SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) 1976

Inquiry into the circumstances of the death of Audrey Johnstone.

PAISLEY, 26 June 2008.

The Sheriff, having considered all the evidence adduced, the submissions and the relevant statutory provisions, **DETERMINES**:-

(i) in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 that Audrey Johnstone, born 27 April 1963, who resided at 107 Hillend Road, Clarkston, East Renfrewshire, died at 1655 hrs on 19 February 2006 at Hairmyres Hospital, East Kilbride;

(ii) in terms of section 6(1)(b) of the said Act that the cause of Mrs Johnstone's death was a suspected drug overdose.

NOTE:

This fatal accident inquiry into the death of Mrs Audrey Johnstone, aged 42 years, who resided at 107 Hillend Road, Clarkston, East Renfrewshire was heard over the course of several days in weeks beginning 19 May and 3 June 2008.

Mr Anthony Quigley, procurator fiscal depute, conducted the inquiry on behalf of the Procurator Fiscal. Mr Douglas Jessiman, solicitor, represented Dr Sarah Holmes and Dr Laura Nicol, and Mr Robbie Wightman, solicitor, represented Greater Glasgow Health Board.

The procurator fiscal led evidence from 7 witnesses, namely, Mr John Johnstone, husband of the deceased, Dr Sarah Holmes, consultant psychiatrist, Dr Laura Nicol, GP, Dr Marjorie Black, Consultant Forensic Pathologist, the University of Glasgow, Mr Denis Feeney, staff

nurse, Leverndale Hospital, Glasgow, Mrs June McLeod, Adult Inpatient Service Manager, Leverndale Hospital, Glasgow, and Police Constable Mark Robertson, Strathclyde Police, Helen Street, Glasgow. The evidence of Dr Alistair McLennan c/o the Accident & Emergency Dept Hairmyres Hospital, East Kilbride was agreed by Joint Minute.

It is important in my view that the objectives of a Fatal Accident Inquiry should be understood. An essential feature of the procedure is that evidence is given in public so that the knowledge of those responsible for investigation of the death is shared with the public and in particular with legitimately interested parties. The inquiry therefore fulfils the important purpose of enlightening those with a legitimate interest in the death, for example the relatives of the deceased, as to the cause of death. It also serves the purpose of enlightening the public at large, including the relatives, as to whether any reasonable steps could or should have been taken whereby the death might have been avoided.

There may be lessons learned from the facts which emerge at an inquiry. If so, the Sheriff may in his Determination set out the circumstances under one or more of paragraphs (c), (d) and (e) of Section 6(1) of the 1976 Act, all as more particularly specified herein. He may also make "recommendations", for instance, directing attention to ways whereby practices which may have contributed to the death can be improved. Moreover, the provisions of Section 6(1)(e) of the Act entitle the Court to comment upon, and where appropriate, make recommendations in relation to any matter which has been legitimately examined in the course of the inquiry, as a circumstance surrounding the death, if it appears to be in the public interest to make such comments or recommendations.

It is also important, however, that the limitations of this form of inquiry should be borne in mind. An inquiry of this type is essentially an exercise in fact finding, not in fault finding, and it is not the function of the Court to make findings or express opinions on questions of fault or liability, or to attempt to apportion blame. This does not mean, of course, that the evidence lead at an inquiry may not disclose fault. In that event, a finding implying or imputing fault is competent and where the evidence is sufficiently compelling, the responsibility of exposing and finding fault should be accepted. The whole object of impartial public inquiry is to get at the truth, to expose fault where fault is proven to exist, and in all cases to see to it so far as

humanly possible that the mistake, whether it arises through fault or some other reason, is not made in the future.

The very wide power given to a Sheriff in a Fatal Accident Inquiry must also be exercised with caution, bearing in mind the summary nature of the proceedings and the lack of formal pleadings. It is no doubt partly at least for this reason, that Section 6(3) of the Act provides that the Sheriff's determination in a Fatal Accident Inquiry may not be founded upon in any subsequent proceedings.

Background Matters Admitted or Undisputed

1. Mrs Johnstone married her husband John Douglas Johnstone on 15 May 1992. She gave birth to their daughter in 1995.
2. Prior to her marriage Mrs Johnstone had experienced mental health difficulties. As a consequence of a mental disorder she had been an inpatient in a mental hospital in Aberdeen.
3. In 2000 Mrs Johnstone began to display mental health problems. She was given medication to combat stress and was also prescribed antidepressants.
4. Mrs Johnstone and her husband separated in March 2003. They were not divorced.
5. After the separation Mrs Johnstone bought a house and started her own business as an accountant.
6. In July 2005 Mrs Johnstone was admitted for the first time to Leverndale Hospital, Glasgow. In that year she was in and out of hospital two or three times. On all occasions Mrs Johnstone was a voluntary or informal patient, that is she was not detained compulsorily.
7. In January 2006 Mrs Johnstone visited her parents in Elgin and stayed with them for one week or so. When she returned to Glasgow at the end of that month her husband was concerned about her mental health.
8. On 1 February 2006 Mr Johnstone accompanied his wife to a consultation with Dr Susan White, consultant psychiatrist, Leverndale Hospital, Glasgow. At this consultation Dr White encouraged Mrs Johnstone to go into Leverndale Hospital as a voluntary patient. Mrs Johnstone agreed to do so. The next day, 2 February 2006, Mr Johnstone drove his wife to Leverndale Hospital, where she was re-admitted.

9. Crown Production 4 comprises the Medical and Nursing Records in relation to Mrs Johnstone.
10. Page 230 of said Production comprises part of the clinical notes for 2 February 2006 following upon Mrs Johnstone's re-admission. Under the heading of "Thoughts" it is recorded "Increased thought suicide/deliberate self harm. Increased evidence formal thought disorder/delusions/paranoia".
11. Page 231 of said Production is a continuation of the clinical notes for 2 February 2006. This records that Mrs Johnstone's medication was to be changed.
12. Page 232 of said Production includes an entry for 6 February 2006 which records, inter alia, "Not wanting to go on anymore, but no plans suicide".
13. On 9 February 2006 Mrs Johnstone removed her daughter's pet rabbit from the garage, left a note that her daughter was not to be allowed into the garage and then drove her car into the garage. Mrs Johnstone appears to have been disturbed by a neighbour and she then drove to see her doctor. Mr Johnstone was made aware of this incident by the neighbour about two days later. He did not tell the hospital authorities about this. Mrs Johnstone discussed this incident with a Doctor and with Nursing staff when she returned to the Hospital.
14. On 9 February Mr Johnstone collected his wife from the doctor's surgery and he then drove her back to hospital.
15. Page 399 of said Production is a copy of the nursing notes for 9 February 2006. This records an entry at midday, viz "Audrey's ex-husband came to ward, distressed re phone call received from her to say she could not live anymore. Staff spent a lot of time reassuring him of Audrey's programme. A phone call received from Audrey's GP informing staff that Audrey was at his surgery seeking help for her suicidal ideation and this was the second day in a row that she had visited GP. Audrey also phoned her friend to say she was suicidal".
16. Page 233 of said Production is a copy of the clinical notes for 9 February 2006. This records inter alia, that Mrs Johnstone has stated that she is having fleeting suicidal thoughts particularly when lying in bed at night, and that she is frightened as she has never had these before.
17. Page 401 of said Production contains an entry for the afternoon of 11 February 2006 which states that Mrs Johnstone had left the ward in good order for an afternoon/evening pass.

18. Page 236 of said production contains an entry for a Multi Discipline Team meeting held at the hospital on 15 February 2006. This records, inter alia, that Mrs Johnstone had been given an overnight pass from 14 to 15 February. She had gone home and had slept well.
19. Leverndale Hospital operates a "pass" system whereby patients, both voluntary and detained, are given a pass to go out of the hospital. A pass can be for a number of hours or for days or weeks. A pass can also be issued on an overnight basis.
20. On 17 February 2006 Mrs Johnstone and her husband had a meeting with Dr Sarah Holmes, consultant psychiatrist. Dr White, who had previously been looking after Mrs Johnstone had retired and Dr Holmes had replaced her at the beginning of February 2006. Pages 236 and 237 of said Production contain a record of said meeting. Dr Holmes has recorded Mrs Johnstone as being very anxious with suicidal thoughts but with very little plans regarding these. The entry records that Mrs Johnstone's medication is to be changed. The entry concludes "At present no overnight passes". This was agreed by Mrs Johnstone with Dr Holmes.
21. Although it was stated that Mrs Johnstone should not have an overnight pass, it was agreed with Dr Holmes that Mrs Johnstone should continue to be given day passes since she said that she derived benefit from going out with friends during the day.
22. Page 404 of said production is a copy of the Nursing Notes for, inter alia, 17 February 2006. This records that Mrs Johnstone had returned (from an overnight pass) in good order. This entry also records that there have to be no overnight passes meantime.
23. On 18 February 2006 Mrs Johnstone was given a day pass so that she could go out for the day with a friend. Page 405 of said production is a copy of the nursing notes for that day. An entry for "am" records that Mrs Johnstone is to return to the hospital around "dinner time". This would be about 5 pm.
24. Mrs Johnstone did not return at "dinner time". Page 405 of the nursing records contains an entry written at 2325 hrs by Staff Nurse Dennis Feeney. This records that Mrs Johnstone had failed to return from her day pass with a friend and that Mr Feeney had tried telephoning Mrs Johnstone's home number on three occasions with no reply. He had also telephoned her father's home number with a view to obtaining Mrs Johnstone's mobile number but there was no answer. Mr Feeney then discussed the situation with the duty doctor, Dr Laura Nicol.

25. Both Mr Feeney and Dr Nicol considered that they had a good relationship with Mrs Johnstone and that they knew her well. They had no concerns that she was likely to take steps to harm herself.

26. Where a voluntary patient fails to return from a day pass the patient is often given an overnight pass retrospectively. Because it was recorded in Mrs Johnstone's notes that she was not to be given overnight passes she could not be granted a retrospective overnight pass and it was agreed between Mr Feeney and Dr Nicol that Mrs Johnstone would be placed "AWOL" (absent without leave) at midnight. No other steps were taken by the hospital authorities at this time.

27. In February 2006 Leverndale Hospital did not have an agreed Protocol to deal with patients who failed to return from a day pass. In general terms, in such a situation it was likely that there would be a discussion at the shift hand over at 9.00pm. If the missing patient was a voluntary patient, nothing would be done unless it was decided that the patient was at risk of causing injury to himself or others.

28. At midnight a record is made of patients present and patients absent at that time. Nothing else is done unless it is considered that there is a risk to the health of the patient or others. It is likely the duty Doctor would be informed but this was not mandatory or part of a written protocol

29. In February 2006, the fact that a patient was marked "AWOL" was not necessarily a catalyst for further action.

30. At 10.30am on 19 February 2006 nursing staff tried to contact Mrs Johnstone by telephone but there was no answer. At about this time a friend of Mrs Johnstone's arrived on the ward and it was then decided to contact Strathclyde Police. This was done. Page 406 of Crown Production 4 records that at 11.45am Strathclyde police telephoned back to the ward asking why staff were concerned about Mrs Johnstone.

31. Police officers attended at Mrs Johnstone's home at about midday on 19 February 2006. The front door was locked and the keys had been left inside in the lock. There was no entry possible at the rear. Police officers forced the front door and effected entry to the house.

32. The police officers searched the house systematically. They found some tablets in a packet downstairs. These appeared to have been prescribed rather than illicit. In an upstairs bedroom police officers found Mrs Johnstone lying on her front, face down on top of a bed. She was clothed. She was still alive but she could not be wakened. An

ambulance was summoned immediately. This arrived a short time later and Mrs Johnstone was taken to Hairmyres Hospital, East Kilbride.

33. Police officers also found a note on a dresser in the bedroom. This appeared to have been written by Mrs Johnstone. Crown production 5 is a copy of said note. It states:-

"Sorry

Mum and Dad, all my family and friends. I love you all very much. I want you to know that there was nothing else you could have done. I just couldn't go on any longer.

I know Amy will be well looked after. I am so proud of her. Please tell her every day how much I love her.

Audrey"

34. Mrs Johnstone did not regain consciousness and died at Hairmyres Hospital, East Kilbride on 19 February 2006 at 1655 hrs.
35. Expressed suicidal ideation amongst patients suffering from depression is very common.

Subsequent Procedure

1. Crown production 2 is a post mortem report dated 28 March 2006 in relation to Mrs Johnstone, prepared by Dr Marjorie Black, forensic pathologist, the University of Glasgow, following upon a post mortem examination of Mrs Johnstone's body on 21 February 2006.
2. Crown production 3 is a toxicology report dated 27 March 2006 of various samples of blood, serum and urine from Mrs Johnstone supplied to the toxicology department. The toxicology report was available to Dr Black when she prepared the post mortem report.
3. The toxicology report discloses that in the blood sample taken post mortem there was a high concentration of Phenytoin. In the blood sample taken from Mrs Johnstone at Hairmyres Hospital there was a high concentration of Amitriptyline along with traces

of Lorazepam. The time at which this latter sample was taken at Hairmyres Hospital is not recorded.

4. Phenytoin is an anticonvulsant drug which was given to Mrs Johnstone on her admission to Hairmyres Hospital.
5. Lorazepam was one of several drugs given to Mrs Johnstone when she was a patient at Leverndale Hospital.
6. Amitriptyline is a well-known drug taken by people who intend to overdose. The level of Amitriptyline in Mrs Johnstone's body at the time the blood sample was taken at Hairmyres Hospital was higher than might have been expected if she had been taking it as a prescribed drug but it was not within a range reported in the literature as being sufficient to cause death.
7. The post mortem examination disclosed no evidence of any natural disease which would account for Mrs Johnstone's death.
8. It cannot be ascertained at what time Mrs Johnstone ingested the Amitriptyline. Since it is not known when the blood sample was taken at the hospital it is not possible to ascertain or calculate how much Amitriptyline was taken by Mrs Johnstone.
9. Dr Black concluded on the basis of the circumstantial evidence known to her, including the finding of the note, crown production number 5, that Mrs Johnstone had taken a drug overdose and that the primary cause of death was a suspected drug overdose.
10. Pages 5 – 7 of Crown Production 4 is a copy letter by Dr Sarah Holmes to Dr Linda Watt, Medical Director, Gartnavel Royal Hospital, Glasgow dated 20 February 2006. This letter takes the form of a report to Dr Watt following upon Mrs Johnstone's death.
11. After every death in Leverndale Hospital, including deaths by natural causes, a review is held. Crown Production 1 is a copy Critical Clinical Incident Investigation Report which was issued following upon the review of Mrs Johnstone's death. This identifies various issues and makes five recommendations including the review and updating of risk assessments at weekly multidisciplinary team meetings.
12. Since the time of Mrs Johnstone's death a Protocol has been developed giving guidance to staff where patients have failed to return timeously to the Hospital Ward. Training in relation to this Protocol was due to be initiated at the Hospital at the end of May 2008.

13. The Protocol does away with the concepts of "dinner time" and "tea time" and recommends that the pass stipulates the actual time the patient is expected to return to the ward. The Protocol sets out a timetable for action and recommends that each patient's Care Plan should include an agreement as to what will be done when a patient has failed to return to the Ward at the agreed time.
14. At the time of Mrs Johnstone's death a patient's Clinical Notes and Nursing Notes were kept separately. These notes now form part of the one document for each patient.

Submissions

Mr Quigley, Mr Jessiman and Mr Wightman kindly provided me with copies of their detailed written submissions. As these have been lodged with the papers for the Inquiry I need only give a summary of these.

(a) Submissions for the Procurator Fiscal

Mr Quigley submitted that I should make formal findings in terms of Sections 6(1)(a) and (b) of the 1976 Act.

In relation to Section 6(1)(c) Mr Quigley submitted that the fact that the cause of death could not be established definitively made it difficult to set out reasonable precautions whereby death might have been avoided and even it were accepted that Mrs Johnstone's death was at her own hand there was no evidence as to when the drugs had been ingested and, consequently, whether it could be said that earlier medical intervention would necessarily have altered the outcome.

In relation to Section 6(1)(d) Mr Quigley highlighted six matters of concern which had been raised during the course of the Inquiry, and I shall return to these later.

Mr Quigley submitted that no formal findings were required in terms of Section 6(1)(e) of the Act.

(b) Submissions by Mr Jessiman on behalf of Dr Sarah Holmes and Dr Laura Nicol

Mr Jessiman invited me to make formal findings in relation to Sections 6(1)(a) and (b) and to make no further findings.

In relation to Section 6(1)(c) of the Act, Mr Jessiman submitted that no expert evidence had been led to show that anything done by Dr Holmes or Dr Nicol was not reasonable, and in the absence of such evidence the Court could not find that there was a reasonable precaution which either doctor could have taken whereby the death might have been avoided.

Mr Jessiman analysed the involvement of Dr Holmes and Dr Nicol in Mrs Johnstone's case and invited me to hold that there was no evidence to suggest that their decisions in the treatment of Mrs Johnstone were anything other than entirely reasonable.

(c) Submissions by Mr Wightman on behalf of Greater Glasgow Health Board

Mr Wightman invited me to make a formal finding in relation to Section 6(1)(a).

In relation to Section 6(1)(b) of the Act Mr Wightman referred me to the evidence of Dr Black where she had recorded the primary cause of death as a "suspected drug overdose". In view of the lack of certainty as to the precise cause of death Mr Wightman questioned whether it was possible for me to make a determination in terms of Section 6(1)(b). If that were the case it would not be possible for me to make determinations under sub-sections (c), (d) or (e).

Assuming, however, that I was inclined to make a determination in terms of Section 6(1)(b) Mr Wightman submitted that it was clear that Mrs Johnstone had at no time lacked capacity. Indeed, while a patient at the Hospital she had endeavoured to continue her practice as an Accountant and had operated "at a high level".

Mr Wightman referred me to Mrs Johnstone's husband's criticism of the lack of consistency and lack of continuity of care and his suggestion that Mrs Johnstone should have been given "electric shock treatment". He invited me to dismiss these criticisms.

In analysing the evidence of Staff Nurse Denis Feeney and Dr Nicol, Mr Wightman submitted that there was no evidence from any source that either they or Dr Holmes had acted unreasonably in any way.

Discussion

It must not be forgotten that Mrs Johnstone was a voluntary, or informal, patient at Leverndale Hospital and as such was entitled more or less to come and go as she pleased.

Persons who require to be detained compulsorily are normally, but not exclusively, detained in a mental hospital initially in terms of a short-term detention certificate before a Compulsory Treatment Order is granted. For a short-term detention certificate to be granted five criteria require to be met, viz:-

(a) that the patient has a mental disorder; and
(b) that, because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired; and
(c) that it is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or giving medical treatment to the patient; and
(d) that if the patient were not detained in hospital there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person; and
(e) that the granting of a short term detention certificate is necessary.

Dr Holmes' opinion was that Mrs Johnstone did not satisfy all five criteria. I do not think anyone would seriously take issue with that opinion. Accordingly, not only would it have

been entirely inappropriate to attempt to detain Mrs Johnstone compulsorily, such detention would have been unlawful.

Section 6(1) of the 1976 Act specifies the matters which should be the subject of the Sheriff's determination following upon an Inquiry such as this, viz:-

> "6(1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction –
>
> (a) where and when the death and any accident resulting in the death took place;
>
> (b) the cause or causes of such death and any accident resulting in the death;
>
> (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
>
> (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
>
> (e) any other facts which are relevant to the circumstances of the death

I now deal with each of these sub-sections in turn:

(a) The date, time and place of Mrs Johnstone's death is as I have stated at the commencement of this Determination.

(b) Dr Marjorie Black, a very experienced and highly regarded Forensic Pathologist, concluded that the cause of Mrs Johnstone's death was a suspected drug overdose. I refer to my findings in fact under the heading "Subsequent Procedure".

Mr Jessiman, in the course of his submission, suggested that I could make a finding, on the balance of probabilities, that Mrs Johnstone took an overdose of amitriptyline on the basis that, although the level of amitriptyline from the samples taken was not at a fatal level, it was higher than would have been expected in a normally prescribed dose.

Mr Wightman questioned whether, even on the balance of probabilities, there was sufficient evidence to enable me to make any determination in terms of Section 6(1)(b) of the Act.

In a Fatal Accident Inquiry the general standard of proof required is proof on the balance of probabilities.

Doctor Black was unable to say categorically that Mrs Johnstone had taken an overdose, nor which drugs were involved, but, in the absence of anything else to account for her death, Dr Black concluded that the cause of Mrs Johnstone's death was a suspected drug overdose.

Given Mrs Johnstone's history, the events and circumstances in the days leading up to her death and the finding of the note (Crown Production Number 5) I think I am entitled to conclude, on the balance of probabilities, that the cause of Mrs Johnstone's death was indeed a drug overdose.

Towards the end of her evidence Dr Black issued a word of caution. She pointed out that the drug screen test which her department carries out does not cover every drug. The ingestion of some drugs is only disclosed if a specific test is carried out for that particular drug. Accordingly, while it is beyond doubt that Mrs Johnstone ingested amitriptyline, it cannot be said categorically that she did not ingest another drug or other drugs which did not show up in the drug screen test.

Accordingly, I think it is appropriate that I should state on the balance of probabilities that Mrs Johnstone died of a drug overdose, without specification of the drug or drugs involved.

(c) All parties submitted that in view of the uncertainty as to the cause or causes of Mrs Johnstone's death it was not possible to formulate the reasonable precautions which could have been taken whereby the death might have been avoided.

On the assumption, however, that the cause of death was as opined by Dr Black, it is still not possible, in my opinion, to state what reasonable precautions if any could have been taken to avoid Mrs Johnstone's untimely death.

There was no clear evidence as to the precise time Mrs Johnstone left Leverndale Hospital on the morning of Saturday 18 February. Evidence to the Inquiry disclosed that she was found at home by Constable Robertson at about 12.15 pm on Sunday 19 February. A blood sample taken by Hairmyres Hospital was supplied to the toxicology department. This disclosed the levels of amitriptyline and lorazepam as detailed in the Toxicology Report.

It is clear from the evidence of Dr Black that amitriptyline can remain in a person's body for a substantial period of time. She said that a half-life of this drug, that is, the time it takes the level of the drug in the body to fall by half, varies between 8 and 51 hours. There is no evidence to show how much of this drug was taken by Mrs Johnstone and when it was taken. It is only possible to estimate the time when the blood sample was taken by the hospital at between 12.30 pm and the time of Mrs Johnstone's death at 4.55 pm. Dr Black accepted, in reply to a question put to her by Mr Wightman, that it was "likelier" that a fatal dose of amitriptyline (if, indeed, a fatal dose of that drug is what she took) was ingested more than 16 hours before the blood sample was taken. In view of all the uncertainties, however, it is not possible to exclude the suggestion that a fatal dosage was taken by Mrs Johnstone at least 24 hours prior to the taking of the blood sample by Hairmyres Hospital and, obviously, therefore, at a time prior to Mrs Johnstone's expected return to Leverndale Hospital at "dinner time".

In the course of his submission Mr Jessiman analysed the actings of Dr Holmes and Dr Nicol. He pointed out that Dr Holmes had been the only psychiatrist to give evidence. She had indicated that she was satisfied with the treatment given to Mrs Johnstone and with the drug regime which had been recently reviewed by her when she was appointed to Leverndale Hospital at the beginning of February 2006.

In relation to the involvement of Dr Nicol, Mr Jessiman also referred me to the evidence of Mr Feeney, a very experienced mental health nurse. It was he who had reported Mrs Johnstone's failure to return to the hospital to Dr Nicol. Mr Feeney had access to Dr Holmes' note in the clinical records regarding the agreement with Mrs Johnstone that there should be no overnight passes meantime. Both Mr Feeney and Dr Nicol knew Mrs Johnstone reasonably well. They were aware of her mental health history and came to the view that Mrs Johnstone should be marked in the records as "AWOL".

Mr Jessiman accepted, with the benefit of hindsight, that it might be suggested that something more should have been done by Dr Nicol or Mr Feeney when Mrs Johnstone did not return, but there was no evidence to suggest that Dr Nicol's actions were unreasonable and no evidence that if she had done something different the outcome might have been different.

As Mr Jessiman pointed out, there was no evidence before the Inquiry that a particular act or omission by one of the parties involved was not reasonable and he submitted that in the absence of such evidence the Court could not find that there was a reasonable precaution which could have taken whereby the death might have been avoided.

I agree with the submissions made to me in relation to this subsection that it would be inappropriate for me to make any findings in terms of Section 6(1)(c) of the Act.

I should also say, by way of a footnote to this subsection, that it was perfectly clear from the evidence of Dr Nicol and Mr Feeney that they did not even contemplate the need to contact the police. On the basis of their knowledge of Mrs Johnstone they obviously did not consider that she might attempt to take her own life.

As Mr Feeney pointed out in his evidence, it is important that a good relationship is built up between medical and nursing staff on the one hand and a patient on the other. There requires to be an element of trust and to call out the police for an informal patient, when there was no need to do so, would destroy any relationship between the hospital and the patient.

(d) In the course of his submission Mr Quigley drew my attention to various matters of concern which had been raised during the course of the Inquiry. These were:

(i) The continuity of treatment provided to Mrs Johnstone. Mr Johnstone, in the course of his evidence, stated that Mrs Johnstone had been "disconcerted" by the lack of continuity of care.

Dr Susan White, the psychiatrist who had been involved in Mrs Johnstone's care had retired. Dr Ellison, another member of the psychiatric staff had been off for some time

due to illness. These changes were unfortunate but were obviously unavoidable in the circumstances.

As I understand it, there would be a responsible medical officer for each patient, but every patient would be seen by a number of Doctors.

Similarly Mrs Johnstone would receive nursing care from a variety of nurses as the shifts rotated. This is obviously perfectly normal in any hospital.

There was nothing to suggest that these changes had a detrimental effect on Mrs Johnstone's health.

(ii) The fact the Mrs Johnstone was not the subject of a compulsory admission to hospital. I have already dealt with this. To make Mrs Johnstone the subject of a Compulsory Treatment Order would have been illegal.

(iii) The medication programme and its effects. Dr Holmes gave evidence that when she started work at Leverndale Hospital in early February 2006 she became aware that Mrs Johnstone and her husband had expressed concerns about the medication she had been prescribed.

It was clear to the Inquiry from the evidence of Dr Holmes that Mrs Johnstone had had some input into the discussion regarding her medication and that some changes to her medication were carried out in consultation with her.

There was no evidence before the Inquiry to suggest that these changes had had an adverse effect on her state of mind or that they had in any way exacerbated her mental condition.

Mr Johnstone had said in evidence that he had expressed concern that his wife had not been given electric shock treatment/therapy. Dr Holmes stated that she used this form of treatment on a fairly regular basis but it was her opinion that such treatment would

not have been appropriate for Mrs Johnstone. There was no evidence that the decision by Dr Holmes not to use this form of treatment was incorrect.

(iv) The separation of clinical/medical notes from nursing notes. In February 2006 the practice at Leverndale Hospital was to store clinical notes and nursing notes separately. There now has been a change in policy in that clinical notes and nursing notes are kept together. There was no evidence that the practice in 2006 was in any way detrimental to Mrs Johnstone's care since medical staff had access to the nursing notes and nursing staff to the medical notes.

(v) Recording and storing of personal data/information. During the course of Mr Feeney's evidence it emerged that after he had been unsuccessful in trying to contact Mrs Johnstone by telephone he had telephoned her father to see if he had another telephone number for her. The number kept for her father was incorrect.

Mrs McLeod gave evidence that there has been a change in policy and that on a patient's admission all relevant telephone numbers are recorded and the records of these telephone numbers are checked periodically for accuracy.

(vi) The administration of the pass system. The Inquiry heard a considerable amount of evidence in relation to this.

Both informal and detained patients are entitled to be given a pass to leave the hospital. As I have found in fact, a pass can be for a few hours or a period of days or even weeks. A patient can also be given a pass on an overnight basis. Essentially, a pass is given to allow a patient to leave a ward for an agreed period of time.

Mr Feeney described some of the practical difficulties involved in administering the pass system. He said that a lot of patients come back late so that they can extend their time away from the hospital. A patient may be drinking. He won't wish to come back to the hospital under the influence of alcohol so he will wait until the next morning to return. Some patients return to the hospital early, if, for example, their transport arrives early or if they fall out with their family. Occasionally patients state that they are not

coming back when they are expected to return and patients in that situation often point out that they are not at the address at which they are expected to be in any event. All of these situations require that the nursing staff adopt a flexible approach and only in exceptional circumstances, when dealing with an informal patient, would the police be contacted. I have already mentioned the need not to break the bond of trust which had been built up between patient and the hospital.

In relation to Mrs Johnstone, after nursing staff had been unable to contact her by telephone, Mr Feeney and Dr Nicol discussed the situation. They could not grant her an overnight pass retrospectively because Dr Holmes had stated there were to be no overnight passes given to Mrs Johnstone, and accordingly, in terms of their procedures, there was no option but to record her as "AWOL".

While, at first blush, it would seem that this is certainly not a very proactive approach, I accept the evidence presented to the Inquiry that Dr Nicol and Mr Feeney assessed the situation properly, and took a decision which, in all the circumstances, was entirely reasonable. While Mrs Johnstone had expressed suicidal ideation, she was no different from a very high percentage of Dr Holmes' patients who suffered from depression (she said at least 80% of her patients with depression talked in such terms). There was no suggestion in Mrs Johnstone's behaviour that she was likely to take her own life and there was no evidence before the Inquiry that Dr Nicol and Mrs Feeney could have, or should have, acted differently. As Mr Feeney said in evidence, when Mrs Johnstone was not back when his shift finished at 7am on Sunday 19 February, he was not at all anxious about her. If he had been, he would have done something about it before he left the ward. He also said that if he had telephoned the police at midnight they were likely to seek his guidance and rely on his experience of the patient.

I also accept the evidence presented to the Inquiry that, in essence, the decisions taken by staff, such as Dr Holmes, require to be a sort of balancing act. More harm than good can be done to patients who are forced to remain in hospital, because hospital takes away their supports. They become dependant on the system. They need to get out and about to maintain an ability to cope out of the hospital. Mrs Johnstone had an insight into her condition and recognised the need for her to be allowed out of the hospital.

Mrs Johnstone was a voluntary or informal patient and, as Mr Quigley succinctly put it in the course of his submission, "she was in control of her own destiny".

Accordingly, I consider, for the above reasons, that there were no defects in the working system which contributed to Mrs Johnstone's death.

(e) Following upon Mrs Johnstone's death an Inquiry was carried out and various recommendations made in terms of the Critical Clinical Incident Investigation Report. A Protocol had now been put in place to provide a timetable, and clear guidance to staff, when a patient fails to return to hospital timeously. Their existence in February 2006 would not necessarily have prevented Mrs Johnstone's death, but lessons have been learned and the procedure has been more precisely set out.

Accordingly, I do not consider there are other facts which are relevant to the circumstances of the death and I make no finding in relation to Section 6(1)(e) of the Act.

Finally, I extend my condolences to Mrs Johnstone's parents, her daughter, her husband and family. It is clear that at one time Mrs Johnstone had been an able professional person able to deal with a high pressure job. She had always been a loving mother to her daughter Amy. It is very sad that her life was brought to a premature end.

I am most grateful to Mr Quigley, Mr Jessiman and Mr Wightman for the professional way in which they each presented their respective cases and for the clear and careful closing submissions, which have been of great assistance to me in preparing this Determination.