SHERIFFDOM OF GLASGOW AND STRATHKELVIN AT GLASGOW

[2025] FAI 32

GLW-B642-24

DETERMINATION

BY

SHERIFF PAUL ANTHONY REID

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

into the death of

TC

GLASGOW, 4 July 2025

DETERMINATION

The sheriff, having considered all the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accident and Sudden Deaths etc (Scotland) Act 2016 (hereinafter "the Act"), that:

1. In terms of section 26(2)(a) of the Act, TC, born 20 September 1966, died at 1950 hours on 21 January 2019 within Glasgow Royal Infirmary, Castle Street, Glasgow.

2. In terms of section 26(2)(c) of the Act, the cause of death was:

   1(a) carbon monoxide poisoning.

3. In terms of section 26(2)(b) of the Act, no accident took place and accordingly no finding requires to be made under section 26(2)(d) of the Act.

4. In terms of section 26(2)(e) of the Act, there were no precautions which could reasonably have been taken which might realistically have resulted in the death being avoided.

5. In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to the death.

6. In terms of section 26(2)(g) of the Act, there are no other facts which are relevant to the circumstances of the death.

RECOMMENDATIONS

The sheriff, having considered the information presented at the inquiry, makes no recommendations in terms of section 26(1)(b) of the Act.

NOTE

Introduction

[1] This determination is made following the Fatal Accident Inquiry held under the Act into the circumstances of the death of TC, born 20 September 1966, who died within Glasgow Royal Infirmary on 21 January 2019.

Procedural history

[2] A notice of the inquiry was given by the procurator fiscal under section 15(1) of the Act on 8 May 2024. The sheriff pronounced a first order on 8 May 2024 assigning a preliminary hearing for the inquiry to be held on 25 June 2024 at 10.00am within the

Sheriff Court House, Glasgow Sheriff Court, 1 Carlton Place, Glasgow, G5 9DA. Eabha Sweeney, procurator fiscal depute represented the Crown. At the preliminary hearings Eleanor Paton, solicitor, represented NHS Central Legal Office, Greater Glasgow Health Board and Lanarkshire Health Board (hereafter "the Boards"). At the inquiry itself the Boards were represented by Mr J McConnell KC. Initially DM, the daughter of the deceased intimated her intention, through a solicitor, to participate in the inquiry. A further preliminary hearing called on 19 August 2024 to allow the court to be advised as to parties' state of preparation and to clarify whether the solicitor for DM had secured funding to be present at the inquiry. A further preliminary hearing was assigned for 15 October 2024 to allow the solicitor on behalf of DM to make continued representations to the Scottish Legal Aid Board to secure funding for their attendance on her behalf at the inquiry. When the matter called on that date I was advised that the solicitor had been unable to secure funding and as a consequence withdrew from acting on her behalf. Following discussions with the procurator fiscal depute she undertook to engage with DM and to present on her behalf, as best she could, the issues which she wished to raise and have considered at the inquiry. A further preliminary hearing was assigned for 3 March 2025 to allow parties to finalise the terms of a joint minute and to lodge affidavits of the witnesses from whom parties intended to lead evidence. These affidavits would comprise their evidence in chief. The hearing on evidence was assigned to commence on 22 April 2025 at 10.00am. Having heard evidence on 22 and 23 April 2025, the inquiry was adjourned until 4 June 2025 to

allow for written submissions to be lodged by parties. Thereafter on that date I made avizandum.

[3] Both the procurator fiscal depute and Ms Paton entered into a joint minute, lodged in process on 22 April 2025, which agreed a considerable part of the formal evidence which was to be led at the inquiry. In terms of the joint minute parties were agreed that the productions lodged represented a true and accurate copy of the originals. A number of productions were lodged by the Crown comprising medical records and reports. On behalf of the Boards one production was lodged being a report from Dr J Callender dated 16 June 2024.

Legal framework

[4] The inquiry was held under section 1 of the Act. The procedure was governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. The inquiry was a discretionary inquiry under section 4(1)(a)(ii) and 4(1)(b) of the Act 2016: the Lord Advocate having considered that the death occurred in circumstances giving rise to serious public concern and that it was in the public interest for a public inquiry to be held into the circumstances of the death of TC.

[5] Section 1(3) of the Act sets out that the purpose of the Fatal Accident Inquiry is to establish the circumstances of the death and consider what steps, if any, might be taken to prevent other deaths in similar circumstances. The inquiry itself is an inquisitorial process. It is not the purpose of having an inquiry to establish civil or criminal liability. The matters which should be considered in a determination are contained within

section 26 of the Act and they have been set out above. Section 1 of the Act also sets out the requirement that the procurator fiscal, who represents the public interest at an inquiry, must investigate the circumstances of death and arrange for the inquiry to be held.

Summary

Background

[6] TC was 52 years of age at the time of his death, having been born 20 September 1966. He was married to LC. There were three children of the marriage. He was employed as an engineer. TC had no known previous psychiatric history by way of presentation to psychiatric health services but had previously suffered with low mood over a period of 2 years. He had been prescribed anti-depressants by his GP on a previous occasion. He was not known to have any other significant health problems. In January 2019 TC encountered relationship problems with his wife which led to their separation.

[7] On 16 January 2019 TC was taken to University Hospital Monklands (hereafter "Monklands") by ambulance following an emergency call from his family regarding his behaviour. He had sent a number of text messages that he was going to complete suicide. At Monklands, TC was assessed by Psychiatric Nurse Ian Munro. His notes of the assessment described a reaction on the part of TC to recent life events, and that whilst he had ongoing suicidal ideation he had no firm plan or intent. At the assessment he observed no evidence of psychotic illness. TC expressed a reluctance for any form of

admission to hospital and agreed to short-term crisis support. A referral was made to the North East Area Crisis Team at Kirkintilloch Health & Care Centre (hereafter "Crisis Team") who were contacted by telephone at that time. The assessment was completed and TC returned home. The Crisis Team accepted the verbal referral they had received by telephone.

[8] Later that day the wellbeing of TC deteriorated whereby he intimated to his family an intention to end his life. His sister called the police and the family GP. The GP, Dr Heidi Parkinson, attended at the home of TC. She found TC to be continuing to show an intention to end his life whilst refusing to tell her what he planned to do. He did advise her he had a definite plan. The family were concerned. They did not feel they could keep TC safe. They informed the GP he had attempted to end his life some 3 weeks previously. The GP contacted the on-call psychiatric team at Stobhill Hospital requesting an immediate assessment.

[9] TC agreed to attend Stobhill Hospital with family members. He was assessed by the duty doctor, Dr Gareth McGuigan, a core psychiatry trainee. Dr McGuigan was unable to discuss matters with the Crisis Team by telephone, nor was he able to access the records of the assessment that had been carried out at Monklands earlier in the day. He spoke by telephone with the GP of TC.

[10] He telephoned Monklands for information regarding the earlier assessment but was unable to get through or speak to anyone who could assist. He telephoned the Crisis Team but was unable to discuss matters with a team member. He proceeded to interview TC and made his own assessment of him.

[11] His examination noted the intense suicidal feelings of TC concerning his ongoing marital problems and an argument with his son. TC expressed a view that he felt out of control at times. At the time of this assessment these feelings had abated. He noted that TC sought to be reflective and thoughtful, and that he wanted to focus on becoming happy. In particular Dr McGuigan formed the view that the children of TC had got through to him and that he now wished to stay alive and work on his relationship with them. His assessment found no biological or cognitive symptoms of depression or signs of mental illness. He attributed TC's episode to distress arising from the break-up of his marriage. He discussed a safety plan with TC's sister and brother-in-law. TC did not wish to be admitted to hospital but said he was willing to do so if this was deemed necessary. Having considered matters he decided that the risk of hospital admission, which would include reduction of present coping mechanisms, separation from family support and a difficult ward environment, outweighed the benefits in terms of the safety of TC remaining within his family environment.

[12] It was agreed TC would stay in the care of his sister that night and would start engagement with the Crisis Team the following day. He prescribed 3 days' supply of diazepam tablets for TC to use in situations where he felt panicked and suicidal. He ensured that TC had the contact details for the crisis and out of hours services should his situation change. He made these clinical decisions himself and did not contact anyone else for advice. He felt comfortable with the decisions he made, in particular for TC to return home with input and support from the Crisis Team. Following this assessment he wrote to the GP of TC setting out the details of the presentation.

[13] On 17 January 2019 the Crisis Team sought to telephone TC at various times on his mobile phone and landline. Eventually a call was made that day to TC, and crisis practitioner Paula Sludden was able to speak with him. It was noted he was bright and reactive on the phone and agreeable to an assessment that day at 1.00pm. Crisis Team practitioners met with TC at his family home at 1.00pm on 17 January 2019. An adult mental health Crisis Team assessment was completed. It was recorded that TC presented as flat and tearful, which appeared to be reactive to his current social situation. It was noted that whilst he had voiced thoughts of suicide, he described no formal plan or intent of acting on these thoughts. He displayed insight into his current difficulties and an awareness that his current social circumstances were related. He expressed the view he was overwhelmed by his family support. His children at home were provided as good protective factors. His mood was rated as 5 out of 10. There was no evidence of paranoia or psychotic behaviour or symptoms. TC reported his marriage as being over. He reported drinking at the weekend. The daughter of TC informed the Crisis Team staff that the family had taken the air out of his works van tyres so that he could not go anywhere on his own. It was recorded as part of the risk management/safety plan that the Crisis Team would continue to access and support TC in the community. It was proposed the Crisis Team would facilitate regular home visits to assess and monitor TC's mental state and mood. TC agreed to use the telephone numbers provided or seek support from his family should this be required. It was agreed that staff from the Crisis Team would call TC on 19 January 2019 to arrange an appropriate time to visit. TC was provided with contact details should he require

support out with the planned contact. He was also advised that family members could telephone if they were concerned. It was agreed that the Crisis Team would discuss with other multi-disciplinary team members the care of TC. They would discuss a further 3 day supply of diazepam with medical staff.

[14] On 18 January 2019 the duty doctor for the GP contacted TC. He advised her he was feeling better but had difficulty sleeping. The duty doctor was not minded to prescribe more sleeping tablets as he was due to meet the Crisis Team the following day, but did prescribe one tablet for him to take that night.

[15] On 19 January 2019 the Crisis Team telephoned TC to arrange a home visit for 2.00pm that day. Due to service activity and workload the Crisis Team later telephoned TC to postpone the meeting until 3.30pm later that day. TC advised that time did not suit as he was planning to go to his sister's. It was instead arranged for a call to be made to him the following day.

[16] On 20 January 2019 a Crisis Team practitioner telephoned TC at 10.00am. There was no reply. A message was left for a return call. The Crisis Team spoke with TC by telephone at around 1.00pm. TC advised he was with his daughter and added that he was okay. He advised he was due to return to work the following day on a phased return. He advised that he was looking forward to this but was also feeling apprehensive. He advised he was available for a visit that afternoon. The Crisis Team practitioner advised that due to workload this would not be possible. It was therefore arranged that a Crisis Team practitioner would telephone TC the following day to arrange an appointment.

[17] On 21 January 2019 TC telephoned his GP surgery around 12 noon asking for sleeping tablets. The GP advised him, given he was to be assessed later that day by the Crisis Team, they should not be prescribing out with advice from the Crisis Team. The GP advised that if the Crisis Team felt a further prescription was appropriate then he could contact the surgery. At around 4.30pm TC telephoned the Crisis Team. He advised he was awaiting a call from staff that evening and that he had not been sleeping well and would require night sedation. The practitioner advised TC that the Crisis Team would visit him at home the next day and discuss the prescription of sleeping tablets with the duty doctor prior to their visit. TC voiced some concerns about work. He had gone back but it had not worked out. The practitioner felt TC seemed okay and happy to be seen the next day.

[18] Later in the evening of 21 January 2019 the sister of TC visited him. She considered him to be fine and did not notice anything out of character. Later that evening TC telephoned a friend to advise of his intention to commit suicide. This friend telephoned the brother-in-law of TC to inform him. Efforts were made to call TC but received no answer. The sister of TC travelled to his address. She met her nephew, the son of TC, who advised her that his father had gone out into his works van which was parked in the driveway. Neither of them could see TC within the van. They could hear the van running and thought it must have been the generator. They tried to gain access to the van along with the help of a neighbour. They were unable to overcome the security of the locked door. They contacted the emergency services. The police and fire

service attended at 6.47pm. They managed to force entry at 6.54pm. TC was found within the van unconscious and not breathing.

[19] The fire service carried out CPR until the arrival of the ambulance service at 7.04pm. Paramedics were able to regain a weak pulse and conveyed TC to Glasgow Royal Infirmary. Further resuscitation attempts were made at Glasgow Royal Infirmary however these were unsuccessful. Life was pronounced extinct at 1950 hours.

[20] The post-mortem examination was carried out on TC on 30 January 2019 at the Queen Elizabeth University Hospital, Glasgow by Dr John Williams, Forensic Pathologist, University of Glasgow. The final cause of death was provided as:
1(a) carbon monoxide poisoning.

[21] At the hearing on evidence the first matter addressed was the terms of the joint minute. This was read by the procurator fiscal depute into the record of the proceedings. Thereafter the fiscal chose to lead evidence from a number of witnesses.

Dr Gareth McGuigan

[22] The first witness led was Dr Gareth McGuigan. He was 37 years of age, a psychiatric trainee, level 6, working from Leverndale Hospital, Glasgow. He was presently employed as a specialist Registrar in Psychiatry. He had provided an affidavit dated 15 April 2025 which had been signed by him and notarised. He confirmed he was content to adopt the terms of the affidavit as his evidence in chief.

[23] He carried out an assessment of the mental state of TC on 16 January 2019. He was the on-call doctor for the out of hours service at Stobhill Hospital. TC had been

referred there for assessment. He was made aware that TC had been assessed earlier that day at Monklands. Details of that assessment were not available to him. He could not access the records of that attendance. He telephoned Monklands but was unable to discuss matters with anyone who had knowledge of the assessment. He also called the Crisis Team but was unable to speak to a member of staff there.

[24] He recalled TC reported acutely distressing personal issues that had precipitated his suicidal ideation. He discussed matters with TC and carried out his assessment. He was confident in his own ability and experience. He considered the case was not complex. He did not consider it necessary to obtain the views of a senior colleague. He did not consider it necessary that TC be admitted to hospital. His suicidal ideation had abated significantly. He enjoyed strong family support which he described as pulling him through the difficulties. This support was key to the abating of his suicidal thoughts. He would not have considered detaining TC in terms of the mental health legislation, there being no basis to do so. He considered that if TC had been admitted and then chosen to discharge himself from hospital, there was no basis to have him detained in terms of the mental health legislation. He considered the ward at that time was not a therapeutic environment for TC. The process of the assessment was regularly disturbed by the sounds and behaviour of an agitated patient. This impacted considerably upon TC. He did not want to be admitted to hospital. His assessment determined there was no evidence of significant mental illness. TC had no specific plan as to how he would end his life. He considered the suicidal thoughts of TC appeared to be waning in intensity and had abated significantly at the time of their meeting. The

risk of hospital admission outweighed the benefit. He considered if TC was removed from his ongoing family support his condition would worsen. The witness spoke with members of TC's family after the assessment to summarise his impression and to discuss his recommendations. He discussed with them safety planning and follow-up arrangements from the Crisis Team. The members of family were concerned about the health and wellbeing of TC. He gave the contact details of the Crisis Team to the family members. His expectation was that TC would receive daily support from the Crisis Team. This did not mean daily visits but rather assessment and engagement with the Crisis Team. The suicidal ideation of TC had abated. His desire to die had virtually disappeared. His children and family members had got through to him. The witness was satisfied that after careful consideration, if confronted with the same situation again, he would not have done anything differently.

Nick Morgan Curtis

[25] The next witness led was Nick Curtis. He was 40 years of age and presently employed as a mental health assessment nurse. He was employed by Lothian Health Board. He was employed previously as a member of the Crisis Team. He had provided an affidavit dated 6 March 2025 which was signed by him and notarised. He was content to adopt the terms of that affidavit as his evidence in chief.

[26] At the time of his dealings with TC he was a staff member of the Crisis Team. He assessed TC at his home on 17 January 2019 following a referral from Monklands. His assessment identified a number of strong protective factors. TC displayed insight

into his social difficulties. TC did not wish to be admitted to hospital. His assessment identified significant social stressors and also several protective factors. He denied any plan or attempt at suicide. He displayed insight into his difficulties and displayed no evidence of any capacity impairing illness. At the time of his engagement with TC the Crisis Team were inundated with work dealing with a large number of patients and resources were stretched as a result cases required to be prioritised. In general they offered those referred to them a number of services including intensive home treatment as an alternative to hospital admission. Having completed his assessment it was decided to treat TC on an outpatient basis. The carrying out of assessments in matters of this sort was a major part of his job and was done by him on an almost daily basis.

[27] He also spoke with TC on the telephone. TC described having had a difficult time. He wanted medication to facilitate sleep. There was nothing arising from that conversation that was of concern to him. He did not consider TC needed medication. Whilst he had difficulty sleeping, TC agreed to wait until the next day to receive a prescription. He advised that the process had now changed and he was now able to prescribe medication without waiting for a doctor. He had considered and reflected on matters carefully and in his opinion, if confronted with a similar situation again, he would not have done anything different.

Dr John Callender

[28] For convenience, given the availability of witnesses, the next witness, led out of order, was that of a Dr John Callender. He was a witness on behalf of the Boards. He

gave his evidence by WebEx. He was an expert in the field of psychiatry. He was retired. He had prepared a report dated 16 June 2024 (Production 1 for the Boards). He was content to adopt the terms of his report as his evidence in chief.

[29] In preparing his report he had considered the medical records and notes relating to the engagement of TC with mental health services. He had also considered a report from Dr Khan. He noted that TC was seen by four clinicians over a short period of time, none of whom recommended he be admitted to hospital. In his opinion the decisions by these clinicians not to admit TC to hospital were in keeping with usual and normal practice. He considered the arrangements put in place for follow up contact by the Crisis Team were also in keeping with usual and normal practice. He considered the reasons expressed by Dr McGuigan for his proposed treatment plan were cogent. He noted TC was seen by the Crisis Team on 17 January 2019 and then spoken to by telephone on 19 January 2019. He considered this was not an unreasonable lapse of time. A failure to update records in relation to TC following his assessment at Monklands had no material impact on the outcome. He noted there had been a delay in establishing contact due to the patient's commitments and the workload of the Crisis Team. He did not consider this would have altered the outcome. As a senior doctor he would not have overruled the view taken by Dr McGuigan. He considered the reasons expressed by Dr McGuigan for his proposed treatment in the community were appropriate. He noted that TC had a strong positive factor which was his family support.

[30] He noted TC was given a 3 day prescription of diazepam on 16 January 2019. On 17 January 2019 he was prescribed a further 3 day supply which in effect would provide him with a supply of medication for the Saturday, Sunday and Monday of the following week.

[31] He reviewed the approach adopted by Dr McGuigan. He considered that Dr McGuigan dealt with the matter appropriately. His assessment was thorough and carefully considered. The reasons he produced for his plan were cogent. It was in keeping with accepted clinical practice. A junior doctor may on occasion seek the advice of a more senior colleague. The junior doctor would advise the senior colleague of his plan and ask the senior colleague if he agreed. If, in the circumstances of this case, he was the senior doctor consulted, he would not have overruled the plan.

[32] He agreed that the Crisis Team offer general support. He was of the view that a hospital setting would not be an appropriate environment for TC. It would be an unpleasant experience for him. TC needed support and assistance to get through his crisis. He was of the view that the period of involvement of the Crisis Team was short. He advised that it normally takes a few meetings with a patient to establish a therapeutic relationship.

[33] He was familiar with a report produced by Dr Khan. He noted there was a failure by TC to contact the Crisis Team. There was no indication that TC should have been hospitalised. People who are referred for assessment are not normally admitted to hospital. He advised that admission to hospital would not have prevented suicide. There is no information that this would accelerate the behaviour on the part of TC. The

process adopted by the mental health services was robust. The patient was seen the following day when a full assessment was made.

[34] The witness had considered the records from Monklands. He noted from these records that a nurse having carried out an assessment reached the conclusion that TC did not require hospital admission. There was nothing in these records which would have influenced the assessment carried out by Dr McGuigan. He noted also that TC was seen by a psychiatric nurse, by Dr McGuigan, by members of the Crisis Team and two GPs. None of these clinicians formed the view that he required to be admitted to hospital. None of these clinicians considered TC was suffering from a mental illness. The act of broadcasting ones intentions to commit suicide usually suggests lower risk. There are no specific treatments for problems such as these endured by TC. Medication can provide short term relief from certain symptoms such as anxiety and insomnia.

Dr Khan

[35] The next witness led was Dr K H Khan. He also gave evidence by way of WebEx. He had produced a report dated 7 April 2021 which was lodged as Production 18. He was prepared to adopt the contents of the report as his evidence in chief.

[36] The approach Dr Khan adopted was in keeping with the founding principles of the mental health legislation. In particular exercising the least restrictive option. This legislation encompassed several founding principles designed to meaningfully and robustly manage patients with mental health difficulties. For example, one would endeavour to prescribe oral medication before intravenous or manage a patient in the

community rather than detained in hospital. In this case TC was managed in the community.

[37] Dr Khan stated that in the context of this case TC was suffering with an acute situation crisis arising from relationship issues. From a diagnostic point of view the patient was suffering an acute stress reaction. The response in areas of cognitive emotional appearance were manifestly of anxiety. It could be more severe if the patient had lost touch with reality. He considered that support measures required to be put in place including psychological intervention, medication and risk assessment. For example is the patient eating, sleeping or enjoying family support. The choice could have been hospital admission or intense support in the community.

[38] His criticism related to what he described as defects in communication between services which if improved would lead to more robust accountability and better use of resources. He confirmed that in his medical career patients suffering in this fashion are difficult to manage. What happened was unfortunate in this particular case. He would not criticise anyone involved on an individual basis.

[39] He confirmed the patient had spoken to his sister, and she considered him to be fine. He accepted that patients hide their true feelings and there is a possibility the patient was not entirely truthful.

[40] In practice, when a GP makes a referral of a patient for assessment then a more intensive support is required including admission to hospital. He was of the view the medical records did not bear out the anxiety and stress of the patient. At the time everything was moving fast. He was critical of the communication issues between

services which arose. He considered the difficulties amounted to a defect in the system of working. In particular an absence of robust communication channels, in person regular professional support and addressing the issue of pharmacological insomnia. He did not consider the community care plan to be robust. He recognised that the action plan prepared by the Boards addressed these criticisms and should help prevent future difficulties.

[41] Upon further consideration he modified his criticisms of the Crisis Team when it was explained to him their efforts to engage with TC. He had misunderstood the evidence of the GP believing she had recommended detention when she in fact had not. He had misunderstood the nature of TC's presentation to Dr McGuigan suggesting the patient displayed ongoing suicidal ideation when he had not. His criticism regarding the prescription of medication also was modified when presented with the reality of the situation involving TC, being that he had a prescription until the following Monday and family members advised TC appeared normal although the medication had not been prescribed.

Gillian Riley

[42] The next witness led was Gillian Riley. She was 52 and the interim head of service, specialist mental health services. She spoke to a report prepared by a Dr A Thom dated 19 April 2021 lodged as Production 19. This report was prepared in response to events involving TC. It addressed five recommendations to action. She confirmed that changes had been implemented to the Crisis Team and how they would

operate. They had been relocated to a new site allowing close working with the Mental Health Assessment Unit. A senior member of staff was allocated the coordination of work load. A policy was implemented to address increased staffing during busy periods. Staff numbers at the weekend had been increased.

[43] The admission process for patients presenting out of hours had been revised. Two units based in hospitals had been established for the purposes of assessment of those referred. There are two consultant psychiatrists based in the units. They are staffed by nursing staff on a full shift basis with medical cover provided by junior and senior medical staff as required. All staff can access the record systems to obtain information about a patient. Greater numbers of staff were now able to prescribe certain medications which alleviate anxiety and insomnia. These staff can prescribe without the need for medical review. All doctors in training are instructed to contact a senior colleague on call for advice if they do not assess a patient as requiring admission. This is repeated throughout their subsequent training.

[44] With the evidence of this witness concluded parties referred to the affidavits lodged of certain witnesses. These affidavits comprised their evidence to the inquiry. They included an affidavit from DM, the daughter of TC. She spoke to her concerns regards the manner in which her father was dealt with and what she perceived to be failings therein. The affidavit of Dr Heidi Parkinson confirmed she did not consider that TC be admitted to hospital but rather he be assessed as to whether that would be necessary. Dr Laher discusses the issue of prescribed medication and why he chose not to prescribe when requested out with the Crisis Team being aware. There are affidavits

of staff members of the Crisis Team discussing their engagement with TC and how in so doing there were no red flags or warnings suggesting he was in acute crisis at that time and their observations of the nature of his ill health. There was no evidence presented to them that he would need more frequent follow up contact. To allow parties the opportunity to reflect on the evidence and issues raised I adjourned the inquiry until 4 June 2025 for the presentation of written submissions. When the matter called submissions had been lodged along with supplementary submissions on behalf of the Boards following consideration of the submissions lodged by the Crown. At that hearing I made avizandum.

Submissions for the Crown

[45] The submissions invited that mandatory formal findings be made. In particular there was no reasonable precaution which could have been put in place that would have prevented the outcome. In so far as defects in the system of working were concerned they conceded that whilst there was a number of systematic issues in respect of the care offered to TC there was no direct causal connection between them and his death. There were evident record keeping and communication issues between services in the days leading up to the death. They noted the changes implemented by the Boards including relocation of staff, availability of staff, enhanced prescription powers, greater access to computer systems and newly configured Mental Health Assessment Units.

[46] The submissions highlighted the absence of face to face contact with the Crisis Team particularly when TC was at a heightened risk of suicide. The evidence

recognised that developing a therapeutic relationship with a crisis partner would have been of benefit to TC. The absence of face to face meetings was down to work load and other priorities. There was acknowledged the changes involving relocation of the team, a senior member of staff appointed to coordinate work load and increased staff at the weekends to deal with matters as and when they arise. Insofar as medication is concerned the unavailability of medication arose due to the breakdown in communication. Recent changes by the Boards ensured that an advanced nurse practitioner was able now to prescribe medication. They addressed the issue of distress. In particular concerning patients who are suicidal but not suffering from a diagnosable mental illness. There is scope for improvement in respect of practitioners dealing with a patient who are going through an acute crisis. All practitioners considered the changes implemented by the Boards would mitigate the risk to those in the situation of TC.

Submissions for the Boards

[47] The submissions advanced an argument that the death of TC was an unpredictable and unpreventable event. No one who met him considered he was at such a risk as to require hospital admission. The submissions considered and commented upon the evidence led. They addressed the involvement of Dr McGuigan and the approach adopted by the Crisis Team. The system now employed by the Boards has changed and takes into account the circumstances of this matter and certain of the observations of Dr Khan. They conclude by advancing that the death could not have been avoided. There is no real concern regard record keeping. The issue was an

inability of Dr McGuigan to access records from Monklands. Changes to the service since address this issue. There was an inevitability that changes in meetings with TC would be required in emergency or busy situations. Insofar as prescribed medication is concerned they highlighted that TC had sufficient medication to last him until the following Monday. Practitioners were alert to a scenario allowing the deceased to stock pile medication.

Decision

[48] The death of TC was a tragic and unfortunate event. He suffered from no diagnosed mental illness but was in a state of acute distress. The consequences of this were managed to an extent by the robust loving support provided by members of his family. They did all they could to prevent TC from carrying out his threats of self-harm.

[49] The first matter to consider in terms of the notice is whether TC should have been admitted to hospital for treatment. There was no medical basis for such an interference with the life of TC. He was not suffering from a diagnosed mental health illness. He did not meet the criteria for admission in terms of the mental health legislation. A number of clinicians had assessed TC, and all agreed admission was not necessary. Indeed the view expressed was that an admission to a noisy ward occupied by patients suffering from serious mental health issues could have had a more adverse impact upon TC. The assessment carried out by Dr McGuigan was carried out next to the ward. The disruption emanating from the ward upset TC who made it clear he did not wish to be admitted. The approach adopted by Dr McGuigan for treatment in the

community was recognised as acceptable clinical practice and could not be criticised by experienced clinicians, who had familiarised themselves with the medical records and had knowledge of what was acceptable practice. There was no medical or legal basis which would have justified hospital admission. The view was expressed that if having been admitted TC decided to leave the ward there would have been no basis to prevent this. The treatment in the community plan envisaged regular support and counselling from the Crisis Team along with the robust family support enjoyed by TC. Having heard the evidence in relation to the assessments, the follow on calls and the clinical decisions made, I am content that it was the correct decision by Dr McGuigan and did not cause or contribute to the outcome.

[50] The next issue to be considered is whether having determined that TC be treated in the community was there a failure in the service provided by the Crisis Team. At the outset of their engagement the Crisis Team met personally with TC, where a full assessment was carried out by experienced members of staff. This assessment led to the service being provided initially by telephone contact, direct meetings with TC were not considered necessary. Thereafter due to the commitments of TC and demands made of the Crisis Team contact did not occur precisely when it was supposed to. Whilst the contact could have been on a face-to-face basis it is clear from the evidence of what was discussed during the telephone calls that no warning signs arose which would have alerted the Crisis Team that the health of TC had deteriorated. His family reported he was normal. The engagement of the Crisis Team with TC was over a relatively short period. A matter of days. Nothing was flagged that suggested a deterioration in his

health. The Crisis Team during calls established he was as well as could be expected. Appointments for telephone consultations were made and rearranged due to a clash of commitments and other emergency priorities taking precedence. A comprehensive review has been carried out by the Boards. This has led to a restructure of the service with increased staffing and protocols in place for busy periods and at the weekend. I am satisfied on the evidence I heard that the failure to follow up was not unreasonable, in particular it was appropriate to the circumstances faced by the Crisis Team and that it did not contribute to or cause the eventual outcome.

[51] In so far as the issue of the prescription of medication is concerned, what the evidence revealed was TC had been prescribed sufficient medication to take him through to the following Monday. The GP chose not to prescribe when requested by TC until he had engaged with the Crisis Team later that day. This avoided the prospect of over prescription and the possibility of the stock piling of medication. This has been addressed by the Boards in their review. There are now senior nursing staff who can prescribe certain medication without medical oversight in the newly established dedicated units. I am content having heard the evidence that the issue of the prescription of medication did not contribute to or cause the eventual outcome.

[52] The final issue to consider is the inability of Dr McGuigan to access records or make contact with the personnel involved in the assessment carried out at Monklands. I am sure for the sake of completeness it would have assisted to have had such access but the evidence suggested it was not essential and made little difference to the approach adopted by Dr McGuigan. If they were essential Dr McGuigan did not impress me as a

practitioner who would have proceeded with his task without recourse to them. Dr McGuigan was content to proceed with his own assessment. He did not consider it a difficult assessment. He did not consider it a complex matter. I do not consider their absence would have impacted upon the approach and outcome adopted by Dr McGuigan. I am satisfied on the evidence I heard this inability did not cause or contribute to the eventual outcome.

[53] At the conclusion of the crowns submission I was invited to comment as to whether there is scope for improvement in respect of health professionals who treat an individual who does not have a recognised mental illness but rather are enduring an acute crisis. I would be reluctant to do so given this was not the primary focus of the inquiry. The witnesses were not invited to discuss in any great depth their views on the topic. I do observe that the care and treatment afforded to TC was fairly intense involving daily contact of a sort over different days. Those involved were clearly monitoring the situation to prevent it escalating to a more serious level. Regrettably despite their best efforts they were unable to prevent the tragic outcome.

[54] Finally I wish to conclude this determination by expressing my sympathies and condolences to the next of kin of TC.