SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES & GALLOWAY AT LANARK

INQUIRY HELD UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY (SCOTLAND) ACT 1976

INTO THE DEATH OF

HUGH JAMES O'NEILL

DETERMINATION by PETRA M. COLLINS, Sheriff of the Sheriffdom of South Strathclyde, Dumfries & Galloway following an Inquiry held at LANARK on 26 – 30 March 2007 and 11 May 2007

Lanark: 2007

The Sheriff, having considered all the evidence adduced, **DETERMINES**:

1. that in terms of section 6(1)(a) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Hugh James O'Neill, born 2 February 1974, who resided at 9 Glenview, Renton, died between 4 and 6 December 2005 at Douglas Water, near Tower Farm, South Lanarkshire;

2. that in terms of section 6(1)(b) of the said Act the cause of death was carbon monoxide poisoning.

NOTE

This Inquiry into the circumstances of the death of the late Hugh James O'Neill proceeded before me at Lanark Sheriff Court. Evidence was led on 26 to 30 March 2007 inclusive, and I heard submissions on 11 May 2007. Mr. Houston, the Procurator Fiscal, represented the public interest. Mr. Cairns appeared for Mrs. Marion O'Neill, the mother of the deceased. Mr. Wightman appeared for Greater Glasgow Health Board, the successor to NHS Argyll and Clyde.

Mr. O'Neill attended three times at Vale of Leven Hospital, Alexandria, in the week prior to his death, seeking admission to the psychiatric ward there. He was psychiatrically assessed on the first two occasions and a decision was taken not to admit him, but rather to treat him on an out-patient basis. On the third occasion a decision was taken not to see him. His body was found at Douglas Water, near Tower Farm, South Lanarkshire some two days after he left Vale of Leven Hospital.

In this Inquiry evidence was led exploring the medical decisions that were made in relation to Mr. O'Neill's case, and exploring the decisions that were made subsequent to his death.

The Evidence

I heard evidence that Mr. O'Neill, was a 31 year old man in good physical health. He was single, lived alone and was employed as a lifeguard and a gardener. He saw his mother, Mrs. Marion O'Neill, on an almost daily basis.

For some eight years prior to his death Mr. O'Neill had suffered from depression. Over that time he was prescribed various anti-depressants. It seems that he unilaterally stopped his medication three times over that period. In November 2000 he presented at the Accident and Emergency Ward of Vale of Leven Hospital complaining of feeling depressed. He was referred to the on-duty Psychiatric Senior House Officer at Christie Ward. Christie Ward is the acute psychiatric ward at the hospital. It is a short-stay ward. Mr. O'Neill was not admitted then as an in-patient.

He was assessed, prescribed the anti-depressant Paroxetine and referred for outpatient psychiatric follow-up. He failed to attend the out-patient appointment given. His General Practitioner continued to prescribe Paroxetine. At least four months prior to his death Mr. O'Neill ceased taking Paroxetine.

Some two months prior to his death his mother noticed that Mr. O'Neill's depression seemed to be getting worse. She saw differences in his appearance. He complained of feeling old. All his friends were married and he felt he should be too, with a couple of kids. Some two weeks prior to his death he was tearful, began asking his mother for cuddles, and reacted tearfully to an injury his nephew sustained. His behaviour was out of character for him.

Between Monday 28 November 2005 and Wednesday 30 November 2005 Mr. O'Neill stayed overnight with his uncle, Mr. Hugh O'Neill Senior. Mr. O'Neill asked to stay with his uncle, saying he did not feel right. During Monday he attended his doctor's surgery. He was prescribed the anti-depressant Fluoxetine (Prozac). He returned to work after this, and finished his shift at 10pm. He did not go back to work thereafter. Over the time he was with his uncle Mr. O'Neill repeatedly complained of feeling suicidal and that he felt he could take a knife and stab members of his family. His uncle took all this with a pinch of salt.

On Thursday 1 December 2005 Mr. O'Neill asked his mother to accompany him to see Dr. Stevenson, his General Practitioner. He complained of feeling suicidal and desperate. Dr. Stevenson referred him to Christie Ward at Vale of Leven Hospital for assessment. Mr. O'Neill and his mother went straight there.

Mr. O'Neill told his mother that if he didn't get taken in to Christie Ward he'd kill himself. He said he wanted sectioned – locked away. His mother told him not to be so stupid – he was only young and had his whole life before him. She kept telling him that "this is no place for you". She said of her son, "his mind was still alert, but he was depressed as well….He was very, very down when he went in."

At about 7pm that same evening Mr. O'Neill was assessed by Dr. Melia Begum, the on-call Psychiatric Senior House Officer, within a consulting room in Christie Ward.

At that time Dr. Begum was some six years qualified and approaching the end of her four year Senior House Officer training. She had just over four years of continuous psychiatric experience, including six months at the State Hospital, Carstairs. She had vast experience of assessing and treating patients who had indicated suicidal tendencies. She estimated that she had seen in the region of 500 patients per year in this category.

The purpose of Dr. Begum's assessment was to ascertain whether or not Mr. O'Neill was suffering from a mental illness, and whether treatment or intervention was required. Her competence to undertake such an assessment was not in dispute.

Dr. Begum spent about two hours in assessing Mr. O'Neill. The assessment was very thorough. Dr. Begum made contemporaneous notes (Production 13, pages 28-32). She recorded from Mr. O'Neill a personal and family history, and a full psychiatric history. The latter included feelings of depression, suicidal thoughts and thoughts of harming others, in particular his young nephew. He was having thoughts of seeing himself hanging and words like "massacre" came to his mind. He said he needed to be put into hospital. He said he had been admitted to the Christie Ward in 2002 for suicidal feelings. He said he had taken anti-depressant medication before, but irregularly, it had not really benefited him and he had stopped six months ago. His GP had started him on the anti-depressant Prozac some five or six days previously. He said he had travelled, that he was a physically attractive guy, that he had done a lot in his life and that he was still able to attract the opposite sex. He had £30,000 of debt.

Dr. Begum recorded her "mental state examination" of Mr. O'Neill. She found a mismatch between his expression of serious thoughts, and how he appeared to her objectively. His symptoms were vague without objective evidence of depression. On the contrary, Mr. O'Neill had good eye contact, very good rapport, his speech was spontaneous, the tone and volume of his speech was quite good, his interaction with her was good, his self-care was good and Dr. Begum saw no evidence of self-neglect. At times during the assessment Dr. Begum said Mr. O'Neill was quite playful and flirtatious. He began the assessment by wanting to lie on the couch instead of sitting. Dr. Begum discouraged him in this. Although he claimed thoughts of harming

himself and others he said he knew and believed he would not do that. No psychotic features were present. There were no auditory hallucinations or perceptual abnormalities or delusional beliefs.

Dr. Begum inferred that Mr. O'Neill had long-standing personality issues, a maladaptive pattern of relating to others and an impulsive personality. Her impression was that he harboured deep feelings of insecurity and fear of rejection and abandonment, stemming from his childhood. She found no evidence of a major mental disorder, in other words, no depressive illness or psychotic illness. She did not admit him because there was no indication for an admission. Her management plan was to refer him for outpatient psychiatric follow-up, to give him 5mg of diazepam to reduce his agitation, to give him a prescription for diazepam and for him to see his GP the next day. Given her level of clinical experience Dr. Begum felt she had made the right decision.

Even if there had been evidence of a major mental disorder Dr. Begum said she would still not have admitted Mr. O'Neill because he said he knew and believed he would not act on his thoughts of harming himself and others. That was a conclusion of his risk. Dr. Begum had no reason to believe he would carry out his thoughts. He had no plan to do so, and he clearly believed he would not carry out his thoughts by actions. The management plan would still have been the same.

In Dr. Begum's view Mr. O'Neill accepted her decision not to admit him, although he did not appear very happy. He waited outside whilst she wrote his prescription. Mrs. O'Neill said her son came out of the consulting room with his head down. Her impression was that her son was disappointed.

Mr. O'Neill stayed at his mother's house overnight. The next day, Friday 2 December 2005, Mr. O'Neill left to get his prescription for Diazepam made out.

At 3.40pm on that afternoon Mr. O'Neill presented at the Medical Assessment Unit at Vale of Leven Hospital on a voluntary basis. He had just taken an overdose outside Christie Ward. His overdose was recorded as 100mg of Fluoxetine (5 tablets) and 42mg of Diazepam (21 tablets). He was admitted to Ward 3, the acute medical ward,

treated and observed overnight. There were no medical concerns overnight. He later admitted to taking only one Fluoxetine tablet – his usual dose.

The Medical Assessment Unit is the successor to the Accident and Emergency Unit at the Vale of Leven Hospital. About 5% of admissions per year to the Medical Assessment Unit are overdose patients. On average, an overdose patient is admitted every two days. The vast majority stay in hospital overnight for observation and, having been psychiatrically assessed, are discharged from hospital the next day, with a medical follow-up plan. Many instances of overdose are not thought to be genuine attempts at suicide, but para-suicide attempts where there is no serious intent to actually die. In layman's terms these might be called cries for help. It is very unusual for psychiatric assessment of overdose patients to result in admission to Christie Ward, the acute psychiatric ward.

Mr. O'Neill's mother and a friend, Mrs. Christina King, visited him on Ward 3 early that Friday evening. Mr. O'Neill said that he'd kill himself if they didn't take him into the hospital. He said he wanted sectioned – locked away. He had said the same things to his mother the previous night. His mother thought it was just talk and that he would not kill himself. She thought he'd taken the tablets as a cry for help. Mrs. King was concerned. She felt Mr. O'Neill was very different from his normal presentation. He told her he just needed somewhere to stay safe until his tablets started to work. He was worried he was going to hurt someone and he needed away somewhere to stop that.

On the morning of Saturday 3 December 2005 Mr. O'Neill was seen in Ward 3 by Dr. Hugh Carmichael, a Consultant Physician, who assessed him as medically stable. Dr. Carmichael has no psychiatric training. Mr. O'Neill had no medical signs of overdose, but none would be expected as any overdose would most likely be largely metabolised by that time. Dr. Carmichael, in accordance with usual practice in such cases, referred Mr. O'Neill for psychiatric assessment. Mr. O'Neill did not express to Dr. Carmichael any suicidal intent or desire to be admitted to the Christie Ward.

Lilian McCurley, a Registered General Nurse of six years experience, was working in Ward 3 on Saturday 3 December 2005. She has no psychiatric training. She spoke to

Mr. O'Neill. She made it clear to him that she had no psychiatric training. Mr. O'Neill told Nurse McCurley that he had suicidal thoughts. He said he would gas himself in the car park of Christie Ward. He was concerned he was going to harm a young relative. This thought worried him more than anything. He repeated his thoughts of self-harm, and harm to his relative. He wanted to be admitted to the Christie Ward as they would help him and understand the way he was feeling. In Nurse McCurley's experience very often overdose patients just want to speak to someone in confidence. She felt that was the situation with Mr. O'Neill. He was quite openly happy to tell her what the problem was. He told her about his past, his previous relationships, his work and that everything was going wrong.

Dr. Begum then saw Mr. O'Neill for psychiatric assessment in an interview room within Ward 3. She spent some 30-45 minutes with him. She said Mr. O'Neill appeared very, very angry at her. He said "Didn't I tell you I was going to take an overdose!" which in fact he hadn't done. He continued to say he would harm himself or others. He clarified the quantities of Fluoxetine and Diazepam which he had taken, which did not correspond with his earlier report. Dr. Begum told him there was a management plan in place for him and he needed to follow that by attending the outpatient clinic. He said that whilst he was in the ward he felt like harming the old folks in the other beds. Dr. Begum told him that if he did so she'd have to tell the police. Mr. O'Neill responded that he had to be in a locked ward, or even a straight jacket. Dr. Begum told him that that would not be appropriate and that he needed to take responsibility for his own actions. Mr. O'Neill became increasingly angry. Dr. Begum said that his presentation was not that of a depressed person – it was of an angry person.

Dr. Begum recognised that contrary to his clear denial at his first assessment that he would act on his thoughts of harming himself and others, Mr. O'Neill had now taken an overdose. Dr. Begum decided to speak to the on-call Senior Consultant Psychiatrist, Dr. Fiona Coulter, outwith Mr. O'Neill's presence. She wanted to inform Dr. Coulter of this difference from her first assessment of Mr. O'Neill. However, Dr. Begum's view was that the context in which Mr. O'Neill overdosed, in particular just outside the hospital, suggested it was not a serious attempt to take his own life. Mr. O'Neill said that if Dr. Begum did not take responsibility for him then he'd harm

himself and others. Dr. Begum felt that Mr. O'Neill was trying to put responsibility for his actions onto her, and that this was a way to gain admission. It remained her view that his threats to harm himself and others were not serious, but rather were a way to gain admission to Christie Ward. There was no evidence that his presentation was the result of a mental disorder. She did not ask him if he had any plans to kill himself because she knew he would say "yes", but it was important for him to take responsibility for himself. She did not believe at all that he would carry out his threats because of her assessments of him, the *way* in which he took the overdose and the inconsistency in his reporting of the overdose.

Dr. Begum spoke to the Senior Consultant, Dr. Coulter, by telephone. She told her about both assessments of Mr. O'Neill. Dr. Begum said that Dr. Coulter decided, with her agreement, that it would be counter-productive to admit Mr. O'Neill and that the same management plan should be adhered to.

Dr. Begum then told Mr. O'Neill of that decision. He was angry. He asked Dr. Begum what would happen to *her* legally if he killed someone else. She responded that he did not have a mental disorder, that she would document that, and that he needed to take responsibility and face the legal consequences of his decisions. Mr. O'Neill then asked what would happen to her legally if he killed himself. Dr. Begum repeated her earlier response. Mr. O'Neill continued to be angry and Dr. Begum told him she would have to stop the interview. The last thing he said to her was "just watch and see." That exchange did not cause Dr. Begum to doubt her assessment. As a psychiatrist Dr. Begum hears threats all the time. She said that sometimes it is crucial for a psychiatrist to tell the patient that the psychiatrist doesn't take responsibility where the patient tries to direct responsibility for his own actions onto the psychiatrist.

Dr. Begum said she then telephoned Dr. Coulter, explained what had happened and they agreed to continue with the same management plan.

Dr. Fiona Coulter recalled two telephone consultations with Dr. Begum that day. In the first of these Dr. Coulter's recollection was that Dr. Begum discussed Thursday's assessment of Mr. O'Neill *before* reviewing him on the ward. Dr. Begum

went through Mr. O'Neill's full psychiatric history. In particular she told Dr. Coulter that Mr. O'Neill felt suicidal, homicidal and wished admitted to the psychiatric ward. Information was given regarding his personal and family history. Information was given about Dr. Begum's "mental state examination" of Mr. O'Neill. Dr. Begum told Dr. Coulter that she felt as if Mr. O'Neill was chatting her up. Information was given about his anti-depressant medication. Dr. Begum told Dr. Coulter about her management plan for Mr. O'Neill.

On the basis of the information provided, Dr. Coulter agreed that Mr. O'Neill did not have a major depressive disorder. He did not have the expected features of such a disorder. Dr. Coulter thought that Dr. Begum's decision not to admit Mr. O'Neill after the first assessment was appropriate.

Dr. Coulter recalled a second telephone consultation between Dr. Begum and herself. At this stage Dr. Begum had completed her second assessment of Mr. O'Neill. Dr. Coulter thought Dr. Begum was looking for feedback because Mr. O'Neill had taken an overdose. Dr. Begum had found really no difference in Mr. O'Neill other than the fact of his para-suicide attempt. In Dr. Coulter's view the nature of Mr. O'Neill's overdose revealed no serious intent to actually die. In her view it was *not* an indicator of an increased risk of suicide. *Repetitive* self-harm is such an indicator, but that was not the case here. Dr. Begum told Dr. Coulter about Mr. O'Neill's request to be locked up in a secure unit and about their exchange regarding his responsibility for his own actions. Dr. Begum felt admission to hospital was not required but psychiatric follow-up would be.

On the basis of both assessments, including taking account of Mr. O'Neill's overdose, Dr. Coulter supported Dr. Begum's decision not to admit Mr. O'Neill that Saturday. On that basis it was a joint decision. The management plan for Mr. O'Neill remained in place.

Given the information provided by Dr. Begum, Dr. Coulter foresaw disadvantages in admitting Mr. O'Neill. She was concerned that it was not possible to provide Mr. O'Neill with what he was looking for – Christie Ward is not a secure ward. Patients are not locked up or restrained in straight jackets. This was not a case where Mr.

O'Neill met the criteria where compulsory measures of detention under the Mental Health legislation might be invoked. If admitted, there was a risk that his behaviour might escalate when he was not getting what he was asking for, putting himself and other patients at risk. In Dr. Coulter's experience it was a very common phenomenon for a patient's condition to worsen by virtue of admission.

Nurse McCurley spoke to Mr. O'Neill when he came out the interview room. He told her he hadn't been admitted and that he was intent on committing suicide. Nurse McCurley was concerned. She spoke to Dr. Begum. She told Dr. Begum that Mr. O'Neill was still expressing suicidal intent and she was concerned, especially regarding him harming someone else. In her view he seemed genuinely at risk of doing something to himself or someone else. Dr. Begum said she had fully assessed Mr. O'Neill and sought guidance from Dr. Coulter who agreed with the decision not to admit him. Dr. Begum understood that Nurse McCurley had concerns and she took those concerns into account, but ultimately admission or not was Dr. Begum's decision to make. Nurse McCurley accepted Dr. Begum's decision. Nurse McCurley acknowledged that it was a very complicated situation. She believed that Dr. Begum felt the right decision had been made, and that one of the factors in that regard was to seek advice from Dr. Coulter. In Nurse McCurley's view there is a good culture of trust between medical and psychiatric staff at Vale of Leven Hospital, and there are no issues of mistrust between them.

Mr. O'Neill remained on the ward for about an hour longer. Nurse McCurley wanted to try to settle him. He was finding it hard to accept he wasn't being admitted. He took a Fluoxetine tablet on the ward. Nurse McCurley gave him a second tablet for Sunday and a discharge letter to see his GP on Monday. A family friend, Mr. James Bollan, was in attendance. Mr. O'Neill repeatedly told Mr. Bollan that he felt he would harm himself or his mother, grandmother or nephew. Mr. Bollan felt Mr. O'Neill shouldn't be left on his own. He took Mr. O'Neill back to his mother's house. From there, Mr. O'Neill went home.

That Saturday evening Mr. O'Neill phoned Greg Moy, a friend, asking for help. He said he might harm himself or someone else. Mr. Moy contacted NHS 24 then went to Mr. O'Neill's house at about 10.30pm. Some 25 minutes later Dr. David Troup,

the on-call GP, telephoned Mr. O'Neill. Mr. O'Neill repeated his intention to kill himself. He said the reason for doing that was so he didn't harm anybody else. Dr. Troup explained that only the on-call psychiatrist could admit him and arranged for him to attend at the Out-of-Hours Centre at Vale of Leven Hospital. Mr. Moy took him there.

Dr. Brian McLachlan has some 19 years experience in General Practice including lots of experience of psychiatric patients through his work as a GP. He arrived at the Out-of-Hours Centre at about 11pm on Saturday 3 December 2005 to take over from Dr. Troup. Dr Troup passed on the detail of his telephone conversation with Mr. O'Neill to Dr. McLachlan.

Mr. O'Neill arrived at the Out-of-Hours Centre at about midnight. Dr. McLachlan consulted with him. Mr. O'Neill presented as someone "in a bit of a personal crisis". He was polite, pleasant and reasonable. He felt low, depressed, vulnerable and desperate. It was very clear what his agenda was – to be admitted to the hospital. He clearly saw that as the solution to his predicament.

Dr. McLachlan ascertained that Mr. O'Neill had been on anti-depressants for many years. Mr. O'Neill described himself as well over most of that time. He had stopped his anti-depressant medication four months previously. He had a previous psychiatric attendance but no on-going psychiatric contact. Instead his condition was managed by his GP. His mood had deteriorated recently, he had seen his GP on the previous Monday and been prescribed Prozac. Mr. O'Neill's perception was that he had a recurring depressive illness due to stopping his anti-depressant medication.

Dr McLachlan was concerned by Mr. O'Neill suggesting that he might stab others, jump out a window, go into a police station and smash it up, or use a hose pipe to gas himself. Mr. O'Neill said he had considered other methods of suicide. Dr. McLachlan had significant concerns about his threat to wreck a police station, but this was clearly designed to gain admission to hospital. Dr. McLachlan felt that Mr. O'Neill had a significant degree of insight. He had no auditory hallucinations and if he carried out that threat his actions would be criminal. Dr. McLachlan told him he

shouldn't do that. He thought his talk of harming others was designed to get him admitted.

Very quickly Dr. McLachlan thought that the most satisfactory solution for Mr. O'Neill's presentation would be to admit him to the Christie Ward for a period of assessment and to allow management of his agitated depressed state. He had significant markers of serious suicide risk, in being a young male, living alone, with specific plans in relation to how he would commit suicide. Dr. McLachlan considered that the recent para-suicide attempt was also a significant marker. Whilst another patient with similar markers might be able to be managed in the community where the patient "bought into" that concept, Mr. O'Neill's expectation was for admission to hospital. That expectation, allied to these markers, informed Dr. McLachlan's view that the best outcome would be admission.

In Dr. McLachlan's experience a patient threatening suicide is an alarmingly frequent presentation, together with repeated acts of self-harm, and often the abuse of drugs and/or alcohol. Such patients are difficult to assess, but are usually managed in the community. The medical perception is that it is unusual or unrealistic to admit them. However, in Dr. McLachlan's view Mr. O'Neill did not fit that profile. His presentation was different for him, and that in itself was important. Dr. McLachlan's perception was that Mr. O'Neill's presentation was a situational crisis, as opposed to a pattern of behaviour. Both he and Mr. O'Neill had an open expectation that Mr. O'Neill would be admitted, his situational crisis would settle, his mental health would improve and supports would be put in place for his release back into the community.

At 00.16 hours on Sunday 4 December 2005 Dr. McLachlan telephoned the on-call psychiatrist who was Dr. Begum. Production No. 9 is a transcript of the call. Dr. McLachlan asked Dr. Begum to see Mr. O'Neill for assessment "for me". Dr. Begum asked "What happened tonight?" to which Dr. McLachlan responded "Nothing happened at the moment but he's up threatening suicide, self-harm or harming other people and such like, the whole flavour of his presentation is very much designed to be admitted and is manipulative round about that." No further information was conveyed as to Mr. O'Neill's presentation.

An exchange then followed in which Dr. Begum indicated that she had assessed Mr. O'Neill twice already. He was medically and legally responsible for his own actions. She knew Mr. O'Neill was running away from something, and speculated as to whether it was something to do with his debt of £30,000. It was a waste of her time to see him again. Twice during that exchange Dr. McLachlan pressed Dr. Begum to see Mr. O'Neill to convey her view. He then said "So you don't want to see him?" Dr. Begum responded that she had completed her assessment and that was not going to change. She had seen him recently, she had done a very thorough assessment and he had no major mental disorder.

Dr. McLachlan felt surprised, disappointed and angry. He was in broad agreement with Dr. Begum's assessment that Mr. O'Neill had no major mental disorder – he had no psychotic illness, he had insight, he was responsible for his actions and some of his distress was situational. However, he felt that whether or not a patient reached the criteria for major mental disorder was an unreasonably rigid way of deciding whether to admit to hospital. His impression was that had Dr. Begum seen Mr. O'Neill her decision would not have changed. He thought she was inflexible or fixed in her viewpoint. Out of perhaps 300 referrals to a psychiatrist over 19 years of practice, this was the first and only time in Dr. McLachlan's experience that the psychiatrist had not seen the patient.

Dr. McLachlan told Mr. O'Neill that Dr. Begum didn't think further assessment would be helpful. Mr. O'Neill had anticipated this outcome, "if it was the same doctor". Mr. O'Neill became resigned. He did not repeat his earlier threats of harm. He was calm and polite. Dr. McLachlan negotiated a follow-up plan with him to see his own GP on Monday and to contact Dr. McLachlan or one of the Out-of-Hours doctors if he had further problems. Mr. O'Neill agreed to that plan. He did not show any anger or hostility. Mr. O'Neill shook hands with Dr. McLachlan, smiled and left alone, Mr. Moy having left the hospital earlier.

During the course of Sunday 4 December 2005 Mr. O'Neill's family made various attempts to contact him. Mr. Moy telephoned him at his home and spoke to him. Mr. O'Neill sounded very, very low. A neighbour reported seeing Mr. O'Neill leave

his house in his car at 2pm. At about teatime that day his mother telephoned the police and reported Mr. O'Neill as a missing person.

At about 7.45am on Monday 5 December 2005 Mr. Thomas Templeton, a bus driver, was at Douglas Water, South Lanarkshire, travelling to work. He noticed motor vehicle registration number W107 WGA parked facing the road, at the entrance to a field near Tower Farm. Mr. Templeton couldn't see anyone in the car and assumed it had been abandoned.

At about 7.45am on Tuesday 6 December 2005 Mr. Templeton noticed the car was still in the same position. Having completed a bus run, he decided to stop at the car and report it abandoned. On looking in the car he saw Mr. O'Neill in a sleeping bag on the folded down back seat. A hose was lying on the front passenger seat and ran out the tailgate of the car to the exhaust pipe. The ignition was on, the engine was not running and the fuel gauge was empty. There was a handwritten note on the passenger seat. Mr. Templeton phoned the police.

The police attended shortly thereafter, as did Dr. John Copland, a Police Surgeon of some 18 years experience. The car had been locked and had to be forced open. There were no signs of criminality. Dr. Copland formally pronounced life extinct at 10.20am on 6 December 2005.

A typewritten copy of the note was lodged as the only production for the family. It includes the following passage: "….I HAVE BATTLED THIS ILLNESS FOR NEARLY 8 YEARS NOW, I HAVE FOUGHT IT AS HARD AS YOU COULD NEVER IMAGINE, BUT IT HAS OVERCOME ME. THIS IS NOT A SELFISH ACT BY ME, I HAVE BEEN HAVING THOUGHTS OF HARMING OTHER PEOPLE AND I NEVER WANT TO DO THAT, IT'S JUST THE WAY THIS ILLNESS TAKES OVER YOU. I NEED TO BE AT PEACE AS MY MIND IS IN A TURMOIL…."

At 10am on 8 December 2005 a post-mortem examination was carried out on the body of Mr.O'Neill. A sample of blood was retained for toxicological analysis. The

post-mortem findings, together with the results of the blood analysis confirmed that Mr. O'Neill died as a result of carbon monoxide poisoning.

Dr. Begum's reaction to the news of Mr. O'Neill's death was one of complete disbelief. However, the fact of his death did not cause her to doubt the earlier decision to not admit him. In retrospect, given the fact he killed himself, she could say that Mr. O'Neill needed to be admitted. But at the time the decision was made, in her view admission was not in the best interests of Mr. O'Neill. If presented with the same scenario she would not make a different decision on admission. Dr. Begum observed that certain patients with personality issues, because of trauma in childhood, live with fear of rejection and abandonment. They attend hospital in crisis and want to be admitted to hospital for relief. The problem is that when such patients are discharged they experience that as rejection and abandonment. The patient may find that intolerable. The patient may become destabilised and their risk is increased in the long-term. Contrary to common belief hospitalisation is not a neutral form of intervention. Whether to admit or not is a very complex decision. In this case Dr. Begum was of the view that admission would have reinforced Mr. O'Neill's behaviour and done more harm than good.

The fact of Mr. O'Neill's death caused Dr. Coulter to re-examine the decision not to admit him to Christie Ward. Having reviewed the situation, she did not think that decision was the wrong decision to make. Dr. Begum was an experienced doctor and was absolutely competent to undertake the assessment of Mr. O'Neill. It was a very thorough assessment. There weren't really any distinguishing factors which would have helped her and Dr. Begum to know that he would take his life. Even after the event there appeared to be no significant identifiable factors in this regard.

It became apparent whilst Dr. McLachlan was giving his evidence to the Inquiry that he was not aware firstly that Dr. Begum had seen Mr. O'Neill only some eight to nine hours prior to his attendance at the Out-of-Hours Centre, and secondly that Dr. Begum consulted with Dr. Coulter on whether or not to admit Mr. O'Neill, at that time. Nor was he aware of the management plan in place for Mr. O'Neill.

Dr. McLachlan conceded that Mr. O'Neill had been seen very recently in relation to him seeing Mr. O'Neill, which he had not understood previously. Further, Dr. McLachlan conceded that as he hadn't seen Mr. O'Neill at his assessments on Thursday and Saturday he couldn't comment on those difficult decisions on admission at that stage. He wasn't in a position to contradict the reasonableness of those decisions. He observed that he had no doubt Dr. Begum made those decisions diligently, wanting the best care for the patient. Her telephone consultation with Dr. Coulter reinforced his view that Dr. Begum acted diligently. Further, Dr. McLachlan accepted that out-patient follow-up was one of a range of options, and indeed the preferable option if the patient was conducive to that.

However, Dr. McLachlan remained of the view that when Mr. O'Neill attended at the Out-of-Hours Centre he should have been seen then admitted to Christie Ward. Dr. McLachlan's reasonable expectation was that Dr. Begum would see Mr. O'Neill, although he felt that had she done so her decision would have remained not to admit. He said that this was one of the most eminently preventable deaths he had ever been involved in. He was very confidant that if Mr. O'Neill had been admitted he would not have committed suicide within the short time frame to the finding of his body on 6 December 2005. Outwith that time frame, Dr. McLachlan could not say whether or not Mr. O'Neill would have committed suicide. He agreed that admission on Saturday night would have been short-term relief.

Dr. Begum felt that the information conveyed by Dr. McLachlan in his telephone call as to Mr. O'Neill's presentation was the same as before. What he said was consistent with someone with personality issues, whose presentation was designed to gain admission to hospital, and was manipulative round about that. That accorded with her own findings regarding Mr. O'Neill. She felt that if she saw Mr. O'Neill her management plan would be the same. She felt that if she saw Mr. O'Neill that would reinforce and promote his anger towards her, and therefore she refused to see him. He would not have developed a depressive illness in the short space of time since she had last seen him.

Given the fact that Mr. O'Neill went on to commit suicide, in retrospect Dr. Begum felt she should have discussed her decision not to see Mr. O'Neill with Dr. Coulter.

However, she was competent to make the decision not to see him, and did not have any reason to think Dr. Coulter would disagree with that decision.

Dr. Coulter emphasised in her evidence that the policy at Vale of Leven Hospital is a patient should be seen by a junior psychiatrist where referred for assessment by a GP. If the junior psychiatrist feels that he or she should not see the patient then the on-call Senior Consultant must be consulted. In other words a junior psychiatrist cannot decline to see a patient without the approval of the on-call Senior Consultant. As at December 2005 it was not made absolutely clear to junior psychiatrists that consultation must take place before a decision not to see the patient was made, although that was the expectation.

Dr. Coulter's expectation would be that on 4 December 2005 Dr. Begum should have consulted with her before refusing to see Mr. O'Neill. The decision to see or not, was a clinical decision based on the psychiatrist's medical areas of competence and expertise. Given that some three hours of assessment had been carried out over two days it was questionable as to whether or not there was any value in a further assessment a few hours after the last. However, Dr. Coulter's view was that if the GP insisted, the patient should be seen. Having said that, she thought it unlikely that there would be a different outcome if Mr. O'Neill had in fact been seen.

Various events took place after Mr. O'Neill's death. The exact nature and chronology of these events, and how they related to each other was not altogether clear, but factually it appeared that very shortly after Mr. O'Neill's death his family involved their local councillor and MSP, and a complaints procedure was triggered at Vale of Leven Hospital. This procedure apparently included advice not to discuss Mr. O'Neill's case with his family. There was an impression from the evidence that that decision probably exacerbated what was already a traumatic and very difficult time for the family. In addition it appeared from the evidence that at Vale of Leven Hospital a "significant event analysis" was instigated in relation to the case. Matters seem to have been complicated by the fact that NHS Argyll and Clyde was in the process of being dissolved and its services transferred to NHS Greater Glasgow and Clyde. In the meantime Mr. O'Neill's death was reported to the Procurator Fiscal for investigation.

From 1 February 2006 West Dunbartonshire Community Health Partnership became operationally accountable for mental health services for Argyll and Clyde. In March 2006 the Director of the West Dunbartonshire Community Health Partnership, Mr. Keith Redpath, and Dr. Liz Jordan, then Medical Director of NHS Argyll and Clyde, commissioned an external Independent Review of Mr. O'Neill's care over the few days preceding his death. This was carried out by Dr. Stella Clark, the Medical Director of Primary Care, NHS Fife, and a Psychiatrist of over twenty years experience. Dr. Clark reported in April 2006. Production No. 6 is her report. She interpreted her remit as relating to systemic and management issues and reported with recommendations thereon. Eleven separate recommendations were made which prompted the formulation of a managerial and clinical Action Plan in response thereto. Most of the matters raised by Dr. Clark, whilst obviously important, fall outwith the scope of this Inquiry. However, in the context of this Inquiry, three areas of concern were flagged up as requiring further investigation. Firstly, was there a culture of junior psychiatrists refusing to assess referrals from General Practitioners? In this regard it was recommended that a clear policy should be developed and communicated to all medical staff to provide clarity about the responsibility of junior psychiatrists to assess all patients referred to them. Secondly, was there a long-standing issue of mistrust between the medical and psychiatric services? Thirdly, it was recommended that a policy should be developed which would facilitate a critical incident review process across the Hospital and community psychiatric care services, including the early identification of an individual who would take responsibility for contacting the family.

Mr. Redpath spoke in evidence to the Action Plan formulated from the recommendations in Dr. Clark's review. Productions No. 5 and 5A set out the Action Plan, including the action taken and the outcome of that action. The reported culture of junior psychiatrists refusing to assess referrals from General Practitioners was investigated and it was concluded that there was no such culture. In response to the recommendation that there be a clear policy on the responsibility of junior psychiatrists to assess all patients referred to them, Dr. Coulter issued clear written instructions to all junior psychiatrists to the effect that a patient should be seen by a junior psychiatrist where referred for assessment by a General Practitioner. A junior

psychiatrist cannot refuse to see a patient without consulting with and obtaining the approval of a Senior Consultant. On the reported mistrust between the medical and psychiatric services, discussions with senior clinical staff within mental health and acute services did not indicate mistrust between these clinical areas. In relation to the facilitation of a critical incident review process across the psychiatric care services the model now adopted is that of Greater Glasgow Health Board Critical Incident Review process, which includes services having a responsibility for contacting families where appropriate.

Mr. Redpath, together with Dr. Jordan, visited Mrs. O'Neill at about the beginning of March 2006. Mr. Redpath felt that the then existing system had not dealt with this, and that some three months of non-communication with the family was not acceptable

Mr. Redpath, who was personally involved in investigating the reported culture of refusal to see, and the reported mistrust between the medical and psychiatric services, did not accept after investigation that there was a defect in any system of work generally.

On 14 August 2006 an Investigatory Hearing was held to review the issues relating to Dr. Begum's conduct in Mr. O'Neill's case. Dr. Peter Edwards, a Consultant Psychiatrist, attended the Hearing at which Dr. Begum responded to questions concerning her contact with Mr. O'Neill. Dr. Edwards' remit at this Hearing was to comment upon any medical issues which arose.

Dr. Edwards is based at Vale of Leven and Dumbarton Joint Hospital and has some 35 years experience in the field of psychiatry. He is currently the Consultant Psychiatrist with responsibility for developing psychotherapy services, including the training of junior doctors, within his region. Dr. Edwards gave evidence at the Inquiry. He spoke to Production No. 10. His opinion was that he was broadly satisfied that Dr. Begum conducted herself appropriately and in a manner that might be expected of a currently practising medical practitioner of her rank and experience. Further, in making her assessment of Mr. O'Neill Dr. Begum was being asked to do something very difficult. Dr. Edwards thought her approach was reasonable. She certainly wasn't casual. He had no sense of her being unthinking, uncaring or not

thorough. Dr. Edwards did not feel that in her decision not to admit Mr. O'Neill Dr. Begum made a grave error of judgement.

Whilst broadly supportive of Dr. Begum's approach, Dr. Edwards did have some qualifications and observations to make. His qualifications and observations were themselves tempered by the fact that the decisions made by Dr. Begum had to be looked at in their context and hindsight was not necessarily helpful, by the fact that Dr. Edwards did not feel judgemental about the decisions Dr. Begum made and respected the decisions of colleagues not to admit to hospital even where he would have acted differently, and by the fact that he was by nature professionally cautious.

Dr. Edwards' first observation was about the dynamic he sensed between Dr. Begum and Mr. O'Neill, precipitated by Mr. O'Neill's flirtatiousness towards Dr. Begum. Dr. Edwards sensed that that interaction was difficult for Dr. Begum to deal with and caused her to back off. He sensed that for Dr. Begum there was an element of personal discomfort with Mr. O'Neill. In turn he sensed that Mr. O'Neill experienced that as a rejection. It was possible that the male/female dynamic between the two interfered with the objectivity of Dr. Begum's diagnosis. Dr. Edwards also sensed that there was some dynamic going on where Dr. Begum refused what Mr. O'Neill wanted. He suggested that there can sometimes be a power issue between psychiatrist and patient. In that situation it might be easier to have someone like a community nurse come in to diffuse the situation. In interacting with a patient, it is crucial that the Psychiatrist recognises when to take a controlling role – to contain the patient – and when to take a facilitating role – to help the patient to stand on his own two feet. Raising the awareness of Psychiatrists as to how *they* react to, and interact with, patients is a training issue. Psychiatrists have to learn to recognise their own feelings towards the patient and be able to step back, for example if they find themselves becoming critical, angry or exasperated with the patient. Training in this regard is now being addressed as part of Dr. Edwards' current job responsibility.

Secondly, Dr. Edwards felt that a more investigatory approach might have been prudent in this case, because he didn't see the whole picture with Mr. O'Neill. It wasn't clear as to what triggered Mr. O'Neill's mental state at the relevant time. There was a tendency to think dichotomously – to draw a line of mental illness,

whereas in Dr. Edwards' view there is a spectrum of distress. Mr. O'Neill's was a borderline case – he didn't reach the criteria for mental illness, he was responsible for his actions, but he was clearly disturbed. The ambiguity in Mr. O'Neill's case made it difficult to assess. It is a feature of those with personality issues that their condition fluctuates. Sometimes in these borderline cases, the most difficult of cases, the lines drawn to help the diagnosis of mental illness are not always helpful. There is no clear answer in such cases. On the one hand the Psychiatrist is dealing with the assessment of complex clinical states, and on the other complex and unknowable issues such as changing human need and motivation. Clearly it is neither feasible nor appropriate to admit to hospital all who present with threats of self-harm. However, in Mr. O'Neill's case Dr. Edwards felt that as he did not know what Mr. O'Neill's agenda was in continually presenting at the hospital, he may have adopted a more cautious approach.

In this regard there were a number of things which Dr. Edwards might have done. He might not have admitted Mr. O'Neill there and then, but negotiated with him to see him the next morning. At some point in the process of assessment he might have called upon an experienced nursing practitioner, who was not involved in the case, to "get another dynamic" on the case. He might have admitted Mr. O'Neill to observe him over 48 hours. That would contain Mr. O'Neill and give time for a more rounded assessment of what was happening with him. Admission on this basis may not change the assessment, but can make the psychiatrist feel more safe about his decisions. Where the patient is discharged after such admission, there is still the risk that the condition blows up again and the patient kills himself. Dr. Edwards had experience of that very scenario. Thus, even if Mr. O'Neill had been admitted there was no guarantee that the outcome would have been different. His suicide was still a possibility, or even a strong possibility. Even containment in hospital does not guarantee that the patient will not kill himself – Dr. Edwards had direct experience of a patient managing to commit suicide whilst actually in hospital.

Dr. Edwards observed that there are risks associated with admission. There is a risk that where someone is in difficulties in the outside world and is offered security in hospital, a pattern develops. Whenever the person is in crisis, rather than facing up to his issues, he self-harms as a means to gain admission to hospital. In addition, there is a fear that admission in itself can escalate the patient's condition. Dr. Edwards

recognised that this was Dr. Begum's fear in Mr. O'Neill's case. When asked if *he* thought admission would have escalated Mr. O'Neill's condition Dr. Edwards replied "I don't think I know". However, he pointed out that sometimes after admission the patient does get worse, then he wants to leave, then it is necessary to invoke the statutory powers of detention and the patient becomes embroiled in the Mental Health Act and is set on "the career of the psychiatric patient". This is a real fear, and can happen.

Whilst admitting a patient may be beneficial to deepen the assessment, admission is not the only way to do that. Another option would be to refer the patient to an out-patient psychiatrist, and that may in fact be a better option as there would be consistency of exploration by the same psychiatrist. Dr. Edwards saw the formulation of the management plan for the patient as a negotiation between psychiatrist and patient, and that negotiation was in itself an opportunity to assess the patient's reaction to what was proposed. An out-patient appointment was offered in Mr. O'Neill's case. However, the difficulty Dr. Edwards saw was that Mr. O'Neill did not accept what Dr. Begum was offering, so the carrying through of that negotiation was not there.

On Dr. Begum's decision not to see Mr. O'Neill when he re-presented at the hospital on the night of 3-4 December 2005, Dr. Edwards thought it was possible that Dr. Begum might have picked up some change which might have occurred in Mr. O'Neill's presentation, but there was no indication from Dr. McLachlan that Mr. O'Neill's condition had changed. Dr. Edwards thought it was unwise of Dr. Begum not to see Mr. O'Neill because Dr. McLachlan was an experienced "frontline practitioner with concerns". He understood that there was a general assumption that if the GP referred the patient to the on-call psychiatrist, then the on-call psychiatrist would see the patient. It would be the exception not to see the patient.

When asked if admission would have stopped Mr. O'Neill from killing himself, Dr. Edwards responded that things weren't clear, and he couldn't say with any degree of certainty. Nor could he say what might have happened if Dr. Begum had seen Mr. O'Neill on referral by Dr. McLachlan, although it seemed likely that Dr. Begum's decision would be the same. It would have been possible for Dr. Begum to see Mr.

O'Neill with Dr. McLachlan, although given the existing practice, that would have involved thinking "outside the box". It might be that the two professionals wouldn't reach a true consensus, and at the end of the day it was the psychiatrist's decision whether to admit or not. However, Dr. Edwards would have erred on the side of caution where an experienced GP was expressing concerns. If the two professionals seeing the case from their different perspectives couldn't resolve matters, then something was going on.

Submissions on the reasonable precautions, if any, whereby the death might have been avoided

The main area of controversy at the Inquiry related to the reasonable precautions, if any, whereby this death might have been avoided (section 6(1)(c) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976). The arguments focused on the decision not to admit Mr. O'Neill to Christie Ward on 1 and 3 December 2005, and the decision not to see Mr. O'Neill in the early hours of 4 December 2005.

The Procurator Fiscal pointed out that there was evidence that had Mr. O'Neill been admitted on 3 December 2005 his death would probably not have taken place so long as he remained a patient in Christie Ward. However, he submitted that what was critical to a finding under section 6(1)(c) was whether or not Dr. Begum's decision not to admit Mr. O'Neill was unreasonable in the circumstances. The Procurator Fiscal rehearsed Dr. Begum's assessments of Mr. O'Neill, the fact that she had consulted with Dr. Coulter and Dr. Edwards' view as set out in Production No. 10, that he was broadly satisfied with her conduct in carrying out the assessments.

Whilst Dr. Begum accepted with hindsight that she should have consulted with Dr. Coulter before deciding to refuse to see Mr. O'Neill in the early hours of 4 December 2005, she justified her decision not to see Mr. O'Neill. She had seen him only a few hours previously and did not think he would have developed a condition which would require his admission within such a short space of time. To see the patient again might have an adverse effect upon him emotionally. There was some evidence from other psychiatrists to the effect that it would not always be prudent to re-examine a patient.

Dr. Coulter, in her evidence, was not able to say whether or not she would have supported Dr. Begum's decision not to see Mr. O'Neill. Dr. Edward's mentioned it would have been wiser for Dr. Begum to see Mr. O'Neill, although he thought any such re-assessment would not have changed her decision on admission.

The Procurator Fiscal emphasised the words of Dr. Edwards, that presentations such as that of Mr. O'Neill are "not infrequent and are very difficult" and that "It is neither feasible nor appropriate to admit to hospital all who present with threats of self-harm".

The Procurator Fiscal concluded that Dr. Begum was justified in her decision not to admit Mr. O'Neill to Christie Ward, and that whilst such a "precautionary measure" would undoubtedly have prevented his death in the shorter term, Dr. Begum's decision in all the circumstances was reasonably based.

Mr. Cairns argued that it would have been a reasonable precaution to have admitted Mr. O'Neill to Christie Ward at some point between 1 and 4 December 2005. Dr. Begum made two wrong decisions – the decision not to admit and the decision not to see. Those decisions were "outwith the grey area" of decisions. He argued that the only reasonable decision if Dr. Begum had assessed Mr. O'Neill on 4 December 2005 would have been to admit him.

Mr. Cairns based his arguments on the views of Dr. Edwards. On the decision not to admit he highlighted the problematical dynamics between Mr. O'Neill and Dr. Begum. He advised that Mrs. O'Neill thought it beggared belief that her son was jovial and flirtatious with Dr. Begum. Mr. Cairns was content to accept that that was Dr. Begum's view, but submitted that view was a "wrong interpretation" and coloured her entire approach to Mr. O'Neill. Mr. O'Neill would have been looking for care and may have confused Dr. Begum's role as a doctor and her role as a woman – hence the suggestion from Dr. Begum of Mr. O'Neill being flirtatious and challenging her. That "wrong interpretation" created a barrier between the two whereby she was resistant to him and in particular his wish to be admitted. It became almost a battle of wills and the professional, objective approach was not as open as it should have been. Dr. Edwards suggested that there can almost sometimes be a pathological anxiety

about not going along with a patient – a power issue, which is when it would be helpful to involve some one else such as a member of the nursing staff. Mr. Cairns did not suggest that Dr. Begum *deliberately* set out to resist Mr. O'Neill – if she did resist him that may well have been subconscious, but the dynamics between her and Mr. O'Neill skewed her judgement. That skewed picture could have been presented to Dr. Coulter.

Mr. Cairns rehearsed Dr. Edwards' observations on assessments, on what Dr. Edwards might have done, on the process of negotiation between psychiatrist and patient, and on getting another view on the assessment. Whilst Dr. Edwards was broadly supportive of Dr. Begum's approach, Mr. Cairns submitted that that broad support was heavily qualified. Whilst describing Dr. Begum's decision not to admit Mr. O'Neill as "not a grave error of judgement" it was clear that Dr. Edwards did nevertheless regard it as an error of judgement.

Mr. Cairns highlighted the views and experience of Dr. McLachlan, in particular that in Dr. McLachlan's view Mr. O'Neill's death was one of the most eminently preventable deaths that he had ever been involved in. Mr. Cairns submitted that if Dr. McLachlan's evidence was accepted the only conclusion was that Dr. Begum was wrong – and unreasonably so – in declining to see the patient at all. She would also have been wrong – and unreasonably so – if she had seen the patient but had decided not to admit him.

Further, Mr. O'Neill's friends and family all gave evidence as to how seriously they regarded his distress and of their expectation that he should have been admitted. Whilst their views were those of the layman, on the other hand they had had the benefit of seeing Mr. O'Neill and observing his mood.

Mr. Cairns submitted that the reasonable conclusion from the evidence was that Dr. Begum had allowed her professional judgement to be influenced adversely, although perhaps subconsciously, by personal considerations. As a result she did not approach her assessment of Mr. O'Neill in a reasonably open and objective manner. As a result her decision not to admit him to Christie Ward on 1 and 3 December 2005 was wrong and unreasonable, and even more so was her decision not even to see him on 4

December 2005. If she had admitted him on 1 or 3 December, or if she had seen him and admitted him on 4 December, which she should have done, then Mr. O'Neill's death might have been avoided.

Mr. Wightman emphasised that it is not the function of the Inquiry to look for evidence of fault in Mr. O'Neill's clinical management. The exercise of considering whether reasonable precautions were available which might have prevented the death is a wholly different exercise from the resolution of an action of damages for negligence (*Black v. Scott Lithgow Ltd. 1990 SLT 612*).

The first consideration for the court was what constituted a "reasonable precaution". Mr. Wightman submitted that the different exercise of a clinical judgement which later, with hindsight, may be said to have been preferable, cannot now be described as a "precaution". Similarly, if there was a range of reasonable options, and it is now clear that the one chosen was not optimal and another would have been preferable, the court should not select that other preferable choice as the subject matter of a section 6(1)(c) finding.

On the decision not to admit to Christie Ward Mr. Wightman contended that admission was one reasonable option. However, a reasonable psychiatrist of ordinary competence acting reasonably might reasonably have chosen not to admit Mr. O'Neill. That was another reasonable option. The decisions not to admit Mr. O'Neill were made after assessment and, on 3 December 2005, also after consultation with Dr. Coulter. Those decisions were taken at the time in the best interests of Mr. O'Neill. A management plan was put in place. It could not be said that admitting Mr. O'Neill would have been a "reasonable precaution".

On the decision not to re-examine Dr. Begum gave sound clinical reasons for her decision. She had seen him only a few hours before and did not consider that he would have developed a condition requiring admission within that time scale. She considered her assessments were exacerbating Mr. O'Neill's emotional response and that seeing him repeatedly would escalate the situation. The other psychiatrists who gave evidence all agreed that there were situations in which it would be appropriate not to re-examine a patient.

Dr. Begum accepted that she should have obtained the authority of Dr. Coulter before refusing to see Mr. O'Neill. Dr. Coulter did not feel in a position to say whether she would have supported the decision not to re-examine. However, it could not be said from the evidence that on a balance of probabilities a re-examination would have caused Dr. Begum to change her views with regard to admission.

Mr. Wightman pointed out that it was clearly a regular occurrence for someone asking to be admitted to the psychiatric ward to not be admitted. What was extremely rare was for this to result in tragic consequences. The decision on admission was necessarily the decision of the psychiatrist. It was a difficult decision. Only the psychiatrist was qualified and in a position to take a rounded view of the best long-term interests of the patient with regard to their psychiatric care, whilst at the same time weighing up the risk factors. In Mr. O'Neill's case the decision not to admit was taken with his best long-term interests in mind. Dr. Begum weighed the risk factors against the benefits of non-admission and considered that appropriate assessment and treatment was best provided in an out-patient setting.

Mr. Wightman submitted that if it was agreed that the decisions Dr. Begum made were reasonable, it was not necessary to consider whether the death "might have been avoided". However, he pointed out just how rare an occurrence suicide is in patients with similar presentations to Mr. O'Neill. At the time it could not reasonably be foreseen that Mr. O'Neill would take his own life. His mother and his uncle, although aware of his suicidal threats, did not believe he would carry them through. Although his history and condition meant he had a higher risk of suicide than the population at large, that is the case for most if not all patients seen by psychiatric services.

It would, Mr. Wightman submitted, be entirely speculative to consider whether death might have been avoided with hospital admission. The motivation behind Mr. O'Neill taking his life could not be known. His suicide note gave only a limited insight to his motivation, and it was not appropriate to subject that to legal analysis. More could have been known if Mr. O'Neill had been the subject of further assessment, but that further assessment could have taken place either as an in-patient or as an out-patient.

Mr. Wightman's submission was not only that admission could not be considered a "reasonable precaution" in terms of the Act, but also that it was impossible to say that the death might have been avoided if the patient had been admitted.

Determination

In my view it is important to bear in mind, at all times, the scope of any Fatal Accident Inquiry. That scope is statutorily defined in section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (hereinafter "the Act"). Thus it is provided that the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his or her satisfaction, namely:-

(a) where and when the death….took place;
(b) the cause or causes of such death….;
(c) the reasonable precautions, if any, whereby the death….might have been avoided;
(d) the defects, if any, in any system of working which contributed to the death….; and
(e) any other facts which are relevant to the circumstances of the death.

Accordingly, the essential purposes of an Inquiry are to inform the family as to the cause of death, and to inform the public at large, including the family, as to whether any reasonable steps could or should have been taken whereby the death might have been avoided in order that lessons may be learned for the future. In fulfilling those purposes fault may be disclosed, but the Inquiry is not the proper forum for the *determination* of any questions of civil or criminal liability, and it is not the function of the Inquiry to make specific findings of fault or to apportion blame.

At this Inquiry there was no real dispute on the evidence as to where and when the death took place, and the cause of death. Accordingly I have set out those circumstances of the death in terms of section 6(1)(a) and 6(1)(b) of the Act.

For me, one of the disturbing aspects of this Inquiry was just how common it is for patients to present at hospital threatening suicide, or indeed having over-dosed.

For those so presenting at Vale of Leven Hospital all are psychiatrically assessed. The vast majority are discharged after assessment with a treatment plan in place for psychiatric follow-up in the community. Very few are assessed as requiring admission to Christie Ward.

On the evidence it is not at all unusual to have patients demand admission to Christie Ward and make threats when admission is denied. Threats of suicide are common. Threats to kill others are not so common, but have been encountered before. Where such threats are made and the patient is not suffering from a major mental disorder, as in Mr. O'Neill's case, it is obvious that the psychiatrist has a very difficult task in assessing whether or not to admit the patient. As Dr. Edwards noted following the Investigatory Hearing of 14 August 2006 (Production 10):-

> "In my experience presentations like the one under consideration are not infrequent and are very difficult. One is dealing with on the one hand the assessment of complex clinical states and on the other complex and unknowable issues such as changing human need and motivation. Clearly it is neither feasible nor appropriate to admit to hospital all who present with threats of self harm."

Doctor Coulter observed that what was unique about Mr. O'Neill's case was not the nature of the threats he was making, but the fact that he subsequently killed himself in such a short time frame. In twenty four years of practice Dr. Coulter had never before encountered a person not suffering from a major mental illness, threatening suicide and not admitted who had gone on to kill himself shortly thereafter.

That experience was echoed by Dr. Edwards who, in thirty five years in the field of psychiatry, could only recall one other case where the decision was made not to admit a patient with a history of previous self-harm episodes, and the next day the patient made a serious suicide attempt, although did not die.

Clearly, the task of assessing a patient can be an immensely difficult one. In this Inquiry it is not for me to say whether Dr. Begum's decisions in relation to Mr. O'Neill were medically right or wrong. Nor is it for me to decide whether or not she was competent to take such decisions – her competence was never in dispute. It is for me to determine, on the evidence, whether the decisions she made were

reasonable. Were the decisions she made a reasonable exercise of her clinical judgement?

On 1 and 3 December 2005 Dr. Begum was faced with a patient whom she had to assess. On the evidence before me she carried out full and thorough assessments. Her assessment of 3 December 2005 was bolstered by consulting with her Senior Consultant. Whilst there are discrepancies between Dr. Begum and Dr. Coulter regarding their telephone contact on Saturday 3 December 2005, there is no doubt that that contact did take place. I am satisfied on the evidence that all relevant information as to Mr. O'Neill's presentation over both assessments was conveyed to Dr. Coulter in that consultation process. In my view Dr. McLachlan was right to concede that he was not in a position to contradict the reasonableness or otherwise of the decisions not to admit on 1 and 3 December 2005.

It was clear from the evidence that the decision not to admit Mr. O'Neill was not made solely because he did not have a major mental disorder. That was only one factor in arriving at the decision. Another factor was obviously Mr. O'Neill's statement to Dr. Begum that he knew and believed he would not act on his thoughts of harming himself and others. Another factor was the weight to attach to Mr. O'Neill's para-suicide attempt. Another factor was the perception that admission in itself might reinforce his behaviour and do more harm than good in the long-term, increasing his risk.

Deciding whether or not to admit a patient is an exercise of clinical judgement, based on the psychiatrist's medical areas of competence and expertise. Ultimately it is the psychiatrist's decision to make. The decision must necessarily include an assessment of the patient's risk. As I understood the evidence a patient with Mr. O'Neill's presentation will carry a life-time risk of self-harm. There will always be a tendency for that person to take his or her own life. It is for the psychiatrist to assess how best to manage that risk.

It was not my impression from the evidence that Dr. Begum adopted an inflexible and rigid approach to the task of assessment in Mr. O'Neill's case. My impression was that she adopted a holistic approach, including consulting with Dr. Coulter and a

consideration of the possible consequences of admitting Mr. O'Neill. It seems to me eminently reasonable that the psychiatrist should consider the impact of hospital admission upon the patient. As was said in evidence, contrary to common belief hospitalisation is not a neutral intervention. The possibility that admission might aggravate the patient's condition should be considered. Dr. Coulter opined that in the long-term she felt a likely diagnosis for Mr. O'Neill would be that of a personality disorder. If that was to have been his eventual diagnosis that in itself would impact on his management. Dr. Coulter pointed out that hospital admission for those with personality disorders could well lead to an escalation of their situation.

Obviously the assessment of Mr. O'Neill was to be an ongoing process. As I understood the evidence a number of management options might have been put in place for Mr. O'Neill, including ongoing assessment as an in-patient, or as an out-patient. Indeed, in his evidence Dr. Edwards mulled over possible management plans for Mr. O'Neill, including *not* admitting him with a follow-up plan to see him the next day. It is important to note that the decision not to admit Mr. O'Neill was not a decision not to *treat* him. In Mr. O'Neill's case it was recognised that there was a risk of self-harm and suicide. It was accepted that he needed help, and help was provided, although not in the form that he was looking for. In the event a management plan was put in place for psychiatric follow-up on an out-patient basis.

I found Dr. Edwards a singularly impressive witness. I felt he made his measured and tempered observations in an effort to assist the Inquiry, and that is the spirit in which I have taken his views. I have also taken his views subject to his own careful qualifications. I feel it would be a disservice to him to do otherwise, in particular because although what he said made sense, there was a speculative element to some of it. So, whilst very properly flagging up possibilities and areas of concern, I did not take Dr. Edwards to be making judgements. It is important to bear in mind, as I think Dr. Edwards did, that he didn't have direct contact with Mr. O'Neill and wasn't personally privy to the interaction, spoken and unspoken, between Dr. Begum and Mr. O'Neill. It is extremely important to bear in mind that, because of the summary nature of any Inquiry, including the lack of written pleadings which would give advance notice of any line of criticism, Dr. Edward's concerns were not put directly to Dr. Begum for her comment, or indeed to the other psychiatrists who gave evidence.

As has been said before, the court must be cautious of drawing sweeping conclusions from evidence which may be incomplete.

I accept Dr. Begum's evidence that at times during her assessment of Mr. O'Neill on 1 December 2005 he was quite playful and flirtatious. I can see no reason why a person in Dr. Begum's position would make something like that up. Whilst I appreciate that Mrs. O'Neill now says this description "beggared belief", I note that in her evidence to the Inquiry she very fairly conceded that she didn't know how her son behaved at that assessment because she wasn't in the room at the time. I have to consider *on the evidence* what impact Mr. O'Neill's behaviour had on Dr. Begum's decision-making process, bearing in mind that Dr. Begum was not asked directly about this at the Inquiry.

Mr. O'Neill's flirtatiousness was part of the "mismatch" that Dr. Begum observed between his expression of serious thoughts and his objective appearance. In that sense Mr. O'Neill's flirtatiousness was a factor which Dr. Begum took account of in her "mental state examination". I note that Dr. Begum told Dr. Coulter about his flirtatiousness, so that that aspect of the assessment of 1 December was there for Dr. Coulter's consideration, along with all the other aspects of the assessments of 1 and 3 December. But it was not explored in evidence with Dr. Begum whether or not Mr. O'Neill's flirtatiousness skewed the objectivity of her decision-making process. She was not asked how, subjectively, *she* reacted to that behaviour. In the absence of that evidence, I am not prepared to infer that because of his flirtatiousness Dr. Begum did not approach her assessment of Mr. O'Neill in a reasonably open and objective manner. In my view to do otherwise would be an exercise in speculation, not an inference from facts.

In my view on the evidence the decision to treat Mr. O'Neill in the community was a reasoned and reasonable one. Very sadly, Mr. O'Neill committed suicide. Of course, with the benefit of hindsight, it is possible to argue that had Mr. O'Neill been admitted to Christie Ward at some point between 1 and 4 December 2005 his death might have been avoided *for the time he remained in hospital*. However, the fact of his suicide does not make the decision to treat him in the community unreasonable, or indeed make an alternative management plan including admission a "reasonable

precaution". In my view it is not helpful to characterise one reasonable exercise in clinical judgement over another reasonable exercise in clinical judgement as a "reasonable precaution".

Although in submissions before me parties compartmentalised Dr. Begum's decisions into "the decision not to admit" and "the decision not to see", it is important to remember that the decision not to see was predicated upon the two earlier assessments of Mr. O'Neill. In considering the content of the telephone conversation between Dr. Begum and Dr. McLachlan it is possible to see how Dr. Begum thought that she and Dr. McLachlan were more in accord than discord with each other. It is not a criticism, but Dr. McLachlan did not in fact express his opinion on what it was about Mr. O'Neill's presentation clinically which would warrant his admission. Indeed his summary of Mr. O'Neill's presentation, that "the whole flavour of his presentation is very much designed to be admitted and is manipulative round about that" was consistent with Dr. Begum's assessment. As Dr. Edwards put it, there was no indication from Dr. McLachlan that Mr. O'Neill's condition had changed.

Given that Dr. Begum had seen Mr. O'Neill only some eight to nine hours previously, she opined that he would not have developed a depressive illness in the interim period. She felt that if she did see Mr. O'Neill her management plan would be the same. There was some support for Dr. Begum's reasoning from Dr. Coulter, who queried whether, having carried out some three hours of assessment, there was any value in seeing the patient again so soon.

In the context of her refusal to see Mr. O'Neill on 4 December 2005 it was put to Dr. Begum that her approach blinded her to Mr. O'Neill – the man – and that there was a battle of wills between Mr. O'Neill wanting admission and Dr. Begum refusing admission. This was as close as the Inquiry got to exploring directly with Dr. Begum whether or not a personal element was introduced into her decision-making process which skewed its objectivity. In reply, Dr. Begum said that she wasn't biased in her approach and did not accept the characterisation of her decision not to admit Mr. O'Neill as a battle of wills. Rather, she explained that the reason for not admitting Mr. O'Neill was that in her view admission would reinforce Mr. O'Neill's behaviour and do more harm than good. She felt it would be counter-productive to repeatedly see a

patient where her assessment only exacerbated his emotional response. Whether one agrees or disagrees with that reasoning, *on the evidence* I cannot say that, if there was a dynamic between Dr. Begum and Mr. O'Neill, it was such that allowed her professional judgement to be influenced adversely by personal considerations.

Again, it is not for me to decide whether Dr. Begum's decision not to see Mr. O'Neill was medically right or wrong. It is for me to determine, on the evidence, whether that decision was a reasonable exercise of her clinical judgement. The decision not to see Mr. O'Neill was one Dr. Begum was competent to make. In my view the evidence led was not sufficient to allow the inference that that decision was motivated or skewed by personal considerations. Over and above that, it was not in fact my impression from the evidence that the decision not to see Mr. O'Neill was motivated or skewed by personal considerations. It was a clinically reasoned decision, and as such was a reasonable exercise of Dr. Begum's clinical judgement.

That reasonable exercise of clinical judgement does not become unreasonable because it would have been more politic and wiser for Dr. Begum firstly to have consulted with Dr. Coulter and secondly to have seen Mr. O'Neill. Dr. Coulter could not give a definitive answer to the question of whether or not she would have approved Dr. Begum's decision not to see Mr. O'Neill. However, in any event the weight of evidence was to the effect that even if Dr. Begum had seen Mr. O'Neill the likelihood is that she would have adhered to her original management plan not to admit. Here one is entering into the realms of speculation. It is not known on the evidence whether, if Dr. Begum had seen Mr. O'Neill on 4 December 2005, she would have detected any change in his presentation which warranted his admission. It is not possible for me to say on the evidence that had she seen Mr. O'Neill and decided not to admit him that would have been an unreasonable exercise of clinical judgement, let alone a wrong exercise of clinical judgement. On the evidence, I certainly cannot say that the *only* reasonable decision if Dr. Begum had assessed Mr. O'Neill on 4 December 2005 would have been to admit him.

One of the upsetting things about this Inquiry was the sense that it remained unknown as to why Mr. O'Neill chose to take his own life when he did. The risk of suicide was there, but the fact that Mr. O'Neill took his own life in such a short time frame was

not anticipated by either Dr. Begum, or Dr Coulter. Dr. Coulter said that even if Mr. O'Neill had been admitted, she didn't know whether that would have stopped him taking his life, because it was not known why he took his life *at that time*, as opposed to any other time in the eight years he suffered from depression. His suicide note was an indication of how he personally felt at the time he wrote the note, but it was very difficult to say if his note indicated a change in mood from his two assessments. In addition, when looking for possible reasons for the deterioration in Mr. O'Neill's mental condition, and contrary to what might have been expected, evidence led at the Inquiry was to the effect that Mr. O'Neill's history of taking anti-depressant medication on an irregular basis could be discounted in this regard.

Dr. McLachlan clearly recognised when he saw Mr. O'Neill that the latter presented a greater than normal risk of harming himself. However, my impression from Dr. McLachlan was that at the time Mr. O'Neill left him, Dr. McLachlan felt that he had negotiated a management plan with Mr. O'Neill which had the latter's agreement. Mr. O'Neill had agreed to see his General Practitioner on Monday, and to contact the Out-of-Hours Centre if there were further problems. At that time, Dr. McLauchlan hoped that he and Mr. O'Neill had managed to agree a way forward. It was only in hindsight, given the fact of Mr. O'Neill's death, that Dr. McLachlan re-interpreted Mr. O'Neill's polite and reasonable demeanour on leaving as alarming. It was only in hindsight that Dr. McLachlan wished he had been more firm in his statements to Dr. Begum in their telephone conversation.

It is inevitable that everyone involved with Mr. O'Neill in the days preceding his death, whether they were family, friends or professionals, will go through a mental reappraisal along the lines of "what if….." in the light of his death. I can well understand the family's distress and confusion that Mr. O'Neill was not admitted to hospital, when he went on to take his own life. However, hindsight does not necessarily illuminate what was going on at the time. Dr. Edwards opined that even if Mr. O'Neill had been admitted there was no guarantee that the outcome would have been different. His suicide was still a possibility, or even a strong possibility. Mr. O'Neill did not die *because* of the decision not to admit him to hospital. To say otherwise would be to abrogate responsibility for his actions to others, and Mr. O'Neill was a man, who although clearly distressed and disturbed, was responsible for

his own actions. It may be small comfort, but on the evidence I could not say other than that all involved in Mr. O'Neill's medical care made the decisions they made, at the time they made them, with the best interests of Mr. O'Neill at heart. It was not my impression at all that the decisions made in respect of Mr. O'Neill were thoughtless or unreasoned. As Dr. Edwards observed (Production No. 10):-

> "Unfortunately, all practising psychiatrists will encounter situations and outcomes like this on occasion as they are dealing with a high risk and unpredictable population. When there is a tragic outcome it is clearly devastating for the family and friends of the deceased and also affects the health professionals concerned significantly."

Other matters arising from this Inquiry

In terms of section 6(1)(d) of the Act I have to consider the defects, if any, in any system of working which contributed to Mr. O'Neill's death. As a precondition to making any finding under section 6(1)(d) the court must be satisfied that the defect in question *did* in fact cause, or contribute to the death. I have decided that on the evidence the decisions taken by Dr. Begum were a reasonable exercise of her clinical judgement. Accordingly, I am not satisfied on the evidence firstly that the reasoned decisions she made can properly be characterised as "defects in any system of working", and secondly that the reasoned decisions she made did in fact contribute to Mr. O'Neill's death. Nor can I detect in the evidence any other matter which could reasonably be defined as a defect in any system of working which contributed to Mr. O'Neill's death. Accordingly, in my view it would be inappropriate to make any finding in terms of section 6(1)(d) of the Act.

In terms of section 6(1)(e) of the Act I have to consider, so far as established to my satisfaction, any other facts which are relevant to the circumstances of the death. It is not necessary that there be a causal link between such facts and the death. However, in my view to be relevant the facts must have some evidential bearing upon the circumstances of the death.

Dr. Clark's review highlighted matters in relation to the style and standard of note-taking and Dr. Begum's letter of 9 December 2005 to Mr. O'Neill's General Practitoner. These are important matters which deserved to be highlighted and have

now been attended to internally, but they did not in this case have an evidential bearing upon the circumstances of Mr. O'Neill's death. Similarly, there was some evidence about accessing Mr. O'Neill's previous psychiatric records, but again in this case that had no evidential bearing upon the circumstances of his death.

On the evidence in my view it would not be appropriate to make any finding in terms of section 6(1)(e) of the Act.

Whilst in my view the evidence at this Inquiry was not sufficient to justify formal findings in terms of section 6(1)(c), 6(1)(d) and 6(1)(e) of the Act, a number of issues were raised which I feel I should nevertheless mention.

I was satisfied that at Vale of Leven Hospital there is not in fact a "culture" of junior doctors refusing to assess referrals from General Practitioners. The evidence led at the Inquiry did not support a "culture" of refusal to see, and that was not in fact Dr. McLachlan's experience. If there was any dubiety about the responsibility of junior psychiatrists regarding their responsibility to assess patients that has now been clarified by the issuing of written instructions. Having said that various witnesses referred to the apparent perception in psychiatry that admission was an indication of failure or weakness on the part of the admitting psychiatrist. Dr. McLachlan observed that referring to a psychiatrist can be difficult. General Pracitioners perceived a culture within psychiatry to try and manage outwith hospital, and often a resistance to admitting patients. Dr. Edwards observed that "there was a bit of a tradition in psychiatry that if you admit someone you're a failure – you're a bit wimpish". The decision to admit or not is an exercise of clinical judgement. I am sure this is not the case, but it would be worrying if a decision not to admit was based to any degree on a psychiatrist's personal desire not to appear a wimp.

How we personally react to any given situation leads on to Dr. Edwards' very interesting evidence about raising the awareness of psychiatrists to how they react personally to their patients, and vice versa. This is being addressed in the training of psychiatrists, along with training on understanding the potential impact of earlier life experiences on mental state and behaviour. In my view such training can only be a good thing.

It seemed to me that one recurring theme of this Inquiry was communication. It can only be to the overall good if the medical professionals involved in the care of a patient are able to communicate their legitimate concerns, knowing that those legitimate concerns will be taken on board by the decision-maker. Each medical professional might have something to bring to bear on the formulation of the decision. That process of communication should not detract from the responsibility of the decision-maker to make the decision, but it might make the reasoning behind the decision more acceptable. Dr. Edwards opined that consideration be given to complex assessments being made jointly by the duty psychiatrist and an experienced nursing practitioner. In my view it is healthy that such matters should be considered.

Another recurring theme at this Inquiry was negotiation. It seemed to me an important point that in making a clinical decision the patient directly affected should feel that the decision acknowledged his viewpoint and that, in so far as possible, the treatment plan was one with which he was prepared to co-operate. Dr. Edwards spoke of developing an alliance between doctor and patient. It seemed to me that that was a positive thing to strive for in every interaction between doctor and patient.

I am sure that the health professionals involved in this case are already very much attuned to these matters. However, they are of sufficient importance that I feel they should be set down here. It is only right that the very sad circumstances of Mr. O'Neill's death should prompt a reappraisal of how best to care for those with mental health problems.