreed with Dr Ashman that he would let Borders CAMHS know as soon as a bed became available there (CP, p 295).

20. Dr Ashman referred Harris to Lothian CAMHS that day (CP 5, p 313).

21. As there were no beds available in the other YPUs, Dr Ashman telephoned Huntlyburn Ward. She discussed admission of Harris with Senior Charge Nurse Lisa Clark. Nurse Clark said that she was worried about placing Harris in an adult unit as there were already patients on constant watch. Dr Ashman spoke with Philip Grieve, operations manager at Huntlyburn Ward. Following discussion, Mr Grieve agreed to admit Harris to Huntlyburn Ward. Dr Ashman understood that changes would be made to Huntlyburn Ward to suit Harris. Dr Ashman contacted Dr Macdonell and told her that Harris would be admitted that evening. Dr Macdonell said that she would take him there (CP 5, pp 295-296).

22. Dr Ashman noted that the admission was 'informal', but also that, if Harris refused to be admitted, use of the Mental Health Act (i.e. Mental Health (Care and Treatment) (Scotland) Act 2003) 'should be considered'. She noted that, once admitted, Harris was for constant observation ('constant obs') due to his age on an adult ward. She noted that Harris could have escorted passes with staff and, at the staff's discretion where able to be facilitated, with family. She noted that Harris was to continue on 20mg fluoxetine daily. She noted that input would continue from Borders CAMHS and that she would remain Harris's

responsible medical officer and would review him on the ward the following afternoon (2 February 2018) (CP 5, p 52).

23. At 7.30pm on 1 February 2018 Harris attended Huntlyburn Ward with his mother, who remained until 9pm. Harris was noted as being 'pleasant and reactive during admission', but also 'anxious re being on ward' (CP 5, p 56).

24. Harris was admitted Dr Grace Hill, Psychiatrist (CP 5, pp 17-23). She completed the 'Borders Risk Assessment Tool' (CP 5, p 22). Dr Hill noted that Harris was 'on waiting list for IPU CAMHS bed' and that the plan was 'to transfer when bed available' (CP 5, p 23). A physical examination of Harris took place the following morning (CP5, p 21). A 'Safety Care Plan' was prepared at about 8pm on 1 February 2018 (CP5, p 53). In the section headed 'Measures in Place to Reduce Risk', that plan noted that a senior review by CAMHS was to be undertaken at 3pm on 2 February 2019. In the section headed 'Current Situation', it noted: 'Harris has been admitted to Huntlyburn as a place of safety until bed is available at the YPU. Due to Harris being under 18 years old (14-06-01) on an adult inpatient unit – for his own safety and vulnerability requires a member of staff to be with him at all times / Harris is also [at] risk of DSH [deliberate self-harm]'. In the section headed 'Goal', it noted: 'To be transferred to age appropriate unit – YPU [-] when bed becomes available / To be safely managed on the ward'. It noted that there was to be daily contact with Edinburgh YPU for updates on the availability of a bed for Harris. Harris was to

continue on 20mg fluoxetine a day. He was to be allowed to leave Huntlyburn Ward on an escorted pass in the company of family and/or staff (CP 5, pp 54-55).

25. Dr Ashman reviewed Harris on the afternoon of 2 February 2018. She noted a background of 'severe depressive episode on background possible neurodevelopmental difficulties, suicidal ideation, impulsivity, odd ideas / ?? emerging psychotic depression (not clearly delusional at present)'. As part of the review, she noted that Harris remained 'flat in affect' and 'struggled to engage at interview'. She explained to Harris that he was under constant observation due to his age and that they were awaiting a bed in Edinburgh YPU. It was noted that Harris was 'feeling safe on ward'. The care plan remained in place. CPN McLaughlin was to review Harris on Monday (5 February 2018). Dr Ashman was to review him on Tuesday (6 February 2018). Dr Wilson was to review him on Wednesday (7 February 2018) (CP 5, p 25).

26. Earlier that day Harris had gone out with his mother and returned after lunch. He spent large periods of the day with his family. His mother had remained on the ward until about 9pm (CP 5, pp 57-58). On 3 February 2018 Harris had left the ward at 9.50am to spend the day at home with his family and to watch the rugby and that he was due back later that evening (CP 5, p 58). From 8.30pm to 9.30pm that day he was in his room with his family (CP 5, p 78).

27. Harris left the ward on the morning of 4 February 2018 to spend time with his family. He was due to return after teatime (CP 5, p 58). He returned to the ward at about 9.30pm (CP 5, pp 80, 151).

28. At about 10am on 5 February 2018 Harris and his mother had a consultation with CPN McLaughlin. CPN McLaughlin noted that Harris had had an 'ok' weekend visiting his family, but that he had not been keen to return to the ward and that his mother had found him climbing out of his bedroom window. She noted that Dr Macdonell was feeling exhausted (CP 5, pp 59, 295). Harris's father visited him between 5.30pm and 6.30pm that day (CP 5, p 81).

29. At about 10am on 6 February 2018 Harris was reviewed by Dr Ashman, who also met his mother. Dr Ashman's impression remained that Harris was having a moderate to severe depressive episode on a 'background of possible underlying neurodevelopmental difficulties'. Her plan included continuing Harris on fluoxetine and continual review (CP 5, pp 62-64). Harris went for a walk with his mother in the afternoon. His father visited him between 8.30pm and 9.30pm (CP 5, pp 64, 76, 150, 156).

30. On the morning of 7 February 2018 Harris was seen by Dr Wilson. Also present were Dr Macdonell, CPN McLaughlin and a staff nurse. The purpose of Dr Wilson's visit was to review Harris's progress and to ascertain whether there was an appropriate role for psychology at this point in his mental health care (CP 5, p 295). Between 11.30am and 13.30pm Harris was out with his mother for a walk and lunch. His mother visited him in the ward between 6.30pm and 9.30pm (CP 5, pp 158-159). He completed a physiotherapy self-referral and underwent a basic assessment for exercise (CP 5, pp 150, 160-163, 182).

31. On 8 February 2018 it was noted that Harris had been 'up and on the go' in the morning, had gone on the internet (to google 'psychopath') and had contacted his mother on the phone twice to ask her to watch a video on Facebook. He then attempted to abscond from Huntlyburn Ward, but came back when staff asked. He stated that he was feeling frustrated at being in hospital and on constant observation. (CP 5, pp 149, 169).

32. Between 1.30pm and 2.30pm Harris left the ward with his mother to go shopping for clothes in Galashiels and, after returning, spent time with her in the ward. His father visited him between 6.30pm and 7.30pm (CP 5, pp 169-170).

33. Dr Ashman reviewed Harris that day, with his mother present. As to his earlier attempt to abscond, Dr Ashman noted that Harris had walked out of the front door and run to the car park and then returned willingly when staff shouted after him. Harris denied having had any intention to harm himself, but was unsure what his intention had been. He reported having felt very frustrated in hospital and just wanting to leave. When Dr Ashman asked him what he thought about his ongoing admission, he said that he was safe there and that it was better for his mother for him to be there. He did not express any wish to be discharged. He said that he had had visits from his family and had enjoyed this. Dr Ashman recorded as follows: 'Explained still awaiting bed in Edinburgh [YPU]. Mum and Harris not too keen on transfer, advised that our policy would generally be transfer him and I do not think he will be ready for discharge in the next couple of days, but that if and when bed available may need to be discussed

then if feel strongly otherwise.' Harris's prescription for fluoxetine was increased from 20mg to 30mg on the same date. It was noted that he would continue to be reviewed and could continue with escorted passes with his family (CP 5, p 177).

34. Harris struggled to sleep on the night of 8/9 February 2018 and, in the early hours of 9 February 2018, was given 3.75mg zopiclone. He then settled to sleep (CP 5, p 149).

35. On 9 February 2018 Harris attended a tai chi group session on the ward. Initially he appeared restless, but he appeared more relaxed as the session progressed. On the ward Harris did not wish to discuss how he was feeling or current events. He spent time in his room doing schoolwork. His mother visited him between 10.30am and 11.30am and he returned with her to the family home. They went to play tennis and then returned home. Harris had lunch and a shower. He then failed to return from a trip to the toilet. His family found him on the roof of the house in a state of distress. He agreed to return to Huntlyburn Ward, but, on leaving the house to do [so], ran away from his mother, went back into the house and again climbed onto the roof. He would not come down. His mother climbed onto the roof to speak to him. Police attended, along with the fire service. He and his mother climbed down using a ladder provided by the fire service. He was returned to Huntlyburn Ward by ambulance (CP 5, pp 148-149, 173-175, 198-199, 294). Between 9.30pm and 10.30pm it is recorded as follows: 'Had a brief chat with Harris, reports he feels safe now that he is back on

the ward. Harris stated the reason he went on the roof was because he didn't want to come back to the ward.' (CP 5, p 175).

***10 February 2018***

***Events Leading to SAER 1 and Treatment***

36. On the morning of 10 February 2018 Harris was observed to be 'agitated and irritable'. When asked by staff why he had climbed onto the roof the previous day, he said 'I just didn't have the balls to jump' . When asked what had been going through his head at the time, he said that he had 'just wanted to die, end it all'. (CP 5, p 147). He absconded later that day. At about 1.55pm he was with staff in the dining room, engaging in arts and crafts. When others entered the room, he ran out of the building. He ran in the direction of the bypass, towards Tweedbank. Staff used the ward car to search for Harris and found him walking along the bypass. He agreed to return with them. He appeared calm and relaxed and smiled as he got into the back of the ward car. He showed no overt signs of distress or agitation. As they were driving at a speed of between 30 and 40mph, Harris jumped from the vehicle. He sustained soft tissue facial and scalp injuries and abrasions over both elbows. He was taken to Borders General Hospital, where he remained, under the observation of two members of staff, until he was transferred to St John's Hospital, Livingston. He did not return to Huntlyburn Ward (CP 5, pp 90-91, 96, 146-147).

37. Harris was seen by Dr Lucy Calvert, Consultant Psychiatrist, at Borders General Hospital on the evening on 10 February 2018. He reported to Dr Calvert that he had 'not been right' since early December 2017 and felt that he did not fit in and felt anxious. He reported feeling low in mood and was concerned that there was something wrong with him. He reported that he had felt 'het up' earlier that day and had needed to escape the ward. He was unable to describe why he had jumped from the ward car. He acknowledged that impulsivity had been a problem over the past few weeks. Dr Calvert asked for his views about being on Huntlyburn Ward. Harris said that he felt safe and was agreeable to remaining on the ward and that he was also supportive of the plan 'to go to YPU'. Dr Calvert suspected 'significant depression', but noted that Harris's mental state was difficult to assess 'as clearly he [was] acutely distressed and [appeared] overwhelmed by events'. She considered that he required 'ongoing psychiatric inpatient care for further assessment and risk management' and that there was a 'substantial risk' of self-harm due to impulsive acts, 'which have not been managed through constant observation on the ward environment'. As an approved medical practitioner, Dr Calvert granted a short-term detention certificate in respect of Harris in terms of section 44 of the Mental Health (Care and Treatment) (Scotland) Act 2003. She placed him under the special observation of two staff members, one of whom required to be a registered mental {health] nurse. She discussed Harris with Dr Brown, who advised that there would be no beds available in YPUs in Scotland 'until at least next week'.

It was decided that, due to the possible increased risk of impulsivity on fluoxetine, Harris's prescription for fluoxetine should be withheld over the weekend. Lorazepam was to be prescribed (CP 5, pp 34, 145-147; CP 6, p 665).

38. On the afternoon of 11 February 2018 Harris was seen by Dr Catherine-Anne Convery, Psychiatrist. His mother was also present. He was transferred to St John's Hospital at about 1pm, escorted by two members of staff in an ambulance (CP 5, pp 85-86, 144).

39. That afternoon Dr Calvert spoke with Harris's parents over the phone. From her conversation with Harris's father, Dr Calvert records as follows: 'Re-iterated current situation being that of no suitable YPU bed existing in Scotland. Advised that CAMHS may be able to liaise with Edinburgh YPU on Monday to explore possible options, including prioritisation of his care given the incidents that have occurred however made no guarantee of a transfer from [Livingston] being possible. / Family have sought help from a cousin and are exploring options in Gloucester. Advised that legal implications may complicate such a move, with English law requiring to be applied which differs from Scottish law.' She recorded: 'David stated that the family had lost faith in the service and under no circumstances would support [Harris's] return to Huntlyburn. I acknowledged that the circumstances have been extremely strained for the family however the difficulties are that of resourcing which cannot easily be address.' (CP 5, p 181)

40. From her conversation with Dr Macdonell, Dr Calvert records as follows: 'Discussed ongoing difficulty in finding suitable [inpatient] resource. [Advised] that CAMHS teams would look at possible options on Monday. She queried what other resources may exist [outwith] the area; if risk was deemed substantial advised that consideration may be given to specialist/private unit if available. / She reiterated her concerns about his care to date, saying she had lost all faith in the service.' (CP 5, p 181).

41. Harris underwent plastic surgery at St John's Hospital on 11 February 2018 and was discharged the following day.

42. A Significant Adverse Event Review (SAER) in relation to the events of 10 February 2018 was commenced on 15 February 2018 and completed on 10 December 2018. Crown production 7 is the report of the SAER.

***12 February 2018 – 6 April 2018***

***Admission to Edinburgh YPU***

43. On 12 February 2018 Dr Brown called Dr Ashley Cameron, Consultant Psychiatrist with Borders CAMHS, to advise that a bed was available for Harris at Edinburgh YPU, within the Royal Edinburgh Hospital. Harris was transferred there that day (CP 5, pp 195, 293-294). He remained there until 6 April 2018.

44. On 15 February 2018 Dr Ashman spoke with staff at Edinburgh YPU. She noted that Harris had been reviewed by Dr Brown, who was querying a

diagnosis of 'ADHD/ASD' [i.e. attention deficit hyperactivity disorder/autism spectrum disorder] and was going to pursue assessment of those (CP 5, p 293).

45. On 15 February 2018 Harris was assessed by Susan McConville, Assistant Clinical Psychologist, supervised by Louise Duffy, Consultant Clinical Psychologist. She noted as follows: 'Harris's responses indicate that he is not experiencing clinically significant symptoms of anxiety and/or depression' (CP 6, p 516).

46. On 16 February 2018 Dr Ashman spoke to Dr Macdonell over the phone. It is recorded that Dr Macdonell reported her feeling that, 'if different action had been taken on the Friday [9 February 2018] after he was returned to the ward following being on the roof at home (in particular if he had been transferred to a locked ward such as Edinburgh IPU at that point) he may not have been in the situation where he needed detained' (CP 5, p 293).

47. On 16 February 2018 Dr Ashman spoke to Dr Brown over the phone. The latter reported that Harris '[seemed] happy to stay at present'. His working diagnosis was ADHD and ASD. Harris felt that his mood was less of a problem and was 'more a crisis in relation to realisation/confirmation of being 'different' precipitated by move to Loretto [School]' (CP 5, p 292).

48. On 22 February 2018 an Early Care Planning Meeting was held at Edinburgh YPU. Dr Ashman and Dr Brown were present. After about half an hour Harris and his parents joined the meeting. The hypothesis of 'the main picture being ADHD and ASD' was repeated and it is noted that 'Harris and

family aware of and in agreement with hypothesis'. It is noted that they were happy with the plan. Harris's parents had brought his school reports to help with the assessment for ADHD. After reviewing the school reports, Dr Brown recorded that Harris had ADHD (CP 5, p 292; CP 6, p 564).

49. Dr Brown prescribed a trial of Concerta XL (ADHD medication), initially at 18mg and increased to 36mg on 8 March 2018. Concerta XL appeared to be of limited benefit to Harris compared with the side effects. Accordingly, this prescription was stopped on about 9 March 2018 (CP 5, pp 290, 292; CP 6, pp 564-565, 572-573, 579-581).

50. On 26 February 2018 Dr Brown concluded that Harris no longer met the criteria for detention and that the short-term detention certificate should be revoked. The short-term detention certification was revoked on 27 February 2018, but Harris remained as an inpatient at Edinburgh YPU (CP 5, pp 318-319).

51. Multidisciplinary meetings were held on 8, 15 and 22 March 2018 (CP 5, pp 322-332). From 15 March 2018 Dr Brown prescribed Harris 40mg atomoxetine. This was stopped prior to Harris's discharge from Edinburgh YPU (CP 5, pp 289, 327).

52. Harris was assessed for ASD during his time at Edinburgh YPU.

53. On 8 March 2018 a multidisciplinary meeting was held. Before the meeting, Dr Louise Duffy, Consultant Clinical Psychologist, had met Harris's parents on 26 February and 5 March 2018 to go through the Autism Diagnostic Interview – Revised (ADI-R). Dr Duffy noted that their responses gave a scoring

profile not consistent with a diagnosis of ASD, but that a full report was to {follow]. She noted that Dr Macdonell had provided a 'comprehensive Developmental History' (CP 5, pp 322-324, CP 6, pp 630, 654-657).

54. On 8 March 2018 Dr Brown noted that Harris was 'pleased by the news that ASD [was] not present' (CP 6, p 579).

55. On 27 March 2018 Harris was assessed by Dr McConachie and Dr Skouta using the Autism Diagnostic Observation Schedule (ADOS-2). They concluded that Harris's communication and reciprocal social interaction indicated through the interview that he would be within the autism range for the ADOS interview. They concluded: '[Harris's] individual autism observation and individual interviews while an inpatient to a variety of clinicians concur in the view that Harris is within the autism spectrum, but also has a lot of strengths which makes his autism a difference rather than a disability. The developmental history elicited with the structured interview didn't score within the range indicating autism, however this is frequent for the older Adolescent population with high level of functioning. In these case[s], the individual assessment carries much more weight [than] the developmental history.' (CP 5, pp 234-236)

56. On 3 April 2018 Dr Ashman was contacted by Charge Nurse Jackie Rose at Edinburgh YPU. Nurse Rose reported that Harris was 'doing fairly well' and had been home on overnight passes and was on one at present. She said that, if Borders CAMHS were happy after review, Harris could be discharged without returning to Edinburgh YPU (CP 5, p 289).

57. On 5 April 2018 Dr Ashman and CPN McLaughlin reviewed Harris. He reported that an advantage of being in Edinburgh YPU was 'being closer to friends in Edinburgh and meeting new people'. He reported that he had been told by Edinburgh YPU that [he had] 'high functioning autism' and that he felt unsure about that. He also reported that he had been told that he had ADHD and that he disagreed with that diagnosis, as he did not feel that it fitted for him. When asked for his thoughts on them, he said that he did not know a lot about personality disorder/psychopathy, but admitted that he had been researching (CP 5, pp 288-289).

***6 April 2018***

***Discharge from Edinburgh YPU***

58. On 6 April 2018 Harris was formally discharged from Edinburgh YPU. On discharge, diagnoses were noted to be 'ADHD – primarily inattentive', 'Autism spectrum disorder' and 'Mild or moderate depressive episode'. He remained on 20mg fluoxetine daily (CP 6, p 405).

59. On 11 April 2018 Harris was reviewed by CPN McLaughlin. His mother was present and reflected that she felt that Harris had been more upbeat and engaged in recent days. It was noted: 'Harris would be keen to meet again to talk more about how to improve his functioning and mood through further exploring his ways of functioning' (CP 5, p 288).

60. On 25 April 2018 Dr Ashman met with Dr Macdonell while Dr Wilson was seeing Harris. Dr Wilson joined Dr Ashman and Dr Macdonell at the end to report concerns about Harris's level of agitation and that he had made an inappropriate comment to her. Dr Ashman agreed to review Harris's medication, mental state and risk the following day, together with CPN McLaughlin (CP 5, pp 286-287).

61. On 26 April 2018 Dr Ashman and CPN McLaughlin consulted with Harris to assess his mental state 'in light of yesterday's agitated presentation and to monitor medication'. He denied feeling agitated currently or over the last few days. He denied any side effects from the fluoxetine and it was decided to continue on 20mg fluoxetine (CP 5, p 286).

62. At a multidisciplinary team meeting on 10 May 2018 concerns were raised that 'Harris [was] possibly trying to adapt his behaviour to fit his rigid and obsessional belief that he [was] a psychopath'. If that was the case, it was noted that 'there may be an escalation in deviant or risk taking behaviour'. It was noted: 'Current presentation does not fit with reports from family or school about his past functioning which [means] there has been a change in behaviour that coincides with fixation on psychopathy.' (CP 5, pp 284-285)

63. On 14 May 2018 Dr Wilson met with Dr Macdonell and the deputy head teacher of Selkirk High School, Mr Marshall. Mr Marshall reflected that Harris was presenting generally more agitated in manner and anxious than during his

previous time at the school. It was noted that staff at the school should be observing any noticeable changes in his presentation (CP 5, p 284).

64. On 1 June 2018 Dr Ashman consulted with Dr Macdonell over the phone. She reported that Harris was doing okay and had stopped taking fluoxetine on 9 May 2018. It was planned that he should remain off fluoxetine (CP 5, pp 283-284). By letter dated 13 June 2018 Dr Wilson updated Harris's GP on her meetings with him since his discharge from Edinburgh YPU. She noted that '[Harris's] presentation over the sessions has been variable'. She noted also that Dr Ashman remained involved in Harris's care and that Harris '[remained] open CAMHS' (CP 5, pp 344-345).

65. On 5 July 2018 Dr Macdonell emailed Dr Ashman and Dr Wilson reporting that Harris 'was gradually appearing more relaxed and continuing to enjoy sport and social events'. However, he was not 'spontaneously talking about anything in relation to his thoughts or hopes'. Dr Macdonell reported that [he had]been out with an 'Edge Autism' support worker (CP 5, p 354).

66. On 15 August 2018 Dr Macdonell attended a consultation with Dr Ashman and Dr Wilson. It was noted that Dr Macdonell was '[n]ot really worried about [Harris's] risk to self at present', but was '[s]tarting to worry a lot more about him longer term, his ways of coping and vulnerability'. A cognitive assessment with a speech and language therapist was to be organised (CP 5, pp 282-283).

67. Dr Donna Paxton, Clinical Psychologist, assessed Harris's cognitive functioning on 19 September and 26 September 2018. Ellen Baird, speech and language therapist, attended on both occasions to assess any anomalies in Harris's language and communication. The results were discussed with Harris at Selkirk High School on 14 November 2018 (CP 5, pp 237-239, 281-282).

68. On 1 October 2018 a multidisciplinary team meeting took place at Selkirk High School. Harris attended with his mother (CP 5, p 281).

69. On 13 November 2018 Dr Macdonell emailed Dr Ashman. She noted the apparent sides effects of Concerta XL and atomoxetine and queried if it would be worth considering guanfacine. Dr Ashman responded that she 'would be more than happy to consider a further trial of medication for Harris' (CP 5, pp 358-359). On 22 November 2018 Dr Macdonell informed Dr Ashman over the phone that Harris agreed with proposed trial of ADHD medication. They arranged to meet in two weeks for further discussion (CP 5, p 281).

70. On 7 December 2018 Harris and his mother attended a consultation with Dr Ashman to discuss ADHD medication. It was agreed that they would seek approval to prescribe guanfacine (CP 5, pp 280-281). Approval was given for prescribing guanfacine on about 19 December 2018 (CP 5, pp 280, 379). Harris's GP prescribed 1mg guanfacine daily (CP 34, p 1000). This was increased gradually to 4mg by 22 February 2019 (CP 5, pp 278-279).

***May to October 2019***

***Transfer from CAMHS to Adult Mental Health Services***

71. Dr Ashman reviewed Harris on 5 April 2019, with his mother present. Harris reported that he was 'feeling happy' on his current dose of 4mg guanfacine and that it was helping him to concentrate. He reported that his sleep and appetite were both good, as was his mood. As Harris was due to turn 18 in June 2019, Dr Ashman said that they would need to consider referral to adult mental health services if Harris thought he might want to continue guanfacine. She reported that Dr Macdonell was keen that he be referred to adult services for an initial appointment and that Harris consented to this (CP 5, pp 208-209).

72. On 18 April 2019 Dr Ashman wrote to Dr Amanda Cotton, Consultant Psychiatrist, to arrange a joint review to consider transitioning Harris to adult mental health services (CP 5, pp 206-207).

73. On 25 June 2019 there was a meeting at Selkirk Health Centre attended by Dr Ashman, Dr Cotton and Harris, accompanied by his mother. The purpose of the meeting was to discuss the transition of Harris to adult mental health services. Harris reported that he was much better now that his exams had finished. He had taken four Highers and felt that they had gone quite well. His sleep and appetite were described as normal and he described his self-confidence as 'quite high'. He denied any thoughts of self-harm or suicide or anxiety symptoms. Dr Cotton found it 'rather difficult to elicit moderately impairing ADHD symptomatology from the description or the particular effects of

medication'. She did not find Harris to be currently depressed. Nor was there any evidence of anxiety disorder. It was clear to Dr Cotton that Harris was 'very keen to get off medication', i.e. guanfacine. It was agreed that Harris should reduce his intake of guanfacine by 1mg daily per week (CP 5, pp 144, 211-214).

74. Dr Cotton and Dr Darragh Hamilton, Consultant Psychiatrist, reviewed Harris on 22 October 2019. It was noted that he had stopped guanfacine, as per the plan and that he had no residual ADHD symptoms, specifically no impulsivity or suicidal thoughts. It was noted that his mood was 'very good', that he had plans to look for a new job and was going to the gym and fitness classes. It was noted that he was happy to be discharged that day from the care of South CMHT. He was discharged from their care (CP 5, p 144). By letter dated 14 November 2019 Dr Hamilton reported Harris's discharge from the care of South CMHT to his GP (CP 5, p 216).

75. From then until May 2020 there was no contact between Harris, or those on his behalf, and the mental health services.

***Care of Harris from May 2020***

76. On 18 May 2020 Dr Macdonell contacted Dr Cotton regarding Harris's mental health. She wrote: 'I hope [it's] okay to contact you about Harris / He saw you once after the transition appointment with Dr Ashman last autumn and was discharged / Life was going quite well until Covid – he was involved in rugby and had started an access course at Edinburgh College in January / there's been a

marked deterioration over the last few weeks. He is very withdrawn and is not communicating with any of us in the family unit now other than to sit for a short time for quick meal / He has not managed to keep up with his course online. He becomes quickly agitated and leaves the room if we try to engage in conversation. I would say overall that his is worse now than he was on discharge from the YPU 2 years ago. We've been trying to keep going as usual but I'm worried that he may deteriorate further. / I'm not sure what you can offer but wonder if there's any supports for us as parents that you could recommend locally?' (CP 5, p 219)

77. Dr Cotton responded and there followed an exchange of emails (CP 5, pp 218-219).

78. At 12.30pm on 18 May 2020 Dr Macdonell wrote to Dr Jeff Cullen, General Practitioner, to advise that she had made an appointment for Harris with him for the following day (CP 5, p 224).

79. Dr Cullen consulted with Harris on 19 May 2020. He noted that there were increasing concerns about Harris being withdrawn and not engaging with [his family]. He noted that Harris had denied any suicidal thoughts. He noted: 'Clearly main issue is ADHD/autism and unwillingness to engage/understand diagnosis'. He noted also that Harris was declining assistance from Number 6, a charity for people diagnosed with ASD (CP 34, p 999).

80. On 22 May 2020 Dr Cullen emailed Dr Hamilton for advice about Harris. They exchanged emails. Dr Hamilton noted that, when he had been depressed

before then, Harris's behaviour had been 'very impulsive', 'resulting in him exiting a moving vehicle and needing plastic surgery for his injuries'. She wrote: 'With that in mind, and with depression in autistic people often presenting atypically, I think I should see him.' She said that, if acceptable to Harris, she would be able to see him within two weeks. Dr Cullen then updated Dr Macdonell (CP 5, p 220; CP 35, pp 1008-1009).

81. Dr Cullen made an urgent referral to South CMHT (CP 5, p 221).

82. An appointment was made for Harris to see Dr Hamilton (virtually, using the NHS Attend Anywhere video call system) on 10 June 2020 (CP 5, p 227). Dr Hamilton requested that an Occupational Therapist attend the appointment to enable joint assessment presentation and formulation of a management plan (CP 5, p 226). Harris spoke to Dr Hamilton over the phone after failing to attend the appointment via NHS Attend Anywhere. Harris stated that he was not sure how to work the technology and preferred to talk over the phone.

83. Dr Hamilton noted that the conversation was 'quite stilted', 'with Harris alternating with answering very quickly "yes/fine" or with long latency of answers, mostly monosyllabically'. She suspected that he found the interaction awkward and irritating. Harris reported that his mood was good and denied suicidal thoughts. He reported that he felt bored around the house due to lockdown, but was out cycling often and spending time happily on his phone. He said that he was inclined to agree that he had withdrawn a bit from the family, but said that this was because he was just bored. He denied any stress at

home or with college work. He reported that his appetite, sleep, energy levels and concentration were 'fine'. Dr Hamilton considered that there was 'nothing in [Harris's] conversation that indicated a severe mood disorder'. Harris declined to give Dr Hamilton permission to speak to his mother for a collateral appointment. Dr Hamilton wanted to see him face to face and a further appointment was made for 22 June 2020 with Rhona Harkness, occupational therapist (CP 5, pp 228-229).

84. Harris did not attend the appointment to see Dr Hamilton and OT Harkness on 22 June 2020. It was attended by his mother and his older sister Katie. Harris had told his mother that 'there was nothing wrong and he didn't see the merit in attending'. Dr Macdonell and older sister provided a collateral history, which was noted. Dr Hamilton noted that there had been 'a full discussion about risk'. She noted: 'I don't have sufficient evidence to say that he's suffering with a psychotic mood-related illness at present and his family agree'. Her view was that his social withdrawal, while uncharacteristic, could be in keeping with typical teenage behaviour and is temporarily clearly linked to lockdown, with the subsequent loss of hobbies, social outlet, physical stimulation and daily routine. She noted that, according to his mother, Harris had always been 'a bit of a risk taker'. She noted the family's concerns, but considered: 'I think with what we know of Harris at the moment through this collateral information, it would be unreasonable and unethical to take a more assertive

approach to assessment at this current time although this may change in the future. Jane and Katie were in full agreement with this.'

85. Dr Hamilton noted that she advised the family on 'red flags' that could indicate illness, such as a paranoid behaviour or talking to himself. All were in agreement that Harris was not keen to engage with the South CMHT, but particularly medics, and that it would be best if Dr Hamilton withdrew and OT Harkness 'took the lead with a practical OT-based approach'. Dr Hamilton added that she 'would act quickly if there [were] are signs of illness or escalating risk that require intervention'.

86. The OT plan was to be a 'comprehensive sensory based assessment'. There was to be engagement in a weekly intervention programme to re-engage Harris in physical exercise, 'with a view of this being the first step in re-creating structure back into [Harris's] daily life' (CP 5, pp 249-252).

87. On 7 July 2020 OT Harkness spoke with Dr Macdonell over the phone. Dr Macdonell advised that there were down south on holiday with family and that Harris continued 'to be disengaged with everyone' (CP 5, p 142).

88. OT Harkness met Harris for their first session on 16 July 2020. They went for a cycle. OT Harkness noted that Harris cycled in a way 'evidently impulsive in nature'. She noted that he answered questions 'often abruptly and very minimally' and 'did not spontaneously offer information'. A second session was arranged for 23 July 2020 (CP 5, p 142).

89. Harris refused to engage in the second session. OT Harkness spoke to him through a closed door. He said that he was willing to try again another time, but was unable to say why he did not want to engage that day. OT Harkness had a discussion with Harris's parents, who remained concerned about Harris. A session was arranged for 17 August 2020 (CP 5, p 141). Later that day OT Harkness emailed Dr Macdonell with some suggested activities for Harris (CP 5, p 276). She wrote: 'Can you please let me know what gym equipment you have and I will pull together a gym programme. I am back in the office August 17th … I will be out to you at 10am that morning. If you need to speak with someone in the meantime, there is someone on duty within working hours 9am-5pm on the number given below and [outwith] hours it is NHS 24.' (CP 5, pp 276-277)

90. On 27 July 2020 Dr Macdonell emailed Dr Cullen. She reported that Harris's mental state was continuing 'to gradually deteriorate' and that he was keeping 'completely out the way of the family with headphones on constantly'. She reported: 'He is angry and irritable, his whole demeanour and facial expression is worrying and he's lost weight / Any conversation about trying to set up a timetable is met with irritation. He mumbles about Huntlyburn and I think he knows he's not well but terrified about what happened the last time … Really at a loss as to what to do here' (CP 34, pp 1006-1007).

91. Dr Cullen responded on 11 August 2020, following his return from holiday. He queried if Harris was back at rugby training and if that was helping

in any way. He noted that the letter from Dr Hamilton said that they could contact South CMHT directly with concerns (CP 5, p 249). However, he thought that 'unhelpfully' Dr Hamilton had 'just left the department', although there would presumably be another consultant to take over (CP 35, p 1006).

92. Dr Hamilton had not in fact left South CMHT.

93. On about 30 July 2020 Dr Hamilton discharged Harris from her caseload, as she had no active involvement in his management. She noted that ongoing management was 'with OT' (CP 5, p 141). At 3.55pm on 30 July 2020 Dr Hamilton emailed OT Harkness, copying in Dr Sibel Turhan, Consultant Psychiatrist: 'As I'm not actively involved in [Harris's] care I'm going to discharge him from my caseload. Sibel [Dr Turhan] is taking over the Selkirk patch and will be happy to discuss him with you when/if needed.' (CP 5, p 275)

94. On 17 August 2020 Dr Macdonell had a discussion with Dr Cullen. She reported that on Saturday [15 August 2020] Harris had taken a car that did not belong to him and that the police had been called. She reported that Harris had had a 'meltdown' the previous night and that she had given him some diazepam (CP 34, p 999).

95. At 1.52pm that day Dr Cullen emailed Dr Kimberley Blyth in South CMHT. He reported that it was 'a very difficult situation' and that Harris had recently 'appropriated a car from the family'. He wrote: 'My main question is whether there are any adult Autism services available, e.g. in Edinburgh who may have greater experience of dealing with issues. [Harris] hasn't got on great

with medication in the past, but the concern is his ongoing very impulsive behaviour.'

96. Dr Blyth responded that she was not aware of what services were available in Edinburgh, but could take it to their team meeting on Wednesday morning [19 August 2020] and get back to him following this (CP 35, pp 1004-1005).

97. Harris had a session with OT Harkness on 17 August 2020. They did High Intensity Interval Training at the village hall. OT Harkness noted that Harris 'engaged in the entire session demonstrating a good level of fitness, motor planning and coordination' and that he was 'more interactive and willing to engage in conversation [than] in last two session' (CP 5, pp 140-141). In a discussion with OT Harkness Dr Macdonell described having had a 'challenging weekend with Harris' and wondered about medication for Harris 'to support him with his level of anxiety'. OT Harkness noted that she said that she would discuss this possibility with the team (CP 5, pp 140-141).

98. On the morning of 19 August 2020 Harris's presentation and his mother's query about medication were discussed at a multidisciplinary team meeting. It was concluded that the priority for South CMHT was '[s]upporting Harris to understand how he perceives and understands the world, in line with his diagnoses of ASD and ADHD'. It was noted that Harris did not accept those diagnoses and that the OT was working to develop a therapeutic alliance with Harris in order to support him to understand himself better and develop self-

regulation strategies. It was concluded that ADHD medication could be considered, but that Harris may not accept this due to his rejection of the diagnosis. Dr Blyth and OT Harkness were to discuss the case further with Dr Turhan on her return from annual leave. Dr Blyth was to email Dr Cullen 'to inform him of Number 6 ASD Service in Edinburgh' (CP 5, p 140).

99. At 11.25am on 19 August 2020, following the meeting, Dr Blyth emailed Dr Cullen. She wrote that the difficulty appeared to be that Harris did not accept his diagnosis and was refusing to engage. She wrote that they were hoping to organise an appointment with Dr Turhan to discuss diagnostic formulation with Harris and his mother and 'the role/benefits and limitations of [medication]'. She made reference to the Number 6 in Edinburgh, but added that, if Harris was not acknowledging his diagnosis, their involvement would not be beneficial (CP 35, p 1004).

100. A Significant Adverse Event Review (SAER) in relation to the events leading to Harris's death was commenced on 19 August 2020 and completed on 16 September 2020. Crown production 8 is the report of the SAER.

**Discussion and Conclusion**

[4] As is clear from my description of the law applicable to the inquiry this provides a specific set of questions that require to be answered.

[5] The amended First Notice (Form 3.1) identified the following issues for the Inquiry:

**"T**he circumstances which led to the admission of Harris into an adult residential psychiatric facility in NHS Lothian and NHS Borders in 2018.

The procedure for accessing available adolescent inpatient psychiatric beds in the Scottish Borders, other parts of Scotland and England in 2018, for Harris Macdonell, being a Scottish adolescent patient in need of such inpatient care.

The nature and extent of the care provided to Harris by NHS Borders whilst within the adult psychiatric facility.

The diagnosis and treatment of Harris within the residential CAMHS Unit at the Royal Edinburgh Infirmary with particular regard to the assessment and diagnosis of ASD and ADHD.

The arrangements for continued care and monitoring of Harris' mental health following his 18th birthday.

The decision by NHS Borders to discharge Harris without follow up review or care in late 2019.

The assessment of Harris' mental health condition by NHS Borders in June 2020.

The arrangements for and suitability of the care and management of Harris's mental health from June 2020 together with communication of those arrangements to Harris, his medical team and his family.

The supervision, support, training and education of psychiatric health professionals in NHS Lothian and NHS Borders engaged in the care and treatment of Harris in understanding and treating young people with ASD and ADHD including their presentation when suffering a mental health crisis and more generally on accessing available advice and resources.

The provision of consistent and maintained mental healthcare by NHS Borders within the community notwithstanding annual leave and rotation of personnel.

The accessibility of the electric pylon wires notwithstanding the preventive measures installed on pylons."

[6] Ultimately it was agreed by all parties that the final question identified no longer warranted inquiry.

[7] In my opinion there are four distinct areas of Harris's care that need to be considered, namely: his admission and care in Huntlyburn Ward; his admission to and treatment at Edinburgh Young Persons Unit; his discharge from adult services: and his care from May 2020.

**Admission and Care in Huntlyburn Ward**

[8] Taking the issues in turn, the circumstances which led to Harris being admitted to an adult psychiatric ward are straight forward. It was clear to all that in the February of 2018 Harris's mental health had deteriorated to such a degree that he needed to be hospitalised. Given his behaviour of climbing on to the roof of his home, it was obvious that he was a potential danger to himself. He was not made subject to any short term detention order, rather he was a "voluntary inpatient." The simple reason why he was in an adult ward was there were no adolescent beds available in Scotland. In fact there were only three units in the whole of Scotland that provided beds for adolescents. At the material time there was a 12 bed unit for the East of Scotland based in Edinburgh, a 24 bed unit for the West, based in Glasgow and a 12 bed unit located in Dundee for the North.

[9] None of the parties to the Inquiry have asked the court to make any formal findings in relation to this chapter of the Inquiry, although the Crown do have

observations in relation to Section 26(g) of the Act. However there are two aspects of the events at Huntlyburn Ward which in my opinion do require comment.

[10] What is not made clear in the Joint Minute is that Huntlyburn Ward contains voluntary inpatients and patients who are detained under compulsory measures. In particular paragraph 37 does not make it clear that the ward is not locked, at least during the day.

[11] I find this surprising at a number of levels.

[12] I raised this with parties and was referred to guidance on the matter provided by the Mental Welfare Commission (MWC) (6/2/5 of process) by NHS Lothians and NHS Borders. The document produced is dated March 2021, but I was told that it did not vary significantly from the guidance in place at the material time. In the course of the Inquiry it was said on behalf of NHS Borders, that in not locking the doors of the ward, they were following the guidance of the MWC.

[13] Looking at the guidance provided the first point to be made is that the guidance appears to be general and not specifically directed at hospital wards that have patients who are subject to detention orders.

[14] The second point to be made is looking at the guidance it is not as definitive as appeared to be suggested in evidence. As can be seen from the quotation below there is reference to a person "is at risk; out and about". Almost by definition someone who requires to be detained is at risk "out and about".

4.3.1 Freedom

Freedom to move around and to go where one wants is normal. Any restriction placed on that freedom by others is a serious matter and should only be considered when an individual is: at risk; out and about unsupervised; and has diminished capacity to judge when and where it is safe to go. Consideration must also be given to any potential risks to others.

[15] It is not clear to me that there has been proper consideration of the guidelines by NHS Borders.

[16] Whatever the guidance may be, NHS Borders chose not to lock Huntlyburn Ward. It was said in evidence that were there a perceived risk of a patient attempting to leave then a system of enhanced monitoring was used. Laura Clark, who was a senior charge nurse on Huntlyburn Ward at the material time described the enhanced supervision as there being a nurse within sight or earshot. As Harris's case clearly and sadly demonstrates this will not always be enough. A young fit individual, as Harris was, who is determined to leave, is unlikely to be prevented from leaving by close monitoring. Indeed it is difficult to see what value there is of being in earshot if the patient is not in sight.

[17] I find it surprising that in a ward, that by definition contains highly vulnerable individuals, there is an "open door policy", such that there is no control over who even enters the ward.

[18] I am aware from personal experience that wards such as wards 230 and 231 in the Royal Infirmary Edinburgh have a buzzer system whereby you require to be

given permission to enter and leave, presumably for the perfectly sensible reason that those in charge of the ward know who is present. This does not constitute an infringement of the human rights of either patients or visitors. There is no suggestion that a patient cannot leave if they wish.

[19] I would add that I advised parties of my knowledge of wards 230 and 231 in the course of the Inquiry. Accordingly, it was open to them to comment on my observation if they chose to do so, in the course of final submissions.

[20] If such a relatively simple system were in place then the unfortunate events of 10 February 2018 might well have been avoided. It can only be a matter of speculation what the consequences would have been if Harris had been prevented from absconding.

[21] What or what may not be the influence of MWC on the decision of NHS Borders not to have some system of entry and exit on Huntlyburn Ward, the lack of any system of control simply defies common sense.

[22] The other surprising event was the failure to have some measure to control Harris when the nurses recovered him after his "escape." I accept what happened in Harris throwing himself out the car was a highly unusual event and as such might explain the lack of a procedure or protocol for recovery of patients who have absconded at the material time. Odd as it may seem that the doors were not locked I was provided with no information about the car and whether it had child locks or any form of central locking. Therefore I am not prepared to make any critical observations on the question of why the car doors were not locked.

However, if it were not possible to control exit and entry to the vehicle by way of door locks, common sense would dictate that some form of control should have been used. As I have said, Harris throwing himself from a moving vehicle was an unusual event and as such, not predictable, but given he had absconded before, absent of any control, it was at least possible that when the vehicle stopped he would have absconded again.

**Stay at YPU Edinburgh**

[23] As is clear from the Joint Minute Harris was a resident in the Unit from 12 February 2018 to 6 April 2018. In the course of his stay his condition gradually improved.

[24] In the course of his stay he was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Autism. Professor Hill, the Crown's expert witness, was sceptical about the diagnoses of ADHD. However there was no dispute between Dr Brown, a consultant child and adolescent psychiatrist, and the only consultant in the unit at the time of Harris's stay, and Professor Hill that the principal factor in influencing Harris's behaviour was his Autism.

[25] No party is asking the court to make any determination in relation to this phase of Harris's care. However, I cannot leave this chapter without highlighting one part of Dr Brown's evidence. In this regard I can do no better than quote his affidavit. At paragraph 48 of his affidavit he states:

> "In the period since 2018, there has been a significant deterioration in the care and treatment of young people in the YPU (now the Melville unit located in the Royal Hospital for Children and Young People in Edinburgh) generally, and in regard to those with NDs [Neurodevelopmental disorders] in particular. GAP [General Adult Psychiatry] services are overwhelmed, so although there are few[er] admissions of young people to adult wards in Lothian, this is because there is no capacity to do so. Instead, delay to admission is prolonged with young people at very high risk meantime. The incidence of severe eating disorder has almost doubled globally since the pandemic, so demand for admission is high with no sign of return to baseline. Rationing of care is a common occurrence, and triage decisions unthinkable pre-pandemic have to be made. Neurodevelopmental assessments are no longer to be carried out during inpatient admissions, though observations to the outpatient team to follow up. The standard of care received by Harris in 2018 would be unattainable now"

[26] It must be a matter of profound concern that, as Dr Brown said, the unit was not in a position to offer the care now that they offered Harris in 2018.

[27] In the course of submissions Counsel for NHS Lothian drew my attention to appendix one of her submissions which is a document signed by Tracy Gillies, Medical Director of Lothian Health Board. In this, it is said, that it is the intention of the Board to create two 6 bed units with different pathways. This, it is said, is a response to the dramatic increase in eating disorders in adolescents.

[28] It is not for this Inquiry to judge whether that is an adequate response to the problem identified by Dr Brown.

**Discharge 2019**

[29] Following Harris's 18th birthday on 14th June 2019, his care was transferred over to the Community Mental Health Team. At this juncture, Harris was receiving Guanfacine, and an appointment was made in order for the prescription to be reviewed.

[30] By November 2019 those treating Harris were of the opinion that he was not suffering from any ongoing mental illness, and given Harris's entirely understandable desire to be discharged, he was discharged from the care of adult services.

[31] In the course of the Inquiry, there was a discussion as to whether Harris should be "kept on the books". I think this was an expression used by Professor Hill to describe his practice of providing his contact details to patients he was no longer actively treating. The rationale being that it provided a quick route back to the consultant who had provided the original advice. It was the Professor's opinion that Harris should have been kept "on the books" for the above reasons.

[32] Dr Timney, NHS Lothian and NHS Borders expert was of the opinion that the discharge was appropriate and in line with general practice.

[33] While Professor Hill's approach, may in an ideal world have much to recommend it, however against a backdrop of the current demands on the service I can well understand that the practice is to discharge.

[34] As events transpired nothing turns on the point. By 18 May 2020 Harris's mother, Dr Macdonell, was getting increasingly worried about her sons mental health and as the Joint Minute sets out, contacted Dr Cotton, a Consultant Psychiatrist with NHS Borders by email on 18 May 2020, who responded within the hour, recommending

she make an appointment to get a GP assessment. This Dr Macdonell did and an appointment was arranged with Dr Cullen for 19 May 2020. So concerned was Dr Cullen with Harris's presentation that he contacted Dr Hamilton by email on 22 May 2020. The upshot of which was that a virtual consultation for Harris with Dr Hamilton was arranged for 10 June 2020. If Harris had remained "on the books" it is difficult to imagine that a consultation would have taken place much earlier.

[35] Although dealt with under the events of May to August 2020 the family ask me to make a determination in terms of section 26(2)(e) of the Act, that it would have been a reasonable precaution for Harris to remain "on the books". As the family acknowledge there is a two stage test to be passed for a determination to be made. The first part of the test is whether the proposed precaution is reasonable. While in certain cases I can see it might be desirable but without more evidence as to the consequence of keeping patients on the books and what effect it would have on workload etc, I cannot say that such a step would be a reasonable precaution. In any event given the facts outlined in paragraph 34 and the absence of any evidence of how quickly Harris would have had a consultation if he had remained "on the books", I am not in a position to make a finding that if he had remained "on the books" there would be a realistic chance the death could have been avoided. Apart from this there was no evidence that an earlier consultation would have made any difference to the tragic events that unfolded.

**May to August 2020**.

[36] This is the most problematic of the four areas the Inquiry has had to consider. In his written submissions on behalf of the family Mr Rodger makes a series of criticisms of Harris's care in the period from May to August 2020. The starting point for this is the argument I have already dealt with namely that he should have stayed "on the books".

[37] It is perhaps easiest if I simply quote the submission:

> "Further, it is submitted that had full cognisance been given to Harris' recent history in or around July 2020, his death may have been avoided. Harris' stint on Huntlyburn (and subsequent SAER) was known to the Mental Health Team in June/July 2020. They knew he found the experience troubling. They knew he had partaken in risk-taking behaviours, driven by distress. They knew he had exhibited thoughts of self-harm and suicide, each of which had been noted as a risk factor upon admission to Huntlyburn. They knew he had ASD and potentially, ADHD, which increase risk of suicide. They knew his behaviour was deteriorating and becoming increasingly bizarre. They knew he had lost routine due to lockdown. The plan which centred solely on Occupational Therapy was, as a stand-alone approach, insufficient. By attributing Harris' condition to a lack of sensory stimulation, no consideration was given to his recent history, and risk-taking behaviours. No consideration was given to his escalating erratic actions. No consideration was given to the lack of assessment, which brings with it increased risk, owing to the unknown. It ought to have been apparent to the Occupational Therapist that Harris was not fully-engaging with her plan. It ought to have been apparent the plan was not working as it should, owing to Harris' sporadic engagement, and increasingly troublesome presentation. It is unquestionably reasonable for the Occupational Therapist to have escalated matters to the MDT meeting sooner than she did. Even once she did, this was only done to consider medication, not in relation to Harris' deterioration. The Consultant, Dr Cotton, at the MDT meeting on 19th August immediately recognised the level of risk had increased, and a different approach was required. However even then, matters were not considered of such urgency that they could not wait until Dr Turhan's return from holiday. Sadly, we know this decision came too late for Harris. Thus it follows had matters been brought to their attention sooner, said alternative approach/urgent assessment would have been implemented earlier, and Harris' death may have been avoided."

[38] The short answer to the submission lies in its own final sentence, where it says Harris's death may have been avoided. As has been made clear, before a finding under section 26(2)(e) can be made the measure proposed must have a realistic prospect of avoiding death and Mr Rodger's own submission does not go that far.

[39] That said out of respect to the submissions it is appropriate that I consider them in more detail. In my view the starting point and the real difficulty all parties had at this period was Harris's lack of cooperation. The consequences of this are made clear by Professor Hill at paragraph 100 where he states:

> "Secondly the fact that Harris would not engage with medical intervention and barely tolerated the efforts of the occupational therapist trying to engage him. It was impossible to assess him fully or engage him in treatment. Because of his refusal or inability to communicate his feelings and ideas with his parents of health service staff, no-one had any idea what was going on in his mind when he became anxious, agitated and irritable or. Indeed, when he decided to end his life."

[40] In the same paragraph Professor Hill goes on to note that Harris's compulsory admission was carefully considered by Dr Hamilton and Harris's family and all were agreed that this would have been inappropriate. Professor Hill offers no criticism of this decision but he does point out that the lack of a compulsory admission meant that an opportunity to gain a better insight into Harris's state of mind was lost. I note at paragraph 100 Professor Hill refers to 26 June 2020, but I suspect what he is looking at is Dr Hamilton's letter to the G.P. I do not understand the family to be saying that Harris should have been made subject to a compulsory detention. It is almost certain that Harris would not have agreed to be a voluntary inpatient.

[41] Self-evidently his reluctance to engage presented Dr Hamilton and those treating Harris with a difficulty. If he would not engage how could they determine the nature of his condition and the appropriate treatment?

[42] This brings me to the decision to appoint Rhona Harkness an occupational therapist with 20 years' experience working with people with Autism. The reasoning behind it was two-fold, but based on the fact that Harris did not accept his diagnosis and lack of engagement. The two reasons being namely to assess how far his sensory seeking behaviour could account for his impulsive behaviour and to build a therapeutic relationship using physical activity. At paragraph 52 of his report Professor Hill describes this as a pragmatic interim plan. To the layman this decision may appear odd, as there might be an expectation that someone in Harris's position would be treated by a psychiatrist. However, given Harris's particular circumstances all professionals appear to accept the idea as reasonable.

[43] As the Joint Minute makes clear Rhona Harkness saw Harris on the 16 July 2020 and attempted again to see him on 23 July 2020 but he refused to engage on the second occasion. Rhona Harkness then goes on leave. Professor Hill appears to be critical that no cover was arranged for Rhona Harkness's leave. I think that is misplaced. If part of the rationale for the appointment of Rhona Harkness was to build a relationship, sending someone else to see Harris would not have assisted in that process and indeed may have set it back.

[44] Professor Hill is critical of Dr Hamilton's decision to remove Harris from her active case list. The professor's perception being this effectively left Harris's care in the

sole hands of Rhona Harkness He makes two points in this regard. The first is that it was premature given that there had not been a full psychiatric assessment. Secondly, it cut the family off from direct access to the CMHT (Community Mental Health Team). Dr Timney's response to this is that the criticisms are misplaced. His view is that there had not been a complete delegation to Rhona Harkness as Harris remained part of the system. That he was still part of the system is clear from the fact that his case was discussed at the meeting of 19 August 2020, albeit too late to do any good.

[45] I am simply not in a position to judge if Dr Hamilton had not discharged Harris, what, if any, difference this would have made. There is nothing before me to suggest this would have allowed the family quicker access to drugs or a better conduit for the family's increasing concerns.

[46] In any event as Rhona Harkness observes at paragraph 126 of her affidavit at her session with Harris on 17 August 2020 and in her discussions with Dr Macdonell, her concerns were over Harris's anxiety. She also makes the point that there was no mention of possible suicide or of an escalated risk.

[47] In any event I do not understand Professor Hill to suggest that prompt availability of the correct medication to treat Harris's anxiety would have had a bearing on his suicide.

[48] I note at paragraph 64 the Professor returns to the question of admission for Harris. I find this odd. Firstly, it would almost certainly mean him returning to Huntlyburn Ward which by common consent had a detrimental effect on Harris. Secondly, it is highly unlikely Harris would have agreed to this. Thirdly Professor Hill

does not address the fundamental question did Harris actually meet the criteria for compulsory detention?

[49] Even if Harris had not been discharged in 2019; he had been treated by a consultant psychiatrist; not been taken off Dr Hamilton's list; he had immediate access to medication for his anxiety and there had been better communication with the family there is nothing to say this would have prevented his suicide.

[50] Sadly, I agree with Professor Hill's final paragraph when he says: "Without knowing what Harris had on his mind I think it impossible to say what could have prevented his death."

**Conclusion**

[51] Looking at the issues identified for consideration by the Inquiry most of them have been dealt with either directly or indirectly in the discussion above. That said it is appropriate I deal with them specifically.

1 The circumstances which led to the admission of Harris into an adult residential psychiatric facility in NHS Lothian and NHS Borders in 2018.

[52] The answer to this is straight forward, Harris was admitted to Huntlyburn Ward because of a lack of available beds in a unit suited to young persons. It is acknowledged by all that this is highly undesirable, yet as Dr Brown so powerfully observed, the position is worse now than it was in 2018. The sad truth is that young persons continue to be admitted to wholly inappropriate adult wards. The MWC note that in the year 2023/24 there were 67 admissions involving 59 children and young persons under 18 to

adult wards. In the same year there were 5 children admitted to what is euphemistically referred to as non-specialist facilities in NHS Borders.

[53] It is not for this Inquiry to question the allocation of scarce resources, however it is appropriate for the Inquiry to highlight the problem.

2. The procedure for accessing available adolescent inpatient psychiatric beds in the Scottish Borders, other parts of Scotland and England in 2018, for Harris Macdonell, being a Scottish adolescent patient in need of such inpatient care.

[54] The reality is that in 2018 there was no procedure as such, rather the "system" involved daily calls, to check on availability. No attempt was made to check the position in England. It appears that there is now a procedure in place albeit it may relate only to beds in Scotland.

3. The nature and extent of the care provided to Harris by NHS Borders whilst within the adult psychiatric facility.

[55] The consideration of this issue has to be seen in the context that in an ideal world Harris should not have been in Huntlyburn Ward in the first place. That said, the Inquiry has no direct criticism to make of the care in the ward, bar what the Inquiry considers to be a major defect, namely the lack of control on the doors.

4. The diagnosis and treatment of Harris within the residential CAMHS Unit at the Royal Edinburgh Infirmary with particular regard to the assessment and diagnosis of ASD and ADHD.

[56] There appears to be a difference of opinion between Dr Brown and Professor Hill in relation to the diagnosis of ADHD, beyond that observation the Inquiry has no criticisms to make of Harris's care in the CAMHS unit.

5. The arrangements for continued care and monitoring of Harris's mental health following his 18th birthday.

[57] The Inquiry is satisfied that the transfer of Harris's care after his 18th birthday was well managed.

6. The decision by NHS Borders to discharge Harris without follow up review or care in late 2019.

[58] This is discussed in some detail above I do not think NHS Borders can be criticised for following what, as Dr Timney observes, are national guidelines.

7. The assessment of Harris's mental health condition by NHS Borders in June 2020.

[59] As identified above Dr Hamilton was faced with a fundamental difficulty in June 2020, namely Harris's unwillingness to engage. Professor Hill agrees that the decision to involve a specialist occupation therapist was a pragmatic one. Although to the layman it may appear odd that the Inquiry has no criticism to make of the attempts to assess Harris's mental health in June 2020 and later. As the Inquiry has previously observed the assessment of Harris's mental health was a fundamental one and to which there was no easy answer.

8. The arrangements for and suitability of the care and management of Harris's mental health from June 2020 together with communication of those arrangements to Harris, his medical team and his family.

[60] I have already touched on the first part of the above question. I am satisfied that Harris's care and management from June 2020 was appropriate. No doubt communications with his family could have been improved, communication is rarely perfect, but any imperfections had no bearing on later events.

9. The supervision, support, training and education of psychiatric health professionals in NHS Lothian and NHS Borders engaged in the care and treatment of Harris in understanding and treating young people with ASD and ADHD including their presentation when suffering a mental health crisis and more generally on accessing available advice and resources.

[61] This aspect of the Inquiry did not feature largely in the evidence led. So far as NHS Lothian is concerned there was virtually no evidence on the matter.

[62] As for NHS Borders, I note that Dr Turhan, who was a consultant in the CAMHS team at the material time, states she was unaware of any specific training in NHS Borders in relation neurodiversity.

[63] That said the training or lack of it has had no effect on the sad events of 19 August 2020.

10. The provision of consistent and maintained mental healthcare by NHS Borders within the community notwithstanding annual leave and rotation of personnel.

[64] I have already considered this and the fact that Rhona Harkness was on holiday and her position was not covered was understandable given part of the reasoning behind the appointment of Rhona Harkness was to build a relationship with Harris, in the hope he would open up to her.

[65] In terms of Section 26(2)(g) of the Act I have held that there were two matters relevant to Harris's death. The first is the lack of beds for children and adolescents. All are agreed that this should not happen. What contribution to Harris's death this had is impossible to say, but it may well have contributed to his reluctance to engage in June 2020. The second factor is the lack of control over entry and exit at Huntlyburn Ward. If there had been control over entry and exit, Harris would not have absconded. If he had not absconded, then he would not have thrown himself from the car. Again it is not possible to say what contribution, if any this made to his death, but again it may have contributed to his reluctance to engage in June 2020.

**Postscript**

[66] I would also like to add a personal note to express my deepest sympathy for the loss the whole family has suffered. It must be a matter of pride to Mr and Dr Macdonell how they were supported by the family throughout the Inquiry. Finally, I cannot conclude this determination without highlighting the courage Dr Macdonell showed in giving evidence to the Inquiry. Losing a child in any circumstance is tragic and a source of unimaginable pain and suffering, but to be able to give evidence about it in public took remarkable courage.