SHERIFFDOM OF GRAMPIAN, HIGHAND AND ISLANDS AT ELGIN

[2023] FAI 11

ELG-B135-22

DETERMINATION

BY

SHERIFF OLGA PASPORTNIKOV

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

into the death of

FRANK YULE KINNIS

ELGIN, 17 February 2023

Determination

1. The Sheriff, having resumed consideration of all the evidence presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 ("the 2016 Act"):

In terms of 26(2)(a) of the 2016 Act (when and where the death occurred):

2. The late Frank Yule Kinnis (hereinafter also referred to as 'Mr. Kinnis') who was born on 2 June 1936, and resided in Elgin, Moray, was confirmed deceased at 1432 hours on 21 October 2019 at Dr. Gray's Hospital, Elgin, Moray.

In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in death occurred):

3. No accident occurred.

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

4. The cause of death was

1a – Blunt force head and facial injuries

In terms of section 26(2)(d) of the 2016 Act (the cause or causes of any accident resulting in death):

5. There was no accident. No findings are made.

In terms of **section 26(2)(e) of the 2016 Act (any precautions which (i) could reasonably have been taken and (ii) had they been taken, might realistically have resulted in death, or any accident resulting in death, being avoided):**

6. There are no precautions which could reasonably have been taken that might realistically have resulted in the death being avoided.

In terms of section 26(2)(f) of the 2016 Act (any defects in any system of working which contributed to the death or the accident resulting in death):

7. There were no defects in any system of working which contributed to the death.

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

8. There are no other facts which are relevant to the circumstances of the death.

9. No recommendations are made in terms of section 26(1)(b) and (4) of the 2016 Act.

NOTE

Legal framework

[1] The inquiry was held under section 1 of the 2016 Act and was conducted in accordance with the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 Rules"). It was a discretionary inquiry in terms of section 4(1) of the 2016 Act as Frank Yule Kinnis died as a result of being assaulted by David Johnstone, who was not criminally responsible for his conduct due to mental disorder at the time of the incident. This inquiry was to examine the mental health care and treatment provided by medical professionals to the said Mr Johnstone prior to the incident.

[2] The purpose of the inquiry is set out in section 1(3) of the Act as being to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. It is not intended to establish liability, either criminal or civil. It is an inquisitorial process. The Crown, in the form of the Procurator Fiscal represents the public interest.

[3] In terms of section 26 of the Act the inquiry must determine certain matters, namely where and when the death occurred, when any accident resulting in the death

occurred, the cause or causes of the death, the cause or causes of any accident resulting in the death, any precautions which could reasonably have been taken and might realistically have avoided the death or any accident resulting in the death, any defects in any system of working which contributed to the death, and any other factors relevant to the circumstances of the death. It is open to the Sheriff to make recommendations in relation to matters set out in subsection 4 of section 26 of the Act.

Introduction

[4] This inquiry was held into the death of Frank Yule Kinnis. Mr Kinnis was walking his dog in Birkenhill Woods, Elgin, on 21 October 2019. He was attacked by David Johnstone. He suffered injuries to his head and face and died in hospital as a result later the same day.

[5] Three preliminary hearings were held by Webex on 10 November, 22 and 30 December 2022. At the hearing on 10 November 2022, Richard Johnston, the father of David Johnstone appeared. He confirmed that he would not be seeking to enter into or be represented at the inquiry, but would provide any information requested of him and attend as a witness if required.

[6] This inquiry proceeded before me at Elgin Sheriff Court on 23 and 24 January 2023 in a hybrid fashion whereby all parties and witnesses attended court and Doctors Palin, Stevenson and Krauth were connected to the court room by live link for their evidence. Parties were as follows:

1. Ms Lixia Sun, PF Depute, represented the Crown;

2. Ms Iridag, Advocate, for Central Legal Office, Edinburgh, represented Grampian Health Board;

3. Mr Campbell, Advocate, for MDDUS, Glasgow, represented Dr Kerry Anne Cattanach.

[7] The representatives had agreed a significant amount of evidence in terms of a Joint Minute of Agreement. This meant that a number of witnesses did not require to attend. It also meant that the medical witnesses could adopt the contents of their reports and questioning could be focussed only on matters of controversy. The only aspect at issue was a very narrow one, namely the adequacy of the steps taken in relation to diagnosing and/or treating David Johnstone between 25 June and 21 October 2019. That notwithstanding, all evidence was nevertheless led in considerable detail. I anticipate that that was for the benefit of the families of Mr Kinnis and David Johnstone who were observing proceedings. I consider that this was the appropriate way to proceed.

[8] I heard evidence from the following witnesses:

1. Dr Kerry Anne Cattanach, general Practitioner at the Maryhill Medical Practice, Elgin

2. Dr Bruce McGregor Davidson, Consultant in Psychiatry, NHS Grampian

3. Pamela Elizabeth Cremin, deputy Chief Officer for NHS Highland

4. Dr Alistair Noel Palin, Consultant in Psychiatry, NHS Grampian

5. Dr Gary Stevenson, Consultant in Psychiatry, NHS Tayside

6. Dr Guy Hansen Krauth, General Practitioner, Summerside Medical Practice, Edinburgh

[9] Doctors Palin, Stevenson and Krauth also adopted the contents of their reports in the course of their oral testimony by prior agreement of the parties.

[10] The Crown also lodged an inventory of productions as follows:

1. Autopsy report
2. Toxicological report
3. Toxicological report 2
4. Death Certificate
5. Medical records
6. Medical records 2
7. Elgin Health Centre Significant Event Analysis 08.09.2020
8. NHS Grampian level 3 review report 21.09.2020
9. Expert report by Dr Gary Stevenson dated 08.08.2021
10. NHS Grampian response to Dr Stevenson report dated 08.08.2021
11. Dr Cattanach (GP) response to Dr Stevenson report
12. Dr Gary Stevenson response to NHS comments
13. Dr Gary Stevenson response to Dr Catanach (GP) comments.

[11] On behalf of Grampian Health board, the following productions were lodged:

1. Letter from Dr Davidson to Dr Cattanach dictated 3 July and sent 11 July 2019
2. Letter from Dr Davidson to David Johnstone dictated 3 July and sent 11 July 2019

[12] On behalf of Dr Cattanach, the following productions were lodged:

1. Expert report, prepared by Dr Guy Krauth, dated 25 November 2022

NICE Guideline, "Psychosis and Schizophrenia in Adults: Prevention and Management", published 12 February 2014

2. NICE Clinical Knowledge Summary, "Psychosis and Schizophrenia", last revised in September 2021

3. Mental Welfare Commission, "Mental Health Act – Principles of the Act" – available at: https://www.mwcscot.org.uk/law-and-rights/mental-health-act

4. SIGN Guidance, "Management of Schizophrenia", published March 2013

5. Scottish Executive, "Approved Medical Practitioners: Mental Health (Care and Treatment) (Scotland) Act 2003 Training Manual", published April 2005

6. GMC, "Confidentiality: Good Practice in Handling Patient Information", published January 2017

7. Mental Health (Care and Treatment) (Scotland) Act 2003

The facts

[13] The facts which had been agreed were as follows:

Background

1. Frank Yule Kinnis was born on 2 June 1936 and at the date of his death was ordinarily resident at Elgin.

2. David Johnstone was born on 11 June 1984. He was single and prior to his remand in the State Hospital, Carstairs, Lanark, lived alone in Elgin. Until June 2019, David Johnstone was employed as a design technician at a local company. At that time his employment was terminated due to repeated non-attendance.

3. David Johnstone was registered with Maryhill Health Centre, Elgin. He was briefly prescribed antidepressants for anxiety in April 2019 but stopped taking the medication after only a short period. At the time of the offence on 21 October 2019, he was not prescribed any medication.

4. David Johnstone had been regularly using cannabis from a young age.

5. David Johnstone had no formal psychiatric history and had never been assessed by psychiatric professionals prior to October 2019. His family members, however, had had concerns about his mental welfare for a few years. David Johnstone's brother had previously contacted the general practitioner's practice in September 2016 concerned about his behaviour. That resulted in David Johnstone being assessed by a doctor from the practice in October 2016. The doctor concluded that David Johnstone was not manic.

6. On 21 October 2019, at Linkwood Farms, Barmuckity, Elgin, David Johnstone attacked the now deceased, Mr Frank Kinnis, who was unknown to him and was walking his dog at the locus at the time. Following the attack, David Johnstone was restrained and arrested by police officers attending at the scene. Mr Kinnis was conveyed to Dr Gray's Hospital, Elgin, where he

succumbed to the injuries sustained from being attacked by David Johnstone. Mr Frank Kinnis' life was pronounced extinct at 1432 hours on 21 October 2019.

Involvement of General Practitioner Practice in relation to David Johnstone

7. On 24 June 2019, per Richard Johnstone's (his father's) request, a doctor from Maryhill medical Centre attempted a house visit at David Johnstone's home address. This was unsuccessful. No assessment was carried out due to no answer at David Johnstone's home address. Follow up plans were made for a repeat visit on 25 June 2019.

8. Between the evening of 24 June 2019 and the morning of 25 June 2019, Richard Johnstone contacted Grampian Medical Emergency Department (GMED) Out of Hours Service and consulted with an out of hours general practitioner doctor with regards to his ongoing concern for David Johnstone's mental health. Following the consultation, Mr Richard Johnstone was advised that a request had been sent to the in hours general practitioner team who would follow David Johnstone up on 25 June 2019. This consultation was recorded and as shown on pages 48 - 50 of Crown Production number 5 "Medical Notes 1".

9. On 25 June 2019, following a telephone conversation with Richard Johnstone, Dr Kerry Cattanach, a general practice doctor from Maryhill Medical Practice, Elgin arranged to meet him at David Johnstone's home address for a planned complex house visit.

10. On 25 June 2019 at David Johnstone's home address, Dr Cattanach carried out an assessment on his mental health during which David Johnstone had denied any suicidal thoughts or any thoughts of harming others. On completion of the assessment, Dr Cattanach made an urgent referral to adult psychiatry at Dr Gray's Hospital, Elgin for David Johnstone to be reviewed there. Pages 53-55 of Crown Production No 5 "Medical Notes 1" refer.

Involvement of Psychiatric Services in relation to David Johnstone, NHS Grampian

11. David Johnstone was offered an appointment on 1 July 2019 by the Mental Health Service at Dr Gray's hospital but had failed to attend this appointment. This outcome was thereafter intimated to Dr Cattanach by a phone call from Dr Bruce Davidson, Consultant Psychiatrist from Dr Gray's hospital on 1 July 2019 and subsequently by letter. Pages 34 and 44-45 of Crown Production No 5 "Medical Notes 1" refers respectively.

12. Following his failure to attend for an appointment on 1 July 2019, a letter was sent to David Johnstone from Dr Gray's hospital mental health service team advising him to contact the hospital to arrange a further appointment.

Post Mortem

13. On 22 October 2019 at Aberdeen Mortuary, Pathologists Dr Leighanne Deboys and Dr Tamara McNamee undertook a post mortem examination of

Mr Kinnis. The cause of death was given as 1(a) blunt force head and facial injuries. The results of the post mortem examination are recorded in the Post Mortem Report dated 21 January 2020 (Crown Production number 1) and the contents of said report are agreed to be true and accurate.

Productions and labels

14. Crown Productions number 5 and 6 are true and accurate copies of the NHS Medical Records pertaining to the said David Johnstone.

15. Crown Production number 7 is a true and accurate copy of Elgin Health Centre Significant Event Analysis dated 8 September 2020 pertaining to the said David Johnstone.

16. Crown Production number 8 is a true and accurate copy of the NHS Grampian level 3 Review Report dated 21 September 2020 pertaining to the said David Johnstone.

17. Crown Production number 9 is a true and accurate copy of an Independent Expert Psychiatric Report prepared by Dr Gary Stevenson instructed by the Crown.

18. Crown Production number 10 is a true and accurate copy of a letter containing the response to Independent Expert Psychiatric Report prepared by Dr Gary Stevenson from Dr Alastair Palin.

19. Crown Production number 11 is a true and accurate copy of the response to Independent Expert Psychiatric Report prepared by Dr Gary Stevenson from Dr Kerry Cattanach.

20. Crown Production number 12 is a true and accurate copy of the response to Dr Alastair Palin prepared by Dr Gary Stevenson.

21. Crown Production 13 is a true and accurate copy of the response to Dr Kerry Cattanach prepared by Dr Gary Stevenson.

Issues for the Inquiry

[14] The facts here were not in dispute. That being the case, after hearing from witnesses, I intend to simply outline the additional facts which I found proved at the inquiry, the reasonable inferences from those facts and the circumstances relevant to the issue that David Johnstone was not seen by any medical professionals between 25 June 2019 and Mr Kinnis' death on 21 October 2019.

[15] The main issue for this inquiry was whether anything was lacking in the care or treatment of David Johnstone which could have prevented him from attacking Mr Kinnis.

[16] The Crown position was that, had David Johnstone been detained in hospital on or after 25 June 2019, Mr Kinnis' death on 21 October 2019 would have been preventable.

[17] The Crown also sought that the inquiry consider the wider issue of whether the standard of care offered to David Johnstone had been adequate.

[18] On behalf of Dr Cattanach, it was submitted that no grounds for detention existed on 25 June 2019.

[19] On behalf of Grampian Health Board, it was submitted that Dr Davidson had followed correct procedures in trying to establish contact with David Johnstone.

Involvement of General Practitioner Practice in relation to David Johnstone

[20] Prior to visiting David Johnstone for a complex house visit on 25 June 2019, Dr Cattanach reviewed the electronic medical records.

[21] She noted that there had been intermittent mental health issues over the years, specifically relating to low mood and anxiety. She also noted from the medical records that, following a period of low mood and anxiety, David Johnstone's condition had been improving as a 25 May 2019 and he had returned to work.

[22] His mental health condition had had peaks and flows - acute periods of poor mental health and periods of improvement.

[23] On attending at David Johnstone's house, Dr Cattanach had been let in by his father. Initially, David Johnstone had indicated that he had not asked for a doctor and that he would come downstairs naked because he was not ready. Dr Cattanach had shouted up to encourage him to come down. He then had a shower and came downstairs appropriately dressed. He had recognised her from a surgical procedure she had performed on him in 2018. He had been calm.

[24] Before discussing anything with Dr Cattanach, David Johnstone asked that his father leave the house.

[25] The meeting lasted over 2 hours. David Johnstone had remained calm and coherent throughout.

[26] Dr Cattanach formed the view that David Johnstone was suffering from psychotic symptoms and possibly a schizophrenic type illness. She considered the risk.

[27] In having regard to the Guideline from the National Institute for Health and Care Excellence ("NICE") for prevention and management of psychosis and schizophrenia in adults, Dr Cattanach assessed the risk that David Johnstone may pose to himself or others.

[28] On direct questioning, David Johnstone had denied any suicidal thoughts. The house had been well kept and tidy and he had been eating. He mentioned that he had been shopping in "Asda" and there were signs of litter in the kitchen. He did query whether he ought to be eating as a result of the "energy". He did not appear to be acting in response to any command hallucinations. He did not display any aggression nor intention of harming anybody else. There was no history of violent behaviour.

[29] Dr Cattanach took the view that, although there was no emergency and David Johnstone did not meet the criteria for hospital detention, an urgent referral out to be made to psychiatric services. She considered that this was the correct course of action, as opposed to Dr Stevenson's view that she ought to have engaged the services of a Mental Health Officer. Although Dr Cattanach accepted that it was open to her to have done so, this would only have been in an emergency situation if she had considered that he ought to be detained in hospital. She considered that she had examined David Johnstone and was better placed to make the clinical decision.

[30] In terms of the legislation, the form of treatment has to be the least restrictive measure on a person's freedom.

[31] Dr Cattanach returned to her practice later on 25 June and dictated a letter of referral which was then typed and sent to the psychiatric team the following morning, 26 June 2019.

[32] At that stage, the duty of care in relation to David Johnstone's mental health passed to the secondary care team, namely the psychiatric team, once they accepted the referral. The general practitioner retained the primary care for David Johnstone's other medical issues. They would also be notified once the psychiatric service had been closed to David Johnstone as his mental health care would then revert to the general practitioners.

[33] Pamela Cremin explained the various levels of referral to psychiatric services by a general practitioner. If it is an "emergency", the patient should be assessed within 24 hours. If it is "urgent", then that should be within 7 days. If it is "routine", then it is a matter of course.

[34] For an emergency situation, the general practitioner would telephone there on call duty consultant psychiatrist and a course of action would be planned. Police and/or ambulance staff may be there as well as a Mental Health Officer and anyone else deemed necessary.

[35] Dr Palin confirmed that a person should not be detained against their will if there is no need for it. He confirmed that he had many patients who were psychotic and

were treated informally in the community. If there was no propensity for violence, they would continue to be treated in the community.

[36] Dr Palin also expressed the view that most patients experiencing psychotic symptoms do not pose a risk to others, any risk would be mainly to themselves. His view was that there had been no imminent risk at the time on the basis that the attack by David Johnstone on Mr Kinnis had come 4 months later.

[37] Dr Krauth's report and testimony were entirely supportive of Dr Cattanach's actions and her position in relation to the referral to psychiatric services. His view was that trying to encourage David Johnstone to attend for his psychiatric appointment went beyond her duties as a general practitioner; encouragement ought to have been by the psychiatric team.

Involvement of Psychiatric Services in relation to David Johnstone, NHS Grampian

[38] Dr Davidson is a specialist in general adult psychiatry with endorsement in substance abuse psychiatry. He is "attached" to the Maryhill medical Practice for the purpose of psychiatric referrals. He is also the specialist in relation to substance abuse for the Moray area.

[39] An appointment for from psychiatric services was offered to David Johnstone for 1 July 2019 at some point on or after 26 June 2019. When he did not attend, on the same date, Dr Davidson telephoned Dr Cattanach to discuss the best way to try and engage with David Johnstone.

[40] Dr Davidson's considered that, although the referral letter had provided a very detailed and helpful assessment, he wanted to see whether a mental health assessment in the community should be considered and whether David Johnstone was at the level where the mental health team should go out and see him.

[41] The conversation was between professionals who considered the best and least restrictive way forward to engage David Johnstone. Having discussed the matter with Dr Cattanach, Dr Davidson thought that the best way to deal with David Johnstone was to take an "open door" approach. This would allow him to contact the mental health team and make an appointment to come in or to be seen at home.

[42] Following the discussion, it was not considered appropriate to try and visit David Johnstone at home.

[43] Dr Davidson accepted that he may have discussed the non-attendance with Dr Cattanach at a professionals' meeting on 17 July 2019, but it is not disputed that David Johnstone had failed to make contact at that time.

[44] Dr Davidson accepted that the situation did not stop becoming "urgent" but, in the event of no engagement, there is no option other than to await the patient coming to his attention again. The case would be reviewed from time to time if brought to his attention by colleagues.

[45] If there had been further cause for concern, Dr Davidson would have expected to be alerted. He considered that keeping David Johnstone open to psychiatric services was appropriate.

[46] Dr Palin's practice was to allow a timeframe for a response when writing to a patient and advising them that, failing which, their case would be closed. He did, however, accept that his expertise lay in the field of general adult psychiatry as opposed to substance abuse. In his report, he also acknowledged that such a course of action may create barriers for the patients. He confirmed that people with psychosis are capable of responding to letters.

[47] Dr Stevenson was critical of the fact that more was not done by medical professionals to force David Johnstone to engage. He did not agree that there was no reason to think that David Johnstone would not engage with the psychiatric service. This was on the basis of information in his medical records of prior failed engagement. Further, there was evidence in the medical records that he queried whether he should be eating and that suggested that he might struggle to identify that he was suffering from any illness. He did concede, however, that he had not personally met with David Johnstone. He therefore had to accept that Dr Cattanach had, and stated that David Johnstone accepted that he had an issue and needed treatment. Similarly, there was no suggestion that that statement by David Johnstone had been anything other than genuine.

[48] Dr Stevenson accepted that the non-attendance of David Johnstone at Dr Davidson's clinic triggered a telephone discussion with Dr Cattanach and that this was the appropriate course of action.

[49] Pamela Cremin previously worked in the Moray area managing inpatient and addiction services. She explained that in the morning of 21 October 2019 there had been

contact from A&E at Dr. Gray's because they saw on the system that David Johnstone was open to psychiatric services. It is not an unusual occurrence for A & E to advise that one of the patients from the addiction services is there.

[50] Pamela Cremin also confirmed that the service is tailored to individuals who may disengage and then re-engage with the psychiatric service and so to simply close a case on the basis of non-attendance may not always be appropriate.

[51] SIGN Guidelines are in place for those with a history of non-attendance, but not for a missed first referral appointment in relation to management of schizophrenia, but of course there was no diagnosis of David Johnstone in any event.

Crown submissions

[52] Ms Sun very helpfully provided written submissions.

[53] In terms of section 26(2)(a) and (c) She invited me to make findings in relation to the date, place, time and cause of death. In terms of section 26(2) (b),(d), (e), (f) and she asked me to make no findings.

[54] In terms of section 26(2)(g), she submitted that the lack of proactive and assertive management by the mental health service following the non-attendance of David Johnstone at an urgent psychiatric consultant's clinic given the information provided by the GP is of concern and defective in the system of working. This being so, there ought to be guidance as to what should happen in the event of non-attendance at an appointment by an individual requiring urgent assessment or treatment, particularly in cases where an individual may not be capable of acting in their own best interest.

[55] Ms Sun concluded by expressing her condolences to the family and friends of Mr Kinnis for their loss.

Submissions on behalf of Grampian Health Board

[56] Ms Iridag confirmed that the findings sought by the crown were not in dispute in relation to section 26(2) subsections (a) to (f).

[57] In relation to 26(2)(g), she submitted that there were no relevant facts before the inquiry of a lack of proactive management or a defective system of working. There was no evidence from any source as to what should have been done.

[58] David Johnstone's failure to attend appointments with his general practitioner was not consistent. When his mental health improved, he attended and apologised.

[59] there was no evidence before the inquiry that David Johnstone was an individual incapable of acting in his own best interests when it came to his mental health.

[60] Patient care is guided by the least restrictive method and by patients and their individual circumstances.

[61] The assault on 21 October 2019 was not foreseeable and nothing could have been done for the death to have been avoided.

[62] To alter the approach to mental health care on very limited evidence, prioritises liability over patient care.

[63] Ms Iridag concluded by expressing her condolences to the family of Mr Kinnis for their loss.

Submissions on behalf of Dr Cattanach

[64] Mr Campbell also helpfully provided written submissions and confirmed that the findings sought by the crown were not in dispute in relation to section 26(2) subsections (a) to (f).

[65] In relation to 26(2)(g), he submitted that there was no sound evidential basis to criticise Dr Cattanach's decision to make an urgent referral to the psychiatric team on 25 June 2019. She took time and care to assess David Johnstone and was aware of the legal framework relating to detaining him in hospital.

[66] There were no circumstances justifying detaining of David Johnstone in hospital.

[67] There was no requirement or need for Dr Cattanach to involve a mental health officer in terms of section 36 of the 2003 Act. There was no evidence from any mental health officer.

[68] After care had passed to the psychiatric team, Dr Cattnach was entitled to rely on the next steps as determined by the specialist.

[69] There was no evidential basis to hold or infer that a different course of action would have prevented the death of Mr Kinnis and so no potential steps could have been taken to avoid deaths in similar circumstances. In particular, there was no evidential basis for any inference that any particular action, taken on any particular date, might realistically have avoided the death.

Discussion and conclusions

[70] As already stated, the factual evidence was not in dispute. The issues can be further focused as follows:

A. Were there grounds for Detention of David Johnstone under the Mental Health (Care and Treatment) (Scotland) Act 2003 as at 25 June 2019;

B. Should there have been greater effort made by either the general practitioner or the mental health services to engage with David Johnston between 1 July and 21 October 2019.

A. Were there grounds for Detention of David Johnstone under the Mental Health (Care and Treatment) (Scotland) Act 2003 as at 25 June 2019;

[71] In terms of the legislation, section 36 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") sets forth the criteria to be satisfied before a person can be detained in hospital for treatment of their mental health.

[72] The medical practitioner (in this case Dr Cattanach) must have been satisfied of **all** of the following aspects:

(a) that the patient has a mental disorder; and

(b) that, because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired.

[73] Further, (c) that it is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment requires to be provided to the patient; and

(d) that if the patient were not detained in hospital there would be a significant risk—

(i) to the health, safety or welfare of the patient; or

(ii) to the safety of any other person.

[74] In this case, although Dr Cattanach believed that David Johnstone may have been suffering from a mental disorder, she was not satisfied that his ability to make decisions about the provision of medical treatment was significantly impaired to the extent that it was necessary as a matter of urgency to detain him in hospital. Nor was she satisfied that David Johnstone posed a significant risk of harm to himself or others.

[75] There was no evidence to gainsay the exercise of Dr Cattanach's professional judgement had been correctly done and, accordingly, I accept that there were no grounds for the detention of David Johnstone in hospital in respect of his mental health as at 25 June 2019.

[76] A mental health officer would only be involved if emergency admission is to take place. Mental health officers are not medically qualified. They are social workers and in these circumstances it was not considered necessary to engage their assistance.

B. Should there have been greater effort made by either the general practitioner or the mental health services to engage with David Johnstone between 1 July and 21 October 2019?

[77] Dr Cattanach had attended at the home of David Johnstone and his father had to let her in. Initially, David Johnstone did not welcome the attendance of the doctor. A short time later, however, Dr Cattanach was able to hold a lengthy meeting with

David Johnstone. Following the meeting, she made an urgent referral to the mental health services first thing the following day. David Johnstone had specifically asked that no information about him be shared by Dr Cattanach with his father or any other family members. David Johnstone did, however, appear to recognise that he required assistance and told Dr Cattanach that he would engage with the mental health services.

[78] At some point before 1 July 2019, the Psychiatry Department at Dr. Gray's hospital in Elgin wrote to David Johnstone offering him an appointment on 1 July 2019, so within 5 days of the referral from Dr Cattanach.

[79] When David Johnstone failed to attend the appointment, Dr Bruce Davidson telephoned Dr Cattanach to get a better insight into how to engage with him.

[80] After discussion he took the view that a letter was the best way forward.

[81] A decision was reached for both doctors to write to David Johnstone to try and encourage engagement with the psychiatric team. It was agreed that if he did not engage, it would be a case of waiting until "crisis point", that is, until he was brought to the attention of medical staff once more, probably by family members.

[82] With the benefit of hindsight, a visit to David Johnstone's home by the mental health team might have been worth attempting. That said, on the basis that David Johnstone did not want his family to be involved, without the assistance of his father, entry to his home may not have been gained.

[83] In any event, there can be no criticism for Dr Davidson failing to attempt this course action so based on the information given by Dr Cattanach and Dr Davidson's practice of dealing with such patients. It was a clinical decision. Although Dr Palin said

that his own practice was to write with a timescale for responding after which time the case would be closed, he did defer to Dr Davidson's specialist knowledge and methods in dealing with those who abuse drink or drugs.

[84] Dr Davidson advised that he regularly writes to his patients for the purpose of making appointments. His practice is not to write saying that a patient would be discharged back to the care of the general practitioner for the purposes of mental health treatment. This is so that the case remains open to the patient to attend for treatment if required without having to await a referral from the general practitioner again.

[85] In any event, if such an "ultimatum" letter had been issued to David Johnstone, there is no guarantee that it would have elicited any response.

[86] One cannot speculate as to what may have or not have happened if David Johnstone had attended an appointment with Dr Davidson. In June 2019, it was unclear whether David Johnstone was suffering a psychotic episode induced by drugs or whether it was part of an ongoing deterioration in his mental health.

[87] Therefore one cannot say with any certainty whether any treatment would have been required or, if required, would have been successful or indeed whether David Johnstone would have complied with any such treatment.

[88] When he was examined by a general practitioner after concerns raised by his brother in 2016, David Johnstone subsequently went back to work.

[89] It would appear that David Johnstone's family were very concerned about his mental health and, whenever there was a manifestation of poor mental health, called the general practitioner. This is documented in the medical records and indeed it was

Richard Johnstone's concerns that caused Dr Cattanach to attend for a complex house visit with David Johnstone on 25 June 2019.

[90] It is of note, therefore, that no incidents of concern were reported by any member of David Johnstone's family, nor did David Johnstone come to the attention of the police in the community between 5 June and 21 October 2019.

[91] It is also of note that David Johnstone had no history of violence prior to 21 October 2019.

[92] Once the referral had been made by Dr Cattanach and an appointment sent to David Johnstone by the psychiatric team, the duty of care remained with the psychiatric services in relation to David Johnstone's mental health care. That notwithstanding, Dr Cattanach took it upon herself to write a letter to David Johnstone to try and encourage his engagement with Dr Davidson or to see her at the practice if he would rather.

[93] The period of time which elapsed between Dr Cattanach seeing David Johnstone and his attack on Mr Kinnis was just short of 4 months. It was not an excessively long time for a referral to have been kept open.

[94] David Johnstone had regularly had changes in his mental health condition and at no time had he been deemed to have been a danger to himself or others.

[95] I do not consider, therefore, that the lack of further effort to engage with David Johnstone between July and October 2019 was in any way inappropriate.

[96] On the basis that I am satisfied that there were no grounds to detain David Johnstone in hospital on 25 June 2019, it would be speculative and therefore

inappropriate to try and consider what would have happened if he had attended for an appointment with Dr Davidson between 1 July and 21 October 2021.

[97] There are too many "unknowns". By way of example, it is not known whether David Johnstone would have satisfied the criteria for detention if he had been seen by Dr Davidson nor is it possible to say whether any treatment would have been prescribed/taken.

[98] All medical professionals gave evidence that the vast majority of patients with symptoms of psychosis are not at risk of harm to others.

[99] There was no formal diagnosis in respect of David Johnstone's condition. His symptoms did not necessarily mean he was schizophrenic. Potentially, he could have been suffering from stress induced psychosis, chronic cannabis use or an acute physical illness.

[100] There is a system in place whereby if an individual who is open to psychiatric services is admitted to casualty, the psychiatric team is alerted as there is a marker on the electronic medical records. Psychiatric services may also be alerted by police if behaviour is brought to their attention. In both scenarios this would be helpful to psychiatric services to monitor their patients and, if appropriate, arrange a visit.

[101] Historically from the medical records, whenever David Johnstone's mental health deteriorated significantly, family members were instrumental in alerting medical professionals.

[102] This was the "crisis point" scenario that Dr Cattanach had discussed with Dr Davidson.

[103] A review by Grampian Health Board of the procedures taken by medical staff in this case was conducted and a report issued on 21 September 2020. The only recommendation made was that, a letter should be sent to Primary Care (the general practitioner) to confirm when people referred to Secondary Care (Mental Health) services have their case closed when they do not attend. I consider that this action would have not have assisted in the circumstances here, nor is it always the appropriate course of action given Dr Davidson's practice in dealing with his particular group of patients.

[104] Having taken all these factors into account, therefore, I do not consider that there is anything which could have been done by either Dr Cattanach and/or Dr Davidson, nor could they have taken any further reasonable precautions, made any improvements to their system of working, introduced a system of working or taken any further steps which might have realistically prevented other deaths in similar circumstances.

[105] I do not consider the Crown's submissions in relation to concerns about individuals not attending for urgent referral psychiatric appointments to be something this inquiry can issue any recommendation on. It is not a case of "one size fits all." As Dr Palin succinctly expressed in his evidence, mental health care has to be a patient centred approach; if a blanket approach to the treatment of those suffering from mental health issues were to be taken, there would be the fear of going back to the days of large psychiatric institutions.

[106] The untimely death of Frank Yule Kinnis was a horribly tragic event arising from a most unfortunate combination of unpredictable circumstances.

[107] The families of both Frank Yule Kinnis and David Johnstone attended proceedings and I appreciate that they chose to do so. I commend them on their dignity throughout proceedings and appreciate that this must have been difficult for them at times.

[108] Lastly, I once again express my sympathy to the family of Frank Yule Kinnis for their loss.