SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2020] FAI 26

B1002-18

DETERMINATION

BY

SHERIFF WENDY A SHEEHAN

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

into the death of

CLARE SHANNON

Edinburgh, 8 June 2020

Determination

The Sheriff, having considered the information presented to the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 that Clare Shannon who was born on 13 October 1983 died on 4 April 2014.

In terms of section 26(2)(a), the death occurred in Resuscitation Room 2, Edinburgh Royal Infirmary at 19:17 hours on said date.

In terms of section 26 (2)(b), the accident resulting in the death occurred in the toilet block, Barcarres Ward, Royal Edinburgh Hospital, 23 Tipperlinn Road Edinburgh. EH10 5HF on said date.

In terms of section 26(2)(c), the cause of death was:

1a. choking

1b. aspiration of plastic lid (Crown label 1)

In terms of section 26(2)(d), the accident was caused by Clare Shannon deliberately swallowing a plastic lid (Crown label 1).

In terms of section 26(2)(e), a reasonable precaution which could reasonably have been taken which, had it been taken, might realistically have resulted in the accident resulting in the death being avoided, would have been to amend Clare Shannon's nursing care plan in early 2014 to provide that she should be directly observed when using the toilet at all times.

In terms of section 26(2)(f), there was a defect in the system of work on the Balcarres ward, Royal Edinburgh Hospital, which on 4 April 2014, allowed two nursing staff (one of whom was a nursing assistant with no formal qualifications and less than a year's experience) to care for 20 acutely unwell patients (at least one of whom required

constant observation and others who had a propensity to self-harm). This was unsafe and contributed to the accident resulting in Clare Shannon's death.

In terms of section 26(2)(d) – the following facts are relevant to the circumstances of the death:

(i) in 2013/14 NHS Lothian did not have, and at the current date they do not have, any service to treat patients who require adult inpatient psychiatric care other than by way of admission to acute wards (which are designed to assess, stabilise and discharge patients over a 10-14 day period). Acute wards, by their nature, do not provide an environment where patients with serious, chronic conditions may receive specialist clinical psychology treatment to address their core psychopathology. Acute wards are also not designed to provide the safe, therapeutic and intensive care environment, length of admission or staffing ratios which patients undergoing such treatment require.

(ii) the NHS Lothian clinical observation policy applicable in 2013/14 was inadequate to ensure the safe and therapeutic care of patients who made repeated suicide attempts. The policy required to be reviewed and updated. On 26 April 2016 NHS Lothian introduced updated guidance 'Standard Operating Procedure: Safe and Therapeutic Observation of Adult Mental Health Inpatients'. That guidance made modest improvements, setting out a competency framework for nursing staff and recognising the requirement

for patient engagement and therapeutic intervention during clinical observations rather than this being conducted as a standalone task. That guidance did not adequately address the '*radical change to the wider culture and practice linked to observation*' which is recognised and addressed in the 2019 guidance issued by Healthcare Scotland: 'From Observation to Intervention'. The introduction of the 2019 guidance in all NHS Lothian adult inpatient psychiatric wards might realistically prevent other deaths in similar circumstances.

Recommendations – section 26(1)(b) such recommendations (if any) as to (a) the taking of reasonable precautions, (b) the 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:

(i) NHS Lothian should ensure that the Royal Edinburgh Hospital (or one of its associated services) is in a position to offer adult psychiatric inpatient care for patients diagnosed with EUPD who require admission (beyond the average 10 to 14 day period of stabilisation and assessment which is offered on acute wards) in a safe, secure and therapeutic environment with access to the specialist clinical psychology treatments which are recognised as the appropriate clinical pathway for their condition.

ii) NHS Lothian should fully implement the 2019 Healthcare Scotland Guidance 2019 'From Observation to Intervention – A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care' in all inpatient adult psychiatric wards as soon as is practicably possible.

NOTE

Introduction

[1] The Inquiry was held under the Fatal Accidents and Sudden deaths etc. (Scotland) Act 2016 ("the 2016 Act") into the death of Clare Shannon ("Ms Shannon"). In terms of section 4(1)(a)(ii) of the 2016 Act, the Lord Advocate considered that her death occurred in circumstances which gave rise to serious public concern and that it was in the public interest for an inquiry to be held into the circumstances of her death.

[2] The circumstances surrounding Ms Shannon's death were subsequently investigated by Police Scotland, the Health and Safety Executive, the Scottish Fatalities Investigation Unit and the Health and Safety Investigation Unit.

[3] The first notice in the Inquiry was lodged by the Crown on 23 August 2018, some four years and four months after Ms Shannon's death. That delay is regrettable.

The participants and their representatives in the Inquiry

[4] The following persons participated in the Inquiry:

- The Procurator Fiscal, represented by Ms F. Caldwell, Senior Procurator Fiscal Depute.
- National Health Service (NHS) Lothian, represented by Mr B. Ross Advocate.
- Ms Louise Shannon (the deceased's sister) as attorney for Mrs Norma Shannon (the deceased's mother), represented by Ms G. Galbraith Advocate, instructed by Mrs E. Motion, Balfour & Manson

[5] A number of preliminary hearings were held. The parties have worked closely in collaboration in preparation for the Inquiry. A cooperative approach was taken in relation to the recovery and disclosure of a substantial amount of the relevant documentation and the agreement of same in terms of a detailed seven page joint minute of agreement (13 of process). *Inter alia* the parties agreed the terms of seven volumes of the deceased's medical records and summary of her treatment (Crown production 49), the Adverse Event Review template record dated 18 July 2014 (Crown production 22), the Scottish Ambulance Service Patient form relating to the attendance by paramedics at the Balcarres ward on 14 April 2014 (Crown production 28), the maps and photographs of the locus (Shannon family productions 18/5 and 19/3), the staff rotas for 4 April 2014 (Crown production 36) the training records of the relevant medical and nursing staff (Crown productions 32 and 39 of process), the relevant observation practice guidance and policies at and following 4 April 2014 (Crown productions 5,6,7,8, and 34) and a significant amount of documentation in relation to the procedure for out of area referrals both in general terms and in respect of the steps taken to secure a referral to the Surehaven Clinic for the deceased in the months immediately preceding

her death (Crown productions 24,25,29,31,36,3 and 40-46 inclusive and Shannon family productions 18/4 and 19/4).

The evidence

Affidavit evidence

[6] Affidavits were obtained from 23 witnesses significantly reducing the need for parole evidence to be led at the Inquiry.

[7] In particular, affidavits were submitted in respect of the evidence of the following witnesses:

1. David Grant Thomson, nursing assistant (Crown production 16/4)
2. Detective Constable Emma Wilkinson (Crown production 16/5)
3. Gillian McDonald, registered mental health nurse (Crown production 16/8)
4. Hamish Jack , registered mental health nurse (Crown production 16/9)
5. James Martin, registered mental health nurse (Crown production 16/10)
6. Kirsty Stewart, registered mental health nurse (Crown production 16/11)
7. Linda Lumley, registered mental health nurse (Crown production 16/12)
8. Neil Rafferty, registered mental health nurse (Crown production 16/15)
9. Nicola Crowe, paramedic (Crown production 16/16)
10. Merrick Pope, specialist –self-harm nurse (Crown production 16/23 of process)

Parole evidence

[8] The Inquiry also heard parole evidence over nine days. The undernoted witnesses gave parole evidence to supplement their affidavits:

1. Louise Shannon (Crown production 16/19)
2. Funmilayo Obafemi, nursing assistant (Crown production 16/14)
3. Tim Montgomery, General Manager REH (Crown production 16/21)
4. Michael Gall, mental health nurse (Crown production 16/13)
5. Andrew Wills, mental health nurse (Crown production 16/2)
6. Dr Peter LeFevre, Associate Medical Director REH (Crown production 16/7)
7. Dr Donald MacIntyre, Consultant Psychiatrist (Crown production 16/18)
8. Dr Joy Tomlinson, Public health consultant (Crown production 16/1)
9. Dr Nicola Lewthwaite (Crown production 16/17)
10. Brian Caldwell, nursing assistant (Crown production 16/3)
11. Dr Ishan Kadar, Clinical Director REH (Crown production 16/6)
12. Dr Andrew Watson, Associate Medical Director REH (Crown production 16/22)

[9] In addition, the following witnesses gave parole evidence to the Inquiry:

1. Dr Brian Timney, Consultant Psychiatrist – report (NHS Lothian production 18/1)
2. Professor Sashidharan , Consultant Psychiatrist –report (Crown production 33)

3. Dr Gary MacPherson, Consultant Clinical Psychologist report (Crown production 34)
4. Brodie Paterson, Mental Health Nurse – report (Crown production 35)

The statutory framework

[10] The Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (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.

[11] Section 26 of the 2016 Act states, among other things, that:

(1) As soon as possible after the conclusion of the evidence and submissions in an Inquiry, the sheriff must make a determination setting out –

(a) in relation to the death to which the Inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection,

and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers as appropriate.

(2) The circumstances referred to in subsection 1(a) 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 deficits 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.

(3) 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.

(4) The matters referred to in subsection 1(b) are –

(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.

[12] The procurator fiscal represents the public interest. An Inquiry is an inquisitorial process and it is not the purpose of an Inquiry to establish civil or criminal liability.

Issues for the inquiry

[13] The Crown lodged a Note of Issues for consideration by the Inquiry (9 of process). The issues which all participants agreed to be the pertinent matters for the Inquiry to consider are as follows:

1. **The adequacy of the care provided to Clare Shannon during her admission to the Balcarres ward of the Royal Edinburgh Hospital ("REH");**
2. **The adequacy of the constant observations undertaken within the Balcarres ward at the REH at the time of Clare Shannon's death;**
3. **The arrangements for securing specialist services outwith NHS Lothian for Clare Shannon;**
4. **The care and treatment provided to Clare Shannon on 4 April 2014.**

Clare Shannon

[14] Ms Shannon was the youngest of three daughters. Her father was diagnosed with early onset dementia/Alzheimer's disease when she was around seven years of age. He was admitted to long term hospital care when she was 12 years of age. Ms Shannon

had a close and loving relationship with her sister Louise and her family. She was less close to her mother Norma Shannon and her elder sister Colette Shannon.

[15] Despite her difficult childhood, Ms Shannon was a bright and creative student who did well at school. She left school at 16 before sitting her Highers but hoped to sit them later at college. Her journals, some of which are lodged as productions, show intellect, humour and creativity. Her poignant film "Unwell" gives an insight into her mental health difficulties and also demonstrates her self-awareness and emotional intelligence. She worked only briefly, in an internet café, aged 16. She was a church member and had a handful of close friends. Her closest relationship was with her sister Louise who visited her in hospital regularly, was her named person, advocated on her behalf in relation to her treatment and who has represented her family's interests in relation to the Adverse Event Reviews, a formal complaint made to NHS Lothian and throughout this Inquiry.

Psychiatric diagnosis – Emotionally Unstable Personality Disorder ("EUPD")

[16] There was a consensus amongst all of the clinicians who assessed Clare Shannon that she suffered from EUPD[1]. Her illness was at the most serious and severe end of the EUPD spectrum having manifested at an early age, involving high levels of distress and impairment to her life. Her illness precluded her from study, employment or adult relationships. She suffered from comorbid mental health conditions – severe depression

[1] See para. [17] below for the definition of EUPD.

and psychosis involving auditory hallucinations and post-traumatic stress disorder ("PTSD").

[17] The term Emotionally Unstable Personality Disorder is used in the Diagnostic and Statistical Manual of Mental Disorders ("DSM") and is classified as DSM 5). The term Borderline Personality Disorder ("BPD") is used in the World Health Organisation classification ("ICD") and is classified as ICD 11). The terms and classifications have the same meaning and are inter-changeable.

[18] The evidence of the clinicians was that EUPD is a chronic mental illness characterised by emotional dysregulation, significant anger and anxiety, low mood, detachment from reality and difficulty in making and sustaining relationships. Recurrent feelings of impulsivity, deliberate self -harm and suicidal ideation are common features of the illness.

[19] Approximately 80% of people diagnosed with EUPD make at least one suicide attempt in their life time and many make multiple attempts. Approximately 9-10% of those diagnosed with EUPD successfully complete suicide . Around a third of all suicides in the UK are committed by people diagnosed with EUPD.

[20] Adverse life events such as childhood trauma may be an underlying cause of EUPD. It often manifests at an early age. Substance and alcohol abuse, eating disorders and depression are commonly associated with EUPD.

[21] Prescribed medication will not cure EUPD. It is used to ameliorate some of the symptoms. Treatment is typically by way of psychological therapy. There are a variety of types of therapy which might be appropriate: cognitive behavioural therapy ("CBT"),

Dialectical behavioural therapy ("DBT"), Mentalisation therapy, Schema Therapy, Psycho-dynamic/Analytical Psychotherapy, and Eye Movement Desensitisation Therapy ("EMDR"). Therapies which target emotional regulation, reducing anxiety and agitation or aim to elevate the patient's mood are reported to have the greatest success. The development of a cooperative therapeutic relationship between patient and therapist is an important element of successful therapy as is continuity of care.

[22] There is limited clinical data to support the success of any one therapeutic regime. A range of factors impact on prognosis, including the age of onset of symptoms, their severity and comorbid mental health disorders. Approximately 20-30% of patients with EUPD are responsive to treatment to the extent that they are asymptomatic. Another (undefined) proportion of patients experience an amelioration of their symptoms.

Ms Shannon's medical history

[23] In order to consider the issues for the Inquiry (as set out on page 6/7) it is necessary to first set the context of the deceased's medical history.

[24] As touched on above, Ms Shannon experienced mental health problems from an early age. She reported having first experienced symptoms of depression and self-harming behaviour at the age of four. She first came into contact with NHS mental health services at the age of 13 in March 1997 following a referral by her school doctor to a child psychologist at the Royal Hospital for Sick Children. Her anxiety centred on her relationship with her father. Even at this early stage there were issues with self-harm

and suicidal ideation. She was seen as an outpatient until May 1999 when she was discharged from the service with no follow-up, having decided that she no longer wished to attend appointments.

[25] Her GP re-referred her to mental health services four months later in September 1999. She was seen at the Young Persons Unit ("YPU") at the REH aged 16 years and was diagnosed with suffering a major depressive episode. Her self-harming and suicidal behaviour escalated in her teenage years. She hit herself, burnt herself and cut herself regularly. On one occasion she broke bones in her arm with a hammer. She tried to hang herself when aged 14 and 16 years. She expressed the intention to throw herself off bridges. She also swallowed objects in an attempt to choke herself. In May 2000, aged 17, she was admitted as an inpatient to the REH following attempts to suffocate herself with a pillow and to hang herself. This was to be one of six inpatient admissions during her treatment at the YPU between September 1999 and May 2003. Each admission followed a crisis presentation with suicidal ideation and attempts to kill herself. By this point in time she had withheld permission for clinicians to discuss her treatment with her mother.

[26] Between September 1999 and May 2003 Ms Shannon was treated at the YPU. Her treatment was overseen by a consultant psychiatrist who prescribed anti-depressant, anti-psychotic and mood stabilising medication. She received 1:1 psychological therapy from a Consultant Clinical Psychologist during this period. The principal focus of this treatment was to look at issues surrounding her self-harm, particularly the triggers for this behaviour, and finding alternative coping methods for

her destructive feelings and impulses. Her medical records note her difficulty in expressing her emotions appropriately and to her having few resources for coping with distressing emotions other than to hurt herself or to threaten to do so. She is noted to have been suffering from post-traumatic symptoms including nightmares, flashbacks, psychotic symptoms including auditory and visual hallucinations, guilt and self-blame. In 2002 she was referred to the Child Sexual Abuse Team following disclosures of childhood sexual abuse which had started at the age of four. During her time at the YPU she engaged with and benefitted to some extent from, clinical psychology treatment and high levels of therapeutic contact with her keyworker and clinicians.

[27] In July 2003, aged 19 years, Ms Shannon was referred to Adult Psychiatric Services with a diagnosis of EUPD, depression, psychotic symptoms and PTSD. She continued to have contact with mental health services during 2004, continued to express suicidal ideation and complained of an increase in her psychotic symptoms. In November 2004 her notes record:

> "Clear signs of BPD presenting with deliberate self-harm… due to the nature of poor coping strategies, emotional liability and self-isolating tendencies, there remains the long-term possibility that she could potentially kill herself".

Her engagement with mental health services became poor with intermittent crisis presentations after attempts to kill herself/expressions of suicidal ideation, some of which resulted in short-term inpatient admissions and all of which were followed by a lack of engagement without outpatient services.

[28] Between 3 and 16 February 2009, following a referral from her GP, Clare Shannon was seen by the Intensive Home Treatment Team ("IHTT"). She was noted to

have been experiencing command hallucinations to hurt herself. Her anti-psychotic medication was increased and she was discharged back to the care of her GP. A year later between 19 January 2010 and 1 February 2010 there is a similar entry in her records.

[29] Between February 2010 and April 2012 Ms Shannon had no contact with mental health services. Her prescribed medication was monitored by her GP. In April 2012 her mental health deteriorated. She was referred to the IHTT for four weeks and was then discharged with no follow-up. She had contact with emergency mental health services on 27 and 31 July 2012 following urgent referrals from her GP. It would appear from her records that she was unwilling to engage with outpatient psychiatric treatment after these short-term crisis interventions.

[30] In the latter part of 2012, following a further referral from her GP, Clare Shannon was seen by Dr Dalkin, Consultant Psychiatrist at the REH. She was persuaded to agree to ongoing psychiatric follow up. She was to remain under the care of psychiatric services at the REH for the remainder of her life. Her medication was reviewed in 2012, she had support from a CPN and a psychiatric review in October 2012. She required periods of IHTT assistance in November 2012 and March 2013 at which point she was noted to be "feeling intensely suicidal".

[31] On 7 March 2013, two days after Dr Dalkin had referred Clare Shannon to the IHTT, she was admitted to the Balcarres Ward, REH, under the care of Dr Donald MacIntyre, Consultant Psychiatrist. She described auditory hallucinations - hearing six voices, one of which was that of her deceased father. The predominant theme of the voices was instructions to kill herself by overdose or suffocation. She expressed

consistent suicidal ideation and made multiple attempts to strangle herself with various ligatures. She made frequent attempts to abscond from the ward. On 22 March 2013 she was made subject to a short-term detention certificate followed by a compulsory treatment order ("CTO") on 30 April 2013.

[32] A course of electro convulsive therapy ("ECT") was attempted between 3 and 17 June 2013. This had no therapeutic benefit.

[33] Ms Shannon was prescribed multiple cycles of antidepressant, anti-psychotic and mood stabilising medication which were regularly reviewed but which resulted in no significant clinical benefit.

[34] Ms Shannon continued to engage in self-harming behaviour and to make repeated attempts to commit suicide, often either by ligature strangulation or by attempting to swallow items to choke herself.

[35] Ms Shannon was admitted to the Intensive Psychiatric Care Unit (IPCU) at St John's Hospital between 8 and 24 July 2013 following numerous attempts to self-harm. On her discharge back to the ward there was no change in her clinical condition and she continued to experience command hallucinations, expressed a clear intention to kill herself and made further attempts on her life.

[36] On 30 August 2013, Ms Shannon was discharged from the Balcarres ward into the care of the IHTT following a moderate improvement in her symptoms. There remained concern about her mental state and her overall functioning. It was recognised that her difficulties were difficult to manage on an acute admissions ward and that alternative treatment options should be considered. Her mental state did not improve

during her discharge. Her risk of suicide and self-harm could not be managed in the community and she was re-admitted to the Balcarres ward on 9 September 2013 following an attempt to strangle herself with her bra.

[37] On 11 September 2013, two days after her re-admission, she was transferred to the IPCU at St John's Hospital as it was proving difficult to manage her in an open ward and her levels of self- harm were such that special observation was required. She was acutely distressed in the IPCU, punching herself and banging her head off the walls, at points needing to be physically restrained in order to prevent her from self-harming. She remained in the IPCU until 20 September 2013, when she returned to the Balcarres Ward. She was detained under a short-term detention certificate, which was followed by a CTO on 27 September 2013.

[38] Dr Pauline McConville, Consultant Psychiatrist was asked for a second opinion by Dr Donald MacIntyre, Ms Shannon's treating psychiatrist and registered medical officer ("RMO"). Dr MacIntyre was by then concerned about the efficacy of the treatment regime on Balcarres ward and wished to consider a specialist referral. Dr McConville's opinion was received on 18 September 2013 (Crown production 49, vol 6 p19). She agreed with Dr MacIntyre's diagnosis of EUPD. She commented, referring to Ms Shannon, that

> "*unfortunately she has not found psychological treatments particularly helpful in the past but it may be worth trying to engage her in a specific project designed to reduce the number of incidents of self-harm and the seriousness of the type of harm she engages in… If her difficulties with repeated attempts at strangling herself continue, I think it would be well worth obtaining an opinion from a specialist unit, as this type of behaviour is very difficult to manage adequately on a general adult ward*."

[39] There was no significant change in Ms Shannon's clinical presentation during the rest of 2013. She continued to present with a high risk of self-harm and persistent suicidal ideation. She repeatedly tried to leave the ward. She was re-referred to the IPCU in October but as there were no beds available she remained in the Balcarres ward. She was placed in a single room in order to restrict her movements and to monitor her more carefully. She suffered from ongoing psychotic symptoms including visual and auditory hallucinations and command hallucinations to kill herself, and she made repeated attempts to strangle herself with items of clothing and to swallow items such as medicine cups and bottle tops.

[40] On 29 December 2013, Ms Shannon was observed trying to make herself vomit. Following staff administering back slaps and the Heimlich manoeuvre, a medication cup was dislodged from her throat. Ms Shannon had taken the medication cup from the dispensary on the previous day and concealed it until an opportunity arose to allow her to swallow it when unobserved.

[41] According to her medical notes, there was no change in Ms Shannon's clinical presentation during the months leading up to her death. She continued to express suicidal thoughts and the wish to die, on an almost daily basis. Staff were aware of her repeated and determined attempts to find objects to swallow and to choke herself. Staff intervention was regularly required to prevent this from occurring. On 9 March 2014, she attempted to choke herself by swallowing a medicine cup. On 15 March, she swallowed a bottle top on two occasions. Similar incidents occurred on 16, 17, 18 and 26 March. On 18 March, she ate/swallowed plastic cups and on 19 March, she attempted

to swallow crisp packets, which she had retrieved from the bins. She sustained a Mallory-Weiss tear – a tear to her oesophagus – as a result.

[42] During the week immediately prior to Ms Shannon's death, she continued to express her wish to die on a daily basis. She took a spoon from the kitchen and attempted to swallow it on 1 April 2014. On 3 April 2014, she told staff that she felt unsafe using a razor in the shower as she may attempt to swallow it. She said to nursing staff that she was struggling to cope, that she needed to hurt herself and that she was feeling impulsive.

Evidence in respect of the issues for the Inquiry

1. The adequacy of care provided to Ms Shannon during her admission to the Barcarres Ward, REH

[43] Ms Shannon was an inpatient in the Balcarres ward between 7 March 2013 and the date of her death on 4 April 2014, with the exception of her two periods of admission to the IPCU between 8 and2 July 2013, and 9 and 20 September 2013, and the period of her unsuccessful home discharge to the care of the IHTT between 30 August 2013 and 9 September 2013.

[44] The Balcarres ward was an acute adult psychiatric admissions ward. The ward was an open one with 40 beds, 20 for each sex, in two wings. It was a busy, noisy environment, most patients sharing four- bed rooms with communal toilets, showers, a kitchen and recreational room. The ward was designed to assess and treat patients with acute illnesses with a view to them beginning to recover within days or weeks and then

returning home with outpatient care. The aim of admission was to address the patient's initial crisis presentation, to stabilise them and then to identify the level of care and support required to enable them to return to the community safely. The average length of admission was 10-14 days. Patients were admitted to the ward with a range of conditions including schizophrenia, Bipolar Affective Disorder, severe depression, drug-induced psychosis, EUPD, self-harm and attempted suicide. The ward had a high turnover of both patients and staff.

[45] On 7 March 2013, it was not anticipated that Ms Shannon would require such a lengthy admission. However, there was no other viable option to treat her as an inpatient in the Lothian area. She could not be released to the care of the IHTT (as the failed suicide attempt between 30 August and 9 September 2013 demonstrated).

[46] The IPCU is a short term adjunct to acute admissions wards. It is designed to manage acute short term risk, not to function as a treatment option. Patients admitted to the IPCU are floridly unwell and highly disturbed. Based at St John's Hospital in Livingston, the ward was a 20 bed mixed-sex ward. The environment was designed to allow close observation of patients and the staff ratio was double that on acute admissions wards. Admission to the IPCU can be a bewildering, frightening and distressing experience for patients as they are likely to encounter shouting, screaming and violent behaviour from fellow patients, who may be restrained and injected with medication against their will. The evidence was that Ms Shannon found her admissions to the IPCU to be profoundly distressing and that she expressed a strong disinclination to repeat the experience. The views of the consultant psychiatrists who gave evidence to

the Inquiry described the careful decision making process required when considering whether to admit a patient to the IPCU as this was a balancing exercise between managing risks safely and the distress and potential deterioration in the patient's mental state that such an admission may cause.

[47] The clinical team on the Balcarres ward treating Ms Shannon during her admission was headed up by Dr MacIntyre whose role was to provide consultant psychiatry input for all adults (between the ages of 18 and 65) on the ward who were registered with a GP surgery in North East Edinburgh and who required in-patient psychiatric care. Dr MacIntyre was appointed as a consultant in 2007 and he worked on the Balcarres ward between 2012 and 2016. He oversaw and trained many junior doctors during that period. Ordinarily there would be a foundation year 2 doctor and a core trainee working under him. The doctors on the ward worked clinic hours rather than shifts.

[48] The nursing team was headed up by Hamish Jack, a band 7 Senior Charge Nurse with responsibility for both the male and female wings of the ward. *Inter alia* Mr Jack had overall responsibility for staffing issues and rotas, training, safety of the ward environment, setting standards and managing budgets. He had more limited patient contact given his management role but responded to clinical emergencies, was involved in cases with unusual presentations and managed out of hours admissions. Mr Jack was registered as a mental health nurse in 1993 and he had worked at the REH since he qualified.

[49] The nursing complement on the Balcarres ward was five staff on each of the early and late/back shifts and three staff on the night shift. There was a mixture of registered nurses and nursing assistants on each shift. Short-staffing on the ward was a common occurrence in 2013-2014. There was a high level of stress-related staff absence. There was a high prevalence of patients self-harming on the ward.

[50] Each patient on the ward had a key worker who was responsible for preparing and reviewing their care plan. Care plans were part of the risk assessment carried out in respect of self-harm risks. Michael Gall (a band 5 nurse) was Ms Shannon's key worker until a month before her death. The role was then taken over by a colleague, Nicky MacIntyre (band 5 nurse). She did not give evidence to the Inquiry. As key workers would only be on the ward for four shifts in any given week, each patient also had a named nurse allocated to them on each shift whose responsibility it was to speak to the patients allocated to them at least once during the shift and to be the contact point for them and their families. The named nurse was expected to keep an eye on the patients allocated to them and was responsible for writing up their notes at the end of each shift.

[51] Ms Shannon's care plan provided for her to have regular 1:1 discussions for 30 minutes with either her key worker or named nurse. Initially these were to take place daily but during the weeks immediately preceding her death these discussions were reduced to three times a week and were sometimes undertaken by two staff members together. The evidence was that the 1:1 sessions provided a valuable outlet for Ms Shannon to express her feelings and that they could elevate her mood, albeit temporarily. When the ward was particularly busy or short-staffed, the nursing focus

changed from therapeutic care to one of containment and prioritising patient safety. In such circumstances the planned 1:1 sessions did not take place. Staff were too busy to engage with the patients.

[52] There was a multi-disciplinary team on the ward. Occupational therapists offered artistic, creative and food preparation/baking activities and coffee mornings for patients. There was limited scope for such activities on an acute admissions ward. Ms Shannon was rarely able to participate given the risk posed by access to potential objects with which she could self-harm. During periods of her admission she was precluded from entering the communal kitchen at all (having deliberately scalded herself and swallowed cutlery), was denied access to bins (as she removed items from them with which to self- harm) and was only given access to basic items such a pens if the lids were removed and she could be very carefully observed using them. There was a recreational nurse who arranged activities for patients but as, mostly, these took place outwith the ward, Ms Shannon could not safely participate in them.

[53] On the date of Ms Shannon's death, 4 April 2014, Mr Jack worked an early shift from 7am to 3pm. He had no contact with Ms Shannon that day. The ward was understaffed. The late/back shift that day was covered by four staff: Kirsty Stewart (a band 5 nurse who had worked on the ward for approximately nine years), Michael Gall (a band 5 nurse who had worked on the ward for approximately eight years), David Thomson (a nursing assistant with 12 years' experience on adult psychiatry wards at the REH) and Funmilayo Obafemi (a nursing assistant with less than a year's experience).

At the time of the accident leading to Ms Shannon's death, only two staff, Mr Thomson and Ms Obafemi, were on the ward, the others being on a 30 minute break.

[54] There was contradictory evidence about whether more than one patient on the ward on 4 April 2014 required constant observation. Hamish Jack recalled that there were two such patients. Michael Gall's evidence was that Ms Shannon was the only such patient (as, if there had been two patients who required constant observation, then a fifth member of staff would have been allocated to the ward). Regardless, on any view, the staffing levels on the Balcarres ward on 4 April 2014 were inadequate. In particular, a system of work which allowed two nursing staff (one of whom had no formal qualifications and less than a year's experience) to care for 20 acutely unwell patients at least one of whom required constant observation and others who had a propensity to self-harm, was unsafe.

Psychotherapy / therapeutic engagement with patients on the Balcarres ward

[55] Allyson Lumsden, psychotherapist, offered Ms Shannon two blocks of psychotherapy: the first block of seven sessions was between 4 April 2013 and 4 July 2013, the second block of 8 sessions between 31 October 2013 and 18 December 2018. Psychotherapy is a broad term and those delivering it have a range of qualifications. Ms Lumsden did not give evidence to the Inquiry. There was no information regarding her qualifications or experience. A letter (appended to an affidavit, Crown production 16/23) addressed to Dr MacIntyre confirmed the extent of her contact with Ms Shannon. There is virtually no record of what was discussed during the sessions. Dr

MacIntyre's evidence was that he did not know what was discussed or the type of therapy that was offered. His assumption was that Ms Lumsden focussed on the day to day management of Ms Shannon's behaviour rather than attempting to address her core psychiatric pathology. He understood that the therapy would have reflected Ms Shannon's emotions back to her and gently explored the scope for change in her behaviours.

[56] Merrick Pope, a clinical nurse specialist with the self-harm service provided an affidavit to the Inquiry which is limited in its scope (Crown production 16/23). Ms Pope did not give parole evidence to the Inquiry about the nature of the treatment she gave Ms Shannon. She set up the self-harm service at the REH and had worked in this field for nine years in 2014. She offered Ms Shannon sessions to try to address her issues with self-harm. Ms Pope worked a 30 hour week during which she typically saw seven in patients and six out- patients, offered five hours of staff reflective practice and attended multi-disciplinary team meetings. She did not see Ms Shannon during her blocks of psychotherapy. There was no communication between these two services and they did not overlap. Ms Pope worked with Ms Shannon in a block of seven sessions between 22 July 2013 and 27 August 2013 and then in a block of 12 sessions between 6 January 2014 and 4 April 2014. The work undertaken was described as 'nursing interventions'. It was not structured psychotherapy. Sessions lasted an hour and their objective was to reduce self-harm by finding more adaptive ways of coping with distressing thoughts and feelings. Sometimes practical, less damaging alternatives were suggested. Grounding techniques were used to contain and manage emotions. The sessions

provided an outlet for Ms Shannon to express her emotions. They were unstructured, looked at the triggers for self-harming behaviour and reflected the patient's thoughts and feelings in the moment rather than their origins.

[57] Ms Pope also had a role on the ward in providing reflective practice discussions with the nursing staff. These sessions were designed to promote better understanding of certain mental health conditions such as EUPD and the challenges of treating patients who repeatedly self- harm. The aim was help nurses to see the condition underlying a patient's behaviour. The sessions provided a confidential forum for staff to express their difficulties in caring for certain patients and to combat therapeutic nihilism – staff losing hope of a patient ever recovering in the face of a difficult diagnosis or constant adverse events such as suicide attempts. There was no evidence regarding the content of these sessions, which staff attended or which patients were discussed. The sessions were voluntary, confidential and no records were kept.

[58] The clinicians' evidence to the Inquiry was that patients with EUPD are amongst the most challenging to treat and the phenomenon of 'splitting' occurs. This manifests in a numbers of ways. Nursing teams managing frequent suicide attempts can become polarised, some staff believing that the patient is being manipulative leading to the need for firm control measures on the one hand and, on the other, staff who become over-protective and tolerant beyond reasonable limits. Another facet of splitting is that the patient demonstrates black and white thinking regarding their relationships with staff members, seeing them as either good or bad and refusing to work with those perceived

as bad and becoming over-involved with those perceived as good. The evidence was that Ms Shannon manifested splitting and fitted into these behavioural patterns.

[59] One of the purposes of the scheduled 1:1 sessions with nursing staff was to try to instil a sense of hope and optimism that things could get better for a patient and that there was a prospect that their health would improve. Some conversations with nursing staff did elevate Ms Shannon's mood, albeit temporarily. However, the evidence was equally that some nursing staff lacked the skills required to support someone with persistent suicidal ideation or to offer insightful, compassionate and empathetic support. Nursing staff sometimes regarded Ms Shannon's behaviour as attention seeking or did not know how to respond to what she said in a helpful way.

[60] Hamish Jack, a very senior mental health nurse, had a good relationship with Ms Shannon. He described '*getting on quite well with her*' in his evidence and referring to her compassion and humour in his affidavit. He acknowledged that she had different relationships with different members of staff '*some good, some okay, some not so good*'. Michael Gall, another very experienced mental health nurse who was Ms Shannon's key worker throughout most of her admission, described her as '*a friendly, pleasant girl*' in his affidavit but said that

> '*as a nurse, I found it difficult to engage her in therapeutic intervention. At no point did she express a willingness to get better. Her focus was on dying. She wanted to be discharged so that she could kill herself. I found this difficult*'.

Mr Gall handed over the role of Ms Shannon's key worker to colleague a month before her death as '*I found I wasn't getting anywhere with Clare*'. On the Balcarres ward in 2014 three or four patients would self-harm each day. Sometimes two or three patients

required constant observation by staff. The stress and emotional toll which this took on staff was considerable. The 24/7 shift work environment, high turnover of patients and short staffing issues mitigated against nursing staff having a shared understanding of the therapeutic needs of patients and their care and also made opportunities for reflective practice or support for staff.

[61] Brian Caldwell, a nursing assistant on the ward who worked with Ms Shannon regularly, was a caring and compelling witness whose evidence was '*I got on great with Clare. I had a good rapport with her. Most days I got a smile and some chat from her*'. He said that Ms Shannon believed that some of the staff did not like her and this made her reluctant to interact with them. His perception was that some staff preferred not to interact with Ms Shannon as they did not know what to say to her. They preferred to silently observe her. Mr Caldwell was clearly attuned to Ms Shannon's mood fluctuations. Sadly, he resigned as mental health nursing assistant in 2014 as within a matter of months, nine patients he had cared for had taken their lives, two of whom he had spoken with within an hour of their death. He spoke eloquently about how upsetting it was to '*feel useless*' in such situations.

[62] Funmilayo Obafemi was the nursing assistant allocated to observe Ms Shannon during the hour preceding the accident leading to her death. She had no formal qualifications or training to give her insight into Ms Shannon's psychiatric condition or how to communicate effectively with her. She had been in post for less than a year in April 2014. Her basic induction training covered first aid, basic life support, and manual handling. Her colleague Michael Gall's evidence was that '*she did not have a sound*

understanding of risks and potential consequences'. Even allowing for the anxiety of giving evidence, Ms Obafemi appeared to lack empathy or warmth. Her evidence was that she had watched Ms Shannon but had not attempted to interact with her as '*she wasn't very chatty*' and that '*she wasn't in the best frame of mind*'. She saw her role as being one of silent observation. She did not find it to be a rewarding job to sit and watch a patient. She was less vigilant than her colleagues. She sometimes had to be prompted to be more vigilant when her attention wavered. She did not try to speak to Ms Shannon as she did not know what to say to her. Louise Shannon's evidence was that her sister did not have a good relationship with Ms Obafemi, was aware of her lack of consistent vigilance and that she took advantage of that.

[63] The system of work on the Balcarres ward in 2014 did not consistently provide adequate training, support, clinical supervision or reflective practice for nursing staff working with patients with persistent suicidal ideation and self- harm/suicide attempts.

Changes in staffing levels on NHS Lothian acute inpatient wards since 2015

[64] Anne Langely, Operational Manager for the acute wards at REH and the IPCU, gave evidence to the Inquiry (affidavit Crown production 16/20) that staffing levels on the wards were reviewed in January 2015. The Balcarres ward was allocated a senior charge nurse (band 7) and a charge nurse (band 6) for each of the male and female wards. Early and late shifts were to be covered by five staff, three registered nurses and two nursing assistants. If more than one patient was under a constant observation regime then another member of staff was allocated to the ward.

[65] Tim Montgomery, General Manager of the REH, in his letter to Louise Shannon dated 18/7/14 (20) commented:

> '*I also think her death was preventable had we put in place a bespoke and* dedicated *care plan and dedicated a smaller number of staff to work with her and to have direct leadership from a designated care manager – an experienced staff nurse*'.

Ms Shannon did have a key worker who was an experienced charge nurse throughout her admission who was responsible for her nursing care plan. It is not clear what Mr Montgomery envisaged by a 'care manager' as opposed to a key worker. This was not explored in the evidence. It was clear from the evidence that it was and is not feasible to staff three shifts over a 24 hour period and to meet the needs of all of the patients on an acute ward whilst also providing a small team of familiar and experienced staff to work with one patient.

[66] In 2016 the Balcarres Ward was replaced by a new 'Craiglockhart' ward which has a male and a female wing each with 16 patients. Staffing levels have remained the same despite the reduction of patient numbers from 20 to 16 in each wing. This has improved staff/patient ratios.

Care Plans and communication with professionals

[67] Ms Shannon's medical care was reviewed weekly at a multi-disciplinary team ("MDT") meeting attended by all available staff involved in her care. The meetings were chaired by Dr MacIntyre and in this forum any changes to her drug regime, observation levels, planned activities, care plan changes and nursing issues would be discussed. Patient wishes were considered as part of this process.

[68] At each shift hand over there was a 'safety huddle' or 'rapid rundown' for approximately 30 minutes. All staff gathered in the nursing room to discuss any relevant issues with each patient on the ward in turn. This covered changes in presentation, episodes of self-harm, patient complaints and requests or any other pertinent matters.

[69] A patient's written care plan was predominantly used by the nursing staff and was updated the patient's key worker. The plan was reviewed with the patient and from time to time at MDT meetings. Care plans are intended to be part of a risk assessment carried out in relation to self-harm attempts, to be dynamic and adaptive to changing circumstances. There were tweaks to Ms Shannon's plan from time to time (eg to prevent her accessing the shared kitchen area to remove objects with which to self-harm). However, no special incident review took place after any of her self-harm attempts. There was no evidence of reflective practice or discussion about steps which might be taken to mitigate the risk of repetition – at least insofar as changes to her care plan indicate. There appeared to be no clear risk management plan with proposed interventions to reduce, contain or otherwise ameliorate risks. Hamish Jack's evidence was that self-harm incidents happened with such frequency that '*nurses became desensitised to things, they may not have felt it was worth noting*'. Ms Shannon was intelligent, inventive and determined in her attempts to obtain items from the ward environment with which to self- harm – using items of clothing to fashion ligatures and swallowing a wide variety of objects in an attempt to choke herself. She would take items when being directly observed resulting in staff having to intervene and remove

them from her. Various *ad hoc* changes were made to her care plan. However, there was no coherent system in place for reviewing her episodes of self-harm, the patterns emerging and putting in place a system for reviewing and managing specific risks.

Psychiatric / clinical psychology treatment

[70] Dr MacIntyre had overall responsibility for Ms Shannon's treatment. He was an impressive witness who gave his evidence in a thoughtful and reflective manner. He considered that the clinical team on the ward had tried to support Ms Shannon as best they could. In his letter to her family on 7 November 2014 he wrote '*the main thing I have to say is that I apologise to you and to your family. We cannot help everybody, but I thought we could help Clare recover and I dearly wish we had. I am truly sorry*.' Within the constraints of available resources, Dr Macintyre endeavoured to ensure that Ms Shannon received appropriate treatment during her admission – primarily drug therapy. Various cycles of medication were prescribed in a logical order, taking into account the side effects of each. Ms Shannon's own wishes and her willingness to engage with treatment were also considered (there was a period when she declined to take Lithium when prescribed as she believed that any improvement would be temporary and would ultimately cause disappointment). However carefully calibrated the drug regime was, it could only achieve the objectives of reducing the intensity of some of her symptoms and level of her distress. It did not alter the core psychiatric pathology of her EUPD. Medication simply treated her comorbid conditions of anxiety, depression and psychosis. The prescribed medication at the point of Ms Shannon's death was;

- **Trazadone** (a sedative antidepressant) 600g nocte (at night)
- **Lithium** (a mood stabilising medication) 400g nocte (at night)
- **Quetiapine (**an anti-psychotic medication) 200f tds (3x daily)
- **Diazepam (**an anti- anxiety medication) 5mg tds (3x daily)
- **Omeprazole (** for gastric reflux/ stomach acid) 20mg daily

[71] The Inquiry has had the benefit of an independent expert opinion from Dr Brian Timney, a consultant psychiatrist with NHS Tayside (his report is NHS Lothian production 18/1). Dr Timney also gave parole evidence to the Inquiry. He has held the post of consultant psychiatrist since 1990 and has been in post at the Carseview Centre Dundee since 2005. Around 60% of his clinical work is with in patients in acute psychiatric wards. Treatment of patients with EUPD is a core part of his work. Dr Timney was instructed by NHS Lothian. His evidence was

> '*My opinion is that there appeared to be appropriate, considered assessment, evaluation, diagnosis and use of what would generally be considered standard approaches to care for someone presenting with a personality disorder' and 'appropriate and sensible pharmacological management*'.

He also concluded that '*the clinical staff at the REH, while faced with an extremely challenging and difficult scenario, did their best and generally followed clinically relevant treatment options*'.

[72] The Inquiry also had the benefit of an independent expert opinion from Professor Sashidharan, consultant psychiatrist (his report is Crown production 33). Professor Sashidharan also gave parole evidence to the Inquiry. He is a very eminent psychiatrist who was Medical Director of North Birmingham Mental Health Trust. He is a board member of the Mental Welfare Commission. However, it should be noted that

he has not worked in inpatient psychiatry since 2008. Consequently while he could assist the Inquiry by giving a well-informed expert perspective, he was less able to give evidence about current practice on an acute admissions ward.

[73] Dr Timney and Professor Sashidharan discussed their respective reports and furnished the Inquiry with a jointly prepared document 'Responses to the Issues' (14 of process). They concurred that Ms Shannon's treatment was unduly focussed on medication and nursing care and lacked the full multi-disciplinary consideration that the severity of her condition, symptoms and chronicity required. In particular, there was a lack of comprehensive psychological assessment and psychological treatment offered during her admission to the Balcarres ward.

[74] Professor Sashidharan's evidence was that he had assumed that a psychologically informed package of care would have been available on any psychiatric ward, as that had been his experience. In his view the lack of psychological assessment and treatment meant that Ms Shannon's treatment was '*inadequate and inconsistent with her clinical needs*' and that it '*fell below what may be considered as optimal or appropriate*'.

[75] Dr Timney's evidence was:

> '*I am surprised, given the length of time Clare spent in hospital with her clinical presentation, that a psychologist was not involved. This could have taken the* form *of advice and support to the ward staff in managing a complex and difficult clinical case as well as some 1:1 consultations and psychological interventions*'.

[76] However, it was clear from the evidence that a comprehensive psychological assessment/formulation and psychological therapy was not undertaken because this was not a resource available on the Balcarres ward, or indeed on any other acute psychiatric

ward in the NHS Lothian area in 2013/14. Dr MacIntyre did not have access to any clinical psychology resource for patients in his care at that point in time.

[77] By August 2013, five months after Ms Shannon's admission to the Balcarres ward, Dr MacIntyre recognised that '*despite our best efforts, we were finding it difficult to engage Clare in therapeutic activity in a general adult setting and that specialist services might be necessary*'. He sought a second opinion from Dr Pauline McConville (his letter is Crown production 49 vol 6/54. Her response is Crown production 49 vol 6/19) as referred to at paragraph 38 above.

[78] Ms Shannon was also assessed by Dr Clare Jackson, consultant clinical psychologist on 19 March 2014 in the context of her subsequent referral to the private Surehaven Clinic. (Dr Jackson's report is Crown production 49 vol 7/37). She noted:

> '*Clare appeared bright and* reactive. *She was articulate, made appropriate eye contact, engaged well and appeared to have good insight into her current difficulties and the impact that her early traumatic experiences have had on her life to date…. Clare appeared reasonably positive and seemed to hold out some hope that the treatment might be beneficial. Nevertheless, she was clear that she considered this to be a last resort and felt that if there was no change in the way she felt, she would, eventually, kill herself.*'

Dr Jackson's impression of Ms Shannon was of '*an intelligent and psychologically minded young woman*' who may have gained benefit from the intensive therapeutic approach that the Surehaven Clinic offered - psychological treatment with a trauma focus. It was noted that in the past she had responded well to validating and supportive relationships with therapists which may serve to provide a good foundation to support her to move to community services. Dr Jackson acknowledged that it was difficult to gauge how

Ms Shannon would respond to this type of psychological therapy but it was recognised to be the best treatment option for her at that juncture,

[79] Ms Shannon was ambivalent about psychological treatment. Dr MacIntyre's evidence was that she tended to focus on drug therapy requesting regular changes to her medication and that her engagement with clinical psychology had been intermittent in the past. She had commented that she had not always found this to be particularly helpful. This ambivalence was considered to be a common facet of patients with EUPD by all of the consultant psychiatrists who gave evidence to Inquiry.

Professor Sashidharan's commented at paragraph 63 of his report:

> '*many people with EUPD have ambivalent feelings about having psychological therapy but this, in itself, cannot be a barrier to ensuring they receive appropriate psychological treatments. Even those with high levels of disturbance and poor motivation to change may benefit from referral to psychological therapy and specialist services*'.

[80] Psychological therapy for a patient diagnosed with EUPD would require to be delivered by a consultant clinical psychologist with a doctoral level of training specialising in this area. The Inquiry benefitted from the evidence of Dr Gary Macpherson, consultant forensic clinical psychologist, fellow of the British Psychological society. (His report is Crown production 34.) Dr Macpherson has held a number of senior posts with head of service and board level responsibilities. His evidence was that

> '*self-harm behaviours are a common aspect of BPS (EUPD) as patients with the condition have problems with emotional regulation and cut themselves to reduce painful inner states and to relieve emotional tension. Trauma is most often at the root of BPD. Therapy looking at the underlying cause might reduce the level of anxiety and distress*'.

Dr Macpherson commented at paragraph 83 of his report '*Literature on psychotherapy for patients with BPS captures expert consensus and review of common factors across five therapies;*

behavioural therapy, CBT, DBT, schema therapy and psychodynamic therapies.' The common factors in the success of the various models were a stable framework, therapist confidence in the model, a strong and patient/therapist relationship with clear boundaries, fostering a greater sense of agency in the patient and the patient's belief in the possibility that they might get better.

[81] Dr Macpherson's report concluded at page 47(4):

> '*I would also highlight the absence of any referral to clinical psychology for assessment or treatment and the absence of any contact at all with clinical psychology. Psychological therapies have been found to be the most successful method of addressing affective instability and emotional dysregulation in clinical trials and are superior to the medical management of BPS and so the absence of any clinical psychology input to Clare Shannon's care and treatment within NHS Lothian is surprising, particularly when her transfer to Surehaven appeared to be largely in the context of a managing her behaviour via psychological therapies*'.

[82] Dr Andrew Watson, consultant psychiatrist is the current Associate Medical Director of the REH. He gave evidence to the Inquiry and adopted his affidavit (Crown production 16/22). He confirmed that in 2014 there was no dedicated inpatient psychological assessment or access to psychological therapies on acute wards. He did not disagree that clinical psychology input would have been an appropriate route for Ms Shannon. He commented that while the reasons for the lack of access to psychological services on acute admissions wards in 2013/14 were partly a matter of policy and budget, there was also a cultural issue – the average patient stay on the Balcarres ward was 10-14 days. Psychological therapy for EUPD is a lengthy process - often taking 12-18 months. Specialist psychology services of this type were easier to access in the community, albeit with significant waiting lists (over a year). It was hard

to recruit and retain appropriately trained clinical psychologists on inpatient wards. Nevertheless, he recognised that there was a good evidence base for the success of certain psychological therapy models in the treatment of patients with EUPD and that ideally Ms Shannon would have been assessed by a consultant clinical psychologist at a much earlier stage after her admission and attempts could then have been made to access appropriate treatment for her. Those avenues were not open to Dr MacIntyre in 2013/14

[83] Since 2016, the successor to the Balcarres ward, the Craiglockhart ward, has a dedicated clinical psychology resource amounting to 50% of a 37.5 hour week (18.75 hours a week). Dr Watson's evidence was that if a patient with Ms Shannon's profile had been admitted to the ward from 2016 onwards then she would have been assessed by a clinical psychologist within a short time (weeks) of her admission and that she would then have received a psychologically informed treatment plan. The clinical psychologist on the ward could deliver 1:1 psychological therapy to patients and could also offer input to MDT meetings, suggest appropriate therapeutic interventions and deliver clinical supervision/reflective practice to nursing staff.

[84] However, there are significant limitations to the clinical psychology service available to patients on acute wards for patients; firstly, it should be noted that clinical psychologists are not specialists in the treatment of all psychiatric disorders. EUPD is specialist field and there was no evidence, that the clinical psychologist allocated to the Craiglockhart ward has this specialism. Secondly, clinical psychologists are each trained in certain modalities of therapeutic interventions and they are not necessarily well

placed to offer CBT, DBT, EMDR etc. There was no evidence about the specific modalities / psychotherapeutic interventions offered by the clinical psychologist on the Craiglockhart ward, or indeed on any other NHS Lothian acute ward. It is surprising that this area was not explored in the evidence. Thirdly, whilst there is notionally a clinical psychologist allocated to all acute psychiatric wards (including the Craiglockhart ward) in practice this service has been difficult to deliver. One psychologist is on maternity leave and another on long term sick leave. There is no *locum* cover. NHS Lothian clinical psychologists do not work collegiately to cover each other's wards during absences. Recruiting and retaining clinical psychologists to acute wards has proved very challenging.

[85] Lastly, clinical psychology input which addresses the core underlying pathology of a patient with EUPD ordinarily involves psychological treatment over 12 to 18 months. This is not deliverable on an acute ward designed for patients with an average admission period of 10 to 14 days. Whilst the evidence was indicative of the increasing likelihood of patient with EUPD on an acute ward being psychologically assessed and having a psychologically informed care and treatment plan, it was equally clear that a course of specialist clinical psychology treatment to address the core underlying psychopathology of a patient with EUPD would be very unlikely to be delivered on an acute ward. Specialist clinical psychology treatment of this type is more commonly delivered in an outpatient setting over a period of 12-18 months. The waiting list for this service in the community is over a year long.

[86] It is concerning that the most effective treatment methods for patients with EUPD, who account for a third of all suicides in the UK and 9-10% of whom successfully complete suicide, are such a scarce resource. It is not suggested that the clinical psychology service on the Craiglockhart ward, if available in 2013/14, would have provided the type of specialist clinical psychology treatment over a sustained period that Ms Shannon's condition required. That service was then, and is now, unavailable in NHS Lothian.

[87] Dr Watson's evidence was that NHS Lothian can now '*buy in*' clinical psychology support for patients requiring specialist support in acute wards. While this is to be welcomed, the evidence did not indicate that this is a resource readily available on acute wards, due to the scarcity of appropriately qualified psychologists and the intense completion for their services.

[88] There is clearly a significant unmet need for specialist clinical psychology services for patients with EUPD whether in the community, on acute wards or in low secure wards (such as the Surehaven clinic). The need to recruit, retain and increase their complement of clinical psychologists should be an important focus for NHS Lothian and indeed NHS services throughout Scotland. The evidence to the Inquiry indicated a woefully inadequate access to the specialist clinical psychology services which are vital for early and accurate patient assessment, informed referral to other services, (such as rehabilitation wards, the IHTT or low secure services), the delivery of therapeutic interventions on acute wards (either by clinical psychologists or by nursing staff trained and clinically supervised by them) and specialist clinical psychology

treatment to address the core psychopathology of patients with serious mental health conditions such as EUPD.

2. The adequacy of the constant observations undertaken within the Balcarres Ward at the REH at the time of Clare Shannon's death

[89] The NHS Lothian 'Policy for Clinical Observation of patients with mental health problems' dated June 2012 (Crown production 15) sets out the relevant guidance to clinicians regarding observation of inpatients in adult psychiatric wards during the period Ms Shannon's admission to the Balcarres ward. That policy requires to be read in conjunction with the NHS Scotland good practice statement 'Engaging People – Observation of People with mental health problems' referred to as the CRAG 2002 guidance. The NHS Lothian 2012 policy categorises three levels of patient observation as follows:

- **General** – a member of staff should have knowledge of the patient's whereabouts at all times; within mental health areas this is the responsibility of the Floor Nurse and within other clinical areas usually the nurse in charge or designated deputy. This is the 'norm' for most patients and the minimum level of observation.
- **Constant** – an allocated member of staff should be constantly aware of the patient's specific whereabouts and general physical/psychological condition. This may be carried out on two levels – within sight and sound or within sound. This is an intermediate level of observation and is generally

appropriate for patients who might abscond, be physically aggressive or deliberately self- harm.

- **Special -** a designated member of staff should be in sight and within arm's length of the patient at all times and in all circumstances. Reasons for this level of observation may include the risks detailed above as well as patients who might have impulsive suicidal behaviours or an acute clinical condition.

[90] All ward staff required to familiarise themselves with the 2012 NHS Lothian policy. Nursing staff required to demonstrate their understanding of the policy by completing an online learning module 'Learnpro'. Training on observing patients was otherwise gained on the ward by working with patients and observing colleagues.

[91] The focus of the policy was on providing 'safety for an individual during periods of distress'. There is one reference in the policy to the fact that '*with practice, staff will develop the necessary skills and will begin to understand the importance of applying brief psychological and practical interventions, which will be benefit the patient*'. This comment is not elaborated on and the evidence was that staff were not trained to deliver such interventions. Whilst individual practice varied, in 2013/14 undertaking constant observation of a patient was often seen as a standalone task. It was frequently carried out by nursing assistants as the registered nurses on the ward had other tasks to undertake such as dispensing medication and writing up patient notes. It was sometimes considered that a patient requiring constant observation was too unwell to engage in any level of interaction and would benefit from reduced stimulation. The evidence of Ms Shannon's sister Louise was that some of the nursing staff on the

Barcarres ward were reluctant to speak to Ms Shannon, that they did not how to speak to someone who was feeling suicidal with compassion, empathy and patience and that they were of the view that conversations with her should be confined to her 1:1 sessions with the registered nurses. Sometimes constant observation involved patients being confined to their rooms with a nursing assistant sitting in the doorway or in their room in silence watching them. Such observations had a custodial feel. This type of observation was likely to increase the patient's social and psychological isolation at a time of distress and thereby actually increase the risk of self-harm or attempted suicide. Ms Shannon reported such difficulties to her sister

[92] The Inquiry was told that special observation could only be implemented by the admission of a patient to the IPCU. Other than during her two brief periods of admission to the IPCU, Ms Shannon was under constant observation between 7 March 2013 and 4 April 2014 on the Balcarres ward. It was considered that she presented a risk of absconding from the ward, self-harming or attempting to commit suicide throughout this period and that a regime of constant observation was necessary to provide her with a safer environment and to reduce the means and opportunity for her to engage in these behaviours.

Was the level of observation appropriate?

[93] Dr Timney and Dr Macpherson shared Dr MacIntyre's view that this was the appropriate level of observation for Ms Shannon during the period of her admission to the Balcarres ward. Dr Macpherson's evidence was that

> '*most patients with BPS, despite having suicidal thoughts for long periods of time and multiple suicide attempts, never kill themselves… the clinical management is therefore, based on accepting a calculated risk… a very difficult balancing act between managing the risk to patient – that is to say Clare Shannon attempting to choke herself with an object – and ensuring the appropriate level so as not to harm/distress with intrusive supervision and observations. Such increased observation can be counter-productive and can lead to regression and increase of symptoms based on the behavioural reinforcement or suicidal behaviour. The continuum based approach to care of scaling interventions up and down was in my view appropriate and I would add that even with special observation, there would be no guarantee that the risk of suicidality would diminish as the literature notes the high percentage of patients with a diagnosis of BPS who end their lives by suicide*'.

At paragraph 87 of his report Dr Macpherson notes:

> '*one review of literature notes that suicidal thoughts by themselves are too common to be useful in predicting suicide actions and patients suicidal behaviour have a statistically higher risk, however, one cannot predict who is most likely to die by suicide'*.

[94] Dr Timney's evidence was that '.' He considered that special observation of Ms Shannon for a prolonged period

> '*would have been too intrusive and is usually only used for brief periods within the setting of the IPCU… given her particular presentation, clinical needs and risk, constant observation was a sensible and reasonable decision*.'

[95] Dr MacIntyre's evidence was that special observation would have been inappropriate for any significant length of time and would have necessitated a transfer to the IPCU which would have been '*tortuous for the patient*'.

[96] Professor Sashidharan took a different view. His opinion was that at some (undefined) point between January and April 2014, the deterioration in Ms Shannon's mental health and the increased number of instances of attempted suicide involving compromise of her airway, were posing a sufficient risk that the balance of her interests

favoured increasing the level of observation from constant to special, even if that necessitated her admission to the IPCU.

[97] The 2012 observation policy required clinicians to reconcile competing principles: '*all patients must be* kept *safe and protected from physical or psychological harm, have their privacy and dignity respected, the right to be treated as individuals and to receive care in the least restrictive environment appropriate to their needs*'. Each of the consultant psychiatrists who gave evidence to the Inquiry explained the intrusive nature, complete lack of privacy and distressing nature of special observation whereby a staff member must be directly watching and at arms' length from the patient at all times. Added to which, this level of observation would have necessitated an admission to the disturbing and distressing environment of the IPCU.

[98] Dr Timney stated in his report that

> '*on reviewing the risks, it does not appear that there was any evidence of significant deterioration in her mental state or increase in the level of risks around the time of her death. However, throughout her admission the level of distress and risk of self-harm remained high with multiple worrying attempts that had the potential to prove fatal….. I saw no indication for example, in the lead up to Ms Shannon's death that her observation levels should have been moved up from constant to special*'.

[99] The consensus of the experts who worked in inpatient psychiatric care units as part of their core daily practice was that special observation of Ms Shannon over a prolonged period of time was simply not a realistic option. Their evidence is to be preferred to that of Professor Sashidharan on this issue as he had no similar, recent experience from which to draw and he was also unable to give a considered view as to when such a regime should have been instigated and for what period of time.

[100] For the sake of completeness, I mention at this stage the evidence of Dr Brodie Paterson, registered nurse. I did not find his opinion evidence on this issue to helpful to my determination. Dr Paterson was last in practice in an inpatient setting in 1986 and in any event, as a registered nurse, he was not qualified to give an expert view in relation to the issue of appropriate levels of observation or whether there should have been an admission to the IPCU, as those decisions were within the sole ambit of the consultant psychiatrist in charge of Ms Shannon's care.

Was there sufficient recording of the observation activities and changes in environmental risks to adequately assess the level of risk to Ms Shannon's safety on the ward?

Did the observation policy lack details to enable a consistent approach to be taken by staff caring for Ms Shannon?

[101] There was an overlap in the evidence in relation to these two questions which were posed in submissions and which are more appropriately considered together.

[102] On 4 April 2014, Ms Shannon was able, whilst under constant observation by a nursing assistant, to take the lid of a deodorant can, enter a toilet cubicle, swallow the lid and choke herself to death.

[103] Tim Montgomery, Director of Operations at the REH concluded that Ms Shannon's death

> '*was avoidable or preventable on that day and that the observation in place should have prevented serious harm, as it had done on many previous occasions, by removal of the means. However, the frequency by which Clare voiced her intention to commit suicide and the attempts by which she sought the means to choke herself perhaps suggests that she would ultimately succeed as she did on 4 April 2014 or that it could have happened earlier, on a different shift, with a different set of staff if they hadn't observed her earlier in each of the events identified in the timeline*.'

[104] A constant observation regime does not always succeed in keeping patients alive. Patients recognise the gaps in their care in order to have the opportunity to complete suicide. There was contradictory evidence about the extent to which such deaths had occurred in NHS Lothian psychiatric wards in 2014. Tim Montgomery's evidence was that there were two such deaths, but only one when the patient was under constant observation. Anne Langley also understood there to have been two deaths, one of the patients being admitted to the IPCU – and therefore potentially under a special observation regime. However, Brain Caldwell, nursing assistant, gave evidence that within the space of a year, nine patients he had cared for had completed suicide, two of whom he had observed an hour before their deaths. The three witnesses may have each considered a slightly different timeframe (*eg.* the year running up to Ms Shannon's death or the calendar year 2014) or accessed different statistical records to underpin their evidence to the Inquiry. Nevertheless, it is clear that Ms Shannon was not the only patient to have committed suicide whilst under either constant or special observation in an NHS Lothian psychiatric ward in 2014. This evidence fits with the evidence of Dr Macpherson that a proportion of patients whilst under such an observation regime, manage to successfully complete suicide.

[105] The environment on the Balcarres ward was not well designed to manage the risks of a patient persistently and creatively trying to acquire everyday items with which to asphyxiate herself. The ward had four-bed rooms. There were shared common areas. There was a high turnover of patients. Patients expected to be able to move about the ward freely and to have unrestricted access to their personal belongings. Ms Shannon's toiletries were, in the main, kept locked in the office and only given to her for use with the lids removed. However, the evidence was that this policy was not universally applied and also that Ms Shannon asked to borrow items from other patients or acquired items by stealth. She was both opportunistic and capable of pre-planning – acquiring items and concealing them for later use. The ward layout, the sight lines and lighting did not facilitate the prevention of such behaviour. The evidence was that Ms Shannon was adept at distracting staff and was increasingly creative in her attempts to obtain items with which to self-harm. The number, frequency and seriousness of her attempts clearly indicate that the constant observation regime was not operating in such a way as to prevent her either from acquiring items or putting them in her mouth.

[106] The observation policy allowed a margin of discretion to staff in its application. The evidence was that some staff adopted a more therapeutic approach, balancing the patient's need for privacy and dignity, particularly when dressing and using the toilet, with the need to keep them safe. (An example of this which was given that some staff would watch a patient put their bra on and insist that it was handed to them immediately after removal – this being a common item used for asphyxiation, whereas

others would allow the patient some privacy in dressing and putting clothes away.) The observation policy itself did not provide this level of detailed guidance to nursing staff.

[107] Some staff on the Balcarres ward were more risk adverse than others when caring for Ms Shannon. It was also clear that the registered nurses and more experienced nursing assistants were more insightful regarding the potential risks and more vigilant than the more junior nursing assistants. However, all of the staff on duty on 4 April 2014 had prior experiences of Ms Shannon acquiring items and swallowing them in an attempt to asphyxiate herself whilst under constant observation and had intervened when necessary. The nursing assistants on the ward had no formal qualifications or training in mental health. The compulsory elements of their induction training included the manual handling of patients, basic life support/first aid and dealing with patient aggression. They were unlikely to have an insightful understanding of self-harming/ suicidal behaviour and the underlying psychopathology of a patient with Ms Shannon's condition.

[108] There were lapses in the application of the policy. Constant observation of a patient ordinarily took place for periods of up to 72 hours. It was accepted by all of the clinicians who gave evidence to the Inquiry that that there was an increased potential and likelihood of staff becoming lax in the application of the policy over a protracted period – in this case for over a year. Staff also became desensitised to the level of self-harm taking place given its frequency, to the point that many incidents were not even recorded in Ms Shannon's notes. Louise Shannon's evidence was that her sister was adept at retrieving items from rubbish bins when being observed, that observation was

not provided during family visits and that on at least one occasion the staff member carrying out the observations fell asleep. On one occasion Ms Shannon was able to abscond from the ward. A system of hourly recording of observations may have improved vigilance but the evidence did not support a finding that changes to the policy of this nature would have made a material difference.

[109] The NHS Lothian policy was applicable to all patients on inpatient psychiatric wards. By its nature, it could not provide detailed guidance for the risks posed by individual patients. Each patient had their own risk profile and a policy direction, for example, that all patients under constant observation should be in a direct line of sight in a toilet cubicle at all times would not have been appropriate or proportionate for all patients given the lack of privacy and dignity that such a measure entailed. The evidence did not support a finding that this would have been a reasonable precaution for NHS Lothian to have taken in relation to the policy applicable to all patients under constant observation.

[110] Each of the staff on duty on 4 April 2014 were asked in their evidence to explain their understanding of correct application of the constant observation policy to Ms Shannon when she used the toilet. Hamish Jack, senior staff nurse, did not undertake this task personally and did not give a view other than to reiterate the general requirement for a patient to be in sight or sound at all times. Kirsty Stewart, staff nurse, explained that whilst ordinarily she would give a patient a degree of privacy in the toilet by maintaining a dialogue with them through an ajar door, that '*Ms Shannon had tried to harm herself so many times that I did not feel confident about letting her out of my sight even*

when she went to the toilet'. Ms Stewart said that this was a 'personal opinion' and not '*a specific instruction given to colleagues'*. As female staff members took Ms Shannon to the toilet, the male members of the team did not have direct experience of this particular task. Michael Gall, staff nurse, commented that he '*was aware that female staff would generally keep the door open and watch Clare'*. David Thomson, an experienced nursing assistant, said that it was a matter of personal choice how to conduct constant observation of patient like Ms Shannon in the toilet but that he would tend to stand outside the door and maintain verbal contact. Funmilayo Obafemi was the most junior nursing assistant on the team. Her practice was to keep the door ajar. On 4 April 2014 she had not spoken with Ms Shannon for '*about a minute'* after she went into the toilet cubicle and the evidence indicated that this was not an uncommon method of her observing Ms Shannon in the toilet. More senior staff members on the ward had warned Ms Obafemi about the need for vigilance but this did not translate into direct and specific instructions either to directly observe Ms Shannon at all times or to maintain a constant dialogue with her when in the toilet. She was left to exercise her own discretion in applying the observation policy.

[111] There was also varying practice for searching Ms Shannon for potentially harmful items before she entered a toilet cubicle. Brain Caldwell's evidence was that he would ask Ms Shannon to turn out her pockets. Kirsty Stewart's evidence was that she would search Ms Shannon and her belongings '*if I had suspicions but not on every occasion*'. Funmilayo Obafemi said '*I normally asked her if she had anything in her pockets*'.

Ms Shannon hid items in variety of ways on her person (for example, under her armpits). She was not routinely searched before entering a toilet cubicle.

[112] At the handover of each shift there was a meeting between all of the ward staff – referred to as 'safety huddles' or 'rapid rundowns' – where information was exchanged regarding any changes in a patient's mental state or significant events which had taken place during the previous shift. Louise Shannon expressed the readily understandable viewpoint that '*Clare's many attempts to choke herself provided numerous learning opportunities for staff and yet this was the very method she used to end her life*'.

[113] There was no evidence any detailed review or specific change to Ms Shannon's care plan as a result of her increased suicide attempts. This, in Professor Sashidharan's opinion, amounted to a serious failure in Ms Shannon's care and management on the Balcarres ward. He commented that

> *'a risk assessment is only effective if it is followed by an effective management plan that includes some form of intervention to reduce, contain or otherwise ameliorate the risk, thus changing the outcome'*.

In his report Professor Sashidharan notes that by the end of 2013 it was clear that swallowing items was the main way in which Ms Shannon was trying to kill herself and that in the three months prior to her death there was an escalation of her behaviour:

> *'It had become an almost daily event that she would try to choke herself and the staff were unable to stop her form finding/ concealing and then swallowing objects such as bottle tops, medication cups, crisp packets etc*.'

[114] In his evidence, Dr Timney said that

> '*as her treatment progressed it would have been reasonable to have made changes to how her constant observations were implemented that would have required either direct observation in the area or a necessity to search her prior to going to the toilet*.'

He identified as a specific precaution that Clare Shannon could have been kept under direct observation in the bathroom area and/ or to have been searched prior to entering the bathroom. Professor Sashidharan agreed, saying that in the last two to three months of Ms Shannon's admission there should have been direct supervision of her in the toilet and that this should have been part of her care plan in the absence of a special observation policy. In cross-examination, Dr MacIntyre said that the question of direct observation in the toilet was considered. Nursing staff had tried to strike a balance between respecting Ms Shannon's privacy and ensuring her safety. Being directly observed using the toilet was very distressing and demeaning for patients. However, he conceded that at times that balance was not struck correctly. He agreed, perhaps with hindsight, that the observation level could have been increased so as to provide for Ms Shannon to be searched or kept within direct sight when using the toilet at all times and that this could have been specified in her care plan.

[115] Examples of Ms Shannon's nursing care plans were lodged for the Inquiry (Crown production 18). These contain specific measures for nursing staff to follow in order to reduce risk; eg.

> 8 October 2013: '*when dressing/undressing Care is to be supervised in order to prevent her from secreting items with which she could self-harm. When showering, a female member of staff must stand outside the shower cubicle with the door ajar*';
>
> 27 December 2013: '*under no circumstances is Clare to be given a medication cup*'.

[116] Whist the Inquiry inevitably has the benefit of hindsight, the consensus of the expert evidence was that there was inadequate recording of Ms Shannon's self-harm attempts, insufficient reflection on the amendments to her care plan which could have

been made to mitigate future risk and that it would have been a reasonable precaution for Ms Shannon's nursing care plan to have been updated in early 2014 to require that she be searched prior to using the toilet and/or that she required to be directly observed whilst using the toilet by the member of nursing staff conducting her constant observation. Had such precautions been taken, the accident resulting in Ms Shannon's death might realistically have been prevented because the bottle top could have been found (if she was searched) or the attempt to swallow it prevented (if she had been directly observed).

[117] The conclusions of the Adverse Event Review conducted by Dr Kadar (Clinical Director with overall responsibility for adult psychiatric care, NHS Lothian) and Andrew Wills, Clinical Development Manager, are set out in the template (Crown production 22). Under the heading 'Care and Service Delivery Problems that led to the Adverse Event' there are findings that:

> '*While the patient was on constant observation, activities and areas of the ward which presented a risk to the patient were changing frequently, there was insufficient recording of these providing opportunities in inconsistencies of care leading to increased risk*'; and: '*the patient's self-harming behaviours were not fully understood within the team*'.

[118] However, the key findings of the review pertinent to the issue of observation of patients were:

> '*NHS Lothian Observation Policy requires to be reviewed and updated to improve the delivery of safe and therapeutic care…. Localised and formalised clinical forums should be escalated to ensure the provision of reflection and support reflection to all members of the team in the provision of patient care*'.

Changes in ward environment since 2016

[119] The new Craiglockhart ward (which replaced the Balcarres ward in 2016) was designed with patient safety in mind. The fixtures and fittings were designed to reduce the scope for self-harm (eg no ligature points). Patients have single ensuite rooms where their belongings are kept. The lighting and sight lines for observation are clearer.

Changes in the NHS Lothian observation policy following the Adverse Event Review

[120] The Inquiry heard that the risk of harm, particularly suicide, is dynamic, complex and extremely difficult to predict, manage and eliminate in mental health care because of a myriad of human factors (both patients and staff) and unknown chance factors (such as access to means of lethality, recent loss or behaviour) even with the use of risk assessments and observation practice.

[121] Emerging evidence (meta-analytical studies) are challenging traditionally held assumptions around suicide risk assessment by discovery that such assessments (including checklist format suicide risk assessment) do not accurately predict or prevent suicide or self-harm. These findings demonstrate only weak or modest links between suicidal intent, suicidal behaviour and death by suicide, with accurate predictions only marginally greater than chance predictions. The evidence supports 'trauma-informed care environments' for patients with complex mental health issues such as EUPD. Standalone observations whereby a staff member observes from a distance (rather than being with the patient and engaging with them, developing a therapeutic relationship) can adversely affect patients with a trauma background.

[122] In April 2016, NHS Lothian issued guidance regarding all inpatients in adult metal health wards entitled 'Standard Operating Procedure: Safe and Therapeutic Observation of Adult Mental Health Patients' ('2016 Guidance)(Shannon family production 18/2). *Inter alia*, that guidance sets out a competency framework for those undertaking observations. The nurse in charge of the ward is tasked with ensuring that the person carrying out the observations is competent to do so. There are three levels of competency in the guidance; basic, intermediate and full. The framework requires that for the basic level, a staff member must be able to demonstrate knowledge of the policy, the skills to put it into practice and the correct attitudes – putting the patient's needs first, safety, dignity and privacy at the centre, understanding their responsibilities to the patient and correctly ordering priorities to keep the patient safe. These skills and attitudes are demonstrated by an oral assessment which must be passed before the staff member can undertake constant or special observations. This policy is more robust than previous guidance which required the completion of an online learning module demonstrating little more than a simple understanding of the three levels of observation. The intermediate level of competency makes reference to patient engagement and therapeutic interventions to improve the patient's experience of being observed and their wellbeing. The staff member requires to demonstrate a clear understanding that the observation of patients is a skilled and therapeutic task which requires engagement, adds to the ongoing assessment of a patient and contributes to their recovery. The full competency level can be achieved by registered nurses only and requires the nurse to demonstrate an attitude of skilled professional judgment and responsibility. This

competency level appears to be tailored primarily to making delegated decisions about appropriate observation levels.

[123] Neither the 2016 Guidance nor the competency framework documents appended to it indicate the extent to which staff at any of the three levels have received or will receive training or have the knowledge, skills or attitudes required to deliver therapeutic interventions or what those interventions should entail. The guidance notes that

> '*engaging with highly distressed individuals is a skilled job and it is important that observations are carried out by a range of grades of staff to allow for assessment and engagement by registered as well as non-registered*' (nursing staff).

[124] The Healthcare Scotland document 'From Observation to Intervention' 2019 ('the 2019 guidance') (Shannon family production 19/3) recommends that

> '*observation is carried out by experienced staff who are knowledgeable about the effect of trauma and who have the skills to build positive, trusting* relationships *and to deliver effective care and treatment interventions*'.

This should be delivered by a core team of staff familiar to the patient working with allied health care professionals such as clinical psychologists. The value and importance of clinical teams being able to access the expertise of psychology colleagues is acknowledged in the 2019 guidance in order to '*carry out a psychological formulation to tailor and align therapies both to patients' clinical needs and their capacity to engage with them*'. Risk assessments should not be carried out as a standalone exercise but, instead, should be incorporated into a comprehensive psychological assessment, treatment and safety plan for each individual patient which allows the patient's clinical needs and risk factors to be identified and to reduce the potential for harm. Observation should be 'purposeful' with clearly planned and specific interventions/activities.

[125] The 2019 guidance refers to '*skilled therapeutic interventions*' being carried out by staff with '*appropriate seniority, training and capability*'. There is no detail in the guidance about professional qualifications, training or competencies required by a particular staff member to deliver these interventions. There is simply general guidance on the need for staff carrying out enhanced observations to have 'trauma informed skills' and to be '*skilled, competent, caring and familiar to the patient*'. There is general reference to the need for staff to have support for their own learning and for supervision / reflective practice to become routine.

[126] Logically, the guidance implies that registered nursing staff may be well placed to offer psychotherapeutic interventions, if trained appropriately. The interventions which the guidance categorises as '*lower intensity psychological interventions*' such as distress tolerance, mentalisation, mindfulness and guided meditation are the types of interventions which may have been offered on the Balcarres ward in 2014 by Merrick Pope, specialist self- harm nurse. With specialist training in delivering these interventions, experience and clinical supervision/ reflective practice, registered nursing staff could develop some or all of the required skills. However, undertaking a patient assessment and psychological formulation with a trauma-informed treatment and safety plan along with delivering 'higher level psychological interventions' such as CBT and DBT could only be delivered by a consultant clinical psychologist. Clinical psychology input would also be needed to identify the appropriateness of lower level interventions, the patient's ability to engage with them and to provide clinical supervision/reflective practice to the staff involved in delivering them.

[127] The 2019 guidance acknowledges the need for these interventions to be delivered by '*core, familiar staff skilled in a range of psychotherapeutic interventions*'. However, in reality, the observation of patients on acute adult psychiatric wards is often carried out by unfamiliar/junior staff who may not be equipped with the skills and knowledge to identify, address or respond to the risks and problems posed by the most unwell and complex patients. The guidance is intended to apply to all NHS inpatient psychiatric wards. The issues posed by the need to staff acute admissions wards, covering three shifts a day with a reliance on unqualified nursing assistants and bank/agency staff, are difficult to reconcile with this guidance. Equally, the specific steps required to enable staff to gain the necessary skills, training and competence are not outlined in the guidance. The difficulties in recruiting, training and retaining staff with such expertise are not touched on. The introduction to the guidance acknowledges that

> '*some degree of education and training, as well as workforce planning and duty of care may be required in the lead-up to full implementation of this guidance*'

and that

> '*it is understood that sometimes it may be necessary to deploy bank staff to carry out enhanced observations, but again, it is important that permanent staff do carry out observations during every shift*'.

[128] The intention of Healthcare Scotland was that the 2019 guidance would be fully implemented in March 2019. The evidence given to the Inquiry was that it has yet to be implemented and that no clear date for its implementation has yet been identified. That is unsurprising given the level of education, training and workforce planning which would be required to implement this guidance. The evidence to the Inquiry clearly

supported findings that its early introduction would be likely to result in more effective observation and care of patients with EUPD (particularly those with a history of trauma), a safer system of work in relation to the constant observation of patients and a more informed system of identifying and mitigating the risks posed by patients being observed. However, it should be noted, that the evidence did not support a finding that this would predict and prevent suicide by all patients being constantly observed.

[129] The 2019 Guidance, once implemented, is likely to enable a number of patients to be more safely managed on acute psychiatric wards. However it should be noted that the main focus of this guidance is on therapeutic engagement with patients. The intention is that therapeutic interventions will be delivered by nursing staff. There was no evidence to the Inquiry about what would be involved in the very significant change in ward culture, approach and training required to implement this guidance and to ensure that the nursing staff, particularly nursing assistants, would be well-placed to implement this. The evidence did not explore the nature of the various therapeutic interventions or the qualifications and training needed to deliver them. There was no evidence about training programmes being planned or delivered or of changes in ward culture and practice having taking place at the date of the Inquiry, as acute wards move towards the implementation of this guidance. The 2019 guidance also underlines the importance of clinical supervision and reflective practice forums for all staff undertaking therapeutic interventions. Whilst there was some evidence that such sessions are now offered to staff on acute wards, the evidence did not detail the specifics of what this involved. Sessions seem to be voluntary and to take place on an *ad hoc* basis when the

clinical psychologist allocated to the ward is available for the staff who happen to be on shift at the time. No mandatory structured system of clinical supervision was discussed in the evidence. The challenges in recruiting and retaining adequate clinical psychology resources to deliver the high level therapeutic interventions and to train, support and clinically supervise nursing staff in delivering the lower level therapeutic interventions described in the 2019 guidance are likely to pose obstacles to its introduction and effective implementation on NHS acute wards.

Low secure psychiatric wards

[130] Low secure psychiatric wards provide a higher level of patient security than acute wards. They are typically used for patients who have challenging behaviour including extensive and frequent suicidal behaviour. The evidence did provide a clear definition of what a low secure environment entailed. There are no such wards in NHS Lothian hospitals. Low secure wards have an emphasis on patient safety, the physical environment being designed with minimising opportunities for self-harm and facilitating staff observation. The setting was described as 'more intensive' with dedicated staff and higher staff/patient ratios.

[131] In common with many other parts of Scotland, NHS Lothian has no low secure facility. It was the position in 2013/14 and remains at present, when this option is required for a patient, an out of area placement at a private clinic funded by NHS Lothian is the only option which can be considered.

[132] As part of the REH redevelopment programme, phase 2, 'a low secure option' for female patients with complex needs is under consideration. Dr Andrew Watson, the current Associate Medical Director of the REH gave evidence to the Inquiry that a 'dedicated clinical pathway' with three low secure 'pods' each with eight ensuite rooms had been proposed. The 'clinical output specification' had been agreed as had the 'outline business case' but this has yet to be approved in detail. He said that whilst '*there is a clear intention on the part of Lothian health board to make this happen*', the detailed plan and capital expenditure have yet to be approved. The normal timescale from planning to delivery is three to four years.

[133] Low secure wards do not simply provide a safer environment and higher staff ratios but also deliver 'high intensity programmes' – high level psychological interventions on a level not deliverable in acute wards. Patients are admitted for longer periods. A low secure facility would be much better placed to the needs of patients with EUPD and a history of persistent self-harm/suicide attempts.

[134] The Adverse Event Review template (Crown production 22) noted

> '*the patient had been identified as requiring specialist services, those services are currently not available within NHS Lothian, therefore to receive this service required admission to a private facility*'.

In 2014 and at present, the only options available in Scotland are referral to either the Surehaven clinic in Drumchapel or the Ayr (Priory) clinic. Ms Shannon was referred to Surehaven. The assessment referral form (Crown production 29) under the section 'reasons for referral' notes:

> '*It is believed that the most beneficial form of treatment would be within a specialist personality disorder service. A focussed treatment programme, which can manage risks within firm boundaries and provide intensive inpatient care. There is no specialist unit of this kind within NHS Lothian, nor is there the provision for intensive psychological therapy on an inpatient ward at the REH*'.

That would equally be the situation should this assessment have been made at the date of the Inquiry.

[135] The clinical psychologist who assessed Ms Shannon for admission to Surehaven, Dr Marie-Louise Holmes, concluded that she could be '*safely managed within a controlled secure environment, initially on constant observations due to current risk and poor mental state*' and that '*her self-harming and suicide attempts appear that they are well within the range that Surehaven can contain*' and that she would benefit from a 'low-secure environment'. Dr Holmes was also of the view that Ms Shannon '*may benefit from engagement with psychology, occupational therapy and regular therapeutic interventions led by our skilled multi-disciplinary team*'.

[136] All of the clinicians who gave evidence to the Inquiry agreed with that assessment.

[137] In 2014 and at present, there is neither a low secure facility nor the specialist clinical psychology services required to safely and effectively treat patients with Ms Shannon's condition within NHS Lothian. There is uncertainty about whether these services will be available in NHS Lothian by 2024/25.

[138] The evidence about the success of out of area referrals to private low secure clinics was not persuasive. The patient is often admitted for over a year. This brings a sense of isolation and less contact with family members who may be a valuable support.

The patient remains under the clinical oversight of an NHS Lothian consultant psychiatrist and the placement is reviewed every six months. However, robust governance, assessment of outcomes and review is difficult. One female patient referred to Surehaven in 2014 returned to an NHS Lothian acute ward within a year. Surehaven is not a specialist service for patients with personality disorders. Many of the patients have behavioural difficulties which are caused by disabilities or head injuries. Surehaven may have been the only viable option for an out of area referral where both a low secure environment and specialist psychology services were offered. Ms Shannon may have experienced an amelioration of symptoms as a result of the treatment regime at Surehaven but equally she may have been one of the cohort of patients with EUPD who do respond positively to specialist psychological therapy. It must be remembered that her condition was at the most serious end of the EUPD spectrum. Nevertheless, it was the best and only viable clinical option available to her. A low secure facility at the REH, with a specialist clinical pathway for female patients with EUPD which enabled regular visits and support from her sister Louise to continue, would clearly have been a much better option for Ms Shannon.

[139] The evidence was that the cost of a place at Surehaven is around £180,000 per patient, per year. On average 24 NHS Lothian patients are placed out of the area at a total cost of approximately £5.5m per annum. Many of those patients could benefit from a low secure placement and clinical psychology therapy at the REH (if such a facility were built as part of the second phase of the REH redevelopment programme) as an alternative to an out of area placement. It is not difficult to understand why an outline

business case for such a facility has been approved but in economically challenging times, approval of the capital expenditure and delivery of the project is quite another matter. The recruitment of appropriately skilled clinical psychologists to such a facility may be challenging as there is intense competition for their recruitment and retention to inpatient wards. The evidence was that Surehaven has '*struggled to retain clinical psychology input*' and that their current waiting list for admission is over 12 months.

3. The arrangements for securing specialist services outwith NHS Lothian for Clare Shannon;

[140] Dr MacIntyre considered that Ms Shannon's clinical needs could not be met on the Balcarres ward. He sought a second opinion from Dr McConville who reinforced his view, concluding that Ms Shannon's persistent self-harm/suicide attempts were difficult to safely manage on a general adult ward and that she would benefit from specialist psychological therapy which was only available in a specialist unit such as the Surehaven clinic.

[141] The following table, excerpted from NHS Lothian's submissions sets out the chronology and timeframe of the steps which followed in respect of Dr MacIntyre's referral/request for Ms Shannon to receive out of area private treatment at the Surehaven clinic, funded by NHS Lothian:

TABLE: CHRONOLOGY FOR OUT OF AREA REFERRAL PROCESS

DATE	ACTION
13.08.2013	Dr McIntyre sought second opinion from Dr McConville, Consultant Psychiatrist regarding *inter alia* whether referral to specialist services should be sought in the event that the planned trial discharge to IHTT was unsuccessful.
18.09.2013	Dr McConville provided an opinion advising that "*If her difficulties with repeated attempts at strangling herself continue I think it would be well worth obtaining an opinion from a specialist unit as this type of behaviour is very difficult to adequately manage on a general ward*."
07.10.2013	Dr McIntyre emails his Clinical Director Dr Ihsan Kader, Clinical Director to request advice on obtaining an opinion from Surehaven with a view to transfer to a specialist unit
08.10.2013	Dr Kader replied to Dr McIntyre querying whether a rehab opinion had been requested and advising *'once we exhaust local options I can look at taking this forward*.' Dr McIntyre replies saying he has requested rehab opinion and been told by Dr Mountain that "this is a formality only." Dr Kader advises "*Clare will need to have a rehab assessment before she can be considered for any out of area placement*."

09.10.2013	Rehabilitation assessment requested.
19.11.2013	Rehab assessment received marked "declined."
22.11.2020	Dr Kader confirmed support as clinical director.
12.12.2013	Dr McIntyre submitted a request for funding for specialist personality disorder treatment to Dr Tomlinson, Consultant in Public Health, attaching letter to Dr Lefevre of 09.12.2013 requesting out of area referral
17.01.2014	Dr McIntyre contacted Safe Haven to ask what was happening with the referral. Email from Safe Haven to Dr McIntyre advising that they are still awaiting supportive statement from Dr Lefevre. Dr McIntyre replied on the same day indicating that Dr Lefevre was supportive of the request.
17.01.2014	Dr Tomlinson arranged meeting of Out of Area Group for 14.02.2014
14.02.2014	Out of Area Group meet. Agreement in principle to fund out of area referral subject to assessment by Surehaven and psychological assessment
17.02.2014	Date of referral for assessment by Surehaven
24.02.2014	Surehaven assessment carried out
18.02.2014	Email from Surehaven to Dr Tomlinson enclosing 'pre-admission' assessment advising that transfer is appropriate and a bed will be made available in 2 -3 weeks

19.03.2014	Psychological assessment carried out by Dr Clare Jackson, Clinical Psychologist
27.03.2014	Dr Tomlinson confirms funding for Clare Shannon to go to Surehaven. No bed available at that stage.

[142] The witnesses who gave evidence to the Inquiry on this aspect of matters all accepted that the process was unduly cumbersome and there was undue delay in processing the referral. Professor Sashidharan's view was that the delay in seeking and agreeing Ms Shannon's urgent transfer to a more appropriate facility was inconsistent with good clinical practice and amounted to a significant failure in ensuring appropriate treatment and risk management of a highly vulnerable woman with complex mental health needs. In their joint opinion document, Professor Sashidharan and Dr Timney expressed the view that '*there was undue delay in Ms Shannon's referral to specialist services even after the RMO (Dr MacIntyre) made an early and appropriate decision that a referral to specialist services was necessary.*' Dr Timney commented that the length of time taken to approve the transfer was '*excessive and overly bureaucratic*' and that this amounted to a failure in Ms Shannon's care.

[143] The Inquiry was assisted by the evidence of Dr Joy Tomlinson, Public Health Consultant. She explained the procedure for referring a patient for an out of area specialist service with reference to a flowchart (19/4). In 2014 the governance for out of area referrals was a shared responsibility between the Public Health Department 'Safe Haven' along with the treating consultant, their Clinical Director and Associate Medical

Director. A joint oversight 'Out of Area Referral Group' considered applications once a letter was received from the treating consultant along with a supporting statement from their Clinical Director and Associate Medical Director. Decisions were usually made within eight weeks and were discussed at meetings but could be considered on a shorter timescale by email in appropriate and urgent cases.

[144] Dr Tomlinson referred to the 'Out of Area Activity; Principles, Practice, Governance and Planning Protocol' appended to her affidavit (Crown production 16/1) which sets out the principles underpinning consideration of such applications. Whilst availability of funding was an important element and a placement at Surehaven was '*a costly package*' Dr Tomlinson could not recall a single application which had been rejected on financial grounds during her tenure nor was this the primary factor accounting for the length of time taken by the process. In most cases there were points of clarification raised by members of the group. It was necessary to establish that there was no appropriate local provision, to identify the expected outcomes for the placement, the treatment goals, anticipated pace of progress and plan to return to local services. Due diligence required to be followed before an application could be approved.

[145] The evidence covered an exploration and analysis of the chronology of events set out in the above table and identified delays at various points in the process which attracted criticism.

[146] On 7 October 2013 Dr MacIntyre contacted Dr Kader, Clinical Director, to seek his support with making the referral and his advice on appropriate procedure. Dr Kader's view was that in order to persuade the Out of Area Referral Group that all

appropriate local options had been exhausted, a referral required to be made to the Rehabilitation Service to rule this option out purely '*as a formality only*'. Dr MacIntyre made the referral immediately. The assessment was completed and reported back on 19 November 2013. This was the normal turnaround period for such referrals. The evidence of Dr Tomlinson, Dr Lefevre, Associate Medical Director (in 2014) and Dr Watson (the current) Associate Medical Director, was that whilst any referral must address the issue of appropriate local provision, there was discretion to decide, in the circumstances of a particular patient, that a formal assessment was not required. The assessment by Gillian McDonald, Care Manager of the Rehabilitation Service REH was that Ms Shannon was not suitable for the service as she required a period of inpatient care in a specialist unit to address her complex psychological needs. Dr MacIntyre's initial discussion with Dr Deborah Mountain from the Rehabilitation Service before the formal referral was made, clearly identified that this would not be a viable option for Ms Shannon, that the assessment was a formality and that its conclusion was clear before it was formally undertaken. This step of the process could have been circumvented if an appropriate submission was made to the Out of Area Referrals Group regarding the unsuitability of this option by senior clinicians. No formal assessment by the IHTT was required as this option had been unsuccessfully tried and could be ruled out. It would appear that Dr Kadar's understanding of the protocol was that a formal assessment was required in order to rule out the rehabilitation option. That was incorrect. Dr Watson's evidence was that the Rehabilitation Service could quickly have been ruled out as a care model unsuitable for a patient with Ms Shannon's needs.

[147] The assessment report from the Rehabilitation Service was received on 19 November 2013. On 22 November 2013, Dr Kadar confirmed his support for the referral as Clinical Director. On 12 December 2013 Dr MacIntyre submitted the formal request to the Out of Area Referrals Group, copying in his letter to Dr Lefevre, Associate Medical Director. Dr Tomlinson's evidence was that the request was not progressed at this stage because a letter of support/approval was required from Dr Lefevre. Dr Lefevre did not appear to be aware of that requirement. His evidence was that he thought his view could be given at the round table meeting of the group to discuss the referral. He was not specifically asked for a letter by Dr MacIntyre, Dr Kadar or Dr Tomlinson. However, as Associate Medical Director, he ought to have known that he required to provide a letter of support in terms of the protocol, given his role in relation to the consideration of all such adult psychiatry referrals for out of area placements. This glitch in the process accounted for a further unnecessary delay until 17 January 2014.

[148] On 17 January 2014, Dr MacIntyre contacted Dr Tomlinson to chase up the referral and found out that the lack of a supportive letter from Dr Lefevre had held up the process. This was chased up and immediately provided. Dr Tomlinson then expedited the process and the application was granted in principle on 14 February 2014. Her evidence was

> '*there were no timescales for cases to be processed as each placement was tailored to the individual circumstances*'… '*in general they (the Out of Area Referrals Group) aimed to make a decision within eight weeks but a referral could be processed more quickly in particular circumstances*'.

Accordingly it is unclear, particularly given the intervening festive period, whether the application would have been likely to have been processed more quickly had Dr Lefevre submitted an immediate letter of support on 12 December 2013. The evidence was that urgent requests could be processed by email without the need for a round table meeting.

[149] The next steps in the chronology involved the Surehaven clinic undertaking their pre-admission assessment and a bed being made available. In tandem with this, a clinical psychology assessment was undertaken by Dr Jackson. Agreement had been given in principle by this point. Dr Jackson's assessment did not impact on the timeline in any way. Formal approval was given on 23 February 2014. These steps were dealt with expeditiously.

[150] The avoidable steps and delays could have accounted for two to three months overall lack of progress in the referral to Surehaven. The NHS Out of Area Referrals process did not operate as it should have – primarily due to a lack of understanding of the precise requirements by Dr Kadar and Dr Lefevre. However, it is difficult to reach a clear conclusion about whether this would necessarily have resulted in Ms Shannon's earlier admission to Surehaven. That would involve a degree of speculation about the timeframe within which the Out of Area Referrals Group would have met and considered the application, impact of the intervening festive period on the process, the timeframe for the Surehaven pre-admission process and their waiting list (anticipated to be 2-3 weeks on 28 February but in fact no bed had been offered by 4 April 2014).

[151] The question of whether Ms Shannon's admission to Surehaven was likely to have been successful is not an easy one to answer. It is tempting to apply hindsight and

to consider whether Ms Shannon may still be alive today had her earlier admission to Surehaven been secured. Dr MacIntyre speculated about this in his evidence. He was clearly regretful that this had not been achieved. Ultimately, Dr MacIntyre considered that it was very difficult to be certain about whether delay had played a part in the outcome given the seriousness of Ms Shannon's condition and the nature and extent of her suicidal behaviour. There was also no guarantee that her admission to Surehaven would have prevented an accident of the type which led to her death. The evidence pointed to an increased level of risk as result of her anxiety about the move, her clearly expressed intention to try to abscond or to take her life and her ambivalence about the referral. Whilst there was some cautious optimism about the referral, it was also seen as last resort. Specialist psychological therapy may have succeeded in ameliorating her symptoms. A more therapeutic observation regime in a safer environment may have prevented a successful suicide attempt by asphyxiation. The failure to secure this treatment option for her at an earlier stage was a clear failure in her therapeutic care. However the evidence was not sufficiently clear to enable the conclusion to be reached that the delay in securing Ms Shannon's referral to Surehaven at an earlier stage directly contributed to her death.

Improvements in the system for considering out of area referrals since 2014

[152] Since 2014 the system for making out of area referrals has changed significantly. As Dr Watson explained in his evidence, budget and responsibility have been moved to the Royal Edinburgh Hospital and Associated Services. The membership of the Out of

Area Group is drawn from there. There is a dedicated administrator. The referral form requires clinicians to consider any local alternatives that may be available but there is no mandatory requirement to secure an assessment by a specific service before an application is progressed. The group meets every two months but applications can be progressed electronically by exchange of emails in urgent cases.

4. The adequacy of the care and treatment provided to Clare Shannon on 4 April 2014

[153] No significant changes in Ms Shannon's clinical presentation were recorded in her medical notes on 4 April 2014. She was seen by Merrick Pope, specialist self-harm nurse at 12 noon that day. The entry in her records is as follows;

> "C was able to talk about feeling angry following our meeting the previous week and that she had not felt supported in her distress. We spoke about her having a choice about what she talked about during a session and that she had concerns about being distressed afterwards as she did not want people to see how she felt. C spoke about her future plans after she had been through the Surehaven programme whilst also stating that she would attempt to abscond during the transfer due to anxiety about the unknown of being there"

Shortly after this session with Ms Pope, Ms Shannon was observed to be on her bed with her hooded top pulled down over her eyes and her bed covers pulled up over her mouth, withdrawn and uncommunicative. This presentation, whilst clearly indicative of her distress, did not differ from her presentation on other days during the weeks preceding her death.

[154] Shortly after 6pm on 4 April 2014 Ms Shannon asked to use the toilet. She was accompanied to the toilet block by Funmilayo Obafemi, the nursing assistant who was

undertaking constant observation of her. Ms Obafemi removed the rubbish bin from the toilet to prevent Ms Shannon taking items from it and undertook a sweep of the area for any items with which Ms Shannon could potentially self-harm. She was not searched before entering the toilet cubicle. The door was kept ajar. No dialogue was maintained. There were no sounds heard which were consistent with the removal of clothing or use of the toilet. Approximately one minute after entering the toilet cubicle, Ms Shannon was heard to cough. Ms Obafemi opened the door of the cubicle and observed Ms Shannon to be standing up, fully dressed, facing away from the door and coughing, consistent with choking on something.

[155] Ms Obefemi 'dragged' Ms Shannon from the cubicle by the hand, over to the sinks and asked her to spit the item (which she believed had been swallowed) out and administered back slaps. At this point, Michael Gall, band 5 nurse, was undertaking 'an environmental check' of the ward and he heard Ms Obafemi say '*spit it out Clare*' from the corridor a distance of about 10 metres from the toilets. He ran into the toilets where he saw Ms Shannon standing at a sink with Ms Obafemi '*at her arm*'. Mr Gall had recently undertaken a life support course and in terms of his training he administered five backslaps and then undertook the Heimlich manoeuvre five times. He then activated his personal alarm and issued a '22: 22' alert –an emergency call to bring the assistance of a doctor. He left the toilet cubicle for around five seconds to tell his colleague Kirsty Stewart, who had returned from her break in response to the call, to direct the on-call doctor to the toilet block. He directed Ms Obafemi to continue to

administer back slaps. She attempted to do so but in the few seconds when Mr Gall was out of the toilet block, Ms Shannon slumped against the wall and down to the floor.

[156] Brian Caldwell, nursing assistant, also responded to the emergency call and took Ms Obafemi's place in the toilet, assisting Mr Gall in moving Mr Shannon into a better position on the floor and together they continued to attempt the Heimlich manoeuvre and to administer backslaps to attempt to dislodge the foreign object from Ms Shannon's airway. They asked her to cough to help them to dislodge the item but by this stage she was unresponsive and was losing consciousness. Nursing staff followed the appropriate life support protocol 'algorithm' in terms of their training and took all appropriate steps.

[157] Dr Nicola Lewthwaite was one of two GP Special Trainees undertaking a six month placement at the REH. She was undertaking a 12 hour shift which had started at 9am that morning. She was the only doctor on site with the responsibility to respond to all medical calls throughout the hospital. She was '*bleeped constantly*'. In 2014 she had completed her foundation training and was two and half years into her specialist GP training. She was trained in the Advanced Life Support Algorithm but not in emergency medicine.

[158] At 6.14pm Dr Lewthwaite was in her office in the Jardine clinic when she received the 22:22 emergency page. She responded as expected by dropping everything and running to the Balcarres ward, arriving within a couple of minutes. On arrival she observed Ms Shannon on the floor of the toilet cubicle and Mr Gall and Mr Caldwell administering back slaps and the Heimlich manoeuvre. She told them to stop to allow her to assess Ms Shannon. Whilst conditions were cramped on the toilet floor, she

described the situation as calm and said that it was immediately apparent to her that the situation was serious. She observed Ms Shannon to '*look blue*' and to be losing consciousness. Using her stethoscope she assessed her airway, breathing and circulation noting that there was no air going in and out of her chest, that she was not breathing and that her pulse was 50 bpm but '*thready*'. Dr Lewthwaite shouted to nursing staff to bring the cardiac arrest trolley which contained a defibrillator, oxygen cannulas and various masks and bags. This was brought promptly by staff nurse, Neil Rafferty.
Dr Lewthwaite also sought confirmation that a 999 call had been made for an ambulance. It had been.

[159] Dr Lewthwaite noted that Ms Shannon had no pulse and appeared to be in cardiac arrest. She then followed the Pulseless Electrical Activity Algorithm putting in an intravenous line with adrenaline and beginning chest compressions. She took turns with nursing staff to administer chest compressions. Defibrillator pads were attached to Ms Shannon's chest. The evidence did not indicate that the machine had been used during the short interval before paramedics arrived. The post mortem report (Crown production 1) confirmed evidence of peri-mortem resuscitation attempts characterised by some bruising and abrasions of Ms Shannon's left chest, a rib fracture and haemorrhage in her chest wall. All appropriate steps were taken to attempt to resuscitate Ms Shannon before the ambulance crew arrived.

[160] Dr Lewthwaite took what steps she could to reduce the level of obstruction of Ms Shannon's airway. She asked Mr Rafferty to bring her a suction machine. The first suction machine (a cordless version) was immediately brought and was used by

Dr Lewthwaite to aspirate fluids (saliva, blood and vomit) from Ms Shannon's mouth in order to allow a clearer observation of her airway. The suction machine worked for only one to two minutes. A second suction machine was then brought. Dr Lewthwaite's evidence was that suction machines are used purely to remove fluids from a patient's mouth to enable a clearer view of the top of the airway. Suction machines should not be used to attempt to dislodge a foreign body as this carries a risk of pushing the object further into the patient's airway.

[161] Dr Lewthwaite's evidence was that the correct procedure for removal of a foreign body from a patient's airway is by use of a laryngoscope – a long metal blade with a handle and specialist McGill forceps. Only clinicians who have been trained to a higher level of airway management involving the skills required to intubate patients are permitted to use this equipment. Paramedics, doctors specialising in emergency medicine and anaesthetists have this training. She did not have access to this equipment and was not trained in its use.

[162] The Scottish Ambulance Service report of the incident (Crown production 28) confirms that the 999 call was received at 18.14 and that the nearest crew were diverted from another incident and allocated the call at 18.17, arriving on the scene at 18.18. The first crew on the scene were Nicola Crowe, paramedic and Cheryl McBain ambulance technician. They were directed immediately to the toilet block where Ms Crowe described (affidavit Crown production 16/16) that Ms Shannon was lying on the floor, unresponsive, not breathing, cyanotic, asystolic with no pulse. She was in cardiac arrest and at 18.25 a backup ambulance crew was called for. They arrived at 18.35. In the

intervening time Ms Crowe asked Dr Lewthwaite to step aside and she took over control of Ms Shannon's airway. Using a laryngoscope and McGill forceps she was able to see 'a tiny bit of white'. She used the forceps to pull the foreign body out. It took her a few minutes to do. She found this difficult as the item was 'surprisingly far down Ms Shannon's airway and she could only see the tip of it. The item removed was Ms Shannon's throat was the lid (Crown label 1) of a Dove brand deodorant aerosol can (Crown label 2). It is not known, and the evidence did not reveal, when and how Ms Shannon obtained this item.

[163] Full advanced life support was then commenced at the scene. Ms Shannon was intubated and then moved on to a gurney and transported to the Accident and Emergency Department of the Edinburgh Royal Infirmary by ambulance leaving the REH at 18.52. Paramedics continued to treat Ms Shannon en route however she was in cardiac arrest when booked in on arrival at 19.04. She was pronounced dead in Resus Area 2, Edinburgh Royal Infirmary at 19.17 when further attempts to resuscitate her failed.

[164] The autopsy conducted by Dr Clare Bryce on 9 April 2014 (Crown production 1) confirmed the cause of death to be: 1a Choking 1b Aspiration of plastic lid.

[165] There was no evidence of any failure on the part of nursing staff on the Balcarres ward, Dr Lewthwaite, paramedics, doctors and nurses in the Accident and Emergency Department or any other clinicians in terms of the emergency response to the accident which led to Ms Shannon's death. In their Joint Report, Professor Sashidharan and Dr Timney stated that the emergency response by the staff on the Balcarres Ward and

the other agencies was appropriate and adequate in all the circumstances. Ms Shannon received appropriate care and medical treatment following the accident which led to her death.

Submissions

[166] Detailed written submissions were lodged on behalf of all of participants in the Inquiry on 21 February 2020. Further supplementary written submissions were then lodged on behalf of the Shannon family and NHS Lothian on 28 February. The submissions each contained a helpful précis of the evidence and the suggested conclusions to be drawn therefrom. I am indebted to Ms Caldwell, Ms Galbraith and Mr Ross for their submissions to which I have given careful consideration. I will refer to the key points raised in the submissions by each of the parties in my conclusions.

Discussion and conclusion

Section 26(2)(e) Any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death or the accident resulting in the death being avoided.

[167] The Crown, founding on the evidence of Professor Sashidharan, submitted that by 11 February 2014 (or at another unspecified date in early 2014) it should have been apparent to clinicians that the constant observation plan in place for Ms Shannon was ineffective and was unlikely to prevent her from succeeding in attempts to choke herself

to death and that the balance of her privacy and dignity versus her safety should have shifted to recognise a greater risk of harm. I accept that general proposition.

[168] The Crown invite the Inquiry to accept Professor Sashidharan's evidence that in those circumstances Ms Shannon should have been placed on a regime of special observation even if that resulted in a lengthy admission to the IPCU.

[169] The Shannon family, referring to the evidence of Dr Macpherson, also submitted that the evidence supported a finding that Ms Shannon's mental health deteriorated between January and April 2014. NHS Lothian, founding on the evidence of Dr Timney, did not accept the proposition that Ms Shannon's mental health deteriorated during that period, as her levels of distress and high risk self- harm persisted throughout her admission to the Balcarres ward. That was also Dr MacIntyre's view, albeit it was conceded that the uncertainty and delay regarding Ms Shannon's potential transfer to Surehaven contributed to her anxiety and distress. On balance, the evidence did not support a finding that there was a material deterioration in Ms Shannon's health in the period of January to 4 April 2014. However, the numerous persistent attempts to swallow items with intention to choke herself which Ms Shannon made during this period were under-recorded in her records and as found by the Adverse Event Review (Crown production 22) there was insufficient recording of the risks leading to inconsistencies in Ms Shannon's care. There was a failure to recognise the consistent and escalating risk of such incidents recurring, missed learning opportunities from which lessons could have been learned and risk management measures which could have been taken to mitigate the risks of Ms Shannon taking her life by these means.

[170] Neither NHS Lothian nor the Shannon family shared the Crown's view that it would have been a reasonable precaution to have placed Ms Shannon on a regime of special observation and admitted her to the IPCU. I accept these submissions - it would not have been realistically practical to place Ms Shannon on a regime of special observation for a period of weeks or months. Dr MacIntyre's evidence was that this would have been inappropriate, unworkable, intrusive and tortuous for her. Dr Timney's evidence was that there was no indication that observation levels should have been elevated to special observation during the period leading up to her death. Dr Macpherson concurred. These witnesses all work on inpatient wards, treating patients with EUPD as part of their core clinical work and on this issue their evidence is to be preferred to that of Professor Sashidharan. The evidence did not support a finding that on any particular date between 1 January 2014 and 4 April 2014 the balance of Ms Shannon's safety versus her privacy, dignity and wellbeing, justified the clinical decision to elevate her observation level to special observation and to admit her to the IPCU. Ms Shannon's previous admissions to the IPCU had been bewildering, frightening and distressing experiences which she was anxious to avoid repeating and which had failed to improve her mental health in the past. It is perhaps in recognition of this fact that her family did not advance the proposition that it would have been a reasonable precaution to take to have admitted her to the IPCU and to have placed under a regime of constant observations during the months leading up to her death.

[171] Dr MacIntyre used careful professional judgment to balance the need to manage the risks which Ms Shannon posed with the distress and deterioration in her mental

state which were likely to have resulted with a further admission to the IPCU. The preponderance of relevant expert evidence given to the Inquiry did not support a finding that a regime of special observation should have been instigated in the months leading up to Ms Shannon's death or that this would have been a reasonable precaution to take in all the circumstances. There was also no obvious date/point in time which was identified in the evidence at which such a judgement could reasonably have been made by Dr MacIntyre.

[172] During the Inquiry the phrase 'enhanced constant' was used to indicate some form of hybrid level between special and constant observation of a patient. There is no provision for this in the 2012 clinical observation guidance (Crown production 15) which clearly sets out three levels of observation – special, constant and general, with a clear definition of what each level entails. Nursing staff were trained in terms of this guidance. It is not appropriate for the Inquiry either to retrospectively re-write the 2012 guidance to identify some hybrid fourth category of observation nor to conclude either that nursing staff ought to have departed from that guidance or that to have done so would have been a reasonable precaution for them to have taken.

[173] However, the circumstances of Ms Shannon's death clearly invite consideration of the application of the constant observation policy when she was using the toilet. Had Ms Shannon been searched before entering the toilet cubicle on 4 April 2014 then the bottle top which she used to asphyxiate herself could have been found and removed and/or had she been directly observed when using the toilet, her attempt to swallow it could have been prevented.

[174] NHS Lothian submitted that it would have been a reasonable precaution for Ms Shannon to have been searched before entering the toilet cubicle and directly observed when using the toilet and these measures could have been recorded in her care plan to ensure consistency in her nursing care. The Crown shared that view and submitted that not only could this have been done, it should have been done. Ms Shannon's care plan contained other entries giving specific instructions for the way in which observations were to be conduct in specific circumstances such as when she was dressing or using the shower, and preventing her from being given medication cups. I have set out at paragraphs [110] – [111] the divergences in practice amongst the staff observing Ms Shannon when using the toilet. The registered nurses, who had a greater understanding of the risks and insight into Ms Shannon's self-harming behaviour, applied the observation policy more strictly. It is surprising that the registered nurses did not provide specific instructions to the nursing assistants on the ward regarding this aspect of Ms Shannon's care and that, in particular, her care plan was not revised to specify a that a greater level of vigilance was required when observing Ms Shannon in the toilet to ameliorate the risk, given the number of previous instances when she attempted to self-harm in precisely the manner which led to her death.

[175] On 4 April 2014, Ms Obafemi used her discretion to apply the observation guidance, she kept Ms Shannon '*within sound*' and stood outside the ajar door of the toilet cubicle whilst she used the toilet. She failed to maintain a dialogue with her for '*about a minute*'. Her approach was undoubtedly at the more lax end of the spectrum of

approaches taken by nursing staff but it cannot be said that she failed to comply with the guidance. It was submitted on behalf of the Shannon family that Ms Obafemi ought to have used her initiative to ensure that Ms Shannon had nothing with her before entering the cubicle and, that when she went into the toilet, to have kept her in a regular dialogue and if there was a period of silence, to have opened the door to observe her.

NHS Lothian's submission was that, as it was neither a requirement of the observation policy/ guidance nor specified in Ms Shannon's care plan that this should have been done, individual criticism of Ms Obafemi for not implementing such measures on her own initiative is not justified. I accept NHS Lothian's submission on this issue.

[176] The NHS Guidance on constant observation applied to all adult patients who were inpatients in psychiatric wards. It would have been neither appropriate not proportionate for the policy to have specified that all patients under constant observation should be directly observed when using the toilet. Such a measure would have been a distressing, demeaning and entirely unnecessary measure for many patients.

[177] However, when considering the acute risks and safety concerns posed by Ms Shannon, it ought to have been recognised that nursing staff, particularly nursing assistants, should not have been given a margin of discretion to apply the policy insofar as it related to Ms Shannon's use of the toilet, with a resulting divergence of practice. Dr Timey and Professor Sashidharan were both of the view that Ms Shannon's care plan should have been updated to require her either to be searched before entering the toilet and/or directly observed. Dr MacIntyre accepted (albeit with hindsight) that the balance

between Ms Shannon's privacy and dignity and her safety had not been struck correctly and that her care plan should have been amended to provide for her to be searched before entering, or kept in direct sight when using, the toilet at all times.

[178] The evidence regarding searching Ms Shannon was mixed. This is not routinely done in psychiatric wards. Nursing staff sometimes asked Ms Shannon to turn out her pockets or searched her belongings if they were suspicious of her movements. However, she was inventive, determined, patient and opportunistic in obtaining items which she could swallow in an attempt to asphyxiate herself. Such items were readily available on an open ward with a high turnover of patients and shared bedrooms. She took items and hid them for a considerable period until an opportunity arose (on one occasion secreting a medicine cup in her armpit for 24 hours before swallowing it). Whist not fully explored in the evidence. I am not persuaded about the viability of nursing assistants undertaking a thorough and invasive search on every occasion that Ms Shannon used the toilet. However, an entirely sensible, proportionate and reasonable precaution to have taken which might realistically have resulted in the accident which resulted in Ms Shannon's death being avoided, would have been to amend her care plan to provide that she should be directly observed when using the toilet at all times.

Section 26(f) Defects in any system of working which contributed to the death or the accident resulting in the death

[179] When interpreting and applying section 6(1)(d) of the Fatal Accident & Sudden Death Inquiries (Scotland) Act 1976 (which is identical terms to section 26 (2)(f) of the 2016 Act) in his determination into the death of James McAlpine, dated 17 January 1986, Sheriff Kearney said:

> 'in deciding whether to make any determination (under section 6(1)(d)) as to defects, if any, in any system of working which contributed to the death or any accident resulting in the death, the court must, as a precondition to making any such recommendation, be satisfied that the defect in question did in fact cause or contribute to the death'.

[180] The environment on the Balcarres ward was not well designed to manage the risks of a patient persistently and creatively trying to acquire everyday items with which to asphyxiate herself. The ward had four bed rooms and shared common areas. Patients expected to be able to move about the ward freely and to have unrestricted access to their personal belongings. Ms Shannon's toiletries were usually kept locked in the office on the ward and were only given to her for use with the lids off. The evidence was that this policy was not universally applied, that Ms Shannon asked to borrow items from other patients and acquired items by stealth. The ward layout, sight lines and lighting did not facilitate the prevention of such behaviour.

[181] The successor to the Balcarres ward, the Craiglockhart ward, which opened in 2016, was designed to reduce the risks posed by patients who persistently self-harmed; patients have single ensuite rooms (where their belongings are stored) the fixtures and fittings are designed to reduce the scope for self-harm (anti-ligature design and limited

scope to conceal items), better lighting and clearer sight lines. These changes are to be welcomed and undoubtedly result in a safer ward environment for patients with a tendency to self-harm or attempt suicide. However, it is not known from the evidence given to the Inquiry, how Ms Shannon obtained the lid of the Dove deodorant can (Crown label 1) which she swallowed with the intention of asphyxiating herself on 4 April 2014. Accordingly, I am unable to conclude that the poor design of the Balcarres ward, as an environment to mitigate the risks posed by a patient who was persistently attempting suicide, did in fact cause or contribute to Ms Shannon's death.

[182] The nursing complement on the Balcarres ward was five staff on the early and late/back shifts and three on the night shift – a mixture of registered nurses and nursing assistants. Short staffing on the ward was a common occurrence in 2014. There was a high prevalence of patients self-harming and attempting suicide. There was contradictory evidence about whether more than one patient required constant observation on 4 April 2014. On that date, during the late/back shift, there were four nursing staff on the ward, two registered nurses and two nursing assistants to care for 20 acutely unwell patients. Two staff members, one registered nurse and one nursing assistant, were on a 30 minute break when the accident leading to Ms Shannon's death occurred. She was being observed by Ms Obafemi, a nursing assistant who had no formal qualifications, no insight into her psychopathology or adequate appreciation of the risks posed by her self-harming behaviour. The evidence was that Ms Shannon was opportunistic and that she was capable of hiding items with which she could self-harm and then waiting until a staff member who was less vigilant and less rigorous in

conducting observations was allocated to her for an opportunity to use them to arise. This was a known risk. It was also intended that a staff member tasked with constantly observing Ms Shannon should do so for an hour before switching duties with a colleague as the level of vigilance tended to wane after this period. However, short staffing on the ward meant that this did not always happen and the task of constant observation was often delegated to the most junior staff member on the ward as a standalone task and for longer periods of time at a stretch. The staff numbers on the ward on 4 April 2014 meant that the approach to patient care became one of containment rather than therapeutic care. The evidence was that Ms Obafemi's senior colleagues recognised that she sometimes lacked the requisite rigour and vigilance required when conducting Ms Shannon's constant observations. Training in that task, after completing a basic Learnpro online module, which was confined to basic knowledge of the three levels of observation, was delivered on the job. Supervision and training of junior staff would not have been possible with such low staff numbers where a policy of containment of patients was the focus on the ward.

[183] A system or work on the Balcarres ward which allowed two staff members, one registered nurse and one nursing assistant, to care for 20 acutely unwell patients, at least one of whom required constant observation and others who had a propensity to self-harm, was unsafe. Furthermore, in circumstances where the evidence clearly identified that Ms Obafemi, as an unqualified and inexperienced nursing assistant, who was known to lack the necessary skills of risk assessment and vigilant supervision and yet was tasked with observing Ms Shannon for a protracted period without adequate

supervision or guidance from a senior colleague, was clearly unsafe. Ms Shannon was aware of the opportunity that such a situation may offer and took advantage of it. This defect in the system of work on the Balcarres ward did in fact contribute to the circumstances of the accident which led to her death.

[184] This defect was recognised by NHS Lothian and staff/patient ratios were reviewed. In 2015 as senior charge nurse (band 7) and charge nurse (band 6) was allocated to each of the male and female wings on the ward. Early and late/back shifts are covered by a minimum of five staff, three registered nurses and two nursing assistants. When more than one patient requires constant observation, another staff member is allocated to the ward. In 2016 the Balcarres ward was closed and it was replaced by the Craiglockhart ward. Patient numbers were reduced to 16 without any reduction in nursing staff, further improving staff/patient ratios. It is unnecessary for me to make any recommendation regarding staffing levels on acute wards as the issues have been addressed by NHS Lothian.

[185] Ms Shannon's family submitted that the lack of access to clinical psychology assessment and treatment on the Balcarres ward (and indeed on all NHS Lothian acute wards) amounted to a defect in the system of work on the ward. The provision of sessions with the self-harm nurse and psychotherapy from Alyson Lumsden did not in any way provide Ms Shannon with the intensive, organised, regular and directed therapy that her condition required. Dr Macpherson's evidence was referred to in this context. It was submitted that there was a failure to set out a clearly defined care plan involving a robust multi-disciplinary approach. The evidence did not elucidate the

qualifications, experience, or nature of therapeutic interventions offered by Ms Pope or Ms Lumsden. Contact with them was intermittent, likely involved short term distress tolerance or grounding techniques and offered only brief respite from Ms Shannon's symptoms.

[186] Ms Shannon received 1:1 sessions with nursing staff. Latterly, these did not take place daily and were missed during busy periods on the ward or when the ward was short-staffed. Interaction with nursing staff was not always a positive experience. Some staff lacked understanding of and insight into Ms Shannon's condition and her behaviour, seeing her as difficult and challenging to care for.

[187] The fact that Ms Shannon's treatment was unduly focussed on medication, nursing care and lacked multi-disciplinary consideration and the lack of comprehensive psychological assessment and treatment were also submitted to be defects in the system of work on the ward.

[188] The Crown also highlighted this issue, submitting that the failure to provide a psychological assessment and therapy was a failure to provide the best evidenced care for Ms Shannon's acute mental health condition which contributed to her death.

[189] I accept the submission that the severity of Ms Shannon's condition, her symptoms and the chronicity of her condition clearly merited psychological assessment and treatment. The clinicians who gave expert evidence to the Inquiry all concurred that the most effective form of treatment for patients with EUPD is specialist clinical psychology treatment in the form of tailored therapies such as CBT, DBT, EMDR, Schema or Psychodynamic therapies delivered over a sustained period of time

(12-18 months). Trauma is often at the root of EUPD and therapy which examines the underlying cause may reduce the levels of the patient's anxiety and distress. She Shannon's treatment was suboptimal.

[190] NHS Lothian accepted that the Balcarres ward was ill equipped to treat long term patients who required psychological therapy as a mainstay of their treatment but submitted that this did not amount to a defect in the system of work as the ward was designed to assess and treat patients with an acute mental illness with a view to them beginning a recovery within hours or days of admission and return home (ordinarily after a period of 10 to 14 days). It was the least bad option for Ms Shannon. Staff followed clinically relevant treatment options and did their best when faced with an extremely challenging and difficult scenario.

[191] Having regard to all the evidence and submissions, I am unable to conclude that the lack of access to clinical psychology assessment and therapies did, in fact, contribute to Ms Shannon's death. Ms Shannon's illness was at the most serious end of the EUPD spectrum having manifested at an early stage, involving high levels of distress and impairment to her life and precluding her from study, employment or adult relationships. The expert evidence was that approximately 20-30% of patients with EUPD are responsive to psychological treatment to the extent that they become asymptomatic. Another (undefined) proportion of patients experience an amelioration of the symptoms. Sadly the remaining proportion, are unresponsive the treatment. Approximately 9-10% of patients with EUPD commit suicide.

[192] Whilst there was some cautious optimism that Ms Shannon's admission to Surehaven – a low secure ward with tailored clinical psychology treatment – might help her, it was difficult to gauge how she may respond. Ms Shannon herself was ambivalent about this treatment, saw it as a last resort and stated that if there was no change in how she felt, she would kill herself. She had engaged with and benefitted from clinical psychological treatment which explored the underlying trauma at the root of her EUPD when aged between 16 and 19 years but, as is apparent from her medical history, this had no lasting impact on her self-harming behaviour, the ongoing acute concern that she may take her life being noted in her medical records at the conclusion of that treatment.

[193] As it cannot be concluded that psychological assessment and therapy would have ameliorated Ms Shannon's symptoms to the extent that she would desist from attempting to take her life by swallowing items with the intention of asphyxiating herself, it equally cannot be concluded that the lack of clinical psychology resources on the Balcarres ward did in fact cause or contribute to her death. Accordingly, no finding falls to be made under section 26(2)(f). However, I will return to this issue under the heading of section 26(2)(g) of the 2016 Act.

[194] The Crown submitted that the substantial delay in obtaining authorisation for referral to Surehaven negatively impacted on Ms Shannon's mental health and contributed to the escalation of her suicide attempts, culminating in her completed suicide. This submission is under the heading of section 26(2)(f) in the Crown written submission, so it is inferred that this is submitted to have been a defect in the system of work on the ward, although that is not specifically stated.

[195] The Shannon family submitted that there were three specific failings in the out of area referral procedure – Dr MacIntyre's delay in make the application to the out of Area Referrals Group after Dr McConville's second opinion was received (accounting for the period of 18 September 2013 – 7 October 2013); Dr Kaydar erroneously insisting on a formal referral and assessment by the Rehabilitation service (accounting for the period of 8 October 2013 – 10 December 2013); and Dr Lefevre's failure to provide a letter of support for the referral until prompted to do so (accounting for the period of 10 December 2013 – 17 January 2014). It was submitted that these failings were defects in the system of work for making out of area referrals.

[196] It was further submitted that it would be open to the Inquiry to find that if the referral had been received and processed on 9 October 2013, that is likely that Ms Shannon would have been transferred to Surehaven in early January 2014. Had that been the case, she would have been removed from the environment and regime in the Balcarres ward and she would not have been in a position to take her life there on 4 April 2014. It was the view of the Shannon family that the evidence given to the Inquiry allowed the inference to be drawn that these delays contributed to Ms Shannon's death.

[197] NHS Lothian's accepted that the process for referring Ms Shannon to Surehaven took too long. It was submitted that there were avoidable delays in the process but that that these did not arise from any particular defect in the system for considering out of area referrals which was based on sound principles and fit for purpose. The system did not operate as it should in this case. It was also submitted that the evidence did not

provide a sufficient basis for a determination either that Ms Shannon's earlier admission to Surehaven would necessarily have been achieved but for the delays or that that delays in making the referral contributed to her death.

[198] I have set out my assessment of the evidence on this aspect of the Inquiry at paragraphs [140] to [151] of this determination. There were avoidable delays in the referral, in particular: the formal assessment by the Rehabilitation Service (the result of which was a foregone conclusion) and Dr Lefevre's failure to provide a letter of support for the application are significant. The avoidable delays could have accounted for a period of two to three months overall but it is difficult to conclude that this would have resulted in Ms Shannon's earlier admission to Surehaven since this involves speculation about the timeframe within which the Out of Area Referrals Group would have considered the application, the impact if any of the festive period on the timeline and the Surehaven waiting list. Whilst it is tempting to apply hindsight in asking whether Ms Shannon may be alive today had her earlier admission to Surehaven been secured, such a conclusion would be speculative. Failure to secure this treatment option for her earlier did result in her receiving suboptimal care. She may have responded positively to the treatment regime at Surehaven but this falls some way short of a conclusion that the failure to refer her to Surehaven earlier did in fact cause or contribute to her death.

[199] I accept NHS Lothian's submission that, whilst there were unacceptable and avoidable delays in making an Out of Area Referral for Ms Shannon, these occurred as the system did not operate as it should and not because of defects in the system itself.

[200] It is also appropriate to note under this heading that since 2014, the NHS Lothian system for making out of area referrals for mental health patients has changed significantly. Budget and responsibility have been moved to REH and membership of the Out of Area Referrals Group is drawn from there. There is a dedicated administrator. While the referral form requires clinicians to consider local alternatives, there is no mandatory requirement to secure an assessment by a specific service before an application can.

Section 26(2)(g): other facts relevant to the circumstances of the death

[201] The experts who gave evidence to the Inquiry concurred that Ms Shannon's care '*fell below what may be considered as optimal or appropriate'*. Professor Sashidharan was clear in his evidence that Ms Shannon's ambivalence about psychological therapy should not have been a barrier to treatment as '*even patients with high levels of disturbance and poor motivation to change may benefit from referral to psychological therapy and specialist services*'. The medication prescribed to Ms Shannon was to ameliorate some of her comorbid conditions and to attempt stabilise her mood. It did not and could not have treated the core psychopathology of her EUPD. The psychotherapeutic interventions and sessions with the self-harm nurse on the ward aimed to 'ground' her emotions, to increase her 'distress tolerance' and to encourage her to develop alternative coping strategies than self-harm as an outlet. These sessions and the 1:1 discussions with

nursing staff provided a confidential space for her to express her feelings. However, the evidence was that any elevation in her mood which resulted was temporary.

[202] The evidence about clinical research on treatment of patients with EUPD was fairly stark. It bears repeating in this context. Only 20-30% of patients respond to clinical psychology treatment to the extent that they are asymptomatic. A further (undefined) percentage experience an amelioration in their symptoms to the extent that their condition does not significantly impair their lives. It cannot be known whether Ms Shannon would have responded well to treatment to the extent that she could have been discharged from hospital and treated in the community. Dr Timney was of the view that she may have done. Ms Shannon herself encapsulated what even a modest improvement in her symptoms may have meant for her when discussing her condition during the assessment undertaken by Dr Jackson, consultant clinical psychologist in February 2014: *'if the voices were no longer there then I would still want to die but the urge to act on this would not be so strong'*. The specialist psychological therapies recognised as appropriate forms of treatment for EUPD were not experimental or unusual. Clinical psychology treatment was the recognised clinical pathway for effective treatment of EUPD. Professor Sashidharan commented that a patient with any other type of clinical need would not have been treated in this way. Ms Shannon was 30 years old when she died. She was willing to engage in psychological therapy, to move away from her family and community for a period of time in order to be admitted to an unknown clinic for this purpose and whilst ambivalent about the prospects of success and understandably apprehensive, she was cautiously optimistic and hopeful. She should

not have spent over a year on the Balcarres ward without receiving the specialist clinical psychology treatment which her condition required.

[203] Psychological therapy for patients with EUPD is delivered by consultant clinical psychologists, trained to a doctoral level with specific training in delivering therapies which have a specific theoretical base in a particular order. There are a number of different therapies: DBT, CBR, EMDR, Schema and Psychodynamic therapies which are tailored to the particular patient but may also be dependent on which modalities the clinical psychologist has been trained in. Those undertaking this work have specialised clinical supervision.

[204] In 2014, these clinical psychology treatments were not available in any NHS inpatient ward in Scotland. In 2020 that remains the situation. Dr Timney's evidence was that the availability of psychologists to inpatient wards is variable throughout Scotland. Many wards do have access to clinical psychology resources but these are generally used for assessments of patients, recommendations for treatment post-discharge and assisting nursing staff to understand patients with complex presentations and challenging behaviour. The successor to the Balcarres ward, the Craiglockhart ward, has a dedicated clinical psychology resource of 18.75 hours a week. That psychologist conducts assessments, attends MDT meetings, supports nursing staff with care of patients and offers reflective practice sessions to staff. Whilst some 1:1 patient therapy can be offered, this would be unlikely to involve the type of specialist therapies required to treat the core psychopathology of EUPD. Clinical psychologists attached to an acute wards would be unlikely to have the requisite specialism to undertake such

treatment. Acute wards treat patients with crisis presentations who have a number of mental health conditions including schizophrenia, drug induced psychosis, bipolar affective disorder and severe depression and personality disorders. The purpose of admission is to manage the immediate risk, assess the patient in an inpatient setting, stabilise their condition and decide on the best means of future treatment, ordinarily in the community. Average admission is 10 to 14 days. The whole ethos of acute wards is not designed for long term care and therapy. Psychological treatment of patients with EUPD is ordinarily delivered over a 12-18 month period.

[205] Dr Watson's evidence was that the Out of Area referral Group could now 'buy in' private psychology services from the private sector to treat patients on acute wards. This was not developed but the evidence given to the Inquiry did not instil confidence either that this was a readily available resource or that it would be practicable to source and deliver specialist psychological treatment for patients with EUPD on acute wards in NHS Lothian. The challenges in recruiting and retaining consultant clinical psychologists to acute wards give further rise for concern. It is beyond the scope of this Inquiry to explore the issues underlying the difficulty in securing adequate clinical psychology support for acute wards but this is clearly a concern which NHS Lothian will require to address.

[206] Specialist clinical psychology treatment of patients with EUPD is more commonly delivered in a community setting over a period of 12 to 18 months. The waiting list for this service is over a year long. Patients as acutely unwell as Ms Shannon cannot be safely managed in a community setting. The alternative option both in

2013/14 and in 2020 is a referral to one of two private clinics in Scotland, The Priory in Ayr or Surehaven in Drumchapel. The evidence was that these clinics have also had difficulty in retaining appropriately qualified clinical psychologists who have the expertise to treat patients with EUPD. Surehaven now has a waiting list of over a year. Dr Tomlinson and Dr Watson both explained the challenges in treating patients by way of an out of area placement in a private clinic – both for patient, who is isolated from their family, and for NHS Lothian in oversight of the placement and ensuring that the objectives of the referral are met. The evidence given to the Inquiry regarding the success of such placements was not persuasive -paragraphs [138]-[139]. The cost of a place at Surehaven is approximately £180,000 per annum. NHS Lothian places approximately 24 mental health patients out of area annually at a total cost of around £5.5m. Many of these patients require both inpatient care and specialist clinical psychology treatment. Many of them suffer from EUPD. The Priory and Surehaven are both 'low secure' services. Low secure wards provide a higher level of patient safety and are typically used for patients with violent behaviour or those who repeatedly self-harm or attempt suicide. The evidence did not clearly define what a low secure environment entailed.There are no such wards in NHS Lothian. Low secure wards are designed to minimise the opportunities for self- harm, to facilitate the observation of patients and to provide care in a more intensive setting with dedicated staff and higher staff/patient ratio. Such wards are also designed to accommodate longer admission periods and to deliver higher level clinical psychology interventions.

[207] Optimal treatment for Ms Shannon would have involved delivery of specialist clinical psychology treatment on a low secure ward. This would equally apply to many patients at the severe end of the EUPD spectrum. Patients with EUPD are 8.3 times more likely to commit suicide than the general population. Between 9% and 10% of patients with EUPD take their own lives. Patients with EUPD account for a substantial proportion of those admitted to acute psychiatric wards. They also account for a substantial proportion of the £5.5m annual budget which NHS Lothian currently spends on out of area private placements.

[208] The Shannon family submitted that the Inquiry should consider making recommendations that there should be a review of the available capital funding for a new low secure facility at the REH and that there should be a review of the provision of appropriately qualified clinical psychology resources for staff and patients on acute mental health wards at the REH. NHS Lothian submitted that the evidence provided to the Inquiry was that Phase 2 of REH Redevelopment Project aims to provide a range of specialist services which are currently only available out of area. It is intended that there will be a dedicated low secure ward for female patients in 2024/5 which will obviate the need for out of area referral of patients. Accordingly, it was submitted that the Inquiry should decline to make a recommendation requiring NHS Lothian to carry out a review of capital funding as this would be of no benefit. There is a clear policy intention to proceed with the project subject to consideration of public finance policy involving decisions at a government level.

[209] The evidence given to the Inquiry explained some of the benefits of low secure wards. This was not developed and lacked clarity. Low secure wards are designed with patient safety in mind (no ligature points, single ensuite rooms, good lighting and clear sightlines). However, many of these features were also said to be present in more modern acute wards at the REH such as the Craiglockhart ward. Whilst a purpose built low secure ward may provide a good environment to safely treat patients with a propensity to self- harm or attempt suicide, the evidence did not support the conclusion that the physical environment of low secure wards was the only viable alternative to treating such patients out of area in private clinics. The submission that recommendations involving considerations of public finance and decision-making at a governmental level are beyond the scope of this Inquiry is well founded.

[210] However, it is relevant to record that in 2013/14 and at the current date, NHS Lothian have no service to treat patients who require adult inpatient psychiatric care other than by way of admission to acute wards which are designed to assess, stabilise and discharge patients over a 10 to 14 day period. Such wards, by their nature, do not provide an environment where patients with serious, chronic conditions may receive specialist clinical psychology treatment to address their core psychopathology. Even where a clinical psychology resource can be maintained on acute wards, it is very unlikely that such treatment would be delivered. Acute wards are also not designed to provide the safe, therapeutic and intensive care environment or staffing ratios which patients undergoing such treatment require. Accordingly, I recommend that NHS Lothian should ensure that the REH (or one of its associated services) is in a

position to offer adult psychiatric inpatient care for patients diagnosed with EUPD who require admission (beyond the average 10 to 14 day period of stabilisation and assessment which is offered on acute wards) in a safe, secure and therapeutic environment with access to the specialist clinical psychology treatments which are recognised as the appropriate clinical pathway for their condition.

[211] The reasons for the lack of availability of appropriately qualified clinical psychologists on acute mental health wards were not explored in the evidence. This is clearly a challenge for the NHS throughout Scotland. I am not persuaded that making a recommendation that NHS Lothian should undertake a review of the provision of appropriately qualified clinical psychology resources for staff and patients on acute wards is appropriate. This is a necessary requirement to treat patients on acute wards which has been recognised and is being addressed.

[212] The need for clinical psychology resources on acute wards to provide, *inter alia* training and clinical supervision/reflective practice for nursing staff was identified in the Crown submissions with reference to the findings of the Adverse Event Review (Crown production 22). On behalf the Shannon family, it was submitted that the Inquiry should make a recommendation that NHS Lothian should be required to carry out a programme of training for nursing assistants in relation to the conduct of observations, with particular emphasis on the importance of therapeutic engagement.

[213] This issue has and will come to the fore following the issue of the 2019 Clinical Observation Guidance issued by Healthcare Improvement Scotland in January 2019; 'From Observation to Intervention – A proactive, responsive and personalised care and

treatment framework for acutely unwell people in mental health care' (Shannon family production 19/3) ("The 2019 Guidance"). This is the remaining area which I consider to be relevant to the circumstances of Ms Shannon's death in terms of section 26(2)(g), as I have recommended that the introduction of this guidance might realistically prevent other deaths in similar circumstances.

[214] The opening paragraph of the introduction to the 2019 guidance acknowledges that there have been instances of patient suicide whilst those patients were subject to constant observation in NHS inpatient adult psychiatric wards. There have been such deaths in NHS Lothian wards. The evidence given to the Inquiry regarding this aspect is set out at paragraph [104] of this determination. A proportion of patients will, whilst under constant observation, manage to commit suicide but this number can be reduced, the risks can be mitigated and other such deaths might realistically be avoided.

[215] An outline of the 2019 guidance is set out at paragraphs [124]-[127] of this determination. The guidance envisages clinical teams on inpatient wards having access to the expertise of clinical psychologists to assess patients, with such assessments incorporating a psychological formulation, treatment and safety plan. The 2019 guidance also refers to 'higher level' psychological interventions which, it is inferred, could only be delivered by a consultant clinical psychologist. NHS Lothian acute wards now have a clinical psychology resource. This will require to be adequately and reliably available in order for the 2019 guidance to implemented and adhered to. The evidence identified challenges for NHS Lothian in meeting this requirement.

[216] The Adverse Event Review (Crown production 22) identified that that there was no common understanding of the source of Ms Shannon's self-harming behaviour, causing differences of opinion and understanding in her management, that engagement with her was variable and that his did not provide the uniformity of approach that her care required. The lack of a framework and opportunities to support the clinical team to reflect upon their care and treatment of Ms Shannon and to provide support for nursing staff when caring for complex patients was identified as a key issue.

[217] The 2019 guidance addresses these concerns and recommends that observation is carried out by experienced staff who are knowledgeable about the effect of trauma and who have the skills to build positive, trusting relationships with patients and to deliver effective care and treatment interventions. Observation of patients should be 'purposeful' with clearly defined therapeutic interventions tailored to the patient's clinical needs. These skilled therapeutic interventions require to be delivered by staff with 'appropriate seniority, training and capability'. The importance of clinical supervision or reflective practice is also identified.

[218] Healthcare Improvement Scotland recognise

> '*the need for some degree of education and training, as well as consideration* of *workforce planning and duty of care in the lead up to full implementation of the guidance'*.

There are no specific recommendations about what this should entail. The guidance states that it

> '*supports and challenges mental health care professionals to reframe traditional assumptions about observation practice and work towards a framework of proactive, responsive, personalised care and treatment with the patient at the centre*'.

There was no evidence to the Inquiry about what would be involved in introducing this very significant change to ward culture and what training will be required to ensure that nursing staff, particularly nursing assistants, become be well-placed to implement this guidance. There was no exploration of the specific nature of the various therapeutic interventions referred to in the guidance and the qualifications/training needed to deliver them. It is unclear whether training is to be delivered at a national or local level.

[219] The evidence given to the Inquiry was that NHS Lothian intend to implement the 2019 guidance but no specific date has been identified for its introduction. There was no evidence indicative of changes in ward culture and practice in relation to clinical observation of patients having taking place at the date of the Inquiry, of changed workforce planning/staffing on acute wards or of training programmes for nursing staff being planned or delivered - all of which would logically require to take place in order to introduce and implement the 2019 guidance.

[220] The challenges in recruiting and retaining adequate clinical psychology resources to deliver the high level therapeutic interventions and to train, support and clinically supervise nursing staff in delivering the lower level therapeutic interventions described in the 2019 guidance are likely to pose obstacles to its early introduction and effective implementation on NHS acute wards.

[221] Neither the nature of the evidence given to the Inquiry nor its scope make it appropriate to make recommendations with a view to micro-managing the steps which NHS Lothian will require to take to effectively implement the 2019 guidance. These matters are more properly considered by the relevant professionals in NHS Lothian.

However, I do recommend that NHS Lothian should fully implement the 2019 Guidance in all inpatient adult psychiatric wards as soon as is practicably possible. The evidence given to the Inquiry has led me to the conclusion that the introduction of this guidance is likely to mitigate the risk of patients with EUPD who persistently self-harm or attempt suicide taking their lives whilst under clinical observation and that this may avoid other deaths in similar circumstances in future.

Concluding remarks

[222] All appropriate steps were taken to treat Ms Shannon medically and to attempt to resuscitate her after the accident which sadly resulted in her death occurred. No submissions were made in relation to any criticism of the emergency response or medical treatment provided to Ms Shannon on the Balcarres ward, by ambulance staff or at Edinburgh Royal Infirmary on 4 April 2014. Accordingly, no findings are made in respect of this aspect of the evidence.

[223] I should like to thank the Crown, counsel and agents for NHS Lothian and the Shannon family. Throughout this lengthy Inquiry the standard of preparation, document management, constructive co-operation and professional courtesy was exceptionally high.

[224] Finally, I should like to express my sincere condolences to the Shannon family for the loss of Clare, a much loved sister and daughter and an emotionally intelligent, loving and insightful young woman who tragically died at the age of 30.