SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT PERTH

[2021] FAI 23

PER-B308-19

DETERMINATION

BY

SHERIFF KEITH O'MAHONY

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

into the death of

WILLIAM CLARK

Perth, 22 March 2021

Determination

The Sheriff, having considered all the evidence adduced and the joint minute of agreement, determines:

1. **In terms of section 26(2)(a)** of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, that William Clark, date of birth 25 April 1950, formerly residing at 26 Primrose Place, Perth was pronounced dead at 1413 hours on 24 July 2016. The precise time of death is unknown.

2. **In terms of section 26(2)(b)** of the said Act, makes no finding as the deceased's death was not the result of an accident.

3. **In terms of section 26(2)(c)** of the said Act that the cause of his death was:

    1a) Multiple Injuries

1b) Blunt Force Trauma

1c) Fall From Hillside

4. **In terms of section 26(2)(d)** of the said Act makes no finding.

5. **In terms of sections 26(2)(e)** (precautions which (i) could reasonably have been taken, and (ii) had they been taken might reasonably have resulted in the death being avoided):

Arrangements being made to have the deceased examined and assessed by the on-call Doctor following the behaviours he exhibited on the night of 22 July 2016.

6. **In terms of section 26(f) and (g)** makes no finding.

NOTE

Introduction

[1] This inquiry was held into the death of William Clark, who was born on 25 April 1950. At the time of his death Mr Clark was a patient at the Leven Ward, Murray Royal Hospital, Perth.

[2] Preliminary hearings were held on the 20 December 2019, 24 of January and 14 February 2020.

[3] I heard evidence on 24 February 2020, the 25 February 2020, 7 October 2020, and 19 November 2020. With the exception of the final witness evidence was led physically within the courtroom. The final witness was heard via video link. I heard final submissions from parties on 18 January 2021.

[4] Mr Sadiq, procurator fiscal depute, represented the Crown. Mr Rolfe, advocate,

represented Tayside Health Board. Doctor Albert Bil represented the next of kin.

[5] The following witnesses gave evidence to the inquiry:

1.	Hazel Scott	Nurse
2.	Nicola Cruickshank	Nurse
3.	Lynn-Ann Bell	Nurse
4.	Catherine Tierney	Nurse
5.	James Easton	Security Officer
6.	Andrew Duncan	Security Officer
7.	Dr Neil Prentice	Consultant Psychiatrist
8.	Mark Dickson	Clinical Governance & Risk Management Coordinator
9.	Sally Forlong	Clinical Professional Team Manager Tayside
10.	Diane Gardiner	Interim Head of Nursing
11.	Dr Alan Scott	Independent Expert Instructed by the Crown
12.	Dr Jacqueline Scott	Independent Expert Instructed on behalf of Tayside Health Board

[6] In addition a joint minute of agreement was entered into by parties.

The legal framework

[7] The inquiry was held in terms of section 4(1) of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 on a discretionary basis.

Summary of evidence

[8] The following facts were led in evidence:

1. William Clark was born on 25 April 1950 and formerly resided at 26 Primrose Place, Perth.

2. Mr Clark was married to Elizabeth Clark.

3. Mr Clark's first documented contact with any NHS psychiatric services was in 1991 at which time he was 41 years of age. At that time he was admitted as a voluntary patient to the Murray Royal Hospital. He was diagnosed with depressive illness and received a traditional antidepressant drug treatment. He recovered from the depression, returned to his work and was subsequently discharged from out-patient review in March 1992.

4. In October 2002 he was re referred to the psychiatric outpatient department by his GP because of agitation and depression. At that time his symptoms of depression had largely responded to a robust dose of a traditional antidepressant drug.

5. In April 2003 he was again referred to the psychiatric outpatient department because of a relapse in his depressive illness. At that time he was also troubled by physical problems including chronic pain in his shoulders, neck and lower back. He again responded well to an antidepressant drug.

6. In July 2004 he was reviewed again in the psychiatric outpatient department and responded well to a drug treatment.

7. Mr Clark had no more documented contact with NHS psychiatric services

until his admission in 2016.

8. On 11 January 2016 Mr Clark's wife was admitted to hospital in Dundee. Mr Clark continued to live alone at his home address. During this time it was noted that Mr Clark was not coping with his wife being at the hospital and was struggling to carry out daily tasks such as feeding himself.

9. Mr Clark moved in with relatives and during his stay it was noted that he was not his usual-self and he consistently stated that he could not do things for himself.

10. Mr Clark met with his GP on 4 May 2016 and following that appointment the GP requested an urgent psychiatric outpatient appointment for him. His GP described him at that time as suffering severe depressive symptoms and having fleeting suicidal thoughts. At that time Mr Clark's wife was still in hospital.

11. The following day Mr Clark was assessed as an outpatient at the hospital by a specialist registrar in psychiatry. He was low in mood. Mr Clark stated at that time that he had had thoughts of suicide but would not act on these. Later that day he was admitted to ward four at the Kingsway Care Centre. A Clinical Risk Assessment and Management Plan was completed that evening which noted that he had been admitted because he had expressed suicidal ideas before admission.

12. The risk management plan that was completed that evening included actions to "maintain a safe environment" and "monitor potential for suicide".

13. On 6 May 2016 Mr Clark was reviewed by a consultant psychiatrist. His

mood was described as low and it was documented that he wished "never to wake up". It was also documented at that time that he had no plans for self-harm or suicide. The consultant psychiatrist recommended that he be considered for detention subject to mental health legislation if he wanted to leave the ward.

14. On the morning of 8 May 2016 the Clinical Risk Assessment was repeated. No modification was made to the existing risk management plan.

15. On 9 May 2016 Mr Clark was transferred as a voluntary patient to the Leven Ward, Murray Royal Hospital, Perth. He told a junior Doctor there that he had thoughts of suicide but that he did not have "the bottle". He was documented as saying that he had thoughts of "jumping off bridges and in front of cars".

16. On 10 May 2016 he was again reviewed by a Doctor. It was documented at that time that he had an anxious appearance overlying a depressed mood. He had a negative view of himself, his situation and the future. He again repeated that he did not have "the bottle" to take his own life. He was diagnosed at that time as having a relapse of a depressive disorder characterised by disabling anxiety. A course of citalopram was continued with an additional prescription of quetiapine.

17. At a team meeting on 16 May 2016 Mr Clark's leave status was recorded as "escorted" and this status remained throughout the entirety of his admission. The import of this was that Mr Clark was not permitted to leave the ward

unaccompanied.

18. On 30 May 2016 he was reviewed by the consultant psychiatrist in charge of his care, Dr Neil Prentice. He prescribed a change of antidepressant drug from citalopram to mirtazapine.

19. On 31 May 2016 Mr Clark reported to nursing staff that he felt like running away from the garden the previous day. When asked where he would run he said "up the hill". When asked why, he did not reply. When asked about killing himself he said "what else can I do?". He was offered and accepted a sedative drug, lorazepam.

20. On 4 June 2016 it was noted in the Risk Assessment Record pertaining to Mr Clark that he had said that he simply wanted to run away. He went on to state he would head up to Kinnoull Hill but says he would then "just freeze".

21. On 6 of June 2016 he consented to a course of electroconvulsive therapy (ECT). Between the 9 June and the 19 July 2016 he received 12 treatments of ECT.

22. On 12 July 2016 the prescription of mirtazapine was augmented with a second anti-depressant drug, venlafaxine.

23. On 21 July 2016 he visited his wife who remained an inpatient at hospital. He was accompanied by ward staff. After the visit he told staff that he was a "horrible person" for letting his wife "see me like this" and that he would be "taken away" for the "horrible things" he had done.

24. While within Murray Royal Hospital, Mr Clark was visited on a weekly basis by his sister. Until his final departure Mr Clark never left the hospital ward

unaccompanied and nor had he tried to do so.

25. Staff nurse Hazel Scott started her shift within the Leven Ward at around 9.30pm on 22 July 2016. Ms Scott is an experienced nurse having initially qualified in 1978. Ms Scott recalled Mr Clark as a patient on the ward.

26. At around 10.00pm on that date she went into Mr Clark's room on the ward and offered him help to get ready for bed. He refused help but did not verbally say anything. That was in character for Mr Clark. Ms Scott left his room.

27. Ms Scott returned to Mr Clark's room around 15 minutes later. He had still not got ready for bed. At that time Mr Clark put out his hand towards Ms Scott. She asked him what that was for. He asked her for a gun. Ms Scott asked why he wished a gun. Mr Clark did not verbally respond. Ms Scott continued to speak with Mr Clark for a period of time in an attempt to reassure him. However, her interpretation was that he did not appear to accept that reassurance.

28. A short time later Ms Scott left Mr Clark's room to go to the nursing office within the ward. Mr Clark followed her to the nursing office door. She observed him gesture with two fingers towards his own head as if he was holding a gun to his head. She then observed Mr Clark deliberately strike his head once on a wall**.** Ms Scott had never before seen Mr Clark imitate the use of a gun nor deliberately strike his head.

29. Ms Scott took Mr Clark into the sitting room on the ward again in an

attempt to reassure him. Mr Clark was unable to verbalise what was troubling him. She offered him medication for anxiety and agitation which he accepted. That medication was lorazepam. That was the only occasion on which Mr Clark had been given lorazepam twice in one day during the index admission.

30. Up until that point Mr Clark was subject to 30 minute nursing checks in terms of his management plan. Ms Scott decided to increase the frequency of those checks to every 15 minutes during the course of the night.

31. Later that night, during a routine check, Ms Scott observed Mr Clark on his bed. She noted Mr Clark was lying on his back and had a pillow under his chin. On previous occasions Ms Scott had observed Mr Clark asleep in the same position but with a phone or photograph on his chest. Miss Scott did not know what was under the pillow. She had no particular concerns as regards the pillow or that it might be used in some way to self-harm. She stated she increased the frequency of checks on Mr Clark simply in case there was a phone or photograph on his chest and it fell off.

32. Ms Scott did not consider there had been any significant change to Mr Clark's presentation. Her assessment was that while Mr Clark had expressed suicidal ideation he had not expressed any intent in the form of planning. Had he done so she said she would have acted differently by discussing it with him and thereafter discussing it with Doctors. That could potentially have resulted in the door being locked to prevent Mr Clark's departure. Ms Scott was aware of the statutory powers of detention she has in her capacity as a nurse.

33. At the conclusion of her shift Ms Scott handed over to the day staff and briefed the oncoming staff as to Mr Clark's behaviours the previous night. She also recorded those behaviours in the digital patient record relating to Mr Clark.

34. There was no notification made to the on-call Doctor in relation to Mr Clark's behaviours with a view to an examination being made. Nor was any change made to the risk assessment pertaining to Mr Clark.

35. At times in the past Leven Ward had operated a "locked door" policy in connection with certain patients. That was in the event that a patient was disorientated or it was regarded as dangerous for them to leave. At no time was there a "locked door" policy implemented in respect of Mr Clark. Such a decision in relation to whether the door should be locked in relation to a particular patient is normally taken by the multi-disciplinary team.

36. Even in the absence of a "locked door" policy the ward door is routinely locked between 8.00pm and 8.00am after the departure of visitors.

37. Nicola Cruickshank began her shift as charge nurse at Leven Ward at around 7.00am on 23 July 2016. She took the handover from Ms Scott and was made aware of Mr Clark's behaviour the night before. While Miss Cruickshank recalled little of the shift itself she was able to say there was nothing untoward about the shift and had not noted any particular issues with Mr Clark's presentation during her shift.

38. Miss Cruickshank was aware of the possibility of a locked door policy being used at the Leven Ward. That was implemented if a patient was at risk of

absconding. Miss Cruickshank was asked what she would have done if Mr Clark had tried to leave the ward unaccompanied while she was on shift. She indicated that she would have stopped him as he was not allowed out on his own due to his "escorted" status. Miss Cruickshank was aware of the statutory power of detention she has in her capacity as a nurse but did not ever recall needing to utilise them during her career.

39. At some point during the day shift of 23 July 2016 ligature risks were removed from Mr Clark's room. This included the removal of bags and belts. Miss Cruickshank was unable to recall precisely who had removed the ligature risks but it seemed likely this was done while Mr Clark was taken for a walk by staff members. Miss Cruickshank described the reasoning for this as simply being over cautious. As the nurse in charge the removal of ligature risks would have had to have been authorised by Miss Cruickshank.

40. Miss Cruickshank did not consider Mr Clark to be at risk of absconding. She did not recall ever having seen Mr Clark make attempts to leave previously. She had no concerns that Mr Clark intended suicide and would have contacted the on-call staff at if she thought that he would attempt to abscond.

41. Catherine Tierney was on nursing duty on 23 of July 2016 and remembered Mr Clark. Miss Tierney started her shift on 23 July 2016 at 7.00am. She received the handover from Nurse Hazel Scott. She was aware of the issues regarding Mr Clark's presentation the night before.

42. Miss Tierney confirmed it was her who removed all the ligatures from

Mr Clark's room. She described herself as being overcautious in so doing. This had been prompted by Mr Clark asking for a gun the previous night. She stated that there was nothing to suggest Mr Clark would try and leave the ward.

43. Miss Tierney could recall little else of that particular shift. She did not recall updating the risk assessment after removal of the litgatures. She confirmed that to the best of her knowledge Mr Clark had never tried to abscond from the ward before. Additionally, she confirmed that nursing staff tried to take the least restrictive approach to patients as possible in all of the circumstances.

44. Miss Tierney confirmed that there was nothing else according to her recollection that Mr Clark had done that day which gave rise to the suggestion of suicidal thoughts on his part.

45. At around 3.00pm on Saturday 23 July 2016 Mr Clark was visited by his sister. At that time she noted that Mr Clark was withdrawn and not engaging in conversation. He stated that "I am not feeling good and can't tell you what's on my mind". Despite further efforts by Mr Clark's sister to clarify what was troubling him he declined to engage and said "I'd like to tell you but I can't".

46. Lynn-Ann Bell was a staff nurse at the Leven Ward as at 23 July 2016. The shift she was working that day was from 2.00pm until 10.00pm.

47. Mrs Bell took a handover from Miss Cruickshank. Mrs Bell was made aware that the previous evening Mr Clark had asked for a gun and gestured as if to shoot himself. Mrs Bell said that was very unusual and he had never

expressed anything like that to her before.

48. Mrs Bell assessed that Mr Clark had presented that day as he normally would. She stated that that he appeared anxious, withdrawn and often mute. Mr Clark was often uncommunicative and would hover around the office door without saying what he wanted.

49. Mrs Bell was also aware that ligatures had been removed from Mr Clark's room. Mrs Bell stated the removal of ligature doesn't necessarily equate to restricted movement on the part of the patient. She had never observed him expressing desire to leave the ward unaccompanied. The nurses on Leven Ward always try to work to as least a restrictive approach as possible.

50. Mrs Bell was the only trained nurse on duty during the course of that shift. Her three colleagues were healthcare assistants.

51. Mrs Bell recalled having spoken to Mr Clark on a number of occasions that day and having seen him around 5.00pm. Mr Clark did not appear to be any more distressed than any other day during the course of her shift. Mr Clark would often just stare at his food but she recalled that he ate his evening meal that night. She recalled that she had spoken to Mr Clark at around 6.00pm in the corridor when she noted he was hanging around. She asked him if he needed anything. He simply shrugged his shoulders. She observed him going into the sitting room.

52. At around 8.00pm it is usual practice for patients to be given tea and biscuits. It was at that time Mrs Bell noticed Mr Clark was no longer present.

She informed other staff members and they made their way around the rooms within the ward.

53. Mr Clark was not present in his own room nor in any of the other rooms. Mrs Bell said this was just after 8pm. She began to think his absence was strange. She considered his absence to be out of character. She asked one of her colleagues to search the corridor outside the ward. That was done but there was no trace of Mr Clark. Colleagues also searched the hospital car park but again to no avail.

54. Ultimately Mrs Bell contacted the police at 8.35pm. Mrs Bell confirmed that if she had observed Mr Clark leaving she would have stopped him and was aware of the existence of the statutory powers available to nurses to prevent patients leaving where appropriate.

55. Mrs Bell also confirmed that the approach taken by staff towards patients is always as least restrictive as possible. There was nothing in Mr Clark's presentation which gave her the impression he was intent on absconding. On being asked whether someone should have implemented a locked doors policy due to Mr Clark's presentation Mrs Bell pointed out that the concerning behaviour had taken place 14 hours previous to her shift.

56. Mrs Bell was very shocked that Mr Clark had left the ward. She had no anticipation that he intended to commit suicide or harm himself in anyway.

57. Prior to his death the most recent addition to Mr Clark's risk assessment record had been made on 21 July 2016. It had not resulted in any change to the

level of risk applying.

58. James Easton was employed as a security guard at the hospital as 23 July 2016. He was stationed at the reception area of the hospital. Sometime after 8.00pm on 23 July 2016 Mr Easton was made aware that a patient was missing. He went out into the car park with a torch and searched for him but there was no sign of that patient.

59. CCTV evidence confirmed Mr Clark leaving the main entrance of Murray Royal Hospital at around 19.17 hours on 23 July 2016. At that time he was unaccompanied.

60. After being contacted by the hospital the police carried out various searches for Mr Clark. At around 1.00pm on Sunday 24 July 2016 a Mountain Rescue Team was deployed to carry out a search of Kinnoull Hill. Kinnoull Hill is around 600 metres from Murray Royal Hospital.

61. At around 2.07pm on that date members of the Mountain Rescue Team spotted the body of Mr Clark lying around 30 metres from the base of the cliff there. Various injuries were noted to Mr Clark.

62. An Emergency Medical Technician with the Mountain Rescue Team, Police Constable Paul Morgan, examined Mr Clark's body for signs of life. Life was pronounced extinct by PC Morgan at 14:13 hours on 24 July 2016.

63. On 26 July 2016 a post-mortem examination was carried out on the body of Mr Clark. The cause of death was certified as:

1(a) Multiple Injuries

1(b) Blunt Force Trauma

1(c) Fall from Hillside.

64. Toxicological analysis confirmed the presence of therapeutic levels of the medication prescribed to Mr Clark.

65. A Local Adverse Event Review (LAER) was held in respect of the death of Mr Clark. Such reviews are held in relation to all significant events.

66. Mr Mark Dickson is employed as a clinical governance and risk management coordinator with NHS Tayside. He had been due to facilitate or chair the LAER into the death of Mr Clark but had been unable to do so due to illness. In his absence Diane Gardiner, a senior nurse, had been asked to chair the review and had agreed to do so. Both Mr Dickson and Mrs Gardiner spoke in evidence to the conclusions of the LAER. For reasons that never became clear Nurse Hazel Scott was not asked to participate in the review.

67. The LAER made a number of findings but most salient for the purposes of this inquiry, the following:

- The risk assessments were all in place for the patient, and a risk assessment had been updated two days prior to the event. The [LAER] group heard that the ward round allows for an ongoing discussion regarding risk factors, sense checking treatment and continuity of care. For this patient there was no escalation of risk identified.
- When he could not be located in the ward or in the immediate vicinity, the site security member of staff was contacted at approximately

2010 hours. They had not seen the patient, but the group noted that this member of staff may not always be at the reception area. It was further noted that the patient was not detained under the Mental Health Act so the member of staff would not have been able to stop the patient from leaving.

- The review group agreed that the patient had been assessed appropriately on his admission to the ward and throughout his inpatient stay. The medication he was prescribed, along with the ECT therapy, did not appear to have much effect on his presentation or symptoms.
- The night before he absconded from the ward he made an offhand comment to a member of staff that he wished he had a gun. This remark appeared to be in keeping with previously expressed feelings of hopelessness. The following morning the patient was noted to be his usual self.
- After the patient had absconded and contact was made with the patient's sister, she mentioned that he had absconded during a previous inpatient stay (although this was around 25 years ago). This fact was not known to ward staff before this time.
- The group felt that this event was not avoidable and there was nothing to suggest on the day of the event that the patient was at risk of absconding.

68. Mr Dickson advised that Doctor Prentice had written to him afterwards

raising concerns in relation to the LAER and as a consequence Sally Forlong, a Clinical and Professional Team Manager with NHS Tayside, was asked to carry out a further review. A further addendum was added to the LAER as a result. That addendum reached various conclusions including (and again most relevantly for this inquiry):

- Risk assessments and care plans regarding the patient were regularly updated.
- There were subsequent care plans in place resulting from this risk assessment. However, it would have been useful for further clarity regarding at what point his risk would be considered increased and what actions were necessary.
- Although the comment made by the patient and his behaviour on the evening of 22 July was not completely unusual, staff recognised this as a sign of increased distress and instigated 15 minute observations and made his room ligature safe. The day staff did not maintain the observation levels, this was partly due to his limited mobility and therefore the belief that he was a low risk of absconding although this decision and the rationale for discontinuing should have been documented in the electronic patient record.

69. Mr Dickson advised that the action points identified in the addendum have been implemented.

70. Miss Forlong had carried out the further review in relation to the death of

Mr Clark by reviewing the electronic patient records and speaking with relevant staff members.

71. Doctor Neil Prentice was the consultant psychiatrist in charge of Mr Clark's care. Doctor Prentice had practised in the field of psychiatry since 1987. He had practised at Murray Royal Hospital since April 1998. Doctor Prentice retired in March 2018.

72. Doctor Prentice recalled having Mr Clark in his care. He carried out clinical assessments and risk assessments in connection with Mr Clark on a weekly basis.

73. Doctor Prentice confirmed that Mr Clark had never at any point been detained in terms of the Mental Health Act 2003. Doctor Prentice highlighted that there are five criteria applicable before detention in terms of the legislation can be effected, those being:

- a suspected mental illness
- the availability of treatment
- the presence of risk
- a lack of insight
- detention must be necessary

74. All five of these criteria required to be met and in Mr Clark's case it was the view of Doctor Prentice that they had not been met.

75. Doctor Prentice confirmed that Mr Clark was subject to "escorted status" that meaning that he was only permitted to leave the ward in the company of

another. Doctor Prentice was not aware of any instances when Mr Clark had expressed a desire to leave the ward unaccompanied.

76. Doctor Prentice was referred to the medical records of Mr Clark. In particular he was referred to an entry dated 4 June 2016 in which it had been noted that Mr Clark had stated he wanted to run away to Kinnoull Hill and thereafter he would "probably freeze". Doctor Prentice confirmed that he had seen that note before although he was not the author.

77. Doctor Prentice was also referred to an entry dated the 9 May 2016, in which Mr Clark had confirmed that he had thought about suicide and an entry dated 3 June 2016 in which Mr Clark had said that he had "said his goodbyes". Again Doctor Prentice confirmed that he was aware of these entries.

78. Doctor Prentice advised that Mr Clark did indeed at times have suicidal ideations. However, he had never formulated any clear plan for suicide and Doctor Prentice considered that these were passive suicidal ideas. He stressed the difference between suicidal thoughts and actual planning for suicide.

79. Doctor Prentice remained satisfied at the point he was giving evidence that Mr Clark did not meet the criteria for detention.

80. Doctor Prentice confirmed that Mr Clark had been subject to ECT treatment but unfortunately was ultimately unresponsive to that treatment.

81. In Doctor Prentice's experience Mr Clark was generally reluctant to go out of the ward.

82. Doctor Prentice was not on duty on the 22 and 23 July 2016.

83. Doctor Prentice was aware of the fact that Mr Clark made reference to a gun from reading the records. He had been made aware of that the Monday following. He had been unaware that the nurse had increased the checks on Mr Clark to 15 minutes rather than the usual 30 minutes. Doctor Prentice was aware that all the potential ligatures had been removed again from a reading of the records.

84. Doctor Prentice stated that given the events of 22 July 2016 he would have expected nursing staff to contact the duty Doctor in order to have Mr Clark examined. In particular Doctor Prentice regarded the comments relating to a gun as looking like an increase in suicidal ideations due to the description of a possibly violent method. Mr Clark's comments were a new and violent idea which represented a change. Doctor Prentice was of the view that given that change there should have been a fresh examination of Mr Clark.

85. While Doctor Prentice was of the view that the changed presentation should have resulted in a re-examination of Mr Clark he, of course, was unable to say what his own assessment of Mr Clark would have been had he carried out that assessment. That would have been dependent not only on the known history pertaining to Mr Clark but also his presentation during the course of that examination.

86. Doctor Prentice confirmed that he had been a participant in the LAER. In essence he considered that process was an information gathering exercise. Doctor Prentice felt that the LAER findings were inadequate and he had written

to Mark Dickson in December 2016 to express that. He felt that crucial individuals were not present at the LAER meeting and that accordingly there were gaps in information made available.

87. Doctor Prentice was shown the LAER report. He indicated that he did not agree with the entirety of the report. In particular he disagreed with the conclusion that the comments made by Mr Clark that he wished to have a gun was in keeping with his previously expressed feelings of hopelessness.

88. Doctor Prentice also took issue with section 7 of the same report. In particular at paragraph 2 where it was stated that there was no escalation of risk identified, Doctor Prentice was of the view that his presentation had changed and it would have been appropriate to undertake a fresh examination and risk assessment of Mr Clark. He also disagreed with paragraph 10 insofar as it stated that staff would not have been able to stop Mr Clark from leaving the ward as in the view of Doctor Prentice nursing staff do have a holding power which they can utilise if need be.

89. Doctor Prentice was critical of the fact that whatever the nurses' clinical assessment of Mr Clark was following on the various comments which he had made on 22 July 2016 that assessment was not recorded.

90. It was put to Doctor Prentice that the nurses did not consider that Mr Clark was at risk of absconding. Doctor Prentice advised it was difficult for him to respond to that as he did not know what their clinical judgement was.

91. Doctor Prentice emphasised throughout his evidence that he had not

examined Mr Clark himself following on the events of 22 July 2016.

Doctor Prentice also acknowledged that the May and June entries of the records did not represent Mr Clark's state of mind as at the 22 and 23 July 2016.

92. Doctor Prentice also acknowledged it was entirely possible that, following a medical examination of Mr Clark, there would have been no locked doors policy implemented in respect of Mr Clark and it was equally possible he would not have been detained in terms of mental health legislation.

Expert evidence

[9] The inquiry heard evidence from two experts.

Dr Alan Scott

[10] Doctor Alan Scott is a retired consultant psychiatrist. During evidence he gave a full account of his extensive experience and academic qualifications. He was clearly qualified to provide expert evidence to the inquiry.

[11] Doctor Scott gave evidence in connection with his report at production number 36.

[12] Doctor Scott's report had been prepared following his perusal of various documents including the medical records relating to Mr Clark. Doctor Scott provided a background history of the medical conditions of Mr Clark and the various treatments which he had been given over the course of a number of years.

[13] Doctor Scott advised that the LAER confirmed that day staff on 23 July 2016 did

not maintain the same observation level on Mr Clark that had been instigated the previous night however this was not recorded within the contemporaneous nursing record. The record for the rest of that day read:

> "Billy has remained anxious and withdrawn this afternoon, he has not been able to engage in any conversation, mute but occasionally shrugging shoulders or moving his head. Accepting of diet and fluids without prompting at teatime. Restless spells in the evening, but able to sit in the sitting room, unable to concentrate on the TV".

[14] Doctor Scott gave evidence in relation to the ECT treatment and, despite a technical problem during the course of the sixth treatment, was of the view that the practical administration of the course of treatment was consistent with guidelines.

[15] Doctor Scott did not offer any criticism of the care plan to which Mr Clark was subject during his index admission.

[16] Doctor Scott was of the view that there were serious warning signs in relation to Mr Clark's psychiatric condition in the 24 hours prior to him leaving the ward unnoticed. Doctor Scott's opinion was that these warning signs should have had at least two consequences. Firstly, they should have been interpreted as emphasising the need to prevent Mr Clark from leaving the ward unaccompanied. Secondly, these warning signs should have led to an urgent assessment of whether or not he had decided to act on his repeated thoughts of suicide. There was no documented evidence that any member of the ward staff had tried to ask him about this after the night of 22 July 2016.

[17] In relation to the fact that Mr Clark was a voluntary patient at the time he left the ward, it was the opinion of Doctor Scott that there had not been the grounds to detain him in terms of the mental health legislation at any point earlier in the index admission.

Dr Jacqueline Scott

[18] Doctor Jacqueline Scott is a practising consultant psychiatrist. During evidence Doctor Scott provided details of her considerable experience and qualifications and indeed I was provided with a copy of her CV. Again, I am quite satisfied that Doctor Scott was fully qualified to provide expert evidence and comment to the inquiry.

[19] Doctor Scott gave evidence in connection with the report which she had prepared in advance of her appearance in court. That report had been prepared following detailed perusal of the documentary productions relevant to the case. Doctor Scott's reports also deals with the background history of Mr Clark which does not significantly depart from that which is noted above.

[20] Doctor Scott confirmed that Mr Clark had been admitted to the Murray Royal Infirmary on an informal basis following a marked deterioration in his mood and anxiety. Doctor Scott had no particular criticisms of the care plan to which Mr Clark was subject during the index admission. Doctor Scott felt that Mr Clark was appropriately reviewed for symptoms of low mood and anxiety including regular reviews of his medication. His treatment included appropriate ECT interventions and medication. Doctor Scott felt that Mr Clark was regularly assessed for his suicidality and also emphasised that there are no perfect assessment tools in relation to suicidality.

[21] Doctor Scott noted that there had been no previous episodes in which he had hit his head and agreed that this was a change. However, this episode appeared to reflect acute distress and at no point had he voiced suicidal thoughts or made attempts to leave the ward.

[22] Doctor Scott confirmed that the nursing staff responded to this change in his presentation on 22 July by ensuring there were no ligatures available and his observation levels were increased.

[23] On 23 July Mr Clark was documented to be presenting as more like himself although he may have remained agitated. There is no indication of any other aspects of concern. He was reported as settled, was eating and no other change in presentation indicative of distress.

[24] Doctor Scott was of the view that based on the reported agitation of Mr Clark on the night of 22 July and his subsequently more settled presentation on 23 July there appears to be limited clinical rationale as to why the ward doors should have been locked. Moreover, Doctor Scott considered that given Mr Clark was presenting more like himself on 23 July the rationale for reducing the nursing observation levels was not unreasonable. He did not present as agitated during 23 July.

[25] Doctor Scott observed that Mr Clark had no prior history of absconding from the ward. The fact he was more agitated on 22 July and required additional medications was not indicative of a risk of absconding. There was nothing to suggest that while agitated on 22 July he had made attempts to leave the ward.

[26] Doctor Scott noted that the policy for locking doors would be a last resort. There was no indication during 23 July that his risk of suicide had increased. He intermittently voiced suicidal thoughts during his admission but had never attempted to leave the ward. On 23 July there were no noted thoughts of self-harm.

[27] Doctor Scott stated in her experience many patients become agitated and it is not

standard procedure that the ward would then be locked. Had he been on 15 minute observation levels his absence from the ward may have been identified sooner but whether this would have changed the outcome is unclear.

[28] On balance Doctor Scott was of the view it is not possible to find an identifiable root cause which would have led to a change in the outcome for Mr Clark nor any deficits in the care and treatment provided.

Submissions

Submissions for the crown

[29] In summary, beyond the formal findings, the Crown urge a finding in terms of section 26(2)(e) of the Act that a "locked door" policy in respect of Mr Clark may have prevented Mr Clark's death. Additionally, the Crown submit that it is arguable that had Mr Clark been subject to a further risk assessment following his behaviour on the evening of 22 July 2016 this may have resulted in a different outcome.

[30] The Crown observed that security within the hospital was ineffective; merely visual and security services were cosmetic. Moreover, the Crown submit the system of work to protect Mr Clark from leaving the ward was either defective or non-existent.

[31] The Crown sought no other findings.

Submission for NHS Tayside

[32] Beyond the formal findings, counsel for NHS Tayside urged the court to consider Mr Clark's demeanour throughout his time at Murray Royal Hospital rather than simply

the snapshot that was offered as at 22 and 23 July 2016. It was submitted that whether Mr Clark was acting in a manner that gave cause for concern or that should have prompted action can only be judged by reference to Mr Clark's typical presentation. Mr Clark's presentation and demeanour gave no cause for concern as at 23 July 2016 and he was back to normal following the episodes of the night before. Accordingly, it was submitted that no determination ought to be made in terms of section 26(2)(e) or (f) of the Act.

[33] Specifically, it was submitted that to have locked the doors of the ward would have had the concomitant effect of detaining all the residents of Leven Ward. Such an action was not reasonable at the material time given the absence of anything within Mr Clark's demeanour to suggest a risk of self-harm or absconding. Moreover, it was submitted that for the nurses to use their statutory power of detention would have required them to have a perception that Mr Clark's behaviour indicated a risk of absconding. There was no evidence to that effect. Indeed, it was submitted that their evidence was to the contrary as the nurses spoke to Mr Clark being back to his usual self on 23 July. Absent a reason to detain Mr Clark it cannot have been reasonable to have done so.

[34] It was considered that a medical assessment during 22 or 23 July 2016 of Mr Clark might have changed his management plan but there can be no certainty that that change would have prevented him from absconding. The outcome of such an assessment is uncertain and accordingly it cannot be the case that such an assessment might realistically have avoided the death.

[35] Further submissions included the fact that the 2016 act does not empower a determination of matters occurring post-death and accordingly any failing in the post incident investigation of the circumstances surrounding Mr Clark absconding do not fall to be considered by the inquiry.

Submissions for the family of Mr Clark

[36] It was submitted on behalf of the family of Mr Clark that they feel a string of failures had occurred in relation to his hospital care. These included a failure to get hospital discharge dates correct on a number of occasions, a failure to carry out a prescribed and agreed care plan, a failure to take time to listen and to ask the right questions of the patient, a failure by nursing staff to monitor and understand fully suicidal ideation and its wider implications and a failure by nursing staff to care and respond to a rapidly escalating end of week deterioration in Mr Clark's mental condition.

[37] It was further submitted that the family feel NHS Tayside have shown not only a lack of public transparency and accountability but also a lack of willingness to work positively and constructively with the family towards understanding how Mr Clark's death came about.

[38] The family considered that two questions remain uncertain: firstly, how did a very sick man get out of a supervised ward without challenge or detection; secondly, why was a very sick man of slow walking steps not located in the last hours of his life before he tumbled over Kinnoull Hill to his death?

Discussion and conclusion

[39] The purpose of a fatal accident inquiry is clear from section 1 of the legislation:

> "1. Inquiries under this Act
>
> (1) Where an inquiry is to be held into the death of a person in accordance with sections 2 to 7, the procurator fiscal must—
> (a) investigate the circumstances of the death, and
> (b) arrange for the inquiry to be held.
>
> (2) An inquiry is to be conducted by a sheriff.
>
> (3) The purpose of an inquiry 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.
>
> (4) But it is not the purpose of an inquiry to establish civil or criminal liability"

[40] The subsequent determination should address the issues specified in section 26 of the Act:

> "26 The sheriff's determination
>
> (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 (2), and
> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers 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 in the death occurred,
> (c) the cause or causes of the death,
> (d) the cause or causes of any accident resulting in the death,
> (e) any precautions which—
> (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.

(5) A recommendation under subsection (1)(b) may (but need not) be addressed to—

(a) a participant in the inquiry,

(b) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

(6) A determination is not admissible in evidence, and may not be founded on, in any judicial proceedings of any nature.

[41] I have noted the formal findings in respect of section 26(2)(a) to (c) above. I shall now address the remainder of that section.

Section 26(2)(d) – the causes or causes of any accident resulting in the death

[42] Mr Clark's death was not consequent to any accident and accordingly I make no finding in respect of this subsection.

Section 26(2)(e) – any precautions which might reasonably have been taken etc

A. Mr Clark's status during the index admission

[43] I found Doctor Prentice to be a candid and impressive witness. He had clearly reflected on the care provided by himself and colleagues to Mr Clark even to the extent of questioning some of the findings of the LAER. It seemed to me he was keen to cast light on all of the issues relating to the sad death of Mr Clark.

[44] Doctor Prentice gave careful, detailed and knowledgeable evidence in relation to the grounds for detention available to medical practitioners in terms of the legislation. He remained satisfied that grounds for detention were not made out during the index admission.

[45] Neither of the experts gave evidence questioning of that and I am satisfied there is no evidence to suggest that there was any mistaken assessment in that regard.

[46] Similarly, I might just add (in order to address an issue raised by those representing the next of kin) that there was no suggestion either the ECT treatment or the medication regime was in any way inappropriate. As I understand it from the evidence it is unusual to see a patient presenting with symptoms similar to that of Mr Clark being unresponsive to ECT treatment. It is unfortunate that the effect on Mr Clark's condition was less than would have been hoped by the clinicians.

B. Mr Clark's behaviours on the night of 22 July 2016 and 23 July 2016

[47] This is the crux of this inquiry.

[48] From his admission and until the evening of 22 July 2016 Mr Clark had made

reference to suicidal thoughts. These were documented on 6 May, 9 May, 10 May, 31 May and 4 June 2016. All of these were regarded as passive. They did not result in any change to his status nor to the level of risk it was assessed attached to Mr Clark.

[49] On 22 July 2016 matters manifestly changed. Mr Clark asked for a gun. He motioned towards his own head with his hand as if he was holding a gun to his head. He also, for the first time, was violent towards himself by striking his head on a wall.

[50] In respect of this episode I prefer the evidence of Doctor Alan Scott over that of Doctor Jacqueline Scott. I also disagree with the LAER assessment that the remarks made on 22 July 2016 were in keeping with Mr Clark's previously expressed feelings. Those behaviours, being in stark contrast to his previous behaviours, indicated a potential warning sign that his psychiatric condition had worsened and merited further examination with a concurrent renewed risk assessment.

[51] I am fortified in that view by the evidence of Dr Prentice, probably the best equipped of all the clinicians to assess the significance of this changed behaviour. It was the view of Dr Prentice that given the events of 22 July 2016 he would have expected nursing staff to contact the duty doctor to have Mr Clark examined. He regarded the comments made by Mr Clark in relation to a gun as being a change in Mr Clark in that they represented a new and violent idea. Previously he had had negative ideas but now had expressly made reference to a violent method.

[52] Moreover, there appears to have been at least a de facto recognition by nursing staff that things had changed in relation to Mr Clark. Lorazepam was given in an attempt to calm him, the first time that had had happened twice in one day since his

index admission. Night staff instigated an increased observational regime on Mr Clark (from every 30 minutes to every 15 minutes). Day staff removed the ligature risks from his room. I heard evidence that was done because staff were being "over cautious". Whatever descriptor is applied to the reasoning, it demonstrates that there must have been a (possibly unspoken) feeling amongst nursing staff that the level of risk applying to Mr Clark had elevated.

[53] I am satisfied in those changed circumstances that arrangements should have been made to contact the on-call doctor with a view to a fresh medical examination of Mr Clark's condition and a renewed risk assessment. The evidence demonstrated that could have been carried out the following morning, i.e. the morning of 23 July 2016. I cannot, of course, say what the outcome of that examination and assessment would have been. I heard evidence that there would have been a range of possible different outcomes, including mandatory detention in terms of the legislation and/or a "locked door" policy being implemented in respect of Mr Clark. The test imposed by the legislation is whether such a precaution "might realistically" have resulted in the death being avoided. I am satisfied that test is met.

[54] I also observe that the nursing clinical assessment of Mr Clark's behaviour on the evening of 22 July was not recorded. Nor was the rationale for reduction in checks on 23 July or the rationale for the removal of ligatures. These are adminicles of information that should have been recorded. However, there is no evidence that the failure to do so resulted in a different path being taken as regards Mr Clark.

[55] This was very much a situation specific episode. Having regard to my finding

above I have considered what recommendations I could make of a type which is anticipated by the legislation. Given its very specific nature I am satisfied there are no recommendations I can make in this regard.

C. "Locked Doors" and Nurses' Powers of Detention

[56] A common thread through the evidence related to the powers that a nurse may have to detain an individual. There was a recognition from the medics who gave evidence at the inquiry that a nurse can exercise a statutory power of detention in terms of the Mental Health (Care and Treatment) (Scotland) Act 2003 where the criteria found therein is met. The nurses who gave evidence (when asked about this power) universally indicated they were aware of it but had not exercised it. There was also some very limited discussion in evidence about how that might be achieved.

[57] I was invited to consider whether a finding should be made that at the material time the ward doors should have been locked to Mr Clark. That, of course, is a decision which may or may not have been made further to a medical examination by a doctor. But if it is suggested that had the nursing staff utilised their detention powers it might realistically have prevented the death then I reject that.

[58] The behaviour giving rise to concern that Mr Clark's risk of self-harm was escalating occurred around 21 hours before he departed the hospital. Had the nursing staff deployed their detention powers at that time – or even at 8am the following day when the doors were routinely unlocked – those powers would have expired long before Mr Clark departed the ward. As a matter of chronological logic it cannot be the

case therefore that had they exercised their powers of detention it might realistically have resulted in the death being avoided. The nurses' power of detention would only have had any efficacy if it were deployed in tandem with a fresh examination of Mr Clark which might have led to longer term detention measures. Accordingly, the critical point here is not whether the nurses should have exercised their detention powers but rather whether a medical examination and risk assessment should have been carried out further to his behaviour. I have made my view on that clear in the paragraphs above.

[59] Moreover, I have regard to one of the common threads in evidence throughout the inquiry, that being that Mr Clark had not given any indication of an intention to abscond. Indeed the evidence seemed to suggest that he was often reluctant to leave the ward.

[60] I was also urged to consider what might be an appropriate method of implementing a "locked doors" policy might be. Of course, given my findings here it is unnecessary to do so but I simply observe that the evidence showed a 'locked doors' policy had been implemented in the past and there was nothing to suggest it had been ineffective.

[61] The extant rule applying to Mr Clark was escorted leave. Given there was no suggestion from him at any time that he would attempt to abscond I am satisfied that it was reasonable for nursing staff to continue with that regime. However, that does not dilute from the fact that a fresh medical examination, with a renewed risk assessment would have allowed consideration of whether a "locked doors" policy should have been

applied to Mr Clark on a longer term basis.

Section 26(2)(f) – Defects in System of Work etc

[62] I have no observations to make.

Section 26(2)(g) – Any Other Relevant Factors.

[63] I have no observations to make.

[64] I am grateful to those appearing at the inquiry for their careful efforts in agreeing evidence where appropriate and summarising their position with written submissions.

[65] Finally, I join with other parties to the inquiry in offering my sincere condolences to the family and friends of William Clark.