SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT DUNDEE

2020 FAI 32

DUN-B558-19

DETERMINATION

BY

SHERIFF LORNA A DRUMMOND QC

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

into the death of

SOPHIE ANNE PARKINSON

Dundee, 30 September 2020

The Sheriff, having considered the information presented at an inquiry on 10, 11, 12, 13, 14 and 20 August 2020 under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 finds and determines:

(1) That in respect of paragraph (a) of section 26(2), Miss Sophie Anne Parkinson (formerly Goring), born 2 June 2000, died on 1 March 2014 at 7.05am at 4 Tayview Drive, Liff, Dundee.

(2) That in respect of section 26(2), paragraph (c), the cause of death was suspension by the neck from dressing gown cord ligature (hanging).

(3) I have no findings to make under paragraphs (b) and (d).

(4) I make the following findings under paragraph (e) (precautions which (i) could reasonably have been taken, and (ii) had they been taken might realistically have resulted in the death being avoided):

(a) NHS Tayside Child & Adolescent Mental Health Services (CAMHS) using a structured risk assessment and accordingly correctly categorising Miss Parkinson's suicide risk;

(b) CAMHS implementation of a care plan which included a greater level of engagement with Miss Parkinson and consideration of a more intensive level of community care;

(c) CAMHS making a formal diagnosis of Miss Parkinson's psychiatric condition and assigning formal diagnostic labels;

(d) CAMHS' clinicians modifying their approach to patient confidentiality and accepting Miss Parkinson's drawings and paintings when presented by her family and school;

(e) CAMHS allowing Miss Parkinson's family greater input into Miss Parkinson's care and providing them greater advice and assistance;

(f) CAMHS offering Miss Parkinson and her family further family therapy to address her persistent difficulties with family conflict and attachment issues;

(g) CAMHS having more interaction with the High School of Dundee regarding Miss Parkinson's care;

(h) CAMHS referring Miss Parkinson's case to Dundee City Council Social Work Department in November 2013 and January 2014 for a social work assessment to be carried out regarding her and her family's needs.

(5) I make the following findings under paragraph (f) (any defects in any system of working which contributed to the death):

(i) CAMHS' systems for guiding the direction and oversight of a CAMHS' patient's care during September 2013 to February 2014 were confusing and inadequately explained to Miss Parkinson's family;

(ii) CAMHS' system of patient risk assessment and risk management was defective; and

(iii) CAMHS system of communicating and recording patient care with patients, their parents and third parties was defective.

(6) I make the following findings under section 26(1)(g) (any other facts which are relevant to the circumstances of the death):

(i) that Mrs Moss was supplied with insufficient advice regarding prescription of anti-depressants for Miss Parkinson;

(ii) CAMHS failed to keep full records, particularly recording of discussions between clinicians and of information showing an ongoing risk assessment was being carried out;

(iii) there was a failure to properly record and share the outcome of the Initial Referral Discussion Meeting on 26 September 2013.

RECOMMENDATIONS

(7) I make the following recommendations under section 26(1)(b) and (4) (the taking of reasonable precautions, the making of improvements to any system of working, the introduction of a system of working, the taking of any other steps, which might realistically prevent other deaths in similar circumstances):

(i) I recommend CAMHS provide written information to CAMHS patients and their carers explaining the organisational structure and role of clinicians within CAMHS;

(ii) I recommend that CAMHS investigate the viability of "safe space" beds as currently provided to CAMHS patients of the Lancashire and South Cumbria NHS Foundation Trust;

(iii) I recommend that CAMHS provide an out of hours contact number for CAMHS patients so that patients and their carers know how to contact CAMHS' out of hours.

NOTE

Introduction

[1] This is a discretionary pubic inquiry into the death of Miss Sophie Anne Parkinson in terms of section 4 of the 2016 Act since the Lord Advocate considered it occurred in circumstances giving rise to serious public concern and decided that it was in the public interest for an inquiry to be held into the circumstances of her death. The

purpose of the inquiry was to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances.

The participants and their representatives at the inquiry

[2] The Procurator Fiscal issued notice of the inquiry on 8 August 2019, five years and five months after Miss Parkinson's death. That is a significant delay and is regrettable. Preliminary hearings took place at Dundee Sheriff Court on several dates before the inquiry was initially fixed for five days starting 23 March 2020. However, due to the Covid-19 pandemic, the inquiry was postponed and held on 10 to 14 and 20 August 2020 instead. Mr Quither, Procurator Fiscal Depute, appeared for the Crown. Mr Adams, counsel, appeared on behalf of Miss Parkinson's mother, Mrs Ruth Moss, Mr Pugh, counsel, appeared for Tayside Health Board and Mr Anderson, counsel, for the High School of Dundee.

The witnesses

[3] The parties co-operated and worked closely together to agree a lot of evidence in a substantial joint minute of agreement (Production 3 of Joint Bundle prepared by Tayside Health Board), a chronology of events (Production 4 of that Joint Bundle) and a joint note of issues (Production 5 of that Joint Bundle). Most of the witnesses' evidence in chief was by way of their witness statements, significantly reducing the need for oral evidence at the inquiry. The witnesses were cross examined orally by the parties by video link. Evidence was led in this way from Mrs Moss, Mr Stephen Thomson

Psychotherapist, Dr Caroline Smith, Clinical Psychologist, Dr Luke McQuitty, Consultant Psychiatrist, Ms Lynette Bastianelli, Head of Nursing in respect of the Child & Adolescent Mental Health Services (CAMHS) Service, Tayside, Dr Gemma Watt, Consultant Child and Adolescent Psychiatrist and Dr John Graham, Consultant Psychiatrist. In addition, three independent experts, Dr John Marshall, Consultant Clinical & Forensic Psychologist, Dr Aileen Blower, Consultant Child & Adolescent Psychiatrist and Dr Mischa Mockett each prepared reports which are productions in the inquiry. They gave oral evidence in chief and cross examination concurrently by video link. They prepared a joint minute of agreement between the experts (Production 1 of the Joint Bundle) and a joint minute of disagreement between the experts (Production 2 of the Joint Bundle). The statements of Mrs Lise Hudson, then Deputy Rector at the High School of Dundee and Mrs Susan Williams, Guidance Teacher at the High School of Dundee, were agreed and not subject to any cross examination. Mr Quither read out the terms of the Joint Minute of Agreement.

The legal framework

[4] 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.

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 defects in any system of working which contributed to the death or any accident resulting in the death;
(g) any other facts, which are relevant to the circumstances of the death.

(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.

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. The standard of proof at any Inquiry under the Act is the civil standard of proof on the balance of probabilities."

Summary

[5] This summary is drawn from the parties' joint minute, the witnesses' statements and the oral evidence. Where there were discrepancies in the evidence, significant to my findings, I have addressed these when considering the issues before the inquiry. I narrate below the care that Miss Parkinson received from Tayside Health Board Child and Adolescent Mental Health Services ("CAMHS"), the involvement of Miss Parkinson's family and the High School of Dundee at the relevant times, as the focus of this inquiry is on the care and treatment provided to Miss Parkinson by CAMHS.

[6] Miss Sophie Parkinson, also known as Sophie Goring, was born on 2 June 2000. Her mother, Mrs Moss, married her father Simon Goring in 1996 and they had two children together. The marriage was a difficult one and ended at the end of 2001/beginning of 2002 when Miss Parkinson was nearly 2 years old. Both children continued to see their father but Miss Parkinson did not have a positive relationship with him. Mrs Moss felt he always seemed to favour Miss Parkinson's brother and Miss Parkinson craved her father's affections. When Mrs Moss married Mr Pat Parkinson in 2004, Miss Parkinson changed her name to Parkinson whereas her brother kept his name as Goring. That seemed to cause difficulties with Miss Parkinson's father who excluded her from activities with him thereafter. According to Mrs Moss, Miss Parkinson blamed herself for her father not wanting to see her. When her father moved to China in around 2006, Miss Parkinson tried to keep in contact with him but he did not reciprocate. Miss Parkinson was close to Mr Parkinson and viewed him as her father.

[7] In 2006, when Miss Parkinson was six years old, Miss Parkinson's primary school raised some concerns about her poor concentration and volatile personal relationships amongst peers. She had 28 sessions of non-directive play therapy with Insight counselling, a local counselling charity. At this stage Miss Parkinson wasn't showing signs of distress at home.

[8] In March 2008, when Miss Parkinson was seven years old, she was referred to Speech and Language Therapy Paediatric Services due to concerns about her social interaction skills. She was assessed as presenting with social interaction difficulties in association with generally low self-esteem but as not requiring further input from that service at that time. The Speech and Language Therapist recommended that Miss Parkinson be referred to CAMHS for further investigation.

[9] On 18 July 2008 Miss Parkinson was referred to CAMHS by her GP. She had a number of appointments with Dr Joy Olver, Consultant Psychiatrist, Dr Eve Wilson, Clinical Psychologist, and Mrs Hynes, Specialist Nurse. Mrs Moss was informed after one of these sessions that Miss Parkinson had stated that her father had hit her when she was younger and left marks on her. Mrs Moss thereafter would not let Miss Parkinson see her father alone. Her father reacted by rejecting her.

[10] On 1 May 2009, eight years old, Miss Parkinson was assessed by CAMHS in relation to her social functioning. In summary, Miss Parkinson did not display any particularly striking or inappropriate behaviours, although inattention appeared to be an issue. On 27 May 2009, CAMHS updated Miss Parkinson's GP on a number of issues, including Miss Parkinson's presenting concerns and the formulation and treatment plan.

That letter noted, inter alia, that overall it was felt that Miss Parkinson's difficulties were not indicative of any psychiatric disorder; however, she clearly demonstrated both emotional and attachment difficulties which impacted significantly on her social and educational functioning and which were likely to make her vulnerable to the development of difficulties in the future.

[11] Mrs Moss occasionally attended the sessions at CAMHS but Miss Parkinson also had sessions on her own. There was clear feedback from Dr Olver to Mrs Moss. CAMHS spoke to Miss Parkinson's head teacher and counsellor at school when making their assessment. It was concluded that Miss Parkinson would benefit from a referral to the Brief Therapy Clinic within CAMHS.

[12] On 19 June 2009, Miss Parkinson was recommended for discharge from NHS Tayside Speech and Language Therapy Paediatric Service for a second time. The Service noted that school staff could help Miss Parkinson put her knowledge of specific social skills into practice by continuing to include her in any social skills group which was being run, something which the Service could support throughout the academic year by advising school staff and suggesting materials for use within the group. It was further noted that at that time Miss Parkinson was receiving regular input from Child Psychology and Insight Counselling Services for emotional, social and behavioural difficulties. On 23 July 2009, Miss Parkinson was discharged from NHS Tayside Speech and Language Therapy Paediatric Service.

[13] Between September 2009 and October 2010, Miss Parkinson attended family therapy sessions with Mr Bill Ness, family therapist at CAMHS. Mrs Moss attended all

those appointments and sometimes Miss Parkinson's brother and Mr Parkinson would attend too. They discussed a variety of issues, including managing Miss Parkinson's tantrums, her low self-esteem and the rejection she had experienced from her father. Miss Parkinson formed a good relationship with Mr Ness and opened up to him. The family decided to take a break from these sessions because of difficulties in the marriage and also because Miss Parkinson seemed to be getting better, and they felt more able to cope on their own.

[14] At the beginning of 2011, Miss Parkinson was presenting with really difficult behaviour. Miss Parkinson developed early and by the age of ten had started to enter puberty. It seemed to Mrs Moss that the personal issues Miss Parkinson faced were being exacerbated and coming to the surface more. Mrs Moss separated from Mr Parkinson and Miss Parkinson took that badly. Because Miss Parkinson and her brother were not Mr Parkinson's biological children, he had minimal contact with them although he saw Miss Parkinson's brother since he was of an age to help Mr Parkinson at his place of work. This upset Miss Parkinson who saw this as further rejection and similar to her father favouring her brother over her. She seemed to take this inwardly, blaming herself and thinking that there was something wrong with her that made people reject her. There was a subsequent incident where Mr Parkinson hadn't recognised her after not having seen her for a while which had also upset her. In July 2011, Mrs Moss began a relationship with Mr Craig Moss, who she is married to now. He got on well with Miss Parkinson. However, Miss Parkinson's behaviour was a real

cause for concern, as she struggled with low self-esteem and was very angry and unpredictable at times.

[15] Miss Parkinson was referred back to CAMHS in 2011. However by then Mr Ness had retired and the family were assigned family therapist, Mr Stephen Thomson. Between September 2011 and March 2012 Miss Parkinson had four appointments with Mr Thomson. Miss Parkinson disengaged in the sessions with him and was not allocated to another family therapist. Miss Parkinson refused to re-attend after the fourth appointment, so the family stopped going for about six months in an attempt to try to manage things at home.

[16] In August 2012, Miss Parkinson started secondary school education at the High School of Dundee (HSD). HSD were not made aware by Longforgan Primary School or Miss Parkinson's parents when Miss Parkinson started school that she had any previous involvement with NHS Tayside Speech and Language Therapy Paediatric Service or CAMHS.

[17] On 3 September 2012, Mr Thomson wrote to Miss Parkinson's GP recording that Miss Parkinson had been discharged by CAMHS. That letter recorded that when Miss Parkinson and her mother Mrs Moss had attended CAMHS in March 2012, both had reported that Miss Parkinson had developed sustained friendships at school with peers which was a positive development.

[18] In May 2013 Miss Parkinson had made some marks on her arm by constantly rubbing her skin. This was the first time she had self-harmed. On 10 May 2013, Miss Parkinson and her mother attended her GP Dr Herrington, who decided to refer

Miss Parkinson back to CAMHS. In the referral letter dated 13 May 2013, Dr Herrington recorded that Miss Parkinson was doing well academically and was missing some days due to just wanting to stay in bed. She noted that Miss Parkinson "admits to feeling low in mood and wishing that she felt better" and "she denies any suicidal ideation but recently took to rubbing her skin vigorously until it bled and showed me several scars on her arm and hand from doing this." Dr Herrington encouraged Mrs Moss to speak to Miss Parkinson's guidance teacher at school, although Mrs Moss at that stage did not contact HSD in relation to the referral to CAMHS. Dr Herrington marked the referral as urgent. However, when the referral arrived at CAMHS, it was downgraded to "routine" on the basis that there were "no immediate clinical risks indicated to warrant an urgent appointment."

[19] On 6 June 2013, Specialist Nurse Lynette Bastianelli, from the CAMHS Emergency Response Team, assessed Miss Parkinson. On 11 June 2013, she wrote a letter recording that Miss Parkinson had reported that she liked school and was doing OK but wanted to move schools as she was not getting on with some people. She said she cried a lot and got very angry at home and at school. Nurse Bastianelli in summary did not feel that Miss Parkinson presented with a depressive illness and informed Mrs Moss of the same. She felt she was a very unhappy girl due to the relationship difficulties she had with her mother. She discussed referring the family to family therapy and had spoken to Mr Thomson to accept the referral. Nurse Bastianelli agreed to see Miss Parkinson and her mother again once they had spent time together to improve their relationship. By the time Miss Parkinson saw Nurse Bastianelli again on

21 June 2013, she had begun rubbing her arms with scissors. Mrs Moss later joined the session but the session was difficult due to the difficulties in the relationship between Miss Parkinson and her. It was agreed that further family work was required and they were referred back to Mr Thomson. Miss Parkinson received a leaflet telling her to paint on her wrists or ping an elastic band on her wrist instead of self-harming. HSD was not informed of the emergency referral made on 6 June 2013.

[20] In August and September 2013, Miss Parkinson's self-harming had increased to cutting and she began verbalising her suicidal thoughts. She was also displaying other very erratic behaviour and lying about where she was. She told her mother she was playing hockey after school and would leave the house in the morning and return home by bus after the practice with her hockey stick, putting her hockey kit in the laundry. However her mother was later informed by HSD that Miss Parkinson had never attended after school hockey. Miss Parkinson never told her mother where she went instead. Miss Parkinson also became very angry over the smallest things, resulting in her being very irrational and physically aggressive.

[21] On 29 August 2013 at 1445, a HSD Child Protection Concern Reporting Form was raised in relation to Miss Parkinson. The concern was initially raised by pupils who had observed scratches on Miss Parkinson's leg at the sports field and suspected these may have been caused by self-harming. The matter was referred to Mrs Hudson, the then Depute Rector. Mrs Hudson initiated child protection procedures. Mrs Williams, Guidance Teacher, spoke to Miss Parkinson that day about issues with her father when she was very upset. During the discussion Miss Parkinson informed Mrs Williams for

the first time that she had been receiving support from CAMHS. Miss Parkinson indicated to Mrs Williams a reluctance to engage with CAMHS. HSD followed the matter up with her parents, recording that they would monitor the situation and suggest appropriate support.

[22] In August and September 2013 the family attended appointments with Mr Thomson. At the start of September 2013 Mrs Moss discovered that Miss Parkinson had been Snapchatting males on her mobile phone and had met a 17 year old boy. Her mother saw Miss Parkinson had images of semi-naked men on her mobile phone. Miss Parkinson had been speaking to these men over the course of around six months and been pretending to be older than 13. She had created an entirely fake online persona for herself. Mrs Moss also discovered that she had been accessing violent pornography sites on her mobile phone. Mrs Moss was horrified and wanted to contact CAMHS for support. However, these discoveries occurred outside business hours and Mrs Moss had no information about how to contact CAMHS out of hours. Mrs Moss called out of hours social work and the police for help. The police attended and later removed all electronic equipment in the house for investigation. Miss Parkinson's phone was examined by the technical support unit. The images and messages included mentally disturbing images and pornography.

[23] On Tuesday 3 September 2013, Mrs Moss telephoned Mr Thomson to raise concerns about Miss Parkinson being in contact with older men and accessing violent pornography on her mobile. She also raised concerns about Miss Parkinson's low mood and suicidal thoughts. An appointment was arranged for 9 September 2013.

[24] Later that same date, Mrs Moss met with Mrs Williams. At the meeting, Mrs Moss expressed concern about the decline in Miss Parkinson's mental health. Mrs Moss also raised additional concerns, including in relation to Miss Parkinson's inappropriate telephone/internet use. Mrs Moss advised HSD that Miss Parkinson had been receiving counselling from CAMHS. She was very keen for the school to be involved in supporting Miss Parkinson. Mrs Williams suggested to Mrs Moss that Ms Sheena MacQueen, the school nurse, would be the suitable person to liaise with CAMHS and work on a co-ordinated NHS support plan. Following the meeting, Mrs Williams telephoned Ms MacQueen who agreed to contact CAMHS.

[25] On 9 September 2013, Miss Parkinson and her mother Mrs Moss attended a meeting with Mr Thomson at CAMHS. Mrs Moss again raised the issue of Miss Parkinson's inappropriate internet use. Mr Thomson records that Miss Parkinson stated that she felt particularly low after her mother had gone into HSD about her mobile phone use and felt like walking into traffic on the way home, although had no suicidal ideation at present. On the same day Mrs Hudson and Mrs Williams spoke to Miss Parkinson and discussed amongst other things the importance of Miss Parkinson working with CAMHS. Mrs Moss was updated as to the meeting.

[26] On 10 September 2013, Mrs Moss telephoned Mr Thomson at CAMHS concerning Miss Parkinson's contact with older men, viewing violent pornography and that the previous evening she had run away from home when the police and out of hours social work had been contacted. Mrs Moss was advised that Miss Parkinson's inappropriate internet use would be referred by the police to child protection

authorities. The police were retaining Miss Parkinson's phone for evidence of this and her contact with older men. On this call, Mrs Moss asked Mr Thomson if Miss Parkinson had been assessed yet given her history of low mood and threats of self-harm. Mrs Moss recalls that she asked for the name of Miss Parkinson's consultant but was told that she didn't have one as she hadn't been clinically assessed yet. Mrs Moss advised that Miss Parkinson was self-harming, had been accessing inappropriate material on her phone and had written down very dark violent feelings which Mrs Moss had shown to police also. Mr Thomson explained he would discuss these concerns with colleagues and arranged an appointment for 16 September.

[27] Mr and Mrs Moss had a meeting with Mr Thomson on 16 September 2013 when Mrs Moss reported that she did not think Miss Parkinson was being open about the longstanding nature and severity of her low mood and suicidal ideation. It was decided that Miss Parkinson should be re-assessed by CAMHS medical staff and an individual worker identified for her.

[28] On 26 September 2013, an Initial Referral Discussion ("IRD") meeting took place to discuss Miss Parkinson and in particular her inappropriate internet use. That multi-disciplinary meeting was attended by representatives from Tayside Police, NHS Tayside (Mr Thomson), Dundee City Council and HSD (Mrs Williams and Ms MacQueen). Mrs Williams advised the meeting in detail concerning her counselling of Miss Parkinson during 2012-13 school year concerning family matters as well as more recent issues concerning self-harm and internet misuse. The meeting noted that Miss Parkinson was being assessed by a psychiatrist that day. The police took the

decision not to interview Miss Parkinson at that time as that would not be helpful in relation to the work then ongoing with CAMHS. CAMHS did not make Mrs Moss aware of the multi-disciplinary meeting and she was not invited to attend although the police had informed her that such a meeting would be usual procedure.

[29] Around the end of September and beginning of October and in November 2013, Miss Parkinson made two suicide attempts. On the first occasion, she tried to jump out of a moving car and on the second occasion, she drank from a bottle of vodka and took paracetamol. On the first occasion, she had been really happy but when the conversation went away from her, she quickly became angry and distressed after which she tried to jump out of a moving car. Mrs Moss took six weeks off work to look after her daughter around October time as she was concerned about her deteriorating mental health.

[30] Miss Parkinson met with Dr Luke McQuitty, trainee consultant psychiatrist, on 26 September 2013 for an initial referral discussion. Her mother attended with her but Miss Parkinson did not want her to go in to the appointment so she waited in the waiting room. Dr McQuitty recorded that Miss Parkinson reports her mood has been "very, very low just now." He also recorded that she has felt like this since at least late spring, early summer and her mood has been consistently low. He noted that there is evidence of anergia (abnormal lack of energy) going on for at least 2 months, that her sleeping pattern is poor and there has been a history more recently of deliberate self-harm. He recorded that Miss Parkinson has increasing frequency and intensity of suicidal ideation and claims she has had suicidal thoughts from the age of nine or ten

but that in the last few weeks these have become more frequent and intense. She last had these thoughts in mid-August 2013 when she thought about throwing herself in front of a car. He found significant evidence of low mood, anergia, anhedonia (inability to feel pleasure) and biological features of depression. He was keen that she continued follow up with psychological services in the first instance. He prescribed her Fluoxetine 20mg in order that she could maintain her level of function and lift her mood.

Dr McQuitty recorded that her mother is aware of this plan and is in support. The letter was copied to Mr Thomson. According to Mrs Moss, the prescription was handed to her in the waiting room where other patients were present. There was no discussion with her about what the medication was for or what the side effects might be. There was no written information except the leaflet inside the box which didn't mention children.

[31] On 8 October 2013, CAMHS wrote to Miss Parkinson's General Practitioner. The letter recorded that Miss Parkinson felt tired when at school and was facing a difficult time at school in her interactions with other young people. Mrs Williams was not aware of these specific difficulties. Miss Parkinson did not attend an appointment with Mr Thomson on 10 October 2013 and he arranged for her to see Dr Caroline Smith, trainee consultant psychologist.

[32] Mrs Moss called Mr Thomson on 15 October 2013 as she was becoming more and more concerned about Miss Parkinson. Her self-harming had increased and there were cuts from her knees upwards. Her mood continued to be very low. Miss Parkinson and Mrs Moss attended an appointment with Mr Thomson on 18 October 2013.

Mr Thomson recorded that Miss Parkinson was reluctant to talk about her mood but

was interested in individual work with Dr Smith. She had been reluctant to talk about her self-harm other than to say that the distractions given to her by the self-harm team didn't work but Mr Thomson recorded it is hoped she would be able to open up a bit more about her mood and self-harm issues at individual sessions with Dr Smith.

[33] In October 2013, the police informed Mrs Moss that they wouldn't be pursuing matters any further and that they weren't going to speak to Miss Parkinson for fear of compromising her mental health further. No feedback was provided to Mrs Moss about this by CAMHS.

[34] In October and November, Mrs Hudson and Mrs Williams met with Mrs Moss. They had serious concerns about Miss Parkinson's mental state. She had been expressing suicidal thoughts to her RE teacher, Mr Goodey, visiting the school nurse regarding her self-harm and threatening to harm herself and run out of school. HSD were very supportive towards Miss Parkinson and organised weekly meetings for her with Mrs Williams where she could talk about her feelings.

[35] On 31 October 2013, Mrs Moss met with Mrs Hudson and Mrs Williams to discuss the range of support that was in place for Miss Parkinson. On 5 November 2013, Mrs Williams spoke with Miss Parkinson. Miss Parkinson appeared animated and agitated, although chatty and open. She showed Mrs Williams artwork on a suicidal theme which caused Mrs Williams concern. It was noted that Miss Parkinson had an appointment with her psychiatrist the following day and her counsellor the following week. Mrs Williams encouraged Miss Parkinson to be forthcoming with them. She agreed to see Miss Parkinson again the following week. Mrs Williams also raised her

concern about the artwork with Mrs Hudson and it was agreed that HSD should meet with Mrs Moss as soon as possible.

[36] On 6 November 2013 Miss Parkinson had an initial assessment appointment with Dr Smith and Dr Eve Wilson. In the notes, it is recorded that Mrs Moss attended for the first five minutes. Mrs Moss doesn't recall being given any feedback after this appointment. The notes record that Miss Parkinson felt her Fluoxetine prescription had helped lift her mood and felt less need to self-harm over the last few weeks. She described how she had felt suicidal two to three weeks previously and had tried to self-harm. This had been triggered by an argument with her mother for which she blamed herself. Previously she had self-harmed after an argument with her brother. Dr Smith recorded Miss Parkinson as having cared for her wounds each time and using art and writing as alternatives to self-harm. She planned to meet her again on 18 November 2013.

[37] On 11 November 2013 Miss Parkinson had another appointment with Dr McQuitty. Dr McQuitty noted "a paradoxical slight increase in deliberate self-harm and thoughts of suicide although again there is no obvious planning or preparation associated with this and these feelings and thoughts tend to be short lived". He also recorded less evidence of anergia and anhedonia. Dr McQuitty noted that staff at HSD had become concerned about Miss Parkinson's low mood, deliberate self-harm, suicidal thoughts and decreasing ability at school. It was further noted that Miss Parkinson had suffered what appeared to have been a panic attack at school the previous week and that on that occasion and others her RE teacher had been a very supportive point of contact

for her. Dr McQuitty had agreed, with Miss Parkinson's agreement, to write a short letter to HSD regarding Miss Parkinson's case. Dr McQuitty was pleased that HSD were keen to be involved in Miss Parkinson's care. Dr McQuitty recorded that he took the opportunity to speak to Mrs Moss alone who had reported Miss Parkinson was not cutting herself as much. According to Mrs Moss, the conversation with Dr McQuitty was a fleeting one held in the waiting room. The next scheduled appointment with Dr McQuitty was Friday 13 December 2013.

[38] On 12 November 2013 Miss Parkinson had gone to school without telling her mother that she had self-harmed. Miss Parkinson requested a bandage for her arm from a HSD school nurse. Her arm was injured due to apparent self-harm. Mrs Williams was aware of general staff concern about Miss Parkinson who had spoken to a number of staff members she felt she could trust. Miss Parkinson had been reporting suicidal ideation and HSD felt it necessary to supervise Miss Parkinson until Mrs Moss was able to collect her from school. When Mrs Moss attended at the school, she met with Mrs Hudson. Mrs Hudson expressed the view that it was becoming increasingly difficult to manage Miss Parkinson in school and that her mood swings suggested the need for urgent medical and psychological support. Mrs Moss expressed concern about, as she saw it, a lack of assistance from CAMHS. Mrs Hudson discussed what HSD could do to assist. Mrs Moss agreed to provide the relevant contact details for CAMHS in order that HSD could contact CAMHS directly. Mrs Moss indicated that she would contact CAMHS the following day and that Miss Parkinson would not be in school that day. Mrs Moss later that day sent an email to Mrs Hudson and Mrs Williams thanking

them for their care and help to date and providing them with details of those within CAMHS then providing care to Miss Parkinson. Mrs Moss indicated that she intended to contact CAMHS on 13 November 2013 to seek an emergency appointment.

[39] On 13 November 2013 at 0900 Mrs Moss left a telephone message with CAMHS. Again, Mrs Moss relayed her concern about Miss Parkinson arising from the previous day. At 1045 that same day, she spoke to CAMHS by telephone relaying the same concerns. She was concerned about Miss Parkinson's safety following the incident at school the previous day. Mrs Moss explained that she wished Miss Parkinson to be assessed for in-patient admission. She was concerned what would happen if Miss Parkinson's mood worsened and she was alone. Dr Smith records in her notes that she discussed the situation with her supervisor Dr Wilson and Dr Graham, consultant psychiatrist. She noted that it did not seem that Miss Parkinson's risk level was high enough to warrant in-patient admission but further assessment was needed. She agreed to meet with Miss Parkinson that day and noted Dr Graham would be available by telephone should she be concerned about risks after meeting Miss Parkinson.

[40] Miss Parkinson and Mrs Moss attended the meeting with Dr Smith on 13 November 2013. At this appointment, Dr Smith and Miss Parkinson drew up a safety plan together. Dr Smith recorded in her notes that the safety plan included strategies for Miss Parkinson to use if she noticed her mood deteriorating, signs for mum and Miss Parkinson to look out for when things are worsening and who Miss Parkinson and her mother could speak to if things deteriorated further. She recorded that Miss Parkinson and her mother agreed to try to follow the plan until the next

appointment on Monday 18 November, although Mrs Moss disputes that she was in fact present when the plan was discussed. It was agreed that CAMHS would contact HSD to see how CAMHS could support HSD to help Miss Parkinson within school hours.

[41] On 13 November 2013, Mrs Hudson wrote to CAMHS concerning Miss Parkinson. The letter was sent by email also. Mrs Hudson expressed her concerns about Miss Parkinson's mental wellbeing. She reported Miss Parkinson's recent suicidal ideation and self-harm. She was worried about recent and more erratic behaviour and interactions which led the school to have serious concerns about Miss Parkinson's state of mind. Mrs Hudson was of the view that Miss Parkinson and Mrs Moss required additional support. Mrs Hudson offered to discuss Miss Parkinson more fully with CAMHS and hoped to do so as soon as possible. An offer to meet was made. On 13 November 2013, HSD received a brief response from CAMHS (Dr McQuitty) stating that he would like the chance to discuss the case with his supervisor and Mrs Hudson and would get back to her with further information.

[42] On 14 November 2013, Dr McQuitty wrote to Miss Parkinson's GP summarising his meeting with Miss Parkinson on 11 September 2013 and his undertaking to write to HSD. Dr McQuitty also responded to HSD on 14 November 2013 noting that he was pleased that HSD were taking an active interest in Miss Parkinson's case and that CAMHS case manager Mr Thomson had agreed to liaise with the school to provide support and advice for staff as needed regarding her difficulties. However, the letter was never received by HSD.

[43] On 15 November 2013 Dr McQuitty sent an email to HSD, which in error referred to "Mrs Parkinson" rather than Miss Parkinson. CAMHS expressed the view that a core group meeting with mental health professionals for further formulation of Miss Parkinson's case was essential. On 15 November 2013, Mrs Hudson replied by email indicating that HSD would be more than happy to attend a core group meeting if that would be appropriate.

[44] On 18 November 2013 at 1530, Miss Parkinson attended another appointment with Dr Smith. Miss Parkinson reported finding school stressful. She had gone to the school nurse that day to have her cut treated as it was infected. Miss Parkinson reported attending and enjoying extra-curricular activities at school. In the notes Dr Smith recorded that Mrs Moss was present for the final 25 minutes. This accords with Mrs Moss's recollection that she attended the latter part of the meeting. It is also recorded that Miss Parkinson asked to leave shortly after her mother joined and came back in for the last five minutes but did not appear comfortable talking with her mother present. Dr Smith recorded that the safety plan was discussed at this meeting. Mrs Moss does not recall that. Mrs Moss felt she had reached breaking point. Miss Parkinson's behaviour had been very erratic and difficult, with threats of suicide and declarations that she no longer wanted to live. After the appointment, the discussion about in-patient care took place in the waiting room. Mrs Moss explained that she felt she couldn't keep Miss Parkinson safe anymore but Dr Smith had replied that Miss Parkinson was not ill enough to warrant an admission and that beds were very limited. She said that if admitted she would only be checked on every 15 minutes as a

suicide watch anyway. Mrs Moss tried to establish the process for allocating in-patient beds without success. Dr Smith recorded that she planned to discuss Miss Parkinson's case with Dr McQuitty and Mr Thomson and to contact the school too.

[45] On 21 November 2013 Mrs Moss and her father attended an appointment with Mr Thomson. This meeting was requested by Mrs Moss because she was finding it very difficult to get feedback from CAMHS. Mrs Moss asked her father to come up from Cumbria to attend the meeting as support. She asked Mr Thomson for an update on whether Miss Parkinson had made any progress in terms of her mood and treatment, etc. He explained that he would pass on this request to her doctor, but Mrs Moss wasn't clear if that happened. Mrs Moss's impression was that Mr Thomson did not know much about Miss Parkinson's psychiatric or psychological care. There wasn't a sense of joint working amongst those involved in Miss Parkinson's care. She also requested advice on how to manage situations of conflict after which Miss Parkinson would go to her room and self-harm. She told Mr Thomson about her concerns regarding Miss Parkinson's suicidal thoughts, suicide attempts and risky behaviour. They discussed how she could best support Miss Parkinson at that time. As is recorded in the notes, he suggested maintaining routines and consistency at home, avoiding conflict and trying to remain calm as well as seeking opportunities to nurture Miss Parkinson and boost her self-esteem. These were not new ideas to Mrs Moss. She tried to implement the ideas which would work for short periods of time but Miss Parkinson would have an extreme reaction to very small episodes of conflict and she didn't feel that Mr Thomson was taking what she reported seriously.

[46] On 26 November 2013 Miss Parkinson saw Dr Smith again. Mrs Moss did not attend that appointment. They discussed relationships, thoughts of self-harm and distraction techniques. Dr Smith recorded that she suggested that it would be helpful for Mrs Moss to be in the room but Miss Parkinson had not wanted that. Dr Smith recorded that she told Miss Parkinson she would leave it to Miss Parkinson to feedback relevant information about the session to her mother but would revisit that at the next appointment.

[47] The next appointment with Dr Smith was 3 December 2013, which Mrs Moss did not attend. In the notes it is recorded that Miss Parkinson shared that she was having suicidal thoughts, such as wanting to jump off a building, and a bad dream. She had flashbacks and felt overwhelmed at school. She had attended at the school nurse shaking, talking to herself and having suicidal thoughts. She dug her nails into her arm which helped as did speaking to the nurse. Dr Smith set a plan for Miss Parkinson to complete an activity diary recording events, moods and anxiety. Miss Parkinson had said she wasn't sure she could fill it all in, so they agreed the focus would be on what she was finding difficult. Miss Parkinson was to think about how progress would be fed back to her mother and to discuss further next time. Mrs Moss wasn't informed about the diary or the suicidal thoughts.

[48] On 13 December 2013 Miss Parkinson had an appointment with Dr McQuitty who recorded that Miss Parkinson reported arguments with her brother and feeling unwanted, abandoned and rejected. She reported a sudden onset of suicidal thoughts at this stage. He recorded she did seem to report longstanding thoughts of not wanting to

be alive but these seem fairly mild and usually with no obvious associated planning or preparation. He also noted that Miss Parkinson often thought about the effect her death would have on those around her and believed many people would find life easier if she was dead. He described these intense thoughts as tending to be short lived although a general ambivalence to life persisted.

[49] Miss Parkinson reported her suicide attempt when following an argument with her brother she impulsively took four paracetamol tablets and drank half a bottle of vodka. Dr McQuitty stated that Miss Parkinson had advised him that she thought that was a lethal dose of paracetamol but he suspected that was not the case. They discussed how her difficult thoughts were waxing and waning and often precipitated in the short term by social stressors. They discussed coping mechanisms for her to deal with her suicidal thoughts, particularly writing and distraction techniques. Overall Dr McQuitty thought Miss Parkinson had made some improvements and that her mother had also reported Miss Parkinson had been doing better since being on medication. He felt there were improvements to make in light of the intense nature of her suicidal thoughts and increased the dose of Fluoxetine to 40mg. Mrs Moss was unaware of Miss Parkinson having these thoughts at this time.

[50] On 18 December 2013, Miss Parkinson had another appointment with Dr Smith. Mrs Moss did not attend. Miss Parkinson discussed her relationship with her father, having been scared of him and being hit by him. When he left for China when she was seven years old, he left without saying goodbye. She had blamed herself then missed him until she started to think it was his loss. She told Dr Smith she did not want to

attend a planned review meeting. They reviewed the safety plan to use over the Christmas period. Dr Smith recorded that Miss Parkinson had to leave to meet friends but Dr Smith spoke to her mother for 15 minutes after the session. She recorded that Mrs Moss had reported that Miss Parkinson had seemed more emotionally stable on a day to day basis but she was concerned about certain risky behaviour, latching on to Mr Goodey and about boundaries.

[51] Mrs Moss described Christmas as being a really difficult time because Miss Parkinson's father came back from China and Miss Parkinson met up with him in a coffee shop. He never contacted her again and spent considerably more time with her brother instead. Mrs Moss thought this had really escalated Miss Parkinson's depression at this time. At New Year, the family had a small house party and Miss Parkinson invited some of her friends to it. During the evening, one of Miss Parkinson's friends came downstairs very distressed to tell Mrs Moss that Miss Parkinson was threatening to jump out of the window and kill herself. Miss Parkinson denied she was doing this. A short while later, Miss Parkinson left the house with a boy without saying where she was going. Mrs Moss searched for her and found her in the village with two young males who were strangers along with the boy from the party. She denied that she had been smoking but the boy confirmed that she had been. On discussing this with Miss Parkinson the next day she had become very angry. Mr and Mrs Moss decided that with Miss Parkinson being so volatile it would be a mistake to take her on a planned skiing holiday. Miss Parkinson took that very badly and saw it as a punishment, becoming very hostile and angrier. That was how she later

described it to CAMHS but there was never any discussion with Mrs Moss about the decision and the reasons for it.

[52] On 8 January 2014, Mrs Williams spoke with Miss Parkinson who found her to be monosyllabic, fidgety and not wanting to talk much. Miss Parkinson reported incidents over the Christmas holidays including self-harming. Miss Parkinson reported that she was still talking to CAMHS and had an appointment scheduled for 13 or 14 January 2014, which was helping a bit. Mrs Williams agreed to meet up with Miss Parkinson again early the following week.

[53] On 14 January 2014 at 0910, Mrs Moss telephoned Dr Smith to report concerns about Miss Parkinson's behaviour over the holidays, particularly her moods and self-harm. Miss Parkinson had refused to go to school that day. She had asked her mother what would happen if she cut her radial artery. Mrs Moss didn't know what to do about Miss Parkinson's behaviour. She asked Dr Smith if Miss Parkinson had depression. Dr Smith stated that this may be one of the symptoms, along with anxiety and self-harm, but that the root difficulty with Miss Parkinson appeared to relate to insecurities in her attachments. Mrs Moss was confused by the discussion. Miss Parkinson had been on anti-depressant medication for a while, and she couldn't understand why there seemed to be disagreement over whether or not she was depressed. Dr Smith had said this could be discussed at the multi-disciplinary meeting on 16 January 2014.

[54] Dr Smith then telephoned Miss Parkinson who reported that she had been arguing with her mother a lot and her mood was awful. They discussed coping strategies. They agreed Dr Smith would call her mother to tell her the agreed coping

strategies. The records show that Dr Smith telephoned Mrs Moss at 11am and informed her of the strategies Miss Parkinson had agreed to and that Mrs Moss was supportive of allowing her to use these strategies.

[55] A case review meeting took place on 16 January 2014. Dr McQuitty, Mr Thomson, Dr Smith, Mrs Williams and Mrs Moss attended. Miss Parkinson was not present as she had been unwilling to attend. They discussed Miss Parkinson's mood and how she was getting on from the point of view of school, home and with CAMHS. It was reported that Miss Parkinson's mood was very low that week with a recent increase in deliberate self-harm. Mrs Williams advised that that Miss Parkinson was managing surprisingly well academically, and was generally popular with school friends. It is recorded in the minutes of the meeting that Mrs Williams discussed the dark, expressive paintings which Miss Parkinson had shown her, that had themes of blood, suicide, death, physical injury, guilt and anger. Advice was given to avoid discussing the prevalent themes with Miss Parkinson and advise her to liaise with the mental health professionals. Further updates were provided from medical and psychology perspectives, as well as from Mrs Moss. Amongst the outcomes from the meeting that are recorded in the minutes (Crown Production 2, p163) are that it is "Important to remain in open communication with school, mental health worker and family. Some information seems to be lost or distorted when passed directly through Miss Parkinson." A further meeting was organised for 13 March 2014 to discuss Miss Parkinson's progress.

[56] Although Mrs Moss attended that meeting, she wasn't clear what the aims of the meeting were or what the agreed outcomes were when she left. She did not receive any minutes of the meeting). She had asked at the meeting about respite options for the family and was told that the option didn't exist. The minutes recorded that request and noted as an outcome "This can again be discussed with Mr Thomson, although no obvious answer was found at this point". Mrs Moss reported that there was no suggestion from the clinicians that Miss Parkinson's illness was severe or that she was at a high risk of suicide. Mrs Moss found this surprising given that she ticked all the high-risk boxes in Tayside's multi-agency suicide prevention guidance at the time. There was no change in Miss Parkinson's treatment following this meeting.

[57] On 20 January 2014 at 0930 Miss Parkinson attended an appointment with Dr Smith. They discussed the outcome of the review meeting held on 16 January 2014. They discussed her mood and an argument with her mother. They began initial steps of chain analysis whereby Miss Parkinson could begin to identify the point in an argument when she was sure she was going to self-harm and to try to break the chain. They also spoke about school. Miss Parkinson felt Mrs Williams was overly-protective and overly-worried when they spoke. Miss Parkinson stated that she no longer spoke to teachers at all because her mother said she might get kicked out of school. They discussed self-harm strategies and weekly logs.

[58] Later that same date, Mrs Williams met Miss Parkinson to discuss with her the meeting of 16 January 2014. Miss Parkinson was noted as being fairly open and there was discussion about Miss Parkinson taking "timeout" for ten minutes in a specific

room if felt necessary. Miss Parkinson reported that she was still self-harming, but less so than two weeks earlier.

[59] On 27 January 2014, Dr Smith recorded that Mrs Moss had called and indicated that things remained difficult at home. They discussed the possibility of Mrs Moss meeting with Mr Thomson and agreed to send her an appointment.

[60] At Miss Parkinson's meeting with Dr Smith that same day, they discussed her relationship with her mother. They discussed the role of attachment and fear of rejection with Miss Parkinson. She asked Miss Parkinson to continue to complete weekly diaries and gave her the Beck Youth Inventory, a mental health questionnaire, to complete at home and bring to the next appointment.

[61] Mrs Moss was not present at the appointments on 20 and 27 January 2014 and did not receive any feedback from them. Mrs Moss stated that January was a particularly difficult month when Miss Parkinson was particularly volatile and Mrs Moss thought her self-harm had increased.

[62] On 31 January 2014, Miss Parkinson had an appointment with Dr McQuitty. The record of this appointment is retrospective, dated 11 March 2014 as the original dictation was misplaced and accidentally destroyed. Within the letter Dr McQuitty narrated an incident with Miss Parkinson and a man on a bus who had given her a film that she liked to watch. He described Miss Parkinson as presenting somewhat brighter, had found techniques on reducing self-harm to be useful and had no suicidal ideation at the time of review. He described her compliance with Fluoxetine as patchy and that she has experienced little benefit from it. Although it had initially seemed to produce some

improvement in function this had not led to a significant improvement in her mood. He therefore decided to reduce Miss Parkinson's prescription for Fluoxetine over the next week and she was then to begin a course of Sertraline. Mrs Moss stated that she was handed the prescription in the waiting room, with no discussion about Sertraline's potential side effects. She wasn't provided with any information about Sertraline and any increased risks that this might pose.

[63] In early February the family watched Miss Parkinson in a play and had a great time. Miss Parkinson was happy but when they started talking about another actor in the play it was like a switch had been flicked and she turned into being angry and depressed.

[64] On 10 February 2014, Mrs Moss had an appointment with Mr Thomson and Miss Parkinson had an appointment with Dr Smith. Mr Thomson recorded Mrs Moss stating that she was struggling with Miss Parkinson. He invited Mrs Moss to think about Miss Parkinson's experience of rejections from parental figures and her sense of self and self-worth. Mrs Moss expressed deep concerns to Mr Thomson about Miss Parkinson's suicidal thinking at this meeting. She asked what the plan of care for Miss Parkinson was and what her actual diagnosis was, as well as mentioning other mental health disorders. Mrs Moss found Mr Thomson to be very vague about Miss Parkinson's diagnosis suggesting it could be a number of things, including borderline personality disorder. He said that CAMHS used a "formulation" approach instead of giving formal diagnoses. Mrs Moss didn't have any understanding of this

approach and it wasn't explained to her. She was still unclear of Miss Parkinson's diagnosis, in spite of her being on anti-depressant medication.

[65] Mrs Moss recalled that at this meeting Mr Thomson challenged her approach to Miss Parkinson's internet usage suggesting she was overly strict. Mrs Moss could not understand his reaction given that Miss Parkinson had previously been engaged in risky behaviour online. Mrs Moss also recalled that Mr Thomson appeared to underestimate how difficult things were at home for the family. Miss Parkinson was unpredictable and volatile. She had times when she could be physically aggressive and would run away and break things but she didn't feel that was acknowledged. Rather than focus on how the family could support Miss Parkinson, she felt he was focussed on what she was doing wrong as a parent. Mrs Moss felt that meant that the risk of Miss Parkinson's suicidal behaviour wasn't properly acknowledged by him.

[66] At Miss Parkinson's appointment with Dr Smith that day, she reported difficulties with friends at school concerning money, which she had raised with her guidance teacher. Dr Smith noted that she had been keeping mood records on her iPad but that she had lost these when the iPad had been reset. She discussed formulation and asked Miss Parkinson to think further about improving her communication with the people in her life. They agreed to discuss emotion regulation next time and to keep mood records.

[67] The next appointments were on Monday 24 February when Miss Parkinson saw Dr Smith on her own and Mr and Mrs Moss saw Mr Thomson. Mr Thomson's note of the meeting with Mr and Mrs Moss records that he discussed the couple's parenting of

Miss Parkinson from an attachment perspective, stressing the need for structure, consistency and nurturing. He agreed to provide more information in respect of attachment ideas and how Mrs Moss in particular might implement this. He fixed another appointment for 17 March 2014.

[68] The notes of Miss Parkinson's appointment with Dr Smith record that she had been keeping a diary over the weekend and discussed methods of how to relax. It was noted that she initially had suicidal thoughts but weighed up the pros and cons which helped. Those suicidal thoughts included considering death by overdose or hanging. They discussed self-harm and ways to break the chain that lead to self-harm. None of this information was communicated to Mrs Moss.

[69] On one occasion towards the end of February 2014 Mrs Moss observed that Miss Parkinson had drawn a picture of a noose on a mirror in her bedroom and had written the words "WHY NOT?" beside it. Her mother reassured her she should not think this way and the image was then erased, with no more being said and no apparent cause for further concern about it.

[70] On 28 February 2014 as 1215, Ms Douglas (HSD Teacher) raised a Child Protection Concern about Miss Parkinson. The report concerned what appeared to be deliberate self-harm marks on Miss Parkinson's left arm. Mrs Williams called Mrs Moss to advise and also spoke with Miss Parkinson. Miss Parkinson appeared happy and indicated she was looking forward to a date with a boy the forthcoming weekend. Mrs Williams saw no indication of the tragedy which was shortly to occur and invited Miss Parkinson to update her after the weekend as to how her date had gone. Later on

the same day, Miss Parkinson attended a Spanish language class. Mrs Williams checked-up on Miss Parkinson with the Spanish class teacher and all appeared fine. In the circumstances, Mrs Williams did not consider any further action to be necessary. When she received the call from Mrs Williams, Mrs Moss was in hospital for medical treatment, which had caused her some discomfort. When she returned home, she saw Miss Parkinson outside in the garden but shortly thereafter Miss Parkinson came into the house, leaving dirty footprints on the kitchen floor, which had been cleaned earlier that day. When asked by her mother to clean the floor, Miss Parkinson refused. An argument between them ensued, which Miss Parkinson brought to an end by shutting herself in her bedroom.

[71] Due to the discomfort she was in, Mrs Moss went to bed at about 6pm but about an hour later Miss Parkinson came to her room and asked to speak to her, to which her mother told her she was needing to rest for the moment and would speak to her later. Miss Parkinson then returned to her own bedroom. Mrs Moss attended at Miss Parkinson's bedroom door on a couple of other occasions later that evening but found the door closed to her and no sound or sign of movement emanating from the room. She accordingly believed Miss Parkinson to be asleep and considered it appropriate to make no further enquiries. She then retired for the night.

[72] About 0138 on Saturday 1 March 2014, a neighbour of Miss Parkinson was in bed at home when she was woken by what sounded like a voice coming from the approximate direction of Miss Parkinson's home. This was followed by what sounded like a softer, quieter voice but the neighbour concerned was unable to identify whether

the voice was male or female. She looked outside to check but saw nothing untoward and then went back to bed.

[73] About 0630 on Saturday 1 March 2014, a different neighbour observed a bedroom light on at Miss Parkinson's home and, upon looking more closely, observed that a bedroom window was open and that "something" was hanging out of the window. Upon checking the position further with the assistance of binoculars, the neighbour was able to confirm that this was a person (later identified as Miss Parkinson), suspended by a ligature from her bedroom window. Other neighbours were alerted to the situation and emergency services were contacted and attended shortly thereafter, just before 0700, when they went to the front door of the property and were admitted entry by Mrs Moss. The deceased's identity was then confirmed, as was her condition as being incompatible with life, which was subsequently pronounced extinct at 0705 by Isobell Morgan Blake, Scottish Ambulance Service Team Leader Technician. This was subsequently confirmed by Dr Alfaram Kunwar. Accordingly, on Saturday 1 March 2014, Miss Parkinson died.

[74] Scenes of Crime Officers thereafter attended and photographed the deceased and the locus and, with assistance from the Scottish Fire and Rescue Service, the deceased was lowered to the ground. At about 0845 a Police Scotland Forensic Medical Examiner examined the deceased and confirmed neck injuries consistent with said ligature, as well as other further injuries consistent with self-harming but which were not suspicious. A search of the deceased's bedroom was then carried out in the course of which police

officers recovered apparent suicide notes and a pair of scissors with apparent blood staining.

[75] A post mortem examination took place on 3 March 2014 and found the cause of death to be:--1a: Suspension by the Neck from Dressing Gown Cord Ligature (Hanging) (Crown Production 4 (p736). Associated Toxicology analysis of post-mortem blood and urine samples for alcohol, acidic and basic drugs and drugs of abuse found only a therapeutic concentration of (antidepressant) Sertraline in the blood of the deceased, all other analyses being negative.

[76] Intimation of the death of the deceased was provided to the Procurator Fiscal at Dundee by the Registrar for Dundee on 5 March 2014.

Response to Miss Parkinson's death

[77] HSD was informed of Miss Parkinson's death at 1630 on 1 March 2014. HSD implemented its Critical Incident Response procedure, in terms of which immediate support was offered to the family of the late Miss Parkinson, as well as school staff affected by the tragedy. In the day and weeks following Miss Parkinson's death, HSD provided extensive support to its staff and pupils affected by the tragedy. On 5 March 2014, Mrs Hudson contacted Dr Smith to discuss the review meeting previously scheduled for 13 March 2014 and agreed that this should still go ahead as a chance to discuss what had happened. Mrs Hudson undertook to keep Mrs Moss updated on this.

[78] On 18 March 2014, an Initial Case Review Panel of Dundee City Council Child Care and Protection Committee met. It involved senior professionals from Miss

Parkinson's school, police, social work and CAMHS. The meeting concluded that each agency should conduct its own initial case review and meet again together to consider its findings. The meeting chair arranged to feed back to Mrs Moss the following week.

[79] Within weeks of Miss Parkinson's death, CAMHS completed a local incident review to identify the root causes and key learning from the care and treatment of Miss Parkinson (Crown Production 7 p. 801). They concluded that a better system of communication across all agencies involved in care was required. They recommended various actions including a protocol for handling and logging email to and from CAMHS; possibly risk assessments becoming standardised; development of a CAMHS website including contact and referral information; review of the CAMHS Information Leaflet for service users; Out of Hours guidance; consideration of a generic email account, review of the organisational chart, and to work to identify outcome tools to allow comparison with other services. In addition, they recommended that the core worker role and accountability should be clarified and phone calls of condolence as standard practice.

[80] A Significant Clinical Event Analysis (SCEA) Review was recommended and completed by NHS Tayside on 9 October 2014 (Crown Production 8). By then progress was being made on the actions from the local incident review. Its recommendations included a system for Complex Case Reviews, introduction of a mandatory data set and audit of record keeping; staff update on Getting it Right For Every Child (GIRFEC), contact details out of hours for CAMHS; introducing a standardised process for accessing and recording risk.

[81] NHS Tayside published a follow up Review in March 2015 (Crown Production 10). It recommended allocation of a responsible clinician for every complex case, review of the system for recording telephone calls and discussions, review processes for obtaining consent from a child for the family to share information from home with clinicians (materials such as drawings, video recordings); development of processes to ensure formal notes of all meetings; review care planning process and associated documentation to ensure good communication; review risk assessment, formulation and management planning, ensuring identified risks were explicit in care planning process and ensuring awareness of CAMHS staff in GIRFEC approach and associated multi-agency processes.

[82] In February 2015 and July 2015, Dundee Child Care and Protection Committee published a Significant Case Review report (Crown Productions 9 and 11). It examined practice by all agencies involved with Miss Parkinson's care. It recommended that CAMHS provide an update on progress in the action plan from the SCEA to the Committee and to Mrs Moss. It also recommended that all services share and record information and decisions relating to the care of a young person.

[83] During 2014 and 2015, HSD engaged with Dundee City Council Child Care and Protection Committee. The Report by Dundee City Council Child Care and Protection Committee's Significant Case Review dated July 2015, recorded that following the death of Miss Parkinson, HSD had developed an action plan to put in place improvements in the areas of transitions and transfer of pupil information, access to relevant services, staff training, parental engagement, personal and social education and the embedding of

national policies and statutory obligations; a number of actions remained in progress at that time. Since 2015, HSD has continued to improve and refine its practices and procedures.

[84] In 2018 an Independent Inquiry into Mental Health Services in Tayside was commissioned by NHS Tayside to "inquire into the accessibility, safety, quality and standards of care provided by all Mental Health Services in Tayside", including "those delivered as part of the Child & Adolescent Mental Health Services (CAMHS)" and "where necessary make recommendations for improvements, regardless of cost". After consideration of evidence ingathered as a result of *inter alia* a public call for evidence, the Inquiry published its Interim Report in May 2019, Paragraph 4.1.7 of which (p. 1064) confirmed consideration of services provided by CAMHS to be part of a "Key Theme" of the Inquiry, namely Patient Access to Mental Health Services (p. 1062). The Inquiry's Final Report was published in February 2020 (Crown Production 26). Part 6 of it specifically addresses CAMHS, with its Summary and Recommendations relative to CAMHS being contained on pages 79 and 80.

Issues for the Inquiry and parties' submissions

[85] The circumstances mentioned at section 26(2)(a) to (d) are agreed in the joint minute. I therefore make formal findings about those as set out above.

[86] The parties set out in a joint note the issues in dispute at the inquiry (number 57 of process). I deal with each in turn below. They each submitted written submissions

and I heard supplementary oral submissions on 20 August 2020. I refer to the parties' submissions under each of the issues below.

[87] Before doing so I record in general terms what I made of the witnesses I saw and heard at the inquiry. I find all the witnesses who gave evidence to the inquiry to be credible and reliable. I formed the view they were doing their very best to help the inquiry and to tell the truth. There were some differences in the evidence. Where these are significant to my findings I identify below whose evidence I prefer on that particular point and the reasons for that. However, in general I was very impressed by the way Mrs Moss gave her evidence which was straightforward, coherent, clear and substantiated by other evidence I heard. In general I accept Mr Adams' submission that the evidence of Mrs Moss about her involvement in appointments should be preferred to that of the other witnesses. Mrs Moss gave a vivid and consistent account of events that have played a very significant part in her life. The clinicians also impressed me in the manner that they gave their evidence. However, their recall of events, after the passage of over six years, and having consulted many hundreds of patients over the period, was much less clear and not always clarified by their notes which were inevitably a brief summary of discussions that had taken place. It was submitted by Tayside Health Board that Mrs Moss was prone to making broad assertions not backed up by the records. I do not agree: while there may have been one or two occasions where broad statements were made these were isolated and on the whole her evidence was very controlled and well supported. Where there is a significant conflict in the evidence

which is critical to my findings, I explain why I prefer that particular piece of evidence below.

[88] I found the three experts who gave evidence to the inquiry: Drs Blower, Marshall and Mockett to be of great assistance and I am very grateful to them for agreeing various matters and for clarifying what remained in dispute between them all as set out in the joint minutes. They gave their evidence concurrently which had many advantages, not least that they were able to respond to each other's points of view and make clear what remained in dispute and the reasons for that. They are all eminent and highly respected experts in their field and I had no difficulty in accepting their expertise. In particular, Drs Blower and Marshall have significant experience of CAMHS and NHS Scotland. Dr Mockett practices in NHS England and has no experience of NHS Scotland practices. Because of that I found his evidence at times to be less relevant than the others.

Reasonable precautions:

(a) Preparation of a structured risk assessment and categorisation of suicide risk accordingly

[89] I was invited by Mrs Moss to make a finding that (i) the carrying out of a structured risk assessment and (ii) correctly categorising Miss Parkinson's level of risk of suicide were precautions that might reasonably have been taken, and, had they been taken, might realistically have prevented her death from occurring. The Crown sought no findings as to reasonable precautions. Tayside Health Board accepted that a

structured risk assessment had not been carried out and that was something that the Board had recognised in its internal reviews. It was submitted that the clinicians had assessed risk as part of their assessment and treatment and continued to do so throughout the period of care. All of the clinicians felt they had a good grip on Miss Parkinson's risk. Over the period of Miss Parkinson's care she showed signs of improvement which indicated that she was responding to treatment.

[90] Mrs Moss described her daughter as being loving, kind, sensitive and very intelligent, way above her years. Unfortunately towards the end of her life, her daughter became very difficult to manage. She was often angry, becoming angry at the flick of a switch and impulsive. She lied to her mother and others. Mrs Moss was constantly having to manage the conflict within the family. Occasionally Miss Parkinson would tell her mother her true thoughts and Mrs Moss would be able to comfort her, but more and more Miss Parkinson hid behind a mask and did not share her thoughts. Although Mrs Moss recognised that many teenagers hide things from their parents and push boundaries, Miss Parkinson went over the score. She made up an entirely fictitious life for herself contacting older men on line, accessing violent pornography and running away from home. She displayed extreme behaviour with physical tantrums and hitting and kicking which was unsustainable in the house. She self-harmed, attempted suicide and had persistent thoughts of dying. Mrs Moss considered Miss Parkinson's behaviour to be very risky and was concerned that Miss Parkinson did not seem to have any filter or recognition of the risks that she was

subjecting herself to. She was of the view that the clinicians were not taking Miss Parkinson's risks seriously and did not properly assess the suicide risk she posed.

[91] The evidence from Dr McQuitty, Dr Smith, Nurse Bastianelli and Mr Thomson was that they were all assessing risk of self-harm and suicide when they consulted with Miss Parkinson. They all agreed that no formal or structured risk assessment had been carried out and no risk assessment tool used. However, assessments of risk were undertaken and included in the notes at each contact. Mr Thomson explained that because Miss Parkinson was not engaging with him in family therapy, he was unable to carry out a formal risk assessment. Dr McQuitty was of the view that assessing risk was an important part of care management and something he was continuously engaged in at every appointment with Miss Parkinson. Both Drs Smith and McQuitty felt they had a good grasp of Miss Parkinson's risk factors and that no more would have been gained by any formal assessment.

[92] The clinicians described Miss Parkinson's risk of suicide in different ways. Dr Smith was of the view that, with reference to the Tayside Multi-Agency Guidance from 2012 (Mrs Moss Production 11), Miss Parkinson presented as a moderate risk of suicide, although in November 2013 to January 2014 she was closer to the top of that range and in February 2014 closer to the bottom. Dr Smith described Miss Parkinson's behaviours as being common when compared to other CAMHS patients of the same age and gender. Dr McQuitty and Mr Thomson broadly shared Dr Smith's view. Dr McQuitty took the view that by the end of January when he last saw Miss Parkinson she was responding to Fluoxetine, though sub-optimally and was improving.

[93] Dr Smith and Dr McQuitty acknowledged that Miss Parkinson was often likely to react impulsively to distressing situations, such as arguments with family members, by engaging in acts of self-harm, presenting suicidal ideation or attempting suicide. Miss Parkinson's reactions to conflict situations were excessive and linked to her mental health and attachment issues. They accepted that such impulsive behaviour was unpredictable and risky in and of itself. They also accepted that it could be difficult to manage at home. They agreed that at no time did Miss Parkinson present a high risk of suicide. That was supported by Dr Mockett. He was of the view that Miss Parkinson's risk profile was fairly typical of a CAMHS patient. Although he believed her impulsivity was a significant factor, he opined that her suicide risk category was not high at any time.

[94] However, Dr Graham, consultant psychiatrist, accepted that there were times when Miss Parkinson presented as at high risk of suicide and her behaviour was in keeping with that. Drs Blower and Marshall agreed with him. The physical self-harm wasn't high but there was pervasive suicidal thinking which was concerning. One example of a period when she was at elevated risk was in November 2013 when both Mrs Moss and the school had been particularly concerned about Miss Parkinson's mental health. Although both Drs Marshall and Blower agreed that some elements of risk assessment had been carried out then, they both agreed that it could have been more comprehensive and did not comprise a full risk assessment. Dr Marshall viewed Miss Parkinson's risk as consistently high because of her impulsivity. He took the view

that there was no single person making an overall assessment of Miss Parkinson's risk of suicide which was a necessary step in managing her care.

[95] Drs Blower, Marshall and Mockett agreed that the clinicians were assessing risk of suicide and self-harm at appointments and that is documented in the records they kept. However all three agreed that it was important to have a structured risk assessment in place. Risk factors are complex and dynamic. One key factor is the frequency of the patient's thinking about suicide and how captured and dominant the thinking is. Dr Marshall felt there was little flavour of that from the clinicians' notes. Another feature is the balance of hope and hopelessness over time which he also felt was lacking. Dr Blower agreed explaining that presentations of suicidal thinking and self-harm are extremely common in most patient appointments. Based on findings in individual sessions, it would have been difficult for clinicians to identify any particular time when risk was acutely increased. The risk is that a clinician is swayed in the moment, becomes impressed with patient interaction in the session and a change in hope and hopelessness. There is a risk of becoming subjective when the session is perceived to have been well controlled when actually the facts written down are that things are the same or arguably worse. A structured assessment helps clinicians anchor their judgments more objectively and put them in the overall context. Whilst the clinicians had assessed risk at appointments with Miss Parkinson, a structured risk assessment would have given more of a detailed overview and have included, for example, an overview of how often the patient is thinking of dying and what the triggers are, and a view on what the likelihood would be. The priority should have been

to carry out a structured risk assessment if not by Mr Thomson then by another clinician. All agreed that if the child is not willing to engage that should not be an end of it, as information can be gathered from other clinicians or sources.

[96] Tayside Health Board accept that the risk assessment undertaken on Miss Parkinson was unstructured. This is something recognised in their internal review and which resulted in the risk assessment Standard Operating Procedures being put in place. CAMHS have now revised their procedures to include use of a structured risk assessment. It is recognised that one of the benefits of a structured risk assessment is that it is standardised and likely to be more accessible to a multi-disciplinary team.

[97] Agreeing with the experts, in my view it was important to have carried out a standardised risk assessment to reduce subjectivity and have a continuing overall assessment of risk. That structured risk assessment could have been completed and discussed amongst the team treating Miss Parkinson from an early stage. It would have been reasonable for that to begin when Miss Parkinson presented to Mr Thomson. Where she was not engaging, Mr Thomson could have considered asking another clinician to carry out the assessment. A structured risk assessment that had been discussed amongst the clinicians would have documented the various risks Miss Parkinson presented over her period of care, categorised them and allowed for a better understanding of her mental health, how it was progressing and how it should be managed. Unstructured or subjective views of risk are inadequate means of assessing risk when compared to structured assessments, since unstructured assessments can rely too much on the patient’s account rather than basing judgments on a comprehensive

assessment including information from third parties. A structured risk assessment would have been a reasonable precaution to take to ensure that risks were being objectively and consistently assessed.

[98] One of the difficulties of not having had a structured risk assessment is that the clinicians did not have an overview from all clinicians' perspective in a single document to help assess suicide risk. The fact that there are differing views amongst the clinicians of Miss Parkinson's risk of suicide demonstrates it is a complex matter. However all the witnesses agreed that there were times she presented at a higher risk than others, although that is not something which is recorded in the notes. I prefer the evidence of Dr Graham, as the more senior treating Psychiatrist, supported by Drs Blower and Marshall that objectively Miss Parkinson did present at times as at high risk of suicide. Had a structured risk assessment been carried out, that is something that would have been recorded and formed part of an overview of Miss Parkinson's risk assessment and management.

[99] I conclude from the experts' evidence that a structured risk assessment would have given a more accurate and comprehensive picture of risk over time. It would have provided a more objective assessment in the context of overall care provided including a correct assessment of her suicide risk. It was a reasonable precaution therefore to have completed one. I address below whether it might have realistically avoided Miss Parkinson's death.

(b) ***CAMHS implementation of a care plan which included a greater level of engagement with Miss Parkinson and in-patient treatment or a more intensive level of community care***

[100] I was invited by Mrs Moss to make a finding that had the treating clinicians considered and implemented a care plan which included a greater level of engagement with Miss Parkinson with more intensive treatments related to her high level of suicide risk, her death might realistically have been avoided. It was accepted that in-patient treatment may not have been appropriate for Miss Parkinson at the time but it was submitted that more intensive care should have been provided, specifically on Miss Parkinson's presentation on 13 November 2013 and 16 January 2014. The Crown submitted that in-patient treatment was not warranted and there didn't seem to be any need to escalate Miss Parkinson's care to this extent. Tayside Health Board also submitted that in-patient treatment was not warranted. Miss Parkinson was never referred for more intensive treatment as it was never felt she required that level of input. Miss Parkinson was being seen weekly or more frequently when it was felt that was needed, and it was unclear what the more intensive treatment would have achieved.

[101] The clinicians explained that the care plan for Miss Parkinson included a continual risk assessment of her risk of suicide and self-harm as well as safety plans identifying indicators of stress and strategies to help Miss Parkinson manage her mental health. Dr Smith first prepared the safety plan at the appointment on 13 November 2013 which was reviewed at subsequent appointments with Miss Parkinson. Dr Smith recorded in her notes that the safety plan included strategies for Miss Parkinson to use if

she notices her mood deteriorating, signs for Miss Parkinson and her mother to look out for when things are worsening and who Miss Parkinson and her mother can speak to if things deteriorate further. A further plan was prepared on 18 December 2020 which Dr Smith explained was a revision to the earlier plan.

[102] Dr Smith described how she fully considered the need for in-patient care in November 2013 when Mrs Moss telephoned and requested that. In-patient care must be approved by a consultant psychiatrist and she therefore referred to Dr Graham, consultant psychiatrist, for advice. As a result of those discussions the decision was taken that Miss Parkinson's risk level was not high enough to warrant in-patient admission but that further assessment was needed. Dr Smith agreed to meet with Miss Parkinson that day and noted Dr Graham would be available by telephone should she be concerned about risks after meeting Miss Parkinson. Having met Miss Parkinson later that day, Dr Smith concluded that in-patient admission was not warranted.

[103] The experts and other clinicians all agreed with Dr Smith that in-patient care was not warranted in Miss Parkinson's circumstances. All described the pros and cons of in-patient admission. It is a decision that needs to be carefully considered particularly for young people where there is a risk that they may copy behaviour of other patients (referred to as contagion behaviour).

[104] However, Dr Graham explained a more intensive treatment could have been considered instead of in-patient admission. In particular, MACX treatment, provides intensive outreach support for someone who has severe mental health difficulties but who is not engaging, presents with concerning behaviours or as needing more intensive

support. The outreach team can visit the person at home or in the community.
Dr Graham was of the view that Miss Parkinson might have been a candidate for this more intensive support if it was felt that she needed to be seen more often, if she or her family weren't attending or engaging with treatment, although his understanding was nobody suggested a need for MACX treatment at the time and he wasn't clear if it was available then.

[105] Drs Blower and Marshall were of the view that, at Miss Parkinson's presentation at the emergency appointment on 13 November 2013 and from the evidence before the review meeting on 16 January 2014, consideration should have been given to providing her with this more intensive level of intervention. Whether or not it was available at that time, Dr Blower considered that a more intensive function could have been provided by involving an additional worker, for example a nurse practitioner, who could have worked with the family and undertaken home visits. Dr Marshall agreed. He took the view that the dose should be appropriate to the risk that Miss Parkinson presented: it is not only the number of appointments that mattered but also that the contact was matched to her level of risk. Dr Mockett considered that the clinicians' care plan was appropriate both on these specific occasions and more generally.

[106] I accept the clear evidence that in-patient admission was not appropriate for Miss Parkinson. However, I prefer the evidence of Drs Marshall and Blower as to the need to consider a more intensive approach in November 2013 and January 2014. At these times it was clear that Mrs Moss and the school were seriously concerned about Miss Parkinson, that Mrs Moss was struggling at home and that Miss Parkinson was

displaying very concerning behaviours. I do not see from the records or the evidence from the clinicians that having decided in-patient treatment was not warranted, they gave any consideration to more intensive support. In my view that was a precaution that was reasonable for them to take. I address below whether the taking of that precaution might realistically have avoided the death.

(c) By CAMHS making a formal diagnosis of Miss Parkinson's psychiatric condition/s and assigning formal diagnostic labels

[107] Mrs Moss submitted that there was confusion amongst the clinicians about Miss Parkinson's diagnosis of depression, and the clinicians had underestimated the impact that Miss Parkinson's "emotional instability" and preoccupation with death had on her risk profile and that by failing to give sufficient attention to managing and treating the behaviours that were part of her emotional instability there was a failure to take reasonable precautions to properly manage her risk of suicide. Had such steps been taken the death may have been avoided. The Crown submitted that a diagnosis of depression had been made in all but name and it was clear to the clinicians that Miss Parkinson was being treated for that. The clinicians had done a reasonable job of assessing Miss Parkinson's mental state and put that in a wider context. It could not be said what difference would have been made if a formal diagnosis had been made. Tayside Health Board submitted that Dr McQuitty had been clear that Miss Parkinson was being treated for depression and she was being medicated for that. The multi-disciplinary team were all clear that was what Miss Parkinson was being

prescribed medication for. All the experts appeared to agree that borderline personality disorder should not have been diagnosed in one as young as Miss Parkinson. The presentation appears to have been manifest in attachment insecurity which was clearly understood by the treating team.

[108] Dr McQuitty and Dr Smith explained that the clinicians were using a formulation approach whereby clinicians look at the behaviours of the patient to identify what was causing them, maintaining them and improving them. It offers an alternative to psychiatric diagnosis which is a classification system suggesting that emotional suffering can be understood as disease and categorised based on presence, quantity and duration of symptoms. A formulation approach involves assessment of suicidal intention and self-harm as well as a preliminary assessment of the young person's overall mental health and development, their psychosocial situation and the ability of those adults responsible for them to ensure their safety. Formulation should identify factors that may have contributed to the development and maintenance of the person's mental health, and how that may impact on the efficacy of the treatments offered. It is adaptive and can be updated as required should a situation change or new information becomes available.

[109] Dr McQuitty explained that diagnosis is a label and can be unhelpful at times as it may impede a patient's care as the focus is on that and not other aspects. However a diagnostic label can assist in formulation because it provides a reference point.

Dr McQuitty considered that by trying to explore both routes that would give the fullest picture possible. In hindsight, he was of the view that it might have been reasonable to

diagnose Miss Parkinson with depressive episode rather than depressive order. By a depressive episode he meant a short term event that has responded to treatment so that a depression diagnosis was no longer appropriate. He was treating Miss Parkinson for the symptoms of depression, but it was not the only issue. He accepted there was not a specific labelling of depressive illness but Miss Parkinson's symptoms and her prescription for anti-depressant medication were clearly noted in the records. The other clinicians were copied into Dr McQuitty's letter of 8 October 2013 which recorded that and were aware of the medication that Miss Parkinson was taking. Dr Smith, Dr Graham and Mr Thomson all recognised that Miss Parkinson was presenting with depressive symptoms and was being treated for them.

[110] Drs Blower, Marshall and Mockett all considered that there was confusion about whether depression as psychiatric illness rather than a presenting symptom had been formally diagnosed by Dr McQuitty. They were concerned that the position would be unclear to Miss Parkinson and her family and lead to uncertainty. It would make it more difficult to provide coordinated treatment if each member of a multi-disciplinary team did not know whether a formal diagnosis of depression has been made. It is also helpful for clarity in communications with a GP to record that a patient had a particular condition. It then teases out what elements of presentation are being targeted and what not. It can help with monitoring of a patient, as it is then easier to see what symptoms are improving and others remaining. Using both diagnostic assessment and formulation provides a greater understanding of all the problems the patient is presenting with, particularly where presentation is multi factorial as was the case with Miss Parkinson.

They all acknowledged that there is a reluctance to make diagnosis which can be attributed to someone for the rest of their life and there is a concern that it may lead to a narrowing of focus. However part of medical practice is to try to give an explanation to family and patient as to where that label fits in a bigger picture. It can help invite questions as to why a young person might be so unhappy and depressed at a particular stage in the development and more broadly socially. All three agreed that a diagnosis of depression on its own would wrongly give the impression of a young person persistently unhappy with low mood and low activity. That was not how Miss Parkinson presented over time which was marked by liveliness and impulsivity.

[111] All three experts took the view that it would not have been appropriate to diagnose Miss Parkinson with borderline personality disorder. Miss Parkinson was far too young for borderline personality traits to be discussed. Borderline personality disorder defines a persistent and pervasive condition which is a disorder of an adult personality and behaviours. However, Miss Parkinson had emotional and behavioural problems from a young age and it would have been helpful to look at her emotional instability which is common for young people who progress to borderline functioning. Dr Blower’s view was that she would have described Miss Parkinson at the time as showing less biological evidence of depression and more consistent features of emotional instability with impulsivity and fears of abandonment. These were traits that had been evident in Miss Parkinson since primary school. Dr Marshall agreed that one doesn’t suddenly get personality disorder and there are emerging trajectories as described by Dr Blower. Miss Parkinson was showing clear and persistent signs of

"emotional instability" from childhood, including attachment issues, changeable mood, fears of abandonment, impulsivity, a preoccupation with death and seeking adult attention constantly. Whilst these behaviours had been noted by the treating clinicians, they were of the view that they could have been indicative of an emerging borderline condition which would have been a useful descriptor in risk assessment and care plan. Dr Marshall explained this was important as the research indicates suicide rate is high in young girls in this category. Dr Mockett agreed that there was emotional instability going on. He thought that emerging personality disorder would be used for older adolescents, the trajectory from 13 to 18 being too long to say there is an emerging personality disorder.

[112] Mrs Moss was not aware that Miss Parkinson had been diagnosed with depression or was suffering from symptoms of that. She did not understand what was meant by a formulation approach when that was referred to by Dr Smith. She had wanted a formal diagnosis because, in the absence of interactions and communication from CAMHS, she would have been able to research ways of supporting her daughter better. Dr McQuitty candidly accepted that information sharing with Mrs Moss was not as good as he would have liked. There were difficulties as Miss Parkinson did not want Mrs Moss present at their consultations. Having a formulation based approach probably made this aspect of information sharing more difficult.

[113] I accept that the clinicians were all aware Miss Parkinson was being treated for depression and were using a formulation approach that took that into account. In my view, so far as the clinicians' treatment is concerned, there is no evidence that having a

formal as opposed to a working diagnosis of depression, would have made any real difference to Miss Parkinson's care. She was being prescribed anti-depressant medication and the team understood she was being treated for that as part of a multi factorial presentation. However, I do consider that a formal diagnosis of depression was nonetheless a reasonable precaution that could have been taken. It would have provided clarity to others such as Miss Parkinson's family and her school, who could more readily understand that she was suffering symptoms of depression, albeit amongst other factors. I also accept on the basis of Drs Blower and Marshall's views that useful descriptors to use would have been emotional instability with fears of abandonment, pre-occupation with dying and impulsivity. Had these descriptors been used it would have resulted in a more accurate risk assessment and management. Although "attachment insecurity" was understood by the treating team to be Miss Parkinson's key problem, use of these further descriptors are more detailed and accurate, providing a different view of risk and risk management. Accordingly, in my view a formal diagnosis of depression and assigning emotional instability with fears of abandonment, pre-occupation with dying and impulsivity as descriptors were reasonable precautions that could have been taken. I address below whether these might realistically have avoided the death.

(d) By the CAMHS clinicians modifying their approach to the enforcement of patient confidentiality to allow relevant materials composed by Miss Parkinson to be provided to CAMHS by her family and school

[114] Mrs Moss submitted that another precaution that could have been taken that might realistically have avoided Miss Parkinson's death was the treating clinicians modifying their approach to patient confidentiality and accepting copies of Miss Parkinson's drawings and writings. The Crown sought no finding in this respect. Tayside Health Board did not address this specifically in their written submissions but in oral submission submitted that there was a dispute on the evidence whether there was a refusal to accept the drawings which had to be resolved. In any event, there was no evidence that acceptance of the drawings would have added to the clinicians' understanding of the position.

[115] According to Mrs Moss, she tried to present Miss Parkinson's dark writing and paintings regarding suicide, death and torture to Mr Thomson at the review meeting on 16 January 2014. According to Mrs Moss he refused to look at or accept them on the grounds of confidentiality. Mrs Williams also thought CAMHS should look at these paintings but they also told her that they didn't want to see them due to the risk of breaching confidentiality. Mrs Moss explained that she understood as a health practitioner herself that patient confidentiality required to be maintained but her understanding had always been that the patient's safety was paramount and that confidentiality may require to be breached to protect the patient.

[116] Mr Thomson stated that he couldn't recall being handed the paintings or drawings at that meeting or having rejected them. In any event, since he was not treating Miss Parkinson this material was not for him to accept or refuse. His view was that this material should have been provided to Dr McQuitty and Dr Smith as the treating clinicians. Both Dr Smith and Dr McQuitty couldn't recall the material being handed over at the meeting. They explained that they were aware of some drawings and writings from Miss Parkinson that formed part of Miss Parkinson's coping mechanisms and they had discussed them with her at their sessions. Miss Parkinson used drawings and writings as a form of self-help and both Drs Smith and McQuitty saw them as a positive way for Miss Parkinson to express her inward thoughts and emotions. Dr Smith said she would not have accepted the drawings at the meeting on 16 January unless Miss Parkinson had presented them to her. Dr McQuitty said that he never saw this artwork and wasn't sure whether he would have refused to accept it on the basis of confidentiality or not.

[117] It seemed to me that the clinicians and Mr Thomson didn't have any memory of these drawings being presented at the meeting. On the other hand, Mrs Moss had a clear recollection of trying to hand these over, which was supported by the minutes of what was discussed by Mrs Williams at the meeting. I prefer the evidence of Mrs Moss on this point given that the clinicians' memory was vague as to whether or not this had ever occurred.

[118] As Dr McQuitty explained in his evidence, it is very important for the treating clinician to build a therapeutic relationship with the patient. However, there is a balance

between maintaining the therapeutic relationship and the confidentiality of the patient and protecting the safety of the child. He agreed that where there is a high risk of harm to a child or others then there are limits to confidentiality.

[119] Dr Marshall explained that where there is repetitive self-harm, interests in suicide and the clinician's formulation highlighted parental child conflict as a driver for risk, then the focus should be on making an effort to get Miss Parkinson's permission to share information with her mother about risk and risk management, as well as persuading her to allow her mother into clinicians' sessions and for both to participate in family therapy. Confidentiality is not the main consideration when there are risks to the child. The over-riding concern must always be the safety of the child. Concerns about the child's safety should always take precedence over the public and patient interest in maintaining confidentiality (Dr Marshall report 16 June 2017, Crown Production 12, p905). Dr Marshall stated that he would have had no concern at all about accepting the drawings: risk and risk management trumped the sensibilities of the child in this situation. Dr Blower agreed that safety was paramount and was of the view that the clinicians might have wanted to think more about the drawings and discuss them as they showed a preoccupation with death.

[120] I accept the views of Dr Blower and Dr Marshall that the drawings should have been accepted on the basis that patient safety trumps the patient's right to confidentiality. Had the drawings and paintings been received, given their nature, this would have been likely to deepen the understanding of Miss Parkinson's preoccupation with death, her thoughts and emotions. Mrs Moss attempted to hand over the artwork

at the meeting in order to inform the clinicians about Miss Parkinson's interest in suicide, death and hopelessness. By not accepting this information, the clinicians were not relying on information beyond Miss Parkinson's account. I therefore conclude that a reasonable precaution would have been to accept these drawings and paintings and for the clinicians including Mr Thomson to modify their approach to confidentiality where the patient's safety is at risk. I address below whether this is a precaution which might realistically have avoided the death.

(e) By CAMHS allowing Miss Parkinson's family greater input into Miss Parkinson's care and providing them greater advice and assistance

[121] Mrs Moss invited me to find that reasonable precautions that could have been taken were by the clinicians (i) affording Mrs Moss greater input into Miss Parkinson's care and safety planning and (ii) providing Mrs Moss with greater verbal and written advice about the nature of Miss Parkinson's psychiatric illness and how to deal with and monitor her behaviours and keep her safe. Mrs Moss did not have sufficient input and was therefore unable to provide the clinicians with a complete picture, Miss Parkinson was insufficiently monitored at home regarding the impact of care and treatment and the risk coping and management strategies she was given. The Crown invited me to make no finding in this respect. Tayside Health Board submitted that Mrs Moss was involved in the safety plans. A fair reading of the records showed a high level of involvement of Mrs Moss.

[122] A theme that pervaded the whole inquiry was that Miss Parkinson's family, particularly Mrs Moss as her primary carer, were insufficiently involved in Miss Parkinson's care. Generally Mrs Moss perceived that the care given to Miss Parkinson was mostly parent led. She felt as though if she didn't ask for something to happen it didn't happen. The obvious disadvantage was that she was unaware of the various options and often did not know what to ask for. Her experience was that care planning was uncoordinated, muddled and sometimes absent. In particular, on 16 September 2013, she asked Mr Thomson why a psychiatrist had not been allocated to Miss Parkinson when she was deteriorating. She was desperately worried about her and felt helpless. According to Mrs Moss it was at that point that Mr Thomson agreed to a psychiatrist seeing Miss Parkinson. She remembers having to ask for this more than once before it was arranged. Mrs Moss was unclear about the assessment process and how difficult cases might be escalated. She had no idea who was in charge of her daughter's care overall, whether Mr Thomson was the most senior member of staff, or if there was someone above him in terms of experience or overall responsibility. She was extremely frustrated by the lack of understanding about how ill Miss Parkinson was, and the lack of urgency in their response. She explained that she was struggling to keep Miss Parkinson safe, the family were under immense strain and needed more help. She asked for in-patient admission in November 2013 and respite care in January 2014 but was not given any information about it.

[123] Mrs Moss was firm in her evidence that she had not been involved in the making of the safety plan which had been drawn up by Dr Smith and Miss Parkinson together

on 13 November 2013. According to Mrs Moss, she was not in the room when the safety plan was drawn up and was handed it at the end of a session on the way out, by Miss Parkinson as a "fait accompli". She didn't have the chance to read through it with Dr Smith and Miss Parkinson or discuss it in the session. When she was handed it by Miss Parkinson, she didn't know what it was for. There were references to words such as "blu tak" and "vanilla" which meant nothing to Mrs Moss and which she would have queried. There was reference to an out of hours number when, as far as she understood it, none existed for CAMHS and dialling the number would have been futile. The plan suggested Miss Parkinson should be approaching Mr Goodey when the school had advised that she should contact Mrs Williams and not Mr Goodey. This was the only safety plan that Mrs Moss was ever aware of before Miss Parkinson died. However, she found another one in Miss Parkinson's room after her death that she had no previous knowledge of either. (Productions for Mrs Moss, number 31).

[124] On balance, I prefer Mrs Moss' evidence about this. She was clear she didn't understand the terms of the safety plan nor what it was for. Had she been in the room and had she been involved in making it, she would have known its purpose. Had she been involved, I have no doubt that she would have tried to clarify and correct some of the information within the plan. That she wasn't in the room when the safety plan was first drawn up with Miss Parkinson fits with other evidence in the case. All the treating clinicians described how Miss Parkinson was very reluctant to discuss her mental health with her mother present. It is not disputed that Miss Parkinson was not present when the second safety plan was prepared in December. It was submitted by Tayside Health

Board that Mrs Moss' recollection does not accord with Dr Smith's records which suggest that the plan was made in her presence and explained to her. That is so, but the record is brief and does not fully state what was explained or discussed. Moreover the record of 18 November suggests that when Miss Parkinson was brought into the appointment for the last 5 minutes, when the safety plan was discussed, Miss Parkinson turned her back to her mother and did not want to talk in detail with her mother there. That suggested to me that very little discussion if any took place then about the safety plan with Mrs Moss and Miss Parkinson present. The Board questioned why Mrs Moss did not later ask about the safety plan. However, it was plain from her evidence she didn't realise what it was or understand its significance so I don't find it surprising that she did not ask further about it.

[125] Mrs Moss was also unaware that her daughter had been formally diagnosed with depression as part of a wider presentation. She was not provided with any written information about the medication that Miss Parkinson was prescribed by Dr McQuitty. She was unaware of the rationale for prescribing anti-depressants and unclear about their side effects. The prescription was changed to Setraline on 31 January 2014 but again she was not given written information about Setraline, the need for the change, any increased risks that this might pose or the need to closely monitor children in the first four to six weeks of taking Setraline. As with the earlier prescription of Fluoxetine, it was handed to her in the waiting room followed by a brief discussion. She was unaware of any warning signs to look out for in Miss Parkinson's behaviour and therefore unable to take any required action to keep her safe. Dr McQuitty's recording

of the change in prescription and the outcomes from the appointment on 31 January 2014 were not available to her or indeed the rest of the team who were not present (such as Dr Graham) until after Miss Parkinson had died.

[126] Mrs Moss was unclear about who was ultimately accountable and responsible for directing her daughter's care. She did not know how to obtain respite care and persistently asked for advice about how to manage Miss Parkinson's behaviours in the home and in the community.

[127] Mrs Moss felt that Miss Parkinson's treating clinicians were not taking her risk of suicide seriously enough. She was concerned that they were taking her daughter's statements at face value when she would lie to hide her feelings. Examples were that her daughter told Dr McQuitty at their appointment on 31 January 2014 that the man on the bus had a dog similar to her own when, in fact, she had never had a dog. Another was that she had told her mother repeatedly that she was going to play hockey after school and would put her kit in the washing machine on her return home when, in fact, she had not played hockey after school. Nor was she aware about interactions Miss Parkinson had with an older man she met on the bus who had bought a present for her. Mrs Moss saw that as a child protection issue but it was not mentioned to her or brought to anyone else's attention.

[128] Dr Smith noted at the review of care meeting on 16 January 2014 that Miss Parkinson had described herself as "wearing a mask" when discussing her feelings. This was a trait acknowledged by both Mrs Moss and Mrs Williams. Miss Parkinson reflected her concealment of her emotions in her drawings too. All of the treating

clinicians acknowledged that teenage patients can seek to hide how they feel from others including adults in authority. Drs McQuitty and Smith noted that in order to get 'behind the mask', their role was to build a therapeutic relationship with Miss Parkinson, something they felt they had succeeded with to some extent.

[129] Dr McQuitty candidly accepted that his interactions with Mrs Moss were not as good as he would have liked them to be. Miss Parkinson was unwilling to discuss her care and how she felt in front of her mother. This led to Dr McQuitty's discussions with Mrs Moss being short and taking place in a quiet part of the waiting room. Mr Thomson and Dr Smith also reported that Miss Parkinson was not keen to discuss matters with her mother present. This is reflected in Dr Smith's record of appointments with Miss Parkinson on 18 November 2013 where she noted that Miss Parkinson was uncomfortable with her mother being present. After 26 November 2013, all of the appointments with Dr Smith occurred without Mrs Moss present. Dr McQuitty noted that the family therapy was a route for other information from Mrs Moss to be made available to the team.

[130] Dr Blower took the view that mental health care is collaborative: it is a relationship between the clinical team and the parents. Her view was that it did look like the clinical team were initiating anti-depressant treatment and psychology and family therapy. And it did seem to be true they were responding to Mrs Moss as well, so that it wasn't accurate to say everything was parent led. However, obtaining information from Mrs Moss was an important part of carrying out a proper risk assessment, as well as obtaining information from others involved such as the school. It

was important that the clinicians were meeting weekly as part of structured team meetings and had ad hoc meetings, but there was a need to involve the family more. They agreed that discussions with Mrs Moss in the waiting room should have been avoided: clinicians should have followed up appointments with Miss Parkinson with calls to her mother or speaking to Mrs Moss after appointments in a separate room as required. Dr Mockett on the other hand considered that Mrs Moss had been sufficiently involved.

[131] I prefer the evidence of Drs Blower and Marshall over that of Dr Mockett's in this respect. Dr Mockett did not appear to me to have full information about Mrs Moss' lack of involvement, for example, in the preparation of the safety plan. Mrs Moss was involved in Miss Parkinson's care but not, in my view, sufficiently. I have narrated many of these examples above including, importantly, in the preparation of the safety plan which was critical to managing Miss Parkinson safely at home. I don't accept that the care was always parent led as the clinicians were regularly assessing risk and providing appropriate care and treatment to Miss Parkinson. However, there were times when it was parent led and I can understand why Mrs Moss perceived it that way. She made many calls to CAMHS expressing her concerns. She made calls asking for her daughter to be seen, to be assessed by someone other than a family therapist and for in-patient admission. She sought urgent support from social work and respite care.

[132] It's clear to me from the way Mrs Moss gave her evidence that she was genuinely confused as to who was in charge of her daughter's care, as to why Miss Parkinson was not admitted as an in-patient or the criteria for that, and as to her diagnosis and

treatment. The limitations of patient confidentiality were not explained to her. She was not given any written information about the medication her daughter had been prescribed. She was not given any further information as to why respite care was not available. Mrs Moss was not informed about Miss Parkinson's suicidal thoughts particularly that she disclosed to Dr Smith that she had thought about hanging herself or taking an overdose in February five days before her death. All of the skilled witnesses considered that was something that Dr Smith should have raised with senior clinicians as well as Mrs Moss and third parties. She was unaware of meetings that had taken place, such as the Initial Referral Discussion in September 2013, and was not sent minutes of that. Nor was she sent minutes from the Review of Care Meeting in January 2014. The safety plan was never discussed in any detail with her and she was unaware of what it was for.

[133] I appreciate that there were difficulties in involving Mrs Moss in appointments when Miss Parkinson did not want her mother present. The records show that there are occasions when Dr Smith and Dr McQuitty did try to discuss matters with Mrs Moss at an appointment or in a follow up call. However these are relatively few occasions and there were many appointments when Mrs Moss was not present or had fleeting conversations in the waiting room only, and when it would have been appropriate to follow up with a call or separate meeting.

[134] Agreeing with the experts, it is key to involve parents in adolescent patient care. Multi informant accounts are more reliable and accurate than one source. Parents are not only a source of information about a patient's presentation, but the information they

provide also serves as a 'cross check'. This is essential for assessing the veracity of the information supplied by a patient particularly where a patient, like Miss Parkinson, has a tendency to hide the truth. It was vital that Mrs Moss was given advice and assistance about the nature of her daughter's illness, the plan for her care, and the strategies in place so her family could manage her at home to keep her safe. Mrs Moss' involvement was essential in minimising Miss Parkinson's risk of self-harm and suicide.

[135] I conclude that reasonable precautions that could have been taken were (i) affording Mrs Moss greater input into Miss Parkinson's care and safety planning and (ii) providing Mrs Moss with greater verbal and written advice and assistance about the nature of Miss Parkinson's psychiatric illness and how to deal with and monitor her behaviours to keep her safe. I address below whether that was a reasonable precaution that might have realistically avoided the death.

(f) By CAMHS offering Miss Parkinson and her family further family therapy to address the identified relationship difficulties Miss Parkinson was suffering from

[136] Mrs Moss submitted that standing (i) the nature of Miss Parkinson's risk profile and (ii) that part of the reason for this was her persistent difficulties with attachment, a reasonable precaution which could have been taken which might have realistically prevented her death was the provision of further family therapy following her appointment with Mr Thomson on 18 October 2013. The Crown invited me to make no finding in this respect. Tayside Health Board submitted that Mr Thomson had rejected the suggestion that he had been told that Miss Parkinson did not get on with him. He

wouldn't have worked with Miss Parkinson if he knew that she didn't like him. In oral evidence he stated there were other therapists that could have provided family therapy. There was a dispute on the evidence between Mrs Moss and Mr Thomson as to the reason for Miss Parkinson's disengagement with Mr Thomson and family therapy. According to Mrs Moss, from the time when Miss Parkinson had initially been referred to Mr Thomson in 2011, Miss Parkinson had not liked him and that was why she had chosen to disengage. Mrs Moss stated that she had told Mr Thomson that in fairly blunt terms and on more than one occasion. She had asked if there was another family therapist available but was told that the other therapist was Perth based. However, Mr Thomson could not recall being told that by Mrs Moss. He thought it was the sort of thing he would expect to recall as it would be counterproductive to offer therapy to Miss Parkinson if she had that feeling. He was clear that he wouldn't work with a family that didn't want to work with him. His evidence in cross examination was that there were other family therapists available.

[137] I have found this difficult to resolve as a matter of fact as Mr Thomson's statement that he wouldn't work with a family that didn't want to work with him is entirely plausible and I found him an entirely credible witness. But on the other hand, Mrs Moss had a clear memory of explaining to him on more than one occasion that Miss Parkinson did not like him. She also clearly recalled asking for another therapist and being told that there was one available who was based in Perth. Although Mr Thomson explained in oral evidence that there were in fact other family therapists available who he could have referred Miss Parkinson to, he contradicts that in his

statement when he suggests he was the only one available in Dundee. The evidence from his statement seems to be consistent with what Mrs Moss recalls being told. Mr Thomson agreed that Miss Parkinson disengaged in family therapy sessions which is consistent with the explanation given by Mrs Moss that she did not like Mr Thomson and refused to go to sessions with him. On balance, I prefer Mrs Moss' evidence on this point which is more consistent with the other evidence I heard.

[138] When Miss Parkinson was referred to an individual psychologist and psychiatrist, her family therapy sessions ended. Mrs Moss continued to attend family therapy with Mr Thomson where the focus was on assisting Mrs Moss in coping with Miss Parkinson's mental health rather than on the underlying conflict between Miss Parkinson and her family. All the experts in the case agreed that further family therapy with Miss Parkinson should have been continued because of the importance of her underlying attachment issues and family conflict. They all agreed that if that could not be provided by the existing family therapist, because of a lack of engagement or otherwise, family work should have been carried out by another clinician or member of the multi-disciplinary team. I agree with Dr Marshall's description that there was a lack of curiosity by CAMHS as to why Miss Parkinson was not engaging with family therapy after a long period of engagement with Mr Ness. Given how critical Miss Parkinson's family relationships were to her mental health, CAMHS ought to have been openly addressing this and ought to have considered finding an alternative family therapist whilst also pursuing individual work with Dr Smith and Dr McQuitty. In my view it

was a reasonable precaution for that family work to have continued with Miss Parkinson with another family therapist.

(g) By CAMHS having more interaction with the High School of Dundee regarding Miss Parkinson's care

[139] Mrs Moss did not invite me to make any specific finding in relation to this disputed issue. And nor did any other party. However, I note that the experts' agreed view was that it was important for CAMHS to adopt a multi-agency approach to Miss Parkinson's care in order to prepare a comprehensive risk assessment and risk management plan. This involved CAMHS liaising with third parties involved with Miss Parkinson's care and included Miss Parkinson's school. The teachers at HSD already had a working relationship with Miss Parkinson and Mrs Moss. CAMHS has specialist knowledge around risk and mental health and is in a position to support teachers. HSD were clearly concerned about Miss Parkinson's mental health. HSD attended the Initial Referral Discussion in September 2013. HSD were highly supportive of Miss Parkinson and Mrs Moss throughout the period when Miss Parkinson was being treated by CAMHS. They were so concerned that they contacted CAMHS directly by telephone and in writing. It was only after Mrs Hudson wrote to the CAMHS on 13 November 2013, that HSD was invited to attend the Review Meeting on 16 January 2014. A response was written to the school by Dr McQuitty but it was never received by the school. However other than that, there was no other substantive contact directly from CAMHS to HSD. Agreeing with the experts, in my view it is important for

CAMHS to adopt a multi-agency approach and involve third parties throughout a young person's care. HSD teachers were discussing Miss Parkinson's mental health with her on a regular basis and could have provided relevant insight into her mental state. In my view for the reasons given by the experts it was a reasonable precaution for CAMHS to have engaged the school more fully on a multi-agency collaborative approach to Miss Parkinson's care.

(h) By CAMHS or a third party agency offering Miss Parkinson an alternative "safe place" rather than in-patient care;

[140] I heard no evidence of there being safe beds or another safe place available at the time of Miss Parkinson's care and I do not therefore consider this to be a precaution that could reasonably have been taken. No party invited me to make that finding.

(i) By CAMHS or the High School of Dundee referring Miss Parkinson's case to the Dundee City Council Social Work Department for a social work assessment to be carried out regarding her and her family's needs.

[141] Mrs Moss further submitted that another reasonable precaution that ought to have been taken that might have realistically prevented Miss Parkinson's death was CAMHS referring her case to social work on child protection grounds. There was no evidence that CAMHS had considered whether a social work referral was required after Miss Parkinson was referred to CAMHS in 2013. The Crown invited me to make no finding in this respect. Tayside Health Board acknowledged that there was agreement

amongst the experts that social work involvement in Miss Parkinson's care was not high enough. Other than the discussion at the meeting on 16 January 2014, neither CAMHS, the school, nor Mrs Moss felt the need to involve social work after Mrs Moss called them in September 2013. The Board submitted that it was unclear on the evidence whether the referral would have resulted in social work intervening or what would have been done by them to supplement CAMHS work. HSD submitted that by the time of the meeting on 26 September 2013 HSD was aware of social work involvement and the intention for further involvement and that Miss Parkinson was working with CAMHS. The school looked to CAMHS as being the experts in Miss Parkinson's mental health to engage social work further. The inquiry had not heard from any witness from Dundee City Council Social Work Department or an independent witness in social work as to precisely what form a social work assessment would have taken in 2013/2014.

[142] Mrs Moss contacted social work on two occasions in September 2013: first when she discovered Miss Parkinson had been accessing violent pornography sites on her mobile phone and second after Miss Parkinson had run away from home.

[143] An Initial Referral Discussion took place on 26 September 2013 which involved police as well as two members of staff from HSD (Mrs Williams and the school nurse), a team manager from Dundee City Council Social Work Department and Mr Thomson. Following that meeting it was agreed that no joint interview between Miss Parkinson, the police and a social worker would take place until Miss Parkinson's phone had been forensically examined by police in relation to her contact with adult males. It was also felt that as she was currently in the care of CAMHS, there was no need for follow up at

that time. Mrs Moss's evidence was that she was not told that a meeting was taking place nor the outcome of that meeting. Any minutes taken were not sent to CAMHS, Mrs Moss or HSD. No further meeting was arranged. That ended any social work involvement in Miss Parkinson's care in September 2013.

[144] The only other reference to social work involvement in Miss Parkinson's care is contained within the minutes of the 16 January 2014 Review of Care meeting. This was in reference to Mrs Moss's request for respite care. Mr Thomson stated in his evidence that he did not ask the local social work department to consider respite care at that time as he did not believe that this was a service they would have provided from his past experience of working with them. He did not think that sending Miss Parkinson away would have assisted her at that time standing her attachment issues and fears of rejection. He did not provide Mrs Moss with advice about local social work provision. This is consistent with the record of the meeting which states that respite care had been requested but that there was "no obvious answer". Dr Smith's view was that it was unlikely that social work would have provided respite care at that time, as the "social work bar for respite can be quite high". The clinicians' notes do not otherwise refer to any consideration being given by CAMHS to social work involvement.

[145] Drs Blower, Marshall and Mockett were all agreed that a multi-agency approach to Miss Parkinson's care was required. They all believed this required input from the social work department. They were referred to paragraphs 1.1.19 and 1.1.20 of the *Self-harm in over 8s: long-term management, Clinical guideline [CG133] Published date:*

November 2011 published by the National Institute for Heath and Care Excellence (NICE) (Mrs Moss Production 9, 15 (2122) which provides:

> "1.1.19 CAMHS professionals who work with children and young people who self-harm should consider whether the child's or young person's needs should be assessed according to local safeguarding procedures.
> 1.1.20 If children or young people who self-harm are referred to CAMHS under local safeguarding procedures:
>
> > use a multi-agency approach, including social care and education, to ensure that different perspectives on the child's life are considered;
> > consider using the Common Assessment Framework; advice on this can be sought from the local named lead for safeguarding children.
>
> If serious concerns are identified, develop a child protection plan."

[146] Dr Blower and Dr Mockett shared the view that both paragraphs 1.1.19 and 1.1.20 applied to Miss Parkinson's care. Dr Marshall took the view that paragraph 1.1.19 was more appropriate in her case. All three experts agreed that anyone could have referred to social work including CAMHS, HSD, police and social work themselves. Dr Blower thought the onus was less on a GP as the GP had referred the matter to CAMHS. Dr Blower was of the fairly firm view that a referral should have been made in January 2014 and possibly November 2013. She considered Mrs Moss's request for respite care in January highlighted the need for a referral. Dr Marshall believed that a greater onus lay on CAMHS given they have expertise on mental health issues, and that Miss Parkinson was in their care and attending appointments in relation to her impulsivity, self-harm and suicide which give rise to safeguarding concerns. His view was that Miss Parkinson should have been referred in November 2013 and January 2014 because of the level of vulnerability she presented with at those times. Those were the times when there should have been an increased concern for Mrs Moss who was clearly

struggling to keep Miss Parkinson safe at home. Dr Mockett agreed Miss Parkinson should have been referred in January 2014. Dr Mockett's experience was that it often needed to be a multi-agency push to get social care involved. Dr Mockett thought it relevant there was police investigation and contact from Mrs Moss to social work out of hours and it was clear HSD were concerned about Miss Parkinson in school.

[147] HSD did not make a referral to social work in respect of Miss Parkinson. HSD were aware of CAMHS specialist involvement and were proactive in seeking to engage with them directly. They did not consider a social work referral necessary as CAMHS were already providing care to Miss Parkinson and Mrs Moss was very supportive and proactive in her daughter's care. HSD had been advised by CAMHS that they were the appropriate forum to discuss Miss Parkinson's mental health and that there needed to be further discussion with Mr Thomson about respite care.

[148] Whilst the court heard no evidence from social workers, in my view, the experts were able to explain the value of social work input as part of a multi-agency approach. Dr Marshall explained that a social worker would have been able to assess Miss Parkinson's wider needs for care and protection. Miss Parkinson clearly did not understand the implications of exposure to violent pornography, or presenting herself as older in social networking sites or accepting gifts from older men. Parental child conflict was a key driver in Miss Parkinson's self-harm and suicide risk. Miss Parkinson reacted negatively to attempts by her mother to control those behaviours. Her mother was struggling to cope at home and advised CAMHS of this in November 2013 and January 2014. Although the clinicians were doing their best to manage Miss Parkinson from a

mental health point of view, support to ensure Miss Parkinson was kept safe could also have come from social work. CAMHS were not able themselves to do a broad community and social assessment.

[149] I agree with the experts that Miss Parkinson may have benefitted from such an assessment and support from social work. In the face of stresses at home and in the community which are not in the control of the school and NHS or parents, effective risk management required a multi-agency approach. I am also of the view that whilst anyone could have referred the case to social work, agreeing with Dr Marshall, it was reasonable in the circumstances for CAMHS to have done so in November 2013 and January 2014. They had the ongoing responsibility for Miss Parkinson's mental health and were leading her care and treatment. CAMHS were aware of the risks that Miss Parkinson's impulsive, self-harming and suicidal behaviours presented. These risks had to be managed in the context of her mental health, but they also raised safeguarding concerns. Mrs Moss made repeated requests for assistance in managing Miss Parkinson's behaviours at home. CAMHS were aware social work had been involved at an earlier stage in September 2013 at Mrs Moss's instigation. They knew that she was struggling to cope with Miss Parkinson's behaviours in November 2013 and that she sought respite care in January 2014. I conclude that social work referral was a reasonable precaution that ought to have been taken in November 2013 and January 2014.

Had these precautions been taken, might they realistically have resulted in Miss Parkinson's death being avoided?

[150] Mrs Moss submitted that had all of these precautions been taken, they might realistically have resulted in Miss Parkinson's death being avoided. She submitted that these were matters that involved assessment and management of risk, formulation and the care plan. The lack of involvement and input from family and third parties, lack of family therapy for Miss Parkinson and referral to social work all affected the treatment and care provided. The Crown submitted that the experts' evidence fell far short of concluding that Miss Parkinson's death would realistically have been avoided if these precautions had been taken. The clinicians did not feel they could have done more. It was difficult to pick on a single thing that would have altered the outcome. Apart from constant supervision, it was submitted, it is difficult to see how Miss Parkinson's death could have been avoided. At some stage, it was submitted, she would have had an opportunity to take her own life in the manner she did.

Tayside Health Board submitted this was a question of the utmost difficulty. The experts appeared to accept that no one thing could have saved Miss Parkinson's life. Dr Mockett's opinion was that in an ideal world the risk assessment would have covered all aspects that arose. However even then he thought these precautions would not have saved Miss Parkinson's life although they would have reduced the risks. It was submitted that it is unrealistic to conclude that these precautions would have prevented her from taking her own life when one takes account of the history she presented with, the treatment provided and the role of CAMHS.

[151] When asked whether there were reasonable precautions which might realistically have avoided Miss Parkinson's death, Dr Blower was of the view that it was particularly important to have had a comprehensive risk assessment with interventions that were proportionate to the risks that were determined and a senior clinician overseeing the care. Dr Marshall similarly considered the key issue was the structure of the service, the assessment of risks involved, the frequency and quality of intervention.

[152] All three experts in the joint minute of agreement confirmed that with the provision of comprehensive risk assessment, resulting risk management from such an assessment, provision of social work support and further family therapy, the final outcome for Miss Parkinson may have been averted on the balance of probabilities. In oral evidence both Drs Blower and Marshall confirmed that remained that view.
Dr Mockett's departed from the position agreed in the joint minute by all experts, when he gave oral evidence. In oral evidence he was of the view that these were all precautions that would have made services better but that they would not necessarily have prevented the outcome. If everything had been in place he did not think the outcome would have been avoided, but he agreed that the risks would have been reduced.

[153] I find this a difficult question to resolve as there is an element of the unknown, insofar as it cannot be known for certain what would have occurred for example had a comprehensive risk assessment been provided. However it seems to me I am not required to be certain as to what would have occurred had these precautions been taken, but instead must assess whether these precautions might realistically have avoided the

death applying the standard of balance of probabilities. I accept the opinions of Drs Blower and Marshall on this important point, who agree with each other, and who seem to me to come closest to addressing the "might realistically have avoided" test. They both concluded that had these precautions been taken the final outcome "may have been averted on balance of probabilities". That in my view comes close to concluding those precautions might realistically have avoided Miss Parkinson's death.

[154] Dr Mockett's position on this critical point was unsatisfactory on a number of levels: he changed his opinion in oral evidence and departed from the joint minute of agreement without any explanation other than it had been a misunderstanding. It also appeared to me that he was considering whether the death **would** have been avoided by the taking of these precautions, rather than whether it **might realistically** have been avoided.

[155] It is, in my view, difficult to isolate any one precaution that might realistically have avoided Miss Parkinson's death. However, the use of a more comprehensive risk assessment might realistically have flagged up Miss Parkinson as being at times at high risk of suicide. With more intensive services, further family therapy and more involvement of her mother, HSD, and social services the risk of death would have significantly reduced and her death might realistically have been avoided. I find support for that conclusion from Drs Blower and Marshall's views and also to some extent from Dr Mockett, who agreed that had everything been in place the risks would have been reduced. I conclude that all the precautions listed above, particularly the provision of comprehensive risk assessment, resulting risk management from that

assessment, involvement of social work, HSD and family, and further provision of family therapy might realistically have resulted in Miss Parkinson's death being avoided. In my view these precautions would have provided more comprehensive and superior care and treatment for Miss Parkinson, where risks were fully assessed and managed with input from, and support to, the family and third parties. Given the importance of these elements of care and treatment as highlighted above, along with all the other precautions listed above, in my view they might realistically have avoided her death.

Section 26(2)(f) Defects in any system of working which contributed to Miss Parkinson's death

[156] Mrs Moss submitted that the following systems were defective and contributed to Miss Parkinson's death: (1) the systems guiding the direction and oversight of a CAMHS patient's care during the relevant period were confusing and inadequate; (2) CAMHS system of patient risk assessment and risk management; and (3) the system of communicating and recording patient care with patients, their parents and third parties. HSD invited me to make no finding in respect of HSD under this section. The Crown and Tayside Health Board submitted that I should make no findings under section 26(2)(f).

Oversight of patient's care

[157] There was, in my opinion, confusion amongst the clinicians as to who had overall responsibility for Miss Parkinson's care. Miss Parkinson was being treated by a trainee psychiatrist Dr McQuitty (supervised by Dr Graham) and by a trainee psychologist Dr Smith. Mr Thomson was carrying out family therapy work with Mrs Moss but not with Miss Parkinson who was being treated individually by the psychology/psychiatry clinicians. All seemed to agree that the psychiatrist and psychologist and family therapist had responsibility for their own roles. Mr Thomson was the core worker but there was a difference in understanding as to what his role was, whether it was one of overall responsibility, for co-ordinating the care or one of cohesion. Dr Graham described his own role as supervising Dr McQuitty as a consultant psychiatrist but he viewed Mr Thomson as the core worker. However he thought that at the point Dr Smith provided psychology care she became the lead healthcare profession.

[158] Mrs Moss did not know who was in charge of her daughter's care. There was no documented discussion or explanation of who was in charge. Mrs Moss was unaware that Miss Parkinson had a consultant (Dr Graham) who had been involved in Miss Parkinson's care. She only became aware of his existence when he arrived at her house for a visit after Miss Parkinson died. There are no notes in her file to say that he had any involvement in her case. As all accepted, if Mrs Moss was confused and unclear about who was in charge of her daughter's care, it had not been explained adequately to her.

[159] Both Drs Blower and Marshall thought it important to have a senior clinician responsible and accountable for Miss Parkinson's care. The picture was very confused. Dr Marshall suggested that if it was confusing for the clinicians, it was especially confusing for a child and parent in turmoil and other agencies. Dr Mockett thought it was not dissimilar to how his service worked but he recognised that it did cause confusion.

[160] Drs Blower and Marshall described the provision for Miss Parkinson's care as complex with psychiatry and psychology involved. Where complexity and risk arise, it is important that systems respond in a clear and structured way. A range of clinicians can be involved and have separate roles but there should be a case manager who has overall responsibility. It is important for the patient and their carer to know who the core worker or senior clinician is. That is the person who coordinates the care and is overall responsible for it being delivered. There is often a senior responsible clinician who has oversight of the care plan through multi-disciplinary meetings. The safest teams are ones where very clear lines of responsibility exist so that the service is accountable. Although Mr Thomson fulfilled the role of core worker for example when he attended the Review Meeting on 16 January 2014, in a case of complexity such as this, it was critical to have a more senior clinician to coordinate the others.

[161] This lack of senior clinician involvement impacted on the ability to effectively manage and assess risk. A senior clinician would have been able to take an overview of a picture over time of a young girl repeatedly self-harming with a pervasive and fluctuating level of hopelessness with family stresses persisting despite the input of

family therapy at an earlier stage. The senior clinician could have assessed whether other agencies should be involved like nurses or social work. The role is partly an overseeing role and bringing authority where required. A senior clinician would ensure proper co-ordination between agencies and professionals and advocate for further interventions as required. I conclude that so far as the system did not provide for such oversight, it was defective and contributed to Miss Parkinson's death.

System of patient risk assessment and risk management

[162] Mrs Moss submitted that in the absence of a structured risk assessment, there was no uniformity in communicating, identifying and recording risk factors. The failure to involve Mrs Moss and HSD in the risk assessment and management process meant these were incomplete. I addressed in the previous section the significance and importance of a structured risk assessment. Because there was no structured risk assessment there was no systematic assessment of risk of suicide and self-harm. Although the clinicians were continuously assessing risk, a structured assessment would have provided a more objective assessment. It would have enabled effective recording of risk assessment, picking up new and emerging behaviours, considering how the behaviours and symptoms contributed to formulation and diagnosis and what coping mechanisms and treatments should be put in place. It would also have facilitated communicating all of this information to Mrs Moss and HSD and included input from them. Whilst the clinicians did pick up on recurring themes of attachment issues, family conflict and impulsivity, both Drs Blower and Marshall thought that further

consideration was required into Miss Parkinson's suicidal thoughts and self-harming behaviours, her emotional instability and preoccupation with death. The failure to involve Mrs Moss or the school sufficiently in preparation and understanding of safety plans, or in risk assessment, meant there was no cross check and no multi informant basis on which to assess risk. By not involving Mrs Moss, social work and the school more, a multi-agency approach was not adopted and CAMHS were reliant on Miss Parkinson's account of her behaviour and response. By not involving Mrs Moss and the school more fully, CAMHS had insufficient information to adequately manage Miss Parkinson's behaviours. The risk assessment and risk management system was defective and contributed to Miss Parkinson's death.

System of communicating and recording patient care with patients, parents and third parties

[163] I accept Mrs Moss's submission that there were discussions between Dr McQuitty and Dr Graham that went unrecorded as well as discussions at weekly multi-disciplinary meetings that were not recorded. It is important to keep records in a multi-disciplinary team so that information relating to patients can be shared. It also enables information sharing with third parties such as the patient's family and the school. I have already concluded above that CAMHS could have involved Mrs Moss and the school more fully in Miss Parkinson's care plan and could have explained and communicated better. The clinicians accepted that if Mrs Moss had not understood matters, then they hadn't been adequately communicated to her. There was a lack of

clarity and explanation given to Mrs Moss as to who was in charge of Miss Parkinson's care, the criteria for in-patient admission, the risk assessment, management, diagnosis, medication, formulation and treatment of Miss Parkinson. In particular the discussion between Miss Parkinson and Dr Smith on 24 February 2014 where Miss Parkinson disclosed that she was considering suicide by hanging or overdose was not communicated to Mrs Moss. All of the experts stated that this discussion should have been raised with senior clinicians, Mrs Moss and third parties. As explained by Dr Blower, better co-ordination of Miss Parkinson's mental health care and communication with family and professionals would have provided her with more effective treatment and risk management. In my view the system of communicating and recording patient care with patients, parents and third parties was defective and contributed to Miss Parkinson's death.

Recommendations under Section 26(1)(b) and (4) of the Act, to take reasonable precautions, make improvements to any system of working, introduce a system of working or take any other steps which might realistically prevent other deaths in similar circumstances to that of Miss Parkinson.

[164] Since Miss Parkinson's death there have been a series of reviews which have addressed the precautions and defects that I have identified above. In particular, NHS Tayside have identified that a system of regular complex case reviews might have provided Miss Parkinson with more effective treatment and risk management. These were introduced following a review of Miss Parkinson's case in 2015 and developed into

Standard Operating Procedures. (Tayside Health Board Production 4, p 2672). Complex case review meetings are meetings where multi professionals within CAMHS are involved. They are arranged where there is more than one CAMHS clinician regularly involved with a child or young person and there are concerns about suicide ideation, significant self-harm, serious risk to physical health, child protection concerns or severe mental illness. It is mandatory for a responsible clinician to be identified within CAMHS. The need for the complex case review should be documented and considered at each review and monitored. Draft minutes are to be distributed to attendees for approval. Following a CAMHS complex case review meeting, if any areas are identified that have implications or involve any agencies then the Team Around the Child Process or the equivalent in each locality should be initiated. The guidance states that the responsible clinician will be the lead CAMHS healthcare professional involved with the case with overarching responsibility for ongoing management of the case. This should be the most senior clinician involved in the case. NHS Tayside have also put in place regular audits and recording of mandatory data, structured risk assessments, staff training on a multi-agency approach and an escalation policy. Given the steps taken by NHS Tayside following review, I do not need to make any recommendations to address the defects identified above.

[165] However, Mrs Moss invited me to make the following recommendations, under section 26(1)(b) and (4), which she submitted might realistically prevent other deaths occurring in similar circumstances.

Information about prescribed medication

[166] Mrs Moss invited the inquiry to make recommendations that CAMHS should ensure that all psychiatrists have access to hard copies of the written patient information relating to anti-depressants. These should be provided to patients and their parents/carers on prescription of anti-depressants and on request. CAMHS psychiatrists should also inform patients and parents/carers where to find such information online. I agree that it is important for patients and their carers to be fully involved in discussions regarding the prescription of anti-depressants and their benefits and risks, advised of the rationale for the treatment, the potential side-effects, the need to take the medication as prescribed, to closely monitor at the start of the treatment and be provided with a written copy of the patient information about the prescribed medication.

[167] Mrs Moss stated that apart from being told about the prescription she not told about the side effects and what to look for. Dr Blower in her report concluded that Mrs Moss was not provided with sufficient information about the potential risks associated with the change in treatment from Fluoxetine, a first line licensed anti-depressant medication, to Setraline which was a second line unlicensed but commonly used anti-depressant medication. Dr McQuitty's evidence was that he did tell Mrs Moss about the medication as is documented in the records. He had wished he had documented more. He thought that having more written information to hand to give to patients would have been useful but at the time the written information was not available. However he advised that it is common practice today to provide the patient with information in the appointment room and give the patient a leaflet which is ready

to hand with written information about the drugs being prescribed. Patient information is also available now through NICE online. Accepting this written information is now provided to patients, it seems unnecessary for me to make any recommendation about this.

Updating of the CAMHS website with information on CAMHS structure

[168] I was also invited to recommend that the CAMHS website should be updated to incorporate pictures of all treating CAMHS clinicians, provide details of their role and an explanation of where they fit within the CAMHS multidisciplinary structure. I agree it is helpful for CAMHS patients and their parents/carers to have this information so that they understand the structure of the organisation. However, it seems to me there are a myriad of ways to achieve that and thought should be given as to whether that is best achieved through the website or by other means. I recommend that further consideration is given by CAMHS as to how they can provide this information about the treating clinicians, their role and how they fit into the overall structure of the organisation to patients and carers. I leave the means of achieving that to be decided by CAMHS.

Safe beds

[169] I was also invited to recommend that Tayside Health Board investigate the viability of the "safe space" beds which are currently provided to CAMHS patients of the Lancashire and South Cumbria NHS Foundation Trust as raised by Dr Mockett in

his evidence. Dr Mockett explained that as a response to the Covid pandemic, the Trust created "safe space" beds that are not considered in-patient admissions. These are safe spaces for young people to go overnight to take them out of a difficult environment or situation so that they can be assessed by the multi-disciplinary CAMHS team and a decision taken on how best to manage their care the next day. The young person is not formally admitted as an in-patient, but it enables CAMHS to assess the young person overnight. I had very little further information about the provision of safe space beds and whether this is something that might realistically avoid other deaths in similar circumstances. However, on the basis of Dr Mockett's evidence that it was a resource which could provide a beneficial alternative to in patient admission for young people, on balance I am persuaded that it might realistically avoid other deaths in similar circumstances and I recommend that it is explored by CAMHS.

Out of hours CAMHS contact

[170] There were times of crisis in Miss Parkinson's behaviour which occurred out of working hours and when Mrs Moss did not know who to contact to assist with Miss Parkinson's mental health. In early September 2013 Mrs Moss discovered inappropriate material of semi naked men on Miss Parkinson's mobile phone and that she had been accessing violent pornography sites. There was no out of hours number to contact someone in CAMHS and she had no idea who to contact for support in CAMHS. She instead phoned out of hours social work and they advised her to also phone the

police which she did. Subsequently Miss Parkinson ran away from home in the evening and again Mrs Moss phoned police and social work.

[171] Dr Blower and Dr Marshall agreed that out of hours CAMHS contact could have assisted Mrs Moss. However Dr Blower explained that staffing a 24 hour CAMHS out of hours service is a major commitment and realistically it could only be large conurbations that would have the staff to resource that. But there is psychiatry out of hours on call and social work also have an out of hours service which could be a flexible enough provision to do an assessment and assist with care.

[172] Ms Bastianelli explained that as newly appointed Head of Nursing for the CAMHS Service, she was asked to attend the follow up the Significant Clinical Event Analysis Review (an internal review of the medical and nursing records of a patient). Amongst the recommended actions was a requirement for an out of hours CAMHS contact. The majority of the action plan has now been completed. However, work in relation to out of hours service provision is ongoing. This is being progressed through a Joint Psychiatric Emergency Plan Group with adult mental health, CAMHS and partner agencies.

[173] It seems to me that it is already recognised that it is important to have a CAMHS out of hours contact available. It has been over five years since a dedicated CAMHS out of hours contact was recommended. I recommend that CAMHS, through the Joint Psychiatric Emergency Plan Group or otherwise, make provision ensuring that there is an out of hours contact number for CAMHS patients and that CAMHS patients and their carers know who to contact out of hours.

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

Lack of information about prescribed medication

[174] Mrs Moss invited me to find it a relevant fact that Mrs Moss was supplied with insufficient advice regarding the provision of anti-depressants prescribed for her daughter. I accept Dr McQuitty's evidence that he handed Mrs Moss the prescriptions and that he explained to Mrs Moss that Miss Parkinson was being prescribed Fluoxetine and subsequently Setraline. This is consistent with the records he kept. However I accept Mrs Moss's evidence that at least so far as the Fluoxetine was concerned, the discussion was fleeting, having taken place in the waiting room and that she was not advised of the rationale for the treatment or the potential side-effects. I also accept her evidence that she was similarly unaware of the rationale behind the Setraline prescription and was not aware of the side effects nor the need to closely monitor Miss Parkinson at the start of treatment. She was not provided with any written information about either prescribed drug. As explained above it is important to involve parents and carers in the care and treatment of young people so that they can be safely managed. I agree that this was a fact relevant to the circumstances of Miss Parkinson's death.

Beck Youth inventory

[175] Mrs Moss submitted that I should also find that it was inappropriate for Dr Smith to allow Miss Parkinson to complete the Beck Youth Inventory at home and that was a fact relevant to the circumstances of her death.

[176] Dr Smith at her appointment with Miss Parkinson on 27 January 2014 gave her the Beck Youth Inventory to complete. Mrs Moss submits that Dr Smith's provision of the Beck Youth Inventory in and of itself was appropriate. However, she believes that it was inappropriate for Dr Smith to allow Miss Parkinson to complete it at home.

[177] Dr Smith stated that as part of her discussions on formulation at the appointment with Miss Parkinson on 27 January 2014, she asked Miss Parkinson to complete a diary and a Beck Youth Inventory. That was the first time she had asked her to complete the Beck Youth Inventory and to do so at home. It is a self-report questionnaire for young people to identify signs and symptoms of self-esteem, anxiety, anger and anti-social behaviour and to grade how they are feeling. The purpose of self-grading is that the young person's total score is matched to a normative sample of people in that age group. It was to be used as a method of tracking and monitoring Miss Parkinson's presentation (Mrs Moss Production 26, p. 2491). Unfortunately Miss Parkinson did not return the form on either of the two following appointments and it did not form part of her medical records. Mrs Moss found the completed inventory in Miss Parkinson's bedroom after she died.

[178] Dr Smith viewed the decision about where the questionnaire should be completed as a judgment that has to be made by the clinician based on what they knew of the particular individual. She took the view it was appropriate in Miss Parkinson's case. Some individuals prefer to complete it at home and not feel under pressure. Dr Smith said she discussed with Miss Parkinson as to what the questionnaire was about and said she could complete it at home. She recognised that it would have been helpful

to have the assessment as it would have led to discussion, but it is only a snapshot, and she may have completed it differently in a week's time in any event.

[179] Dr Blower thought that there was no difficulty with a clinician giving the patient the questionnaire to complete at home so long as it was explained what it was for and when to complete it. This is often done in her experience. Dr Mockett used different questionnaires in practice but often gave them to patients to complete at home. Dr Marshall had a slightly more nuanced approach He thought that it contained a number of questions that could be taken home but that the questions on depression about, for example, extreme hopelessness and dying, would be best completed in the clinic. They all agreed it was a useful tool.

[180] I agree with Dr Smith's view that the Inventory is a useful tool and something which can be given to complete at home. Dr Smith saw it as a judgment call on the clinician and that view seems to be broadly in line with the three experts. The only different view was that of Dr Marshall but he did agree that it was appropriate for some of the questions to be completed at home. I am satisfied that it was appropriate based on Dr Smith's description of how she explained its contents to Miss Parkinson and judged that for Miss Parkinson it was something she could manage at home. It was unfortunate that Miss Parkinson did not return it, but it is clear from the records that Dr Smith spent the subsequent appointments working with Miss Parkinson on her mood and mental health. The questionnaire is only one tool that was being used by Dr Smith who was working on chain analyses and other means to develop the formulation and coping strategies for Miss Parkinson. It may well have been a valuable

source of information relating to Miss Parkinson's presentation and level of risk but it was only ever a snapshot and Dr Smith at her appointments with Miss Parkinson was able to assess her using other tools. I make no finding in this respect.

Documentation and record keeping

[181] I was also invited by Mrs Moss to make findings about a lack of record keeping, particularly recording of discussions between clinicians and a lack of recording of information showing an ongoing risk assessment with details such as how often Miss Parkinson thought about dying and how pervasive those thoughts were.

[182] There was evidence from Drs Blower and Mockett that they would have expected Dr Graham to note in Miss Parkinson's medical records the terms of his discussions with Dr Smith and Dr McQuitty about in-patient admission and the prescription of anti-depressant medication. They also considered that the treating clinicians' use of descriptors of Miss Parkinson's behaviours needed to be clarified and expanded. While they recorded that Miss Parkinson thought about dying they did not, according to Dr Blower, record how often she thought about it, the nature of those thoughts and how pervasive they were. Dr Marshall further noted that while the descriptors recorded described risk factors, they did not appear to indicate an ongoing process of risk assessment or record the Miss Parkinson's overall risk of self-harm and suicide and the overall likelihood that she might seek to take her own life. I agree that better record keeping of discussions and recording of a more comprehensive risk assessment was relevant to the circumstances of the death as explained above.

Failure to properly record and share the outcome of the Initial Referral Discussion Meeting (IRD)

[183] Mrs Moss has also pointed out in her submissions that the outcome of the IRD was not shared in a recorded form with Mrs Moss, CAMHS and the High School of Dundee. I agree that it is important that the minutes should have been circulated to those present and Mrs Moss. This allows the carer to understand what has been discussed, the outcomes and the next steps. It is unacceptable that Mrs Moss was entirely unaware that there had been an IRD far less what had been discussed, particularly when it concerned a child protection matter raised by her. As is now the case with complex case review meetings, it is important that minutes are circulated to all who attend or are involved in the care. I consider that was a fact relevant to the circumstances of Miss Parkinson's death.

[184] I recognise that it was very unfortunate that Dr McQuitty's dictation of his meeting with Miss Parkinson on 31 January 2014 was lost. It meant that valuable patient information was lost for a critical period of time. In his evidence Dr McQuitty stated that this had never happened before or since. Nonetheless it is concerning that this important written information was not available to Dr Smith when she met Miss Parkinson at appointments in February, including a change in medication. I consider that a fact relevant to the circumstances of Miss Parkinson's death.

[185] Although there was evidence that in correspondence with HSD, Dr McQuitty confused Miss Parkinson's and Mrs Moss' first names, there was no evidence that this had any consequence of any relevance and I do not find that a fact relevant to the circumstances of Miss Parkinson's death.

Conclusions

[186] Following the submissions made and my analysis of them, I find that the precautions set out at paragraph [4] above, could reasonably have been taken and, had they been taken, might realistically have resulted in Miss Parkinson's death being avoided (section 26(2)(e)). I also find that the defects in the system of working identified in paragraph [5] contributed to her death (section 26(2)(f)). Other facts relevant to the circumstances of her death are as stated in paragraph [6]. I make the recommendations set out at paragraph [7] under section 26(1)(b) and (4).

[187] I would like to thank Mrs Moss and all the other witnesses, for the time, co-operation and assistance they gave to the inquiry. I am also very grateful to all the solicitors and counsel involved who were extremely helpful in preparing for and conducting the inquiry and in narrowing down the matters at issue for the inquiry. Finally, I wish to express my sincere condolences to Miss Parkinson's family and friends.