SHERIFFDOM OF NORTH STRATHCLYDE AT OBAN

[2025] FAI 43

OBN-B12-23

DETERMINATION

BY

SHERIFF SHEENA M FRASER

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

into the death of

MARTYN SMITH AND JOHN WHITE

OBAN 21 November 2025

DETERMINATION

The sheriff, having considered the information presented at the Inquiry and the submissions of parties, Determines in terms of Section 26 of the Inquiries into Fatal Accidents and Sudden Deaths Etc. (Scotland) Act 2016 ("the 2016 Act") that:

F1. In terms of section 26(2)(a) of the 2016 Act (when and where the deaths occurred):

That Martyn Smith, born 8 December 1944, died at 1020 hours on 1 October 2018.

That John White, born 11 April 1943, died at 0949 hours on 1 October 2018 within 9 Columba Court, Oban.

F2. In terms of section 26(2)(b) of the 2016 Act (when and where any accident resulting in the deaths occurred):

That neither the death of Martyn Smith nor the death of John White was as a result of an accident.

F3. In terms of section 26(2)(c) of the 2016 Act (the cause of deaths):

That the cause of death of Martyn Smith was 1a Blunt force trauma of chest.

That the cause of death of John White was 1a Ischaemic and hypertensive heart disease.

F4. In terms of section 26 (2)(d) of the 2016 Act (the cause or causes of any accident resulting in the deaths):

That neither the death of Martyn Smith nor the death of John White was as a result of an accident.

F5. In terms of section 26(2)(e) of the 2016 Act (the taking of precautions which could reasonably have been taken, and, had they been taken, might realistically have resulted in the deaths, or any accident resulting in the deaths, being avoided):

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

F6. In terms of section 26(2)(f) of the 2016 Act (defects in any system of working which contributed to the deaths or any accident resulting in the deaths):

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

F7. In terms of section 26(2)(g) of the 2016 Act (any other facts relevant to the circumstances of the deaths):

That there are no facts, beyond the findings set out in this Determination, which are relevant to the circumstances of the deaths of Martyn Smith or John White.

RECOMMENDATIONS IN TERMS OF SECTION 26(1)(B)

In terms of Section 26(1)(b) of the Act, having considered the information presented at the Inquiry and the changes implemented by, in particular, Police Scotland and NHS Highland and Islands Health Board, following their respective reviews, and having regard to the matters mention in section 26(4) of the Act, I make no recommendations.

1. NOTE

Introduction

[1] This was a discretionary Fatal Accident Inquiry in terms of section 4(1) of the 2016 Act into the deaths of Martyn Smith and John White as it appeared to the Lord Advocate that the deaths occurred in circumstances giving rise to serious public concern, such that it was in the public interest an Inquiry be held. A single Inquiry was

held into the deaths of Martyn Smith and John White, because it appeared to the Lord Advocate that the deaths occurred in related circumstances.

[2] Martyn Smith, whose date of birth was 8 December 1944, died on 1 October 2018 as a result of being assaulted by Oscar Rancevs (hereinafter, referred to as "OR"). OR was not criminally responsible for his conduct at the time of the incident, due to mental disorder. OR had had a number of contacts with NHS Highlands and Islands and Police Scotland in the lead up to this assault. Despite these contacts, his presentation was not noted by NHS Highlands and Islands as requiring immediate further treatment, nor noted by Police Scotland as requiring any immediate action. He was not considered to be a risk to himself or others to the extent that no emergency action (such as detention in hospital or referral to mental health crisis services) was deemed appropriate.

[3] John White, whose date of birth was 11 April 1943, also died on 1 October 2018. He also had been assaulted by OR and had witnessed OR's assault on Martyn Smith. OR assaulted John White shortly before OR assaulted Martyn Smith and John White's death occurred whilst he was on the phone to a 999 operator. The police officers who attended in relation to the 999 call were not instructed to make immediate contact with John White to ensure his safety.

[4] OR appeared on an Indictment at High Court of Justiciary in Glasgow, on 13 November 2019, libelling the following charges:

> "(01) On 1 October 2018 at Columba Court, Castle Road, Oban you OSKARS RANCEVS did behave in a threatening and abusive manner which was likely to cause a reasonable person to suffer fear and alarm and did repeatedly bang and kick on the door of the house at Flat 13, then occupied by

Martyn Smith, shout at him and demand that he open the door: CONTRARY to Section 38 (1) of the Criminal Justice and Licensing (Scotland) Act 2010;

(02) On 1 October 2018 at Columba Court, Castle Road, Oban, you OSKARS RANCEVS did assault Martyn Smith, then residing at Flat 13 Columba Court and did shout at him, repeatedly push and kick him on the body whereby he fell to the ground, drag him along the ground and repeatedly jump on his body, repeatedly punch and kick him on the head and body, repeatedly stamp on his head and body, thrown items at, or over, him and you did murder him;

(03) On 1 October 2018 at Columba Court, Castle Road, Oban, John White, then residing at Flat 9 Columba Court having witnesses the assault upon said Martyn Smith, as libelled in charge (02) above, and he being in the course of telephoning the Police to report said assault, you OSKARS RANCEVS did thereafter assault said John White and did strike him on the body, run towards him and pursue him and repeatedly kick him on the body, place him in a state of fear and alarm for his safety and in consequence of said assaults said John White sustained a fatal heart attack and you did kill him; and

(04) On 1 October 2018 at Columba Court, Castle Road, Oban you OSKARS RANCEVS did resist, obstruct, and hinder Scott Deakin and Peter MacMillan, both Constables, Police Service of Scotland, Albany Street, Oban and did brandish a glass at them, decline to put it down when requested to do so, shout and scream at them, and struggle with them in an attempt to resist arrest: CONTRARY to Section 90(2) of the Police and Fire (Reform) (Scotland) Act 2012"

[5] The Crown accepted pleas of not guilty to all charges and the court acquitted OR in terms of section 53E of the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act") by reason of the special defence under section 51A of that Act stating that OR, was not criminally responsible for the conduct constituting the offence by reason of his mental disorder.

[6] OR was made subject to an Interim Compulsion Order in terms of Section 53(2) and (7) of the 1995 Act.

[7] On 5 February 2020 again at the High Court of Justiciary at Glasgow, OR was made subject to a compulsion and restriction order to be detained at the State Hospital at Carstairs without limit of time.

[8] Prior to 1 October 2018 OR had a number of interactions with various departments within NHS Grampian, Highlands and Islands ("NHS") and the Police Service of Scotland ("PSS"). This enquiry was convened to examine those contacts with PSS and NHS prior to the incident, and to establish whether there were missed opportunities to intervene whereby steps might have been taken to avoid either or both deaths.

The Legal Framework

[9] The Inquiry was held in terms of section 4(1) of the 2016 Act and was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017.

[10] In terms of section 1(3) of the 2016 Act, the purpose of the Inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. It is not intended to establish liability, either criminal or civil. The Inquiry is an exercise in fact finding, not fault finding. Section 26 requires the Sheriff to make a determination, which sets out the following factors relevant to the circumstances of the death, insofar as they have been established to their satisfaction. These are:

(i) when and where the deaths occurred;

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

(iii) the cause or causes of such deaths;

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

(v) any defects in any system of working which contributed to the deaths;

(vi) any other factors which are relevant to the circumstances of the deaths.

[11] In terms of section 26 subsections (1) (b) and (4), the Inquiry is to make such recommendations (if any) as the Sheriff considers appropriate as to:

(a) the taking of reasonable precautions;

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

(c) the introduction of a system of working, and;

(d) the taking of any other steps, which might realistically prevent other deaths in similar circumstances.

[12] An Inquiry is an inquisitorial process and the way evidence is presented is not restricted. The Court proceeds on the basis of evidence placed before it by the Procurator Fiscal and by any other party to the Inquiry. The determination must be based on the evidence presented at the Inquiry and is limited to the matters defined in section 26 of the Act as narrated above. Section 26(6) of the Act provides that the determination shall not be admissible in evidence or be founded on in any judicial proceedings, of any nature. This prohibition is intended to encourage a full and open exploration of the circumstances of a death, while also reflecting the position that it is

not the purpose of a Fatal Accident Inquiry to establish civil or criminal liability (section 1(4)).

[13] The scope of the Inquiry extends beyond mere fact finding. It looks to the future and seeks to prevent deaths occurring in similar circumstances. Where the circumstances have given cause for serious public concern and inquiry may serve to restore public confidence and allay public anxiety.

Proceedings and parties

[14] A number of Preliminary Hearings took place and the Inquiry heard evidence on 6, 7, 8, 9 and 10 November and 5, 6 and 7 December 2023, then further evidence on 2 and a hearing on submissions on 2 February 2024. All the evidential hearings took place in person at Oban Sheriff Court.

[15] The Crown represents the public interest in a Fatal Accident Inquiry and Ms Brown, Procurator Fiscal Depute appeared.

[16] Other Participants and representation were as follows:

- Ms Watt, Advocate, for NHS Highlands and Islands (hereinafter referred to as NHS Highlands)
- Ms Leslie, solicitor, for The Chief Constable
- Mr Burton, solicitor, for Jacqueline Beaton, Community Psychiatric Nurse
- Mr Templeton, Advocate, for OR

Evidence

[17] The inquiry heard evidence as follows:

a) From a number of witnesses, both in person and via Webex. Those witnesses were:

1. Stephen John Paterson
2. Margaret Elizabeth Ashman
3. Jacqueline Beaton
4. PC Colin Oman
5. PC Daniel McBeth
6. PC Charles Masterton
7. Dr Krzyzstof Krajewski (by Webex)
8. Clare McDonald (by Webex)
9. Lindsay MacCalman
10. DI Andrew Doherty (Webex)
11. DS James McArthur
12. Gordon Parker
13. Dr Daniel Bennett
14. Dr Fiona Mohammad (led by OR)
15. Dr Rebecca Helliwell (led by Health Board)

b) By agreement of the parties, the statements of Catriona Currie, ambulance technician and Kenneth McIntyre, Relief Trainee Ambulance Technician were to be taken as their evidence.

c) An affidavit taken from Dr Paul MacKenzie Sheard, Consultant Specialist Psychiatrist

d) Three Joint Minutes of Agreement were lodged and read to the Inquiry, the first of which was extensive. The Joint Minutes agreed, amongst other things:

(i) the provenance of the various documents lodged as productions, including medical records relating to OR;

(ii) the medical/psychiatric history of OR including his various diagnoses and prescribed medication;

(iii) OR's level of engagement with NHS and other medical and mental health services over the years, together with the nature of the incident of 10-12 September 2017 which resulted in his being detained under an Emergency Detention Certificate in terms of s 36 of the Mental Health (Care and Treatment (Scotland) Act 2003 and thereafter under a short-term Detention Certificate at Gartnavel Royal Hospital in Glasgow. This included agreement that he remained there until he was transferred to Lochgilphead Hospital on 4 October 2017. The order ended on 10 October 2017, but OR remained in Hospital as a voluntary patient until 23 October 2017.

(iv) OR's ongoing treatment in the community, and his level of engagement with that, and his contact with family and police on 28 September and the events of 1 October themselves.

(v) Police training in relation to mental health and suicide prevention.

(vi) the chronology of events leading up to the deaths and shortly thereafter.

[18] When setting out my findings in fact, I have not repeated the contents of the Joint Minutes in full, as much of what was agreed can be summarised without any loss of substance. Also some of the unchallenged evidence I heard from witnesses complements and builds on the facts in the Joint Minutes, so I considered it appropriate and easier to follow, to simply combine that evidence as established facts. Further there were some anomalies in the Joint Minutes, for example, the Hospital that OR was taken to in Glasgow in 2017 was referred to sometimes as Gartnavel, Gartnavel General Hospital and Gartnavel Royal Hospital. I was happy to conclude from the evidence of witnesses that it was Gartnavel Royal Hospital, that was being spoken of and have amended the facts accordingly.

[19] From the Joint Minutes and the evidence, I was satisfied of the following:

Introductory matters and background

1. Oskars Rancevs (OR) was born in Latvia and as an adult, worked, *inter alia*, as a professional dancer on cruise liners.

2. Between 2006 and 2013 he had five acute psychiatric admissions for psychosis. Four of the acute psychiatric admissions were within Latvia where he was diagnosed with "Paranoid schizophrenia, episodic, with a progressive development of 'negative' symptoms in the intervals between psychotic episodes."

3. As a result, OR was treated with various prescribed medications.

4. While working on a cruise liner, OR had a psychotic episode which led to his hospitalisation in Uruguay from 1 through to 25 January 2014. His treatment there

included one based on electroconvulsive therapy, with premedication. This was due to his poor response to injections of Haloperidol, an antipsychotic drug.

5. At the beginning of 2014 OR moved to live with his mother and stepfather (Mr and Mrs Stephen Paterson) in Emsworth, Hants, England. He resided there for about 14 months and during this time was monitored and treated by local services. He appeared relatively well and was stable in mood.

6. On 23 March 2015, at his last mental health review before he moved to Scotland, OR didn't present with frank delusions, but was able to admit that during each psychotic episode, he experienced mania together with grandiose delusions about being God. The Consultant Psychiatrist noted in OR's medical history, that all of the psychotic episodes were in conjunction with mania with seemingly little evidence for ongoing psychotic symptoms during periods of euthymia. OR and his Consultant agreed on a working diagnosis of schizoaffective disorder and his medication was adjusted.

7. In March 2015, Mr and Mrs Paterson moved to Connel, near Oban, and OR registered with Taynuilt Medical Practice, there. Shortly thereafter, OR obtained accommodation at The Shore Street Flats Housing Project, in Oban. This accommodation is supported by the Blue Triangle Organisation. Ultimately, he was given his own tenancy at 12 Columba Court, Oban on 23 January 2018.

8. Doctors at the Taynuilt practice referred him to North Argyll Community Mental Health Service on 4 August 2015, for the attention of Dr Sheard, Consultant Psychiatrist, following OR advising medical staff that he wanted to stop his medication regime. The presenting complaint was described as schizoaffective disorder and Schizophrenia. He

was also referred to the NHS community mental health team based at Willowview Community Care Centre (hereafter 'Willowview), in Oban.

9. Dr Sheard met with OR on a number of occasions, frequently with his stepfather or mother present. He noted, OR was an intelligent individual who disliked having to take medication, both because it reminded him of his illness, and because it impacted on his moods and his physical health. He was not always completely honest with those involved in his treatment and care, and was capable of telling them what he considered they wanted to hear. He had a history of not taking his prescribed medication.

10. The first time Dr Sheard met OR was on 13 August 2015 at Oban Hospital, in the presence of Mr Paterson. OR presented with mood swings, but was alert, coherent and co-operative. He was able to give a clear account of his situation and difficulties and there was no evidence of inappropriate mood; insight and judgement were both present. OR was noted to be of above average intelligence and there was no suggestion of hallucinations or delusions at that time. Dr Sheard gave a provisional diagnosis of bipolar disorder with the manic phase being in remission. Dr Sheard altered OR's prescribed medication to improve OR's concentration and to tailor his drug regime as OR wished to lose weight. Dr Sheard considered OR would benefit from input from a community psychiatric nurse (CPN) and therefore copied his correspondence to Willowview where that service was based.

11. Dr Sheard reviewed OR on 20 August 2015 and at that appointment refuted the previous diagnosis made in Latvia of schizophrenia and noted that if OR did have

schizo affective disorder, as diagnosed in England, the treatment would not be affected. Dr Sheard still diagnosed bipolar disorder in partial remission at that time.

12. Dr Sheard reviewed OR again on 3 September 2015 in the company of his mother. OR was about to travel to Latvia, so Dr Sheard recommended his medication be increased as a precaution. At the review OR was noted to be energized which at times prevented him from either initiating sleep or resulted in him waking early and going for a long walk. Dr Sheard continued to encourage OR to connect with a local drop-in centre and to connect with CPN Jacqueline Beaton who was supporting him.

13. At a further review with Dr Sheard on 1 October 2015, OR had returned from a successful visit to Latvia where he saw his son every second day. He was noted to be much more euthymic in mood with more motivation, and improved concentration and attention span. No medication changes were made after this review.

14. Dr Sheard reviewed OR again on 19 November 2015. By this time OR was living in a one bedroomed flat in Shore Street, Oban, which he enjoyed as it was located in a quiet area. OR had a Healthy Options pass to attend 3 times a week at the Atlantis Leisure Centre gym and twice a week was attending at Ballet West for conditioning. He had been invited to join them on a more frequent basis, due to his dance talent. There was no suggestion that OR was having difficulty sleeping or having racing thoughts. During the medication regime then in force, he had gained weight, which Dr Sheard thought likely to be due to the medication Aripiprazole, at that time prescribed at 10mg a day. The management plan after this review was to reduce this drug to 5mg a day, with a view to discontinuing it at the end of December. Dr Sheard recommended that

OR should attend the Surgery within the ensuing week for a Valproate trough level. OR advised he was planning to travel to Latvia for a week and the next review was planned for January 2016.

15. Dr Sheard again reviewed OR on 7 January 2016, by which time OR had visited Latvia, but was no longer involved with Ballet West. Dr Sheard noted concerns with OR's sleeping habits, so decided to maintain his level of Aripiprazole. In Dr Sheard's opinion, if OR could negotiate his sleep/wake arrangements to sleep at a sensible time through the night then the Aripiprazole could probably be discontinued. OR agreed to continue taking Aripiprazole at 5mg per day for a few more months, which was reflected in the management plan.

16. A further review took place on 18 February 2016. At that time OR was still prescribed Aripiprazole 5mg and Sodium Valporate 500mg per day. Dr Sheard noted that OR was planning to go to Latvia to visit his son for 2 weeks and that he continued to lie awake at night for hours before falling asleep. As a result, Dr Sheard considered that OR should remain on the minimum medication regime possible and therefore no change was made to this.

17. By the time of the next review on 30 March 2016, Depakote was also included in OR's medication regime. At that time, OR was describing a euthymic mood and a tendency to be involved in local activities, including learning English. He planned to go to Latvia on 27 April 2016.

18. On 6 April 2016, OR met with his CPN, Jacqueline Beaton, and reported being stable in his mental health. He was more motivated and was attending various activities

locally. In particular, he was playing volleyball, attending the Library for English lessons and going to the Link Club. CPN Beaton and OR discussed both short and long term goals in maintaining a daily routine, continued engagement with activities and vocational rehab. CPN Beaton noted OR presented well and appeared to be managing his illness and they discussed OR's mood and whether it was slightly elevated. OR advised CPN Beaton that he managed better when his mood was slightly elated.

19. On 7 April 2016 Mrs Paterson, OR's mother, telephoned the CPN and advised her that OR had not been taking his medication for the past 2 weeks. Mrs Paterson was concerned that continued non-compliance with his medication regime would lead to an escalation of his mood. Mrs Paterson reported OR was staying awake at night for long periods of time and on some occasions, he did not sleep at all. CPN Beaton advised Mrs Paterson to highlight the importance of medication compliance with OR. CPN Beaton emailed Dr Sheard on the 7 April 2016 to advise him of the current position regarding OR's non-compliance with the medication regime. Dr Sheard advised CPN Beaton that OR had not told him he had stopped taking his medication and noted in his email to her "this could go pear shaped in short order". CPN Beaton had an appointment letter for 9 May 2016 sent to OR which included information regarding forthcoming groups at the Drop In Centre he attended. CPN Beaton noted that as OR resided in the Shore Street Flats he would have access to Carr Gomm staff who would contact his GP or Community Mental Health Service if they had any concerns regarding his mental health.

20. OR was next reviewed by Dr Sheard on the 2 June 2016, when Dr Sheard's impression was recorded as "bipolar disorder - currently in remission". At this review OR admitted he had previously been untruthful and had discontinued his medication as he felt the drugs made him drowsy and dysthymic. Although CPN Beaton had persuaded OR to re-start his medication, by the time of the review he was taking no medication.

21. At the next review on 28 July 2016, Dr Sheard noted OR's diagnosis as "bipolar disorder current episode hypomania". OR reported racing thoughts and inconsistent sleeping, in that he was waking at 2am and attending the Leisure Centre as early as 6am for a swim. In addition to his ongoing medication, Dr Sheard recommended the mood stabilizer drug Risperidone, with the instruction that should OR find it too sedating, the dosage could be reduced by half. Dr Sheard was also made aware that OR was writing a book about his psychological and psychiatric experiences in the different countries in which he had been treated. Dr Sheard had agreed to write a small section for the book in relation to the diagnosis OR had received in Latvia of schizophrenia compared to the diagnosis of bipolar from Dr Sheard.

22. On 19 August 2016 CPN Beaton carried out a risk assessment of OR's ongoing mental health monitoring. Opportunities for risk minimisation were noted as: Medication increased and OR accepting of this, contact available by phone should OR require this, OR's previous experience of hospitalisation in his home country was not good therefore he does not wish to end up in hospital, access to support network whilst there – friends, family, etc. would be good protective factor (however OR's family have

refused to let him stay in the family home due to their concern about him living with his grandmother, they feel she is too old to manage him if he is unwell).

23. Dr Sheard had an appointment with OR on the 28 September 2016. At that appointment Dr Sheard's diagnosis was "bipolar disorder currently in remission". No change to his ongoing medicine regime was recommended at that time. OR had returned from a visit to Latvia and was looking forward to participating in a pool tournament in Oban. He was happy in his accommodation. He was having a weekly Sunday dinner with his mother and stepfather at their home.

24. OR was next reviewed by Dr Sheard on 3 November 2016, when his diagnosis was noted as "bipolar disorder current episode hypomanic". Dr Sheard noted he was doing well although was somewhat sedated. He was looking forward to a 2 week visit to Latvia.

25. At the next review on 8 December 2016, OR's diagnosis was "bipolar disorder currently in remission". The management plan noted medication changes, including reduction in the dosage of a particular drug, were recommended due to lingering dysthymia and difficulty with concentration. Dr Sheard noted OR had an enjoyable visit to Latvia and hoped the change in the Valproate medication would give OR extra energy and confidence.

26. OR was reviewed again on 29 March 2017 when Dr Sheard's diagnosis was "bipolar disorder". At that time, OR was taking no medication, although he was still being prescribed Depakote 500mg 1-2 daily. Dr Sheard asked OR to continue taking Depakote or at least to keep a quantity of the medication on his person in the event that

he developed agitation and difficulty coping for more than several days at a time, particularly if OR experienced racing thoughts.

27. The next review of OR by Dr Sheard was on 31 May 2017, when his diagnosis continued to be "bipolar disorder". He had been prescribed Valproate 500mg a day however, he was taking that intermittently, averaging 1-2 doses a week. Dr Sheard recommended OR take Valproate as and when he thought there was a need. In Dr Sheard's view OR was doing reasonably well in terms of focus and concentration, despite having engaged in a skirmish with several neighbours at his unit of flats due to the noise they were making. That issue was resolved.

28. A further review was held on 3 August 2017, when his diagnosis was "bipolar disorder currently in remission". Although Dr Sheard was still prescribing Valproate to be taken daily, OR was not taking this medication. In Dr Sheard's opinion, OR had insight into his condition and capacity to take medication when required. At that time, he was looking forward to a trip to Latvia at the end of August. His next scheduled review was planned for late September 2017.

29. On 15 August 2017, two weeks prior to the planned trip to Latvia, OR had a meeting with CPN Beaton. At that time, he was recorded as attending the Community Link Club, Hope Kitchen, English Class and Guitar Lessons and described as relatively stable in his mental health, despite electing not to take his medication. Prior to the appointment with CPN Beaton, OR had shown reasonable insight into his decision not to take his medication and at times had taken medication when he felt his mood destabilise. He was seen on a regular basis by both Dr Sheard and CPN Beaton, with his

next scheduled appointment with CPN Beaton on 7 September 2017. OR cancelled this appointment and advised staff at CMHS he would be in touch with Dr Sheard or CPN Beaton when he felt it was necessary.

Incident of 12 September 2017

30. At approximately 0750hours on the morning of 10 September 2017 OR attended at the home address of an off-duty police officer, PC Daniel McBeth, in a village just outside Oban, seeking an update on an ongoing enquiry following the theft of OR's laptop some months earlier. OR was agitated, clenching his teeth, clenching his fist, smoking constantly and repeatedly asking the officer questions. PC McBeth explained that he was not on duty and that OR would have to go to the Police Office with his enquiries. PC McBeth's family were at home, so he was concerned about OR's presence and behaviour. Eventually OR left. PC McBeth reported the incident, and at approximately 0930 hours, other officers spoke to OR in relation to his attendance at PC McBeth's home. At that time OR presented as calm to those officers and acknowledged he was wrong to attend at PC McBeth's home. He explained he had only attended there to obtain an update on the laptop enquiry. No further action was taken in respect of OR, but PC McBeth remained wary about any future contact with OR unless strictly necessary.

31. Mr Paterson also contacted Police Scotland that day, to advise he had concerns for OR who had appeared very agitated and had attended at Mr Paterson's home address stating he could fly and was God. Mr Paterson told the officers that OR had left

heading towards Oban Airport. In the early evening of 10 September 2017, officers attended at OR's home address. Although the officers considered OR to be agitated, they did not consider OR required immediate care and officers made Mr Paterson aware of this outcome.

32. In all instances where a police officer deals with a mental health incident or any incident where they identify concern for an adult, whether in a public or private place, in terms of the police Mental Health and Place of Safety Standard Operating Procedures, they require to submit an Adult Concern Form on the interim Vulnerable Persons Database. The officers attending to OR completed and submitted such a form.

33. In the early hours of the 12 September 2017 OR travelled to the home address of Mr and Mrs. Paterson. His behaviour concerned Mr Paterson, who called Police Scotland as he did not want his stepson to remain in their house. Police Officers attended and spoke with Mr Paterson and OR. The officers noted that OR was exhibiting unusual behaviour and was talking about being a messenger and the son of God. As a result, OR was taken by police to Lorn & Islands, Accident and Emergency Department (A&E), Oban. OR refused to engage with Hospital Staff or to discuss his previous mental history, medications or allergies. The officers gave a history of the incident to hospital staff. OR was assessed by a doctor at approximately 0220 hours who deemed him fit to be released. He was thereafter discharged at approximately 0255 hours and taken back to his home address by the officers.

34. These officers also completed an Adult Concern Report in respect of OR in respect of their interaction with him on 12 September 2017.

35. At approximately 0730 hours on 12 September 2017 OR telephoned his mother and made various strange comments to her, such as telling her to "sign the papers and get everything, 3 people need to be sorted out", and that she needed to "sign the divorce papers". Mrs Paterson terminated the telephone call but did not contact Police Scotland at that time.

36. At approximately 0900 hours on 12 September 2017, Police Scotland received a telephone call from staff at the Atlantis Leisure Centre in Oban regarding OR who was outside behaving in an erratic manner and making strange comments. He was spoken to by police officers, but although he was acting strangely, was interacting with the officers and answering their questions. The officers had no concerns about OR's welfare at that time. OR refused to attend the hospital with officers, and he was advised to leave and return to his own home.

37. Thereafter, at approximately 1248 hours same date, police were contacted as OR was within the garden area of a domestic property, playing with the gas pipe whilst attempting to light a cigarette. Police officers attended immediately. OR was detained under the mental health provisions, handcuffed and taken to the Lorn and Islands Hospital, in Oban.

38. The officers interacting with OR in relation to this incident on 12 September 2017 also submitted an Adult Concerns Report.

39. CPN Beaton emailed Dr Sheard on 12 September 2017 to advise of her concerns regarding OR.

40. At approximately 1136 hours on 12 September 2017, Dr Catherine McElroy, General Practitioner at Connel Surgery contacted Dr Sheard to advise OR was showing signs of psychosis and may need admission to ITCU. Dr McElroy considered a Sheriff's warrant might be required if OR was within his own premises and at 1235 hours Dr McElroy was informed that the on-call Mental Health Officer (MHO) was applying to the Sheriff Court for a warrant. At 12.46 the MHO advised Dr McElroy that the warrant only allowed access to OR's property and that police had no power under the warrant to remove OR to a place of safety; that OR required to be assessed by a medic. The MHO intended to contact Dr Sheard to complete the assessment if OR were at home. At 13:44 Dr McElroy was informed that OR had been detained under the Mental Health Act, initially to be reviewed in Accident and Emergency by a Doctor and psychiatry. Dr McElroy passed this information to Dr Sheard and the MHO.

41. At approximately 1315 hours OR was taken by police to Lorn and Islands Hospital, A&E Department.

42. OR was then detained under an Emergency Detention Certificate (EDC) in terms of Section 36 of the Mental Health (Care and Treatment) (Scotland) Act 2003. This Certificate allowed OR to be detained for 72 hours. A bed was found for OR at Gartnavel Royal Hospital, Glasgow, as no beds could be found in any Argyll and Bute facility.

43. At the request of the On-call Consultant Psychiatrist a Sainsbury Risk Assessment was completed by CPN Beaton on 12 September 2017. The assessment found OR to be lacking in insight into his illness with his behaviour becoming grandiose

in ideas and increasingly elated. He believed he was getting messages from God and was threatening in his behaviour towards a police officer and his family. He had been making threatening remarks to others and there was increased risk and unpredictability. OR's odd behaviour was causing concern in the community and there were concerns regarding the safety of others. OR's family were also concerned due to previous experience of OR's behaviour when unwell. At that time OR felt he no longer required input from Mental Health Services and had stopped taking his medication and lacked insight into his illness. Details of the assessment were passed on to the Duty Doctor at Gartnavel Royal Hospital at 1625 hours.

44. Under the EDC, OR was thereafter escorted to Gartnavel Royal Hospital by CPN Beaton and her colleague.

45. Whilst detained there, on 12 September 2017, OR absconded from the ward and was found on top of a portacabin within the grounds of Gartnavel Royal Hospital. As a result of his absconding, a short-term detention certificate, under the Mental Health (Care and Treatment) (Scotland) Act 2003, was sought and granted on 13 September 2017 with an expiry date of midnight on 10 October 2017.

46. The application was completed by Dr Jasmeet Bandra and an MHO, and noted

> "Oskars appears to have a history of Bipolar affective disorder. He is currently irritable, brittle in mood, grandiose, sexually disinhibited, and aggressive. Mr Rancevs has no insight into his mental illness or the need for treatment. He was confrontational and refusing to engage with any discussion about his treatment. I consider that it is likely, for the reasons stated below, that it is necessary to detain the patient in hospital for the purpose of determining what medical treatment for mental disorder should be given to the patient; giving medical treatment to the patient – Mr Rancevs is unknown to our service as he belongs to Oban. He needs a period of assessment to determine what treatment

> he requires. I consider that it is likely, for the reasons stated below, that if the patient were not detained in hospital there would be a significant risk – to the health, safety or welfare of the patient, to the safety of any other person. There is a risk to Mr Rancevs' mental health as he is clearly unwell and would be highly vulnerable if he were to leave the hospital. He has been aggressive, was caught carrying sharp weapons and assaulted staff last night. I consider that it is likely for the reasons stated below, that the granting of this short-term detention certification is necessary e.g., explain why the patient cannot be treated on a voluntary basis – Mr Rancevs had no insight into his mental illness and cannot be treated on a voluntary basis as, he is, not accepting of this treatment voluntarily'. Mr Rancevs did not nominate a named person as he stated he 'did not trust anyone' and would not be nominating a named person."

47. OR applied to the Mental Health Tribunal for Scotland on the 26 September 2017 to revoke his short-term detention certificate. The Tribunal convened a hearing to consider this appeal, at which hearing, the Tribunal was satisfied that OR's detention was necessary at that time.

48. During his detention within Gartnavel Royal Hospital OR acted in a hostile and threatening way towards staff. He attempted to head butt a staff member, punched another staff member in the stomach and acted in a disinhibited manner towards female staff members, invading their personal space or making inappropriate comments to them. These incidents all occurred between the date of his admission and 17 September 2017.

49. OR was detained at the Gartnavel Royal Hospital, Glasgow until his transfer to Succoth Ward, Lochgilphead Hospital on 4 October 2017.

50. He was reviewed within Lochgilphead Hospital, Succoth Ward on 4 October 2017, at which time he agreed his current medication regime was working and acknowledged he had been unwell and high prior to taking that medication. OR felt he

was back to normal but wanted to become established on the medication plan. OR was keen to go onto the depot injection twice monthly as he noted he was prone to stopping his medication because taking the medication served as a reminder that he was not well. During the review OR acknowledged that when he was unwell his speech became fast, he became aggressive, sexually disinhibited and hyperactive. OR stated he was keen to stay within Succoth Ward to become secure in the management of his health and his recovery.

51. On 5 October 2017, OR specifically advised medical staff that he was happy to be within Succoth Ward at that time but hoped to be going home soon. During his review with Dr Sheard, he stated that he was aware that he was ill and required medication. OR continued to assert he was content to remain within Succoth ward and willing to take the depot injection and also to commence Valproate medication. He stated he felt more relaxed on the ward and was content to abide by the ward protocols.

52. On 6 October 2017, there was a further review of OR. It was noted that the Short-Term Detention Certificate (STDC) was due to expire on 10 October 2017. At that time Dr Sheard did not consider that a Compulsory Treatment Order (CTO) was required on expiration of the STDC. Dr Sheard was the Consultant Psychiatrist, based at Oban from December 2010 until November 2018. From approximately August 2015 until December 2017 he was involved in OR's psychiatric care. On 6 October, he was satisfied that OR did not meet the criteria for being placed on a CTO. In coming to that conclusion, he required to follow the fundamental principle of the mental health legislation to take the least intrusive measure for the patient. Further, two of the criteria,

for placing someone on a CTO, are a lack of insight and a lack of clear cut decision making. He noted that at the time of his review, OR had decision making capacity, and had agreed to take depot medication voluntarily. Dr Sheard considered that robust use of the Care Programme Approach (CPA) process would ensure compliance with the medication.

53. He did not place OR on a CTO at this time. This was his clinical decision based on his assessment of OR and the legislation in place. This was a reasonable exercise of his clinical judgement.

54. OR was noted as being pleasant to staff within Succoth Ward. He was due to have a test dose of the depot medication, with the depot regime starting on 10 October 2017. In Dr Sheard's view, if the depot regime was started OR could have a pass home the following weekend. Additionally, Dr Sheard thought OR would benefit from accompanied time off the ward. OR had been assessed as being at risk for non-compliance with medication, with potential for aggression, however at the ward round of 6 October it was agreed this risk could be downgraded from "Red" to "Amber".

55. OR admitted to staff he didn't take medication prior to admission to hospital. He explained he didn't like to take medication as, when he took it, he felt like a person with a mental illness. However, he acknowledged that the medication helped him and prior to taking the medication he was in a bad way. OR was willing to agree with the treatment plan and he was advised to remain in hospital on a voluntary basis, despite the STDC expiring on the 10 October 2017. He was content to stay on the ward if he was allowed more time off the ward. There were several things discussed with OR, which

were important for his recovery, namely that he would see CPN Jacqueline Beaton regularly, continue to take his medication, see Dr Sheard regularly and engage in social activities which helped his recovery. At this stage it was clear he was motivated to take depot medication as he had insight that he was prone to stopping his medication.

56. A Care Plan was drawn up on 7 October 2017 whilst OR was an in-patient on Succoth Ward. The Care Plan noted:

> "Oskar has a diagnosis of Bi-Polar Affective Disorder. He has recently experienced a period of elevated mood due to medication non-compliance. This resulted in some disinhibited behaviour towards female nursing staff in Gartnavel Royal Hospital, also there was aggressive behaviour where he assaulted a female healthcare assistance in Gartnavel Royal requiring placement in IPCU (Intensive Psychiatric Care Unit). His elevated mood has since reduced allowing transfer to Succoth Ward. Currently there is no further evidence of elevated mood, and he is compliant with prescribed medications."

57. The identified plan was to return OR to the community setting in the next 1-2 weeks, establish on depot antipsychotic medication and discontinue oral Risperidone. The care plan noted OR appeared to have some insight into his illness.

58. It was further noted that although OR's STDC was due to expire on 10 October he would remain as an informal patient and commence the depot injections on that date.

59. A "Level 1" Risk Assessment /Management Plan was carried out by a Staff Nurse on 7 October 2017. This recorded:

> "Oskars is a 31 year old man with a diagnosis of Bi-Polar Disorder who became noncompliant with prescribed medications (Sodium Valproate) and became increasingly elated and difficult to engage on an informal basis by the start of September 2017. He was detained under the mental health act on an EDC on 12/9/17 in Oban prior to being transferred to Gartnavel Royal Hospital as no local beds available. Soon after arrival there he was transferred to IPCU as he had absconded from the open ward and was found in the hospital grounds standing on the roof of a portacabin. Oskars has been sexually disinhibited during this

> period of illness and aggressive/violent toward nursing staff when in GRH. However, he was transferred to Succoth Ward on 4 October 2017 as symptoms of his mania have reduced"

60. The Risk Management Plan at that time was to nurse OR on General Observations as per policy and for him to remain on ward only until reviewed by RMO. OR was reviewed on 6 October 2017 and granted unaccompanied time off the ward for "grounds" and accompanied time off ward for "town". It was noted that OR liked consistency regarding "rules" and that staff should be aware of this at all times when interacting with OR and any requests he may make.

61. A further ward round on 10 October 2017 noted OR was settled in his presentation and utilising unaccompanied time off ward with no issues. His depot medication regime commenced with plans for a weekend pass.

62. Despite concerns raised at that time by OR's mother and stepfather, OR continued to present in a settled manner on the ward and to enjoy walks within the hospital grounds and the town of Lochgilphead. OR had a weekend pass from 13 to 16 October 2017. During his pass OR returned to his flat within the Blue Triangle supported accommodation at Shore Street in Oban.

63. Also during his weekend pass, medical staff realised OR's admission note was blank and hadn't been completed. Despite contacting medical records in Leverndale Hospital where OR's medical records were being held on a temporary basis, the Gartnavel Royal admission document was not found. His admission document was thereafter completed on the basis of information provided on the A & E documentation completed when OR first presented at Oban A & E, prior to being transferred to

Gartnavel Royal. Margaret Ashman, OR's MHO was asked to provide her social circumstances report in order that a more accurate note of OR's presenting complaint on admission could be obtained.

64. OR returned from his weekend pass on 16 October 2017 without incident. Despite the family concerns, OR showed no evidence of elation at that time.

65. A Care Plan Evaluation took place on 17 October 2017. At the evaluation OR described good progression in terms of recovery and stated he felt ready to be discharged. He had enjoyed being at home at the weekend on his weekend pass. He filled his time with activities and enjoyed spending time with friends and family. OR felt he had benefited from being in Succoth Ward but reported his mood was now stable and there were no further symptoms of agitation. He stated his mood was slightly low when on the ward, as there was little activity on offer, and he was eating and smoking too much. He believed it would be more beneficial for him to be at home. He described a plan of returning to the gym to exercise and lose the excess weight he had gained since being in hospital. OR had his first depot without any adverse side-effects, although he did feel his concentration had reduced and he described becoming overly focused on small details, which he described as a very distressing feeling. He advised this had also happened when he was previously given depot medication in Latvia. OR was noted as using ground and town leave appropriately.

66. OR was discharged from Succoth Ward on 23 October 2017, at which time he was prescribed, 3mg Risperidone tablets each day, Depixol Injection (40mg) fortnightly,

Diazepam tablets, 5mg per day (to be reduced gradually until stopped) and Sodium Valproate 500mg per day.

67. Thereafter, he attended at the Connel GP's Surgery for depot injections on 24 October, 7 and 21 November and 5 and 18 December, all 2017 and on 3 and 16 January, both 2018.

68. On 7 November 2017, OR advised Dr Fiona McPhee that he had stopped taking Diazepam and the morning dose of Risperidone. OR was advised to restart taking Risperidone in the morning as per his medication regime.

69. On 21 November 2017, OR advised Dr David Harden that he was taking his morning dose of Risperidone again. However, by the next appointment with Dr Fiona McPhee on 5 December 2017 OR had stopped taking Diazepam and Risperidone but was still taking Sodium Valproate. All this information was provided by him while attending the GP Surgery for depot injections.

70. On 30 January 2018 OR failed to attend the GP Surgery for his depot injection. Despite encouragement from the GPs at the Connel Surgery, OR did not attend for any further depot injections and ceased taking oral medication from 30 January 2018.

71. Meantime, Dr Sheard left his post in late December 2017 and his replacement (Locum Consultant Psychiatrist Dr Krzyzstof Krajewski) was not in place until 22 January 2018.

72. On 11 January 2018 Margaret Ashman, MHO, emailed NHS Highland to ascertain who would be reviewing patients in the psychiatric outpatient clinic in the absence of Dr Sheard. In particular, Ms Ashman was concerned about OR as he had

stopped taking his medication and was about to leave the Blue Triangle Project and move into his own tenancy.

73. On 12 January 2018 Acting Team Lead Gordon Parker, based at Willowview raised Margaret Ashman's concerns with the Administration Services Manager with NHS Highland and Dr Burmeister the General Adult Consultant Psychiatrist for Mid Argyll, highlighting that should the locum Consultant not take up post until 22 January 2018 then there would have been no clinics in Oban for over a month. He pointed out the inevitable increased risk of patients becoming unwell. Mr Parker asked if a clinic could be arranged for the following week.

74. On that same day, Dr Burmeister offered to supervise a clinic on either the following Tuesday, Wednesday or Thursday. This information was passed to CPN Jacqueline Beaton on 16 January 2018, with a request to consider whether the urgent appointment was necessary, or whether an urgent appointment was not necessary.

75. OR's next appointment with a Consultant Psychiatrist was on 31 January 2018 when he had an appointment with the Locum, Dr Krzyzstof Krajewski, Dr Sheard's replacement. By this time OR had refused to have the prescribed depot injection and, as stated above, was no longer taking his prescribed medication.

76. This was OR's first appointment with a Consultant Psychiatrist since his discharge from Succoth Ward in October 2017.

77. On examination, Dr Krajewski found OR to be a neatly dressed, well-groomed male. He was co-operative, attentive, polite, calm, displaying normal psychomotor

activity. Dr Krajewski noted OR's affect was blunted but he was able to occasionally smile appropriately. OR's mood was euthymic and no elation of mood was noted, but OR appeared to be overconfident with his plans and acts. His thought flow and form were within normal limits. No psychotic phenomena were reported or noted and OR was well orientated. Dr Krajewski assessed OR to clearly lack insight into his own condition. He noted OR didn't believe he was ill and even if he were ill, OR believed he could be treated without pharmacological intervention. OR reported to Dr Krajewski that he was not suicidal. His sleep was disturbed, his weight was constant, with a normal appetite and stated his energy was "growing". Dr Krajewski noted there were early signs of hypomania, but did not consider that OR fitted the criteria for involuntary admission. This was his clinical judgement. Dr Krajewski's plan going forward was for OR to be encouraged to continue taking the depot injection and Valproate medication at the prescribed dose of 500mg per day. Dr Krajewski expected OR to be seen by CPN Beaton on a weekly basis. Dr Krajewski also noted, "it is highly likely that he will become manic soon."

78. His next appointment with Dr Krawjeski was due to be on Wednesday 28 February 2018. A letter was sent to OR from the Willowview advising him of this appointment. The letter was returned "not at this address". A further letter was sent to OR from the Willowview advising him of an appointment with Doctor Krajewski on Tuesday 24 April 2018. These letters were sent to OR's previous address at Shore Street in error.

79. However, he did still see his GP on occasions as, on 3 April 2018, Dr Julie Gray noted in the GP notes

> "Has been both physically and sexually violent during previous psychotic episodes. Should not be visited alone if psychotic. Not currently on compulsory treatment order. Has seen psychiatrist and has CPN Jackie Beaton. Low threshold for A+B admission if presents psychotic symptoms."

80. By late September OR had not been taking his prescribed medication for about 6 months, despite significant encouragement from his CPN, his family and others to do so.

Events leading up to the incident resulting in the deaths

28 September 2018

81. Mr and Mrs Paterson saw OR on Sunday 23 September 2018 for Sunday dinner, and noted nothing too out of the ordinary at the time. The Patersons then travelled to Latvia for a holiday. On the morning of Thursday 27 September they received text messages from OR telling them he was moving clouds. The Patersons believed he was no longer taking his medication and contacted Willowview to leave a message for CPN Beaton advising of their concerns. Mr Paterson phoned back on Friday 28 September and spoke with Gordon Parker, OR's CPN's supervisor, who confirmed the CPN was dealing with the concerns and that she would meet OR the following week.

82. On the 28 September 2018 at approximately 1640 hours Mr Paterson telephoned Oban Police Office from Latvia and told Police Custody Support Officer of his concern

regarding OR given his mental health issues. Mr Paterson stated that he had spoken to OR's CPN about this and wanted to make police aware of the issue. The Police Custody Support Officer, informed the duty sergeant of Mr Paterson's telephone call.

83. On 28 September 2018 the duty sergeant (Sergeant Lowe) telephoned Mr Paterson to clarify the reason for his telephone call. Mr Paterson informed the sergeant that OR's mental health had been deteriorating, that he had not been taking his medication and had been sending text messages to his mother and himself. Mr Paterson advised that the text messages were not threatening or abusive towards him or anyone else and that he had already contacted the Community Psychiatric team to advise them of his concerns on the 27and 28 September 2018. Mr Paterson further advised he did not want officers to contact OR.

84. The sergeant had a STORM incident report created and added the information given to him by Mr Paterson.

85. The sergeant then printed out a copy of the STORM incident and added it to the Daily Briefing Register which was kept at the uniform bar at Oban Police Office.

86. CPN Beaton had had an appointment with OR on the 17 September 2018 and noted that, although OR was no longer taking his prescribed medication, he remained stable in his mental health and was working within a local restaurant two days a week. OR was continuing to attend health options and the local link club. CPN Beaton had arranged a further appointment with OR for the 11 October 2018.

29 September 2018

87. On the evening of 29 September 2018 OR played an arranged pool match at the Lancaster Hotel, Oban with a friend, Fiona Donn. Ms Donn thought OR appeared very quiet during their game and appeared to be in low mood. OR told Ms Donn that his father had died at 6pm that day in Latvia. It was later established that this was not the case.

88. After the pool match, Ms Donn drove OR to his home at Columba Court, Oban. Once inside his house, Ms Donn attempted to talk to him, but he ignored her. Ms Donn felt uneasy in OR's company and texted a friend saying she was at OR's home and that his behaviour had been odd throughout the evening. Her friend advised her to get out of OR's home immediately. She told OR that she had to leave and then did so. After leaving Ms. Donn called her friend to let him know she was ok. Ms Donn then received a call from the police asking her to go to the police station to speak to them which she did.

89. This was because the friend, following Ms Donn's text to him, had, at 2243 hours, made an emergency telephone call to Police Scotland to report that his friend Fiona Donn was with OR in his flat and was absolutely terrified. He advised the call handler that he had told Ms Donn to leave the flat, but that when he tried to phone Ms Donn back to check if she had managed to leave, her phone was dead. He told the call handler that OR had mental health issues.

90. The Police Scotland call handler created a STORM incident report and transferred the incident to the Area Control Room in Govan, Glasgow (Govan ACR).

91. Two local police constables, PCs Colin Oman and Lisa Neish were actioned to trace the female and establish she was well, and the circumstances which led to the report to the police. A check for OR's address on SID was carried out prior to their attendance and the information passed to the officers. Before the officers left to attend at OR's flat the call handler received a phone call from Ms Donn's friend to advise Ms Donn had contacted him and had told him she had left OR's flat. PCs Oman and Neish were advised of this update.

92. One of the officers, PC Oman, contacted Ms Donn directly to check she was safe and arranged to meet her at Oban Police Station to ensure her welfare.

93. Ms Donn subsequently attended at Oban Police Station and informed the officers that OR had been acting oddly and did not properly engage in discussion. She advised officers that OR had not threatened her but that she felt uneasy in his company, although had not considered contacting the police. PC Oman asked Ms Donn if anything untoward had occurred due to the report by her friend that she had been "terrified". She confirmed she had not been in fear at any point and there was no threatening behaviour from OR. Ms Donn did not feel it was necessary for the officers to attend at OR's property. As a result, PCs Oman and Neish did not attend at OR's flat on 29 September 2018.

1 *October* 2018

94. On 1 October 2018 at approximately 0100 hours a telephone call was received by Police Scotland Govan Service Centre from the now deceased, Martyn Smith. During

this telephone call Mr Smith reported his neighbour (OR) was banging on his front door and shouting at Mr Smith to open the door. Mr Smith advised that he resided at 13 Columba Court, Oban and his neighbour lived at number 12 Columba Court, Oban.

95. During the telephone call between Martyn Smith and the Service Adviser at Police Scotland, Govan Service Centre created a STORM incident.

96. During the said telephone call Martyn Smith advised the Police Scotland Service Adviser that his neighbour (OR) was "bi-polar".

97. The telephone call was classed as Grade 3 Standard (incident not ongoing but police attendance is required and where the outcome could be prejudiced by significant delay). This was in accordance with PSS Command and Control Standard Operating Procedures, version 3, in force at that time.

98. The incident was then transferred to Govan ACR. The Communications Controller at Govan ACR then reviewed the STORM Incident and actioned police resources to deal with it.

99. Police Constables Oman, Masterson, McBeth and Neish attended at Columba Court, Oban. PC Oman knew OR resided at flat 12 Columba Court and therefore suspected OR may be involved in this current incident. PCs Oman and Masterson attended at the common close giving access to flats 12 and 13 Columba Court, Oban. On arrival the officers could hear loud music being played from OR's flat.

100. Officers first attended at Mr Smith's door and he told them his neighbour (OR) had been banging and kicking at his front door asking him to open the door. Mr Smith told the officers he believed his neighbour suffered from bi-polar and obsessive

compulsive disorders. Mr Smith confirmed to the officers that OR had not shouted, sworn or made any threats towards him. PCs Oman and Masterson told Mr Smith they would speak to his neighbour and advised Mr Smith not to open the door should his neighbour return.

101. PCs Oman and Masterson then attended at Flat 12 Columba Court. Officers noticed the music had been turned down and they were invited in by OR. On entering the flat OR asked the officers to remove their boots as he didn't want dirt in his house. When advised that the officers could speak to him outside OR simply asked that they remain standing on the rug.

102. The Officers noted OR to be very articulate throughout their conversation and he did not appear to be under the influence of any substances. His demeanour was calm and at no time did he show any aggression towards the officers or make any threats towards Mr Smith. During their conversation with OR, he made some strange and bizarre comments and when asked for the reason he had been playing his music so loudly, OR stated "my music is for everyone to listen to". The Officers warned OR that playing loud music was unfair to his neighbours and noted that OR seemed to accept this warning, saying if anyone complained about his music, he would turn it off or wear his headphones. PC Masterson advised OR not to return to Mr Smith's door and that if OR had any other problems, he should telephone the police. When asked if he needed any help or support OR said that he didn't need anything, and he was no longer scared. PC's Oman and Masterton did not consider that OR needed immediate care or treatment. On leaving the property Officers Masterson and Oman spoke with

Officers McBeth and Neish who had remained outside to offer support if it was required. Officer Neish inquired whether OR needed to go to hospital and was informed by Officers Masterson and Oman that OR was calm and that no offence had been committed.

103. PC Masterson provided an update on the incident to the Service Adviser at Govan. The Service Adviser thereafter updated the STORM incident by stating "ongoing neighbour dispute both parties spoken to, advice given".

104. PCs Masterson and Oman returned to Oban Police Station and gave an overview of the incident to the duty sergeant. The officers advised Sergeant MacLennan that they had asked OR to turn his music down, which he did, and they warned him regarding the noise and knocking on his neighbour's door. They stated that OR appeared to understand the conversation and was co-operative, and further that although it was apparent he suffered from mental health issues, he did not give cause for immediate concern. They confirmed that he did not show aggression and there was nothing to suggest he was at risk of harm to himself or others. The Officers made Sergeant MacLennan aware of the bizarre comments OR had made to them during their conversation with him, so Sergeant MacLennan instructed Officer Masterson to submit an Adult Concern Report onto the interim Vulnerable Person Database (iVPD). Prior to submitting the Adult Concern Report Officer Masterson requested checks on police databases PNC, CHS, Crime Management and iVPD. The information he received caused no concern and he created the Adult Concern Report. Officer Masterson noted in

the summary, reference to the bizarre comments made by OR and the possibility that OR had a mental disorder and OCD. The iVPD was also sent to Sergeant MacLennan.

105. The sergeant reviewed the information contained within the Adult Concern Report submitted by PC Masterson and noted

> "I was made aware of this incident from the outset and monitored it throughout. It would appear that the subject suffers from mental health problems which he is believed to already be receiving mental health treatment for. No criminality in relation to this incident. Subject declined medical attention. A review of his current mental health may be required."

106. Mr Smith sent an email to West Highland Housing informing them of the police incident in the early hours of the morning. In his email, Mr Smith advised them that after the officers had left it had been quiet until 0645 when OR turned the loud music back on and started some DIY with a hammer before leaving his flat shortly afterwards. Mr Smith noted in his email that OR had previously told him that 'he doesn't care what he does as he is not responsible for his behaviour'.

107. In October 2018 the Mental Health and Place of Safety Standard operating Procedure (SOP) version 6 was in place for Police Scotland. This provided procedures for officers and police staff coming into contact with people experiencing mental health issues. This document also contained guidance notes on police powers under the Mental Health (Care and Treatment) (Scotland) Act 2003 clarifying the procedures to be implemented. The Mental Health and Place of Safety SOP, version 6 refers to, and contains a link to, a National Decision Making Model Applied to Mental Health Incidents diagram. This is applied by officers and staff to the decision making process when dealing with persons with mental health issues. Further The Mental Health and

Place of Safety SOP, version 6 refers to, and contains a link to, further guidance, "Briefing Note on Recognising Behaviours and Signs of Mental Illness". This document was created by the National Police Improvement Agency and was included to help officers and staff recognize signs of potential vulnerability and provide an appropriate criminal justice, social or health care combined response to people they deal with who may have learning disabilities or mental health issues.

108. Section 6 of the Mental Health and Place of Safety SOP version 6, contains guidance regarding officers' powers under the Mental Health (Care and Treatment) (Scotland) Act 2003. This includes guidance on officers' powers upon attending an incident in a private place (i.e. inside a private home or garden) involving a person requiring immediate care and treatment, but where no crime or offences are found to have been committed. In particular, section 6 of the SOP described the actions officers might take in those circumstances. Section 6.2.3 states that:

> "where it is suspected the person has a mental disorder and is in need of immediate care and treatment, the officer(s) should request the attendance of the person's GP to carry out an initial mental health assessment. If the incident is out with the normal hours NHS 24 can arrange for an out of hours GP to attend."

Section 6.1.2 of the SOP provides that removal of a person suspected of having a mental disorder from a private place by a police officer is unlawful unless the person leaves on a voluntary basis and/or the person has committed a crime or offence, and/or where there is an immediate risk to life which can only be mitigated by removal or officers using powers afforded by a Removal Order obtained by a Mental Health Officer.

109. On speaking with OR when they attended his home on 1 October 2018, PCs Oman and Masterton both suspected that he may have a mental disorder. However, neither officer considered he was presenting as being in need of immediate care and treatment or as though he posed a threat to himself or others. Further, the officers did not consider the events reported to them amounted to a criminal offence for which OR should be arrested. The removal of OR by Officers Oman and Masterton would have been unlawful in the circumstances. The conditions in section 6.1.2 of the SOP Version 6, published on 25 May 2018 were not met.

110. In terms of section 6.2.10 of SOP Version 6 in all instances where a police officer deals with a mental health incident or any incident where they identify concern for an adult, a detailed adult concern form must be submitted onto the interim Vulnerable Persons Database (iVDB). Such a report was submitted by PC Charles Masterton on 1 October 2018.

111. The Mental Health and Place of Safety SOP, version 10, is the current version of the SOP document. This contains the same guidance as in version 6 for officers attending persons in a private place who are suspected of having a mental disorder and in need of immediate care and treatment, albeit it is now referenced under section 5.

112. The Initial Training Course delivered by the Scottish Police College is a 12 week programme where all newly recruited probationers are given training in various areas including mental health and suicide prevention training. In 2016 and 2017 mandatory Mental Health Crisis and Suicide Intervention Training was delivered to all frontline officers and staff up to and including the rank of Inspector. This training was based on

three modules, namely, a module called MINDSET developed by Scottish Association for Mental Health providing awareness of mental illness and suicide; a second module focusing on relevant legislation and powers and procedures in relation to mental health incidents and a third module focusing in identifying persons experiencing poor mental health, and on intervention, de-escalation skills and decision making.

113. The Mental Health and Place of Safety SOP and the National Decision Making Model as Applied to Mental Health Incidents were covered at length as part of this mandatory training. In addition, the Mental Health and Place of Safety SOP, version 6, and all subsequent versions are available to all officers on the Police Scotland intranet to provide ongoing guidance. The documents referred to in the SOP, including the National Decision Making Model as Applied to Mental Health Incidents and a Briefing Note of Recognising Behaviours and Signs of Mental Illness are also available on the Police Scotland intranet as documents referred to within the Mental Health and Place of Safety SOP. The Mental Health Aide Memoire Police Scotland Dealing with Mental Health Incidents was provided as a hard copy to officers and also available on the Police Scotland intranet.

Incident

114. At approximately 0940 hours on 1 October 2018 Claire MacDonald, Service Adviser at Police Scotland Motherwell Service Centre received a telephone call from the now deceased John White. Mr White reported that OR was assaulting "an elderly male" (the now deceased Martyn Smith).

115. During the said telephone call from Mr White, Service Adviser MacDonald created a Police Scotland STORM incident.

116. Service Adviser MacDonald classed the call as Grade 1 Immediate (An ongoing incident where there is an immediate or apparent threat to life or a serious crime in progress and an immediate response is required).

117. During the said telephone call Mr White gave his address as 9 Columba Court, Oban and age as 75 years and reported that an "elderly" man was being assaulted. Mr White did not know the name of the assailant but gave his address as 12 Columba Court, Oban. Mr White's phone number was noted as the mobile phone he was calling Police Scotland on. Mr White gave Martyn Smith's name as the man being assaulted and requested that an ambulance also attend at Columba Court. Whilst he was on the phone, Mr White advised he had also been assaulted by the assailant as he walked past him, that the assailant had kicked him in the stomach. He confirmed he didn't need an ambulance. Mr White advised he had gone back into his own flat and had locked the door. The call was recorded and approximately five and a half minutes into the call, the call still being recorded, Mr White is heard to make a gurgling noise and a snoring type of noise. Mr White makes no further response to Service Adviser MacDonald, although heavy breathing sounds can be heard. No verbal response was received from Mr White between 5 minutes and 31 seconds into the call and the recording ending at 08 minutes and 37 seconds.

118. Service Adviser MacDonald cleared the line and assumed that officers would speak to Mr White when they attended or that Mr White would make himself known to attending officers.

119. During the phone call with Mr White, Service Adviser MacDonald continued to update the STORM incident with the information she obtained from the call. This included:

- "caller stated male kicking elderly man" 09:40:47
- caller states ambulance is required" 09:40:54
- caller states make being assaulted is Martyn Smith" 09:41:02
- caller states male is dragging elderly male along the road" 09:41:11
- caller is at number 9 Columba Court" 09:41:30
- caller states he was assaulted by this male earlier" 09:43:40
- caller states male kicked him in the stomach" 09:44:15
- caller is very shaken, caller now not talking online but line is still open, unsure if caller is ok or not 09:47:23
- confirm Police to attend at Columba Court Oban" 09:50:14"

120. After the final update by Service Adviser McDonald at 09:50:14 hours, the incident is transferred from the Service Centre to, and accepted by, the Area Control Room.

121. On acceptance of the STORM Incident in the Area Control Room, the Police Communications Officer (PCO) reviewed the STORM incident report and dispatched police officers to the incident via AIRWAVE radio, to attend the report of an ongoing

assault. The PCO provided information that the incident involved an elderly male being assaulted, getting kicked, the name of the person being assaulted as Martyn Smith and information about him being dragged along the road. The PCO provided updates over the Airwave that "we are phoning an ambulance for him" indicating that the Area Control Room are contacting the Scottish Ambulance Service.

122. On viewing the Police Scotland STORM incident, a Communications Controller at Govan ACR requested an ambulance on the PCO's behalf.

123. At approximately 0940 hours, Police Officers Peter MacMillan and Scott Deakin were instructed by ACR to attend the incident at Columba Court, Oban. On their arrival at approximately 0946 hours they found a male, the now deceased Martyn Smith, lying face down on the ground between two parked cars in Castle Road near to Columba Court. Officers noted Mr Smith to be unresponsive, and bleeding profusely from significant injuries to his face and head. The officers immediately requested an ambulance attend. They also recovered a photographic identity card in OR's name. One of the officers knew OR and believed he was a paranoid schizophrenic.

124. Six further officers attended the incident. Some assisted in providing CPR to Mr Smith and one officer was approached by a witness who had videoed the incident on his mobile phone. This officer mistakenly thought the witness, a Mr Mortimer, was Mr White the reporter of the incident. This officer viewed the footage, returned the phone to Mr Mortimer and advised him another officer would attend at his home and recover the phone. Whilst the officers were dealing with Mr Smith, a witness advised that OR had walked towards the flats at Columba Court and pointed out the flat he had

entered. Two officers attended at this flat which was number 7 Columba Court, however that flat was unoccupied. Whilst within the area, officers heard loud music coming from Flat 12 and attended at that flat, finding OR within. A number of officers attended at OR's flat to assist with his arrest. OR was then transported to Oban Police Office where he was processed as an arrested person.

Transport to hospital

125. Ambulance Technicians attended at the incident scene and observed officers performing CPR on Mr Smith. Despite interventions the technicians couldn't see Mr Smith's chest rise and fall and he remained asystole. CPR was continued on the journey to Oban hospital, with the ambulance arriving there at approximately 1010 hours. A Consultant doctor on duty at Oban Hospital on the 1 October 2018, received a call from A & E at 10.13 hours to attend a cardiac arrest. The Consultant attended immediately and was informed the patient, Mr Smith, had been in asystole since approximately 0940 hours that morning, including throughout the journey to the hospital. The doctor and his colleague both agreed that there were no signs of life evident so any further resuscitation attempts should be stopped. The Consultant pronounced life extinct at 1020 hours.

Locating Mr White

126. The officer who had initially viewed the mobile phone footage of the incident asked another officer, a Police Constable Campbell, to attend Flat 3C Castle Road to

seize the witness's mobile phone. PC Campbell returned and informed the first officer that there was no reply at Flat 3C.

127. On 1 October 2018 at around 1044 hours, the officer who had viewed the footage obtained the mobile number for the reporter, John White, via Airwave. The officer then attempted to phone John White on his mobile. The mobile number went directly to his voicemail and the officer left a voicemail for John White requesting he contact her at Oban Police Station on "101". The officer was attempting to contact John White to obtain a statement from him.

128. At approximately 1046 hours the officer attended at flat 3C Castle Road and, on there being no response, she attended at flat 3D which was answered by the witness who had the mobile phone footage. On taking a statement from him and noting his details, the officer realised this witness was not the original reporter. The officer was not aware that Mr White had been assaulted and believed he would contact Police Scotland on receiving her voicemail message.

129. As part of initial house to house enquiries PC Neil MacLeod attended at 9 Columba Court (Mr White's address) and knocked on the door. Having received no response, he posted a Police Scotland Calling Card through the letterbox.

130. At approximately 1420 hours two officers were actioned to trace Mr White and retrieve his phone. This was in the mistaken belief that this contained the aforesaid mobile phone footage of the incident. They were also instructed to bring Mr White to Oban Police Station to provide a statement. They attended the cordon created at Columba Court and provided their reason for entering the scene as "seize production"

"seize mobile telephone belonging to John White". The officer who had spoken with the mobile phone footage witness, then advised them it was another witness who had filmed the incident, not Mr White, and gave them the phone she had seized.

131. The officers did not then attend at Mr White's home as it was inside the inner cordon designated as part of the scene management of the incident, but attempted to trace him at local pubs he was known to visit and through his family. The Senior officer was updated that the witness who filmed the incident was not Mr White and therefore Mr White was considered as an additional witness.

132. By 1800 hours, Mr White had not been located and concerns were raised regarding confirmation of the identity of Mr Smith. It was considered that Mr Smith was in fact Mr White.

133. DS McArthur was instructed to attend at Mr White's home and force entry to confirm his welfare. DS McArthur arranged for a joiner to be contacted to assist to gain entry to Mr White's home.

134. DS McArthur waited for Identification Bureau staff to complete their examinations as it was raining heavily at that time and the IB team needed to take photographs before any potential evidence was washed away. Whilst he was waiting DS McArthur spoke to Mr White's nephew who provided him with a set of keys. When he attended at the Flat 9, Mr White's home address, DS McArthur was unable to gain access using the keys as there was already a key within the lock.

135. That at approximately 1940 hours that night DS McArthur instructed the joiner to force entry to Flat 9 Columba Court which was completed at 2010 hours. DS James

McArthur and DC Brannan entered the property. They noted a Police Scotland calling card lying on the floor behind the front door requesting that the house holder contact Oban Police Office. The dated and time recorded on the card was 1225 hours on 1 October 2018, but it was not signed by the officer completing same.

136. On entering the living room the officers found Mr White on the couch, holding his mobile telephone in his hand and slumped over to his left-hand side. Mr White showed signs of rigor mortis and his face had postmortem staining.

Police Investigations and Review Commissioner (PIRC)

137. On 1 October 2018, the Police Investigations and Review Commissioner (hereinafter referred to as 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, as amended to investigate the circumstances surrounding the deaths of Martyn Smith and John White.

138. The redacted copy of the PIRC investigation report was lodged as Crown Production number 58.

139. Deputy Senior Investigator, Neil Robertson, was instructed by PIRC to lead the investigation into the deaths of Martyn Smith and John White on behalf of the Commissioner. Following investigations, the findings of DSI Robertson were as follows:

- OR has an extensive history of mental ill-health and had been diagnosed and received treatment in the United Kingdom and abroad for paranoid schizophrenia. At the time of the incidents, he was diagnosed with bipolar

affective disorder and was under the care of and receiving treatment from his local NHS Community Mental Health Team.

- OR's medical records show that on 30 January 2018 he stopped taking his prescribed medication and that without it his mental health was likely to deteriorate. This information was not known to Police Scotland immediately prior to the incidents.
- In September 2017, OR came to the attention of police officers on three separate occasions when he experienced manic and psychotic episodes. On the second occasion an officer took him to the Lorn and Islands Hospital where he was assessed by medical staff who considered that he was not in need of medical treatment. On the third occasion, OR was detained in hospital under the Mental Health (Scotland) Act 2015 and discharged on 23 October 2017.
- Information was held on Police Scotland systems regarding OR's mental ill health, previous criminal actions and his involvement with local police officers.
- On 28 September 2018, a relative of OR telephoned Oban Police Station to make officers aware that he had concerns regarding OR's mental health as he believed he was not taking his prescribed medication.
- The actions of Police Scotland officers in relation to this call were appropriate and proportionate. A police supervisor ensured that this

information was shared with other local officers through established briefing processes.

- The officers who dealt with the incident on 29 September 2018 regarding concerns raised for the safety of Fiona Donn, should have visited OR to check on his welfare instead of relying on Donn's opinion that police involvement would have an adverse effect on him. The officer's supervisor was aware of all the information relating to this incident and should have instructed the officers to take this course of action.
- The officers who dealt with the first incident about 0100 hours on 1 October 2018 regarding OR's conduct which was reported by the now deceased Mr Smith, assessed that no crime had been committed and gave advice to both persons. Although the officers were aware of OR's mental ill health, the concerns expressed by his relative and previous incidents involving him, they did not consider him to be in need of immediate care and treatment by medical staff.
- Despite OR displaying apparent signs of mental ill health and acting bizarrely during his interaction with the police, the officers considered that it was not clear that he was in need of immediate care and treatment and required to be assessed by a medical professional, in terms of the Mental Health (Scotland) Act 2015 and associated police guidance. In the circumstances they could have considered contacting a family member to

clarify their concerns or contacting OR's GP or a member of the NHS Mental Health Team.

- On receipt of the telephone call from the now deceased Mr White about 0940 hours on 1 October 2018, a Service Adviser failed to recognise that the now deceased Mr White was in obvious distress. The updates she added to the STORM incident did not accurately reflect what can be heard in the audio recording of the telephone call.
- The incident was viewed or read by in excess of 100 police officers and members of police staff between 0940 hours and 2010 hours on 1 October 2018. No one identified from the updates that the now deceased Mr White was unwell, injured or in need of urgent medical assistance.
- A Communications Controller at Police Scotland's Govan Area Control Room failed to follow procedures and did not provide the officers attending the incident at Columba Court with the relevant information concerning the now deceased Mr White. The officers should have been told that the now deceased Mr White had been assaulted, was very shaken, was no longer talking on the telephone and the Service Adviser was unsure regarding his welfare.
- Officers who attended the incident had been provided with details of the now deceased Mr White's name, address and mobile telephone number. However, the officers were approached at an early stage by a witness who they incorrectly assessed to be the reporter of the incident i.e. the now

deceased Mr White. This caused confusion and resulted in delays in efforts to trace and interview the now deceased Mr White.

- About 1800 hours on 1 October 2018, officers were instructed to force entry to the home of the now deceased Mr White, due to concerns for his welfare. However, the Police Scotland Crime Scene Manager did not take this action until over 2 hours later. The now deceased Mr White was found dead in the flat seated in a chair and still had his mobile telephone in his hand. Due to the position of the body, it is likely that he died during the telephone call with the Service Adviser or shortly thereafter.
- During the incident, there was a lack of communication between the Service Adviser and the ACR staff and subsequently between the ACR staff and the officers at the scene. Had the attending officers been provided with the relevant information it is likely that earlier attempts would have been made to trace the now deceased Mr White and check on his welfare. However, it is unlikely that he would have been found alive.
- As a result of this incident, Police Scotland have issued updated guidance to Service Centre and ACR staff instructing that where staff assess there is an immediate or critical risk to the life of a caller or other person, then a supervisor must be notified, and their details recorded on STORM incident.

140. The findings set out in the PIRC report were based on the views and assessment of DSI Robertson. There was no finding that the actions of the officers amounted to a breach of any of Police Scotland's policies or procedures.

141. The Police Command and Control Standard Operating Procedure (Command and Control SOP), Version 3 – Service Centre and Control Room Procedures, which was in place in October 2018 was lodged as a Crown Production 25. In terms of Section 2.2.5 of the Command and Control SOP Version 3:

> "on receipt of a report requiring a Grade 1 (immediate) response, the Service Adviser will transfer the incident immediately to the relevant ACR. When such a call is created/accepted at the ACR, the Controller will confirm that the correct priority grading has been allocated and will dispatch the most appropriate resource to attend without delay. Thereafter, the controller will continue to update the officers on route with any additional information as received."

142. Service Adviser McDonald created the STORM incident at 09:40:25 on 1 October 2018 and transferred it to the Area Control Room which was accepted at 09:40:44. The STORM incident was transferred from the Service Centre to, and accepted by, the Area Control Room on a further three occasions at 09:43:30, 09:44:15 and 09:47:26 as it was updated by Service Adviser McDonald in accordance with Command and Control SOP, Version 3.

143. In terms of Section 2.3.1 of the Command and Control SOP, version 3, "In order to protect the public, the police service need accurate, relevant and timely information. All incident information must be recorded in a concise and unambiguous manner." The information provided by Service Adviser McDonald and recorded in the STORM incident was in short, clear and concise sentences. Each sentence starts with "Caller" demonstrating the source of the information being provided. The call from Mr White was recorded at about 0940 hours on 1 October 2018. Comparing this against the information recorded on the STORM incident by Service Adviser McDonald the relevant

details are stated including what type of assault is taking place, the requirement for an Ambulance to attend, the name of the person being assaulted, the nature of the assault continuing, the location followed by a description of the person responsible for the assault. Mr White reports that he was kicked in the stomach, which has been recorded by Service Adviser McDonald, at which point she has added an update that Mr White was assaulted earlier, which is information he provided at the start of the call. Service Adviser McDonald asks Mr White if he needs an Ambulance, however Mr White responds saying "I don't, I don't think so". This is not updated on the STORM incident. Mr White provides the address for the person responsible for the assault, and that he does not know where the person is now and informs Service Adviser McDonald he is now within his flat, which is all recorded on the STORM incident. Mr White stops speaking with Service Adviser McDonald, who is persistent in attempting to continue the conversation and when she gets no response, she updates the incident with "Caller is very shaken, caller now not talking online but line is still open, unsure if caller is ok or not". Immediately after this she transfers the incident to the Area Control Room. The information is updated and recorded on the STORM Incident and is easy to understand, clearly states the information provided by Mr White to the Service Adviser in accordance with Command and Control SOP, version 3.

144. On 2 October 2018, Contact, Command and Control (C3) Division, introduced and immediately circulated to all C3 Division staff specific guidance in relation to incidents involving critically ill or gravely ill persons. This guidance states that:

> "with immediate effect, where a Service Adviser is informed of a set of circumstances that suggests there is an immediate and critical risk to the life of a caller or other person(s), the Service Adviser must immediately highlight the circumstances to the ACR managing the STORM incident. Communication can be made via an internal telephone call made directly to the ACR by them or by highlighting the circumstances to a Service Centre Team Leader who will in turn immediately notify the Controller directly or via an ACR supervisor. This contact should be recorded on the STORM incident."

In addition, instructions were communicated to all staff within C3 Division with proposed wording to be adopted to be included on such incident as follows:

> "To ensure that immediate concerns in relation to critically injured or gravely ill victims or callers are highlighted ASAP by Service Adviser or Controllers to relevant supervisors the following details should be entered promptly on the STORM incident once the concern message has been conveyed either by telephone or via Airwave: *** (enter time) ACR or Service Centre (name of ACR or SC Supervisor contacted to be entered) advised of immediate concern by Tel or Airwave ***"

145. Police Scotland published and circulated further guidance on 14 May 2020 emphasising the importance of supervisory oversight of incidents involving critically injured or gravely ill persons. The guidance remains current in October 2023 as a process to be followed in such situations.

146. In January 2019 C3 Division established the PIRC Review Committee. The purpose of this was to review and capture learning opportunities and develop any necessary improvement plans. The first stage for the committee was to fully understand the organisational learning and individual shortcomings identified from previous PIRC enquiries. This involved reviewing every incident which has resulted in a PIRC referral involving C3 Division to identify common themes which the PIRC Review Committee could then address via improvement actions.

147. This resulted in the introduction of C3 Division National Guidance which was first published on 3 May 2021. This has been updated and the version in place at the time of the review was version 3 with effect from 12 May 2022. This replaced the Command and Control Standard Operating Procedures in place in October 2018.

148. The C3 Division National Guidance provides a consistent framework for police officers and relevant police staff involved in the process of call and incident management. The C3 Division National Guidance includes the Contact Assessment Model (CAM) requiring all calls received by the Service Centres and Area Control Rooms to use the THRIVE (Threat, Harm, Risk, Investigation, Vulnerability and Engagement) process of assessment. The THRIVE process provides a mechanism for the police response to be constantly assessed should other information be received or circumstances change. It takes into account the needs and circumstances of every caller to ensure the most appropriate response is provided. Throughout the entire journey of a call, incidents are assessed based on THRIVE.

149. The introduction of CAM was to significantly improve the service to the public by:

- Improving the assessment of risk and vulnerability whenever a call is received.
- Improving prioritisation decisions.
- Ensuring immediate dispatch of officers whenever required.
- Providing a range of resolution options for calls which do not require an immediate police response.

- Improving caller experience through the introduction of a range of resolution options, and
- Ensuring a more efficient and effective use of police resources.

150. THRIVE is continuously reviewed within C3 Division to identify opportunities to enhance the knowledge and skillset of the staff within the division. Since September 2023, a one day Continuous Professional Development (CPD) day is being delivered to all C3 staff, up to and including the rank of Inspector/Operations manager, which is in the most part focused on THRIVE, identifying each strand of THRIVE and ensuring it is documented clearly. This training was programmed to run until Spring 2024.

151. In 2019 and 2020 a one day in person training course was provided to all staff employed within C3 Division to ensure a comprehensive understanding of the application of THRIVE assessment and recording. The training contained explanation of each strand of THRIVE, the method of recovering the assessment on incidents, the different policing responses available and practical application exercise. Staff that have joined C3 Division from 2020 onwards are provided with this training as part of their induction. Additionally, training is made available to all staff via Police Scotland's electronic learning platform, and this is monitored for compliance.

152. Another improvement that has been introduced by Police Scotland since February 2023 is the "Direct Contact from Scene" which is in partnership with Scottish Ambulance Service, which provides the facility for officers who are on scene to make contact with Ambulance call takers, requesting their service and being in a position to

provide real time information in relation to a patient's condition to identify an appropriate medical response. The introduction in this process has consequently reduced the requirement for ACR staff/officers to be engaged on calls to Scottish Ambulance Service whilst maintaining communication on the divisional talkgroups. The introduction of the Direct Contact form Scene was communicated to all officers/staff by means of a memorandum providing the rational for the change in process along with the necessary contact information for each region of Scotland.

Significant adverse event review - Highlands Health Board

153. A significant adverse event review (hereinafter referred to a SAER) was carried out by Highland Health Board to review the psychiatric care provided to OR prior to the incident on the 1 October 2018. The Report produced by the review panel in relation to the said review was also lodged as a production, Crown Production 36.

154. A pre review meeting was held on the 3 May 2018 attended by the review team panel consisting of an Associate Medical Director (in the Chair), a Consultant Nurse (Mental Health), the Clinical Governance Manager, a Stroke Nurse Specialist, a Consultant Psychiatrist and a Clinical Lead.

155. There were additional review participants who met on the 23 January 2019 and 20 February 2019; these included the Associate Medical Director (chair), the Clinical Governance Manager (Facilitator),the Local Area Manager, Community, Oban (Investigator/author of the timeline), a GP, a Consultant Nurse (Mental Health), a Mental Health Nursing Team Leader, a Community Psychiatric Nurse, a Locum

Consultant Psychiatrist, the Local Area Manager, Lorn and Islands Hospital, Oban, the Lead Nurse Head of Service (East), the Head of Service (West), the Associate Medical Director a Mental Health Officer, a further two Consultant Psychiatrists, and a Personal Assistant who was the note taker.

156. A timeline was prepared and included in an Appendix to the Report being the timeline prepared listing the dates and key events in chronological order in relation to OR's care and treatment.

157. Between 3 August 2015 and 1 October 2018 OR visited Latvia on several occasions to have contact with his son.

158. The review panel found there was no evidence to suggest that the events which followed were predictable. Although there were areas for improvement identified as a result of the SAER process these aspects were incidental and were not considered, by the review panel, to have had a direct influence in terms of the events of 1 October 2018. Overall OR's care was considered, by the review panel, to have been appropriately managed despite challenges associated with OR spending periods of time in Latvia and OR's lack of compliance with medication.

159. The review panel found there had been a three-month period between October 2017 and January 2018, following discharge from Succoth ward, when OR had not been seen by a Consultant Psychiatrist at an Outpatient clinic. During this period OR was seen regularly by his Community Psychiatric Nurse. Further OR attended a Care Programme Approach (hereinafter referred to as CPA) meeting on 30 November

2017 (i.e. within that ttimeframe when his care was discussed with the care team including his consultant psychiatrist.

160. The SAER panel noted changes had already been made whereby on discharge, all patients have a consultant appointment arranged.

161. The SAER panel found, during that time period, within Argyll and Bute Health and Social Care Partnership (hereinafter referred to as HSCP) there was no overall CPA co-ordination. The panel found this process needed to be more robust and required support and investment.

162. The SAER panel identified the following learning points: - a. Further consideration to be given in future to Behavioural Family Therapy/Psychological Therapy in support of families. b. The importance of Management and Clinical supervision for CPNs including discussions about complex cases. c. Cultural differences arising from experience of mental health services in other countries can add another level of challenge. d. Patients travelling frequently abroad can disrupt treatment and continuity of care. e. Transfer of mental health patients from community to hospital needs to be accessible and available as per protocol CPA/co-ordination – additional support required. f. Variations relating to depot injections: In other areas of the HSCP CPNs administer these, in Oban, Lorne and the Inner Isles (hereinafter known as OLI) the GP practice administers these injections. g. Recognising deteriorating patients. h. Prioritising urgent reviews.

163. As a result of the SAER, specific actions were identified to address the above issues and were set out in Crown Production 40. These are:

a. (1) a register of competed trainers in Argyll & Bute was requested from the Behavioural Family Therapy trainer in NHS Highland. (2) Behavioural Family Therapy to be included in future workforce development training plans. (3) a review of CMHS provided overview of training and development needs of CMHS practitioners. (4) NHS education for Scotland – recommends provision of psychosocial interventions in psychosis for practitioners supporting service users with a severe and enduring mental health presentation. Psychosocial intervention training to be available in Argyll & Bute HSCP

b. (1) is now a standing agenda item on Senior Mental Health Nursing Professional Forum (bi-monthly) (2) all mental health nursing practitioners requested to undertake online NES clinical supervision module and an audit of current practices was undertaken

c. no specific recommendation made

d. Main issues were identified through an audit: where escort services were hosted within inpatient wards, staffing issues resulting in it being a challenge to release staff at short notice to support the escort; travel to meet the patient often requires nurses to be transported from the ward by a porter driving them there; this resulted in delays in sourcing ambulance due to staff requiring to make their way there first; and that can result in a

long wait for ambulance and more delay due to staff taking time to get back to the site. The result was Argyll & Bute HSCP Emergency and Urgent Care Mental Health Service commenced December 2019. These aspects were also taken into account when urgent care practitioner roles were being developed. An escort is now delivered by those practitioners for detained persons from the local site.

e. The post of CPA coordinator was reinstated to coordinate and administer the CPA register. Further in order to refresh staff knowledge of the CPA processes, there is now ongoing discussion of those processes through the Mental Health Nursing Professional Forum. Further practitioners have been requested to undertake an online CPA learning module as part of their continuing professional development.

f. CPN's in OLI are to administer depot injections rather than practice staff, in line with other localities. This change is being rolled out.

g. The procedure has been introduced whereby there is a daily meeting, Monday to Friday, where all CMHS/IPS highlight quality and safety issues and any clinical issues. The existing approach is based on clinical need and clinical risks and clinical/professional judgement are to be included in refreshed CM H standards. Additional support is also provided by the newly established Emergency and Urgent Care Mental Health Service.

Post Mortem

164. On 2 October 2018 Martyn Smith's body was examined at the Queen Elizabeth University Hospital, Glasgow by two Forensic Pathologists. In terms of their Joint Post Mortem Report (Crown Production 3) the cause of Martyn Smith's death was: 1a Blunt force trauma of chest 128

165. On 3 October 2018, John White's body was examined at the Queen Elizabeth University Hospital, Glasgow by two Forensic Pathologists. In terms of their Joint Post Mortem Report (Crown Production 4) the cause of John White's death was:

1a Ischaemic and hypertensive heart disease.

166. The Forensic Pathologists noted,

> "the degree of heart disease present at post mortem examination would have rendered Mr White susceptible to developing sudden and potentially fatal cardiac arrhythmias (abnormal heart rhythms i.e., a heart attack), and we acknowledge this could have occurred at any time. However, it is also well recognized and accepted in the medical literature that when some individuals with underlying heart disease (especially coronary artery disease) are subject to acute emotional and/or physical 'stress' they may develop increases in blood pressure and heart rate, abnormal heart rhythms, and potentially cardiac arrest. We also note the expert cardiac pathology opinion that 'as a result of the fibrosis in the left ventricle he (i.e., Mr White) was at risk of getting a cardiac arrhythmia at any time which could be precipitated by stress.'
>
> The described circumstances of this death – with Mr White directly seeing a person being assaulted, and then indicating that he himself had been kicked in the stomach (along with Mr White also indicating that he may also have been previously hit) – are such that they may be reasonably interpreted as being significant stressful events. In our opinion, given the significant underlying heart disease, these stressful events may well have precipitated a cardiac arrhythmia and resultant cardiac arrest, and of importance there would appear to be a clear temporal relationship between the incident and Mr White's death ie, it is reasonable to conclude that Mr White goes into cardiac arrest during the phone call he is making to the emergency services in relation to the incident –

this being clearly recorded and audible and the phone call lasting only a number of minutes with no 'break' in the sequence of events."

167. A report regarding John White was produced by Professor Mary N. Shepherd, Consultant in Cardiovascular Pathology. This was lodged as Crown Production number 7). Based on Professor Shepherd's opinion, John White had cardiomegaly with evidence of hypertrophic changes in the myocytes and left ventricular fibrosis which would be in keeping with both coronary artery disease and hypertensive heart disease. As a result of the fibrosis in the left ventricle Mr White was at risk of getting a cardiac arrhythmia at any time which could be precipitated by stress.

168. Dr Douglas Elder, a Consultant Cardiologist, provided an independent expert report in relation to Mr White's survivability had medical attention been received. He commented on the medical intervention required in that regard. He provided a report to the Inquiry which was agreed to be his evidence in the third Joint Minute of Agreement. That report is Crown Production 85.

169. On the basis of Dr Elder's report:

A. On the balance of probabilities, cardiac arrest occurred as a direct result of witnessing the assault on Mr Smith and the alleged assault on Mr White himself.

B. It is likely that death occurred immediately at the moment Mr White stopped responding to questions on the 999 telephone call; and

C. There is no realistic possibility that Mr White would have survived even if medical attention had been provided to him immediately upon losing consciousness.

Criminal case

170. Martyn Smith and John White's death and the circumstances relating to it were investigated by the Homicide Unit in Crown Office. OR appeared on Petition at Dumbarton Sheriff Court on 2 October 2018. The court heard evidence from Dr Olga McGowan that OR was suffering from a mental disorder and made an assessment order in terms of section 52D of the Criminal Procedure (Scotland) Act 1995, with a review hearing assigned for 29 October 2018. OR was thereafter transferred from Low Moss Prison to the State Hospital at Carstairs.

171. At the review hearing at Dumbarton Sheriff Court on 29 October 2018 a treatment order was made in terms of Section 52(M) of the Criminal Procedure (Scotland) Act 1995. OR remained as an inpatient within the State Hospital at Carstairs.

172. An Indictment was prepared by the Crown and served with the following charges libelled:

> "(01) On 1 October 2018 at Columba Court, Castle Road, Oban you OSKARS RANCEVS did behave in a threatening and abusive manner which was likely to cause a reasonable person to suffer fear and alarm and did repeatedly bang and kick on the door of the house at Flat 13, then occupied by Martyn Smith, shout at him and demand that he open the door: CONTRARY to Section 38 (1) of the Criminal Justice and Licensing (Scotland) Act 2010;
>
> (02) On 1 October 2018 at Columba Court, Castle Road, Oban, you OSKARS RANCEVS did assault Martyn Smith, then residing at Flat 13 Columba

Court and did shout at him, repeatedly push and kick him on the body whereby he fell to the ground, drag him along the ground and repeatedly jump on his body, repeatedly punch and kick him on the head and body, repeatedly stamp on his head and body, thrown items at, or over, him and you did murder him;

(03) On 1 October 2018 at Columba Court, Castle Road, Oban, John White, then residing at Flat 9 Columba Court having witnesses the assault upon said Martyn Smith, as libelled in charge (02) above, and he being in the course of telephoning the Police to report said assault, you OSKARS RANCEVS did thereafter assault said John White and did strike him on the body, run towards him and pursue him and repeatedly kick him on the body, place him in a state of fear and alarm for his safety and in consequence of said assaults said John White sustained a fatal heart attack and you did kill him; and

(04) On 1 October 2018 at Columba Court, Castle Road, Oban you OSKARS RANCEVS did resist, obstruct, and hinder Scott Deakin and Peter MacMillan, both Constables, Police Service of Scotland, Albany Street, Oban and did brandish a glass at them, decline to put it down when requested to do so, shout and scream at them, and struggle with them in an attempt to resist arrest: CONTRARY to Section 90(2) of the Police and Fire (Reform) (Scotland) Act 2012."

173. On 13 November 2019 in the High Court of Justiciary at Glasgow, Senior Counsel representing OR pleaded not guilty on behalf of his client and adhered to a special defence in terms of Section 51A of the Criminal Procedure (Scotland) Act 1995. Said plea being accept by the Crown, the court acquitted OR in terms of section 53E of the Criminal Procedure (Scotland) Act 1995 by reason of the special defence under section 51A of the said 1995 Act stating that OR was not criminally responsible for the conduct constituting the offence by reason of his mental disorder.

174. On joint motion of both the Advocate Depute and Senior Counsel for OR an Interim Compulsion Order in terms of section 53(2) of the Criminal Procedure (Scotland) Act 1995 was made by the court. An interim detention order was made detaining OR within the State Hospital, Carstairs until 5 February 2020.

175. On the 5 February 2020 in light of evidence led from Dr Jon Patrick, Consultant Forensic Psychiatrist and OR's Responsible Medical Officer at the State Hospital, and the written evidence of Consultant Psychiatrist Dr Roger A Blake, the court found that OR had a mental disorder within the meaning of paragraph 328(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 and were satisfied that the conditions contained in section 57A(3) of the Criminal Procedure (Scotland) Act 1995 were met in respect of OR. On that basis the Court made a Compulsion Order in terms of section 57A of the said 1995 Act authorising his detention in The State Hospital and in accordance with Part 16 of the said 2003 Act the giving of treatment to OR. The order restricted discharge without limit of time.

Expert evidence

[20] Finally, I heard oral evidence from three expert witnesses, two of whom, Drs Bennett and Mohammad are Consultant Psychiatrists, commenting on the level of care and treatment afforded to OR by Highlands Health Board, and the third being Dr Rebecca Halliwell, Depute Medical Director of NHGS, covering Argyle and Bute, since 2019, who gave evidence of the Health Board review following the events of October 2018.

[21] Of relevance to the opinion evidence of Drs Bennett and Mohammad is the evidence of both Dr Paul Sheard and Dr Krzyzstof Krajewski:

[22] Dr Sheard gave evidence, as I have said, by way of affidavit and began by setting out his qualifications. He obtained his medical qualifications in 1979, and following his

psychiatric training, became a Fellow of the Royal College of Physicians in Psychiatry in Canada in 1987. He returned to the UK in December 2010 and was based in Oban thereafter, until November 2018 when he moved to a Post in Inverness.

[23] He first encountered OR on 13 August 2015 and saw him regularly at his clinics from then until September 2017. OR was admitted to Gartnavel Royal Hospital, Glasgow under a short-term detention certificate at that point. OR was discharged from that certificate in October 2017 and admitted to Succoth ward in Lochgilphead Hospital. Dr Sheard confirmed OR was not placed on a CTO either by the team at Gartnavel or himself. Dr Sheard set out the criteria for placing someone on a CTO, which includes a lack of insight and lack of clear-cut decision-making. Dr Sheard considered that OR had decision-making capacity at that time and OR agreed to take depot medication voluntarily. Depot medication is administered by injection and is long acting. OR was given Depixol, which is a mood stabilising drug, Sodium Valproate, which is a mood stabiliser and Risperidone, which is an antipsychotic medication as well as a mood stabiliser. The latter is given to deal with grandiose, inappropriate delusions and to reduce mania. Dr Sheard was satisfied that robust use of the Care Programme Approach (CPA) process would ensure compliance with the medication and, even with retrospect, still considered the decision not to place OR on a CTO to be reasonable, noting that it is a fundamental principle of mental health legislation to take the least intrusive measure for the patient. He did however concede, that it would also have been a reasonable option to place OR on a CTO. Dr Sheard advised that a CTO would require two medical reports on the patient. He confirmed that had a first one been completed at

Gartnavel Royal, he would likely have completed a second, but no such report is in the medical records. He stated he had spoken with the consultant psychiatrist at Gartnavel Royal in early October 2023, who confirmed to him that no CTO medical report was completed by Gartnavel Royal on OR, although there was discussion in the notes about it having been considered. Dr Sheard concluded that OR had insight into his condition and understood that he needed to keep taking his medication to avoid relapse and undertook to do so. His plan as at October 2017, was that if OR stopped taking his medication or showed other signs of deterioration, he would initiate a CTO. That plan, however, was not documented in his notes. Dr Sheard confirmed that OR's presentation could change within a day, and the OR said different things to different professionals to hide what was going on. Dr Sheard left his role in December 2017 and had no further involvement in OR's care. He notes from the records that OR remained stable until late September 2018 and confirmed that he would never have predicted the events of October 2018.

[24] Dr Krzyzstof Krajewski, also gave evidence. He is a Locum consultant psychiatrist currently working in Fife. He completed his undergraduate degree in Poland, then achieved his psychiatric specialist training in Iceland before working in South Africa and Iceland. He started working in the UK in 2014 and has worked since as a Locum Psychiatric Consultant. In his view there was no difference between the role of a Locum Psychiatric Consultant and a Psychiatric Consultant. The role of both, was to be in charge of the care and treatment of individuals in both outpatient and inpatient situations depending on the locality of the patient base. He started working as a locum

in Argyll & Bute on 22 January 2018. This post involves predominately outpatients but also included some inpatients in the psychiatric ward of the local general hospital, and some inpatients in the psychiatric hospital in Lochgilphead. He was referred to records which showed that he had a consultation with OR on 31 January 2018. He was referred to his letter dated 21 January 2018 advising Dr Shaw at OR's GP practice of the outcome of that consultation. He confirmed that at the time of the consultation he had the patient's file, so would be aware of the medication that he was on. He confirmed his role was to reassess the patient, which includes an element of diagnosis, and he agreed that the diagnosis of bipolar affective disorder was correct. He was looking for signs of hypomania such as pressure of speech, increased psycho motor activity, agitation, flight of ideas, prominent persecutory delusions, and delusions of grandeur. These were not present. He was aware that OR had refused to take medication and attempted to convince him to restart that medication. At the time of his consultation OR was not displaying any of the symptoms which would have concerned Dr Krajewski. The doctor considered that OR's lack of engagement with taking the medication was caused by a lack of insight on his part as to his illness. Dr Krajewski was asked about the existence of early signs of hypomania, and he indicated that there were not really signs *per se* but given OR's history and his stated preference to be manic, the refusal could be viewed as low-grade mania. This, of itself, would not be cause to admit OR to hospital. If OR had met the criteria for admission, he could have made OR subject to an Emergency Detention Certificate. At the time of the consultation, he was aware of the previous detention, and although he wasn't aware of the full description of OR's behaviour at the

time, they were typical of types of behaviour that would merit short-term detention. Dr Krajewski acknowledged he had concerns about OR not taking his medication but was then made aware from CPN Beaton that OR had travelled recently to his native Latvia and that he was employed in a local restaurant as a waiter. This led the doctor to conclude that he was not manic, as in his experience a patient who was agitated would not be allowed to fly, this being a strictly applied rule by all airlines, and that he could not have worked in a local restaurant were he demonstrating manic behaviour. The doctor in fact had dined at the local restaurant where OR worked and seen his behaviour at work. He considered that to be entirely appropriate at the time. He was asked about the fact that he didn't see OR again at a clinic but advised that he was available to OR at any point. It was not unusual, in his experience, for patients who were not taking their medication also not to maintain contact with their consultant psychiatrist. Dr Krajewski was content that OR was being monitored in the community and had access to mental health staff should he deteriorate. He was never asked specifically to start proceedings for an Emergency Detention Certificate, and in any event could not do so without examining OR. He did not consider that he was difficult to get hold of, spending a number of working hours each week in Oban seeing patients, the rest of the time being in Lochgilphead. The doctor confirmed that at the point that OR was manic in September 2017, he was a potential danger to both himself and members of the public. He accepted that a person can become manic quite rapidly and confirmed that if a patient showed signs of aggression and mania, then he might apply for an Emergency Detention Certificate for that patient. He stressed, however, that he

would require the patient to be presented to him for examination whilst in that condition before he could make the application. He also stated that when a patient is discharged from hospital following detention, that patient may be able to lead a perfectly normal life even without taking medication. The history of violence would of course be taken into consideration, but past violence does not necessarily mean that an individual will be violent each time, and past violence would not, in the Doctor's opinion, fulfil the criteria for detention. It is also not a criterion for detention, that someone is not taking their medication. Dr Krajewski was quite clear on that, stating that this was not his personal opinion, it was the law. Counsel for OR suggested to the doctor, that if OR was not taking his medication then it was not a case of if but when he became manic and the doctor replied that he understood counsel's concern, but confirmed that the criteria for detention at the time of examination is determinative of whether an Emergency Detention Certificate or indeed any other detention certificate can be granted. Counsel again reminded the doctor of the contents of his letter in which he advised OR's GP that it was inevitable that there may be a manic episode and the doctor said that he had said that, but this statement was wrong, because OR had clearly recovered following the meeting in February given that he had subsequently flown. He must therefore have been displaying no signs of agitation at the times of the flight to Latvia and the flight back. He was aware that CPN Beaton had not been seeing OR on a weekly basis, as OR was avoiding her at times, but was not concerned about that as his recollection was that OR was still being seen. He was cross examined by counsel for the Health Board and confirmed that he cannot detain someone who does not meet the

criteria for compulsory treatment or admission to hospital, to do so would be unlawful. Without such detention there can be no compulsory treatment.

[25] Dr Daniel Bennett, a Consultant Forensic Psychiatrist based at the Royal Cornhill Hospital in Aberdeen was led by the Crown as an expert witness and asked to review various records relating to OR. He was referred to his report which was Crown Production number 55. The Report set out the details of his qualifications and he also gave evidence of his own experience and expertise having been a Consultant Psychiatrist for 11 years. He was employed by NHS Grampian and was responsible for patients in a psychiatric care unit in Aberdeen, patients who required specialist forensic management in the community and also examined and provided reports on persons in custody, where there is a concern about their immediate mental health. He not only dealt with those accused of criminal activities but also provided care for persons with learning difficulties and brain injuries, providing care for all adult patients. He was frequently on call for the whole of the hospital, including all inpatients and those referred to the hospital, perhaps by GPs. He had responsibility for training of trainee psychiatrists in the North of Scotland and is a member of a number of steering committees. He was also a lecturer in psychiatry at Aberdeen University. He was also a fully registered Medical Practitioner approved by NHS Grampian under Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as having special experience in the diagnosis and treatment of mental disorder. His expertise to provide appropriate expert opinion was not challenged save for one respect: he was asked questions in cross examination by Counsel representing OR which strayed into opinions

on what steps it would be reasonable for a CPN to take, and that was objected to on the basis that he had no qualifications or expertise in that area. I listened to that evidence under reservation and comment on it below. However, I did not see that as a barrier to accepting his professional expert opinion in all other matters. I had no difficulty accepting his qualifications and expertise in relation to the role of a Consultant Psychiatrist and the role of Mental Health Services in relation to OR's care. His report set out the specific areas that he was asked to address, namely:

a) The role of the CPN and the threshold for compulsory treatment in hospital.

b) What would have been an appropriate response to OR's lack of engagement with Mental Health Services;

c) Whether his lack of engagement should have formed the basis for a revised risk assessment for the safety of the wider community;

d) Given that it was known that OR's behaviour could become erratic when he was off his medication, what was an appropriate action to be taken during this time;

e) What could happen to a patient within the community with repeated behaviours of non- engagement after a period of hospitalisation. And finally,

f) with respect to OR's repeated lack of engagement would permanent hospitalisation ever be a consideration.

[26] Dr Bennett set out the three types of Compulsory Orders that were available to practitioners in Scotland. He described them thus:

A) An Emergency Detention Certificate could be granted by any registered medic, including GPs other than those in their first year out of University. This would be applied for ordinarily with the consent of the Mental Health Officer, but this was not mandatory, if it was not practicable. An Emergency Detention Certificate would last 3 days, or 72 hours from the time of admission to hospital

B) A Short Term Detention Certificate could also be granted by any registered medic, but it must have the consent of the Mental Health Officer. This Certificate allowed for detention for up to 28 days; and finally

C) A Compulsory Treatment Order which had to be applied for with the support of two medical reports, one of which must be by an approved Medical practitioner. In the past the other medic was usually a GP but that was less common nowadays. A Compulsory Treatment Order lasts for an initial period of 6 months and can thereafter be renewed.

[27] Dr Bennett also gave evidence of reviewing the records relating to OR, and local practices relating to record keeping and the impact of the lesser availability of Dr Krajewski to the local team than that of Dr Sheard.

[28] Insofar as the considerations he was specifically asked to address are concerned, he adopted his report in which he first considered the role of Mental Health Services-

what information did they have, what did they do, was what was put in place appropriate?

1. He opined that the Mental Health Services had good information about OR, and that there was a degree of consistency in that he was regularly seen by the same CPN. He identified that there had been a risk assessment undertaken when OR was in hospital in September/October 2017 which identified some factors for risk of violence. Although OR had been violent in the context of his inpatient admission, there was no information available to suggest this could reasonably be expected to escalate to fatal violence.
2. Following his admission, OR was regularly followed up by his CPN and less often, but regularly, by his MHO. He was managed under the CPA which allowed the various agencies involved in his care to share information and to plan his management. His original psychiatrist attended the first meeting but there was no psychiatrist at the subsequent CPA meeting. OR was not reviewed by a psychiatrist following his discharge from hospital for a period of several months. He was reviewed on only one occasion between his discharge and the events of 1 October 2018. There appeared to be poor communication with the psychiatrist. The team were aware that OR was not compliant with his medication. They reviewed this regularly with him and various professionals attempted to persuade him of the merits of taking it. He was not thought to meet the

criteria for statutory intervention under the Mental Health (Care and Treatment) (Scotland) Act 2003 which has principles which favour minimum restriction and informal care.

3. Dr Bennett acknowledged there appear to have been missed opportunities for psychiatric review in the months prior to 1 October 2018 but noted that OR received regular input from a CPN and a MHO.

4. He specifically addressed the concerns raised on 28 September 2018, and the response to those concerns of an appointment being arranged for review on 2 October 2018. In his opinion this was not unreasonable delay for an urgent review which is ordinarily considered to be within one or two weeks. The concerns shared did not indicate an imminent risk of serious violence. He noted that there were concerns raised following the events that preceded the September 2017 admission, concerns that could indicate risk. However, OR had subsequently become unwell, or was thought to be unwell, in late January and early February 2018 and there had been no violence. He acknowledged that there could have been a CPN assessment carried out on 28 September 2018, or the concerns passed to the Consultant, however given the above, Dr Bennett's opinion was that it was difficult to determine that the actions taken were below an acceptable standard of care.

5. He gave an opinion on whether there were any defects in any system of working, or any defects in the system of work, and/or any reasonable precautions which could have been taken, and notes that OR did not

receive regular psychiatric review. He also notes that this was partly due to OR not attending appointments. He confirms there were deficits in the system for review following discharge from hospital which were highlighted in the NHS Highland Adverse Event Review.

6. Further he outlined in his report the role of the CPN and the threshold for compulsory treatment in hospital. He noted in his report that in this case, the CPN appears to have been the member of the team who had the most contact with OR and his family. She met him regularly, and was his CPN throughout his time living in the area. The role of the CPN is wide and encompasses areas such as monitoring his mental state, monitoring his engagement with treatment, suggesting activities or treatments, liaising with relevant agencies and communicating with other members of the team any concerns she might have. She may also be involved in a situation where there were thought to be significant concerns such as those which preceded his admission when she attempted to assess him. A CPN in the community, as here, has no powers to hold patients pending a medical assessment. Further where an individual was not subject to any order under the Act, as here, there is no requirement for him to engage with a CPN.

7. If police are concerned about the mental health of an individual in a public place, they have the power to convey that individual to a place of safety in terms of section 297 of the 2003 Act.

8. He set out in his report the threshold for detention as they are contained in the 2003 Act as follows:

a) an Emergency Detention Certificate in terms of section 36 of the 2003 Act could be applied for by any registered medical practitioner, ordinarily with the consent of a mental health Officer where they consider:

(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 provisions of medical treatment is significantly impaired;

and the medical practitioner is satisfied that the following conditions are met:

(a) that it is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment requires to be provided to the patient;

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

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

(ii) to the safety of any other person; and

(c) that making arrangements with a view to the grant of a short-term detention certificate would involve undesirable delay.

b) A Short Term Detention Certificate in terms of section 44 of the 2003 Act would be applied for by an approved medical practitioner (a medical practitioner

recognised by the Health Board in terms of section 22 of the Act) with the consent of a Mental Health Officer where they consider:

(a) that the patient has a mental disorder;

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

(c) that it is necessary to detain the patient in hospital for the purpose of –

(i) determining what medical treatment should be given to the patient; or

(ii) giving medical treatment to the patient;

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

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

(ii) to the safety of any other person; and

(e) that the granting of a short-term detention certificate is necessary.

9. He confirms that any person carrying out a function under this Act would require to consider the principles in section 1 thereof. These include the maximum benefit to the individual in pursuing the intervention which would represent the minimum restriction upon the individual.

[29] Dr Bennett also provided an opinion on the appropriate response to OR's lack of engagement with mental health services, eg refusing medication and non-attendance at meetings with the CPN. He acknowledged OR's long history of partial and occasional non- compliance with medication but noted his engagement with the Service as a whole

was relatively consistent until his hospital admission in 2017. Following that, he continued to engage with the CPN to a large extent. Given that his not taking medication was not new, it would be important to consider whether there was any change in his mental state. This was being achieved by the CPN and the MHO. He was also reviewed by a locum consultant in similar circumstances in January 2018. Other measures aimed at reducing any barriers to engagement such as changing the medication to minimise side effects were tried as were dose adjustments in an effort to keep him engaged. He was prescribed depot antipsychotic following his discharge and this would have ensured that he had medication in his system over a longer period. However he did not consent to taking this on an ongoing basis and did not meet the criteria for compulsion when assessed by the locum consultant in February 2018. Where there is a clear deterioration despite attempts at engagement it would be appropriate to consider measures under the 2003 Act including Emergency Detention or Short Term Detention Certificates or a longer term order such as a compulsory treatment order with community powers only. However from the information available, it is unclear if OR would have met the criteria for such an order. There could have been communication with the Locum consultant and the CPN about this and the matters discussed in a multidisciplinary way at the CPA meeting to consider any other ways of ensuring engagement.

[30] Dr Bennett gave his opinion on what was an appropriate action to be taken at this time, given it was known that OR's behaviour could become erratic when he was off his medication. The doctor confirmed that it was appropriate to regularly monitor his

mental state and offer medication should it deteriorate. It would also be appropriate to consider whether the criteria for detention under the 2003 Act had become met in order to offer treatment aimed at reducing the symptoms associated with the disorder. It would also have been appropriate for the locum consultant to review OR's mental state although it does seem he attempted to do so.

[31] Dr Bennett also gave an opinion on what could happen to a patient within the community with repeated behaviours of non-engagement after a period of hospitalisation. He stated it would be expected that there was regular follow-up from the community mental health team and good communication with the general practitioner. With this liaison, changes in the patient's mental state could be monitored and any alterations to treatment shared. Efforts should be made to encourage the patient to engage in treatment and consideration given to any barriers there may be to set this such as intractable side-effects of medication et cetera. It is likely that there would be consideration of whether the patient would consent to an informal (voluntary) admission. If such an admission were thought necessary, and they were unable or unwilling to consent, an assessment as to whether the patient met the criteria for further detention intervention under the 2003 Act ought to be undertaken.

[32] Dr Bennett was also asked to give an opinion as to whether permanent hospitalisation would ever be a consideration in respect of OR's repeated lack of engagement. He stated the approach of Mental Health Services is to promote recovery and management in the community wherever possible. There are cases where this is not always possible and longer term civil orders are required (there are also orders imposed

by courts as disposals but they are broadly analogous). The Mental Health Tribunal for Scotland can grant a Compulsory Treatment Order where an application is made by a MHO supported by two medical reports. This can authorise a range of measures including detention in hospital for up to 6 months initially. The order can then be extended for 6 months in the first instance and then annually by the Responsible Medical Officer. It would then be reviewed at least every 2 years by the Mental Health Tribunal for Scotland. Even in the situation where a patient were subject to a Compulsory Treatment Order for a number of years, the principles of the 2003 Act would apply in that the treating team would look to ensure that they were restricting the freedom of the individual in the minimum way possible. This might involve time out of the hospital or leave home, thus there is a presumption that permanent hospitalisation would not be required.

[33] Further in his oral evidence to the court, Dr Bennett, confirmed that Dr Sheard's decision not to apply for a CTO in 2017 was a clinical judgement, and, in his opinion, on the information provided, that decision did not appear to be unreasonable.

[34] I heard limited evidence under reservation (due to the objection taken to the expertise of Dr Bennett in respect of the actings of a CPN) in relation to the steps taken by CPN Beaton following the concerns raised by OR's mother on 28 September 2018, in particular the lack of further enquiries with OR's mother or OR himself about those concerns and the fixing of an appointment for 2 October 2018. Dr Bennett's response was that she possibly should have spoken with the mother, but that he understood her to be in Latvia, so it may not have been practical. He also confirmed that in his view,

given not as a CPN but as a Consultant Psychiatrist, that on the information available to the CPN on 28 September her response was not unreasonable. He pointed out that whilst the events of September and October 2017 could have indicated a similar deterioration could happen a year later, there were other examples of manic behaviour in OR's records where the outcome was not the same. Equally, the actions of the CPN arranging an appointment for 2 October 2018, rather than treating the situation as a more urgent emergency situation, in his view, was a clinical judgement, and standing the information available, a reasonable one. In his opinion, it was not predictable that OR's behaviour would deteriorate to the extent that it did, to the extent of involving fatal violence. I considered he was able to give this opinion in relation to the response by the CPN, *quantum valeat*, as a consultant psychiatrist who worked with patients in the community. In coming to this conclusion, I also accepted the CPN's evidence that the NHS telephone system would not have allowed her to telephone abroad.

[35] Dr Fiona Mohammad, is a consultant Psychiatrist who examined OR following his arrest in respect of the deaths of Mr Smith and Mr White. She prepared a report in relation to his fitness to stand trial and his mental health at the time of the incident on 1 October 2018 and met him on one occasion to do so. She then saw him again, in 2024, to prepare a Report on behalf of OR's representatives for the Inquiry. She too had prepared a report which was lodged as Production 1 for OR and her Curriculum Vitae was lodged as Production 2. She too set out her qualifications and expertise in her evidence.

[36] Dr Mohammad, gave evidence that, standing the pattern of OR's deterioration prior to his detention in 2017, when he stopped taking his medication in 2018, in her opinion it was a matter of when, not if, he would become manic. In her opinion, it would be an essential part of OR's clinical care that a risk assessment be conducted, and noted one in his records dated 12 September 2018, and a further typewritten one dated 7 October 2017. Based on the risk assessment dating from October 2017, she considered OR presented a significant risk of violence to both the general public and health staff involved in his care. In coming to this conclusion, she took into account OR's behaviour prior to his detention in 2017, and his reported violence to staff within the hospital. She was asked her views on what would safeguard against the consequences of OR's inevitable decline without medication and she opined that it was important to have a really robust management plan, with people, including family members involved in his care and having a clear line of communication, with contingency plans in place so everyone knows what to do and when to do it. An appointment system allowing for a same day appointment where necessary, and in particular in relation to OR, she considered that he should have been detained on a Compulsory Treatment Order in 2017 to compel him to take his medication. She concluded that there was nothing more that OR's family could have done other than raise their concerns which they did.

[37] In cross examination by counsel for NHS Highlands, this witness accepted she was not a general psychiatrist which was a similar but different job to that of Dr Sheard and Dr Krejewski. Her caseload demographic was inpatients in hospital rather than working with patients in the community. I considered that to be a significant difference

between her evidence and that of Dr Bennett, whose experience was more in keeping with the roles played by Dr Sheard and Dr Krejewski and his experience in dealing with patients in the community and knowledge of the challenges involved, resulted in him being better suited to give opinions on the appropriateness or otherwise of actions taken by a community team.

[38] For that reason, I preferred the evidence of Dr Bennett to Dr Mohammad's. But I also considered his opinions to be based firmly in the evidence, while Dr Mohammad gave her opinion on methods that in her view ought to have been employed without identifying why those methods would have resulted in the deaths being avoided.

[39] Dr Mohammad criticised the lack of a formal Risk Assessment, and the lack of an individual crisis or contingency plan, stating these could have guided professionals on how to respond in the event of concerns arising. She criticised the lack of an adequately detailed Psychiatry Emergency Plan (PEP) but conceded that it is difficult to say whether the PEP as documented in the documentation provided to her would have been sufficient to have prevented the events of 1 October 2018, as OR was not assessed by Mental Health Services or other medical professionals in the hours or days prior to those events. She states that it is possible that, had he been assessed, he may have been admitted to hospital.

[40] In evidence she stated that if OR was not taking his medication voluntarily then she considered that OR should have been detained on a CTO in 2017. The difficulty with that assessment is that when Dr Sheard took the decision not to place OR on a CTO in October 2017, OR was taking the medication voluntarily. He had agreed to do so. In

any event, a CTO is for 6 months in the first instance, and the patient can be discharge prior to that time. Even if a CTO had been granted in October 2017, there is no guarantee he would still have been subject to that in October 2018. I did not find Dr Mohammad's evidence in relation to the actings of the Mental Health Team in relation to OR to be persuasive and preferred, as I have said, the evidence of Dr Bennett.

[41] Dr Rebecca Halliwell had been Depute Medical Director of NHGS, covering Argyll and Bute, since 2019 and also gave oral expert evidence. Her background was in General Practice and her current role was as professional lead in Argyll and Bute for all doctors there. This included both a regulatory function and clinical governance. She performed that role three out of four weeks then in the fourth week, worked in rural out of hours areas, sometimes also working in forensic medicine. Previously she had worked for 17 years in a GP practice in Lochgilphead. She gave evidence of the Adverse Event Review (SAER) conducted by the Health Board following the events of 1 October 2018. This was a review conducted by a panel of professionals who examine the processes using a reporting system known as DATIX. This review process is used throughout NHS Scotland, to examine, in detail, the actions of any teams involved and identify any areas that could be improved on and learned from. It is not a blame process, but a process to attempt to prevent similar events happening in future. The report was lodged as Crown Production number 36 and she referred to it in her evidence. She described the process involved which included two meetings of all participants. The timeline considered by the review commenced in 2015 when OR's step father advised the local mental health team the OR may be coming to live with him and

his wife and that he had been diagnosed in Latvia with Schizophrenia. The review concluded with the events of 1 October 2018. The conclusion of the review is recorded as:

1. The reported deterioration by family on 27 September was reacted to in line with previous concerns reported by family when they felt OR was becoming unwell. The team had responded in a similar way which is standard- contact patient/family, offer advise re contacting GP and bringing forward outpatient appointments with consultant.
2. There was no evidence to suggest that the events which followed were predictable.
3. Although there were areas for improvement identified as a result of the SAER process, these aspects were incidental and were not considered to have had a direct influence in terms of the events of 1 October 2018 (erroneously stated in the report to be 2019). Overall OR 's care was considered to have been appropriately managed despite challenges associated with OR spending periods in Latvia and his lack of compliance with medication.

[42] The review also identify areas where improvements could be made as follows:

1. There was a 3 month period (October 2017 – January 2018), following OR's discharge from Succoth ward, when OR had not been seen by a consultant psychiatrist at an outpatient clinic. He was seen regularly by his CPN during this period. OR attended a CPA meeting on 30 November 2017 with

the care team including his consultant psychiatrist. As a result of a previous SAER , changes have already been made to ensure that all patients have a consultant appointment arranged at discharge.

2. There is no overall CPA coordination in Argyll & Bute HSCP, further work around this is required. The process needs to be more robust and required support and investment.

[43] The review also identified certain areas where lessons could be learned. These were recorded as:

1. Further consideration to be given in future to Behavioural Family Therapy/psychological therapy in support of families.
2. The importance of Management and clinical supervision for CPN's including discussions about complex cases.
3. Cultural differences arising from experience of mental health services in other countries can add another level of challenge.
4. Patients travelling frequently abroad can disrupt treatment and continuity of care.
5. Transfer of mental health patients from community to hospital needs to be accessible and available as per protocol.
6. CPA/coordination – additional support required.
7. Variation Ray depot injections. In other areas of HSCP CPN's administer. In OLI (Oban, Lorn and Islands) GP practices administer.

8. A number of methods have been implemented to varying degrees across the HS CP to recognise deteriorating patients e.g. Safety briefs, patient status at a glance and daily huddle

[44] The witness spoke of the difficulties employing consultant psychiatrists in rural areas of Scotland. There was a gap following Dr Sheard's departure in 2017 until 2019 which had to be filled by locums. She confirmed that it was also difficult to employ locums and sometimes consultants had to cover patients from outwith their area to assist. The review recognised a difficulty with communication in this case and have recruited a specific administrator and co-ordinator to ensure robust monitoring of the processes, ensuring everyone in the team is aware of the structure and information sharing. The difficulty identified relating to OR's care of a CPA meeting in November 2017 then no other one until November 2018, with no subsequent decision to stop having them, they just stopped, could not happen now. The system in place now will ensure that this is flagged and raised with the appropriate individuals. She also confirmed the other criticism levied of the lack of record keeping from the CPA meetings themselves has also been resolved and an individual has been identified as noter at each such meeting.

[45] Dr Helliwell also advised that in order to ensure that every patient has the appropriate treatment, there has been a review of emergency procedures. The Health Board introduced an Emergency Plan to replace previous guidance. There is now an Emergency Team who would assist with transfer of patients from their place of detention to where a bed had been identified, so that the situation where CPN Beaton

and a colleague had to take OR to Glasgow in 2017 would not happen. There would be a designated team to do that. Further there is a comprehensive document available to all staff and anyone who may need to care for patients in an emergency setting, detailing how to access emergency facilities and contact numbers.

[46] Counsel for OR asked this witness about the repeated reference within the review document to the outcome of the deterioration of OR not being predictable. She responded that the team conducted a very detailed analysis of events and that was their concluded view. She was pressed further about this and noted that some of her understanding now, following the review, was not known to those looking after OR at the time, and that that was an issue with communication which had been rectified, with a common IT system now being used by Social Work and Healthcare professionals, to ensure easier access to information.

Submissions

[47] The Crown and all participants helpfully lodged written submissions, which were adopted and supplemented during a hearing. I do not intend to narrate the submissions in detail but I did take account of them when preparing this Determination. I do consider it might be helpful to briefly outline what the submissions were with reference to the relevant parts of section 26(2) of the 2016 Act. The Crown made submissions in relation to section 26(2)(a), (b), (c) and (d).

Where and when death occurred (Section 26(2)(A) Of The 2016 Act

Martyn Smith

[48] The Crown submitted that Martyn Smith died at 1020 hours on 1 October 2018, being the time that Dr Carswell pronounced life extinct. In support of this they referred me to the first joint minute in which this was agreed. This being in accordance with the evidence, I made a finding in these terms.

John White

[49] The Crown submitted that I should find that death occurred at 9.47.23 hours on 1 October 2018. In support of this they referred me first- to the evidence of Clare McDonald, the call handler, who received a call from him at 9.40.25 hours and the entry she made in the STORM incident report at 09.47.23 that the caller was not talking on line and that prior to making that entry she had made repeated attempts to engage with the caller, having heard him making snoring type noise, second-to the agreed evidence relating to the forensic pathologist's opinion that it was reasonable to conclude that Mr White went into cardiac arrest during the phone call, and third- to the evidence of Dr Douglas Elder, Consultant Cardiologist, that in his expert opinion cardiac arrest due to a cardiac rhythm change is usually instantaneous, with death occurring immediately at that moment. Accordingly, on the evidence I made the finding that Mr White died at 9.47 hours on 1 October 2018 at 9 Columba Court, Oban.

Where and when the accident resulting in the deaths occurred (section 26(2) (b))

[50] The Crown submitted there was no accident resulting in either death, and on the evidence I made that finding.

Causes of Deaths (section 26 (2) (c))

[51] The Crown submission was that I should make findings in relation to the causes of each of the deaths in accordance with the agreed evidence The first Joint Minute formed the basis of my findings in fact in relation to the causes of death. In respect of Martyn Smith, the cause of death was 1a Blunt force trauma of chest; and in respect of John White the cause of death was 1a Ischaemic and hypertensive heart disease.

The cause of accident resulting in the deaths (Section 26(2) (d))

[52] The Crown submitted there was no accident that resulted in the deaths and, in accordance with the evidence, I made a finding in those terms.

Findings sought by Parties in relation to sections 26(2) (e) – (g)

Section 26(2) (e) Any Precaution which could have reasonably been taken and, had they been taken, might realistically have resulted in the deaths being avoided

[53] All parties made submissions in respect of this finding.

a) The Crown asked that I make a finding that the precaution that could have been taken was that OR continued to take his medication on his discharge from hospital on 23 October 2017 and that he remain as an informal patient

on the expiration of his short term detention certificate on 10 October 2017. In support of this submission, they referred to his history of non-compliance with the medical regime prescribed by Dr Sheard and provided by Taynuilt Medical Practice. They also pointed to the evidence of CPN Beaton that when OR attended with her, on 7 September 2017 that although he was no longer taking his medication, he had developed a good awareness of symptoms therefore knew when to take it; and the agreed evidence that following his admission to Hospital in September 2017 he accepted he was aware he had not taken his medication prior to his admission and that this was a deliberate act on his part. They also rely on the agreed evidence that he attended at appointments to be injected with his medication until January 2018, having insight that he was prone to stopping his medication.

b) Thereafter the Crown submissions highlight the response by the Health Board to OR's non-compliance with the medication regime. They highlight the evidence of CPN Beaton that she encouraged OR to take his medication, and the process by which after the CPN had made Taynuilt Medical Practice aware of his lack of compliance she also arranged for him to be seen by Dr Krajewski. This meeting took place on 31 January 2018 and I heard evidence from Dr Krajewski, that OR was showing signs of mania, that he didn't consider he needed to be medicated and that he was intending to travel to Latvia to see his son. Dr Krajewski, noted that OR

had obtained employment, and had seen OR at his work, and considered he was showing no signs of mental illness at that time. On that basis Dr Krajewski did not consider that OR required involuntary admission to hospital at that time, and decided simply to monitor him, and to convince him to take his medication.

c) The Crown also pointed to Dr Krawjeski's evidence relating to his obligations under the mental health legislation, and to his view that he could not detain anyone unless they showed signs of mania. This accorded with the evidence of CPN Beaton, who stated that patients are encouraged to remain within the community with the least restrictions as possible.

d) Dr Krawjeski stated that under the Mental Health (Care and Treatment) (Scotland) Act 2003, he had to wait for OR to become sufficiently ill that he would fulfil the criteria under the Act for compulsory treatment before any medication could be given without consent; and that compulsory treatment could only be given as an inpatient. The Crown submitted that the CPN and Dr Krajewski complied fully with mental health legislation, and were alive to the possibility of his deterioration without medication and was monitoring him. I heard also from Dr Bennett, who set out the legislation and the requirements thereunder.

e) Although none of the parties in their submissions suggest that the deaths could have been avoided had a CTO been applied for while OR was an inpatient at Gartnavel Royal Hospital in October 2017, that was raised in

the evidence of Dr Fiona Mohammad. Therefore, the Crown in their submissions, set out why they say that decision was a clinical one, taken by Dr Sheard, and it was a reasonable one to take on the information available. I agree with those submissions and agree that the purpose of this Inquiry is not to consider clinical decisions which are not unreasonable.

f) The Crown highlighted the expert evidence led from both Dr Daniel Bennett for the Crown and Dr Fiona Mohammad by those representing OR. The evidence of Dr Bennett, they submitted, was supportive of the position that it was difficult to know what, if any, difference a CTO might have made to events in October 2018 if applied for in October 2017. Firstly, on the evidence, it may not have been granted as he was agreeing to take medication at that time, and secondly it may well not have remained been in place a year later.

g) The Crown also set out why I should prefer the evidence of Dr Bennett to that of Dr Mohammed, given their respective experience. In any event in relation to the evidence of Dr Mohammad that she would have taken a different view of OR in 2017 and would have applied for a CTO, they remind me that this is a difference in medical opinion, and clinical judgement, each of which is reasonable. As previously set out, I did prefer the evidence of Dr Bennett.

[54] The representatives of Highland Health Board and CPN Jacqueline Beaton, asked that I made no finding under this subsection.

a) Highland Health Board representatives, in support of this position highlighted the two stage test that must be met for a finding to be made under this subsection. It was submitted that even if the court considered that there is a reasonable precaution that could have been adopted, there was no evidence that it might realistically have avoided the deaths. Further that if the court considered that there is a means by which the death might realistically have been avoided but that it would have required a doctor or nurse to do something which would not, in the circumstances, have amounted to a reasonable precaution, then the test is not met.

b) On behalf of CPN Beaton, again the court was reminded of the two stage statutory test and it was submitted on her behalf that neither stage was met. It was submitted that no fault could or should be attributed to CPN Beaton, as she did not concede fault in relation to her management of OR, and the Inquiry heard no evidence from a suitably qualified expert in community psychiatric nursing expert that would allow a finding of fault. There was, therefore, no basis for a finding of a reasonable precaution which the nurse could have taken when dealing with OR.

c) Further it was submitted that the evidence showed that the appointment on 2 October 2018 offered to OR by CPN Beaton was a reasonable response in the circumstances, and there was no evidence to suggest a more formal risk assessment would have avoided the deaths.

d) And lastly on behalf of CPN Beaton it was submitted that there was no evidence that either stage of the test had been met.

Chief Constable

[55] Those representing the Chief Constable also asked that I make no findings under this subsection, setting out that there was no evidence presented to the Inquiry to suggest that the procedures in place in October 2018 for dealing with persons with mental ill health, namely, the Mental Health and Place of Safety Standard Operation Procedures, version 3, was in any way inadequate or lacking. Furthermore, the evidence of PCs Oman and Masterson was to the effect that they were aware of these procedures and knew what steps to take if someone was in need of immediate care and treatment, but based on their experience and training, their assessment was that OR did not fulfil the criteria. No evidence was presented to the Inquiry to challenge the officers' judgement or decisions at that time. In relation to the death of Mr White, in particular, they submitted that the call from him was dealt with adequately by the service adviser and communications operator at the ACR. There was no evidence before the Inquiry that suggested the procedure in place for responding to calls was defective or inadequate as at 1 October 2018. In particular, the agreed evidence from Dr Elder, consultant cardiologist, was that due to his condition, Mr White died immediately at the time he suffered a cardiac arrest, and that was whilst on the call to the police. There had been no evidence led at the Inquiry to suggest that precautions could have been taken by

any officer or employee of Police Scotland in response to the call from Mr White, that might realistically have resulted in his death being avoided.

Oskars Rancevs

[56] In their submissions to the Inquiry, those Representing OR set out a number of criticisms of the treatment and care of OR. They submitted that had there been better care then the deaths would not have occurred. They submitted that a reasonable precaution, taking into account his diagnosis, his behaviour in September 2017, his history of non-compliance with medication and the concerns of his family, a reasonable precaution would have been to make immediate contact with OR when alerted by the family, in order to assess whether additional steps to treat the patient was required, such as engaging a GP or psychiatrists to initiate a compulsory measure of care.

[57] It was submitted that since the psychiatrists who gave evidence, Drs Mohammad, Krajewski and Bennett, agreed that in order to avoid OR becoming manic, he required to be medicated; and given the evidence of Dr Mohammad, in particular, that if OR stopped taking his medication, it was a question of "when not if" his mental health would decline and he would enter a manic episode; and given OR's violent and sexually disinhibited behaviour in September 2017 when he was previously detained, it ought to have been evident to those caring for him both in Gartnavel Royal in 2017 and thereafter Willowview in Oban, that without medication, OR had the capacity to engage in violence and potentially in acts that were serious risks to life and property.

[58] Further, it was submitted that they would have been able to come to this conclusion had there been a better system of sharing information from Gartnavel Royal Hospital of "the violent act" and the results of a risk assessment carried out within Gartnavel Royal Hospital, with the Community Health team.

[59] It was further submitted that if there is to be a policy of treating individuals with mental health issues within the community then there must be a duty to monitor those individuals when they were at large and to react to concerns and potential risks to the public from potentially violent and dangerous behaviour, such as the behaviour exhibited by OR in 2017.

[60] It was submitted that after OR was treated then released from his detention in 2017, there followed a poor level of supervision by the lead consultant in charge of his care in 2018, namely Dr Krajewski (excepting the period of time that there was no such consultant, due to a vacancy).

[61] It was submitted that a reasonable precaution would have been for CPN Beaton to telephone OR when the concerns were raised on 28 September 2018 to ascertain if further action was required.

[62] There was criticism made of what was described as a lack of supervision of the CPN, a lack of structured arrangement in place to see OR in person and deficiencies in record keeping when his address was not updated, these deficiencies being compounded by OR not taking his medication.

Reasons for my Determination in relation to section 26 (2) (e)

[63] I was asked by the Crown to find that a reasonable precaution that could have been taken which would have prevented the deaths, would be that OR had continued to take his medication, but I have declined to do so. There are two reasons for this:

a) The Inquiry heard evidence that OR was on various medications over the years, but it heard little evidence about the therapeutic effect of those medications, either individually or in combination and either in general, or specifically in relation to OR. The Inquiry heard evidence of the side effects that OR disliked, namely the weight gain and the dampening of his mood, and that in the past when he had omitted to take his drug regime, he became manic. But the Inquiry also heard that his prescribed regime was altered at various times, with medications being added, medications being stopped and dosages of the various drugs being altered. It heard that sometimes his behaviour changed when the drugs were altered and that it was generally accepted that he should continue with his prescribed medication to manage his mania. However, the Inquiry also heard evidence that OR failed to take his medication on a number of occasions, sometimes for weeks or months on end, with no extreme manic behaviour as exhibited on 1 October 2018. No medical evidence was led that would allow me to conclude what effect any particular type of medication he was required to take on 1 October 2018 would have had on OR and why taking that medication would have prevented OR's behaviour that day and

therefore prevented the deaths. I do not consider there is an evidential basis upon which I could make a recommendation that a reasonable precaution would have been for him to take any particular medication.

b) In any event, the Crown are asking that I make such a finding but have also, in a different forum, accepted that at the time of the deaths, he was not criminally responsible for his own conduct. The Crown accepted that he was unable at the time of the conduct, by reason of mental disorder, to appreciate the nature or wrongfulness of the conduct. Conduct at the time of the deaths necessarily includes the decision not to take his medication. The failure to take his medication in the months prior to that date does not fall to be considered, as he had in the past not taken his medication without exhibiting such violent behaviour.

[64] Accordingly, I do not consider, on the evidence, I can make the finding sought by the Crown.

[65] Turning to the submissions made on behalf of OR, I heard no evidence that would allow me to find that the deaths might realistically have been avoided by a reasonable precaution. I do not consider the criticism of the decision to discharge OR without seeking a Compulsory Treatment Order in October 2017, amounts to a reasonable precaution under this subsection. Even if it had, there was no evidence that would allow me to conclude that this would have prevented the deaths a year later. The decision not to apply for a Compulsory Treatment Order, was a matter of clinical judgement. I heard evidence in Dr Sheard's affidavit about this and also evidence from

Dr Bennett, the Crown expert, and from Dr Fiona Mohammad, for OR. For the reasons I have given before, I preferred the evidence of Dr Bennett. He was quite clear in his evidence that the decision not to apply for a CTO in 2017 was a matter of clinical judgement, and on the information available, a reasonable one. In accepting his evidence in relation to this I was mindful that Margaret Ashman, OR's MHO at the time, expressed some concerns about this in her evidence, but she accepted that it was Dr Sheard's decision to make and that he was the one who was best qualified to make such a decision. I also took into account the evidence of Dr Fiona Mohammad, that in her opinion OR should have been detained on a CTO in 2017 to ensure he took his medication. She was not asked if Dr Sheard's decision was simply a different clinical judgement but referred to obtaining the CTO as "good practice". She did not specifically address the duration of the CTO which would have been 6 months in the first instance, and the necessary steps for an extension, but simply seemed to be accepting that it would continue in place to ensure OR took his medication. It is of note, the deaths are a year after the decision was taken not to apply for a CTO. Even if I accepted that there were any reasonable precautions (which I do not) there was no causal link in the evidence that would allow me to determine that such precaution, reasonable or otherwise, would have prevented the deaths.

[66] I also do not consider that there is evidence that would allow me to make a recommendation that a reasonable precaution would have been for CPN Beaton to phone OR after the concerns were raised by his mother on 28 September 2018. The steps

she did take, namely arranging an appointment for 2 October 2018 were, on the evidence, reasonable.

[67] Further, those representing OR criticised the system of sharing information, but this is better dealt with under subsection (f) so I shall address it then.

[68] And lastly it was submitted by those representing OR, that if there is to be a policy of treating individuals with mental health issues within the community, then there must be a duty to monitor those individuals when at large and to react to concerns and potential risks to the public from potentially violent and dangerous behaviour, such as the behaviour exhibited by OR in 2017. The evidence of Dr Fiona Mohammad was that following the concerns raised on 28 September 2018 by his mother, OR should have been seen the next day, rather than 2 October 2018. I preferred the evidence of Dr Bennett, that this was a reasonable time scale for an appointment in the circumstances. His evidence was that the violence recorded in 2017 was not such that it was reasonable to conclude that OR was capable of fatal violence. I heard no evidence to support a recommendation that an earlier appointment was a reasonable precaution and if it were one, that it would realistically have resulted in the deaths being avoided, accordingly I make no such recommendation.

[69] The submissions for the other parties were to the effect there was no evidence that would allow me to make recommendations under this subsection. I accept that and therefore make no such recommendations.

Reasons for my Determination in relation to section 26 (2) (f) (any defects in any system of working which contributed to the deaths or any accident resulting in the deaths)

[70] All of the parties to the Inquiry, other than those representing OR, invited me to make no findings under this subsection.

[71] Those representing, OR invited me to find that there were deficiencies in the sharing of information, in particular of the contents of the risk assessment undertaken in Gartnavel Royal in 2017 and the subsequent failure to undertake a formal risk assessment following his discharge from the hospital in October 2017 amounted to defects in a system of working which contributed to the deaths.

[72] These are two different criticisms. Dealing firstly with the lack of sharing of information: the evidence cited in support of that submission was the evidence from CPN Beaton that had she known of the "inappropriate behaviour" of OR whilst detained she would have possibly dealt with the concerns over OR differently. That was not supported by the evidence led. CPN Beaton was asked if she would have dealt with OR differently had she known of his behaviour and she confirmed she may have. This was not further explored. It was not clear, therefore, if she meant she would have dealt with the concerns differently or if she would have simply interacted with him in a different manner. The submissions on behalf of OR seemed to then make the quantum leap, that this failure to share information led to a more relaxed regime of supervision which amounted to a defect in a system, contributing to a lack of adequate response which thus contributed to the deaths by a lack of appropriate intervention. There was

no evidence led that would support that submission. Whilst the evidence supported some defects in record keeping and sharing of that information, those were all identified in the Health Board review and the systems altered to ensure the same situation does not occur. There was no evidence led that would allow me to determine that those defects contributed in any way to the deaths.

[73] Turning then to the lack of any formal risk assessment being undertaken subsequent to his discharge. There was no evidence that this contributed to the deaths. In any event, CPN Beaton gave evidence, which I accepted, that she and her colleagues dealt with risk each day, and were constantly assessing risk whenever she interacted with a patient. Again there was no evidence that would allow me to determine that this was a defect in a system of work and that this contributed in any way to the deaths.

[74] I note that there was a dispute about the content of a conversation between OR's stepfather and Mr Gordon Parker, team leader and supervisor of CPN Beaton. This conversation does not impact directly on any of my conclusions on this case, but given its clear importance to those representing OR, I should comment on it. I preferred the evidence of Mr Parker regarding this conversation. I have no doubt that Mr Paterson was telling the truth as he recollected and interpreted it, but I consider his evidence to be unreliable on that point, no doubt due to the stress and concern he was experiencing at that time. I do not consider the conversation to be reflective of a "reactive" attitude within the department as suggested. Even if it were, again there was no evidence that would allow me to conclude that that, along with the suggested lack of immediate response, contributed to the deaths.

Reasons for my Determination in relation to section 26 (2) (g)

[75] None of the parties invited me to make findings under this heading. I did not consider that there were any findings I could make under this section, as such findings required to be facts which are relevant to the circumstances of the death.

Findings under section 26 (1) (b) and section 26 (4)

[76] I was invited by those representing OR to make a recommendation under section 26(4) that a system should be implemented by NHS Highlands, whereby a person who has previously exhibited violent behaviour while suffering a mental health episode and has been detained under mental health legislation as a result, be placed on a list, to be held by the NHS. Further that any concerns of abnormal behaviour raised in respect of anyone on that list requires an immediate response, that response to include a check-up taking place within 24 hours. Dr Mohammad proposed in her evidence that this be implemented. There was no detail contained in this proposal such as defining "violent behaviour", defining the nature of the check-up, limiting the duration of inclusion on this list. Nor did she outline how this blanket recommendation might realistically prevent other deaths in similar circumstances.

[77] On the evidence, I did not identify any precautions that might realistically have resulting in Mr White or Mr Smith's deaths being avoided. I have not identified any defects in any system of working which contributed to the death, and any other relevant factor. It follows I have no recommendation to make in this regard.

[78] When considering making recommendations the Inquiry is asked to look to the future and consider if there are any steps which could prevent a similar tragic event from occurring.

[79] The PIRC and Significant Adverse Event Review conducted separately in relation to the Police response and NHS involvement respectively identified certain defects and difficulties, I have considered each of those and consider them to be valid concerns. However, I also note each party's responses to the findings and the changes that have been implemented to ensure that the same difficulties do not arise. These are all difficulties that are of concern, but do not amount to matters that would result in my making formal findings following the Inquiry. In light of the various changes to procedure made, I do not consider it appropriate to make any recommendations under section 26 (1) (b) and section 26(4).

Conclusion

[80] I wish to conclude by formally offering my previously expressed condolences to the loved ones of both Martyn Smith and John White for their tragic loss. I was provided with a note from the family of Mr White which allowed me some insight into the man he was, for which I am grateful.