SHERIFFDOM OF SOUTH STRATHCLYDE DUMFRIES AND GALLOWAY AT HAMILTON

[2025] FAI 23

HAM-B347-23

DETERMINATION

BY

SHERIFF MICHAEL J HIGGINS

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

into the death of

JOANNE GALLACHER

HAMILTON, 31 March 2025

1. The sheriff, having considered the information presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") the following:

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

Ms Joanne Gallacher, born 12 July 1985, died at 6 Sillerknowe Court, Biggar at a point between 2325 hours on 21 December 2018 and 0039 hours on 22 December 2018. Her life was formally pronounced extinct at 0039 hours on 22 December 2018.

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

Ms Joanne Gallacher's death was not caused by an accident. Therefore no finding is made.

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

The cause of Ms Joanne Gallacher's death was stab wounds to the neck and trunk.

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

Ms Joanne Gallacher's death was not caused by an accident. Therefore, no finding is made.

(e) 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 the death, or any accident resulting in the death being avoided):

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

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

That there are no defects in any system of working which contributed to the death.

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

That there are no other facts, beyond the foregoing findings set out in this Determination, which are relevant to the circumstances of the death.

RECOMMENDATIONS

2. In terms of section 26(1)(b) of the 2016 Act, I make no recommendations.

Introduction

[1] This Inquiry was held into the death of Joanne Gallacher ("Ms Gallacher"). Ms Gallacher, aged 33 years, died at a point between 2325 hours on 21 December 2018 and 0039 hours on 22 December 2018. Her life was formally pronounced extinct at 0039 hours on 22 December 2018. She died as a result of being assaulted by James Kennedy ("Mr Kennedy") born 16 February 1987.

[2] Mr Kennedy was charged with the murder of Ms Gallacher.

[3] On 2 May 2019, at the High Court of Justiciary in Glasgow, Mr Kennedy was made subject to a Treatment Order in terms of section 52M(4) of the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act") and was ordered to be detained within the State Hospital, Carstairs.

[4] On 25 June 2019 Mr Kennedy pled guilty to an amended charge of culpable homicide under deletion of the word "murder" in the charge and substitution therefor of the word "kill". This plea was tendered on the grounds of diminished responsibility in terms of section 51B of the 1995 Act. Mr Kennedy was made subject to an Interim Compulsion Order in terms of section 53(2) and (7) of the 1995 Act.

[5] On the 16 December 2019, Mr Kennedy was made subject to a Compulsion Order and Restriction Order.

[6] Prior to 21 December 2018, amongst other agencies, Mr Kennedy had a number of interactions with various parts of NHS Lanarkshire ("NHSL") and the Police Service of Scotland ("PSS") which centred on his mental health and his suicidal ideations in particular.

[7] During these interactions with NHSL, the treating physicians consistently assessed Mr Kennedy as not having a psychotic illness and his presentation was assessed as being the result of drug and alcohol induced psychosis from his illicit drug and alcohol consumption and his lifestyle choices. He was assessed as being a risk to himself by way of self-harm but not a risk to others.

[8] This Inquiry was convened to examine these interactions with NHSL and PSS prior to the incident of 22 December 2018 and to determine amongst other things:

(1) whether any precautions (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in Ms Gallacher's death being avoided and, in this regard, to afford particular consideration to whether the system and documentation in respect of risk assessment and management was sufficiently robust to identify all potential risks to the public and other services, rather than only self-harm.

(2) To determine whether any defects in any system of working contributed to Ms Gallacher's death and in this regard to afford particular consideration to (i) the adequacy of the system of discharge planning in such circumstances; and whether it ensures sufficiently robust care planning for unplanned discharge; (ii) whether the system of referral to Addiction

Services is sufficient; (iii) processes of interagency communication, particularly in relation to communicating risk to other agencies.

[9] In respect of Ms Gallacher's death, the First Notice dated 23 March 2023 intimating the Crown's intention to hold this Fatal Accident Inquiry was lodged with the Sheriff Clerk on 14 April 2023.

[10] A number of preliminary hearings thereafter took place to focus the issues for Inquiry and to discuss the state of preparations of parties for the evidential hearing.

[11] The hearing of evidence in the Inquiry took place on 29 July, 7, 8 and 9 August and 23, 24, 25 and 26 September, all 2024. A hearing on parties' submissions took place on 10 March 2025.

[12] Throughout the evidential hearing the Crown was represented by Ms Brown, Procurator Fiscal Depute; Lanarkshire Health Board was represented by Mr Black, counsel; PSS was represented by Ms Tonner, counsel; Dr YZ was represented by Ms McCartney, solicitor advocate, and Ms Gallacher's family (AA and BB), were represented by Mr Templeton, counsel.

[13] The Inquiry heard from a number of witnesses, whose affidavits/written statements and reports had been lodged before the evidential hearing and were referred to in the course of their parole evidence at the Inquiry.

[14] The Inquiry in addition considered a number of other documentary productions lodged by the parties including extracts from medical and police records and NHLS documentation relevant to the incident. These extended to over 3,200 pages. They included the following:

(i) an Expert Report and Supplementary Reports from Crown witness Dr Ruth Ward, Consultant Psychiatrist and a joint statement produced by the Crown from Dr Ward and Dr Nabilla Muzaffar, Consultant Psychiatrist, all of which were spoken to by Dr Ward;

(ii) The report of the Significant Adverse Event Review ("SAER") into Ms Gallacher's death produced by Lanarkshire Health Board and spoke to by Dr Adam Daly, Consultant in Old Age Psychiatry;

(iii) The report of the Police Investigations and Review Commissioner ("PIRC") into the PSS involvement in the matter.

[15] The parties entered into two Joint Minutes of Agreement the first of which was extensive. These agreed, amongst other things:

(i) that all affidavits and written statements of witnesses, productions and reports (other than those forming Lanarkshire Health Board Productions 1 and 2) can be taken into consideration by the court as evidence before the Inquiry;

(ii) that the copy medical records produced in relation to Mr Kennedy from Wishaw General Hospital, and his Mental Health and MIDIS (electronic patient records) from Lanarkshire Health Board are admitted into evidence without the need to be spoken to by a witness;

(iii) that the copy medical records in relation to Mr Kennedy from Newcastle NHS were admitted into evidence without the need to be spoken to by a witness;

(iv) that the copy medical notes in relation to Mr Kennedy received from the Murray Surgery, East Kilbride incorporating a copy of the medical notes received Greenhills Health Centre, East Kilbride are admitted into evidence without the need to be spoken to by a witness;

(v) the chronology of events, the post mortem examination and its findings, and the timing, nature and outcome of the criminal proceedings against Mr Kennedy.

[16] The witnesses examined were as follows with all clinicians being in the employment of NHSL unless otherwise stated:

For the Crown:

(i) AB, Mental Health Nurse, on 7 August 2024.

(ii) Dr CD, Consultant Psychiatrist, Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust, on 7 August 2024.

(iii) EF, Senior Charge Psychiatric Nurse, on 7 August 2024.

(iv) Dr GH, Consultant Psychiatrist, on 8 August 2024.

(v) IJ, Mental Health Nurse, on 8 August 2024.

(vi) KL, Community Psychiatric Nurse, on 8 August 2024.

(vii) MN, Senior Charge Psychiatric Nurse, on 9 August 2024.

(viii) OP, Mental Health Nurse, on 9 August 2024.

(ix) QR, Social Worker, South Lanarkshire Council, on 23 September 2024.

(x) ST, Police Constable, PSS, on 23 September 2024.

(xi) UV, Detective Constable, PSS, on 23 September 2024.

(xii) WX, Mental Health Nurse, 24 September 2024.

(xiii) Dr YZ, Consultant Psychiatrist, on 24 September 2024.

(xiv) Dr Ruth Ward, Consultant Psychiatrist, on 26 September 2024.

For Ms Gallacher's family:

(i) AA on 29 July 2024.

(ii) BB on 29 July 2024.

For Lanarkshire Health Board:

(i) Dr Adam Daly, Consultant in Old Age Psychiatry, on 25 September 2024.

(ii) CC, Nurse Consultant, on 25 September 2024.

For PSS an affidavit from the following witness, who did not appear personally at the Inquiry, was also lodged:

(i) EE, Detective Inspector, PSS.

The legal framework

[17] This Inquiry was held in terms of section 4(1) of the 2016 Act. It was a discretionary Inquiry in terms of section 4(1)(a)(ii) and (b) of the 2016 Act as the Lord Advocate considered that the death of Ms Gallacher occurred in circumstances giving rise to serious public concern and that it would be in the public interest for an Inquiry to be held into the circumstances of Ms Gallacher's death.

[18] The Inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[19] The purpose of the Inquiry is set out in section 1(3) of the 2016 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.

[20] The Inquiry is an exercise in establishing facts and not in establishing fault. Its purpose is not to establish liability civil or criminal liability. The Inquiry is an inquisitorial process and the Procurator Fiscal represents the public interest on behalf of the Crown.

[21] In terms of section 26 of the 2016 Act, the Inquiry must determine the following matters:

(i) when and where the death occurred;

(ii) when and where any accident resulting in the death occurred;

(iii) the cause or causes of death;

(iv) the cause or causes of any accident resulting in the death;

(v) any precautions which could reasonably have been taken, and had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

(vi) any defects in any system of working which contributed to the death or any accident resulting in the death;

(vii) any other facts which are relevant to the circumstances of the death.

[22] In terms of section 26(4) of the 2016 Act, it is open to the sheriff to make recommendations in relation to the following matters:

(a) the taking of reasonable precautions;

(b) the making of improvements to any system of working;

(c) the introduction of a system of working;

(d) the taking of any other steps;

which might realistically prevent other deaths in similar circumstances.

The facts

[23] Having taken account of all the affidavits, witness statements and parole evidence of witnesses, the Joint Minutes of Agreement and all productions (other than those forming Lanarkshire Health Board Productions numbers 1 and 2), I found the salient and relevant facts in the case to be as follows. Unless otherwise stated, all medical and mental health practitioners mentioned were, at the relevant time, in the employment of NHSL; all hospitals mentioned therein were NHSL hospitals, and the CMHT mentioned therein was Clydesdale CMHT, bases at Lanark Health Centre:

[24] In or around 2010/2011 Mr Kennedy was diagnosed as suffering from low mood and depression and from then until Ms Gallacher's death, Mr Kennedy had numerous and regular interactions with NHSL public health services, including GP services, Community Mental Health Team ("CMHT") services, hospitals, private sector health and support services and PSS in relation to his mental health.

[25] Mr Kennedy had longstanding alcohol and drug misuse issues. Through his own choice he was not compliant with treatment and advice in this regard, particularly when in the community.

[26] On 8 June 2017 Mr Kennedy was taken to hospital by police after he had reported two men had forced their way into his home seeking drugs, held him at knifepoint and threatened to rob him. This was recorded in his hospital notes for that date where it was also recorded that Mr Kennedy was hostile in manner and made a threat to throw acid over his attackers.

[27] On 14 June 2017, OP, Senior Mental Health Charge Nurse, carried out a mental health assessment of Mr Kennedy. OP concluded that Mr Kennedy was not suffering from any acute mental illness and he was discharged into the care of the CMHT.

[28] On 2 October 2017 Mr Kennedy presented himself at hospital after expressing suicidal thoughts. A Mental Health Nurse, carried out a mental health assessment, including a risk assessment, of Mr Kennedy and concluded that Mr Kennedy showed no evidence of any psychosis, and he was discharged into the care of the CMHT.

[29] On 3 November 2017 KL, Mental Health Charge Nurse, completed a mental health assessment, including a risk assessment, on Mr Kennedy. She concluded that Mr Kennedy had a history of self-harm, violence, a previous assault charge and use of weapons. She assessed that his overall risk to himself and others was low.

[30] On 18 May 2018 EF, Senior Charge Mental Health Nurse and IJ, Community Psychiatric Nurse, visited Mr Kennedy at home and they carried out a mental health assessment of him as he had been referred to the duty service of the Community Health Team by his GP who thought he might be psychotic. When they assessed Mr Kennedy that day, although he appeared anxious, they had no significant concerns about his mental health. There was no evidence that he was psychotic and Mr Kennedy did not

say he was experiencing psychotic symptoms. Their risk assessment was that he was an overall low risk to himself and others. They concluded that there was no role for the CMHT Duty Service. A referral to Addiction Services was not made in that regard because Mr Kennedy had already referred there by that time. A new medication prescription was arranged via his GP and he was discharged from the CMHT Duty Service.

[31] On 29 June 2018 EF, Senior Charge Psychiatric Nurse within the CMHT received a telephone referral from Mr Kennedy's GP who felt that he was displaying significant psychotic symptoms and that he required a further mental health assessment. EF arranged for Mr Kennedy to attend Lanark Health Centre that afternoon for another assessment by himself and IJ, Community Psychiatric Nurse, but Mr Kennedy failed to attend. IJ spoke to Mr Kennedy's GP by telephone and told the GP that and that a home visit would be attempted the following day given that he had failed to attend the Health Centre that day.

[32] On 30 June 2028 EF and IJ attended at Mr Kennedy's home to carry out another full mental health assessment of Mr Kennedy. On their arrival there Mr Kennedy told them he had been drinking for 3 days. Their assessment was that there was no evidence that Mr Kennedy was psychotic and that his mood appeared to be caused by alcohol misuse. Mr Kennedy was discharged from the CMHT Duty Service. Mr Kennedy also told them that he had been involved in an altercation with a neighbour involving an axe whereby he had attacked the neighbour's door with same and that he been in a physical fight with the neighbour. They noted blood on the top he was wearing and on the floor

of his home. They saw drug and alcohol paraphernalia around Mr Kennedy's home as well as two large knives, a claw hammer and an axe in the house. Mr Kennedy's case notes on the MIDIS NHSL patient record computer system included a note that he had previously been derogatory about the mental health staff when he was not happy about the treatment he had been given. Mr Kennedy was not threatening or derogatory towards EF or IJ on 30 June 2018 but they both felt uneasy and uncomfortable within Mr Kennedy's home that day. As a result of these factors, EF, as team leader in the CMHT, took the decision that no further home visits by staff would take place at Mr Kennedy's home due to the risk of violence and weapons in his home. He was concerned about staff welfare and safety if visiting Mr Kennedy at his home. At this point Mr Kennedy had not made any specific threat to him, IJ or any other member of staff or to anyone else. EF took this decision out of an abundance of caution for his colleagues. This decision was noted in Mr Kennedy's risk assessment which was updated and an alert was recorded in Mr Kennedy's case notes on MIDIS that there were to be no more home visits by staff to Mr Kennedy at his home due to the risk of violence and weapons in his home. This alert was also shared by word of mouth with other staff within the CMHT at a staff meeting.

[33] On 21 August 2018 Mr Kennedy presented at his GP practice whilst in possession of a knife.

[34] On 28 August 2018 Mr Kennedy disclosed to hospital staff that, on a previous occasion, and whilst he was drunk, he assaulted a girl with a golf club.

[35] At the end of August/beginning of September 2018, Ms Gallacher met Mr Kennedy when they were both inpatients within Hairmyres Hospital, East Kilbride. They entered into a relationship with each other around 3 September 2018 and their relationship continued on and off until Ms Gallacher's death on 22 December 2018.

[36] On 10 September 2018, Mr Kennedy was discharged from hospital to Ms Gallacher's home. He was not referred to Addiction Services on discharge.

[37] On 22 October 2018 Mr Kennedy presented himself at hospital expressing paranoid beliefs that he could read the thoughts of Ms Gallacher and that he believed she planned to attack him when he was asleep. This information was never shared with Ms Gallacher by the treating clinicians. This information was made known to his Consultant Psychiatrist, Dr YZ.

[38] On 22 October 2018 Ms Gallacher contacted the staff at the same hospital and told ward staff that she had been the victim of domestic abuse from Mr Kennedy.

[39] On 1 November 2018 Mr Kennedy was again discharged from hospital to Ms Gallacher's home. He was not referred to Addiction Services on discharge.

[40] On 7 November 2018 Mr Kennedy presented himself at the Great North Trauma and Emergency Centre, Newcastle and said that he had voices inside his head. Background information was obtained from Hairmyres Hospital, East Kilbride that Mr Kennedy had been an inpatient there for a few weeks before then on an informal basis and that assessment there of Mr Kennedy was that there was no evidence of acute mental illness or mental health crisis and that his presentation was linked to drug abuse and housing concerns.

[41] On 8 November 2018 at the Great North Trauma and Emergency Centre, Newcastle, Mr Kennedy was assessed by two mental health nurses. They found no evidence of acute mental illness or mental health crisis and they felt his issues were around substance misuse and housing problems. He was discharged into the community with advice re accessing out of hours support.

[42] On 9 November 2018 Mr Kennedy again presented himself at the Great North Trauma and Emergency Centre, Newcastle having intentionally taken an overdose of paracetamol in the afternoon of 8 November and following his discharge from that hospital earlier that day. He expressed further suicidal ideation and that he would not further attempt suicide while in hospital. He was admitted as an inpatient to the Royal Victoria Hospital, Newcastle and remained there as an inpatient on a medical ward until he was repatriated home to Lanarkshire on 6 December 2018.

[43] Whilst an inpatient at the Royal Victoria Hospital, Newcastle a mental health assessment of Mr Kennedy was undertaken and no clear, persistent, pervasive or severe mental illness was identified. On being told that he was to be discharged from that hospital, Mr Kennedy self-harmed and made threats of suicide.

[44] On 6 December 2018, Mr Kennedy was returned to Lanark Health Centre by ambulance as clinicians in the Royal Victoria Hospital, Newcastle were concerned that he would self-harm on the journey if not supervised.

[45] On 6 December 2018 at Lanark Health Centre, a mental health assessment of Mr Kennedy was carried out by Dr YZ, Mr Kennedy's Consultant Psychiatrist. Mr Kennedy told Dr YZ that, when he was 12 years old, he sexually abused a 6 year old

child and that he continued to have thoughts of sexually abusing children. Dr YZ assessed Mr Kennedy as having capacity for making his own decisions. At that time Mr Kennedy was not on any psychotropic medicines and admission to hospital was not indicated. An arrangement was made for Mr Kennedy to be transported home by taxi and a follow up appointment was made for him to attend Lanark Health Centre at 11.00am the following day to meet with the CMHT duty staff. He was not referred to Addiction Services. PSS were informed that Mr Kennedy was back in the area due to the sexual abuse disclosures he made.

[46] In the evening of 6 December 2018 Mr Kennedy self-presented at Lanark Police Station and expressed suicidal ideation. He was taken by police to hospital. A mental health assessment/psychiatric review of Mr Kennedy was carried out by OP, Psychiatric Liaison Nurse. During the assessment Mr Kennedy expressed further thoughts of self-harm and paranoid type problems but there was no evidence of psychotic disturbance during the assessment and Mr Kennedy did not complain of this. Mr Kennedy was assessed as being cognitively normal, with full capacity for informed decision making and his insight was fully intact. He appeared fully mentally well with no evidence of mental illness. It was noted that he had the said appointment with the CMHT the following day and he was discharged with advice to stay with family or friends and with safety advice given to him.

[47] On 11 December 2018 South Lanarkshire Council Social Work staff visited Mr Kennedy at home following upon the police advising them that they had received a cause for concern report about Mr Kennedy. The Social Work Department were not

aware that, on 30 June 2018, the CMHT had taken the decision not to visit Mr Kennedy at his home any longer due to due to the risk of violence and weapons in his home and following the visit on 30 June 2028 to Mr Kennedy's home by EF, Senior Charge Psychiatric Nurse and IJ, Community Psychiatric Nurse both from the CMHT.

[48] On 12 December 2018, the South Lanarkshire Social Work Department raised an Adult Protection referral in relation to Mr Kennedy and an Adult Support Protection ("ASP") case conference was arranged for 17 December 2018 to have the professionals involved with Mr Kennedy discuss/implement a support plan for him.

[49] On 17 December 2018, Mr Kennedy told Ms Gallacher by telephone that he felt suicidal and Ms Gallacher then telephoned the police and told them so. Police officers attended Mr Kennedy's home to carry out a welfare check on him. They found him within his home with fresh cuts to his arm which Mr Kennedy told them he had made that day. They then took Mr Kennedy to hospital for assessment. A mental health assessment, including a risk assessment, of Mr Kennedy was then undertaken there by MN, Mental Health Nurse. He concluded that there was no indication of Mr Kennedy having any psychiatric illness or illness that required inpatient care at that time and that any crisis which Mr Kennedy was having at the time was more to do with social stressors that anything else.

[50] On completion of the mental health assessment, including a risk assessment, that day, a care plan was agreed between MN, the approved psychiatric medical practitioner (who was also present during the assessment) and the on-call consultant psychiatrist. Amongst other things, this involved Mr Kennedy being discharged back into the

ongoing care of the CMHT and his Consultant Psychiatrist, Dr YZ. The care plan would have been available to all practitioners involved in Mr Kennedy's care who had access to the NHSL MIDIS computer system including Dr YZ**,** Inpatient Services, Psychiatric Nursing Liaison Services, the CMHT, and Primary Care GP Services through the primary care mental health and wellbeing practitioners' clinical portal.

[51] On 17 December 2018 a Multi-disciplinary Team Meeting ("MDT") took place at Lanark Health Centre attended by two members of the Social Work Department, Police Constable ST and his colleague (not a witness at the Inquiry), EF, Senior Charge Psychiatric Nurse and Mr Kennedy's Consultant Psychiatrist, Dr YZ. The meeting had no input from Ms Gallacher. It had been arranged by social work to discuss their concerns that they had not been told of the CMHT decision on 30 June 2018 not to visit Mr Kennedy at his home and that two social workers had attended there on 11 December 2018. The following was noted at the meeting:

(i) EF, Senior Charge Psychiatric Nurse advised there was a risk to staff. Social work were unaware of this risk, and it was agreed by PSS that Social work should have known and that they would update the Police Concern Hub record system to have this information added to concern reports and Adult Support and Protection ("ASP") referrals;

(ii) Dr YZ reported that Mr Kennedy had no mental disorder and that it was his drug use which was damaging him;

(iii) Dr YZ would continue to offer Mr Kennedy outpatient appointments;

(iv) In relation to any further Adult Protection Reports, another visit may take place at Mr Kennedy's home with a police escort;

(v) It was agreed that Mr Kennedy would be again assessed by the CMHT and that the ASP case should be closed to social work.

[52] On 18 December 2018, a Community Psychiatric Nurse attended at Mr Kennedy's home. He spoke with Mr Kennedy via the entrance intercom system and told him that he was there to hand deliver a letter advising Mr Kennedy of an appointment for him to be seen on 19 December 2018 at Lanark Health Centre by Community Psychiatric Duty staff.

[53] On 18 December 2018 at approximately 3.30pm Mr Kennedy ingested weed killer in a suicide attempt.

[54] On 19 December 2018, Ms Gallacher visited Mr Kennedy at his home. She saw a noose there as well as knives on the floor of his home. He told her he had drank weed killer in a suicide attempt. He was vomiting blood. She was concerned for him. She telephoned the CMHT and spoke with a IJ, Community Psychiatric Nurse and told her that she was Mr Kennedy's girlfriend, that he had drank weed killer and that he was vomiting blood. IJ then spoke with Mr Kennedy and obtained his consent to speak with Ms Gallacher. IJ then told Ms Gallacher to telephone an ambulance for Mr Kennedy. Mr Kennedy was taken to Wishaw General Hospital by police who attended his home and he was admitted to hospital. The consent given by Mr Kennedy for staff to discuss his care with Ms Gallacher was in the context of this emergency situation and there was no discussion as to consent in a wider context.

[55] On 20 December 2018 EF, a Senior Charge Psychiatric Health Nurse within the CMHT, was told by telephone by the Primary Care Liaison Service that Mr Kennedy had been admitted to emergency care at Wishaw General Hospital. On that same date the EF received a telephone call from Ms Gallacher. EF had had no contact with her before then but, by that time, he was aware that Mr Kennedy and Ms Gallacher were in a relationship with each other. Ms Gallacher told him that she was Mr Kennedy's former and current partner. She wanted to discuss the situation with him and demanded that he ensure that Mr Kennedy be "sectioned" - meaning compulsorily detained - under the Mental Health Act. EF told her that he did not have Mr Kennedy's consent to discuss his current or past treatment with her but that he would listen to what she wanted to say. Mr Kennedy was not present with him or Ms Gallacher at that time so he could not speak to him to request his consent to speak to Ms Gallacher. She was critical of Mental Health Services generally and she blamed NHSL for Mr Kennedy's then current situation. She said that they had a duty of care towards Mr Kennedy and that they should be visiting him at home. Due to her hostile and verbal aggression becoming more personally directed at ward staff and Mr Kennedy's Consultant Psychiatrist, Dr YZ, EF ended the call. He did not attempt to call her back.

[56] By 21 December 2018 Mr Kennedy had been assessed as medically fit for discharge by ward staff at hospital.

[57] At about 10.00am on 21 December 2018, Ms Gallacher contact PSS via the 101 telephone service and advised the call handler that Mr Kennedy was about to be released from hospital and that she had concerns for his safety. The PSS control room

contacted Ms Gallacher and advised her that Mr Kennedy's release from hospital was a matter for the NHS. At no stage during the telephone call did Ms Gallacher inform the call handler of any perceived risk to others from Mr Kennedy.

[58] On 21 December 2018 a mental health assessment was carried out upon Mr Kennedy at by OP, a mental health nurse within the NHSL Psychiatric Liaison Nursing Service. This was to ascertain if, in terms of his mental health, he was fit for discharge. OP read Mr Kennedy's medical notes on the NHSL MIDIS computer system and saw a note of Ms Gallacher's telephone call of 20 December 2018 with EF, Senior Charge Psychiatric Nurse of the CMHT. OP did not seek Mr Kennedy's consent to discuss his presentation with Ms Gallacher. He did not consult with anyone as to making any attempt to contact Ms Gallacher with or without Mr Kennedy's consent. He had no concerns about any risk posed to Ms Gallacher by Mr Kennedy. In his assessment of Mr Kennedy he found him to be alert and orientated in time and place. Mr Kennedy told him that he could not cope in the community or at home and that he needed to be "in somewhere" to get treatment. Mr Kennedy threatened to overdose again if he was discharged from hospital that day. He found Mr Kennedy to display no evidence of any psychotic type problems. Mr Kennedy appeared fully mentally well and appeared to have full capacity for informed decision making. He considered that there were no grounds to detain or, as Ms Gallacher had described it, "section", Mr Kennedy under the Mental Health Acts. His assessment was that Mr Kennedy did not require psychiatric admission either against his will or with his agreement. He had no concerns as to risk from Mr Kennedy to third parties. He had no concerns as to risk

from Mr Kennedy towards Ms Gallacher. His assessment was an update of a previous assessment which therefore took into account previous risk assessments of Mr Kennedy where the incidents of reported violence with a weapon by Mr Kennedy to a young girl, and a neighbour, threats by Mr Kennedy to throw acid over individuals etc were recorded. His assessment therefor took these incidents and this information into account. He spoke with Mr Kennedy's Consultant Psychiatrist, Dr YZ, who agreed with his plan for Mr Kennedy to be discharged with follow up support from the CMHT over the weekend that followed. He gave Mr Kennedy full safety advice as to whom he could contact for support after discharge and the contact details for the CMHT. He advised Mr Kennedy against further self-harm. He advised Mr Kennedy's Consultant Psychiatrist, Dr YZ, his CPN, the Senior Charge Psychiatric Nurse at the CMHT, and his GP of the discharge details.

[59] Mr Kennedy was then discharged from Wishaw General Hospital on 21 December 20218 into the continuing care of the CMHT.

[60] At about 4.15pm on 21 December 2018, Ms Gallacher telephoned South Lanarkshire Council Social Work Department and spoke to the duty social worker. Ms Gallacher raised her concern following Mr Kennedy's discharge from hospital that day. Ms Gallacher said that she thought that he should remain in hospital, that she viewed him as being at risk of self-harm and that he had told her that he would continue in his efforts at suicide. She said that she felt that nobody was listening to Mr Kennedy and that she believed he would take his own life that day. The duty social worker told Ms Gallacher that if she was in his company or spoke to him by telephone and if she was

concerned about his actions or behaviour then she should not hesitate to call 999. The duty social worker told Ms Gallacher that he would share her concern with the CMHT and he did so.

[61] On Friday 21 December 2018 KL, Charge Nurse, was on duty within the CMHT. She was asked by Mr Kennedy's Consultant Psychiatrist, Dr YZ, to contact Mr Kennedy on Saturday 22 and Sunday 23 December 2018 to offer him support over that weekend and following his discharge from hospital that day. Her task was not to carry out a risk assessment on him. She was told by Mr Kennedy's Consultant Psychiatrist, Dr YZ and by EF, her CMHT Team Leader, that there was a lone worker alert relative to Mr Kennedy that he was not to be visited at home by a lone worker and that he had a history of brandishing a knife at his GP Practice. As at 21 December 2018 she knew from her past contact with Mr Kennedy that he had always lived alone and she knew about his previous disclosure of sexual abuse by him on a child and him accordingly presenting child protection issues.

[62] On 21 December 2018 KL telephoned Mr Kennedy on his mobile telephone from her office. Dr YZ was present in her office at the time and would have heard the call. Mr Kennedy was at home following his discharge from hospital that day. He was happy to engage in conversation with her and was jovial. She asked how he was and he replied stating that he felt "just the same". She asked what he meant by that and he said "well nothings really changed for me, so it is what it is". She took it that he meant that he felt just the same as he did before he attempted suicide by drinking weed killer. He denied having any suicidal ideation at that time. She asked Mr Kennedy if he had

money, electricity, heating and food in the house. He replied that he did and said that he was “sorted for the weekend". He said that he had been drinking cider and planned to continue to drink alcohol. She reminded him of implications of drinking alcohol and the negative effects on his mood/mental health and physical health. He replied "aye I know that". He told her that he did not have plans for over the weekend and was not planning to go out anywhere. He agreed to her telephoning him again over that weekend and she reminded him to keep his mobile telephone charged. He joked that he would prefer a late afternoon call as he “wanted a long lie”. He agreed to attend Lanark Health Centre on Monday 24 December 2018 at 2.30pm for further assessment by his Consultant Psychiatrist, Dr YZ. She then telephoned Distress Brief Intervention (DBI) and Lanarkshire Association for Mental Health (LAMH) to update them as regards Mr Kennedy’s discharge as they were agencies she knew were involved with him at that time. She telephoned the local police office and updated Police Constable ST also. She telephoned and updated the duty social worker about his discharge and his follow up care plan. She telephoned both the police and social work not to request any action by or assistance from them but as a courtesy to them and to share information about Mr Kennedy with them as professionals/services who had been involved in his care prior to his admission to hospital following the attempt to end his life by drinking weed killer.

[63] On 21 December 2018 KL did not have any concerns about third parties at that time. Mr Kennedy did not disclose to her any intent to harm third parties albeit that she did not ask that question of him. At the time of her telephone conversation on

21 December 2018 with Mr Kennedy she was aware that he was in a relationship with Ms Gallacher. At the end of that call she did not have any concerns for Mr Kennedy or for Ms Gallacher's safety from Mr Kennedy. He did not mention Ms Gallacher during the call. At the end of the call she made plans with Mr Kennedy for her to telephone him again the following day, 22 December 2018. KL did not complete a formal risk assessment during her telephone call with Mr Kennedy on the 21 December 2018 other than asking the questions about suicidal ideation, access to lethal means to end his life etc.

[64] At 1718 hours on 21 December 2018 Mr Kennedy telephoned Scottish Ambulance Service (SAS) control. He gave his home address and asked for an ambulance but then hung up. At 1757 hours on that date a request for assistance was received by PSS Control Room at Motherwell from SAS. A police controller telephoned Mr Kennedy's mobile telephone number which PSS had already from earlier contact with him. The call went unanswered and the police controller left a message for Mr Kennedy asking him to call them back to let them know if he required any help. The police controller then telephoned SAS to ascertain if an ambulance was being sent to Mr Kennedy's address. SAS explained that because the nature of the call was unknown, a first response unit would not be sent. SAS asked if PSS could attend and the police controller explained that she would try and send a unit to the address and would let them know if an ambulance was still required.

[65] The police controller telephoned Ms Gallacher on the mobile number which they already had for her and explained the situation to her. Amongst other things

Ms Gallacher told the police controller that Mr Kennedy had just been discharged from hospital that day and that she had made efforts by telephone that day to get Mr Kennedy help for his mental health as he had tried to kill himself and that she felt Mr Kennedy needed to be "sectioned". Ms Gallacher said that if Mr Kennedy was taken to hospital she would go and sit with him. The police controller told Ms Gallacher that she would be updated.

[66] Upon speaking with Ms Gallacher the police controller decided that a police unit would need to be sent to Mr Kennedy's home as soon as possible and one was dispatched. Police Constable ST and a colleague, who were in the area, attended.

[67] When Police Constable ST and his colleague attended Mr Kennedy's home, they were aware of Mr Kennedy and his care plan from the MDT meeting on 17 December 2018 that they had attended and they arranged for him to speak to WX, Community Psychiatric Nurse by telephone in their presence.

[68] On 21 December 2018 WX spoke to Mr Kennedy by telephone whilst police officers were with Mr Kennedy in his home. She found no evidence that Mr Kennedy was under the influence of illicit drugs or was intoxicated. She was aware that he had been assessed by OP, Mental Health Nurse at Wishaw General Hospital that day, who, after liaising with his Consultant Psychiatrist Dr YZ, had assessed him as fit for discharge from hospital that day. He did not voice to her any psychotic or delusional thoughts or beliefs. He said nothing to her that gave her any concern for any third parties including Ms Gallacher. He said that he was sitting at home having a drink and that he had no plans to go out. He did not mention his partner to her other than in his

explanation above as to how the police became involved with him that evening. She was aware of his history of violence and possession of weapons. She knew of him having a knife at his GP's practice and his history of having a dispute with a neighbour but he said nothing to her to suggest that, at the time of their conversation, he was a danger to anyone. Had she thought that he was she would have told the police so. She did not carry out a full risk assessment of Mr Kennedy in her call with him. Her main concern was if there was the possibility of him attempting suicide again. That was the reason she got the call.

[69] WX advised him against drinking more alcohol and told him that help was available to him if he chose to engage with same. She knew that he had a telephone appointment previously arranged for the following day with the CMHT. He told her he intended to keep that appointment and to engage with them. That indicated to her that he had a plan about going forward. She told him he could call her back if he wanted to do so and she gave him the telephone number for out of hours services should he need more support that evening. He seemed to take on board what she said and she was content that he was not psychotic and that he would not harm himself that night. She told the police this.

[70] On 21 December 2018 at 1858 hours the police control were updated by Police Constable ST's colleague that Mr Kennedy appeared safe and well. The police controller updated Ms Gallacher and told her that Mr Kennedy had spoken with a Community Psychiatric Nurse (WX) and that he had been given the CPN's telephone number.

Ms Gallacher told the police controller that she would try and see Mr Kennedy the following day.

[71] On 21 December 2018 at approximately 2255 hours, a taxi driver (not a witness at the Inquiry) picked up Ms Gallacher from a location near Calderwood Square, East Kilbride and drove her to Biggar. Ms Gallacher told him that she was going there to make sure her boyfriend was alright as he had drank weed killer and had recently taken an overdose of paracetamol. She told the taxi driver that she had been arguing with psychiatrists all day as her boyfriend needed help. The taxi driver dropped Ms Gallacher off at Mr Kennedy's home at 6 Sillerknowe Court, Biggar.

[72] On 21 December 2018 at approximately 2330 hours, a neighbour of Mr Kennedy, (not a witness at the Inquiry) was at home and became aware of a vehicle arriving outside. He heard someone exit the vehicle and a female shout "cheerio". He then heard a female shout "Let me in, gonnae let me in". He could hear the stair buzzer sounding in Mr Kennedy's flat. He could hear Mr Kennedy's voice and a female voice coming from the living room in Mr Kennedy's flat. The neighbour heard Mr Kennedy's voice get louder and he heard screaming coming from his flat and could hear the female struggling for breath and her screaming. The neighbour noticed that Mr Kennedy was muttering and that the female was talking in a low voice. He then became aware of blue lights flashing and police officers and an ambulance arrive in the street.

[73] Just after 0000 hours on 22 December 2018, Mr Kennedy made a 999 call to the police control room and advised the police controller that here had been a murder in his kitchen. Police officers were immediately dispatched to Mr Kennedy's address.

[74] On 22 December 2018 at 0017 hours police officers (not witnesses at the Inquiry) attended at Mr Kennedy's address where they found Ms Gallacher lying on the kitchen floor with multiple stab wounds to her neck and chest. She appeared to be deceased. They gave CPR for approximately 15 minutes. They informed the police control room of the situation. Mr Kennedy was handcuffed and taken into police custody.

[75] On 22 December 2018 at 0029 hours paramedics (not witnesses at the Inquiry) attended Mr Kennedy's home. They confirmed that Ms Gallacher had no trace of a pulse, her pupils were fixed and dilated and there was no respiratory effect or heart sounds. Consequently they pronounced her life extinct at 0039 hours on 22 December 2018.

[76] Between 2330 hours on 21 December 2018 and just after 0000 hours on 22 December 2018 Mr Kennedy killed Ms Gallacher within his home at 6 Sillerknowe Court, Biggar, by stabbing her multiple times in the neck and trunk/upper body.

[77] On 22 December 2018 at the request of PSS Dr GH, Consultant Psychiatrist, met with and assessed Mr Kennedy as to his mental health and his suitability for police interview. Mr Kennedy was not known to him before then. He read Mr Kennedy's case notes on the NHSL MIDIS system before meeting him. Mr Kennedy was co-operative, polite and relaxed and did not show any sign of distress or anxiety albeit he was subdued. He did not find Mr Kennedy to be suffering from any significant mental illness or disorder at the time of interview that would impair his ability and understanding of why he was in the police station and what would follow with the police investigation. He found him fit to be interviewed with an adult present. He

thought Mr Kennedy was in a vulnerable position given what had happened. An adult being present was to give him some confidence to answer the police questions. Mr Kennedy expressed suicidal thoughts to him. He said he did not want to live. Mr Kennedy said to him that he was paranoid that Ms Gallacher would attack him and that was why he attacked her. He could not comment on Mr Kennedy's condition the night before when he killed Ms Gallacher but at the time of his meeting with and assessment of Mr Kennedy, Mr Kennedy was not suffering from any mental illness. He was not able to say whether Mr Kennedy was suffering from any psychosis on the night he attacked Ms Gallacher but he did think that, if he was psychotic when he attacked Ms Gallacher the night before their meeting, then he would still have been demonstrating that when he met with and assessed him. His view was that Mr Kennedy retained responsibility for his actions and their consequences. On the day he examined Mr Kennedy, Mr Kennedy definitely understood what he had done and that it was wrong.

[78] The treating clinicians did not involve Ms Gallacher in the planning of or discussions involving any of Mr Kennedy's discharges from hospital. Other than the telephone conversation between IJ, Community Psychiatric Nurse and Ms Gallacher on 19 December 2018, they did not discuss his treatment or share information with her about his care or seek his consent to do so.

[79] Ms Gallacher's death at the hands of Mr Kennedy could not have been predicted and therefore could not have been prevented with certainty.

[80] Mr Kennedy was charged with Ms Gallacher's murder.

[81] On 2 May 2019 at the High Court of Justiciary at Glasgow at a continued preliminary hearing, Mr Kennedy was made subject to a Treatment Order in terms of section 52M(4) of the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act") and was ordered to be detained within the State Hospital, Carstairs.

[82] On 25 June 2019 Mr Kennedy pled guilty to an amended charge of culpable homicide under deletion of the word "murder" in the charge and the substitution therefor of the word "kill". This plea was tendered on the grounds of diminished responsibility in terms of section 51B of the 1995 Act. Mr Kennedy was made subject to an Interim Compulsion Order in terms of section 53(2) and (7) of the 1995 Act.

[83] On 4 September 2019 the High Court extended the Interim Compulsion Order and on 16 December 2019 Mr Kennedy was made subject to a Compulsion Order and Restriction Order.

[84] Mr Kennedy remains detained within the State Hospital at Carstairs under said Orders.

Significant Adverse Event Review Report ("SAER")

[85] A SAER is started by a member of Lanarkshire Health Board staff reporting an adverse event to the Mental Health and Learning Disabilities ("MHLD") Management Team which is made up of the Associate Medical Director, Associate Director of Nursing, Director of Psychology and the General Manager of the service. The report records what happened and what the outcome for the individual involved was. The MHLD share the report with the Commissioner (who alternates by week between the

Medical Director and the Director of Nursing for University Health and Social Care North Lanarkshire). The Commissioner then decides if the event will be reviewed via the SAER process or if another mechanism is better suited.

[86] Normally a SAER involves a case only with medical agencies involved. However, in this case there was social work involvement so the advice of the South Lanarkshire Health and Social Care Management Team as to whether a multi-agency review, involving social work and other agencies, would be undertaken instead of a SAER. This took some time to obtain and caused a delay in the decision to commission a SAER and it actually starting.

[87] When a SAER is commissioned the MHLD Management team selects a group of professionals to carry out the review and for events which are felt to have a greater learning potential (such as inpatient suicide and homicide) a member of their MHLD Management Team usually chairs the review. In this case that was why Dr Adam Daly, Consultant in Old Age Psychiatry, chaired the review.

[88] The SAER involves a review of the patient care in the 3 months before the adverse event and includes a review of the patient case notes and often interviews with the staff involved. Service users and their families are usually asked to participate. The review is carried out from a learning perspective with the purpose of trying to reduce the likelihood of such an event happening again in the future. Any human resources issues being dealt with separately.

[89] The completed SAER is fed back to the teams involved. The SAER concludes with a number of recommendations and the progress of staff meeting those recommendations is reviewed.

[90] The SAER in this case was produced as a production number 12 by the Crown in this case and was spoken to in evidence by Dr Daly.

[91] The SAER found that there were problems with the care provided to Mr Kennedy but concluded that there was no link between these problems and the outcome ie Mr Kennedy killing Ms Gallacher.

[92] The SAER involved a review into the inpatient and community psychiatric care provided to Mr Kennedy. A summary of the key findings and recommendations of the SAER with comments from Dr Daly in his parole evidence is as follows:

Risk assessments

[93] Risk assessments were reviewed often during the admissions and in the community. The assessment of risk and plan to manage this did not change often, and there was evidence of static risk. The assessments continued to state that the risk was overwhelmingly of self-harm, rather than harm to others. Some errors persisted across multiple updates of the risk assessment, possibly indicating a lack of thoroughness regarding the detail of each review. The assessments did not separate the issues of risk to self from risk to others. Much of the risk assessment documentation used "self-harm or harm to others" rather than separating the two into different factors.

[94] Dr Daly said that, in finding the above, the authors of the SAER were not suggesting that the clinicians did not take into account previous risk assessments but rather that, on occasions, there was no record of them having done that.

[95] Similarly Dr Daly said that the authors of the SAER were not suggesting that risks to third parties was not considered by the clinicians when they were updating risk assessments.

Risk management

[96] The management plan of the risk was changed at several points during the episode, and often in relation to changes in the assessment (particularly at times of admission and presentation to Emergency Departments).

Multi-agency working

[97] There were several examples of good multiagency working and good links between liaison staff and the community. However, it was notable that Addiction Service referrals were not made during or after the admissions for drug induced psychosis or the periods following this.

[98] Dr Daly's evidence was that although Mr Kennedy had previously been referred to Addiction Services but failed to engage with them, better efforts could have been made to ensure that Mr Kennedy did actually engage with them.

Adult Support and Patient ("ASP")

[99] Despite the good multiagency working that took place, this could still have been improved. There were several earlier opportunities to pursue ASP and associated support strategies, which may have helped to get a better outcome. All ASP referrals appeared to have been generated outwith health services via the PSS or Social Work Services.

Review commissioning

[100] Normally an SAER involves a case with only medical agencies involved. The SAER was considered as a potential multiagency review given the extensive involvement of PSS and social work and the links to ASP work in the later stages of Ms Gallacher's life. It took over 9 months to determine this would not be done, and, at that point Mental Health Services were tasked with the review. That delay resulted in an increase in staff distress over the matter and several difficulties in carrying out the review.

[101] Dr Daly's evidence was that there is now better engagement between the agencies which should make this a more timely exercise in the future.

Record keeping and letters

[102] Medical record keeping at the CMHT as to appointments and during the liaising with the medical team in Newcastle (where Mr Kennedy was hospitalised in November

to December 2018) was less than ideal. The former relied on letters being typed, which took several weeks, and the latter there was no evidence of.

Conclusions

[103] None of the above issues are likely to have directly affected the outcome of the case.

[104] This event was not predictable nor preventable. There was very little to indicate that such an incident would occur. Although there was some evidence of violence and aggression in the past, detailed and repeated assessments highlighted self-harm as the most likely and concerning risk.

Recommendations

[105] The SAER Report made a number of recommendations including the following:

(i) making their findings known to the various agencies involved and their staff;

(ii) in respect of the new NHSL MORSE computer system, risk assessment could be revised to ensure that users are promoted to proactively review risk, and to consider risk to self and risk to others as separate entities.

(iii) there should be a reflection and improvement plan for local medical staff surrounding note keeping and dictation of letters.

[106] In his parole evidence Dr Daly explained that there was a clear plan made to ensure that the above were actually implemented and a system of monitoring same to ensure the actions were taken timeously.

Analysis of evidence

[107] I found all the witnesses who attended the Inquiry and gave evidence at same as being credible witnesses. They all seemed to me to give their evidence in a straightforward and measured way and I considered that they were doing their best to assist the Inquiry with the task before it.

[108] The evidence was extensive both in terms of the affidavits/written statements and in terms of the parole evidence given by the witnesses during the Inquiry.

[109] As mentioned earlier there was also a large volume of productions.

[110] Parties entered into two joint minutes, one of which was extensive, and the result of both was that a great deal of the facts and evidence before the Inquiry was agreed by the parties. I found this most helpful and I am grateful to the parties in this regard.

[111] I considered all the evidence before the Inquiry. However, I do not intend to repeat it at length. Instead I intend to analyse the evidence with reference to, what I consider to be, the relevant issues that arose in the Inquiry.

(1) Police involvement

(i) Police Constable ST and Detective Constable UV

[112] The Inquiry heard from PC ST and DC UV. PC ST gave evidence of his involvement with Mr Kennedy in his role as Community Police Officer during the several month period leading up to Ms Gallacher's death.

[113] PC ST gave evidence that he had various interactions with Mr Kennedy for some time leading up to events on 21 into 22 December 2018. At the request of Dr YZ he attended the MDT in respect of Mr Kennedy held on 17 December 2018. His evidence was that the purpose of the meeting was to discuss supporting Mr Kennedy at home in the community following his discharge from hospital in Newcastle. His evidence was that the focus of the meeting was the risk from Mr Kennedy to himself and that, apart from the risk to social work staff going to Mr Kennedy's home, there were no concerns raised at the meeting by social work or mental health about Mr Kennedy being a risk to third parties. There was no information presented at the meeting that there were any such risks and no issue raised of any actual threats having been made by Mr Kennedy to mental health staff but that they felt intimidated and uneasy when they visited him at home on 30 June 2018.

[114] PC ST also gave evidence that, along with a colleague, and at the request of his Control Room, he attended Mr Kennedy's home in the evening of 21 December 2018 to do a welfare check on him. They found Mr Kennedy to appear relaxed and he thought Mr Kennedy was clam and in fact calmer than he had previously seen him. He was not agitated. Although Mr Kennedy told them he had drank some alcohol, he did not

consider him to be drunk, and he was lucid and communicative. He had no concern that he was drunk or under the influence of drugs. Mr Kennedy did not express to them any intent to self-harm and he and his colleague had no concerns for their own safety. With Mr Kennedy's consent, two steak knives that were lying on the floor in the living room were removed from the house, not because Mr Kennedy expressed any intent to use them, because he did not, but rather out of an abundance of caution for Mr Kennedy himself and he and his colleague. They had no concerns for any third parties such as neighbours who might visit Mr Kennedy's home. If they did have such concerns they would have telephoned the CMHT On Call Service and informed them or, if they had such concern which was serious, they would have considered detaining Mr Kennedy for a mental health assessment.

[115] PC ST's evidence was that he had spoken with KL, Community Psychiatric Nurse, earlier that day about Mr Kennedy and she had told him that the protocol the CMHT had agreed was that if Mr Kennedy required additional support then he could speak to the duty Community Psychiatric Nurse by telephone. He therefore arranged for him to do so. Other police officers, including DC UV attended before the call actually took place and he and his colleague held over the situation to them and left.

[116] PC ST's evidence was that, when they left Mr Kennedy's home that evening, they had no concerns for Mr Kennedy and there had been nothing in his presentation or discussion with him that evening which could possibly have given he and his colleague any impression of what later occurred between he and Ms Gallacher later that evening

actually happening. His evidence was that Mr Kennedy had not mentioned Ms Gallacher whilst he and his colleague were in his home that evening.

[117] DC UV gave evidence of attending at Mr Kennedy's home in the evening of 21 December 2018 and being present whilst he spoke by telephone with a Community Psychiatric Nurse who assessed his mental condition that evening. Her evidence was that Mr Kennedy's demeanour was "fine" and that there was nothing hostile or negative about his demeanour towards the officers being in his home. She knew that he had drank some alcohol but there was no evidence that suggested to her that he was impaired in any way or that he was under the influence of drugs. Her evidence was that Mr Kennedy, in the presence of she and her colleague, spoke by telephone with the On Call Duty Community Psychiatric Nurse. She heard both sides of the conversation. She heard Mr Kennedy confirm his intention to keep a telephone appointment he had with the CMHT the following day and also a face to face appointment he had with them 3 days later. The On Call Duty Community Psychiatric Nurse advised Mr Kennedy against drinking any more alcohol, to get some sleep and to keep both appointments and the call ended.

[118] DC UV's evidence was that nothing Mr Kennedy said in the telephone call gave her any concern for Mr Kennedy or anyone else and when the call ended there was no reason for her and her colleague to remain in Mr Kennedy's home so they left. If they had had any concern for Mr Kennedy himself they would have taken him to hospital. Before she left Mr Kennedy's home that evening she knew from her Control Room that Mr Kennedy was in a relationship with Ms Gallacher because the Control Room told her

that they had updated Ms Gallacher of the situation. Before she and her colleague left Mr Kennedy's home they had no concerns for Ms Gallacher's safety from Mr Kennedy and he had made no threats towards Ms Gallacher.

[119] I considered them both PC ST and DC UV to be credible and reliable witnesses and I had no difficulty in accepting their evidence in full.

(ii) Detective Inspector EE (Iain Renfrew)

[120] Detective Inspector EE of the PSS is based within the Domestic Abuse Coordination Unit, ("DACU"), in Dalmarnock, Glasgow. He provided evidence by affidavit dated 18 September 2024.

[121] The DACU is responsible for ensuring that PSS is fully sighted on all local national domestic abuse, forced marriage, honour based abuse and stalking and harassment related matters as well as researching and developing good practice across the organisation.

[122] The DACU provides national governance for the Disclosure Scheme for Domestic Abuse Scotland ("DSDAS") which was launched nationally on 1 October 2015. DSDAS provides a formal way of sharing information about a partner's abusive past with a potential victim. In making a disclosure the scheme provides those individuals with information they may have previously been unaware of thereby giving them the power to review their situation and to decide what is best for them and whether to continue their relationship.

[123] DSDAS aims to keep people safe by disclosing information held about potential perpetrators. DSDAS focuses on identifying the level of risk posed by the potential perpetrator and managing that risk at every stage of the process. It endeavours to raise public confidence and increase the protection of potential victims of domestic abuse by sharing relevant information showing, or tending to show, that an individual has a history of domestic abuse. At all times consideration is given to the safety of a potential person at risk.

[124] Ms Gallacher called PSS and, under reference to a disclosure scheme that operated in England, she asked for information about her new partner, Mr Kennedy. She alleged that her ex-partner was harassing her to complete an application in relation to Mr Kennedy. As her call had involved reference to harassment, police officers attended her home on 15 October 2018. They established there had been no criminality on the part of her ex-partner and that no immediate concern was offered by Ms Gallacher in relation to her new relationship with Mr Kennedy. She sought information about applying to DSDAS and the officers submitted an application for her to DSDAS that same day.

[125] Detective Inspector EE reviewed that application and comprehensive police and partner agency checks that were completed in relation to Mr Kennedy. Police systems checked included the Criminal History/Police National Computer, the Scottish Intelligence Database, the Interim Vulnerable Persons Database, all legacy crime management systems and all locally held Family Protection Unit files for Lanarkshire. The application was discussed at a decision-making forum on 25 October 2018. The

forum is a multiagency body of no less than three members of which PSS must be one. The involvement of other relevant domestic abuse partners ensures that the impact of any disclosures and the manner in which it is made, is considered in order that the recipient or wider family/community is not placed at any further risk as a consequence of the disclosure.

[126] The said checks that were completed at the time identified that Mr Kennedy had no recorded domestic abuse history and it was therefore agreed that, as there was no history of domestic abuse by Mr Kennedy, there was no information to disclose to Ms Gallacher. Ms Gallacher would have been told in person by police officers that there was no information of any domestic nature regarding Mr Kennedy to disclose to her.

(iii) Police Investigations and Review Commissioner's Report

[127] On 27 March 2020, the Police Investigations and Review Commissioner ("PIRC") was instructed by the Lord Advocate, in terms of section 33A(b)(ii) of the Police, Public Order and Criminal Justice (Scotland) Act 2006 to investigate the circumstances leading up to the death of Ms Gallacher, in particular, the police contact with Mr Kennedy prior to him killing Ms Gallacher.

[128] As well as recording the history of the police's involvement with Mr Kennedy in the lead up to Ms Gallacher's death, the PIRC's findings included the following:

> "There was no indication that Kennedy presented an immediate risk to himself or others during the officer's interaction with him. There is no evidence that the actions of Police Scotland officers in any way contributed or influenced the subsequent actions of Kennedy. The officers took reasonable and proportionate

> steps to ensure his well-being and dealt with the incident in a competent and professional manner".

[129] The PIRC Report goes on to conclude, on analysis of the evidence available to PIRC, as follows:

> "The available evidence provides that the officers who attended at Kennedy's home on 21 December 2018 dealt with the incident in a competent and professional manner. They correctly involved staff from the local Community Mental Health Team who carried out a full telephone assessment of Kennedy. The nurse had no concerns for him and did not identify any specific risk.
>
> There is no evidence to suggest that the actions of the police had any influence or bearing on the decision making or actions of Kennedy, who was responsible for the death of the deceased. There was no further actions identified by PIRC investigators that the officers could have reasonably considered in the circumstances".

[130] What conclusions can be drawn from this evidence?

[131] I considered that both PC ST and DC UV were credible and reliable witnesses and that they gave their evidence in a straightforward and measured way. I accepted their evidence in full and concluded that they had acted appropriately at all times and with professionalism. I accepted in full the evidence of DI EE given by affidavit which had been introduced as agreed evidence by joint minute.

[132] Having done so I agree with the conclusions of the PIRC that there is no evidence to suggest that the actions of the police had any influence or bearing on the decision-making or actions of Mr Kennedy, the party responsible for Ms Gallacher's death, and that there was no actions, additional to those the police officers carried out, which the officers could have reasonably considered in the circumstances.

(2) The relationship between Ms Gallacher and Mr Kennedy

[133] BB's evidence was that it was clear by around October 2018, when Mr Kennedy moved in with her and Ms Gallacher, that Ms Gallacher was in a relationship with Mr Kennedy. Her evidence was that, at some point after the beginning of November 2018, their relationship changed to being just friends. She recalled Ms Gallacher visiting Mr Kennedy at his home in Biggar, on a few occasions, two of which were on 19 and 21 December 2018.

[134] IJ's evidence was that on 19 December 2018, Ms Gallacher telephoned the CMHT Duty Service and described herself as being Mr Kennedy's "girlfriend". She was therefore aware that Mr Kennedy and Ms Gallacher were in a relationship with each other. She spoke with Mr Kennedy by telephone and he gave her his consent to speak to Ms Gallacher in the same telephone call. She spoke to Ms Gallacher about Ms Kennedy's situation and presentation as at that time. The consent she obtained from Mr Kennedy to speak to Ms Gallacher related to the situation as it was presenting at that time.

[135] EF's evidence was that he received a telephone call from Ms Gallacher on 20 December 2018 and that although he had not spoken to her before that date, he was aware by that date that she and Mr Kennedy were in a relationship with each other. His evidence was that Ms Gallacher told him in that call that she was Mr Kennedy's "former and current partner". He listened to what Ms Gallacher wanted to say as regards Mr Kennedy and his care.

[136] OP's evidence was that he reviewed Mr Kennedy's patient record notes on the MIDIS computer system on 21 December 2018 when he met and assessed Mr Kennedy at hospital and saw from same an earlier note that Mr Kennedy's "girlfriend" ie Ms Gallacher, had telephoned ward staff asking that he be sectioned. That was the first time he became aware that Ms Gallacher and Mr Kennedy were in a relationship.

[137] Dr YZ's evidence was that the CMHT, which included himself, never really knew whether Ms Gallacher's and Mr Kennedy's relation was on or off and that Mr Kennedy told the team on 17 December 2018 that their relationship had ended. The relationship was erratic. Dr YZ said that their relationship had not been long term.

[138] What conclusions can be drawn from this evidence?

[139] I accepted the evidence of Dr YZ as being credible in this regard and the evidence of BB, IJ, EF and OP to be credible and reliable in this regard.

[140] Their evidence in my opinion shows that, as at 19 to 22 December 2018, Ms Gallacher and Mr Kennedy were still in a relationship with each other. In my view, from the evidence, whilst it is not clear exactly what kind of relationship that was, what is clear is that Ms Gallacher was describing herself as Mr Kennedy's "girlfriend" and his "former and current partner" in the 72 hour period leading up to Ms Gallacher's death and that Mr Kennedy's patient notes on MIDIS reflect this.

[141] The relevance of this will be seen later in this Determination when I discuss the issues of risk assessment, consent and information sharing.

(3) Mr Kennedy's mental health condition

[142] It is a matter of agreement between the parties that Mr Kennedy was diagnosed as suffering from low mood as long ago as 2010/2011.

[143] The evidence shows that, in the years that followed, he interacted on numerous occasions with NHSL Mental Health Services and hospitals as well as other hospitals elsewhere, and that almost without exclusion, his presenting complaints were assessed as not amounting to any mental illness and were assessed as being the result of alcohol and or drug consumption and lifestyle choices.

[144] Dr YZ was clear in his evidence that Mr Kennedy did not suffer from any mental illness which would have justified or required his detention in hospital under the Mental Health Acts and that he could not be detained in hospital because of any concerns of future potential violence, if there were any such concerns. Dr YZ's evidence was that keeping Mr Kennedy in hospital as a voluntary patient for longer periods than he actually was could have been counterproductive because patients in such circumstances can become institutionalised and can struggle more when returned to the community than they otherwise might have.

[145] Over the period from 14 June 2017 to 21 December 2018 Mr Kennedy was assessed on various dates by Dr YZ, Consultant Psychiatrist, OP, KL, EF, IJ and MN, all Mental Health Nurses, and also by Mental Health Nurses in Newcastle and the conclusion of all their assessments was that he did not display any evidence of any acute mental illness. The assessment of most of them was that his presentation was linked to alcohol and or drug abuse and other social stressors.

[146] Dr GH's, Consultant Psychiatrist, evidence was that when he met with and assessed Mr Kennedy on 22 December 2018 he was not suffering from any significant mental illness or disorder and, if he had been psychotic the night before when he killed Ms Gallacher, he would have expected Mr Kennedy to still be demonstrating that at the time of their meeting but he did not.

[147] There was some evidence that Mr Kennedy had been assessed by a different Psychiatrist (not a witness at the Inquiry), who was a colleague of Dr YZ, as being psychotic but that Psychiatrist was not a witness at the Inquiry and Dr YZ's evidence was that he disagreed with that colleague's assessment.

[148] Dr Ward, Consultant Psychiatrist and expert witness led by the Crown did give evidence that there was some evidence to suggest that Mr Kennedy may have had an underlying prodromal mental illness and that the paranoid beliefs he had when he was assessed by Dr YZ in 2018 could have been the beginning of a full blown psychotic illness. However, she accepted in evidence that this was a "desktop" diagnosis and she did not seriously contest Dr YZ's evidence in this regard and she said that she would defer to Dr YZ in this regard as he had met with Mr Kennedy and had face to face interaction with him whereas she had not. Dr YZ's evidence was that he strongly disagreed with Dr Ward on this point and that had Mr Kennedy had prodromal symptoms these would have persisted for some time whereas Mr Kennedy was always back to normal in a matter of days.

[149] What conclusions can be drawn from this evidence?

[150] I accepted the evidence of Dr YZ, OP, KL, EF, IJ, and MN as being reliable and credible in this regard. The first Joint Minute of Agreement also agreed the evidence relating to Mr Kennedy's assessments in hospital in Newcastle so I accepted that also as being credible and reliable evidence.

[151] On that basis I have concluded from the evidence that, during the period from 2010/2011 to 22 December 2018, Mr Kennedy did not suffer from any acute mental illness; that his presenting complaints were the result of his alcohol and or drug use and lifestyle choices and some social stresses he was exposed to, and that there were no grounds for detaining him in hospital on the occasions he was a voluntary inpatient. Dr Ward's evidence of the possibility of an underlying prodromal mental illness was, at its highest, a suggestion only and I do not think it was sufficient to conclude that such an illness existed.

[152] In my view the associated issue of whether Mr Kennedy should have been prescribed anti-psychotic medication was a matter for the clinical judgment of Dr YZ.

(4) Risk assessments

[153] It was clear from the evidence of the clinicians that it was normal practice that, when someone is referred to the CMHT or attending hospital with mental health issues, a full mental health assessment would be carried out upon them on each occasion. In Mr Kennedy's case this was done by a Mental Health Nurse or a Community Psychiatric Nurse or his Consultant Psychiatrist, Dr YZ.

[154] I found the evidence of IJ, Community Psychiatric Nurse, to be helpful when she said in evidence that a mental health assessment involves a full assessment of the patient's presenting complaints, history and current presentation and to decide if they require hospital admission or if detention would be required. A full mental health assessment includes a risk assessment.

[155] The evidence of both Dr YZ and Dr Ward was that the purpose of a risk assessment was to identify and minimise an identified risk and not to predict the use of future violence. Dr Ward was clear that a risk assessment could not predict with any certainty that someone with a history of using violence in the past would use violence again and all that could be said is that there would be an increased propensity for that person to use violence again. It is a matter of agreement between the parties that the purpose of a risk assessment is to inform the management plan for the patient. This is with the objective being to minimise risk and to try and make the risk manageable.

[156] It was clear from the evidence led at the Inquiry that there were various problems with the risk assessments carried out on Mr Kennedy.

(i) Risk assessment traffic light tick box form

[157] So far as the actual process of completing a full mental assessment, including a risk assessment, was concerned, I found the evidence of AB, Mental Health Nurse and IJ, Community Psychiatric Nurse to be clear and helpful. They spoke of the process involved.

[158] Helpfully the Crown produced several of the risk assessments completed on Mr Kennedy as part of his patient records before the Inquiry and several witnesses were taken through the risk assessment that they completed and asked about their findings and which boxes they ticked.

[159] The patient record computer system used by NHSL at the time was called MIDIS and the risk assessment form used in that system uses colour coding to categorise risk at four levels:

Green: low risk

Yellow: medium risk

Amber: medium to high risk

Red: high risk

[160] In the form there are a number of questions under separate headings and the clinicians completing the assessment answer by ticking boxes. The available answers are "yes", "no" and "don't know". Depending on the question asked the answer box is rated green, yellow, amber or red with reference to the traffic light risk rating above.

[161] Under the heading "Appearance, behaviour and General Observations" the first question is: "Does the person pose an immediate risk to self, you or others (including family/carers)?"

[162] Under the same heading the third question is: "Does the person have any immediate (ie within the next few minutes or hours) plans to harm self or others?"

[163] Under the heading "What is the overall level of risk – taking into account probability?" the clinician ticks a box where the options are "low"," medium", "medium/high" and "high" risk.

[164] Under the heading "Revised Risk Rating (following actions identified)" the clinician ticks a box where the options are "low", "medium", "medium/high" and "high" risk. This question relates to the overall risk taking all factors of the risk assessment into account.

[165] Dr Daly, Consultant in Old Age Psychiatry gave evidence at the Inquiry. He was the lead for the NHSL SAER into Ms Gallacher's death. The key findings of the SAER were agreed by the parties by joint minute. One of the key findings relating to the risk assessments that were carried out included the following: "… The review team notes that much of the risk assessment documentation uses 'self-harm or harm to others' rather than separating the two into different factors".

[166] Dr Daly's evidence was that the purpose of risk assessments is to try and identify potential areas of risk where the clinicians can intervene and potentially decrease the risk. By asking the questions in the risk assessment, information is gathered to better inform the person carrying out their task of assessment of risk in order to try and minimise the risk. Risk cannot be eradicated. The purpose of a risk assessment is not to predict use of violence in the future or events or outcomes – clinicians have no tools to be able to do that.

[167] The Inquiry heard that NHSL now have a new patient record computer system called MORSE. One of the recommendations of the SAER was that the use of the risk

assessment form in this regard was reviewed and an alternative was developed. The SAER recommended that one of the actions that should be taken was to "consider risk to self and risk to others as separate entities". In his evidence Dr YZ agreed with that suggestion. Dr Daly explained that this is now underway as part of the new NHSL Morse computer system.

[168] Dr Daly also gave evidence in relation to a report he produced in consultation with NHSL, North Lanarkshire Health and Social Care and South Lanarkshire Health and Social Care Partnerships responding, at the request of the Procurator Fiscal, to Dr Ward's report into Mr Kennedy's treatment. He explained therein that having reviewed Dr Ward's report, NHSL thought it appropriate to take other actions in addition to those recommended in the SAER. These included reviewing the inpatient Situation, Background, Assessment, Recommendation ("SBAR") format of nursing notes and to progress an alternative as part of the new NHSL MORSE computer system.

[169] Dr Daly explained that he agreed with Dr Ward that the SBAR system lead to repetition in the note recording which meant that the notes were not as up to date or as insightful as they should be.

[170] The Inquiry also heard from CC, Consultant Adult Mental Health Nurse. She was the clinical lead for Mental Health Services in the migration of NHSL's electronic record keeping computer system from the MIDIS system to the new MORSE system. Her evidence was most helpful in understanding the new system and, in particular, the risk assessment process thereof and how it compares to the old MIDIS system.

[171] She also explained that, at the time of her evidence, a new risk assessment form in the MORSE system – the NHS Lanarkshire "Safety Assessment" Framework form - which specifically considers risk to self and risk to others as separate questions, was being piloted in three areas of NHSL. One of the purposes of this is to make it easier to ensure that historical risk is accounted for. Until this new risk assessment form is approved the old MIDIS risk assessment form is still being used in the areas which are not part of the pilot.

[172] Her evidence was that the new MORSE system involves the clinicians being trained in the use of the new system and the new assessment process and form before they are allowed access to the MORSE system itself. It engages clinicians in considering and gathering information on all of the patient's circumstances as part of the risk assessment and prompts them to ask the correct questions in that regard. It is designed so that staff users consider all risks, even the ones not felt significant and allocated as green in the traffic light system in MIDIS, and which were not considered or considered fully enough under MIDIS.

[173] She explained that under MORSE there will be a single risk assessment for each patient whereby the previous risk assessment requires to be updated rather than a fresh risk assessment being undertaken when the clinician meets/assesses the patient.

[174] She also explained that MORSE allows for alerts, such as a "lone worker" alert, being put on the system to notify users of relevant matters and that these would remain present until and unless they are deliberately removed.

[175] One of the recommendations of the SAER was that practitioners using MORSE would be prompted to proactively review a patient's risk assessment and to consider risk to that patient themselves and risk to others as separate entities when going into that patient's records. CC explained that this is not yet possible on MORSE as there is no way to create a notification that the risk assessment should be reviewed, but it may be introduced in the future.

[176] The detail of the new NHSL Safety Assessment Framework risk assessment form under MORSE was put to Dr Ward. Her evidence was that she thought that it was an improvement upon the traffic light tick box risk assessment used under MIDIS but that she still had some concerns for example that it would only be as good as the training given to the users of same as to what it was about as opposed to just how to fill the form in.

[177] In my view, the evidence demonstrated that the risk assessment form used under the MIDIS system was not particularly precise in its terms. In my view, the tick box traffic light risk assessment seemed general in its terms and almost skeletal and accordingly could have lent itself to generating answers of that nature.

[178] In my view, the question "Does the person pose an immediate risk to self, you or others (including family/carers)?" conflated the questions of risk to self with risk to others. In my view, it could be possible that the answer to one of those questions could be "yes" and the answer to the other could be "no" but the tick box system did not provide a place for that to be recorded. I think that the tick box system could lead to an

unclear, unhelpful and confusing answer no matter which box was ticked in answer by the clinician.

[179] In my view, the evidence also demonstrated that the new NHSL Safety Assessment risk assessment form being proposed and piloted under MORSE was clearer, more insightful and likely to produce clearer, less confusing and helpful risk assessments and could lead to a better conclusion of the matter as a result. This is in line with the evidence of Dr Ward and Dr YZ.

(ii) Multiplicity of risk assessment forms under MIDIS

[180] On the MIDIS system, once a risk assessment is updated, the original is archived and the updated version is saved as the current version. The updated version accordingly shows the details of the most recent up to date risk assessment. The Inquiry heard evidence that this could be confusing. For example, when OP, Mental Health Nurse, was giving evidence about the record on MIDIS of him assessing Mr Kennedy on 21 December 2018, he was not sure and could not tell if some of the details thereon were completed by him as an update or by a colleague as part of an earlier risk assessment.

[181] CC, Consultant Adult Mental Health Nurse, explained that under the old MIDIS system there could be a number of different risk assessments for the same patient all created at different times whereas under the new MORSE system there is only one risk assessment which can be updated by practitioners. As IJ, Mental Health Nurse, said in evidence, the risk assessment is therefore more of a "living document" in MORSE than it was in MIDIS.

(iii) Missing risk assessments and missing information on risk assessment forms

[182] Some risk assessments which had been done were missing from the MIDIS system, for example, the risk assessment done on 18 May 2018 and EF's, Senior Charge Psychiatric Nurse, and IJ's, Mental Health Nurse, assessment of 30 June 2018.

[183] A number of witnesses at the Inquiry conceded that notes of their meetings/assessments of Mr Kennedy did not mention some earlier events which were relevant to the task of risk assessing him. One example was the MIDIS note of MN's, Senior Charge Psychiatric Nurse, assessment of Mr Kennedy on 17 December 2018 did not mention him taking account of a number of earlier incidents such as Mr Kennedy's disclosure on 28 August 2018 that, when drunk, he had attacked a girl with a golf club. Another example was OP's, Mental Health Nurse, MIDIS note of his assessment of Mr Kennedy on 21 December 2018 did not mention a number of earlier incidents such as the lone worker alert recorded against Mr Kennedy following the incident of 30 June 2018 when EF, Senior Charge Psychiatric Nurse, and IJ, Mental Health Nurse, visited his home that day and saw weapons etc in his home and when Mr Kennedy told them of his altercation of that day with a neighbour involving Mr Kennedy using an axe. Another example was put to EF that the MIDIS note of the MDT Meeting attended by him on 17 December 2018 made no mention of various issues having been discussed at the meeting which were said to have been discussed or considered at the meeting.

[184] The evidence was that Mr Kennedy had a history of use of violence, possession of weapons etc and which was documented on MIDIS. Most of those involved gave

evidence that they read and considered Mr Kennedy's notes on MIDIS before meeting/assessing him. Accordingly, although certain aspects of the history of violence etc may not have been recorded in the MIDIS notes of their meetings/assessments of Mr Kennedy, they nevertheless considered the earlier notes. I had no difficulty in accepting their evidence in this regard.

[185] Dr Ward also gave evidence that, ideally, all relevant past historical violent acts, and that those were considered by the clinician carrying out the assessment, should be recorded on the notes of the assessment. Her evidence also was that there is always a tension between, on the one hand, the clinician trying to complete notes which are succinct and meaningful whilst, on the other hand, having other pressures and demands on their time in caring for patients. Her evidence was that this is a problem across the entire NHS. I had no difficulty in accepting her evidence in this regard also.

(iv) Outcomes of risk assessments

[186] One of the key findings of the NHSL SAER into Ms Gallacher's death was the following:

> "Risk assessments were reviewed often during the admissions and in the community. The assessment of risk and plan to manage this did not change often, and there is evidence of fairly static risk. The assessments continued to state that the risk was overwhelmingly of self-harm, rather than harm to others…"

[187] As previously noted, over the period from 14 June 2017 to 21 December 2018 Mr Kennedy was assessed on various dates by Dr YZ, Consultant Psychiatrist, and by OP, KL, EF, IJ and MN all Mental Health Nurses and also by Mental Health Nurses in

Newcastle and the conclusion of all their assessments was that he did not display any evidence of any acute mental illness. To this extent, this was in line with the above finding of the SAER.

[188] The evidence was that, as a result of these assessments, admission to hospital was not justified and could in fact have been detrimental to Mr Kennedy for the reasons explained earlier. Dr YZ gave evidence to this effect. The evidence was that, as a result of these assessments, managing Mr Kennedy in the community remained the principal focus throughout that period.

[189] As mentioned above, although some notes of some of these assessments did not record that the clinician who carried out the assessment consulted and considered previous risk assessments, or made no mention of the record of previous incidents of Mr Kennedy's behaviour being taken into account, most of those witnesses involved said they did read and consider Mr Kennedy's notes on MIDIS before meeting/assessing him. Accordingly, although certain aspects of the history of violence etc may not have been recorded in the MIDIS notes of their meetings/assessments of Mr Kennedy, they nevertheless considered those earlier notes. I had no difficulty in accepting their evidence in this regard.

[190] When he was being assessed by OP, Mental Health Nurse, in hospital on 8 June 2017, Mr Kennedy is recorded as having made a threat to throw acid in the faces of persons he alleged had broken into his home and tried to rob him. The Inquiry heard of a number of risk assessments being carried out thereafter and that none suggesting that he was a threat to others.

[191] One such assessment was on 3 November 2017 when he was assessed by EF, Mental Health Nurse. That recorded that he had a history of, amongst other things, violence, a previous assault charge and the use of weapons. He was assessed that day as being a low risk to others.

[192] On 30 June 2018 when he was assessed by EF and IJ, both Mental Health Nurses, they saw blood on his clothing and on the floor of his home. He told them he had been in an altercation with a neighbour whereby he attacked the neighbour's door with an axe. They saw two large knives, a claw hammer and an axe in his house. Although he was not threatening to them they both felt uneasy and uncomfortable within his home that day and the result of that visit and these circumstances was that EF placed an alert on his notes on MIDIS that he was not to be visited by CMHT staff at his home due to the risk of violence and weapons in his home.

[193] The evidence was that on 21 August 2018 Mr Kennedy attended his GP practice whilst in possession of a knife.

[194] The evidence was on 28 August 2018, Mr Kennedy disclosed to hospital staff that, on a previous occasion whilst drunk, he assaulted a girl with a golf club.

[195] The evidence was that on 22 October 2018, Mr Kennedy presented himself at hospital expressing paranoid beliefs that he could read the thoughts of Ms Gallacher and that he believed she intended to harm him whilst he was asleep. That same day Ms Gallacher telephoned ward staff and alleged that she had suffered domestic abuse from Mr Kennedy. Mr Kennedy was assessed on 6 December 2018 by Dr YZ and later

that same day by OP and on 17 December by MN, all Mental Health Nurses, and no concerns re risk to others was recorded.

[196] The evidence was that Mr Kennedy was then assessed by OP, in hospital and when OP had no concerns about any risk posed to Ms Gallacher by Mr Kennedy.

[197] Albeit that neither KL, Community Psychiatric Nurse, nor WX, Mental Health Nurse, carried out a risk assessment of Mr Kennedy when they both spoke to him by telephone on 21 December 2018, neither had any concern for third parties, including Ms Gallacher, from Mr Kennedy.

[198] This evidence shows that a number of assessments, including risk assessments, were carried out on Mr Kennedy by a number of clinicians against a documented and known background of recorded violence, use and possession of weapons and threatening behaviour by Mr Kennedy yet he was consistently assessed/thought not to be a risk to third parties, including Ms Gallacher.

[199] In my view, the evidence showed three factors which help to put this into context and assists in explaining this outcome.

[200] The first is the tick box traffic light system that was used in the MIDIS system as explained above and the issues of risk of self-harm and risk to others being posed as one question rather than separated into two. In my view this was an unhelpful and confusing approach to use.

[201] The second is that it was a recurrent theme in the evidence that those assessing Mr Kennedy were assessing him, including his risk if any to others, at the point in time they were assessing him ie was he a risk to third parties as at that time and date? In my

view one of the questions asked in the MIDIS risk assessment form under the heading "Appearance, behaviour and General Observations" illustrates this ie "Does the person have any immediate (ie within the next few minutes or hours) plans to harm self or others?"

[202] The third is that, in my view, the evidence showed that the overwhelming focus of the risk assessments of Mr Kennedy was risk of self-harm and not risk to third parties. This was also noted in the SAER. I think a passage in the evidence of OP, Mental Health Nurse, helps to illustrate this. In his evidence OP said, when accepting that the record made by him of his risk assessment of Mr Kennedy on 21 December 2018 did not include reference to various issues such as the weapons etc found in Mr Kennedy's home and his use of violence on 30 June 2018, that the assessment he was doing that day would have been of risk from Mr Kennedy to himself and not to members of the public. He said that it was not normal practice for the Psychiatric Liaison Nursing Service to do a risk assessment as regards risk of violence from the patient to others unless they have been given direct information about that ie "something blatant (had) come up that there was a risk to anyone" and there was no such thing in his view.

[203] What conclusions can be drawn from this evidence about risk assessments of Mr Kennedy?

[204] I accepted the evidence of all of the witnesses mentioned in this section as being credible and reliable but under explanation that, for the reasons explained hereafter, I placed limited reliance on Dr Ward's evidence that some inpatient assessments did not take adequate account of available evidence relating to the risk from Mr Kennedy.

[205] In my view, the factors listed at paragraphs (i) to (iv) combined show that the risk assessment process involving Mr Kennedy was not such that it could not be criticised and I found it most suprising that, given his documented and known history of violence, possession and use of weapons etc, those assessing Mr Kennedy consistently assessed that he was not a risk to third parties.

[206] However, I am not a clinician and those who carried out the assessments were, and some of those were very experienced in their field. They met with Mr Kennedy, spoke to him, listened to him, observed him and experienced his demeanour. Some of them had done so on more than one occasion. Most of them read Mr Kennedy's MIDIS records (where his history of violence, possession and use of weapons etc was recorded) before meeting him and a few had been involved historically in his treatment. It was in these circumstances and in that context that the clinicians made their assessments. They consistently assessed him as not being a risk to third parties and, in my view, there was no expert clinical evidence led at the Inquiry such as to establish a basis for concluding that they were wrong to do so or that their risk assessments were inadequate, unsuitable or insufficient. The Inquiry heard no expert clinical evidence to the effect that the risk assessment process was inadequate, unsuitable or insufficient because it failed to take into account certain identified factors that it should have and, had it done so, the result of the risk assessment could have been different and a different outcome to the matter could have followed.

[207] Dr Ward did say in evidence that, in her view, inpatient assessments in August, October and November did not take adequate account of available evidence relating to

the risk of violence from Mr Kennedy. However, unlike the clinicians involved, Dr Ward, as I understand it, did not have the benefit of meeting Mr Kennedy, speaking to him, listening to him, observing him or experiencing his demeanour. Her opinion in this regard was not informed by the same circumstances and context as the treating clinicians were and was a "desk top" assessment based on examination of records and with the benefit of hindsight. This is no criticism at all, professional or otherwise, of Dr Ward. She herself made the same sort of point when discussing her opinion that Mr Kennedy may have been in the prodromal stages of a psychotic illness as opposed to Dr YZ's opinion that he was not.

[208] In view of this I consider that only limited weight can be given to Dr Ward's opinion and I do not think Dr Ward's evidence was enough to allow me to reach a conclusion that the risk assessment process itself was inadequate unsuitable or insufficient.

[209] Although I found the clinicians' assessments that Mr Kennedy was not a risk to third parties to be most suprising, I accept their clinical conclusions in that regard.

[210] I do not consider that the evidence was such as to allow me to reach the conclusion that the risk assessment process carried out on Mr Kennedy was inadequate, unsuitable or insufficient.

[211] In my view, the new system and proposed risk assessment form under MORSE is clearer, more focussed and hopefully will result in helpful and meaningful assessments. The evidence was that staff are to be trained in its use and in the use of MORSE. Dr Ward's evidence included her saying that in General Adult Psychiatry, staff training

in risk assessment is very important so that those completing the risk assessment know what they are trying to achieve rather than just knowing how to fill out the particular form used for the risk assessment. The evidence also was that it is planned that the new MORSE system will prompt clinicians to proactively review the patient's risk assessment. Dr Ward's evidence was that the new risk assessment form under MORSE is an improvement on the traffic light tick box risk assessment used under MIDIS.

(5) Consent to info sharing

[212] The Inquiry heard evidence that, generally speaking, information about a patient can only be given to a third party with that patient's consent and only in very limited circumstances, ie where there is a significant and immediate danger to that third party from the patient, could information be given to the third party without the patient's consent.

[213] The joint statement of Dr Ward and Dr Nabilla Muzaffar produced in this case includes the following:

> "Doctors owe a duty of confidentiality to their patients, but they also have a wider duty to protect and promote the health of patients and the public.
>
> The clinician should ask for a patient's consent to disclose information for the protection of others and consider any reasons given for refusal.
>
> In cases where a capcious patient ie someone with capacity to make that decision, has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential".

[214] From the evidence it was clear that Mr Kennedy's consent to share information with Ms Gallacher about him and his care was only sought once. That was on 19 December 2018.

[215] One of the issues for the Inquiry was whether such consent should have been sought one other occasions.

[216] On 19 December 2018 Ms Gallacher telephoned the CMHT and spoke to IJ, Mental Health Nurse. She told IJ that she was Mr Kennedy's "girlfriend" and that she was concerned for Mr Kennedy. IJ then spoke with Mr Kennedy (who was with Ms Gallacher) and obtained his consent to speak to Ms Gallacher. Mr Kennedy gave his consent and IJ spoke to Ms Gallacher as to the situation. Ms Gallacher told IJ that Mr Kennedy had drank weed killer and had been vomiting blood. This was an urgent situation. In these circumstances IJ's discussion with Ms Gallacher focused on the urgent situation as it presented itself at that point in time. The priority was Mr Kennedy's physical wellbeing at that point and getting him to hospital. Their conversation was specific to that issue and they did not discuss Mr Kennedy's mental health. IJ's evidence was that she did not have any discussion with Mr Kennedy about him giving his consent for the team to speak to Ms Gallacher about him and his care on a continuing basis and the consent was specific to that telephone conversation and the urgent circumstances as they presented at that time. IJ recorded on MIDIS that Mr Kennedy gave her consent to speak to Ms Gallacher on that occasion and the purpose of same.

[217] The Inquiry heard evidence from EF, Senior Charge Psychiatric Nurse, about his telephone contact with Ms Gallacher on 20 December 2018 when Mr Kennedy had been admitted to hospital. Ms Gallacher had telephoned the hospital. She wanted to speak about Mr Kennedy and his care. He had had no contact with Ms Gallacher before then but by then he was aware that she and Mr Kennedy were in a relationship with each other. His note on MIDIS records that she described herself to him as Mr Kennedy's "former and current partner". His evidence was that he told Ms Gallacher that he did not have Mr Kennedy's consent to speak with her about his care but that he would listen to what she said. He said Ms Gallacher was critical of Mental Health Services generally and she blamed NHSL for his situation and that they had a duty of care towards him and should be visiting him at home. EF's evidence was that due to Ms Gallacher's hostility and verbal aggression becoming more personally directed at ward staff and Dr YZ, he ended the call. His evidence was that he did not call her back. His evidence was that if he thought that Mr Kennedy posed an immediate significant or high risk to others as opposed to himself then he could share that information with others without Mr Kennedy's consent to do so. He had no reason to do that though. He did not consult with anyone about taking steps to tell Ms Gallacher about the risk Mr Kennedy posed to her with or without Mr Kennedy's consent because he had no reason to do so. His evidence was that even if he had Mr Kennedy's consent at that time to share with Ms Gallacher information about his care, he would have had nothing to tell her about any risk from Mr Kennedy because he had no reason to have any cause to believe there was such a risk.

[218] The Inquiry heard evidence from OP, Mental Health Nurse, about his assessment of Mr Kennedy in hospital on 21 December 2018. His evidence was that he read the MIDIS note of EF's above telephone call with Ms Gallacher on 20 December 2018. His evidence was that he did not attempt to contact Ms Gallacher; he did not seek Mr Kennedy's consent to discuss his care with her and he did not consult with anyone about taking steps to contact Ms Gallacher and to share information about Mr Kennedy's care with her either with or without Mr Kennedy's consent. Like EF, his evidence was that had he had Mr Kennedy's consent at that time to discuss his care with Ms Gallacher he would have had nothing to tell her because, based on his interactions with Mr Kennedy that day, he had no concerns about any risk from Mr Kennedy towards her.

[219] Dr YZ's, Consultant Psychiatrist, evidence was that at no time did Mr Kennedy express any specific threats to Ms Gallacher or anyone else in particular. The Inquiry heard similar evidence from others such as Dr CD, Consultant Psychiatrist, EF, Senior Charge Psychiatric Nurse, IJ and WX, both Mental Health Nurses.

[220] Dr YZ's evidence was that at no point did Mr Kennedy ask Dr YZ to contact or speak to Ms Gallacher.

[221] On 22 October 2018 Mr Kennedy presented himself at hospital expressing paranoid beliefs that he could read the thoughts of Ms Gallacher and that he believed she planned to attack him when he was asleep. On 22 October 2018 Ms Gallacher contacted the staff at the same hospital and told ward staff that she had been the victim

of domestic abuse by Mr Kennedy. On 1 November 2018 Mr Kennedy was discharged from hospital to Ms Gallacher's home.

[222] Dr Ward's evidence was that the delusional thoughts about Ms Gallacher expressed by Mr Kennedy on 22 October 2018 should have been shared with her particularly given that the plan was to discharge Mr Kennedy to Ms Gallacher's home - as indeed he subsequently was on 1 November 2018.

[223] Dr YZ disagreed with Dr Ward on this point. Dr YZ's evidence was that these paranoid thoughts were explored with Mr Kennedy by staff and through that process that Mr Kennedy did not disclose any paranoid ideas about any specific person nor did he express any ideas of hostility towards Ms Gallacher. Dr YZ also referred to the concerns he had about the nature of Ms Gallacher and Mr Kennedy's relationship and whether it was on or off – all as mentioned earlier.

[224] Dr YZ's evidence was that there were no concerns for Ms Gallacher's safety from Mr Kennedy and so there was nothing about which to seek Mr Kennedy's consent to share with her. Put simply, there was nothing to tell her.

[225] In his evidence Dr YZ also pointed out two things. Firstly that Mr Kennedy's previous use of violence did not necessarily mean that he using violence in the future could be predicted with any certainty. Dr YZ's evidence was that he could not breach Mr Kennedy's right to confidentiality and, as Dr YZ saw and described it, "criminalise" him simply because he "might" be violent towards Ms Gallacher in the future. Before he could breach Mr Kennedy's confidentiality, he would need to have evidence that Mr Kennedy was harbouring thoughts of violence towards Ms Gallacher and there was

no such evidence. Secondly, from Dr YZ's point of view there remained the difficulty for the CMHT knowing what the status of Mr Kennedy and Ms Gallacher's relationship, if any, actually was.

[226] A closely associated issue was whether information about Mr Kennedy's care should have been shared with Ms Gallacher either, if his consent to do so was sought and refused, or if the circumstances justified the sharing, with or without Mr Kennedy's consent.

[227] Dr Ward's evidence was that, in her experience, this situation does not happen frequently. Her evidence was that, in such a situation, she would not take such a decision on her own and that it would be best discussed at a MDT meeting and be a collective decision thereof. She would also have considered getting an opinion from a colleague and also taking advice and guidance from the Medical Defence Union.

[228] Dr Ward's opinion was that, when Mr Kennedy was being discharged on 21 December 2018, if Dr YZ was aware of the risks of violence to Ms Gallacher from Mr Kennedy, then, with or without Mr Kennedy's consent, Dr YZ should have made Ms Gallacher aware of these risks.

[229] In the joint statement of Dr Ward and Dr Muzaffar the following is stated:

> "Based on the historical risk, particularly the home visit on 30 June, Mr Kennedy's ongoing substance misuse and link with violent behaviour and the plan to live together following discharge on 10th September, Joanne Gallacher should have been made aware of the potential risk to herself."

[230] On this question Dr YZ's opinion was essentially the same, and for the same reasons, as it was specified above in relation to the question of seeking Mr Kennedy's consent to share information with Ms Gallacher.

[231] What conclusions can be drawn from this evidence?

[232] Whilst I accept that the view of Dr YZ and his colleagues was that they considered there was no evidence of risk from Mr Kennedy to Ms Gallacher and so there was no need to seek Mr Kennedy's consent to share information with Ms Gallacher or to share information with her where he refused such consent, or even without his consent, I think the evidence of Dr Ward on these matters is more compelling and I prefer same.

[233] By 22 October 2018 the clinicians were aware of Mr Kennedy expressing paranoid beliefs about Ms Gallacher and, on the same day, that she alleged to hospital staff that she had been the victim of domestic abuse by Mr Kennedy. That was in the context of his previous history of violence, possession of weapons etc also being known. In my view, these factors, in accumulation, were concerning enough to require that the information about his paranoid beliefs about her should be shared with her so that she was aware of same and could take whatever decisions she wished as regards her involvement with Mr Kennedy in the light of same.

[234] Whilst the clinicians considered that there was no risk of violence from Mr Kennedy towards Ms Gallacher, in my view, for the reasons explained above, the clinicians should have shared with Ms Gallacher the information about Mr Kennedy's paranoid beliefs about her when Mr Kennedy was being discharged to her home on

1 November 2018 and, at the least, they should have sought from Mr Kennedy his consent to do so. It appears from the evidence that they did not do so.

[235] In my view, for the reasons explained above, the clinicians dealing with Mr Kennedy on 20 and 21 December 2018, knowing of Mr Kennedy's said paranoid beliefs about Ms Gallacher and, presumably, knowing that information had not been shared with Ms Gallacher before then, should have done so, albeit he was not being discharged to her home then, because the evidence was that they clearly were in a relationship of sorts at those times**.** This is particularly in view of it being known from MIDIS that on 19 December 2018 IJ, Mental Health Nurse, had sought such consent and that Mr Kennedy had provided it albeit for the specific conversation on that day. It appears from the evidence that they did not do so.

[236] On those occasions, whilst Mr Kennedy's consent to do so should have been sought first of all, in my view, if Mr Kennedy had refused to consent to the information sharing, then the clinicians should at least have given consideration to sharing the information without his consent. It appears from the evidence that they did not do so.

[237] Exactly what information could/should have been shared with Ms Gallacher and what the outcome of doing so would have been are completely different matters. In this regard I think it important to note that the joint statement of Dr Ward and Dr Muzaffar states that someone with a propensity to violence is more likely to be violent in the future but whether and when this occurs cannot be predicted with any certainty. It also states that the attack on Ms Gallacher could not have reasonably been predicted.

(6) Addiction Services

[238] The evidence was that Mr Kennedy had drug and alcohol addictions and actively sought admission to hospital. He engaged with care and treatment when in hospital as an inpatient but he would not engage in the community. Dr YZ's evidence was clear about this and it was reflected in the documentary evidence as well.

[239] The evidence was that, historically, Mr Kennedy had been referred to Addiction Services in the past whilst in the community but did not engage with same. The evidence from the various mental health assessments was that he was not further referred. Dr YZ's evidence was that the reason for this was that a patient needs to be at a point where they are able and willing to recognise and accept that they have addiction issues before they are "ready" to be referred to Addiction Services. If they are not "ready" in that sense they would not be committed to the referral and if they are not committed to the referral they will not engage and the referral will not work. A failed referral has a negative impact both on the patient and the Service. Dr YZ's evidence was that "readiness is essential for the success of the intervention" but that Mr Kennedy was never ready in this sense and so there was no point or benefit in referring him again. However, Dr YZ's evidence was that after the presentation at hospital on 19 December 2018 he was considering referring Mr Kennedy to Addiction Services again which, Dr YZ said, showed that he continued to consider the issue.

[240] One of the learning points in the SAER was ensuring that staff are aware of the availability of Addictions Services.

[241] Dr Daly said that the authors of the SAER found that staff were aware of the possible availability of referral to Addiction Services but that it did not seem to be at the forefront of their minds. He said it was something that should always be considered. He said that he agreed with Dr YZ that a patient should not normally be referred to Addiction Services if the patient is not ready for same but he also said that there may be some cases where a referral should be made regardless of the patient's readiness to engage. He said that having Addiction Services attend a hospital and meet with a patient whilst they are an inpatient was an available option for patients but he did not know if that would have improved Mr Kennedy's engagement had that been tried in his case.

[242] Dr Ward's evidence was that it was not necessarily the case that a patient had to be ready in the sense that they accept that they have a problem with alcohol or drugs before a referral to Addiction Services should be made. In her view, it depends on the facts and circumstances of the case. Dr Ward's view was that, given Mr Kennedy's repeated non-engagement with Addiction Services, a "more assertive" approach surrounding Addiction Services should have been taken. One way of doing this could have been having a meeting between Mr Kennedy and addiction staff whilst Mr Kennedy was an inpatient in hospital as that could have improved his engagement with the Service.

[243] Dr YZ's evidence was that he had never engaged Addiction Services staff on the ward with an inpatient in advance, as it were, in an effort to ready the patient for referral to the Service.

[244] One of the key findings of the SAER report was as follows:

> "There are several examples of good multi agency working and good links between liaison staff and the community. However, it is notable that addictions service referrals were not made during or after the admissions for drug induced psychosis or the periods following this".

[245] Dr YZ was clear and firm in his evidence in disagreeing with this finding. His evidence was that his team were working with Mr Kennedy trying to allow him to gain the realisation that he had drug and alcohol problems so that he could be "ready" and committed to a referral to Addiction Services and so that he would engage with same so as to give it a chance of being successful.

[246] What conclusions can be drawn from this evidence?

[247] Whilst I accept Dr YZ's evidence that Mr Kennedy had chosen not to engage with Addiction Services in the past, and, in the absence of any real change in circumstances or his presentation the likely success of another referral could be doubtful, it does seem to me that closing off this possible avenue of assistance without any real time frame for reconsideration was not appropriate. In this regard I prefer the evidence of Dr Ward and Dr Daly and I consider that Mr Kennedy should have been referred again to Addiction Services on each discharge from hospital either with or without having had Addiction Services staff meet with him on the ward beforehand. If that was unsuccessful due to Mr Kennedy's non-engagement then that would have been regrettable but it seems to me that the opportunity should at least have been offered to him in the hope that, on that occasion, he would have taken the opportunity up and engaged.

[248] It is important though to note that Dr Ward's evidence was that whilst, in her view, Mr Kennedy should have been referred to Addiction Services following his discharge from hospital in September 2018, November 2018 and the clinic review in December 2018, there was no certainty that such referrals would have prevented Ms Gallacher's death.

(7) Discharge planning

[249] Dr Daly agreed with Dr Ward that Ms Gallacher should have been included in the discharge planning for Mr Kennedy.

[250] The issue of Ms Gallacher's involvement in the discharge planning for Mr Kennedy in respect of Mr Kennedy's discharges from hospital was linked to the issues of their relationship and consent from Mr Kennedy to involve her. In respect of both of these issues I refer to the evidence discussed in earlier in this Determination in relation to same.

[251] The evidence was that Ms Gallacher was not involved in any discharge planning.

[252] Dr YZ's evidence was that, generally, the clinicians will involve in discharge planning those who are expected to be involved in the patient's care in the community so long as the patient consents for them to be involved. Whenever a patient has capacity, he or she will intimate which address they are to be discharged to and that is something which the clinicians would accept. Dr YZ's evidence was that Mr Kennedy had capacity so he decided the discharge address. His evidence was that at no point did

Mr Kennedy ask the clinicians to involve Ms Gallacher in his discharge planning. Had he done so then she would have been involved.

[253] Dr Ward's evidence was that, in relation to discharge planning, there are two separate but overlapping issues:

(i) Discharge planning should include knowing where the patient will be discharged to and what their support structure outside hospital will be - either living with them or not.

(ii) There should have been consideration of Mr Kennedy's risk of violence to others, as well as to staff. The fact that he kept a store of accessible weapons at home and there was evidence he had used them there indicated to visiting staff that there was a risk of violence to staff visiting him at home. Therefore, there was likely to have been an increased risk to others visiting him at home.

[254] Dr Ward's evidence was that, in a situation where there is no history of violence, the clinicians would normally try and involve the patient's family and support network as much as possible in discharge planning with the patient's consent. In a situation where there is a history of violence and so there is an increased risk of future violence, clinicians might begin to consider breaching the patient's confidentiality in that regard.

[255] Dr Ward accepted in evidence that Ms Gallacher was not a member of Mr Kennedy's family nor his next of kin. She also accepted that when Ms Gallacher telephoned the hospital on 21 December 2018 she was listened to by OP, Mental Health Nurse, and her views were passed on to Dr YZ.

[256] Mr Kennedy was discharged from hospital on 10 September and 1 November both 2018 to Ms Gallacher's home. The discharge on 1 November 2018 was after Mr Kennedy expressed to hospital staff on 22 October 2018 paranoid beliefs that he could read her thoughts and believed that she would attack him when he was asleep. It was after Ms Gallacher told ward staff also on 22 October 2018 that she had been the victim of domestic abuse by Mr Kennedy.

[257] Dr Ward's evidence was when Mr Kennedy was to be discharged to Ms Gallacher's home, then, given his history of violence and the increased risk of violence to Ms Gallacher, Mr Kennedy should have been asked by the treating clinicians if he would agree to her being involved in the discharge planning and, if he would not, then the clinicians should still have considered telling Ms Gallacher about the risk of violence to her. Her evidence was that that would mean that she would be told "the minimum" about Mr Kennedy's past history. In those circumstances, there should then have been a MDT discussion to consider overriding his refusal to allow her involvement in the interests of her safety, that of her daughter (and possibly other visiting children).

[258] In the joint statement of Dr Ward and Dr Muzaffar they expressed the view that Ms Gallacher should have been involved in Mr Kennedy's discharge planning if Mr Kennedy consented to her being involved. They went on to say that, if Mr Kennedy did not consent to Ms Gallacher being involved, then, if the clinicians had recognised the potential risk of violence towards Ms Gallacher, the minimum of Mr Kennedy's confidential information should be disclosed in the interests of public safety, sufficient to

enable Ms Gallacher to decide whether she wished to continue her involvement with him and proceed with the plan for him to move in with her and her daughter.

[259] In the joint statement it is said that the clinicians did not appear to recognise the potential risk of violence to Ms Gallacher or children from Mr Kennedy following his admissions 21 August to 10 September, 22 October to 1 November and 2 to 7 November all 2018 and so there was no risk management plans in place to mitigate these risks. It is also stated that in relation to risk to children, Mr Kennedy's disclosures about the potential sexual abuse of children should have been considered in discharge planning.

[260] Dr Daly's evidence was that Ms Gallacher should have been involved in Mr Kennedy's discharge planning even if that was limited to a telephone call being made to her to try and ascertain what her actual involvement with Mr Kennedy was at that time. Like Dr Ward, his evidence was that, on the occasions that Mr Kennedy was being discharged to Ms Gallacher's home, then with Mr Kennedy's consent, she should have been involved in his discharge planning and if Mr Kennedy refused that consent then thought should have been given to involving her nevertheless.

[261] What conclusions can be drawn from this evidence?

[262] I consider that the evidence shows that, at no point did the clinicians ask Mr Kennedy if Ms Gallacher could be involved in his discharge planning.

[263] Whilst I accept the evidence of Dr YZ as credible, I respectfully think that, following Mr Kennedy's expression of paranoid beliefs about Ms Gallacher on 22 October 2018, Ms Gallacher should have been involved in Mr Kennedy's discharge planning thereafter either with or without his consent or, at the least, thought given to

involving her. This is particularly so in relation to the occasion in November 2018 when Mr Kennedy was being discharged to Ms Gallacher's home. In my view, she should have been involved so that she was aware of said paranoid beliefs and could take whatever decisions she wished as regards her involvement with Mr Kennedy and or his discharge planning and arrangements in the light of same.

[264] In relation to the later and last discharges, as mentioned earlier in this Determination, I consider the evidence shows that Mr Kennedy and Ms Gallacher were in a relationship of some sort as at 21 into 22 December 2018. As Dr Ward mentions in her report, Ms Gallacher telephoned Mental Health and Acute Services three times on 21 December 2018 expressing her concern about Mr Kennedy. I think that is heavily persuasive of them having a relationship which was such as ought to have prompted the clinicians to, at least, think about asking for Mr Kennedy's consent to involve her in discharge planning and, if refused, given Mr Kennedy's paranoid beliefs about her to have, at least, thought about involving her nevertheless. In my opinion, the evidence shows that they did neither.

[265] I consider the evidence of Dr Ward and Dr Daly to be both credible and reliable on this issue and, for these reasons and on this basis, I prefer same to the evidence of Dr YZ on this issue.

[266] I think it important to point out though that, had they involved Ms Gallacher with the discharge planning, with or without Mr Kennedy's consent, what the outcome of that would have been cannot be predicted and is unknown.

(8) Adult Support and Protection.

[267] The evidence showed that there was only one MDT Meeting in this case that being on 17 December 2018.

[268] It seemed to me that there was some dispute as to how that MDT meeting came about. I have noted Dr YZ as saying that he initiated that following Mr Kennedy returning home after discharge from hospital in Newcastle whereas the SAER and QR, Social Worker South Lanarkshire Council both said that QR initiated it after social workers visited Mr Kennedy's home in relation to a vulnerable persons report without knowing about the alert the CMHT had placed a no home visit alert on his MIDIS records. Having said that I do not think that this is of any real importance and I do not think it had any bearing on the outcome of the matter.

[269] Dr Ward's evidence was that such a meeting could have been triggered by the home visit by EF, Senior Charge Psychiatric Nurse and IJ, Mental Health Nurse on 30 June 2018 or after Mr Kennedy disclosing to hospital staff on 4 November 2018 that he had sexually abused a child.

[270] In the joint statement of Dr Ward and Dr Muzaffar, it is said that any form of MDT meeting is likely to have increased the awareness of those involved of the multiple possible adverse outcome – risks to Mr Kennedy himself, risk to others from violence and to children – and thereby have made it more likely that a risk management plan which mitigated these risks was discussed and enacted.

[271] What conclusions can be drawn from this evidence?

[272] I consider that the evidence showed that there were earlier opportunities for a MDT meeting to have been held such as suggested by Dr Ward. I accepted that evidence and preferred her evidence to that of Dr YZ on this issue which disputed same.

[273] Similarly, one of the findings of the SAER was that during the period from October 2018 to 17 December 2018, there were several opportunities for an ASP Meeting to have taken place which, had they been taken, may have helped to get a better outcome than actually happened. I also accept that evidence.

[274] I think it is important to note that Dr Ward in her parole evidence and in her joint statement with Dr Muzaffar said that an ASP held earlier than 17 December 2018 would not have prevented Ms Gallacher's death with any certainty.

(9) Response by NHS Lanarkshire to SAER findings and recommendations

[275] The SAER Report made a number of recommendations including the following:

(i) making their findings known to the various agencies involved and their staff;

(ii) in respect of the new MORSE NHSL computer system, risk assessment could be revised to ensure that users are promoted to proactively review risk, and to consider risk to self and risk to others as separate entities.

(iii) there should be a reflection and improvement plan for local medical staff surrounding note keeping and dictation of letters.

[276] In his parole evidence Dr Daly explained that there was a clear plan made to ensure that the above were actually implemented and a system of monitoring same established to ensure the actions were taken timeously.

[277] Dr Daly also gave evidence in relation to a response given by him on 10 September 2021 on behalf of NHSL, at the request of the Procurator Fiscal, responding to an additional report from Dr Ward.

[278] In particular this included a response to the question:

> "where there are identified 'Lone worker' risks or there are concerns about staff safety sufficient to consider stopping all home visits, how does NHS Lanarkshire ensure that the threat to others visiting has also been considered?"

[279] Dr Daly's explained in response to that question that NHSL had undertaken steps to share documentation between other departments and that on the new MORSE computer system all NHSL Health Board departments would be able to see such alerts. Included in the response is the following:

> "As an action, Lanarkshire will undertake to ensure that the need to share information is more widely known and understood. This will be done via emphasis and awareness raising at key groups – the Mental Health, Learning Disabilities and Addictions Partnership Board in North Lanarkshire and the South Lanarkshire Mental Health and Wellbeing Partnership Board. Both Boards are attended by Health, Social work, police, housing and third sector representatives amongst others. The information can then be further emphasised at Locality Planning Groups in North Lanarkshire and Locality Clinical Governance Groups in South Lanarkshire".

[280] Dr Daly attached to his affidavit of 21 June 2024 an appendix which provided a breakdown, as at that date, of the actions taken by NHSL upon the SAER recommendations and their progress and status as at that date.

[281] I do not repeat these at length but I did take account of them in reaching this Determination. These included designing and implementing standards for patient discharge from inpatient wards. Dr Daly explained that NHSL now have discharge instructions which all clinicians are expected to adhere to and which are audited annually to ensure that clinicians are complying with these instructions. Dr Daly explained that this was to make sure that there were better links across different agencies on a patient's discharge.

[282] Dr Daly explained that he agreed with Dr Ward that the "SBAR" (Situation, Background, Assessment, Recommendations) nursing note keeping tool used by NHSL at the time led to repetition in the note recording which meant that the notes were not as up to date or as insightful as they should be. The actions taken by NHSL also included progressing an alternative to the SBAR format of nursing notes. Dr Daly explained that this has been a more complex issue than was expected and, as at 21 June 2024 when he swore his affidavit, and, as I understand it, as at 25 September 2024 when he gave evidence, it was not yet completed. Dr Daly explained that this is because producing a suitable alternative is holding up the progress and completion of this action. Dr Daly explained that this is linked to a problem which is widespread across the NHS namely the tension that exists between clinicians spending time actually treating and caring for patients on the one hand and, on the other, spending time trying to complete patient notes in a way that is succinct yet comprehensive enough to be meaningful.

Submissions of parties and statutory findings

[283] The parties all lodged detailed written submissions in advance of the hearing on submissions on 10 March 2025. These were most helpful and I thank and express my gratitude to agents and counsel in that regard. In addition I also heard oral submissions at the hearing on submissions.

[284] I do not intend to narrate the submissions in detail but I did take account of them when preparing this Determination.

[285] However, I think it might be helpful simply to record, in the briefest of terms, what the submissions were with reference to the relevant parts of sections 26(2) of the 2016 Act.

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

[286] Parties were in agreement that Ms Gallacher's life was pronounced extinct at 0039 hours on 22 December 2018 at 6 Sillerknowe Court, Biggar. This was in accordance with the evidence and I make a finding in these terms.

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

[287] None of the parties made any submission in this regard and proposed a formal finding only. This was in accordance with the evidence and I make a finding in these terms.

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

[288] PSS made no submission. The Crown, Lanarkshire Health Board, Dr YZ, AA and BB all proposed a finding in this regard that the cause of death was stab wounds to the neck and upper body or trunk. This was in accordance with the evidence and I make a finding in these terms.

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

[289] None of the parties made any submission in this regard and proposed a formal finding only. This was in accordance with the evidence and I make a finding in these terms.

(e) 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 the death, or any accident resulting in the death being avoided):

[290] The court requires to apply a two part test in respect of any finding under section 26(2)(e) of the 2016 Act. Firstly, to identify any precautions which could reasonably have been taken. Secondly, to determine whether any such precaution might realistically have resulted in the death being avoided.

[291] It is a two part test and so both parts of the test must be satisfied before the court can make a finding under section 26(2)(e) of the 2016 Act.

[292] As regards the first part of the test is concerned, the term "reasonably" relates to the reasonableness of taking precautions rather than to the foreseeability of the death or accident resulting in the death.

[293] As regards the second part of the test is concerned, the correct approach was laid down by Sheriff Kearney in his Determination following the Inquiry into the death of James McAlpine (Glasgow, 17 January 1986) as follows:

> "… the phrase 'might have been' avoided is a wide one … it means less than 'would on the balance of possibilities have avoided' and rather direct one's mind in the direction of lively possibilities".

[294] On the same issue, in the Inquiry into the death of Kathryn Beattie (Glasgow, 4 July 2014) Sheriff Ruxton stated as follows:

> "…. the term 'might' should be applied in the sense that it incorporates a notion of something qualitatively more than a remote possibility: a possibility with some substance or potential rather than a fanciful or notional possibility".

[295] The Crown, PSS, Lanarkshire Health Board and Dr YZ proposed that a finding be made that there were no reasonable precautions which could have been taken and which, if taken, might realistically resulted in Ms Gallacher's death being avoided.

[296] AA and BB proposed a finding that there were three precautions which, if taken, might realistically have avoided Ms Gallacher's death and that these are:

(1) A suitable and sufficient identification and assessment of the risk of violence posed by James Kennedy to third parties, and to Joanne Gallacher;

(2) Informing Joanne Gallacher of the risk of violence posed by James Kennedy;

(3) Referring James Kennedy to Addiction Services in September, November and December 2018.

[297] I intend to deal with these in turn.

(1) A suitable and sufficient identification and assessment of the risk of violence posed by Mr Kennedy to third parties, and to Ms Gallacher

[298] AA and BB essentially ask the Inquiry to conclude that the risk assessment of Mr Kennedy was neither suitable nor sufficient.

[299] They say that carrying out a suitable and sufficient identification and assessment of the risk of violence posed by Mr Kennedy to third parties and to Ms Gallacher would have been a reasonable precaution.

[300] I refer to my analysis of the risk assessment process earlier in this Determination and, for the reasons explained therein, I do not consider that the evidence was such as to allow me to reach the conclusion that the risk assessment process carried out on Mr Kennedy was inadequate, unsuitable or insufficient.

[301] However, on the hypothesis of fact that what was actually done in that regard was inadequate, unsuitable or insufficient, could it be said that there is a lively possibility that had a suitable and sufficient identification and assessment of the risk of violence posed by Mr Kennedy to third parties, and to Ms Gallacher been carried out Ms Gallacher's death might have been prevented?

[302] Dr Ward's evidence was that the purpose of a risk assessment was to identify and minimise risk and that a risk assessment cannot accurately predict future violence.

Dr Daly's evidence was the same. Dr Ward's evidence was that Ms Gallacher's death was not predictable. The conclusions of the SAER included findings that none of the issues identified in the report, including the risks assessments, were likely to have directly affected the outcome of this case and that the event was not predictable nor preventable. The SAER concluded that there was very little to indicate that such an incident would occur. Dr YZ's evidence was that there was nothing which made the CMHT think that Mr Kennedy would be capable of carrying out the actions that he did on 21 into 22 December 2018.

[303] I accepted the evidence of Drs Ward, Daly and YZ in this regard as being credible and reliable. Against that background I have reached the conclusion that it cannot be said that, on the hypothesis of fact that the risk assessments were inadequate, unsuitable or insufficient (which I do not accept) there is a lively possibility that the carrying out of a suitable and sufficient identification and assessment of the risk of violence posed by Mr Kennedy to third parties and to Ms Gallacher might have prevented her death.

[304] If the risk assessment was adequate, suitable and sufficient in that regard would it the risk have been assessed differently?

[305] Even if the result of such a risk assessment was that there was a risk of violence from Mr Kennedy to third parties, including Ms Gallacher, would that have mattered given that the evidence was that the use of such extreme violence was not predictable?

[306] A risk assessment helps to inform the patient's management plan. If such a risk assessment was carried out would that have changed Mr Kennedy's management plan

and if so in what way and would that have had any effect on Mr Kennedy and his actions?

[307] If the result of such a risk assessment was that there was a risk of violence from Mr Kennedy to third parties, including Ms Gallacher, would that have been shared with Ms Gallacher with or without Mr Kennedy's consent? If it was shared what would she have been told and what would her decision have been as regards carrying on a relationship with or even just visiting Mr Kennedy?

[308] Whilst these would certainly have been relevant questions there was no evidence available to the Inquiry to answer them and given that evidential gap, I do not think that it could be reasonably concluded that a suitable and sufficient risk assessment of Mr Kennedy might have avoided Ms Gallacher's death.

(2) Informing Joanne Gallacher of the risk of violence posed by James Kennedy

[309] AA and BB ask the Inquiry to conclude that Ms Gallacher should have been told of the risk of violence posed by James Kennedy.

[310] They say that doing so would have been a reasonable precaution. I agree with this proposition so far as it relates to sharing with Ms Gallacher information as regards Mr Kennedy's paranoid beliefs about her and I refer to my analysis of the information sharing process earlier in this Determination and to my criticisms of same.

[311] This is particularly so in relation to the time when Mr Kennedy was being discharged to the home of Ms Gallacher on 1 November 2018.

[312] In my view, the clinicians dealing with Mr Kennedy on 20 and 21 December 2018, knowing of Mr Kennedy's said paranoid beliefs about Ms Gallacher and, presumably, knowing that it had not been shared with Ms Gallacher before then, should have done so as well and shared that information with her. This is particularly in view of it being known from MIDIS that on 19 December 2018 IJ, Mental Health Nurse, had sought consent to speak to Ms Gallacher and that Mr Kennedy had provided it albeit for the specific conversation on that day.

[313] Whilst Mr Kennedy's consent to do so should have been sought first of all, in my view, on these occasions if Mr Kennedy had refused to consent to the information sharing then the clinicians should at least have given consideration to sharing the information without his consent.

[314] However, can it be said that there is a lively possibility that had information about the risk of violence from Mr Kennedy, so far as it related to Mr Kennedy's paranoid beliefs about Ms Gallacher is concerned, been shared with Ms Gallacher might her death might have been prevented?

[315] Dr YZ's evidence was that just because Mr Kennedy had a history of violence did not mean that it could be said with any certainty that he would be violent again in the future. This reflected the evidence of Dr Ward and in the findings of the SAER.

[316] I accepted the evidence of Drs Ward and YZ in this regard as being credible and reliable. Against that background I have reached the conclusion that it cannot be said that there is a lively possibility that informing Ms Gallacher of the possibility of the risk

of violence from Mr Kennedy, so far as it related to Mr Kennedy's paranoid beliefs about Ms Gallacher is concerned, might have prevented her death.

[317] If she was given information in that regard what would that information have been?

[318] Would the sharing of that information have been followed by actual use of violence anyway and, if it was, what kind or degree of violence would that have been?

[319] What would Ms Gallacher's decision have been as regards carrying on a relationship with or even just visiting Mr Kennedy upon receipt of the information?

[320] Whilst these would certainly have been relevant questions, there was no evidence available to the Inquiry to answer them and given that evidential gap, I do not think that it could be reasonably concluded that informing Joanne Gallacher of the risk of violence posed by James Kennedy, so far as it relates to sharing with Ms Gallacher information as regards Mr Kennedy's paranoid beliefs about her, might have avoided Ms Gallacher's death.

(3) Referring James Kennedy to Addiction Services in September, November and December 2018.

[321] AA and BB ask the Inquiry to conclude that Mr Kennedy should have been referred to Addiction Services in September, November and December 2018.

[322] They say that referring him would have been a reasonable precaution. I agree with this proposition and I refer to my analysis of the referral to Addiction Services process earlier in this Determination and to my criticisms of same.

[323] However, can it be said that there is a lively possibility that had Mr Kennedy been referred to Addiction Services in September, November and December 2018, Ms Gallacher's death might have been prevented?

[324] Dr YZ's evidence was that a referral to Addiction Services should only be made when the patient has reached the point of accepting that they have an addiction and are motivated and "ready" to engage with Addiction Services otherwise the referral is unlikely to be successful and a failed referral can be detrimental to the patient and to the Service. His evidence was that Mr Kennedy was not ready for that referral so no referrals were made. Dr Daly agreed with that proposition as a generality but did say that such a referral could in some circumstance be made even if a patient was not ready for the referral.

[325] Dr YZ's evidence was also that a meeting between Addiction Services staff and Mr Kennedy whilst he was an inpatient would not be normal or helpful given that he was not "ready" for such a referral.

[326] Dr Ward's evidence was that it was not necessary for the patient to be "ready" for a referral before one is made and Dr Daly said likewise.

[327] In the joint statement of Drs Ward and Muzaffar they state that a meeting between Addiction Services staff and Mr Kennedy whilst he was an inpatient could have improved his engagement.

[328] Whilst I accepted Dr YZ's evidence as being credible, I preferred the evidence of Drs Ward and Daly and found their evidence to be credible and reliable.

[329] However, even against that background I have reached the conclusion that it cannot be said that there is a lively possibility that referring Mr Kennedy to Addiction Services in September, November and December 2018 might have prevented Ms Gallacher's death.

[330] Dr Ward's evidence was that Mr Kennedy should have been referred to Addiction Services, following his discharge from hospital in September and November 2018 and from the review clinic in December 2018 but that there was no certainty that the referrals to Addiction Services would have prevented Ms Gallacher's death.

[331] All the evidence was that Mr Kennedy had a history of non-compliance with care and treatment whilst in the community. All the evidence was that this was through his own choice.

[332] With that background and history would he have engaged with Addiction Services had he been referred to them in September or November or December 2018?

[333] If he had, to what degree would he have engaged and how long would that process have taken?

[334] If he had, what would have been the outcome in respect of his behaviour towards Ms Gallacher?

[335] Whilst these would certainly have been relevant questions there was no evidence available to the Inquiry to answer them and given that evidential gap, I do not think that it could be reasonably concluded that referring Mr Kennedy to Addiction Services in September, November and December 2018 might have avoided Ms Gallacher's death.

[336] Accordingly, I shall make no finding under section 26(2)(e).

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

[337] None of the parties proposed any finding in this regard.

[338] In order to make a finding under section 26(2)(f) of the 2016 Act, the court must not only be satisfied of the existence of a defect in a system of working, but must also find, on the balance of probabilities, that the defect contributed to the death. Finding that, on balance of probabilities that the defect contributed to the death is a higher demand than the "lively possibility" test mentioned under section 26(2)(e).

[339] In her oral evidence and written report of 10 March 2021 Dr Ward mentions a number of issues which she thinks were failings on the part of NHSL and some of which she considered to be defects in the system of working. Examples were the issues of risk assessment and the consent of the patient to discuss the patient's care with others.

[340] Both the Crown and AA and BB submitted that such issues should fall to be determined under the heading of reasonable precautions and whether they amounted to same. I agree with them in that regard.

[341] I did not consider that there were any defects in any system of working which contributed to Ms Gallacher's death and I make no finding under section 26(2)(f) of the 2016 Act.

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

[342] All parties proposed that no finding is made in this regard.

[343] In their submissions the Crown refer to a number of areas under this section ie Addiction Services, Discharge Planning, Mental Illness, Inpatient Assessment, Adult Support and Protection and Record keeping.

[344] In determining whether any findings should be made under this section of the 2016 Act the court does not require to be satisfied that the facts in question are causally connected to the death, rather the question for determination is whether those facts are relevant to the actual circumstances of the death.

[345] I refer to my analysis of the evidence under the headings, The relationship between Ms Gallacher and Mr Kennedy, Mr Kennedy's mental health condition, Addiction Services, Discharge Planning and Adult Support and Protection. Whilst I considered these matters to be of obvious interest to the Inquiry, I do not consider that any of them or any other facts or issues, including the involvement and actions of any police officers, were relevant to the actual circumstances of Ms Gallacher's death.

[346] Accordingly, I make no finding under section 26(2)(g) of the 2016 Act.

Recommendations

[347] The Crown, PSS, Lanarkshire Health Board and Dr YZ propose that no recommendations are made.

[348] AA and BB made no submissions in this regard.

[349] The SAER Report dated 3 December 2019 made a number of findings relating to risk assessments, risk management, multi-agency working, adult support and protection, review commissioning, record keeping and letters and learning points were identified.

[350] The SAER also made a number of recommendations in relation to the said matters and identified actions that should be taken by NHSL in that regard.

[351] I do not repeat all the detail in this regard and refer to the earlier section of this Determination where the above are described in more detail.

[352] In his parole evidence Dr Daly explained that there was a clear plan made by NHSL to ensure that the above recommendations and actions were actually implemented and a system of monitoring put in place same to ensure the actions were taken timeously.

[353] In her initial report completed on 10 March 2021, Dr Ward commented on the SAER, its findings, learning points and recommendations. In doing so she said that whilst these were valuable recommendations, she did not think that the recommendations were sufficient to significantly reduce the likelihood of a death occurring in similar circumstances and she went on to make a number of further recommendations and identified a number of other learning points.

[354] Dr Daly gave evidence that, in consultation with NHSL, North Lanarkshire Health and Social Care and South Lanarkshire Health and Social Care Partnerships, he responded to Dr Ward's initial report and explained what actions they had taken or intended to take in relation to same.

[355] Dr Ward then responded by a supplementary report completed on 14 July 2021. In that report she said that she was satisfied that NHSL had or was planning to address all but three of her recommendations and all of the learning points made in her report completed on 10 March 2021. She said that of the other three recommendations one of them was partially addressed. In her conclusion to her supplementary report she stated that she was concerned that the areas of MDT decision-making and communication, and ensuring that staff take the wider risk to the public into account in decision-making had not been addressed in NHSL's response to her initial report.

[356] By letter dated 10 September 2021 addressed to the Procurator Fiscal's Office, Dr Daly provided a response to Dr Ward's supplementary report explaining what actions NHSL would or intended to take or what arrangements were in place to address Dr Ward's remaining recommendations.

[357] The Inquiry heard evidence that, subsequent to Ms Gallacher's death, NHSL introduced a new patient record computer system called MORSE which replaced the system called MIDIS which was in use at the time of Ms Gallacher's death. I mention more about this below. I consider that the evidence shows that the new MORSE system and the changes it involved sufficiently addresses the three remaining recommendations that Dr Ward made in her supplementary report of 14 July 2021.

[358] Accordingly, I consider that the evidence shows that NHSL have taken or intend to take actions to appropriately and sufficiently address the recommendations and learning points identified in the SAER Report and in Dr Ward's reports. I found the evidence of Dr Daly and CC as most helpful in that regard.

[359] I think it would be helpful if I now set out what the main actions taken or intended to be taken by NHSL in that regard actually are. They are as follows:

(i) Chief Officers of North Lanarkshire Health and Social Care Partnerships will sit on the relevant groups in South Lanarkshire Health and Social Care Partnerships. It is intended that this will provide a link between the Partnerships and better interagency communication and decision-making pathways. Hopefully, in similar circumstances, this will avoid the type of delay and drift that occurred in this case as to whether a Multi-Agency Review rather than a SEAR should be held.

(ii) All learning points are fed back to those involved.

(iii) Those involved are made aware of the availability of Addiction Services and Adult Support Referrals and support.

(iv) Standards for discharge planning from inpatient wards are to be implemented making better links across different agencies on a patient's discharge.

(v) Each CMHT have a weekly multi-disciplinary meeting where cases can be discussed.

(vi) Team communication and shared decision-making and the importance thereof will be key aspects of staff training.

(vii) The need to share information between groups will be emphasised to ensure it is more widely known and understood. This will be done, amongst other things, by raising the issue at key group Board meetings.

(viii) Use of the new MORSE computer system. This in itself encompasses a number of features as follows:

- Staff must undergo training on the new MORSE system before being allowed access to same;
- The system can be accessed by users in the community, for example on a tablet, as well as on NHSL premises;
- All records from MIDIS have been transferred onto MORSE and can be accessed there;
- If a patient is open to more than one service eg open to health and also social work, then a note recorded by one Service on their part of the system can be accessed by the other(s) on their part;
- Alerts can be recorded and which are clearly visible on the first page of the patient's records and which alert users that an alert in relation to that patient exists and what the alert is eg no lone worker visits are to take place at the patient's home;
- The Alerts remain on the system until a user deactivates same;
- Significant events are documented within a separate form in MORSE and it is accessible to all staff regardless of which team or area they work in. As each significant event is added it creates a timeline and all events are visible in one continuous form which is also available on the existing patient clinical portal and allows multiple professionals to see the details thereof;

- A single risk assessment (now called a Safety Assessment) is used by the system which is updated by users rather than a fresh risk assessment being used each time resulting in a number of risk assessments existing for the one patient as under MIDIS;
- Previous risk assessments are readily available and easily accessible and the information on same is stored and not lost;
- A new risk assessment form is being piloted in MORSE in a number of Board areas and which specifies risk to others as a separate question to risk to self. If successful it will be rolled out across the whole of NHS Lanarkshire;
- The new risk assessment form looks at the whole individual and all their circumstances and is much less of a binary approach as taken in the tick box traffic light system used in the risk assessment form in MIDIS;
- There is capacity for a record to be kept that a patient has given their consent for staff to share details of their care with a particular person or persons;
- The system runs alongside the existing patient clinical portal which means eg that if a GP wishes to see what a patient's position is with Mental Health Services (which would not normally be recorded on the clinical portal), the GP can access this via MORSE.

- One of the recommendations of the SAER was that users of the system are prompted by the system to proactively review a patient's risk assessment but that is not yet possible. However, it is under consideration and may be possible and introduced in the future;
- Dr Ward recommended a review of the nursing staff communication tool "SBAR" (Situation, Background, Assessment, Recommendations) as a framework for inpatient assessments. NHSL recognise that the SBAR tool led to repetition in note recording which meant that the notes were not as up to date or as insightful as they could have been and they plan to replace same under MORSE. This has proven to be a more difficult and complex task for NHSL than first envisaged as it involves a problem, which is widespread across the NHS, namely the tension that exists between clinicians spending time actually treating and caring for patients on the one hand and, on the other, spending time trying to complete patient notes in a way that is succinct yet comprehensive enough to be meaningful. However, an alternative to the SBAR tool is under consideration and may be introduced in the future.

[360] Given the evidence of Dr Daly and CC as to the changes NHSL have made to various aspects of patient assessment, including risk assessment and the form used for same, discharge and note and record keeping and having regard to the evidence of Dr Ward also in that respect, I have concluded that the evidence shows that NHSL have

taken or intend to take actions to appropriately and sufficiently address the recommendations and learning points identified in the SAER Report and in Dr Ward's reports. Accordingly, I have no recommendation to make in respect of these matters.

[361] Furthermore, I do not consider that the evidence led in the Inquiry was such as to justify or require any recommendation being made by me in relation to any other matter raised in the Inquiry.

[362] Accordingly, I make no recommendations.

[363] I had the benefit of a Victim Impact Statement from AA which I have considered and taken full account of. I heard evidence from AA and also BB at the Inquiry. Ms Gallacher's death has, understandably, been a devastating loss for them yet throughout this process they conducted themselves with great dignity and restraint. I conclude by extending my sincere condolences to them and the wider family of Ms Gallacher.