SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY AT HAMILTON

[2026] FAI 2

HAM-B347-24

DETERMINATION

BY

SHERIFF COLIN DUNIPACE

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

into the death of

KERRY ANN FINNIGAN

Hamilton, 30 October 2025

The sheriff, having resumed consideration of the cause, finds and determines that in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the 2016 Act") the following:

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

That the death of Ms Kerry Ann Finnigan , (hereinafter referred to as "Ms Finnigan") born 18 April 1993, occurred at 18.09 hours on 21 December 2019 at University Hospital, Wishaw (hereinafter "Wishaw Hospital").

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

That the death of Ms Finnigan did not occur as a result of any accident.

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

That the cause of death was:

> A postmortem examination was carried out on the deceased Kerry Finnigan on 9 January 2020 at the Queen Elizabeth University Hospital, Glasgow by Dr Marjorie Turner, Forensic Pathologist, University of Glasgow. The final cause of death was provided as: - 1(a) Hanging

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

No accident caused the death of Ms Finnigan.

(5) In term of section 26(2)(e) of the 2016 Act, (any precautions which (i) could reasonably have been taken and (ii) had they been taken might realistically have resulted in the death being avoided):

In general terms, findings under section 26(2)(e) require a causal connection to be established. Section 26(3) provides that the foreseeability of the death if the precaution were not taken is not required, and the Court may employ hindsight when considering section 26 subsections (2)(e) and (g). The Court must therefore be satisfied that any

precaution, which could reasonably have been taken if there is evidence to justify it, and in taking that precaution meant that the death could have been avoided. The following issues have been identified in the context of the death of Ms Finnigan.

Reduction in Observation Level

On arrival at Wishaw Hospital Ms Finnigan was assessed as being at high risk requiring special observations on 17 December 2019, before being re-assessed as being low risk and being placed on general observations within two days of her admission to Wishaw Hospital, following a risk assessment undertaken on 19 December 2019, by Susan Cochrane, a Senior Charge Nurse. In the first instance this risk assessment was undertaken by the nurse concerned in the absence of access to the Multi-Disciplinary Information System (MiDIS), which was the electronic system containing the electronic medical records of Ms Finnigan, and I accept also in the absence of the important information regarding the previous suicide attempts contained in the Discharge Letter form University Hospital, Monklands (hereinafter "Monklands Hospital") of 15 December 2019.[1] Significantly Senior Charge Nurse Cochrane undertook this assessment without knowledge of, and therefore without reference to, Ms Finnigan's multiple suicide attempts whilst in Monklands Hospital only 48 hours before. It was clear from the evidence that Nurse Cochrane did not take these incidents into account when completing her risk assessment. Accordingly the subsequent decision to reduce

[1] Crown Production Three page 9

Ms Finnigan's observations from constant to general observations with the concomitant re-assessment of her as a being a medium risk of suicide rather than a high or medium/high risk was made without reference to these previous suicide attempts, which were clearly extremely significant factors which related to and would have impacted upon the decision to change the risk category. Unfortunately these attempts were not fully considered or explored and had this information relating to these recent repeated attempts to hang herself been considered, then the outcome of the risk assessment and change in observation status would not in all likelihood have occurred when it did. It was also significant that this reduction in Ms Finnigan's observation level, occurring as it did so soon after her admission to Wishaw Hospital took place before she had been seen by her treating doctor there, without any other safety planning being put in place, or consultation with senior medical staff. It was also done in the absence of knowledge of the terms of the Short-Term Detention Certificate (hereinafter "STDC") completed by Dr Karri, and without any further indication of the outcome of this examination by the consultant psychiatrist in the absence of any notes left by that consultant, or indications provided by them to the nursing staff. The decision to reduce observation levels was effectively ratified by Dr Vusikala when he saw Ms Finnigan on 20 December 2019, and again I am satisfied that this decision to maintain the observation level at "general" and the risk assessment as being "Medium" was made by Dr Vusikala without access to the significant information regarding the recent attempted suicide attempts. The decision to reduce the observation level from "constant" to "general" was a matter which may have directly contributed to Ms Finnigan's death. Had the

nurse who reduced the observation level and the doctor who ratified that decision been aware of the recent previous history of self-harm in Monklands Hospital then a reasonable precaution would have been to keep Ms Finnigan's observation level as constant until a discussion could take place regarding these previous attempts at suicide, and a safety plan put in place, with that decision being reviewed by a consultant psychiatrist**.**

(6) In terms of section 26(2)(f) of the 2016 Act, there were a number of defects in any system of working which contributed to the death.

Findings under section 26(2)(f) require a direct causal connection between any such defect and the death or accident, and the Court must be satisfied that the defect in question did, in fact, contribute to the death. The following defects did contribute to the death of Ms Finnigan.

The Standard of Record Keeping

The records from Monklands Hospital were often unclear and contained insufficient detail regarding important aspects of the care of Ms Finnigan. The records were often non-consequential and in particular did not include sufficient details regarding the observation status of Ms Finnigan. There was also insufficient clear information regarding the attempted hanging episodes in Monklands Hospital. There were four separate attempts made by Ms Finnigan, but none of these were recorded in sufficient detail to properly inform future care. The information in relation to the observations of

Ms Finnigan was particularly lacking, in respect that it did not comply with NHS Lanarkshire's "Clinical Observation and Engagement Policy & Guidelines for Best Practice" from 2019, adherence to which required that a "Patient Observation Recording Sheet" was due to be completed in relation to all patients on enhanced observations was not completed. The completion of this Sheet would further have enhanced the information sharing with future care planners and would have fully informed decision makers regarding the repeated suicide attempts by Ms Finnigan. Further there was a lack of review and associated documentation by a Senior Medical or Psychiatric Consultant or by the PLNS. In particular there was also no formal transfer documentation from the Psychiatric Liaison Nurse Service (hereinafter "PLNS") to Wishaw Hospital. The Discharge Letter issued by Monklands Hospital, which contained important information about the suicide attempts was not passed timeously to Wishaw Hospital. Accordingly the information relating to the suicide attempts was not transmitted to Wishaw Hospital, except in the body of the Emergency Detention Certificate (hereinafter the "EDC") which was not included in the electronic records maintained by the Hospital and was clearly missed by the treating staff at Wishaw Hospital. Further there was no contemporaneous reference in the records by the Approved Medical Practitioner (hereinafter the "AMP"), which were not recorded in either electronic or written format other than in the body of the STDC itself. In general there was a clear disconnect between the information held and shared between the two hospitals which led to important information from Monklands Hospital in relation to the repeated suicide attempts not being available to Wishaw Hospital. There was also no

record of the reasons why Ms Finnigan's risk level had been reduced from "Medium" to "Low" on 20 December 2019.

A Lack of Oversight by Senior Medical Practitioner

Despite being admitted to Ward Two in Wishaw Hospital on Tuesday 17 December 2019, Ms Finnigan was not seen by a senior clinician and a plan agreed in terms of a way forward for her until Friday 20 December 2019, a period of some three days, with the exception of her being seen by the duty AMP, which was a separate and restricted examination, and not directly related to her care. Dr Vusikala was Ms Finnigan's Responsible Medical Officer (RMO), responsible for her care and treatment while in Wishaw Hospital but he did not meet with her until Friday 20th December 2019, given that at that time that he was present on Ward Two only on Mondays and Fridays. It is noticeable and welcome that Dr Vusikala now attends on five days a week (Monday – Friday). While Dr Karri as the duty AMP, saw Ms Finnigan on Ward Two on Wednesday 18 December 2019 it was clear from his evidence that this was solely for the limited purpose of a STDC assessment being made and he considered that he was to play no part whatsoever in her care and future planning, his sole role being to provide assessments for urgent Mental Health Act work for people such as Ms Finnigan who needed to be detained. Accordingly, while the role of the AMP was separate from that of the treating doctors, however it was important for the treating team to be aware of the AMP's assessment, decision, and reasons for that decision. Dr Karri clearly considered that the AMP's responsibility was solely to determine whether detention under the

Mental Health Act was necessary, and his role therefore was more limited than that of the RMO. While occasionally, an AMP could adjust a care plan, especially to mitigate risks, the responsibility to prepare and amend the care plan of a patient rested with the patient's RMO. In deciding whether to detain a patient, the AMP would undertake a full assessment of the patient's mental state, and a reasonably full psychiatric assessment, focussing on the five criteria for detention, whereas a full psychiatric assessment undertaken by the patient's RMO was focused, not on these criteria, but on formulating a treatment plan. This latter type of assessment delved more deeply into a patient's history, family history, etc. In-patients should be seen by a treating consultant as soon as possible to allow them, with support from the nursing team to formulate a care plan as necessary. By way of contrast as pointed out by Dr Palin, in areas such as NHS Grampian, patients will have a senior review within 24 hours, to enable a senior clinician to make clear plans for that person which can then be followed until the RMO comes in to assess them. In Ms Finnigan's case the only senior clinical assessment in relation to Ms Finnigan's care was carried out by a consultant psychiatrist three days after her admission to Wishaw Hospital, and it is a matter of great concern that having been admitted on Tuesday 18 December 2019 that it was three days later that Ms Finnigan was seen by her RMO to discuss her care plan, particularly in the context of someone being admitted to a psychiatric hospital. Whilst seen by the AMP, it was clear from the evidence of Dr Karri that the role of the AMP in NHS Lanarkshire was more restrictive than in other parts of the country, such as NHS Grampian. In the context of the lack of oversight from a senior medical practitioner of this patient with regards to

how she should be treated or what care plan should be in place until some three days after her admission, this clearly was a systematic issue at the time of Ms Finnigan's death. This lack of oversight directly related to the lack of knowledge and understanding surrounding Ms Finnigan and particularly her immediate psychiatric history and recent suicide attempts and was ultimately a contributing factor in her death.

The Decision to Remove Observations from Constant to General

Whilst the Risk assessment carried out by Nurse Cochrane on 19 December 2019 was of a high standard and the decision made was said to have been justified on the basis of the available information, it was apparent from the evidence that the decision was made in the absence of crucial evidence, namely that Ms Finnigan had made four attempts to end her life a matter of days before the assessment whilst she was in Monklands Hospital. I did not accept the evidence of Nurse Cochrane to the effect that she had taken this information into account when reducing the observation level and changing the risk assessment. Such a significant level of apparent suicide attempts apparently caused by psychotic illness would in all likelihood have resulted in a different outcome to the Risk Assessment or at least delayed such a decision to allow a more detailed assessment of Ms Finnigan's mental state. It was also a concern that the decision was made within such a short period of time after these attempts and before Ms Finnigan had been assessed by a consultant psychiatrist. Similarly I accept that the decision not to alter

these observation and risk levels by Dr Vusikala on 20 December 2019 was made by him in the absence of knowledge of these suicide attempts.

(7) In terms of Section 26(2)(g) there are other facts which are relevant to the circumstances of the death

Failure of Goelst G-Rail 4100 Load Release System Curtain Rail to Collapse The failure of the aforementioned shower rail to collapse is a matter relevant to the circumstances of Ms Finnigan's death. It was clear from a number of expert witnesses that there was some dispute as to the precise reason that the shower rail did not collapse, although one thing not in dispute was that it did not collapse, allowing it to be used by Ms Finnigan as a fixed ligature point to facilitate her death by hanging. On a balance of probabilities it is likely that the shower curtain rail failed to collapse due to the non-vertical application of weight. Accordingly the shower rail designed to be 'anti-ligature' failed to collapse which tragically led to Ms Finnigan being able to use the rail to complete suicide.

(8) In terms of section 26(1)(b) and 26(4) of the 2016 Act I have recommendations which might realistically prevent other deaths in similar circumstances arising from the evidence.

5.1 The court can make recommendations as to (a) the taking of reasonable precautions, (b) the making of improvements to any system of working, (c) the introduction of a

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

I make the following recommendations.

Recommendation One

All patients admitted to a psychiatric ward within NHS Lanarkshire should be reviewed by a senior clinician within at least 24 hours of admission, a policy, which has been seen to work successfully in other NHS areas such as NHS Grampian. Such a policy would ensure that admitted patients to hospital would have a senior review within 24 hours, thereby enabling a senior clinician to formulate clear plans for that person which can then be followed until a RMO comes on the ward. This level of oversight from an approved medical practitioner at the beginning of admission would have alleviated some of the issues outlined above.

Recommendation Two

All Goelst G-Rail 4100 Load Release System Curtain Rails that are currently in operation within NHS Scotland should be replaced with alternative models. While it has not been possible to definitively resolve the exact reason why this shower rail failed to collapse in the present case, it is likely that it did so because the weight attached to it was not applied vertically allowing the fitting to be used as a ligature point. The fact that it did not and Ms Finnigan was able to use it to complete suicide demonstrates that the system presented a danger in itself, and it was noticeable that the previous an Estates and

Facilities Alert (hereinafter referred to as "EFA") issued in March 2019 identified a similar failure to collapse on a number of occasions when weights were applied at an angle. Patients admitted to psychiatric wards are some of the most vulnerable patients in the country, and the risk of suicide will always be higher with such patients, which is why measures such as the fitting of anti-ligature shower rails within psychiatric wards are put in place to keep them safe. It has been acknowledged by Mr Gray that following their investigation that immediate action was taken to replace these shower rail models within NHS Lanarkshire. Given the concerns that these particular shower curtain rails may still be in operation elsewhere in the country, I would recommend that immediate steps should be taken to replace these in every psychiatric ward.

Recommendation Three

A review of the Clinical Observation and Engagement Policy and Guidelines for Best Practice' for use by the NHS Lanarkshire Mental Health and Learning Disability Service should take place within NHS Lanarkshire. Given that all hospitals have at least the potential to deal with patients experiencing mental health difficulties, the aforementioned Policy should apply across all of the facilities and not just in a mental health setting. In the present instance there was clearly confusion as to whether the observations policy was being followed, and a review of the policy should take place to ensure that there was sufficient oversight of patients with mental health issues being treated within a medical setting. In particular the use of the Patient Observation Recording Sheet should be mandatory whenever patients are on enhanced observations,

to ensure that critical information relating to events during these periods of observation are not lost.

Recommendation Four

A review should be undertaken in respect of the PLNS's role in transferring patients from acute medical ward to psychiatric wards within NHS Lanarkshire, and in relation to the role and interface of the PLNS and Liaison Psychiatry in general within acute psychiatric inpatient services. It was clear that there was significant confusion amongst PLNS nursing staff who gave evidence at the Inquiry as to the extent of their involvement when a patient was being transferred between hospitals or even between wards, particularly in relation to the difference between agreeing admission and arranging it. NHS Lanarkshire should develop and have in place a policy which should set out how and what is done in this regard and by whom, and to provide clear guidelines as to role of PLNS in the transfer process, and in relation to information being passed.

Recommendation Five

The role of the duty AMP Service within Wishaw Hospital and within NHS Lanarkshire in general should be reviewed, and consideration given to extending its current extremely limited role in relation to seeing patients and placing them on STDCs if appropriate. It was clear from the evidence of Dr Karri that he considered that the role of the AMP in NHS Lanarkshire was more restrictive than in other parts of the country,

such as NHS Grampian. When assessing patients, particularly when they have not already been seen by a senior clinician or are unlikely to be seen by a senior clinician for some days, their ambit should be extended to include the development of a care plan in appropriate cases. It should not be the case that a patient presenting to a psychiatric hospital in such a disturbed condition should be waiting for three days before being seen by a senior clinician to develop their care plan.

NOTE:

Introduction

[1] This was a discretionary inquiry held under section 4 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 (hereinafter referred to as "the Act") a death having occurred in Scotland in circumstances giving rise to serious public concern. The Lord Advocate has decided it therefore to be in the public interest for an Inquiry to be held into the circumstances of the death. The procedures to be followed in such inquiries are governed by the provisions of the Act and the Act of Sederunt (Fatal Accident Inquiries Rules) 2017. The purpose of such an Inquiry is to establish the circumstances of the death and to consider what steps, if any, may be taken to prevent other deaths occurring in similar circumstances. Section 26 requires the sheriff to make a determination and section 26(2) sets out the factors relevant to the circumstances of death insofar as they have been established to the satisfaction of the sheriff and which are set out above. The Sheriff has to be satisfied on balance of probabilities of whether there were any precautions which (i) could reasonably have been taken and (ii) had they

been taken might realistically have resulted in the death being avoided or defects in the system of working which contributed to the death and whether there is a reasonable possibility that any recommendations made may prevent deaths in similar circumstances in the future. The scope of the inquiry therefore extends beyond simply establishing the facts relevant to the death of Ms Kerry Finnigan. It is also to ascertain whether steps could be taken to ensure that future deaths occurring in the circumstances or similar circumstances could be prevented, and to restore public confidence and allay public anxiety arises from the circumstances of the death of Ms Kerry Finnigan

[2] The determination is limited to the matters defined in section 26 of the Act which also provides that the determination shall not be founded on in any judicial proceedings of any nature, thus encouraging full and open exploration of the circumstances of a death.

The proceedings and the parties

[3] In terms of the procedural history, this Inquiry went through various preliminary hearings at Hamilton Sheriff Court before the Inquiry itself which took place on 12, 13, 14, 15, and 16 May and 9 June 2025. A Hearing on Submissions took place on 26 August 2025. The various parties were represented as follows:

1. Ms E Sweeney, Procurator Fiscal Depute, represented the Crown;
2. Mr A Rodgers, represented the next-of-kin, Alex Finnigan;
3. Ms E Toner (Counsel) represented Goelst UK Ltd;
4. Ms Y Waugh (Counsel) represented Lanarkshire Health Board

5. Ms V Arnott (Counsel) represented Dr Karri;

6. Mr M Walker represented Dr Vusikala

The sources of evidence

[4] A joint minute of agreement, a copy of which is attached hereto as Appendix A, was entered into by the parties., and I thereafter heard evidence from fifteen witnesses who all gave evidence in person on the following dates at Hamilton Sheriff Court, namely:

1. Ms Lynn Munro or Robertson on 12 May 2025
2. Ms Emma Creilly on 12 May 2025
3. Dr Catriona Sykes on 12 May 2025
4. Mr John Truesdale on 13 May 2025
5. Ms Lynn Wyllie on 13 May 2025
6. Mr Ian Munro on 13 May 2025
7. Ms Nicole Steele on 14 May 2025
8. Dr Ravi Karri on 14 May 2025
9. Ms Susane Cochrane on 14 May 2025
10. Dr Sudhir Vusikala on 15 May 2025
11. Ms Lisa Fenwick on 15 May 2025
12. Dr Alastair Palin on 16 May 2025
13. Professor Anthony Pelosi on 16 May 2025
14. Mr Gordon Gray on 9 June 2025

15. Mr John Holland on 9 June 2025 (witness for Goelst UK)

Affidavit only evidence was also led in respect of the following witnesses:

1. Elsie Donnelly
2. Dr Conor McKeag
3. Lee McSherry
4. Mark Reeves

I would like to state at this stage that I am extremely grateful to all parties for their assistance in the preparation and professional conduct of this Inquiry.

The legal framework/the purpose of this Inquiry

[5] This Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. The 2016 Act and the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 govern Fatal Accident Inquiries. The purpose of the Inquiry in terms of section 1(3) is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the Inquiry is not to establish blame or civil or criminal liability. The process is inquisitorial in character. The Procurator Fiscal represents the public interest at the Inquiry.

[6] As regards the circumstances, a sheriff must make findings regarding:

(a) when and where the death occurred;

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

(c) the cause or causes of the death;

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

(e) any precautions which –

(i) could reasonably have been taken, and

(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

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

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

[7] In terms of section 26(4) the sheriff is entitled to make recommendations regarding:

(a) the taking of reasonable precautions;

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

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

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

Factual Background

[8] Having heard the evidence and having considered the terms of the detailed Joint Minute prepared between the parties, I found the following facts to be established.

(1) At the time of her death, Ms Kerry Ann Finnigan (Ms Finnigan) was 26 years old, having been born on 18 April 1993. She had graduated from the University of Glasgow with a degree in English Literature in 2018, and resided in

Coatbridge, North Lanarkshire with her father and younger sister.[2]
Ms Finnigan's mother had passed away eight years previously, Ms Finnigan having discovered her dead in her bath at that time. [3]

(2) Ms Finnigan reported no long standing reported previous psychiatric history, although in the weeks immediately preceding her death, she had noted a deterioration in her mental health, which included bizarre and agitated behaviour.[4] On 30 November 2019, she had attended a party where she believed that she may have taken cocaine, ecstasy, drugs with psychedelic qualities and possibly been administered Rohypnol, which she reported had resulted in a decline in her mental health.[5]

(3) On 14 December 2019 Ms Finnigan contacted NHS 24, speaking to a Psychiatric Liaison Nurse and reporting that she had been experiencing feelings of paranoia over the preceding two weeks following her attendance at the aforementioned party where she may have consumed cocaine and other drugs with psychedelic properties. She was not assessed as having any active suicidal intent or plans at that time and was offered advice on the services available to her through NHS Lanarkshire's route to services.[6]

(4) At 11:47 on 15 December 2019 Ms Finnigan was brought to University Hospital, Monklands Accident & Emergency Department (Monklands Hospital)

[2] Crown Production Four page138
[3] Crown Production Three page 21
[4] Crown Production Four page 164
[5] Crown Production Four pages 140 & 164
[6] Crown Production Five page 286

by police officers, [7] and by her aunt.[8] It was reported that she had been punching herself to the head and had used a kitchen knife to cut her wrists. The initial triage assessment of Ms Finnigan was undertaken by Nurse Elsie Donnelly at 12.20, who recorded she was having intrusive thoughts that day about harming herself and others, causing the police to be called to her house, although she denied these thoughts at the time of triage.[9] On presentation she bore wounds to her forearm occasioned by self-injury.[10] She denied any past psychiatric history,[11] and was assessed at that time as a "Category Three - Moderate Risk," in relation her being obviously distressed, markedly anxious or highly aroused. [12] The risk assessment wrongly recorded "No" in relation to the question about a history of violence or self-harm.

(5) Ms Finnigan was seen by an unspecified Junior Doctor (Clinical Development Fellow), who recorded that she told them that she had discovered her mother dead in a bath 8 years prior, and that her mother had suffered from severe depression and Obsessive-Compulsive Disorder tendencies.[13]

Ms Finnigan described four weeks of deteriorating mental health with worsening sleep and appetite.[14] She lived with her father who had observed her having

[7] Crown Production Three page 12
[8] Crown Production Three page 12
[9] Crown Production Three page 12
[10] Crown Production Three page 12
[11] Crown Production Three page 12
[12] Crown Production Three page 12
[13] Crown Production Three page 21
[14] Crown Production Three page 21

paranoid delusions.[15] She reported concerns that people were outside speaking about her, although these were not threatening voices.[16] There were concerns expressed about her appearance. [17]

(6) During the consultation, Ms Finnigan referenced possible sexual activity without her knowledge due to alcohol, cocaine and MDMA use and a lack of recollection on her part.[18] She was noted to be possibly paranoid with concerns over her social circle falling out with her. [19] She reported no active wishes to act on images/ intrusive thoughts to self-harm and was agreeable to remaining in the Emergency Department. She reported no clear plans for suicide, only for knife associated self-harm.[20]

(7) The aforementioned doctor discussed Ms Finnigan's case with the Mental Health Assessment Team at Monklands Hospital and at 14.30 that day a joint assessment of Ms Finnigan was undertaken by John Truesdale from PLNS and Advanced Nurse Practitioner Jade Glassford,[21] given the alleged seriousness of the symptoms and the potential need for her to be admitted.[22] Following advice from Dr Eplida Papadantonaki, a Senior House Officer (SHO) based at University Hospital Wishaw, blood samples were requested to rule out

[15] Crown Production Three page 21
[16] Crown Production Three page 21
[17] Crown Production Three page 21
[18] Crown Production Three page21
[19] Crown Production Three page 21
[20] Crown Production Three page 21
[21] Crown Production Four page 170
[22] Crown Production Four page170

contributory medical factors.[23] Given that her bloods appeared deranged, she was reviewed by Dr Laura McGregor to ascertain whether there was a physical cause for her presentation and abnormal thoughts, or whether a psychiatric condition was more likely.[24] It was noted by Nurse Truesdale that they completed Adult With Incapacity (AWI) documentation as well as an Emergency Detention Certificate (EDC), this latter point being incorrect as the EDC was only considered later. The entry noted that Ms Finnigan would be "specialled" overnight, and that best practice would be for this to be with a Registered Mental Health Nurse (RMN) although it could be pamova trained staff if this could not be sourced.[25] The note recorded a request that PLNS have contact the following day for an update on Ms Finnigan's presentation and wellbeing. [26]

(8) Dr McGregor examined Ms Finnigan in the A&E Department at 18.00[27] noting that she appeared floridly psychotic and was without capacity, believing she had a GPS transmitter connected to the police in her brain allowing them to survey her.[28] Ms Finnigan told Dr McGregor she was worried that her sister was going to be murdered and she wanted to leave hospital to rescue her.[29]

Dr McGregor noted concerns about Ms Finnigan's blood results and recorded

[23] Crown Production Four page170
[24] Crown Production Four page 170
[25] Crown Production Four page 170
[26] Crown Production Four page 170
[27] Crown Production Three page 16
[28] Crown Production Three page 16
[29] Crown Production Three page 16

that the abnormalities were due to hyperventilation, self-neglect and not eating.[30] Her white blood cell count was elevated.[31]

(9) Given Dr McGregor could not completely exclude physical causes, she spoke with Consultant Physician Dr Catriona Sykes regarding admitting Ms Finnigan under Medicine with input from the Psychiatry Team.[32] Dr McGregor prescribed oral diazepam given that Ms Finnigan was at that point trying to leave A&E and still hyperventilating.[33] Dr McGregor completed the AWI form[34] following discussions with Ms Finnigan, her father and Dr Sykes.[35] The reason for incapacity was recorded as being acute psychosis symptoms, delusional ideas of persecution, confusion and paranoia which may be due to an organic cause. The incapacity was said to be likely to continue for two days. [36]

(10) Dr Sykes met with Ms Finnigan on 15 December 2019 at an unspecified time, and recorded that she complaining of intrusive thoughts, thought people were following her, hearing voices, thought of harming herself and others, and believed GPS was controlling her thoughts.[37] She had some facial abrasions and self-harm to her arms.[38] Dr Sykes noted that as this was Ms Finnigan's first presentation with psychosis, that it was important to exclude organic causes such

[30] Crown Production Three page18
[31] Crown Production Three page 18
[32] Crown Production Three page 18
[33] Crown Production Three page 18
[34] Crown Production Three page 79
[35] Crown Production Three page 18
[36] Crown Production Three page 79
[37] Crown Production Three page 40
[38] Crown Production Three page 40

as encephalitis prior to offering a psychiatric diagnosis. [39] She confirmed contact with the On-call Psychiatric Team who suggested detention under the Mental Health Act, and there was a note stating RMN to "special" if possible, with a suggestion that there should be a lumbar puncture.[40]

(11) Dr Papadantonaki discussed Ms Finnigan's case with Dr Sykes over the phone,[41] and Dr Sykes considering that she required admission under medicine overnight for monitoring and further investigations (including a lumbar puncture) to exclude encephalitis.[42] Dr Sykes confirmed that an AWI was already in place.[43]

(12) Dr Papadantonaki suggested that an Emergency Detention Certificate (EDC) should be considered and recorded that Dr Sykes confirmed one be put one in place.[44] Dr Papadantonaki further recorded encouraging Dr Sykes to get a registered mental health nurse (RMN) to "special" Ms Finnigan overnight and that the duty doctor in Wishaw or on call consultant could be contacted overnight if further assistance was required.[45] Dr Papadantonaki noted that if all medical investigations had been completed and if Ms Finnigan was deemed medically fit, that she could be transferred to psychiatry in University Hospital Wishaw.[46]

---

[39] Crown Production Three page 40
[40] Crown Production Three page 41
[41] Crown Production Four page 162
[42] Crown Production Four page 162
[43] Crown Production Four page 162
[44] Crown Production Four page 162
[45] Crown Production Four page 162
[46] Crown Production Four page 162

(13) At 21:20, Dr McGinley an FY2 grade doctor, discussed detention of Ms Finnigan under an Emergency Detention Certificate (EDC) with a Mental Health Officer (MHO).[47] The MHO declined to support this at this time given Ms Finnigan was amenable to remaining in hospital voluntarily for further investigations and was taking medication which helped with her agitation.[48] The doctor noted that they would wish a further assessment for an EDC if she became agitated and attempted to leave, although at that time she had insight and was willing to stay. [49]

(14) Ms Finnigan was admitted to Monklands Hospital at 22:00 on 15 December 2018.[50] A nursing record made at 23:00 noted that she seemed paranoid but was comfortable and not agitated and had been placed in a side room to avoid upset or agitation. [51] It was noted that she did not require sedation and that reassurance from staff was adequate. It was noted that staff would continue to monitor, although these notes did not address the observation status of Ms Finnigan on 15 December 2019, nor say when this would be reviewed.

(15) A further record by Dr Papadantonaki at 22.11,[52] referred to a phone call from PLNS Nurse Truesdale, referring to his review of Ms Finnigan with Nurse

[47] Crown Production Three page 42
[48] Crown Production Three page 42
[49] Crown Production Three page 42
[50] Crown Production Three page 23
[51] Crown Production Three page 42
[52] Crown Production Four page 162

Glassford. The doctor referred to the fact that Ms Finnigan had attended at A & E with her family due to concerns about bizarre behaviour. Nurse Truesdale had indicated that she seemed preoccupied and easily startled and that she was describing auditory and visual hallucinations, and paranoid ideas. She admitted taking unknown substances on 30 November 2019 (cocaine/spice) and had felt "spacey" since. She had neglected herself with strong body odour. She had superficial self-harm marks to her arms. She was noted to have no psychiatric history, and as being medically fit. The A & E consultant had referred Ms Finnigan to Dr Sykes, and in the meantime, she had become agitated and was trying to leave, talking about having a chip implanted in her head. Dr Sykes suggested that Ms Finnigan required to be admitted overnight for monitoring and further investigations, including a lumbar puncture. Dr Sykes had put in place an AWI and Dr Papadantonaki suggested an EDC, appropriate medication, encouraging Dr Sykes to get a RMN to special Ms Finnigan overnight, saying that she could contact her or the on-call consultant at Wishaw Hospital overnight if further assistance was required. [53]

Monday 16 December 2019

(16) Ms Finnigan was admitted to the Acute Medical Receiving Unit (AMRU) at Monklands Hospital at 02:30 on 16 December 2019.[54] A Person-Centred Care

[53] Crown Production Four page 162
[54] Crown Production Three page 62

Plan was completed at that time,[55] and it was noted that she was admitted with a query about psychosis and organic causes, with an AWI in place. There were no concerns noted at that time.[56] At an unspecified time in the morning it was noted that Ms Finnigan was agitated and that she had been found in toilet with a cord around her neck. It stated that there was now a nurse in attendance to monitor her and that they were awaiting the mental health team.[57]

(17) At 11:08, Ms Finnigan was reviewed by Dr Conor McKeag, a 2nd Year locum core trainee,[58] who noted that she was floridly psychotic and displaying paranoia.[59] It was stated that she had indicated that she did not want to die immediately, citing her sister and father as protective factors, but implied that she would like to kill herself when her affairs were in order.[60] This note also stated "this am – found in bathroom attempted to hang self."[61]

(18) At 16:00, Ms Finnigan had a lumbar puncture procedure performed.[62] At 23:55, it was recorded that she remained agitated and tearful and was currently being "specialed" and given medication. [63] Ms Finnigan had no senior medical or psychiatry review on 16 December 2019 and PLNS did not visit her that day as

[55] Crown Production Three page 57
[56] Crown Production Three page 62
[57] Crown Production Three page 62
[58] Crown Production Three page 43
[59] Crown Production Three page 43
[60] Crown Production Three page 43
[61] Crown Production Three page 43
[62] Crown Production Three page 43
[63] Crown Production Three page 43

had been planned the day prior. These latter entries made no reference to the observation status of Ms Finnigan.

Events of Tuesday 17 December 2019 – University Hospital Monklands

(19) At 04:10 on 17 December 2019 it was recorded in Ms Finnigan's Admission Record that Ms Finnigan had attempted suicide four times in the past 24 hours.[64] It was not specified whether a doctor or a nurse had made this note. No further specification was provided in relation to these attempts. It was also stated that further strong medication be given as Ms Finnigan was acutely psychotic, [65] and that Ms Finnigan had been detained under the Mental Health Act. [66] In relation to the fourth attempt, she had wrapped a shower head and tubing around her neck which had to be removed by three staff members.[67] The record noted that the medical registrar and mental health liaison nurse had been contacted and that Ms Finnigan, was now detained under the Mental Health Act.[68] The entry concluded by stating that Ms Finnigan was now sitting in bed staring at the ceiling.[69] No other entries in Ms Finnigan's medical records denote attempts at suicide on any other occasion, prior to this date and time.

(20) At 04:20 on 17 January 2019, PLNS Nurse Lynne Wyllie prepared a handwritten note referring to attending with Ms Finnigan after being contacted

[64] Crown Production Three page 44
[65] Crown Production Three page 44
[66] Crown Production Three page 44
[67] Crown Production Three page 62
[68] Crown Production Three page 62
[69] Crown Production Three page 44

for management support and advice,[70] and noting that Ms Finnigan appeared floridly psychotic, and was responding to unseen stimuli. Thought broadcasting was also evident and Ms Finnigan believed people could read her mind, and that an object had been inserted into her. Her speech content was nonsensical at times, and she couldn't bear the thought that people could read her dark thoughts. She believed she could see dead babies and felt that people were watching her. She was reported to be acutely agitated, distracted and pre-occupied with evident paranoid ideation, with medication provided to reduce agitation not working. The nurse recorded that she advised the medic to utilise an EDC due to acute psychiatric presentation, impaired capacity and lack of insight. It was also advised to maintain special observation and attempt to remove any ligatures if possible. Staff were advised to contact PLNS for further management/support.[71]

(21) Nurse Wylie prepared a typed note of this meeting at 04.53,[72] stating that Ms Finnigan had advised being at a party on 30 November 2019 and thought someone had injected 'something' in to her head and that she was given Rohypnol; she had also possibly taken cocaine.[73] Given her acute agitation, Nurse Wyllie suggested 2mg of lorazepam be administered orally.[74] Whilst

[70] Crown Production Three page 45; Crown Production Four page 169
[71] Crown Production Three page 45
[72] Crown Production Four page 169
[73] Crown Production Four page 169
[74] Crown Production Four page 169

administered around 03:20, by 04:10 it had had no settling effect. In addition haloperidol was administered with no settling effect.[75]

(22) Nurse Lynne Wyllie advised the medics to utilise an EDC given Ms Finnigan's acute psychiatric presentation and lack of capacity and insight.[76] She encouraged staff to maintain special observations and obtain a mental health nurse, if possible,[77] advising the ward to contact PLNS if further management was required.[78]

(23) An EDC was completed in respect of Ms Finnigan, providing the duration of the detention to be between 17 December 2019 at 04:10 and 20 December 2019 at 04:10.[79] The EDC noted that: 'Patient has suicidal ideations and has tried to hang herself 4x on the ward. Hearing voices, believes people are watching her'.[80] It also stated that Ms Finnigan had ongoing suicidal action, and was not aware of what was real/ what was hallucinations. [81] The detention was required as Ms Finnigan needed medical treatment and was trying to leave,[82] and the certificate recorded that she had been reviewed by the mental health liaison officer who found that she was psychotic and that there was no other option for patient safety. [83]

---

[75] Crown Production Four page 169
[76] Crown Production Four page 169
[77] Crown Production Four page 169
[78] Crown Production Four page 169
[79] Crown Production Three page 102
[80] Crown Production Three page 104
[81] Crown Production Three page 104
[82] Crown Production Three page 104
[83] Crown Production Three page 106

(24) Dr McKeag recorded an entry at 10.25, [84] which noted that there had been contact with Ward Two at Wishaw Hospital and that Ms Finnigan was to be transferred there with two RMNs. [85]

(25) A record made by PLNS Nurse Ian Munro at 11:21 on 17 December 2019 noted brief contact with Ms Finnigan at 10:45 that day.[86] It was recorded that Ms Finnigan was now detained under an EDC, and a bed had been booked already in Ward Two of Wishaw University Hospital. Nurse Munro noted that Ms Finnigan seemed fairly relaxed, and while believing people could read her mind and having on-going auditory hallucinations, it was not causing her too much distress that day.[87] She reported no ideas of self-harm or suicide that day and appeared to be engaging with staff.[88] Mr Munro noted that she was aware of her detention and was happy to be transferred to Wishaw Hospital.[89] Again no reference was made in this document to Ms Finnigan's previous attempts at hanging within the preceding 24 hour period. There was also no standard document presenting the specifics of Ms Finnigan's level of risk.

(26) A 'Discharge Letter and Prescription' letter relating to Ms Finnigan's discharge from University Hospital Monklands was generated at 17:40 on 17 December 2019 and detailed Ms Finnigan's attempts to hang herself in the

[84] Crown Production Three page 46
[85] Crown Production Three page 46
[86] Crown Production Four page 168
[87] Crown Production Four page 168
[88] Crown Production Four page 168
[89] Crown Production Four page 168

bathroom 4 times stating that she was detained under an EDC before her transfer to Ward 2, University Hospital Wishaw.[90]

Events of Tuesday 17 December 2019 – University Hospital, Wishaw

(27) Ms Finnigan was admitted to Ward 2, University Hospital Wishaw at 14:30 on 17 December 2019, (that is before the creation of the aforementioned "Discharge Letter & Prescription,") and an Inpatient Assessment and Treatment document was completed in respect of her.[91] The document referred to the referrer as PLNS and stated that she came from Monklands.[92] This document under the section headed "Circumstances of admission/assessment" referenced her intrusive thoughts and previous self-harm , namely that she had "slit wrists-superficial" but made no reference to her repeated attempts to hang herself while in University Hospital, Monklands at that section or anywhere else in the admission document.[93]

(28) A nursing note by Nurse Nicole Carr on 17 December 2019 at 17:57,[94] recorded that Ms Finnigan spoke about intrusive thoughts and images that were not hers, and that she was hearing negative voices telling her to kill herself. She described her mood as being a "2 out of 10" due to the negative voices, which were getting progressively worse, but denied any suicidal thoughts at that time.

[90] Crown Production Three page 9
[91] Crown Production Four page 136
[92] Crown Production Four page 136
[93] Crown Production Four page 136
[94] Crown Production Four page 164

She heard voices telling her she was worthless and to kill herself, which she struggled with.[95] Ms Carr noted a plan stating that Ms Finnigan was detained under an EDC, was on constant observations due to psychotic symptoms and command hallucinations to minimise risk and was to be restricted to remain in the ward pending review by a consultant.[96]

Events of Wednesday 18 December 2019 – University Hospital, Wishaw

(29) It was noted on 18 December 2019 at 06:55 that Ms Finnigan may have been responding to loud dynamic noise near her room by fellow peers, believing people were talking about her and reporting shapes in her room. She appeared afraid prior to the noise occurring and remained on constant observations.[97] A further note at 14:21 recorded that Ms Finnigan had been nursed on constant observations this duty, and that during interactions she had been openly responding to unseen stimuli, although she was pleasant and appropriate on interactions with staff. It was noted that she was detained on an EDC. [98]

(30) Dr Ravi Karri, Locum Psychiatrist and Duty Approved Medical Practitioner, (AMP) was contacted by nursing staff on Ward 2 on 18 December 2019 given the Emergency Detention Certificate in respect of Ms Finnigan was due to lapse,[99] and he conducted a joint interview of Ms Finnigan with Mr

[95] Crown Production Four page 164
[96] Crown Production Four page 164
[97] Crown Production Four page 161
[98] Crown Production Four page 160
[99] Crown Production Nine page 357

Thomas Mooney, a Mental Health Officer (MHO).[100] They both agreed the criteria for short term detention was met and a STDC was granted at 16:50 on 18 December 2019.[101] Dr Karri noted in this that Ms Finnigan was having a psychotic episode characterised by auditory hallucinations and delusions that people could see her thoughts which was distressing her. She was experiencing command hallucinations asking her to harm herself and acting on that and was also said to be confused and not sure if she needed a hospital stay or not. Her insight was impaired.[102] This section further noted that Ms Finnigan needed further assessment, and that she had attempted suicide four times by hanging and was at a high risk of self-harm.[103] This certificate was dated and timed at 16.50 on 18 December 2019.[104]

(31) A further nursing report prepared by Nurse Carr was completed at 20.24 and noted that Ms Finnigan had been on constant observations that duty. She had been engaging with staff and attempting to piece together what had been happening over the past few weeks. She spoke about taking drugs and since then had been hearing voices. She reported that those weeks had been a blur, and that all she was doing was sleeping and hearing voices. She felt safer there than in Monklands and that the voices she had been hearing had calmed down whilst she had been in hospital. Constant observations continued in respect of

[100]Crown Production Nine page 357
[101] Crown Production Four page 172-179
[102] Crown Production Four page 173
[103] Crown Production Four page 174
[104] Crown Production Four page 177

Ms Finnigan on 18 December 2019.[105] This note made no reference to the earlier examination by Dr Karri, and there was no reference to that Senior Psychiatric assessment within Ms Finnigan's records or specific reference to her mental state and level of risk that afternoon. There were no written or typed entries in Ms Finnigan's Wishaw Hospital records regarding Dr Karri's assessment other than a copy of the STDC itself. Ms Finnigan's status remained recorded as being under an EDC and not a STDC.[106]

Events of Thursday 19 December 2019 – University Hospital, Wishaw

(32) At 05:02 on 19 December 2019, Staff Nurse O'Donnell noted Ms Finnigan's observation level as being constant.[107] He recorded that she had been asleep for the majority of the duty, although she woke twice and reported to be afraid of disturbing dreams. [108]

(33) At 13:00, Senior Charge Nurse (SCN) Susan Cochrane, noted details of her interaction with, and assessment of Ms Finnigan.[109] Nurse Cochrane recorded that she could not access MiDIS, the electronic case management system to record her notes electronically.[110]

[105] Crown Production Four page 159
[106] Crown Production Four page 159
[107] Crown Production Four page 158
[108] Crown Production Four page 158
[109] Crown Production Four page 226
[110] Crown Production Four page 226

(34) A Risk Assessment Review was completed by Nurse Cochrane on paper as MiIDIS was not operating.[111] This took the form of a pro forma Review document and a lengthy handwritten note. Page one of the proforma document took the form of 28 questions relating to appearance, behaviour and general observations.[112] In this section the only question answered "yes" was question 2.19 which asked whether there were known triggers that increased the risk to the patient and others. In relation to this question the handwritten comment was "Increased risk of psychosis if taking illicit substances – Kerry demonstrated very good insight around this and cause of admission. Denies any hallucinations or thoughts/intent to harm self."[113]

(35) The second page of the Risk Assessment contained a number of sections. The first section was headed "Suicide Risk Screen" and contained ten questions. In this section two question were ticked yes, namely question 3.9 indicating that the patient's family were worried about them and question 3.11 which asked if the person had ever thought of doing something to harm herself. In relation to this latter question a written note was added stating: "self-harm to wrists prior to admission – relates this to drug use."[114] The document continued to state that: "Kerry realises that her recent drug use has caused her psychotic episode, very good insight and remorseful regarding same. Denies any plans or intent at this

[111] Crown Production Four page 227
[112] Crown Production Four page 224
[113] Crown Production Four page 224
[114] Crown Production Four page 225

time.[115] The overall risk identified in the Review was stated to be "High Risk – only due to illicit drug use and recent psychosis." The Review stated: "Further detained under STD and observations reduced to general- Kerry agrees due to improvement in mental state and absence of psychiatric symptoms, and should Kerry go missing NHS Lanarkshire Missing Person Protocol to be initiated." The final part of the review document entitled "Revised Risk Rating following actions identified (taking into account probability) stated that Ms Finnigan's risk was "Medium Risk," instead of "Medium/High Risk."[116] This document did not reference at any stage the apparent multiple suicide attempts whilst in University Hospital Monklands.[117] Whilst Ms Finnigan was assessed as high risk, this was only due to illicit drug use and recent psychosis.[118]

(36) The handwritten note by Nurse Cochrane at 13.00 recorded a lengthy interaction speaking about the circumstances that lead to Ms Finnigan's admission. Reference was made to the party of 30 November 2019 when she was said to have taken cocaine, MDMA and TC2, advising that she had been taking drugs recreationally over a number of years. She did not recall much after this other than being at home and having derogatory auditory hallucinations which she described as her friend's voices, whom she thought she had fallen out with, and who were isolating her from her group. She now understood that this was

[115] Crown Production Four page 225
[116] Crown Production Four pages 225
[117] Crown Production Four pages 224-225
[118] Crown Production Four pages 224-225

delusional and spoke about recent delusional thoughts and odd behaviour and about "superficial self-harm" as a result of this. She denied any psychotic symptoms and spoke about future plans. She asked about the negative effect of drugs on her mental health, and education about this was provided. She appeared remorseful about her behaviour, and was thankful for staff engagement, agreeing that her symptoms were greatly alleviated since admission. She discussed future plans and denied any self-harm/ suicidal ideation. No reference was made to the apparent repeated attempts to commit suicide in Monklands Hospital. It was noted that it was agreed to reduce observations from constant to general (hourly), although she was to remain on the ward until seen by Dr Vusikala.[119] She was re-assessed as a medium risk,[120] and Nurse Cochrane also recorded that Ms Finnigan was "further detained under STD."[121]

(37) A nursing note made at 20.45 on 19 December 2019 recorded that Ms Finnigan had been reduced to general observations, that she had spent long periods of time within a side room and was visited by numerous family members, which she seemed to enjoy. There was minimal interaction with staff, and she was superficial when interacting, with poor eye contact, and facially flat. She had accepted a good diet and fluid intake.[122]

[119] Crown Production Four page 227
[120] Crown Production Four page 225
[121] Crown Production Four page 225
[122] Crown Production Four page 228

(38) A nursing note made by Nurse Nicole Carr at 14:25 stated that Ms Finnigan had been taken off observations after speaking to SCN and reported feeling safe in hospital. During interactions she was pleasant on approach and was brighter in mood and interacting well with staff. She was said to have been settled within the Ward at that time. [123]

Events of Friday 20 December 2019 – University Hospital, Wishaw

(39) A handwritten nursing note at 04.00 on 20 December 2019 noted that Ms Finnigan was settled from the onset of the duty and eventually gained sleep. She woke to report a particularly bad dream but quickly settled with reassurance.[124]

(40) A Multidisciplinary Meeting took place on Friday 20 December 2019 held by Dr Vusikala, Consultant Psychiatrist who was Md Finnigan's Responsible Medical Officer (RMO) accompanied by staff nurse Carly Truscott and a student nurse.[125] It was noted that Ms Finnigan did not present with suicidal intent at that time, that she appeared to be improving and was gaining insight into her condition.[126] A nursing entry that evening noted Ms Finnigan was on general observations, was a low risk of harm and her legal status was STDC.[127]

[123] Crown Production Four page 157
[124] Crown Production Four page 228
[125] Crown Production Four page 156; Crown Production Ten page 361
[126] Crown Production Ten page 362
[127] Crown Production Four page 155

(41) An MDT Progress Note was recorded by Dr Vusikala at 09:27 on 20/12/2019,[128] and he recorded the following summary in the MDT Progress Note: "Noted the circumstances leading to admission. Kerry is presently on STDC. Kerry is not known to the services prior to this presentation. She lives with her dad, sister. Mom died of physical health issues. She stated that she has been partying a lot. She has been drinking quite heavily. She also has been taking various drugs such as cocaine, 2cb – this has psychedelic properties. She has been experiencing paranoia; "people were following me for a couple of weeks". She believed that her account has been hacked, people accusing her; she has been panicking about things. She believed that her friends are talking about her. She stated that since her admission to hospital she has been feeling slightly better. She believes that he thinking is much better and she is not 'confused'.[129]

(42) Dr Vusikala also recorded the Mental State Examination in the Progress Note as follows: "Kerry is a 26-year Caucasian female, casually dressed, comfortable at rest. Rapport has been established, good eye contact throughout the interview. Speech was spontaneous and it was coherent. There was no evidence of any formal thought disorder. The thought content revealed some paranoia about people following her and friends talking about her, no evidence of any fixed beliefs. She denied any suicidal thoughts and stated that she would stay in the hospital. Mood was ok and the overall effect was reactive. There was

[128] Crown Production Twenty-Three pages 483-485
[129] Crown Production Twenty-Three pages 485

no evidence of any hallucinations. She was well orientated to time, place and person. It appears that she is much better compared to the time of admission and slowly gaining insight into her condition."[130]

(43) Dr Vusikala's Plan in the MDT Progress Note was noted as follows: "Impression: Drug Induced Psychosis. Plan. 1. Continue with STDC. 2. General observation. 3. Urine drug screen. 4. Review on Monday."[131]

(44) A nursing note prepared by Nurse Truscott at 13.11 recorded that Ms Finnigan had been quiet in mood and manner and offered some interactions when approached by nursing staff. She did not display any psychotic symptoms and did not appear to be responding to unseen stimuli.[132] A further nursing record from 20.27 made by Nurse Hassan noted that Ms Finnigan continued to present as settled with no issues or concerns and with no evidence of hallucinatory activity. Her observation level was recorded as "General", and her risk assessment was recorded as "Low." Her legal status was also recorded as STD.[133] There was no explanation as to why the risk assessment had been reduced from medium to low on 20 December 2019.

[130] Crown Production Twenty-Three page 485
[131] Crown Production Twenty-Three pages 483-485
[132] Crown Production Four page 156
[133] Crown Production Four page 155

Events of Saturday 21 December 2019 – University Hospital, Wishaw

(45) At 05:26 on 21 December 2019, it was recorded that Ms Finnigan had spent the evening in her room.[134] She had requested prn medication and had woken from her sleep reporting that she had a "night terror." Ms Finnigan's father had phoned the ward and asked that she be given medication as he had spoken to her and she was agitated. PRN zopiclone was administered and support and reassurance given, and thereafter Ms Finnigan appeared to have slept well overnight.[135]

(46) A further note by Nurse Benson at 12.45 recorded that Ms Finnigan had been quiet in mood and manner, offering some interactions when approached by nursing staff. She had not displayed any psychotic symptoms and did not appear to be responding to unseen stimuli. She described being paranoid at times and accepting of reassurance. She was said to have spent long periods in the side room interacting only when approached by nursing staff. She was said to have been pleasant during same. She was encouraged to attend the dining area at mealtimes, although little interactions were offered at that time. It was noted that Ms Finnigan was to have no unescorted time off the ward and that she was on general observations and subject to a STDC.[136]

(47) At 17:00 on 21 December 2019 a senior nurse Lisa Stillie spoke with Ms Finnigan in her room to offer her dinner. No concerns were identified at that

[134] Crown Production Four page 154
[135] Crown Production Four page 154
[136] Crown Production Four page 153

time.[137] At approximately 17:40, staff nurse Lee McSherry received a phone call from Ms Finnigan's cousin who advised that she had been receiving distressing messages from Ms Finnigan.[138] Mr McSherry was concerned by the phone call and terminated the call to check on Ms Finnigan.[139]

(48) On approach to the side room, Nurse McSherry found Ms Finnigan to have her dressing gown cord tied around her neck and the shower curtain rail in the bathroom.[140] The cord appeared to be low to the ground where her knees were almost touching, and she also had earphones on. He called for assistance and Staff Nurses Jamieson and Stillie attended and cut the ligature.[141]

(49) A cardiac arrest call was made at 17:47 and a team arrived at 17:51.[142] Cardiopulmonary resuscitation attempts were commenced and continued for around 20 minutes with no improvement, Ms Finnigan remained asystole throughout.[143] Ms Finnigan's life was pronounced extinct at 1809 hours.[144]

(50) A postmortem examination was carried out on the deceased Kerry Finnigan on 09 January 2020 at the Queen Elizabeth University Hospital, Glasgow by Dr Marjorie Turner, Forensic Pathologist, University of Glasgow. The final cause of death was provided as: -

(51) Toxicology was negative for alcohol and drugs.

---

[137] Crown Production Four page 152
[138] Crown Production Four page 152
[139] Crown Production Four page 152
[140] Crown Production Four page 152
[141] Crown Production Four page 152
[142] Crown Production Four page 269
[143] Crown Production Four page 269
[144] Crown Production Four page 269

(52) A Significant Adverse Event Review was commissioned and undertaken by NHS Lanarkshire in respect of the death of Kerry Finnigan, and a Report was published on 07 June 2020. [145]

(53) A formal review and technical report entitled 'University Hospital Wishaw Ward 2, Room 5, Failure of Anti-Ligature Shower Curtain Rail to Prevent a Completed Ligature Technical Review' was commissioned by NHS Lanarkshire Property Services Division (PSSD) and prepared by the Head of Health and Safety, Lanarkshire Health Board. A review paper was published on 24 December 2020.

(54) Goelst UK Ltd supplied the G-Rail LRS, a safety curtain rail designed to detach under a load of ≤50kg to prevent ligature risks. This rail was designed and manufactured by Goelst NL. The rail in question was installed by Rainbow Blinds and maintained by Serco. The rail was initially marketed as an "anti-ligature" device but had subsequently been re-marketed as a "ligature reduction" fitting.

(55) Prior to this incident an Estates and Facilities Alert (EFA) was issued in March 2019, entitled "Anti-ligature type curtain rail systems: Risks from incorrect installation or modification," advised health boards to review anti-ligature rail systems for possible unexpected failure to operate as intended. This included testing anti-ligature rail systems in line with the manufacturers

[145] Crown Production Five pages 282-297

guidance, which was with weights applied vertically but also at an angle. This document confirmed there had been seven separate incidents in the preceding 12 months involving attempted suicide in a mental health ward where an anti-ligature curtain rail system had failed to operate as expected.

(56) NHS Lanarkshire's findings identified that part of the shower rail system detached from one of the shower rail mounting brackets. Another section was then used in the completed ligature when the remaining shower rail sections failed to detach from the wall and ceiling mounted fittings which facilitated the completed ligature and Ms Finnigan's tragic death.

(57) Subsequent testing of the fitting under controlled conditions showed that it functioned properly under certain controlled conditions. Whilst there were installation issues in relation to misaligned brackets, and non-standard screws these were not deemed to be causative. However the Review concluded that when the load was applied at an angle that the fittings did not always detach. It is accordingly likely that the fact that the fitting did not detach was due to Ms Finnigan being able to apply a non-vertical load to the shower rail, causing it to be effective as a ligature point.

Statement by father and sister

[9] Prior to the commencement of the Inquiry, a statement was read on behalf of the family of Ms Kerry Finnigan. This statement on behalf of Kerry's father read:

> "I relied on Kerry after the death of my wife. She had wished for a high standard of education, and we all believed she would achieve highly in life."

On behalf of Kerry's sister the statement read:

> "Growing up I was always told how lucky I was to have such a great sister. Her homework was used at school as exemplars. Her writing and vocabulary were excellent. I achieved Dux of my school, which would not have been possible without my sister. She was an individual who thrived in difficult situations but was always friendly and accessible."

The family hoped that this inquiry will fully address the circumstances surrounding the death of Kerry.

The Evidence

Witness One: Lynne Robertson

[10] Nurse Lynne Robertson (53) was a Charge Nurse with Lanarkshire Addiction and Recovery Team, a position she had held for approximately 30 months. She provided a statement to Police Scotland regarding these matters on 30 March 2023[146] and adopted the terms of this statement as being accurate. She did not recall Ms Finnigan and provided her statement solely on the basis of medical notes.

[11] At the relevant time she was based at the Receiving Unit at Monklands Hospital and noted that Ms Finnigan was admitted at 02.30 to the Acute Receiving Unit at Monklands University Hospital on 15 December 2019, having been referred there from the Medical Assessment Unit. The witness noted:

[146] Crown Production 24 pages 489-490

> "Kerry Ann admitted to AMRU via MAU with query psychosis, query organic cause. AWI (adult with incapacity) in place. NEWS 3 (national early warning score). Nurse buzzer at hand. No concerns present."

[12] She believed that there were no immediate concerns for Ms Finnigan at that time who had most likely gone to sleep. Upon her entry to the ward, the witness completed a staged person-centred care plan based upon her observations, which was to be reviewed daily, and she completed a 12-stage assessment for treatment.

[13] Given her observations, the witness believed that Ms Finnigan's condition flagged no concerns. At 07.45, on the same day and date, when the new shift came on duty, a group handover was completed, and she had no further interactions with Ms Finnigan. Whilst on duty, she did not recall any reviews from medical or psychiatric staff, although she understood she was seen by a medic before coming to the ward. A medic would have been available if there were concern, s including an on-call consultant. Ms Finnigan had no interaction with psychiatric nurses during the witness's period of duty.

Witness Two: Emma Crielly

[14] Emma Crielly (32) was a Staff Nurse with 10 years' experience working within the Acute Medical Receiving Unit (AMRU) at Monklands Hospital having qualified in 2016 as a Registered General Nurse. She had worked in AMRU since then and worked there at the relevant time. She was a general nurse with no psychiatric expertise.

[15] The witness explained that AMRU admitted patients from Accident and Emergency (A&E) with medical issues following their assessment by a consultant. They

looked after patients until a bed was available in the appropriate speciality. It was in effect a "half-way house," and patients spent varying times there depending on their circumstances. They were not there for long-term care, and it was a busy ward, with 24 beds, turning round all the time. It was classified as an emergency department and their consultants changed daily. Handovers at the end of shifts were mainly verbal although often later typed up.

[16] Nurse Crielly recalled Ms Finnigan's admission to AMRU on 16 December 2019, was she was agitated to an almost unmanageable level. She understood Ms Finnigan was there principally for a physical matter, and it was clear that she was unwell, resulting in her being "specialled" by 22.00. she didn't recall when the doctors arrived.

[17] She recalled that Ms Finnigan was trying to leave, and she needed help to deal with her, which was unusual for her, even though she was accustomed to agitated patients. Normally there were three nurses and two auxiliaries on their night shift, although they were short staffed that day with only two nurses and one auxiliary on duty, with no doctors on their ward at that time. Ms Finnigan was pacing up and down the ward, coming out of her room, asking to leave, and going to the main door of the ward. She was overly talkative, and much of her speech was nonsensical, with bizarre speech about aliens. She requested assistance from the night manager, and an auxiliary nurse was provided to sit with her around 22.00.

[18] Nurse Crielly could not remember the first time that Ms Finnigan attempted to choke herself, but recalled there were several incidents, some involving her phone cable. She specifically remembered removing the shower tubing from round her neck, and she

also at one point she tried to use the phone cord from the TV unit. During this latter incident with the phone cable, an auxiliary was in the room with her as she was being "specialled," which involved a clinical support worker constantly sitting with her. It was not necessarily a mental health nurse, and they were not able to restrain or toilet with the patient. She thought Ms Finnigan was unaware they were in the room with her. Later they discovered Ms Finnigan in her bathroom with shower tubing around her neck, having used the cord from the shower pole to wrap round her neck before trying to sit down. She was still conscious and breathing and the witness and male auxiliary removed the tubing. Nurse Crielly recorded these incidents retrospectively on 17 December 2019 but could not do so contemporaneously as the ward was so busy, with 24 patients on the ward and just two nurses on duty. She stated that Ms Finnigan attempted for the fourth time that evening to hang herself and wrapped the shower head and tubing around her neck. Whilst referring to Ms Finnigan's "4th" attempt to hang herself, she had only recorded one incident, accepting that she should have specifically recorded the other three incidents

[19] The witness subsequently contacted the Psychiatric Nurse Liaison Service (PNLS) and Duty Doctor, who attended, although she could not recall their conversation. Ms Finnigan was sedated and detained under the Mental Health Act, and after sedation she did not appear to further attempt to harm herself. The witness spoke to Ms Finnigan's father by phone, advising him she had been detained, and she received a history of Ms Finnigan in the previous weeks. Her overall impression was that she was quite disturbed and distressed, and she was placed on 4 hourly observations, with

no directions to increase these observations. She stated that she asked to increase these given her attempts to leave the ward.

[20] The witness confirmed that given they were a medical ward, she would probably have contacted a medical doctor and not the on-call psychiatric doctor, and any contact with a psychiatric doctor would have been made by the medical doctor. She was not specifically aware of the Clinical Observation and Engagement Policy & Guidelines for Best Practice from 2019, [147] which included a Patient Observation Recording Sheet,[148] given this was specifically designed for mental health wards, and she was unaware of any similar policy for general wards.

Witness Three: Dr Catriona Anne Sykes

[21] Dr Catriona Sykes (45) was a Consultant in Infectious Disease and General Medicine at Monklands University Hospital, having graduated in 2003 from Glasgow University with an MBChB, also having a CCT in General Medicine.

[22] On 15 December 2019 she was the on-call doctor for general medicine based at Monklands Hospital, explaining that all consultants participated in this rota one day in twenty for a 24-hour period covering medical receiving wards, and seeing patients already seen by junior doctor, and she was aware Ms Finnigan was initially seen in the Emergency Department by a junior doctor.

[147] Crown Production Six pages 298 - 317
[148] Crown Production Six page 316

[23] She recalled that Dr Laura McGregor, the Emergency Department consultant discussed Ms Finnigan's case with her as she thought her condition might be organic. Whilst the witness believed her difficulties were psychiatric, it was not unreasonable to exclude encephalitis, a brain infection which can present with significant behavioural disturbance requiring urgent treatment, and agreed it was reasonable to rule out possible organic illnesses in the first instance. With Dr McGregor and a nurse they met Ms Finnigan and her father in the Emergency Department, when she appeared very agitated, and frightened. She thought people were following her and a GPS was controlling her thoughts. She had no previous psychiatric history, although the witness noted self-harm marks on her arms. Following this initial meeting the witness believed she was suffering from a psychiatric issue, and may be psychotic, but wished to rule out encephalitis, given its symptoms included hallucinations or behavioural problems, particularly as Ms Finnigan's heart was racing, a possible sign of infection, and she had an elevated white cell count. These symptoms caused them to admit her for a lumbar puncture, before admission to a medical unit. The witness was aware that Ms Finnigan subsequently had a negative lumbar puncture test.

[24] The witness discussed the case with the on-call consultant for psychiatry, Dr Telfer, who advised regarding the management of Ms Finnigan overnight including sedation, and one-to-one nursing. An agreement was reached that once any organic illness was ruled out, that psychiatry would take over her care. One-to-one nursing related to fears she may abscond or harm herself. She did not specify further what this entailed.

[25] The witness treated Ms Finigan under the Adults with Incapacity (AWI) legislation, given her lack of capacity to consent to treatment, and recorded she should be detained under the Mental Health Act, which was her only attendance with Ms Finnigan.

[26] The witness referred to the records made by her,[149] wherein she had recorded: "RHM to "special" if possible." Whilst this was her suggestion, it was up to medical staff to decide if they could accommodate that given staff constraints overnight. Whilst named as the consultant on the document, she was not involved in the production of the discharge letter from Monklands Hospital dated 17 December 2019. [150]

Witness Four: John Truesdale

[27] John Truesdale, was a registered Mental Nurse, having qualified in 2008, who had worked as a Staff Nurse in Monklands Hospital before becoming a Community Psychiatric Nurse and transferring to the Psychiatric Nurse Liaison Service (PNLS) Service around 2012, being made Team Leader in 2014, and continuing to work with PLNS until 2022.

[28] The witness explained the role was to respond to psychiatric emergencies across Lanarkshire, undertaking comprehensive and risk assessments with an advanced mental health practitioner for the attention of the referring doctor.

[149] Crown Production Three pages 40-41
[150] Crown Production Three page 9

[29] He met Ms Finnigan at Monklands Hospital on 15 December 2019, with a newly qualified Advanced Nurse Practitioner, Jade Glassford, who wanted a second opinion from him. From his entry in the MiDIS case notes for that date[151] he noted that Ms Finnigan's presentation had been very unusual according to her father and she presented as very disturbed. She appeared manic, with disjointed thoughts and was also unkempt, malnourished, and looked dirty.[152] She was admitted medically given concerns about a brain infection and was to be supported by a nurse trained in the management of violence and aggression on a one-to-one basis. Her bloods were deranged and her physical well-being required assessment.[153] He advised the Senior House Officer in Wishaw and the on-call consultant about Ms Finnigan's presentation, and the latter recommended antipsychotic medication. He spoke to the doctor considering detaining Ms Finnigan, requesting a qualified mental health nurse be with her for support and to reduce her agitation.

[30] He made a note in the paper copy diary held by PLNS nurses for a PLNS colleague to follow up Ms Finnigan the following day, providing a verbal handover to whoever took over from him, with a comprehensive background including reasons for her presentation and current symptoms. He explained that only PLNS, a duty Doctor or a Psychiatrist could admit patients to Psychiatric Wards. On admission, an initial risk assessment was formulated by PLNS, the duty Doctor, or Psychiatrist. PLNS attended Acute Wards on an advisory basis, being generally contacted by phone. When seeing

[151] Crown Production Four page 170
[152] Crown Production Four page 170
[153] Crown Production Four page 170

patients, they wrote in the Medical and the MiDIS Notes. He noted that the MiDIS Records[154] disclosed his entry from 15 December 2019 requesting that PLNS see her the next day but was unaware if anyone from PLNS did actually see Ms Finnigan on 16 December 2019.

[31] He confirmed that a mental health assessment and risk assessment should be undertaken by whomsoever arranged admission, although he could not see these in the Notes. It was not uncommon to have two risk assessments, one from the duty Doctor admitting the patient, and another by the Nurse admitting the patient. He had noted an entry in the Monklands Records on 17 December[155] saying that Ms Finnigan would likely need admission, and that Ward Two had been contacted. He understood that the receiving doctor at Wishaw Hospital would undertake mental health and risk assessments at that point, as they were responsible for assessing and admitting the patient and reviewing their presentation mentally.

[32] When he saw Ms Finnigan, he identified deranged bloods, and a dramatic first onset presentation, which suggested she needed physical investigations as a priority due to a possible brain infection. He would not routinely do a risk assessment when the patient was physically unwell, given their presentation may be due to infection. The witness noted that an entry in MiDIS on 15 December 2019[156] by Dr Papadantonaki recorded a conversation included the suggestion that bloods be taken, meaning

[154] Crown Production Four page 170
[155] Crown Production Three page 46
[156] Crown Production Four page162

psychiatry would not accept a transfer until this was done. These records[157] mirrored his recollection in relation to the taking of bloods. Upon receipt of the blood test results he phoned the on-call psychiatrist, Dr Telfer, at Wishaw, after which Ms Finnigan received an anti-psychotic drug and lorazepam.

[33] He believed it was a doctor and not PLNS nurses, who arranged Ms Finnigan's admission to Wishaw Hospital. Standard practice for PLNS nurses admitting a patient to a Wishaw was to undertake a synopsis, mental risk assessment and a mental health assessment, and detained patients were reviewed by a consultant psychiatrist.

Ms Finnigan was not seen by PLNS again until 17 December when she was seen by a colleague. He confirmed PLNS had no role when a patient was detained, and a consultant psychiatrist would review the patient given only they could revoke an order. He confirmed that if PLNS had arranged admission they would also arrange the transfer, speak to the doctor, and provide a comprehensive handover. They would undertake a full psychiatric assessment and risk assessment when they arrived. However he recalled Ms Finnigan's transfer was handled by a doctor. As soon as a patient was detained, they moved outwith their remit and follow-up was done by the receiving doctor, with no contact with PLNS.

[157] Crown Production Four page162

Witness Five: Lynne Wylie

[34] Nurse Lynne Wylie is a Band 7 Nurse Team Leader for PLNS who assumed this role three years ago, having qualified as a Registered Mental Nurse in 2009.

[35] She described the operation of PLNS as providing assessments for patients who presented to A&E as psychiatric emergencies, and patients admitted to medical wards with suicidal ideation. They also provided a phone service for NHS24. She confirmed that they maintained their own electronic notes, and at the end of every shift there was a verbal handover between them. Their service offered 24-hour cover, but not daily planned input to medical wards, instead being an unscheduled care service, accepting referrals via A&E and medical wards, and not routinely pro-actively visiting patients.

[36] The witness recalled Ms Finnigan. She was contacted by the medical ward on 17 December 2019 for management advice and support as they were struggling to manage her symptoms. She was distressed and agitated., and while advice was generally by phone, given the description of Ms Finnigan's presentation and behaviour, she felt it appropriate to attend the ward to offer advice and guidance. Before doing so she examined her notes electronically on the MiDIS system and noted she had been seen earlier by a PLNS colleague, John Truesdale, on 15 December 2019, and gone from A&E to the short-term medical assessment unit pending medical investigations.

[37] She could not recall whether she was aware of previous self-harm, although there was a record in the handwritten notes about removing ligatures which indicated self-harm attempts. She accepted she should have recorded this in her own clinical note, but explained that when she saw Ms Finnigan, it was very chaotic as she was floridly

psychotic, her speech content was nonsensical, and she was very distressed, pacing the room and gesticulating. Her priority was de-escalation and keeping her safe, and she was unsure if she asked her about self-harm. She accepted she should have completed a formal risk assessment, which is designed to ascertain the risk of self-harm and formed part of the overall assessment. She recommended that Ms Finnigan be placed on "special" observations to mitigate any risks, and that she be detained, which was done. A formal suicide risk assessment was difficult given her high levels of psychosis, paranoid ideas and severe agitation, although she undertook a risk assessment in every instance, even if on a very limited basis. The witness prepared a written note[158] recording her advice.

[38] On attendance the witness noted a lot of furniture and asked for the environment to be cleared. She tried to calm Ms Finnigan as she not making sense and medication was the next step. When this didn't work, she advised the medic about the EDC, and she spent some time on the ward with Ms Finnigan trying to calm the situation. When she left, Ms Finnigan was settling. She asked staff to observe her at all times, suggesting a Registered Medical Nurse undertake special observations. Given the complexities of her presentation, she believed Ms Finnigan should have been assessed by a Consultant Psychiatrist within the 72-hour emergency detention period, allowing a decision about her ongoing treatment and/or discharge.

[158] Crown Production Three page 45

[39] The witness confirmed that often where admission is deemed appropriate, they arranged for transfer to one of the psychiatric wards following a psychiatric assessment when the patient was medically fit. As a detained patient, Ms Finnigan would have required an assessment by a Responsible Medical Officer (RMO) before admission to a psychiatric ward. A risk assessment and mental health assessment should also be done before transfer. If PLNS were involved in the transfer, as well as formulating the ICP documents, they would phone the receiving ward and provide a verbal handover.

[40] In relation to the request by John Truesdale for a review, she thought this unusual and though she would have done it, PLNS did not routinely contact medical wards given they knew how to contact them if necessary, and at that point Ms Finnigan was a medical and not a psychiatric patient. She confirmed that PLNS did not see Ms Finnigan again following the initial meeting with John Truesdale.

[41] PLNS maintained a diary for handovers which she would have read when coming on shift but could not recall if it referred to a follow-up. She considered that they were not in charge of Ms Finnigan's care but were there to provide assistance and advice to medical staff. She recorded her interaction with Ms Finnigan,[159] recalling she was acutely unwell and acting chaotically. She was floridly psychotic and spoke nonsensically, apparently responding to unseen stimuli. She gesticulated with flailing arms and was clearly very unwell. She suggested medication as she was psychotic. and gave advice on an EDC and AWI as she had no capacity. Her handwritten note of

[159] Crown Production Four page 169

17 December 2019,[160] referred to advising staff to remove ligatures, which she had not mentioned in her electronic note.

[42] The witness now did risk assessments in every case, but hadn't in this case, simply making a medical note, as it was a very difficult situation, and her priority was de-escalation and trying to settle her. The witness performed a verbal handover to her PLNS colleague, Ian Munro, and handed over notes in accordance with standard procedures.

[43] In relation to admission to a psychiatric ward, this was not something PLNS routinely did, and as Ms Finnigan was under an EDC, a psychiatrist required to admit her as this required a formal assessment. In relation to the risk assessment and mental health assessment, this should have been done before the transfer and would be the responsibility of the psychiatrist arranging the transfer; however it was not done in this case. Further, as PLNS were not responsible for this transfer they would not have done a verbal handover given Ms Finnigan was still a medical patient at that time. If a patient was medical and PLNS had dealings with them, and they were subsequently admitted to a psychiatric ward, then PLNS would do a handover, but that was not the case here as Ms Finnigan was under an EDC. She was unaware who was responsible for Ms Finnigan's transfer to Wishaw.

[44] The witness was recorded[161] as attending the Acute Medical Receiving Unit on 17 December 2019, and this note referred to Ms Finnigan having made four attempts to

[160] Crown Production Three page 45
[161] Crown Production Three page 44

end her life and recorded this discussion with the doctor. She believed the EDC was to help treatment as Ms Finnigan did not have capacity, given it allowed a patient to be detained in hospital for 72 hours. It did not cover treatment however whereas a STDC was for a longer period, allowed assessment and treatment. The witness noted that the medical practitioner for the EDC was Kimberley Shields,[162] and that the reason for the grant was Ms Finnigan's suicidal ideation as she tried to hang herself four times on the ward, her ongoing suicidal ideation and her trying to leave the ward.

Witness Six: Ian Munro

[45] Nurse Ian Munro was a registered mental health nurse, who had worked in that capacity in various mental health settings for 34 years prior to retiring, although he continued to work on a part-time basis. He previously worked full-time as a Charge Nurse with PSNL and worked in that role in 2019. He remembered Ms Finnigan only vaguely, relying on his notes from 17 December 2019.[163] Before seeing her, there was a handover from his colleague Lynn Wylie, and he recalled seeing Ms Finnigan with two nurses, and he had read the hard copy and the MiDIS notes. Ms Finnigan was settled having recently had medication He noted she did not express ideas of self-harm or suicide.

[46] Ms Finnigan discussed occasional cocaine use, denied any family history of mental illness and described a change in her mental state in the recent few weeks. She

[162] Crown Production Three pages 121 – 127
[163] Crown Production Four page 168

was relaxed with good eye contact, with bruising to her arms and forehead after struggling with police officers. She was aware of her detention and was content to be transferred to the psychiatric ward which had already been arranged.

[47] The witness did not recall any references to four previous suicide attempts but thought it likely he was aware of these as he would have read the notes, and it was his standard practice to specifically ask patients if they had any thoughts of hurting themselves. as well as direct questions about her experiences and mood. He was the last PNLS nurse to see Ms Finnigan before her transfer to Wishaw, and there was a brief mental health assessment in his note of 17 December 2019,[164] but no risk assessment. He was unsure who booked the bed for Ms Finnigan in Wishaw or whether anyone from Monklands contacted Wishaw. After Ms Finnigan went to Wishaw, there was no further interaction with PLNS, and he did not recollect whether a consultant psychiatrist spoke to him about the transfer.

Witness Seven: Nicole Steele (formerly Carr)

[48] This witness was a Registered Mental Health Nurse in October 2018, initially working in Glasgow and latterly in Lanarkshire on the staff bank, usually in Ward Two at Wishaw University Hospital. She remembered Ms Finnigan. The witness explained that upon a patient's admission to the ward, a nurse was allocated to admit them, and there is an admission pack for this purpose, which had a page for the patient's personal

[164] Crown Production Four page168

information and a mental health assessment.[165] After preliminary details the patient would be asked what brought them to hospital, which was used to complete the mental health assessment recorded on MiDIS.

[49] She recalled undertaking the admission assessment, when Ms Finnigan provided information, despite being very distracted. She was responding to unseen stimuli and reported recent drug use, describing odd ideas about her phone and experiencing negative voices telling her to die. Her mood was low, although she denied thoughts of self-harm or suicide. She described negative auditory hallucinations of a command nature, but denied any intent to act upon those, describing protective factors such as her family.

[50] The witness completed a risk assessment, care plan, some basic physical observations (height and weight etc), and updated the mental health assessment and risk assessment from PLNS, as well as a safety plan. The Risk Assessment should have been completed by whoever admitted the patient to hospital, and if not there, she would contact PLNS asking them to complete one. For Ms Finnigan there was no risk assessment. Hard copy notes were held until discharge, while the risk assessment is online.

[51] Normally when patients arrived from Monklands Hospital a risk assessment was expected with a mental health assessment and detention papers. These came hard copy and were the only hard copy medical records received. When patients were

[165] Crown Production Four page 136

admitted from general medical wards, there was usually a verbal handover from PLNS in addition to the relevant online documentation.

[52] The witness remembered saying to whoever was in charge, that Ms Finnigan required constant observations, given that it was the admitting nurse, in collaboration with the nurse in charge, who decided on the observation level of patients, based on their clinical judgement. She was aware Ms Finnigan was on constant observations when admitted to Ward Two but had no access to notes from Monklands Hospital, although PNLS notes would be present on her system.

[53] The witness believed that Ms Finnigan's four previous suicide attempts were not disclosed to her, although she would have expected to have been told this by PNLS. Although she was not sure it would have changed her decision as to observation levels, it would have been taken it into account by her and should have been recorded. Ms Finnigan would have been placed on special observations if she was actively trying to harm herself, but there was no evidence of that. In every case, they checked patient's whereabouts every hour, with any available nurse undertaking this routine check of all patients.

[54] As she was Ms Finnigan's named nurse, she tried to have one-to-one meetings with her as often as possible, although patients were told they could chat to any nurse. Every day a patient's risk assessment was reviewed by whoever was allocated to that group. She believed Ms Finnigan was improving and engaging better with them, talking about a part-time job in the cinema whilst at university. The witness didn't see Ms Finnigan again and was shocked to hear of her suicide.

[55] The witness had completed the Inpatient Assessment and Treatment Form[166] for Ms Finnigan when she presented as acutely psychotic, with auditory hallucinations, being distressed and responding to hallucinations. When a patient was detained, a consultant did the transfer, and she could not recall any discussion with PLNS or with doctors involved in her admission. She could not recall whether there was a verbal handover, although this was normal procedure. The form noted that the referrer's name was PLNS and that Ms Finnigan had come from Monklands.[167]

[56] Ms Finnigan was noted to be subject to an EDC, and on constant observations given her psychotic symptoms and command hallucinations to minimise risk.[168] She was to be restricted to the ward until she was reviewed by a consultant.[169] Observation levels could change depending on presentation, and patients were reviewed daily to ensure they were not on observations any longer than necessary given they operated on a least restrictive basis, and given resource implications.

[57] The witness believed that the Ward Two consultant psychiatrist at that time was Dr Vusikala but did not know who undertook the STDC being present for any STDC assessment, or speaking to a doctor about this, although she was subsequently aware of the STDC. In her note of 19 December 2019,[170] the witness recorded that Ms Finnigan had been taken off observations, after speaking to the Senior Charge Nurse and saying she felt safe in hospital. The subsequent reference to the observation level in the

[166] Crown Production Four page 136
[167] Crown Production Four page 136
[168] Crown Production Four page 164
[169] Crown Production Four page 164
[170] Crown Production Four Page 157

aforementioned note was factually incorrect as it referred to the observation level as being constant when it should have been general. The witness agreed that Ms Finnigan was opening up to them, and when on shift that day she never noted concerning behaviour. They tried to build relationships with patients, for therapeutic reasons and to ensure patients opened up to them. When developing a therapeutic relationship, they gave patients as much space as possible, as observations could be overwhelming, and always adopted the least restrictive observations whilst keeping the patient safe.

[58] Upon detention, a patient's papers came with them in hard copy with online documentation. An EDC lasted for 72 hours, and staff required to see this to know when it expired. Upon arrival general details about the patient were obtained and detained patients were placed in a side room for assessment to preserve their dignity. These rooms were also reserved for more intense observations, although if observation levels were reduced, patients may be moved to a dormitory. Hard copy papers were usually handed to the accepting nurses, and at any handover, staff ensured that the physical hard copy EDC matched the online paperwork, albeit the physical documentation might not always be present at the point of assessment. The staff member would complete an admission hard copy document and thereafter scan and upload it.

[59] The witness was unaware of Ms Finnigan's suicide attempts in MDGH, and although she recognised that the EDC referred to her trying to hang herself 4 times, she did not recall being told about these attempts. If she had been aware she would have recorded this. She believed Ms Finnigan should be on constant observations, as she

presented as acutely psychotic with command hallucinations, and while not acting on these, they were distressing and were a red flag for constant observations. She agreed however with the decision the following day to place Ms Finnigan on general observations, given some improvement in her condition.

[60] Referring to her notes,[171] the witness recalled speaking to Ms Finnigan on 17 December 2019 when she noted her condition based on the patient's history and her own observation. Ms Finnigan was initially diagnosed as psychotic, although by that time, whilst still distracted, she could engage, albeit she remained unkempt and unwell. The witness noted that she was still detained under an EDC and was on constant observations due to psychotic symptoms and command hallucinations. She was admitted on that basis. The following day the witness engaged again with Ms Finnigan, [172] considering that there had been an improvement in her condition, albeit she was still on constant observations.

Witness Eight: Dr Ravi Prasad Karri

[61] Dr Karri (56) was a consultant psychiatrist, who has specialised in psychiatry since 2003. At the relevant time, he worked at Monklands and Wishaw Hospitals in North Lanarkshire, and Bellshill Community Mental Health as a locum psychiatrist. He was also an Approved Medical Practitioner (AMP) on a rota basis, having received training and approval in terms of Section 22 of the Mental Health Act. This rota system

[171] Crown Production Four page 164
[172] Crown Production Four Page 159

ensured an AMP was on duty every day to conduct emergency assessments under the Mental Health Act and to certify compulsory detentions when needed. Whilst treating doctors could grant detention certificates for their own patients, they might not always available when certification was required, thereby necessitating the AMP rota.

[62] When considering the detention of a patient under the Mental Health Act, an AMP worked with a Mental Health Officer (MHO), who provided an independent social work viewpoint on detention. The role of AMPs was solely to determine whether detention under the Mental Health Act was necessary, and it was a more limited role than that of the treating doctor. The responsibility to prepare and amend the care plans of patients always rested with the patient's treating doctor.

[63] When deciding whether to detain a patient, AMPs assessed their mental state, focussing on the five criteria for detention, whereas a full psychiatric assessment undertaken by the patient's treating doctor was focused on formulating a treatment plan. In-patients were assigned a treating consultant supported by the nursing team who formulated a care plan which could be revised after consulting appropriate members of the Multi-Disciplinary Team, (MDT) which included Registered Mental Health Nurses, Occupational Therapists, Psychologists, Dietitians, Duty Doctors, and other care workers.

[64] The witness saw Ms. Finnigan in his role as duty AMP on 18 December 2019, given her EDC was due to expire on 20 December 2019. He assessed whether further detention via a Short-Term Detention Certificate (STDC) was necessary. EDCs were valid for 72 hours, covering emergency situations where patients presented in a highly

disturbed state or were trying to leave when it was clear they risked their own or others safety. Whilst any doctor can issue an EDC, these must be reviewed by an AMP and MHO within 72 hours to determine whether further detention was necessary, and if not, the certificate would be rescinded. If further detention was required, an STDC, valid for up to 28 days, could be issued.

[65] The witness's normal practice was to review the patient's records before attending for assessment. All the NHS Lanarkshire records were collated in one file, notwithstanding the patient was admitted originally to Monklands Hospital, before transfer to Wishaw General Hospital. He could access Ms Finnigan's notes for both Wishaw and Monklands, and although he could not specifically remember doing so in this case, this was his normal practice. He reviewed the EDC on arrival on the ward to understand why the patient was originally detained, and believed he noted the details of Ms Finnigan's previous suicide attempts.

[66] He assessed Ms Finnigan together with the MHO, Thomas Moodie, and a staff nurse, given she was on constant observations. The previous suicide attempts would have impacted on the decision to monitor on a constant level, and he confirmed to the charge nurse that constant observations should continue. He noted Ms Finnigan was experiencing a psychotic episode and considered that further inpatient assessment and treatment were necessary. As she was not agreeable to remaining on the ward voluntarily, both he and the MHO agreed that the criteria for detention were met and a

STDC should be issued. [173] He completed the document referring to Ms Finnigan's previous suicide attempts,[174] and noted she was having a psychotic episode, characterised by auditory hallucinations and delusions that people could read her thoughts. She was distressed, considering ending her life, and experiencing command hallucinations instructing her to harm herself. Her four previous attempted suicide episodes increased concerns about her risk of self-harm. He agreed constant observations were appropriate given her symptoms, and a STDC would allow time for further assessment and treatment as an inpatient. [175] The dates of detention were between 18 December 2019 and 14 January 2020. [176]

[67] The witness gave the STDC paperwork to the staff, explaining that Ms Finnigan was high risk, and that constant observations were to continue. It could not be uploaded onto the electronic patient record; however the hard copy paperwork would have always been on the ward as this was a legal requirement. He confirmed his usual practice was to enter a short note into the patient's electronic record to confirm that he had seen them and awarded a STDC, however, on this occasion, he could not do this given technical issues.

[68] He explained that the MiDIS system used was centralised and any doctor at any location could access this information, albeit he was unsure whether nurses also had access. The day-to-day nursing and doctor assessments were maintained on MiDIS, and

[173] Crown production Four pages 172- 178
[174] Crown production Four page 174
[175] Crown production Four page 174
[176] Crown production Four page 178

there was also a folder with hard copies maintained on the ward with the patient containing mental health records like the EDC and letters from other disciplines e.g. cardiology. It was a legal requirement to keep these documents in hard copy.

[69] The witness confirmed that he never discussed Ms Finnigan with Dr Vusikala, but he expected nursing staff would pass information to him.

[70] As regards the communication of Ms Finnigan's risk level to the staff on Ward Two, he stated that full details of her admission at Monklands, including her initial A&E attendance, were available to the treating team at Wishaw and anyone else performing the role of AMP. He had no access to any information that was not also available to her doctor and treating team. There was reference to Ms Finnigan's four previous suicide attempts by hanging in her discharge letter[177] from Monklands Hospital. All medical and nursing staff were aware that detention would not be granted unless the patient was at high risk, particularly where the AMP confirmed that constant observations should continue.

[71] The witness understood the usual practice was for the hard copy STDC to be given to the charge nurse and kept in the ward. He usually discussed the reasons for granting the certificate with the charge nurse, communicating the level of risk, and discussing the observation level, and he would not leave the ward without discussing this. His expectation was that her treating team would read the STDC, as it was important for them to be aware of the reasons for the detention and to ensure the criteria

[177] Crown Production Three page 9

for detention under the Mental Health Act were still met. He had no reason to believe the STDC would not have been uploaded to her electronic notes.

[72] The witness understood that Ms. Finnigan was assessed by several professionals after his review, and a decision was subsequently made to reduce her observation levels from constant to general observation, following a risk assessment. Although his view on 18 December 2019 was that Ms. Finnigan was at a high risk of suicide, he respected these assessments as suicidal intent could change over time.

Witness Nine: Susan Cochrane

[73] Senior Charge Nurse Susan Cochrane qualified in 2000, working in various settings before becoming a Senior Charge Nurse in 2009. Having worked in various roles, in March 2019 she took up position as a Senior Charge Nurse post in Ward Two at Wishaw, an acute General Adult Psychiatric Ward, being involved in the management of nursing staff on the ward which could hold 23 patients.

[74] From her records she recalled Ms Finnigan's arriving on 17 December 2019 as a detainee, meaning that a medical practitioner had required to arrange her transfer rather than PNLS. The statutory regime required review by an approved medical practitioner within the timeframe of the EDC. The usual procedure was for a verbal handover, although she wasn't present when Ms Finnigan was admitted. Patients arrived with varying amounts of documentation depending on their originating pathway, and there was usually a verbal handover by a nurse or doctor.

[75] She recalled Ms Finnigan was very unwell when she saw her. She was aware of one suicide attempt, involving her placing a shower hose around her neck, and as she usually read detention certificates she would have observed the reference to four suicide attempts, although she could not recall if she read this at that time. Her initial assessment at admission was that Ms Finnigan was at risk of self-harm, as she was unwell, chaotic, disorganised, and psychotic. Her actions were impulsive, and decision-making impaired, requiring staff to constantly monitor her to ensure her safety. Her initial assessment lasted about an hour or more.

[76] Whilst initially unwell and psychotic, Ms Finnigan improved during her time on the ward, her conversations made more sense, she became more engaged, speaking articulately about future plans. She described experiences whilst taking recreational drugs, and there was an in-depth, discussion about her recollection of her behaviours leading to admission. She described hearing questions in her head, and answering them, recognising her behaviour as bizarre and being embarrassed by it. While under the influence of drugs she had superficially cut her arms.

[77] In relation to their observation policy categories, the witness confirmed that "General" involved an awareness of patients' whereabouts with regular checks: "Constant" meant the patient was always within sight of a staff member, and "Special" meant patients were within arm's reach of a staff member. Both constant and special observations are considered intrusive.

[78] When Ms Finnigan had attended, she was on constant observations which was restrictive, and following their policy, this was reviewed at least daily, given patients'

presentations changed rapidly, and legislation required patients be treated in the least restrictive way. Under this policy only senior members of staff could reduce observations, whereas any member of staff could increase observations, with an exception if a consultant decided on a "blue flag" meaning only they could review the observation level. Observations were dynamic and could be changed, although a decrease needed a nurse of level 6 or above, and was often done following discussion with an MHO or doctor. If reduced the consultant would be advised, which the witness believed happened in the present case. The witness undertook multiple risk assessments, about 2-3 per week and audited them for staff.

[79] As the Senior Charge Nurse the witness didn't spend lengthy time with patients, but engaged when she could, and always asked staff about each patient's condition. When asking about Ms Finnigan, they reported her improvement, and throughout her own interactions she saw a great improvement as she became more lucid and reactive, smiling appropriately and conversing.

[80] The witness undertook a Risk Assessment Review of Ms Finnigan on 19 December 2019.[178] Given the electronic record system was down, this was recorded on paper. The full risk assessment completed on admission was referred to alongside subsequent reviews, and when considering the suicide risk she recognised previous self-harm related to periods of drug use, as well as her presentation. She scored Ms Finnigan as a low risk for the suicide based on various areas of the assessment, including a

[178] Crown Production Four page 262

subjective and objective clinical assessment, balanced by the principles of the Mental Health Act, and observation policy. The overall risk was scored as high given her drug use, but when all the sections were considered, her revised overall risk score was medium. The witness recalled being told about previous suicide attempts, which she assumed was done during the verbal handover from either a nurse or a doctor. Whilst the STDC referred to the four previous suicide attempts,[179] she could not specifically remember if she had personally reviewed its terms.

[81] When the witness met Ms Finnigan on 19 December 2019, she prepared a lengthy note of this one-hour meeting. [180] She accepted that the note referred to superficial self-harm to her wrists but did not refer to the four previous suicide attempts, and that there was no reference in her assessment to any previous suicide attempts. At section 3.11, dealing with the category of suicide risk identified, she recorded this as being a "yellow, medium risk." She specifically recorded "self-harm to wrists prior to admission," relating this to drug use. She accepted that if she had been aware of the suicide attempts in hospital then there should have been a record of this which would have been considered in the risk assessment, although it wouldn't necessarily have changed her view. Given that she could not recall if she knew about the previous suicide attempts, she could not say if she took these into account. Looking back at her assessment the witness stated that she would not have changed her opinion, even if she had known about these previous suicide attempts. She stated that from a mental health perspective

[179] Crown Production Four page 174
[180] Crown Production Four page 264

that it was important to gain a perception, and gather insights from the patient, and gauge how they were. She recalled that Ms Finnigan seemed quite open, and articulately spoke about her background, showing insight and remorse, and recognising that drug use had altered her mental state. Her impression was that there was a marked difference in her, that she had progressed greatly and was making future plans. She thought the observations should be reduced to general given this progress and insight, and that continuing with constant observations would have been oppressive. Staffing levels played no part in her decision to reduce her observations. She also believed that Ms Finnigan might have taken more drugs, given that during their conversation she talked about taking psychoactive substances that don't always show up in toxicology. In addressing the speed by which Ms Finnigan went from high risk to low risk in 24 hours, she believed that they always tried to reach a balance and provide the least restrictive treatment.

Dr Sudhir Vusikala (52)

[82] Dr Vusikala has been a Locum Consultant in General Adult Psychiatry at University Hospital Wishaw and Community Mental Health Team Coatbridge, employed by NHS Lanarkshire since 28 August 2017. Since October 2024 he has attended University Hospital Wishaw five days a week, although prior to this he attended on Monday and Friday afternoons between 1pm and 5pm, which was the situation in December 2019.

[83] In 2019 the witness held a number of roles, including seeing new and returning patients in the outpatient clinic, and attending Ward Two at Wishaw Hospital, on Monday afternoons for full Multi-Disciplinary Team (MDT) meetings, and each Friday afternoon for patient reviews. The latter were not full MDT meetings, but included patient reviews, and preparing mental health reports for patients detained under the Mental Health Act.

[84] At the relevant time the witness was the Responsible Medical Officer (RMO) for on average 6-8 patients at Wishaw. Between Tuesday and Thursday AMPs, who were senior doctors trained in the duty system, dealt with matters, including reviewing patients under EDCs. If a patient arrived on Tuesday, he would not know about them until Friday. He was not normally involved in admissions unless with patients from his own clinic. He understood that Ms Finnigan's admission to Wishaw was via a referral from PNSL and a consultant, whom he understood to be Dr Karri. He also understood a risk assessment was undertaken by the duty doctor and nursing staff.

[85] In December 2019, MDT meetings occurred on Monday afternoons as this was the only time a Consultant, a Ward Nurse, an Occupational Therapist and a Social Worker / Mental Health Officer and a psychologist were all present. They assessed progress regarding admission, continued medication, and discharge procedures, and the patient's plans were recorded on MiDIS, the electronic case notes used by NHS Lanarkshire at that time. The personnel could change as not every professional was needed for every case; however most were available on Mondays. On Fridays they

reviewed progress and set plans for the weekend. At weekends a rota for on-call consultants operated.

[86] At MDT meetings those present discussed admissions and their progress, what had occurred over the weekend and whether changes to medication and observation levels were necessary, together with the care plan as to how to proceed with patients. On Fridays they dealt with those admitted after Monday, but these were not full MDT meetings and there was always a gap in attendances between Monday and Friday. Friday meetings established plans for the weekend, including medication, and observations. Between Monday and Friday a junior doctor would attend to Ms Finnigan although ward rounds were not necessarily done every day by a doctor. As Ms Finnigan was admitted on a Tuesday she would not be seen for treatment until the following Friday, and there was no consultant oversight between Tuesdays and Thursdays except in emergencies. In December 2019 between Mondays and Fridays, patient care was managed by a duty AMP on a rota basis.

[87] On Friday 20 December 2019, the witness was the Consultant Psychiatrist on Ward Two at University Hospital Wishaw, and as part of his ward round he reviewed Ms Finnigan for the first time. Prior to this review, he viewed her psychiatric notes on MiDIS with information available on the Clinical Portal, including the documentation from her admission to A&E. His normal practice was to also view the STDC, with any other paper notes placed in a patient's folder kept in the nurses' office. This folder contained general patient information, admission documentation, Mental Health Act paperwork, such as the STDC and lab reports, although he could not specify exactly

which records were available to him at the time, or which records he actually read. He recalled seeing the EDC from Monklands Hospital, and the STDC completed by Dr Ravi Karri on 18 December 2019, both of which would have been in Ms Finnigan's paper notes. From these he was aware that Ms Finnigan had tried to end her life by attempted hanging on four occasions and was a high risk of self-harm. He believed he read the STDC as it was in Ms Finnigan's patient folder, in her "paper-light" notes, and he would have been fully aware of its terms when reviewing Ms Finnigan on 20 December 2019.

[88] The witness reviewed the Risk Assessment Review undertaken by Senior Charge Nurse Susan Cochrane on 19 December 2019,[181] which outlined "self-harm to wrists prior to admission – relates this to drug use." This Review had concluded: "Further detained under STD and observations reduced to general." He believed he would have read these entries when reviewing Ms Finnigan on 20 December 2019, and the "Continuation Notes to the Risk Assessment"[182] completed by Senior Charge Nurse Susan Cochrane on that date which concluded: "Agreed to reduce observations to general however to remain on ward until seen by Dr Vusikala." Prior to seeing her he read her notes on MiDIS and the clinical portal which contained details of her attendances at other departments and hospitals.

[89] He had seen the EDC completed by Kimberley Shields dated 17 December 2019[183] in Ward 2 in the "paper-light notes" held in the folder which also contained minimal information details, and investigation reports like lab reports. He also saw in

[181] Crown Production Four page 262
[182] Crown Production Four page 264
[183] Crown Production Four page 121

the same folder the STDC completed by Dr Karri,[184] which confirmed that Ms Finnigan was having a psychotic episode, characterised by auditory hallucinations[185] and that she required further assessment and treatment as an inpatient.[186]

[90] In relation to the Risk Assessment Review completed by Senior Charge Nurse Cochrane,[187] in the "paper-light" notes, his usual practice was to review this before seeing a patient for the first time, as well as having general discussions with nursing staff about a patients' progress since admission, including their detention status and observation level. He could not recall the full details of his review of Ms Finnigan on 20 December 2019, although he completed a note recording that he had noted the circumstances leading to admission and noted that Ms Finnigan was on a STDC. [188]

[91] The note recording his examination of Ms Finnigan concluded that: "it appears that she is much better compared to the time of admission and slowly gaining insight into her condition." He continued the STDC with general observations. He stated that he was aware of the previous hanging attempts, but that upgrading her observation status was unnecessary, and potentially detrimental to her mental health as well as being against the principles of providing the least restrictive care necessary. He spoke to Nurse Carly Truscott, who completed a note,[189] recording that in the preceding week that Ms Finnigan had no contact with medical input; CPN; psychology or social work.

---

[184] Crown Production Four page 172
[185] Crown Production Four page 173
[186] Crown Production Four page 174
[187] Crown Production Four page 224
[188] Crown Production Two page 285
[189] Crown Production Twenty-Three page 483

He discussed Ms Finnigan's attempted suicide in hospital, and noted that she denied any suicidal thoughts, and stated she would stay in hospital.

[92] Based on her progress since transfer to University Hospital Wishaw and presentation at review, he continued with general observations, noting to review matters the following Monday at a full MDT meeting. He did not record previous attempts at self-harm, as this was already recorded in the documentation on admission and the attempted hangings were noted in the STDC. He accepted that he did not note any discussions about previous suicide attempts and could not explain why that would be the case, given this was an important matter that wasn't recorded. He stated that the lack of a note did not mean that he did not discuss this with her with her, although with hindsight he accepted that it might have been better if he had recorded this information. He noted that Nurse Cochrane had reduced Ms Finnigan's observation level, and he reviewed her risk assessment. Any resource implications of constant observations would not affect his decisions. He had considered the risk of ligatures in Ward Two as part of his risk assessment, process and did not consider the reduction in risk from high to low risk within 72 hours to be unusual given that patients' mental states could change rapidly.

Witness Lisa McDonald Fenwick (46)

[93] This witness qualified as a Registered Mental Health Nurse in 2016 and has been a Staff Nurse since then. She was the nurse in charge of the shift on 20 December 2025. She stated that Ward Two was a busy ward with 23 beds which was almost always at

full capacity. There were normally six nurses on duty, but as they were short-staffed there were possibly only three nurses on duty that evening. As she was the nurse in charge on duty that night, she was responsible for rotating staff to deal with the patients on observations and accordingly was aware of every patient's level of observation. A risk assessment was done daily or more often if there was any change in presentation.

[94] The witness admitted patients to the ward, and in her experience, PLNS nurse typically organised risk assessments. It was common to be contacted by them regarding a patient's admission, enquiring if a bed was available. If there was, they would agree to admission, and PLNS often accompanied the patient to the ward, if they were not detained. The witness usually sent the responsible consultant an e-mail advising of the admission, asking them to review the person and their detention, at their earliest convenience.

[95] When Ms Finnigan was admitted, a risk assessment would already have been done and been accessible in MiDIS. After arrival in the ward, patients notes normally arrived a few days later, being delivered to the ward clerk. Ms Finnigan's risk assessment would have been available, although she did not know who completed it. She was aware that Ms Finnigan had been reduced from constant to general observations and had no concerns about this.

[96] The witness did not recall any contact with or interaction with Ms Finnigan prior to this date, and didn't recall seeing her until dinner time, when she looked in her room and saw her either sitting or lying on the bed, and saying her dad was bringing her takeaway food. After serving dinners, the witness received a concerning call from a

relative of Ms Finnigan and they all ran down to her room. When they entered, Ms Finnigan was leaning forward as if she had strangled, rather than hanged herself. She was in the toilet on the right side and had a cord round her neck, leaning forward. It appeared that she had choked herself. A colleague held her to take the weight from her neck, and they retrieved the ligature cutter, managing to get her down and starting CPR.

[97] The witness noticed that three of the shower rail brackets had "popped out" of the ceiling and one, closest to the wall, hadn't. The rail was buckled and twisted at the point where the rail had turned. She understood that the shower curtains were held in place by magnets, meaning that when loads over a certain weight were applied to them that the rail should have collapsed. She recalled previous issues with the rails and phoning Serco, who were the PFI responsible for maintenance, on their helpline asking them to fix a shower curtain, although it was not necessarily this particular one. Since this event, she recalled that every shower rail was inspected. She confirmed that nursing staff were not involved in the inspection of shower rails, apart from reporting faults, and understood the rail had been reported as faulty and repaired incorrectly. The witness was not aware that Ms Finnigan had previously tried to hang herself in the days before this.

Dr Alastair Noel Palin (66) M.B.Ch.B., F.R.C. Psych, Consultant Psychiatrist for Grampian and Clinical and Medical Director of NHS Grampian Mental Health and learning Disability Services.

[98] Dr Palin retired from his full-time role as consultant in 2014 but returned to act in a number of part-time roles, having a particular interest in clinical governance and adult deaths, including chairing a Senior Medical Managers Group. His full report formed Production Eight of the Crown's Inventory of Productions, setting out his qualifications and findings following his consideration of the medical reports provided to him. He summarised the journey of Ms Finnigan following her admission to Monklands hospital on 15 December 2019in his Report.

[99] The witness observed that these records revealed that Ms Finnigan had presented for the first time to services during an acute psychotic episode with a history of self-harm by cutting her wrists prior to admission to hospital. Her level of risk was recognised within Monklands Hospital given she was apparently "specialled" on constant observations. Notwithstanding the apparent constant presence of a nurse, Ms Finnigan apparently repeatedly attempted to hang herself over a 24-hour period commencing on the morning of Monday, 16 December 2019, although the records did not provide clear or consistent documented evidence relating either to her level of observation or these apparent repeated attempts. The witness concluded this was below the standard of care one would have expected.

[100] The witness considered a document entitled "Clinical Observation and Engagement Policy and Guidelines for Best Practise" used by NHS Lanarkshire's

Mental Health and Learning Disability Service which outlined the different levels of observations and included a document entitled "The Patient Observation Recording Sheet," to be utilised for all patients on enhanced observations. There was however an apparent disconnect between the application of this document and policy with the no reassurance it was applied within NHS Lanarkshire for any hospital.

[101] A further concern related to the interface between the Hospitals around the role of PLNS. He accepted that they were initially appropriately involved at Ms Finnigan' assessment, making helpful suggestions regarding her psychiatric management on 15 December 2019, however there was no further assessment or continued involvement in her management by PLNS until the need for crisis assessment in the early hours of the morning of 17 December 2019. There was also no formal psychiatric review by PLNS on Monday, 16 December 2019 after Ms Finnigan had been admitted placed in special observations overnight following the first PLNS assessment.

[102] The witness was also concerned that Ms Finnigan was admitted to Monklands Hospital with an apparent first episode of psychosis and history of self-harm but had no senior medical review either from a senior medical doctor or a psychiatrist on Monday 16 December 2019, despite apparently attempting to hang herself in the early hours of that morning. Her next contact with mental health services was with PLNS on 17 December 2019, by which time she had apparently repeatedly attempted to hang herself and been placed under an EDC given ongoing concern regarding her mental state and behaviour.

[103] A further concern regarding her care in Monklands Hospital related to the role of the PLNS more generally, particularly their apparent lack of involvement and use of standardised documentation during Ms Finnigan's transfer to Wishaw Hospital. There was also no formal handover from PLNS to staff within Wishaw Hospital, despite their central goal being to ensure an adequate transfer of information to specialist mental health services. This did not occur in Ms Finnigan's case despite her history of apparent repeated hanging attempts.

[104] In relation to her care within Wishaw Hospital, Dr Palin expressed concern about the lack of acknowledgement of Ms Finnigan's recent significant history of apparent repeated hanging attempts when considering her level of risk. A number of opportunities were lost to share this information with staff, both in the transfer of information from Monklands Hospital but also in relation to the assessments carried out following her transfer, and in particular the assessment regarding the application for a STDC by a locum psychiatrist on 18 December 2019.

[105] The immediate discharge letter[190] completed by Monklands on 17 December 2019 specifically referred to Ms Finnigan's attempts to hang herself four times whilst detained under an EDC, yet this information was not provided to Wishaw hospital, particularly by PLNS. Further the standard STDC certificate completed by the duty AMP, Dr Karri on 18 December 2019 specifically commented that Ms Finnigan had tried to end her life on four occasions by hanging and was a high risk of self-harm, yet there

[190] Crown Production Three page 9

was no corresponding written entry from him in the records provided to the witness. Contemporaneous nursing records for 18 and 19 December 2019 continued to erroneously state that Ms Finnigan remained subject to an EDC despite the STDC having been granted on 18 December 2019. Accordingly despite overt acknowledgements within the STDC of the apparent repeated attempts by Ms Finnigan to hang herself, there was no documentation to evidence that this information was ever considered by staff within Wishaw Hospital.

[106] Dr Palin opined that the lack of information sharing by the staff of Ward Two, Wishaw fell well below an acceptable standard both in relation to their interaction with Monklands Hospital but also internally, losing a number of opportunities to share vital information which might have significantly influenced Ms Finnigan's ongoing management there. Further the documentation supporting the risk assessment by Senior Charge Nurse Cochrane on 19 December 2019 did not reference Ms Finnigan's apparent repeated attempts to hang herself only two days before, and this significant risk factor was apparently not considered when reducing the risk level from high to medium with the consequent change from constant to general observations on 19 December 2019. Further it was clear from the records relating to the MDT review on 20 December 2019 that these significant risk factors were again not considered. In the MDT meeting summary by Dr Vusikala , he made no reference to previous self-harm despite a known history of her cutting her wrist prior to admission on 15 December 2019.

[107] The witness considered that the communication between Monklands Hospital and Wishaw Hospital was substandard, and the level of risk posed by Ms Finnigan was not adequately assessed or acknowledged. While the risk assessment undertaken on 19 December 2019 may have been of a high standard, it clearly did not consider all the relevant risk factors relating to Ms Finnigan as presumably the assessor was unaware of them. Dr Palin believed that had she been aware of these significant risk factors, particularly the alleged repeated attempts to hang herself two days before the risk assessment, that the change in observation status would have been different.

[108] Dr Palin also expressed surprised at the rapidity of the change in Ms Finnigan risk, from high risk and requiring special observations on 17 December 2019 to being regarded as low risk and on general observation within 72 hours, particularly given her presentation with first episode psychosis. He believed this level would not have changed so rapidly had all the information regarding significant risk factors been available to the team at Wishaw hospital.

[109] The witness considered the failure to keep accurate records by staff and expressed significant concerns regarding the standard of record keeping, particularly about Ms Finnigan's apparent repeated attempts to commit suicide by hanging, and the lack of any apparent system providing a consistent application of the Observation Policy across NHS Lanarkshire sites. He highlighted concerns about:

1. The lack of review and associated documentation by senior medical or psychiatric consultant by the PLNS on Monday, 16 December 2019;

2. The lack of any formal transfer documentation from PLNS to specialist inpatient service based at Wishaw;

3. The lack of any contemporaneous entry within Ms Finnigan's records by the AMP who carried out the STDC assessment on 18 December 2019. While the STDC specifically referenced Ms Finnigan's apparent repeated attempts to hang herself, there was no similar contemporaneous acknowledgement of this, or record of the AMP assessment in the notes.

[110] Dr Palin believed that it was likely the nursing staff did not consider in detail the contents in the STDC regarding the attempted hanging, particularly given the nursing entries from both 18th and 19 December 2019 continued to indicate that Ms Finnigan had been treated under an EDC and not, as was the case, a STDC.

[111] The witness also considered the absence of a mental health risk assessment being carried out whilst in Monklands Hospital and expressed concerns regarding the lack of liaison between PLNS and Wishaw Hospital. Whilst accepting Ms Finnigan was appropriately assessed by a psychiatric liaison nurse on 15 December 2019 with appropriate suggestions being made, including a planned review on 16 December 2019 (which did not in fact take place), but suggested these records indicated a somewhat chaotic approach to Ms Finnigan's psychiatric management in Monklands Hospital. There was no clear recording of her observation status or detailed entries regarding her repeated attempts to hang herself. He was concerned that this may be a systemwide issue and that NHS Lanarkshire were not applying the same standards of care in different hospital sites in relation to their own observations policy. For example, under

the provided Observation Policy there was a clear expectation that the form relating to enhanced observations would be completed by those observing the patient which would thereafter be available to the treating teams in Monklands and Wishaw Hospitals. This was not done, and this issue required to be urgently addressed by NHS Lanarkshire to ensure an equity of observation provision, and that the appropriate documentation associated with this policy was implemented across every inpatient hospital site, thereby contributing to a more coherent structure around risk assessment. Furthermore as part of this approach the role of PLNS, and how it related to and communicated with the wider system required to be considered, given their significant role in ensuring appropriate risk assessments and sharing relevant information with specialist inpatient psychiatric services.

[112] The witness considered the decision to remove observations from constant to general, and expressed concern about the rapidity of this reduction, particularly so soon after her apparent repeated suicide attempts. He accepted that the risk assessment of 19 December 2019 was of a high standard based on the information available but was concerned that the decision was to reduce from high risk to "medium" risk rather than initially to "medium/high risk." On balance however he accepted the decision to reduce the observation levels was of an acceptable standard and within NHS Lanarkshire policy.

[113] The witness specifically considered whether accurate records of the four full suicide attempts in Monklands would have altered the decision to reduce observations and highlighted missed opportunities to share this information with staff at Ward Two,

Wishaw Hospital. Whilst acknowledging the benefit of hindsight, he believed that had this information been available to the treating team in Wishaw then the decision to reduce levels of observation would have been different, given this was a young woman presenting with first episode psychosis who was apparently making significant attempt to harm herself hours before the reduction in risk level and observation. Specifically the reference to the fact that it took three nurses to get her out of the toilet in the early hours of 17 December 2019 was significant. On balance he believed that awareness of such significant levels of apparent suicide attempts driven by psychotic illness would have altered the outcome of any risk assessment carried out on 19 December 2019, and any decision to reduce observation levels should have been delayed allowing a more detailed assessment of Ms Finnigan's mental state.

[114] The witness considered whether given that Ms Finnigan was detained on a STDC would she be expected to have had access to a dressing gown belt, and he expressed the view that given the treating team were unaware of the recent alleged attempts to hang herself and she was assessed as being at low risk and on general observations, he would not have expected staff have removed items such as her dressing gown belt. A balance had to be maintained between the risks posed by patients and respecting their rights to be treated in a patient centred individual way, which applied equally to individuals detained under STDCs. He did not believe that was inappropriate for Ms Finnigan to have access to the dressing gown belt, although such continued access may have been unlikely if the attempted hanging attempts had been known to her treating team. Furthermore if this information had been available to the treating team, then detailed

consideration regarding her access to potential ligature points would have been carried out, and a different decision regarding access to these items would in his opinion have been different.

[115] Dr Palin also expressed his opinion on the Significant Adverse Event Review undertaken by NHS Lanarkshire dated 7 June 2020, stating an initial concern that the team undertaking the process did not include colleagues from Monklands Hospital, despite the Review being said to consider care from the point of initial admission, meaning it did not address fundamental issues, particularly the lack of recording about Ms Finnigan's attempts to hang herself, which was of particular relevance given concerns in the context of Wishaw Hospital staff not being aware of a significant risk factor. He believed the Review failed to address other significant concerns regarding the role of PLNS and was concerned regarding the lack of senior psychiatric input in Monklands Hospital meaning Ms Finnigan did not receive adequate care or a psychiatric review on 16 December 2019, despite attempting to hang herself for the first time on that date.

[116] The witness also believed that the Review failed to address concerns regarding communication lapses following the admission of Ms Finnigan to Wishaw Hospital on 17 December 2025. The STDC issued on 18 December referred to repeated hanging attempts, yet there was no contemporaneous entry in the mental health records from the AMP regarding Ms Finnigan's mental state at that time.

[117] Whilst acknowledging positive of the Review, the witness believed it did not adequately address a number of significant concerning aspects of her care. He was

concerned about the lack of explanation about why Ms Finnigan was not subject to the appropriate observation policy whilst an inpatient within Monklands Hospital despite her history of self-harm before admission, her history of repeated attempts of significant self-harm driven by psychosis following admission to hospital, and the fact she was detained on an EDC in the hospital. The witness was also concerned about the interface between PLNS and Acute Inpatient Psychiatric settings and the lack of standardised communications about the significant level of risk of hanging during the transfer on 17 December 2019.

[118] Dr Palin also expressed concern about the failure to acknowledge and address the sequence of events surrounding the assessment by a duty AMP on 18 December 2019. While this doctor knew of Ms Finnigan's recent alleged repeated attempts to hang herself in hospital, there was no documentation recording his interaction other than the STDC itself, leading to the suspicion that this document was not read by the treating team in Wishaw hospital, a suspicion bolstered by the fact that it was not acknowledged as a significant risk during the risk assessment by the senior charge nurse the next day, and the fact nursing staff continued to record Ms Finnigan as being subject to an EDC rather than a STDC.

[119] Dr Palin further noted that the Review failed to address the quality of Dr Vusikala's entry on 20 December 2019, and the fact that this assessment only occurred 72 hours after her admission to Wishaw hospital, or why Ms Finnigan was assessed by a duty AMP on 18 December 2019 rather than by Dr Vusikala, or other member of the treating team. Even after the duty AMP assessment, it was some

40 hours before she was assessed by Dr Vusikala, whose entry from 20 December 2019 did not adequately address or record issues such as the previous history of self-harm and suicidal behaviour which were clearly of great relevance. The witness also expected Dr Vusikala would have specifically discussed the previous suicide attempts and to have recorded these discussions. He also observed that "drug induced psychosis" was a lazy diagnosis given many people took drugs but did not suffer the same effects, and when the drugs were out of the patient's system they should soon return to normal. It should only ever be a working diagnosis.

[120] The witness highlighted concerns about the standard of record keeping and psychiatric care offered in University Hospital Monklands; the lack of a standard approach to observation practise and a standardised observation policy across NHS Lanarkshire; the role and interface of PLNS and Liaison Psychiatry in general with acute psychiatric inpatient services; the role of the "duty AMP service" within University Hospital Wishaw and its interface/information sharing with ward-based clinical services; and the quality of clinical assessment at and recording of MDT meetings;

[121] In relation to Nurse Cochrane's Risk Assessment of 19 December 2019, he acknowledged her position but believed that had she known about the previous attempts at hanging that this may have impacted on her decision. Risk assessments had moved away from "tick box" exercises to more individual interviews with assessors looking at past behaviour. There should have been a discussion about why Ms Finnigan had been so distressed which appeared not to have taken place. He was also wary of decisions made without further interaction with the patient, particularly those based on

one interview, and considered that more weight should have been placed on Ms Finnigan's circumstances in Monklands. He remained concerned about the rapidity of the change from constant observations despite the level of risk apparently settling.

[122] Dr Palin agreed that Ms Finnigan's trajectory was good, she was improving and not presenting as acutely distressed, but remained concerned that no-one had considered her management, worked on a safety plan, or considered the risk factors from a few days before. By way of a comparator in the Grampian Health Board area, an AMP was available to deal with emergencies but also to see patients admitted to psychiatry within 24 hours, whereas Dr Karri made clear this was not his role. He was also concerned that Ms Finnigan entered Wishaw Hospital on Tuesday and was not seen by a consultant for three days.

[123] Dr Palin accepted the least restrictive approach as a central tenet of mental health treatment, and that patients required to be always treated with respect, particularly on an acute psychiatric ward, and building a rapport and trust with patients was important. Nurses were trained in observations, as shown in NHS Lanarkshire's Clinical Observation Policy,[191] and he accepted the principles set out in this policy were developed as good practice for clinical observations in mental health. He recognised the three types of observation identified,[192] but believed developments had moved on from that system and in particular he did not recognise what was meant by "specialled" where there did not need to be a nurse present. In terms of patient insight, this was

[191] Crown Production Six page 298
[192] Crown Production Six page 304

double-edged, given that as this was developed, patients could be at a higher risk when they realised how ill they had been, and what harm they had caused to others.

[124] Dr Palin believed the handwritten assessment of Nurse Cochrane in terms of what discussed, was reasonable.[193] Ms Finnigan was gaining insight, and discussing future plans was a good sign. She expressed no suicidal ideation at the time when discussing reducing observations to general, however he re-iterated nothing in this note mentioned the repeated hanging attempts, and Ms Finnigan should have been asked what she remembered of these and asked why she did it. He remained concerned about the lack of conversation about the previous suicide attempts.

[125] On balance the witness considered that on the information offered that he could not say that observations should not have been reduced but felt that a very significant matter was not discussed. Whilst hearing voices was not unusual, the fact she had acted on these so recently concerned him, as the people who worried him most were those who acted on these. He believed the greatest predictor of future behaviour is past behaviour.

Professor Anthony Pelosi (70) Consultant Psychiatrist NHS Tayside

[126] Professor Pelosi was a Consultant General Adult Psychiatrist in NHS Lanarkshire between 1992 and 2012 covering the inpatient and community care of patients aged 18-65 years within Lanarkshire, being mainly based at Hairmyres

[193] Crown Production Four Page 264

Hospital, East Kilbride. He is the Visiting Consultant at the Priory Hospital in Glasgow; was an Honorary Senior Lecturer at the University of Glasgow between 1994-2006; and an Honorary Professor of Psychiatry there since 2006. He has published around 100 research articles and commentaries in peer reviewed journals, a quarter of which concerned clinical services provided to people with psychotic illnesses.

[127] Professor Pelosi noted the history of Ms Finnigan being brought to the A & E Department of Monklands Hospital on Sunday 15th December before being transferred to their medical wards in the early hours of Monday 16th December. Medical investigations, including a lumbar puncture to exclude encephalitis, were undertaken although the consultant physicians considered it more likely that her presentation demonstrated the onset of a severe psychiatric illness such as schizophrenia or psychotic depression, possibly due to hallucinogenic street drugs or a combination of both. Given the lumbar puncture was clear, Ms Finnigan was transferred on Tuesday 17th December to Ward 2 at University Hospital Wishaw, a Psychiatric ward where Dr Vusikala was a consultant.

[128] Dr Vusikala saw Ms Finnigan on the morning of Friday 20th December with Staff Nurse Truscott and a Student Nurse, at what was described in the notes as a Multidisciplinary Team (MDT) meeting, although it was more accurately a ward round or review. Dr Vusikala's MDT meetings at that time were held weekly on Mondays, and constituted the main forum for decisions about patients, being attended by the Consultant Psychiatrist, nursing staff and sometimes a trainee Psychiatrist on the team. Other members of the clinical team such as Occupational Therapists, Social Workers,

and Clinical Psychologists would also if they believed they could contribute to the care plans of the inpatients. Some consultants invited patients' relatives to MDTs, although others avoided this due to time pressures.

[129] The witness suggested that Dr Vusikala's additional Friday ward round, allowing him to assess patients and alter care and treatment plans, was a good practice, allowing decisions to be made before the main weekly MDT meetings, and also helped with decisions regarding observation levels, providing extra time to see newly admitted patients who would otherwise have to wait until the main MDT meeting to meet their consultant. Access to the electronic care records via laptop computers, was available and there were also "paper-light" case records available for each patient. When Dr Vusikala saw Ms Finnigan, he had read these "paper-light" written case records. The witness observed Dr Vusikala's typed notes and considered these to be clear and succinct notes of a careful psychiatric assessment. Ms Finnigan was improving from the very severe psychotic phenomena she had been experiencing, and while noting ongoing paranoid symptoms, these were not fixed beliefs unlike the persecutory delusions in Monklands Hospital. Specifically there was no evidence of hallucinations, again contrasting with the florid hallucinations telling her to kill herself and harm others. Ms Finnigan's mood was noted as being "OK," which was reassuring in relation to the risk of suicide. The comment regarding a rapport being established was particularly important given that patients could be guarded and mistrusting, and meant Dr Vusikala was getting a true picture of Ms Finnigan's experiences in her thoughts and emotions.

[130] Professor Pelosi considered that Dr Vusikala's psychiatric assessment, and brief mental state examination was a careful assessment, covering the most important points. A rapport was established, and whilst he still detected paranoia, Ms Finnigan denied suicidal thoughts. Importantly her mood had improved, and accordingly Dr Vusikala believed it was appropriate for her to be on general observations at that time. He believed Dr Vusikala was aware of the previous hanging attempts, obtaining that information from the certificates. He also noted Ms Finnigan had agreed to stay on the ward and the indicators were she was improving.

[131] The witness noted that the STDC contained information that Ms Finnigan had tried to hang herself and he expected Dr Vusikala had read this. He expected him to record important and salient matters, and if these had been discussed, he would have expected this discussion to be recorded. He was surprised that Dr Vusikala had noted less important details on the note and opined that if there were discussions about the suicide attempts, there should have been a note about these. However he knew of no policies/guidelines about what was an adequate clinical assessment and mental state examination by a consultant Psychiatrist.

[132] He noted that Ms Finnigan was on general observations by the time of Dr Vusikala's assessment and he did not increase this level to 1-1 observations, which he opined was the appropriate clinical decision. The features of paranoia were not fixed and therefore unlikely to lead to disturbed behaviour, and Dr Vusikala was reassured by Ms Finnigan denying thoughts of suicide, and the absence of distressing hallucinations. The trajectory of her condition was one of improvement and without the benefit of

hindsight he could not justify re-introducing a more restrictive, intrusive, and less therapeutic care plan involving increased observations.

[133] Dr Vusikala's brief statement around the circumstances leading to admission were noted and whilst it was "unfortunate" that he did not list everything discussed, the witness's opinion was this was unrealistic in routine ward round notes. He considered that the worrying features of Ms Finnigan's clinical presentation were contained in other parts of the paper and computerised clinical records, and it wasn't possible in a busy general psychiatric practice to list every worrying clinical feature discussed at ward rounds. Any trend towards repeating a patients' past and current clinical problems to demonstrate awareness of every risk factor in the event of subsequent scrutiny of the clinicians' decisions could only occur with extremely small caseloads and not busy psychiatric practices.

[134] In relation to concerns that Dr Vusikala and the Ward Two Team may have been unaware of Ms Finnigan's attempts to hang herself on four occasions while in Monklands Hospital, the witness noted the "Immediate Discharge Letter,"[194] from Monklands Hospital, was very good and incorporated the important features in Ms Finnigan's case. However, he could not find a copy of this in the Wishaw notes provided to him and noted it was written in the hours following Ms Finnigan's transfer. As such he was unsure whether this ever found its way to Ward Two, Wishaw, which would have been a missed opportunity to draw some of the risk issues to the attention

[194] Crown production Three page 9

of the new team after transfer. Notwithstanding this, the EDC did accompany the patient to Wishaw as part of the "paper-light" notes and stated: "Patient has suicidal ideation and has tried to hang herself x4 on the ward." The episodes of hanging were also specifically mentioned in the STDC completed in Ward Two at Wishaw in the afternoon of Wednesday 18th December by Dr Karri, the AMP, and the STDC was also filed in the paper notes.

[135] It was noted that there were no specific mentions of the hanging attempts within other parts of the Wishaw Hospital paper and computerised notes, which may have indicated that this particular worrying aspect of Ms Finnigan's history did not become a part of the shared clinical knowledge of the Wishaw team. Accordingly a piece of recent clinical history that would "ring alarm bells" may not have been factored into the decision-making of the Wishaw Team as a whole, and this gap in clinical knowledge may have caused an underestimation of the severity of Ms Finnigan's psychotic illness, although the other worrying features were noted in various parts of the computerised records and the "paper-light" file.

[136] When Ms Finnigan was admitted to Ward Two by Staff Nurse Carr on Tuesday 17th December, she had noted: "Kerry spoke about getting intrusive thoughts and images that are not hers and is hearing voices which are negative and tell her to kill herself." She also completed the Mental Health Assessment, noting comments such as: "Mood - really low. Rated 2 out of 10"; "intrusive thoughts - people speaking to me - negative - kill family"; "main thing is intrusive thoughts - getting darker and darker. Tell you to harm self. Tell worthless and go die. Had previously but not to extent";

"Not present moment but fleeting thoughts of voices are becoming too much. Protective factors - sister and dad"; "...would come and approach staff if it was getting too much". Nurse Carr had noted "Constant obs due to psychotic symptoms and command hallucinations to minimise risk". Command hallucinations, telling patients to harm themselves and/or others, were a worrying feature in psychiatric practice, and all trained mental health clinicians were aware of these. The witness was confident therefore that this important clinical feature was given to the nurses at each handover.

[137] Other worrying features were documented by various members of staff in various parts of the computerised records and the paper notes, which would have played a part in her remaining on 1-1 constant observations. The witness understood that policy within every British psychiatric hospital is that 1-1 observations must be reviewed at least daily, and the NHS Lanarkshire policy required this could only be done by senior nursing and/or senior medical members of clinical team. A review could take minutes or even seconds if someone was very unwell and levels of risk were obviously high. In Ms Finnigan's case 1-1 observations were continued throughout Tuesday 17th and Wednesday 18th December, being reviewed on Thursday 19th December as part of the clinical assessment and intervention carried out by Senior Charge Nurse Susan Cochrane.

[138] The witness considered that Nurse Cochrane's note was a good narrative summary of Ms Finnigan's experiences through during the psychotic episode, documenting how the intensity of the psychotic symptoms had lessened. They discussed her supportive family, the adverse effects of drugs, and hallucinatory voices

experienced. Ms Finnigan now realised these persecutory beliefs were "delusional," and they discussed how her symptoms were alleviated since admission, and discussed her future plans, her English Literature degree, and working towards becoming a teacher.

[139] Following this discussion and the more structured information obtained from the Risk Assessment Review, it was decided to reduce the 1-1 observations. Nurse Cochrane had written "Observations reduced to general - Kerry agrees due to improvement in mental state and absence of psychotic symptoms." This action plan was agreed by all of the nursing staff, and the improvement in Ms Finnigan's mental state was documented by other nurses in the team. While being aware that she was still having hallucinations, she was brighter and interacted well with staff on 19th December.

[140] The witness opined that the reduction in observations followed a careful structured clinical assessment of a patient. The staff were aware of the initial severity of her clinical presentation and also the improvement in her symptoms and the decision was carried out in line with NHS Lanarkshire's Observations Policy. The witness believed that Ms Finnigan's improved clinical presentation would have reassured the ward team over the following day when she had visitors and the quality of these visits had improved without constant observations. He believed the decision to reduce observations level to general and to continue with these over the next two days was carefully reached and within the evolving standards and approaches of inpatient Adult Psychiatry, and the policies of NHS Lanarkshire.

[141] Addressing the concerns of Dr Palin that Dr Vusikala did not see Ms Finnigan between her admission to Ward Two on Tuesday until his meeting on the Friday

morning, in his experience he believed this was standard practice for consultant Adult Psychiatrists. Given competing demands, many consultant Psychiatrists only attended inpatient units once per week for full MDT meetings, whereas Dr Vusikala also routinely attended an additional team meeting/ward round. A duty AMP system also operated, with senior psychiatrists serving on a rota to deal with urgent clinical matters. The witness believed it was good practice for Dr Vusikala to have this extra meeting/ward round to deal with routine matters about his known patients and to see and assess new patients outwith the MDTs. When wards were busy, consultants might have their own initial meetings and assessments, although it was best practice for a Nurse and, if available, a Trainee Doctor to accompany them for good communication and efficiency when preparing the patients' care plans. In busy psychiatric wards, decisions were made at the MDTs, where case records were available on laptops and access to test results was available online.

[142] The witness believed Ms Finnigan was adequately assessed by Dr Vusikala who carried out an adequate clinical assessment including a high-quality mental state examination. He considered Dr Vusikala was correct not to increase the level of observations to "intrusive and untherapeutic" 1-1 observations. The clinical information available to Dr Vusikala indicated a trajectory of improvement. He was aware from the Certificates within the "paper-light" notes that Ms Finnigan had attempted self-hanging, and he and the nursing team were well aware of how florid and worrying her psychotic illness had been. However this did not "trump" the indicators of improvement and reassurances that she was no longer suicidal. In relation to Ms Finnigan's dressing

gown cord, he believed that given her mental state examination and the trajectory of her illness, it would not have been appropriate to remove her dressing gown cord.

[143] On balance Professor Pelosi considered Dr Vusikala's record keeping to be of an adequate standard when the "paper-light" notes and computerised notes were considered together, and concluded that Ms Finnigan had received high quality and appropriate care for the initial management of a first episode of a psychotic illness during the four days when she was in Ward Two of Wishaw Hospital. This was well-documented by staff, with no evidence of complacency in any of the records. The Wishaw team were aware of worrying clinical features, especially the command hallucinations telling Ms Finnigan to kill herself and harm others, but her clinical management reflected this, and it had changed gradually and appropriately as she showed improvement. A less restrictive care plan was instituted following clinical assessments by senior staff and Dr Vusikala, who carried out a careful mental state examination that provided reassurance that Ms Finnigan was improving and posed a gradually reducing risk to herself.

[144] There were however shortcomings in the communication of information about Ms Finnigan's attempts to hang herself while in Monklands Hospital, and at the very least, there was inadequate documentation held by the Wishaw team of this important part of the clinical history. In particular it was likely that the Discharge Letter[195] did not accompany the patient on transfer, with its information about the hanging attempts not

[195] Crown Production Three page 9

being passed on verbally and in writing to became part of the clinical knowledge of the whole Wishaw Team. It was likely therefore that information about the hanging attempts in Monklands Hospital was "lost" to the Wishaw nursing team. It was impossible to say with certainty however whether this information would have trumped Ms Finnigan's improved clinical presentation.

[145] The witness believed that Dr Vusikala was aware of these attempts from the STDC and agreed that general observations were sufficient given the information he had and Ms Finnigan's clinical presentation. The Wishaw team were aware of the extreme nature of Ms Finnigan's psychotic episode and factored this in when deciding how best to help her with the least restrictive treatment plan possible. Without hindsight, this was the correct decision and similar to decisions made by Dr Vusikala and his ward colleagues several times every week. He believed also that the NHS Lanarkshire Clinical Observation Policy was appropriately applied, and that the case records at Wishaw Ward Two were of an adequate professional standard with the combination of the computerised notes and the handwritten "paper-light" notes which included the EDC and the STDC.

Gordon Gray

[146] Gordon Gray was Head of Health and Safety for NHS Lanarkshire at the relevant time and recalled this incident. He was informed that Ms Finnigan had secured a ligature to a shower rail, and that her cause of death was hanging. He understood that these shower rails were designed to avoid risk by collapsing but evidently this rail had

not done so. He conducted an investigation into the reasons for this non-collapse, and was responsible for preparing two documents, namely a Technical Review Summary Paper issued on 7 September 2020,[196] and a Failure of Anti-Ligature Shower Curtain Rail to Prevent a Completed Ligature Technical Review[197] issued on 24 December 2020 following these investigations.

[147] He confirmed that the shower rail in question was a GOELST G-Rail 4100 Load Release System Curtain Rail, purchased and installed as part of a refurbishment programme in January 2014, having been recommended by the architect. When purchased in 2014 this rail was marketed as an "anti-ligature" shower rail but was now marketed as being a "ligature reduction" fitting. At the time of purchase it was believed that upon stress, the rail would detach from the brackets preventing it being used as a ligature point. In the present case he understood that two or three of the brackets failed to detach and he sought to identify why the anti-ligature mechanism had so failed.

[148] The witness requested that the original specialist installer of the shower provide a report on their findings,[198] and noted as follows:

1. That the shower rail track was installed as part of a refurbishment project overseen by an architect in 2014 and installation followed the manufacturer/supplier's instructions and training received.

2. That prior to removal the contractor noted the pin going into the left wall bracket did not detach from the wall or release the shower curtain rail during

[196] Crown Production Thirteen page 367
[197] Crown Production Fourteen page 371
[198] Crown Production Thirteen page 367

application of the ligature and following the completed ligature it was loose from the track and badly bent. The hanger rod pin was tight to the track and appeared straight. The right-hand wall bracket was detached from the fixing plate.

3. There were filled holes matching the bracket fixture positions to the side of the existing bracket positions, indicating the wall brackets had been moved since the original installation.

4. The specialist installation and maintenance contractor could not confirm if a maintenance regime was in place for this track as their records showed they were never instructed to test, move or replace the red receivers. However they supplied the red receivers to the Private Finance Initiative maintenance contractors who were responsible for the maintenance of the shower curtain rail. They could not confirm if the red receivers had been changed after each deployment in line with the manufacturer/supplier's guidance.

5. Varying sized screws, different to the original installation screws, had been used following previous re-active repairs.

[149] The manufacturer/supplier of the shower rail also reported the following results from the physical investigation of the shower rail, shower rail components, and observation of photographs of the shower rail in situ after its use as a ligature.[199]

1. The shower rail has three fixing points. Two fixing plates on either side of the wall and one on the ceiling. The shower rail had detached from the right-

[199] Crown Production Thirteen page 378

hand wall plate resulting in twisting to the left side of the shower curtain rail and ceiling support.

2. The damage to the single ceiling support was consistent with a load being applied to the right-hand leg of the shower curtain rail, which would cause the left-hand leg of the curtain rail to twist.

3. Following a previous activation one of the two retaining brackets had not been correctly repositioned when the system was reinstated.

4. The shower curtain rail and components showed evidence of multiple activations. Examination of the receivers holding the shower curtain rail in place indicated they had not been replaced on previous deployments as recommended by the manufacturer/supplier.

5. Due to damage sustained it was not possible to undertake a meaningful load test of the shower curtain rail used by Ms Finnigan. However an identical shower curtain rail was set up in a similar setting and tested. During testing the average pull test value was 31 kg and with multiple testing the system deployed at decreasing values.

[150] Having considered these findings the manufacturer/suppliers had concluded that the shower curtain rail system used by Ms Finnigan would most likely perform in line with their expectations, and they would expect it to detach from the mounting brackets if a load exceeding 50 kgs was suspended from it even if the load was applied slowly. Repeated activations reduced the anticipated release load of the shower curtain

rail system to typically 28 kg or less. No feedback was provided as to why the anti-ligature shower rail was successfully used as a ligature anchor.

[151] NHS Lanarkshire's findings identified that part of the shower rail system had detached from one of the shower curtain rail mounting brackets, but another section of the shower rail had remained attached to a ceiling and wall bracket, and the remaining attached curtain rail was successfully used in the completed ligature when the remaining shower curtain rail sections had failed to detach from the wall and ceiling mounted fittings, facilitating the completed ligature.

[152] Maintenance for the shower rail was undertaken by Serco who were the PFI contractor who owned and manage the maintenance of the shower rails. Any entries about the shower rail were limited to reactive maintenance undertaking by on-site maintenance staff who had not received any formal training from the manufacturer/supplier and who were not familiar with the rail system or their components, which was now known to be contrary to the manufacturers recommendations. However this was not believed to be material to the shower rail not fully detaching from the wall and ceiling mounting brackets. Accordingly, although the maintenance may have been contrary to the manufacturer's recommendation, this was not material.

[153] NHS Lanarkshire had commissioned people to oversee the testing ensure it was in line with the manufacturer's guidance, and these tests had been pre-planned and in accordance with the manufacturer guidelines. It was tested regularly and if it failed there would be a request for it to be repaired. On some occasions they would come and

check the area where detached, and on others they may have had to replace it if damaged during detachment. He confirmed that only reactive testing was done. As part of this process he was aware that non-approved fittings including screws were used, however he did not consider this to be material as the pull test of these were all within the manufacturer's tolerances. He noted that the tests with non-approved screws still detached at between 35-40kgs.

[154] An Estates and Facilities Alert (EFA) was issued in March 2019,[200] entitled "Anti-ligature type curtain rail systems: Risks from incorrect installation or modification," and advised Health Boards to review anti-ligature rail systems for possible unexpected failure to operate as intended. This included testing anti-ligature rail systems in line with the manufacturers guidance and also at an angle. This document confirmed there had been seven separate incidents in the preceding 12 months involving attempted suicide in a mental health ward where an anti-ligature curtain rail system had failed to operate as expected, pointing out that they could fail to operate as expected if not installed according to manufacturer's instructions. The document also highlighted that in one particular incident it was identified that an excessive load was required to activate the safety collapse of the rail where angular force (30-45 degrees from vertical) was applied, and normal testing methods would not have revealed this. The witness was not aware of this at the time of the incident involving Ms Finnigan.

[200] Crown production nineteen page 455

[155] The property and support services division of NHS Lanarkshire undertook an audit and inspection of mental health inpatient facilities, shower and bed rails in 2019, reporting all shower and bed rails at University Hospital, Wishaw were compliant, and he believed these checks were done before the incident.

[156] Following Ms Finnigan's death, the head of health and safety for NHS Lanarkshire and the specialist installation and maintenance contractor undertook a joint inspection and testing on an identical shower rail to that installed in Ward Two, Room Five at Wishaw Hospital, carrying out load testing on the shower rails. The contractor found that the rails detached from the fixings when a vertical load was applied within the normal range of 35 kg. It was noted that the manufacturers guidance and training only included undertaking load tests vertically.

[157] The head of health and safety instructed the specialist installation and maintenance contractor to undertake a pull test at an angle on the shower rail. When carried out at an angle, the shower rail and fittings twisted and acted as an anchor point, which led to permanent damage to the rail and a fixed anchor point ligature. This was a destructive test, whereas the manufacturer/supplier guidance was for contractors to undertake non-destructive tests. The damage caused to the shower rail was consistent with the findings indicated by the specialist installation and maintenance contractor and the manufacturer/supplier of the shower rail from the examination of the damaged shower rail fittings and components following the death of Ms Finnigan. The witness noted that the pull test at an angle meant that it twisted and could be used as an anchor point.

[158] During the angled pull test the rail could not be detached from the ceiling or wall mounted brackets. It was concluded that when the shower curtain rail is damaged/twisted there is potential for the fittings to twist and mounting pins become damaged which, under certain circumstances appeared to create a secure anchor point that could then be used as a ligature anchor point to aid deliberate self-harm/suicide. This potentially explained why the shower rail used in the completed suicide failed to fully detach from two of the three fixing points.

[159] Following these results, a rapid review was undertaken to identify a suitable replacement shower rail system. The Kestrel Magnetic System shower rail was selected as it detached when vertical loads were applied as well as loads at an angle. All shower and bed rails in Wards One, Two and Three of Wishaw Hospital were subsequently replaced with this system to prevent similar incidents occurring. The witness confirmed that all the other shower rails in NHS Lanarkshire in mental health settings have been replaced with the Kestrel Magnetic System, which were still in use, to avoid similar self-harm. He was not aware of what other NHS Boards were doing, (other than NHS Highlands who told him they had replaced theirs) but he did make them aware of his findings.

[160] On behalf of the manufacturers it had been suggested that following activation that the system was not re-installed properly and there may have been multiple activations. They observed that due to the damage sustained they had been unable to undertake a meaningful test, although having carried out similar tests they noted that the average pull test value had been 31kgs. However they had only tested with a

vertical load test. It was also found that repeated activations reduced the effectiveness of the system and that when repeatedly activated it tended to reduce the load needed to activate.

[161] The witness confirmed that if a vertical weight was applied that the system detached, but if at an angle it could be used as an anchor point. The witness believed that notwithstanding the terms of the EFA of March 2019, that NHS Lanarkshire had not been aware of any previous failures like this. Having worked in Health & Safety for 27 years, he considered it to be very unusual to undertake destructive tests, and although they did a number of tests, they failed to replicate the result. This had been a complex investigation as they were working with damaged fittings and had to model to find a ligature point.

[162] The witness ultimately concluded that it was not possible to say with certainty how the ligature was able to be completed using the shower curtain rail, but that subsequent testing revealed that the Goelst G-Rail 4100 LRS shower curtain rail, operated in accordance with manufacturer's guidance on vertical pull tests did not release when a load at a varying angle from the vertical plane was applied due to the curtain rail fittings twisting during the test and acting as an anchor. He suspected that Ms Finnigan had used the shower fitting as a ligature at an angle, although he accepted that during tests at slight angles that the rail still detached.

[163] The witness confirmed his background was in Management, and that he was not an engineer. He also did not physically carry out the tests, which undertaken by

Rainbow Blinds and Interiors Ltd, who had fitted these rails. He was aware they were instructed and trained by GOELST and were accredited installers for the rails.

[164] The witness was referred to a photograph of the rail, [201] which showed the bendable shower track still attached to wall on the left but detached from the right-hand wall plate, and also shown the Report by Mr John Holland,[202] which showed the fittings for this system. He confirmed he was familiar with the components used, whereby the receiver will open and release the pin upon a load being applied to it. He had had previous sight of the GOELST G-Rail Load Release System documentation,[203] and had quoted from this documentation in relation to maintenance and inspection.[204] He noted the comments that due to the ageing process of polymers they were advised to check each Load Release Suspension Point for defects every 12 months from the date of installation, and the further recommendation that the receiver units were replaced within four years of installation. This guidance also advised that the receiver unit be replaced immediately after the system had been activated. He accepted the system should have been tested every 12 months, and the receiving units replaced every 4 years, and that this element of his Report,[205] insofar as it indicated that the manufacturers guidance had not specified this was in fact erroneous.

---

[201] Crown Production Fourteen page 382
[202] Production Nine for Goelst page nine
[203] Crown Production Sixteen page 437
[204] Crown Production Sixteen page 439
[205] Crown Production Fourteen page 395

[165] The witness did not recognise the GOELST Technical Report,[206] but accepted that the manufacturers had specified an annual test by trained operatives, and he recognised the importance of training in installation and maintenance. It was observed that the witness had highlighted that there was no evidence that any of the recommended maintenance actions were progressed following installation.[207] In particular he had observed that there was no evidence that any of the recommended maintenance actions were progressed following installation or that that any staff had received product specific training in the maintenance of that particular rail fitting.

[166] The witness had noted that prior to removal that the contractor had observed that the left-hand wall bracket did not detach, and that there were holes which indicated that the wall brackets had been moved after the initial installation.[208] It was also noted that there was evidence of multiple activations. [209] The witness confirmed that there was no planned maintenance programme and that maintenance was reactive. He also confirmed that there had been reactive maintenance on 5 December 2019 and that the unit was re-attached 2 weeks before Ms Finnigan's death.

[167] The witness further acknowledged that photographic evidence[210] showed that holes had been filled in and that the wall plate had not been fitted on a vertical plane. He confirmed however that he did not consider that the screw fittings and wall fitting contributed to the incident.

---

[206] Production one for Goelst page nine
[207] Crown Production Fourteen page 395
[208] Crown Production thirteen page 367
[209] Crown Production thirteen page 368
[210] Production nine for Goelst page 21

John Holland

[168] The final witness was John Holland, a Consultant Engineer involved with the forensic investigation of scientific and technical matters. He held a BSc(Hons) from University College Dublin and was a member of the Institution of Mechanical Engineers. He confirmed his instructions and had prepared a detailed Report on instructions from solicitors. [211]

[169] He had concluded following his inspection of the subject rail and components, and testing of exemplars, that there was no evidence of design or manufacturing defects that would have caused the rail to perform out of specification. His testing when combined with data from the Goelst technical report led him to the view that the shower curtain rail should have collapsed if a load in excess of 50 kg was suspended vertically from it, and it was unclear why it did not collapse on the day of this incident.

[170] He believed that the subject system had deployed more than once and observed that the product brochure clearly stated that inserts should be replaced following every activation, suggesting that the maintenance regime at Wishaw Hospital was deficient, although his testing indicated that repeated activations lowered the release load rather than increasing it.

[171] Whilst accepting the possibility that the components had exceeded their service life, he believed that it was unclear whether this was significant, and whilst it may have

[211] Production nine for Goelst

contributed to the incident, it was not possible to determine by how much. It was also possible that a vertical load of less than 50 kg had been applied to the system during the subject incident, or, that damage caused by twisting during an initial, unsuccessful, attempt may have resulted in sufficient deformation to the system to prevent it from operating properly during the successful attempt.

[172] The witness concluded that the photographic evidence presented showed that the right-hand support assembly remained connected to the rail after the incident, which could not have happened if the wall support had been connected to the wall immediately before the incident. This indicated that the right-hand wall support was probably dismounted manually before the incident, (unless it was dismounted and reconnected to the rail between the incident and photographs being taken), which he believed was a further indication that more than one attempt had taken place.

[173] The witness referred to evidence of possible defective installation or undocumented post-installation modifications having been made, such as the evidence of the right hand-wall plate having been moved and installed at an angle, and not, as required, being vertical. Such angular installation of the wall plate had the potential to increase the release load in the same way as loading at an angle was found to have done by the NHS. However, given the right-hand wall support was not connected to the wall plate at the time of the incident this defect did not contribute to the incident, although it might have had a slight impact given the manufacturers specified that the line had to be vertical. In relation to the original holes in the wall, the witness did not know whether the fittings were ever in the original holes.

[174] The witness concluded that the quoted release loads in the literature applied to vertical loading only, and therefore, the product literature fully outlined the capabilities of the system, and it was fit for purpose. Any requirement for angular load testing, at angles of between 30 and 45 degrees from vertical, appeared only to have been introduced by the NHS in the months preceding the incident. The witness further concluded that it was not clear to him how a person attempting suicide using an elevated shower curtain rail might be able to sustain a load at such angles.

[175] The witness stated that the literature fully set out the importance of proper installation, and he believed that the installation was within the accepted range. In his report,[212] the importance of the pins being correctly located vertically and connected firmly to the receiver was stressed. He noted from the photographic evidence that the wall support assembly at the right-hand end of the rail had separated from the wall plate but was still connected to the rail via the pin and receiver. He believed that had the system operated as envisaged, then the bracket shouldn't have come away from the wall, and that it could only have come off by being pushed upwards and not downwards. In his view this meant that the wall support had either been taken off or upward force had been applied. He accepted that it was possible that the people seeking to rescue Ms Finnigan may have pushed the rail up to release her, although he opined that it would have been easier to pull the rail down and not push it up. He also stated that he would not have expected the bracket to come off the wall.

[212] Production Nine for Goelst page 15

[176] The witness suggested that the photographic evidence demonstrated a considerable twist on the bracket causing the pins to protrude. He noted also that the rail was twisted, and that this showed the direction of twist to the right rail, which seemed to show a significant force to the right rail, although when analysing this he had no indication as to where the ligature had been attached.

[177] In relation to his own tests on exemplars, he tried to recreate what was in the hospital by applying increasing loads until the pins detached. The maximum he found was 50kgs after which it was usually lower when the same component parts were used, in line with was what he would have expected. During testing he found that the units appeared to operate according to the manufacturers specifications and found nothing unusual, although the barbs were slightly dilated which might explain why the detachment load was reduced. This was not unusual, as after repeated activations the barbs increasingly dilated, before eventually not working at all. The fact there was barb dilation, showed that the units had deployed in past.

[178] There was also evidence of a chip of plastic missing on one of the units although this had no relevance. Having examined the physical components he could see nothing to show why the rail didn't collapse, which he still could not explain, other than to suggest that if Ms Finnigan had been leaning forward, that this might reduce the weight to the rail. He considered that it was not clear how a person attempting suicide using an elevated shower curtain rail might be able to sustain a load at such angles.

Affidavit Evidence

[179] The following evidence was provided entirely by Affidavit

Witness Elsie Donnelly

[180] This witness was a nurse with 20 years' experience in Emergency Department nursing who was on duty at Monklands Hospital on 15 December 2019. She had no clear recollection of Ms Finnigan and provided evidence from her notes. As a triage nurse she was responsible for an initial assessment of patients when they arrived in the Department. She noted the information that reception would have taken from the patient, and the handwritten triage category was entered by her following her initial assessment.

[181] She noted the initial mental health assessment, which was only an initial triage assessment and not a full mental health assessment. Whilst she was not a mental health nurse, however she was used to seeing people with mental health difficulties daily. This initial mental health assessment was a pre-printed form which was printed off and completed by hand , reflecting what the patient said at the time and what her observations would have been.

[182] The witness noted that Ms Finnigan was orientated and alert. She was asked if she wanted to harm herself or others and noted that she had ticked the box indicating that there was no immediate risk, reflecting that she someone with her. In relation to self-injury, the witness had noted "wounds forearm", although she could not recall if she was showed this wound, or was advised of it. Ms Finnigan was assessed as being a

"Category 3" patient meaning she would be seen quickly. The witness had no further involvement with Ms Finnigan.

Witness Dr Conor Pádraig McKeag

[183] This witness was a ST1/3 Clinical Radiology/Nuclear Medicine in the West of Scotland, presently based in the Queen Elizabeth University Hospital Glasgow. In December 2019 he was a medical registrar in Monklands Hospital. He had no specific recollection of his involvement, relying on medical notes made at the time.

[184] He met Ms Finnigan on 16 December 2019 at approximately 11.00, in the AMRU, noting she had been admitted due to paranoia, believing she was under observation, and that her sister was at risk. She was having intrusive thoughts of self-harm and had attempted to hang herself that morning before his review. He did not recall the specifics of the event, or how detailed the handover was. On examination, he found Ms Finnigan was exhibiting signs of psychosis, including paranoia, believing there was an implant in her brain tracking her as well as reading her mind and injecting thoughts into her brain. She had pressured speech and was reacting to unseen stimuli. She was keen to remain as an inpatient and to seek treatment and identified her sister and father as protective factors against suicide, although she implied, she would commit suicide when her affairs were in order.

[185] The witness performed a lumbar puncture to exclude central nervous system infection or inflammation and liaised with the psychiatry team. The lumbar puncture was carried out under an AWI (Adults with Incapacity) form as he felt Ms Finnigan did

not have capacity given her mental state and suspected psychosis. The witness next saw Ms Finnigan the following morning at approximately 09.20. He ascertained that overnight she had again attempted suicide by hanging and now would likely need admission to a psychiatric unit. At approximately 10.25 on 17 December 2019, he was advised of a plan to transfer her, with two specialist mental health nurses and he had no further contact with Ms Finnigan after this.

[186] In relation to the procedure for transfer to a psychiatric ward, he did not recall the specifics of this process in Monklands Hospital but believed it was likely to have been a medical and nursing handover. He noted the terms of a discharge letter[213] summarizing the events of the admission to the medical unit generated by one of the FY1 doctors dated 17 December 2019 and noted Ms Finnigan had been discussed with PLNS prior to transfer who were aware of the specifics of her case.

[187] In relation to his own entries into Ms Finnigan's medical notes, he felt that she was likely to have a primary psychiatric condition, but they wanted to exclude encephalitis. He noted she had attempted to hang self. She was floridly psychotic, with pressured speech, and reacting to stimuli outwith reality with paranoia. She was concerned about a GPS implant in her brain reading and injecting thoughts. She was very keen for investigation & medication, stating that she did not want to die immediately. In relation to events overnight, there was a discussion with PLNS who

[213] Crown Production Three page 9

often reviewed patients on medical wards with psychiatric symptoms, and it was agreed that she would need psychiatric admission.

Witness Lee McSherry

[188] This witness was a Staff Nurse since September 2019 in Ward Two at Wishaw Hospital, this being her first post after graduating. Her recollection was that they had six nurses per shift, but two staff were off the ward transferring a patient. It was an acute mental health ward dealing with a variety of mental illnesses, including, depression and schizophrenia. It had 23 beds and was usually full to capacity.

[189] Their observation policy when a patient was on general observations was that they did not need a nurse with them but were subject to hourly checks as to their whereabouts. A patient on constant observations always had a nurse in visual and verbal contact with them, and a patient on special observations always had a nurse within touching distance. Hourly checks were made of all patients, and a member of staff went round the ward to make sure that everybody was accounted for.

[190] The witness recalled the day of the events but had a less clear recollection of events prior to this. She was aware that Ms Finnigan was psychotic when admitted and was hearing voices, but she didn't spend any significant period of time with her prior to this event. Every patient had a named nurse allocated to them who was responsible for carrying out one-to-one sessions with them, although they were aware they could speak to any nurse. The named nurse was a single point of contact to liaise with other services,

and the aim was to have a one-to-one session with them within 24hrs of arrival on the ward.

[191] Patient Risk assessments were updated every day or whenever risk changed, and whichever nurse was on duty for that group for that day, or the named nurse, would review the risk assessment. These risk assessments could also be reviewed following MDTs. A safety brief involving nurses from the four mental health wards, took place and then medications were administered, whilst hourly safety checks went on. Following these, the nurses stared one-to-one sessions with patients, with continual assessment and engagement with patients. After lunch and during the handover period, when the morning shift and the late shift were both on duty there was usually time to complete online paperwork.

[192] In relation to risk assessments, staff checked previous assessments online before considering whether the risk had changed. The witness did not recall any significant conversation with Ms Finnigan and suspected that she may have sat with her at one point carrying out observations. She recalled her generally as quiet. When she came on duty, she was told at the handover that her observations had been reduced from constant to general observations but did not have a great deal of memory about the rest of the shift. She recalled being off duty the two previous days, and at the handover it was reported that she had improved, was brighter in mood and that her behaviour was more settled. She didn't recall having concerns about her specifically as a self-harm risk.

[193] She recalled dealing with dinners around 5.40pm, when Colin Jamieson, a Clinical Support Worker, took a call from one of Ms Finnigan's family members voicing concerns about her which was passed to her, involving concerning text messages saying she was considering harming herself and asking her to take care of her younger sister. Given her concern, she ran to Ms Finnigan's room, where she found her in her en-suite bathroom, hanging by her dressing gown belt. She called for assistance from Colin Jamieson who held her up while she went for a ligature cutter. The Hospital Emergency Care Team (HECT) and duty doctor were called, and they managed to get her down and start CPR. After around 20 minutes, the HECT Team pronounced the time of death, and they had a debriefing with senior managers. The Police attended and took a statement.

[194] She recalled that the part of the rail that Ms Finnigan was hanging from was still firmly intact in the wall. She was kneeling and had taken the weight off her legs and had leaned forward into the fall. Nursing staff do not have any involvement with the shower rails, but she understands they are now on magnets and designed to fall if someone puts weight onto them.

Mark Reeves

[195] Mark Scott Reeves is a Director for Goelst UK Limited, and the sole owner and shareholder of the business, having become a director on 28 March 2014, when Goelst UK Limited became independent from Goelst Nederland BV (Goelst NL) at the end of 2013. He confirmed that Goelst UK supplies the Load Release System (LRS), an anti-ligature safety device used in healthcare settings, but it does not manufacture, install, or

maintain this device. Presently today Goelst NL are their principal supplier of the LRS system, its component parts and they supply any updated product guidance or documentation. The LRS was designed as a ligature reduction safety device for bed, shower and curtain rails, and is designed to accommodate the weight of a standard textile curtain. It will release when a vertical load not exceeding 50kg is applied, provided that it has been correctly installed.

[196] He stated that the individual pins and receivers activate at approximately 35kg. The pin is a stainless-steel pin with a specially shaped head which is inserted into a red nylon polymer receiver which is castellated. This allows the receiver to flex to accommodate the insertion of the pin and the receiver then retracts around the head of the pin to provide the static loading ability of the system.

[197] The witness explained that the Load Release System is designed to reduce ligature risks in bed, shower, and curtain rails, and that it releases under vertical loads of up to 50kg if installed correctly. Its main components include rails, pins, receivers, brackets, and hangers. He confirmed that they supplied LRS only to accredited installation companies, such as Rainbow Blinds Ltd. Whilst Goelst UK provided training to installers, it did not perform installations or maintenance, and installers were responsible for ensuring correct installation per Goelst NL's technical guidance. Proper maintenance included annual inspections, and receiver replacement every 4 years or after deployment. NHS Lanarkshire and Rainbow Blinds were responsible for the installation and maintenance at Wishaw Hospital.

[198] The witness confirmed that the LRS installed at Wishaw Hospital was assessed post-incident, and he believed that the system operated as designed but may have failed due to:

- Improper maintenance.
- Bracket repositioning affecting load release.
- Damage to receiver components.

[199] Goelst UK mandated refresher training every 2 years (since April 2024), and this training included reading the technical report, hands-on demonstrations, and product discussions. Whilst the technical report from Goelst NL had not been updated since 2003 he considered it was still valid, as there haven't been any technical updates to the LRS system or LRS G-Rail Technical Test Report since 2005.

[200] He confirmed that Goelst UK were not involved in product selection or installation decisions at Wishaw, and that NHS and installers are expected to follow product guidance strictly. He had not been advised by NHS Scotland of any updates to their anti-ligature privacy rails policy and requirements.

[201] The witness confirmed that the system is designed to release at one or more points and not fully detach. The term "Anti-Ligature" was changed to "Reduced Ligature" in 2018 as part of a brand refresh.

[202] He agreed that the Kestrel Magnetic system is the only product capable of deploying when pulled at an angle, and that the LRS is designed to operate when a load is applied vertically, which was made clear in all of the Goelst NL documentation.

[203] Having considered the evidence, the witness believed that although there was not a full detachment of the rail, this was likely to have been as a result of the red receiver showing internal and external damage. The barbs on the receivers on the left-hand bracket were showing evidence of previous deployments, plus damage due to rotation of the rail, and thus had not deployed. He believed that the right-hand bracket had deployed quite easily, and Ms Finnigan had then rotated the rail clockwise to produce the damage in the left-hand bracket having the opportunity to do so, thereby creating a ligature point and preventing full deployment. However, even in this situation he believed that the system had deployed as they would have expected in terms of deploying at one or more load release points. He further believed that the product guidance, brochures and testing documents were fit for their product to market purposes, and he did not consider them to be deficient at all.

Submissions for Parties

[204] I heard detailed Submissions on behalf of the parties. I have summarised these submissions as follows:

[205] For the Crown it was submitted that there were a number of clear concerns. In relation to the change in Ms Finigan's Observation Level, it was observed that these were reduced from constant to general within 72 hours of admission. Dr Palin, an expert psychiatrist, had expressed concern that this decision was made without full knowledge of Kerry's recent suicide attempts, particularly as there had been no full discussion between Ms Finnigan and Nurse Cochrane and Dr Vusikala regarding these

previous attempts at suicide in Monklands Hospital. Nurse Cochrane, the nurse who made the assessment, in particular had stated she might not have known about the previous attempts although she stated that it may not have changed her decision.

[206] Concern was also expressed about a lack of senior medical oversight, given that Ms Finnigan was not seen by a senior clinician until three days after admission. This delay was considered a systemic issue in NHS Lanarkshire, contrasting with NHS Grampian's policy of senior review within 24 hours.

[207] There were also concerns about the Shower Rail Failure, given that the Goelst G-Rail 4100 anti-ligature shower rail had failed to collapse, allowing Ms Finnigan to use it as a ligature point. Whilst the Experts could not determine why the rail failed, its failure was acknowledged as a critical safety issue.

[208] There was also an issue with Poor Record Keeping and Communication, with multiple failures in documenting Kerry's suicide attempts and care decisions. In particular there were incomplete records at University Hospital Monklands; a Lack of documentation of key discussions and assessments; and discharge paperwork was delayed and possibly not shared with receiving staff.

[209] An issue had also been identified in relation to the Observation Policy. NHS Lanarkshire's Clinical Observation and Engagement Policy were inconsistently applied, and staff were unclear on how it applied in medical vs. mental health settings.

[210] In relation to the Role of Psychiatric Liaison Nursing Service (PLNS), it was noted that their involvement in Kerry's transfer was unclear and inconsistent. It was

also observed that they should have played a more active role in ensuring a proper handover and continuity of care.

[211] The Crown recommended that there be:

- A Senior clinician review within 24 hours of psychiatric ward admission.
- That all Goelst G-Rail 4100 curtain rails in NHS Scotland be replaced
- That there should be a review to clarify the Observation Policy to ensure consistent application across settings.
- That there should be a review of PLNS procedures for transferring patients between wards/hospitals.

[212] On behalf of Alex Finnigan, Ms Finnign's next-of kin, it was submitted that there had been clear failures in the risk assessment process. Senior Charge Nurse (SCN) Cochrane and Dr Vusikala had failed to fully review Kerry Ann's recent suicide attempts at Monklands before assessing her Whilst these attempts were documented in the Emergency Detention Certificate (EDC) and discharge letter, they were not considered in subsequent risk assessments. Expert witnesses had confirmed that this omission was a major failure in care.

[213] In relation to the observation level decisions, it was submitted that Ms Finnigan and been placed on general observations despite her recent suicide attempts, and that experts had argued that constant observations should have been maintained, as they had previously prevented her suicide attempts at Monklands.

[214] There had also been defective systems of work, and no protocol existed to ensure clinicians reviewed all relevant patient history before assessments. Further, records

were fragmented across paper and electronic systems, leading to incomplete information during critical decision-making.

[215] In relation to the Shower Rail Failure, it was submitted that Ms Finnigan had used a Goelst G-Rail 4100 anti-ligature shower rail to hang herself. This rail was designed to collapse under vertical load but had failed to do so. Subsequent investigations had revealed: poor maintenance and incorrect installation; repeated activations without proper replacement of components; and NHS Lanarkshire lacking a proactive maintenance regime.

[216] For Lanarkshire Health Board, it was noted that a number of key issues had been identified. In relation to suggested Communication & Record Keeping Failures, it was noted that Important clinical information including suicide attempts may not have been properly transferred between Monklands and Wishaw. Further no formal handover note was found, and there was a suggestion that Nursing staff at Wishaw were unaware of Kerry Ann's suicide attempts due to lack of documentation.

[217] In relation to Observation Levels, the evidence showed that Ms Finnigan was initially placed on constant observation, later reduced to general observation. However experts agreed the reduction was reasonable based on her apparent improvement, and there was no evidence to suggest that constant observation would have prevented her death.

[218] In relation to Psychiatric Oversight it was noted that the Crown suggested a lack of early psychiatric review was a system defect, however expert opinions differed, with some supporting early review, and others emphasising multidisciplinary care and

dynamic risk assessment. It was the case that a care plan was in place, and Ms Finnigan was reviewed by multiple professionals.

[219] In relation to the failure of the Anti-Ligature Shower Rail, it was noted that the Goelst G-Rail Load Release System had failed to collapse under pressure as designed, and this failure was deemed directly relevant to Kerry Ann's death. Since the incident all such rails were subsequently replaced across inpatient wards.

[220] On behalf of NHS Lanarkshire it was submitted that while there were regrettable lapses, there was no evidence that these directly caused Kerry Ann's death. The shower rail failure was the critical factor, and the Health Board took corrective action by replacing all similar rails.

[221] For Goelst UK Ltd, it was submitted that they had supplied the G-Rail LRS, which was a safety curtain rail designed to detach under a load of ≤50kg to prevent ligature risks. The LRS was not designed or manufactured by Goelst UK Ltd, but by Goelst NL, and Goelst UK Ltd only supplied the product to accredited installers.

[222] It was further submitted that Testing of the LRS showed it functioned correctly under controlled conditions, and that the independent expert Mr. John Holland could not determine why the system failed during the incident. Certain Installation issues were noted (e.g., misaligned brackets, non-standard screws), but these were not deemed causative. There were certain Positional factors (e.g., Ms Finnigan kneeling and applying a non-vertical load) which may have affected the system's performance, which was designed for vertical loads. However they maintained that the system was not defective and that no further action or recommendations were warranted against them.

[223] On behalf of Dr Vusikala it was submitted that Ms Finnigan's observation level was reduced from constant to general on 19 December by a senior nurse. Dr Vusikala thereafter reviewed and maintained general observation on 20 December and did not change this observation level. However expert psychiatrists agreed this was appropriate given Kerry's improving condition and the principle of least restrictive care.

[224] Dr Vusikala only attended the ward on Mondays and Fridays due to NHS Lanarkshire's staffing model, and when he attended, he assessed Ms Finnigan on Friday 20 December and implemented a care plan. Expert opinion was divided on whether earlier consultant review (within 24 hours) should be mandatory, but in any event, Dr Vusikala now attends the ward five days a week.

[225] In relation to concerns about Record Keeping and Communication, and the Crown concerns about the lack of documentation of Kerry's previous suicide attempts, it was submitted that Dr Vusikala stated he reviewed the Short-Term Detention Certificate (STDC), which included this information. Further the expert Professor Pelosi supported the position that the record keeping was adequate when considering both paper and electronic notes. It was therefore submitted that Dr Vusikala acted within the scope of his role and NHS Lanarkshire's systems.

[226] On behalf of Dr Karri, it was submitted that the STDC assessment was properly Conducted by him. He had assessed Ms Finnigan and found she met the criteria for detention under the Mental Health (Care and Treatment) (Scotland) Act 2003.The STDC was issued and documented appropriately. At that time Ms Finnigan was experiencing psychosis and had a history of suicide attempts. Dr Karri handed over the STDC to a

senior nurse and discussed the reasons for detention and the need for constant observations. He had attempted to record the assessment in the MiDIS electronic system but was unable due to technical issues.

[227] In relation to a suggested a lack of documentation and communication, it was submitted that the STDC itself was the principal record and was available to all staff. Dr Karri resisted personal criticism, stating that any failure was due to systemic issues, not individual negligence. Whilst Dr Alastair Palin had criticised communication he had later conceded he lacked full information, and Dr Pelosi supported Dr Karri's actions and emphasised the importance of team-based care and least restrictive practices.

[228] In relation to observation level decisions, Dr Karri had maintained constant observations during his assessment, and the decision to reduce Ms Finnigan's observation level later was made by other staff and was not attributable to Dr Karri. Whilst acknowledging that NHS Lanarkshire's system in 2019 may have lacked early senior psychiatric review, Dr Karri had acted within the scope of his role and the system in place at that time.

Discussion and Determination

[229] Ms Kerry Ann Finnigan was a young woman aged 26 who lived with her father and sister in Coatbridge. She had graduated from the University of Glasgow with a degree in English Literature and potentially had a very bright future ahead of her, with thoughts of becoming a teacher. She had no antecedent psychiatric history, although

following her attendance at a party on or around 30 November 2019, at which she may have taken certain drugs, she had noted a marked deterioration in her mental health. As a result of this she initially sought telephone assistance from NHS 24, although they appear to have considered that she was not having any active suicidal thoughts or plans at that time and therefore offered her advice on services which might be available to her. Unfortunately the deterioration in her mental health did not abate and she was subsequently admitted to Monklands Hospital following an incident whereby she was said to have been injuring herself, which had resulted in police officers being called, and they brought her to the A & E Department of Monklands Hospital, with her aunt.

[230] Upon her attendance at the A & E Department of Monklands Hospital on 15 December 2019, Ms Finnigan was initially seen by a triage nurse, who recorded that she had been having intrusive thoughts about harming herself and others, although she no longer had these thoughts at the point of triage. She showed signs of self-harm to her arms, and she was recorded as being a "Moderate Risk," which principally related to her being obviously distressed, anxious and highly aroused. Notwithstanding this, the triage assessment undertaken at that time recorded "No" in relation to a question about whether there was a history of violence of self-harm. This was the first example of what, regrettably, became a pattern of erroneous or incomplete recording in relation to Ms Finnigan's mental health difficulties.

[231] Some details of Ms Finnigan's past insofar as they related to her mental health history were obtained by a junior doctor, including an account of the tragic circumstances in which she had discovered her dead mother, and a narrative about how

she had been experiencing four weeks of deteriorating mental health, a pattern which included poor sleep and appetite as well as experiencing paranoid delusions.

Ms Finnigan was able to reference her intrusive thoughts, although at that time she was expressing no active intentions to act on these intrusive thoughts she was experiencing or to have any thoughts of suicide of self-harm. She also agreed to remain in the Hospital. It was noted at that time that she reported no clear plans for suicide, although following this consultation, having regard to the troubling history provided and also due to concerns about her appearance and the fact that she appeared to be having paranoid delusions, the examining doctor discussed Ms Finnigan's case with the Mental Health Assessment Team and a referral was made to PLNS, which was a nursing resource staffed by nurses specifically trained in mental health matters. This was clearly a reasonable step for the treating doctor to take, although at that stage investigations were still ongoing in relation to the possibility that the symptoms might be due to organic factors and in particular encephalitis. Given the early stages of her diagnosis it was also decided that there should in effect be a "twin-track" approach to her initial treatment, given the possibility that her symptoms might have an organic basis, and accordingly as well as this referral to mental health services the aforementioned further enquiries continued, including a lumbar puncture test, to exclude an organic cause for her symptoms and in particular to exclude encephalitis. Having regard to the presenting symptoms and the fact that Ms Finnigan's bloods appeared deranged this also appears to have been an appropriate course of action.

[232] The referral to PLNS resulted in a joint assessment being carried out by the specialist Nurses Truesdale and Glassford from that team. Given that Ms Finnigan appeared to lack capacity and was unable to consent to treatment at that stage it was deemed appropriate to complete Adult with Incapacity documentation for her, the reason for that incapacity being said to be due to symptoms of acute psychosis, delusional ideas of persecution, confusion and paranoia which may be due to an organic cause. Ms Finnigan was seen by Dr Sykes later that day and there was a discussion about detention under the Mental Health Act. Given Ms Finnigan's presentation Nurse Truesdale had indicated following the original meeting that she should be reviewed by a PLNS nurse the following day, which would have been a prudent step, and although there are no records to confirm whether this took place not, it is likely that no such further review actually did take place. This was again a missed opportunity to properly assess Ms Finnigan and to record her condition, and again there was a lack of proper record-keeping during the initial important stage of Ms Finnigan's admission.

[233] Following a discussion between Drs Sykes and Papadantonaki, it was decided that Ms Finnigan required to be admitted overnight to the medicine department for the further investigations to exclude encephalitis, and it was also decided that an Emergency Detention Certificate should be put in place. It was decided that if the medical tests revealed that Ms Finnigan was medically fit then she was be transferred to psychiatry at Wishaw Hospital. By that stage the doctors strongly suspected that it was likely that Ms Finnigan's symptoms were indicative of a psychiatric condition, but it was

reasonable for the treating medical team to take steps to exclude any medical organic causes.

[234] Ms Finnigan was admitted to the Acute Medical Receiving Unit (AMRU) at Monklands Hospital at 02:30 on 16 December 2019 on the basis of the outstanding queries regarding possible psychosis and/or organic causes with an AWI in place. The initial nursing record indicated that there were no concerns regarding Ms Finnigan at that time. She was noted to have seemed paranoid, but she was comfortable, not agitated, and she did not require sedation. At this stage it was noted that staff would continue to monitor Ms Finnigan, but the precise observation status of Ms Finnigan was not stated and there was no suggestion as to when her status would be reviewed. This failure to accurately record details of her observation status was again regrettable, with the only record being to note that if possible that a registered mental health nurse should "special" Ms Finnigan at that time. This procedure appeared to be a slightly nebulous type of observation which was not applicable in other Health Board areas, and in any event, it was not clear from the records whether this had in fact proven to be possible. The lack of any specific written record or discussion specifically addressing the question of Ms Finnigan's observation status at this stage was a significant failing in light of her presentation.

[235] It was accordingly a matter of great concern that it is not clear from the records maintained by Monklands Hospital precisely what was Ms Finnigan's observation status upon admission, and how this was implemented, particularly as Ms Finnigan had presented as a young woman with the apparent onset of a first episode psychotic

illness. There was a clear lack of clarity in relation to the observation status of Ms Finnigan, in relation to who if anyone was involved in her observations, and also crucially in relation to what took place during any periods of observations. This was clearly not in accordance with the "Clinical Observation and Engagement Policy and Guidelines for Best Practice" for use by NHS Lanarkshire Mental Health and Learning Disability Service, which outlined the different levels of observation, but also contained a document entitled "The Patient Observation Recording Sheet" which was to be used for all patients who are subject to enhanced observations. Whilst accepting that Ms Finnigan was in a general and not a psychiatric ward at this time, it would be a matter of good practice if this document was made more widely available to ensure accurate recording particularly given that acute receiving wards will often receive patients suffering from psychotic episodes at the point of admission. The completion of this record would have been of significant benefit to later medical staff dealing with Ms Finnigan's case at a later stage. It was also a matter of great concern that this Patient Observation Sheet was also not utilised even within the specialist Ward Two at Wishaw Hospital.

[236] The lack of accurate recording was greatly concerning in relation to the lack of clear documentation around Ms Finnigan's apparent attempts to commit suicide by hanging overnight in the early hours of 16 December 2019. The record keeping in this regard was far from detailed and fell far below an acceptable standard. Whilst the aforementioned record 02.30 recorded that Ms Finnigan was settled, the later records regarding her multiple subsequent attempts to hang herself were not clear. A further

entry was not properly tine recorded, simply being said to be "a.m" stated that: "Patient agitated +++, found in toilet with cord around neck, now has nurse in attendance to monitor patient, Haloperidol 500 micrograms given, awaiting Mental Health Team." This was clearly a very brief note about a very significant development which was not properly timed and with no details surrounding the background or circumstances of this incident. The reference to the fact that Ms Finnigan "now has nurse in attendance" clearly suggests that there was no such nurse in attendance before this incident, which appeared to be at odds with the suggestion that Ms Finnigan was subject to special observations beforehand. There was also little by way of information about what contact had been made with the Mental Health Team, or explanation as to why they appear not to have attended. The next entry that day was not until 11.08 when Ms Finnigan was seen by a Second Year Locum Trainee, who referred to her as being floridly psychotic and displaying paranoia. The next entry was at 16.00 and related to the lumbar puncture, with the final entry relating to the fact that Ms Finnigan was agitated and tearful. This entry did refer to Ms Finnigan as being "specialled" which did appear to give some indication as to her observation status although this was not fully detailed, and there was no accurate recording of how she had been during this period of observation.

[237] It was also a matter of great concern that during the full day after the suicide attempts by Ms Finnigan that she had no senior medical or psychiatric review at all and that notwithstanding the suggestion of Nurse Truesdale, that there was no contact from PLNS or indeed any member of the Mental Health Team despite this having been

suggested in the "am" record. This lack of any senior clinical reviews was deficient in the context of a first episode psychotic presentation but was particularly regrettable in the context of a potentially suicidal patient. The system as operated in NHS Grampian whereby patients are reviewed by a senior clinician within 24 hours has a great deal to commend it and should be adopted throughout NHS Scotland.

[238] The standard of recording in relation to Ms Finnigan's observation status remained extremely poor at that time. The initial record on 17 December 2019, timed at 04:10 did not specify whether it was made by a doctor or by a nurse, although Dr Palin has assumed that it was made by a medic. It referred to "four attempts at hanging on 17 December 2019 in the past 24 hours, and that "Psychiatric/Mental Health Practitioner attended the ward." In relation to the fourth attempt, Ms Finnigan was said to have wrapped a shower head and tubing around her neck which had to be removed by three staff members. A written entry from PLNS Nurse Wylie times at 04.20 also recorded that Ms Finnigan had been detained under the Mental Health Act on an EDC at 04.11 and made reference to advising staff to maintain special observations and to attempt to remove any ligatures if possible. A further note encouraged staff to maintain special observations of the patient, with the entry concluding by stating that Ms Finnigan was now sitting in bed staring at the ceiling.[214] No other entries in Ms Finnigan's medical records denote attempts at suicide on any other occasion, prior to this date and time. In particular it is regrettable that the circumstances of these incidents were not fully or

[214] Crown Production Three page 44

properly recorded, particularly as these records might have assisted in informing staff treating Ms Finnigan at a later stage. Nurse Wylie also advised the medics to utilise an EDC given Ms Finnigan's acute psychiatric presentation and lack of capacity and insight and also advised the ward to contact PLNS if further management was required.

[239] The EDC completed in respect of Ms Finnigan provided the duration of the detention as being between 17 December 2019 at 04:10 and 20 December 2019 at 04:10 and noted that: ' the patient has suicidal ideations and has tried to hang herself 4x on the ward. Hearing voices, believes people are watching her'. It also stated that Ms Finnigan had ongoing suicidal action and was not aware of what was real/ what is hallucinations. This certificate recorded that Ms Finnigan had been reviewed by the mental health liaison officer who had found that she was psychotic and that there was no other option for patient safety. It would appear that in the circumstances as they had presented themselves that the decision to grant an EDC was entirely justified. However again the records maintained in relation to the specifics or these suicide attempts was extremely lacking. Whilst there was a reference to four attempts at hanging no details in relation to the mechanics of these attempts and the timing of same was maintained. It was not specified what had happened during or between these attempts and whether any steps had been taken to alleviate these or to prevent further attempts. If Ms Finnigan had been under constant observations at the time of these attempts it would have been expected that there would have been separate entries for each of these attempts, detailing what and when had actually occurred on each occasion. This was again a significant failing in the record keeping at Monklands Hospital.

[240] Dr McKeag subsequently recorded reaching an agreement with Psychiatric Liaison that Ms Finnigan would likely need psychiatric admission, and thereafter there was contact with Ward Two at Wishaw Hospital that Ms Finnigan was to be transferred there with two RMNs. PLNS Nurse Ian Munro recorded brief contact with Ms Finnigan observing she was now detained under an EDC, that a bed had been booked in Ward Two of Wishaw University Hospital, and that Ms Finnigan was aware of her detention under the EDC and was happy to be transferred to Wishaw Hospital. An unattributed document written in retrospect observed that Ms Finnigan had attempted to hang herself for the fourth time and that it had taken three members of staff to get her out of the toilet. Again there was a complete lack of detail and clarity in this note.

[241] A "Discharge Letter and Prescription" letter relating to Ms Finnigan's discharge from University Hospital Monklands was generated at 17:40 on 17 December 2019 and detailed Ms Finnigan's attempts to hang herself in the bathroom four times stating that she was detained under an EDC before her transfer to Wishaw Hospital. This letter was however generated after Ms Finnigan had been transferred to and admitted by Wishaw Hospital at 14.30. On balance I do not accept that this letter was transmitted to Wishaw Hospital with Ms Finnigan, and therefore a valuable opportunity to pass extremely important information to Wishaw Hospital about Ms Finnigan's serious attempts to commit suicide was lost. This was an important feature of this case and ultimately, in combination with other factors resulted in important decisions being taken later in relation to Ms Finnigan's risk and observation levels in the absence of extremely

important information about her four suicide attempts in Monklands Hospital. Again this was a major failing in the process of communication between the hospitals.

[242] The foregoing lack of information sharing regarding Ms Finnigan's suicide attempts meant that the receiving staff at Wishaw Hospital were not aware of this significant fact when she was admitted. In this regard it was significant that the "Inpatient and Assessment and Treatment" form completed by Wishaw Hospital at 14.30, in relation to the section referencing her intrusive thoughts and previous self-harm, recorded that she had "slit wrists-superficial" but made no reference to her repeated attempts to hang herself while in University Hospital, Monklands. Indeed there is no reference to these attempts anywhere in the admission document. As with later notes from Wishaw there was therefore reference to the previous superficial cuts to her writs recorded as evidence of self-harm, but no reference to the attempted suicide attempts in Monklands Hospital. It was therefore apparent that this crucial information about the repeated suicide attempts in the preceding 24 hours was not passed to Wishaw Hospital at that time by Monklands Hospital.

[243] It is also noticeable that the aforementioned Inpatient Assessment and Treatment form made reference to the referrer as being PLNS, and yet there is no evidence regarding the role of PLNS in the transfer of Ms Finnigan, and no evidence of a standard patient centred document regarding the specifics of Ms Finnigan's level of risk and presentation being provided by PLNS to Ward Two staff at Wishaw Hospital. The evidence of Nurse Truesdale had been to the effect that if PLNS had arranged admission, they would have arranged the transfer, spoken to the receiving doctor, and

giving a comprehensive handover, although in the present case he recalled that Ms Finnigan's transfer was handled by a doctor, and as soon as a patient was detained, they moved outwith their remit and follow-up was done by the receiving doctor, who would have no contact with PLNS. This would appear to be at odds with the information provided by Wishaw Hospital that the referrer had been PLNS and is further indicative of a degree of ambiguity in relation to the role of PLNS in the transfer of patients, which should be reviewed in due course.

[244] Upon her arrival at Wishaw Hospital, Ms Finnigan was provided with a plan indicating that she was detained under a EDC, that she was to be on constant observations, due to psychotic symptoms and command hallucinations, to minimise risk and further that she was to be restricted to remain in the ward until she had been reviewed by a Consultant. At that stage it would have been obvious to staff that given the working practices of Dr Vusikala that she would not be seen by a consultant until Friday 20 December 2019, some three days later, and there appears to have been no suggestion that she could have been reviewed by another medical member of staff before then, which was extremely unfortunate given her presentation and repeated suicide attempts. It would have been appropriate in these circumstances to arrange for some form of assessment in the intervening period, and given the seriousness of her presentation and the number of suicide attempts, that Ms Finnigan should have been reviewed by a senior clinician within a reasonable period, perhaps 24 hours as in Grampian, and not left without such an assessment for three days.

[245] Overnight into 18 December 2019 Ms Finnigan was kept on constant observations and there were some nursing records regarding the extent of her response to these observations. It continued to be recorded that her status was that of a person detained under an EDC. Significantly however the records of Monklands Hospital, recorded that on 18 December 2019 that Ms Finnigan was seen by the Duty approved AMP, Dr Karri as the EDC was due to lapse. The records from Monklands Hospital confirmed that Dr Karri and an MHO attended at Ward Two, Wishaw Hospital on 18 December 2019 and conducted a joint interview, agreeing that the criteria for a STDC were met and awarding this certificate at 16.50 on that date. This certificate specifically made reference to the fact that Ms Finnigan had attempted suicide on four occasions.

[246] It appears to be the case however that whilst a copy of the STDC was left in the records of Wishaw Hospital, that there were no written or typed entries in Ms Finnigan's Wishaw Hospital records to indicate that Ms Finnigan had in fact been seen by a Senior Psychiatrist. However Dr Karri has made clear that he saw his role as being entirely separate from that of the treating doctors, with his responsibility solely being to determine whether detention under the Mental Health was necessary, and his role was therefore more limited than that of the treating doctor. Again this is a situation which does not subsist in other Health Board areas such as Grampian where AMPs can have a more active role, particularly in situations where the RMO might not be able to assess and review the patient for a number of days. In these Health Boards the AMPs effectively plug a gap in the provision of senior clinical treatment, and NHS Lanarkshire should consider whether this enhanced role for AMPs could be introduced to ensure

that patients would never again require to wait three days or more before being seen by a senior psychiatrist. Accordingly whilst it was clear that Dr Karri did not see his role as being to become involved in the management or treatment of Ms Finnigan and that he saw his role as being restricted to assessing whether the criteria for a STDC were met, it was apparent that this represented a lost opportunity for Ms Finnigan to be assessed by a Senior Psychiatrist and for steps being taken to assess and review her care and planning, particularly in circumstances where she was not due to be seen by her Responsible Medical Officer for a protracted period. Dr Karri confirmed that an AMP could adjust a care plan, especially to mitigate risk, and that he would undertake a reasonably full psychiatric assessment, albeit focussed on the five criteria for detention, and this process should accordingly be reviewed to enable duty AMPs to play an enhanced role in the treatment and assessment of patients, particularly where that patient is presenting in such a disturbed state and yet is not due to be seen by their RMO for three days.

[247] It was also concerning that notwithstanding this limited assessment that there appears to have been a complete lack of communication between the AMP and the treating hospital. There was no indication in the records that the AMP discussed the outcome of his assessment, and particularly his knowledge of the suicide attempts and associated risks with any of the treating team at Wishaw Hospital. Whilst Dr Karri considered that the treating team would review the STDC, it is important to ensure that there are clear records left in relation to the reasoning for the STDC and in the absence of access to the electronic records that there should be a written record left and clear

communication in the form of a handover to the treating team. This lack of communication was patently demonstrated by the fact that the nursing staff continued to refer to Ms Finnigan as being under an EDC and not a STDC throughout that day and indeed the next day. This is also likely to have contributed to the later lack of knowledge of the recent suicide attempts on the part of Dr Vusikala and Nurse Cochrane.

[248] It would appear that Ms Finnigan remained on constant observations overnight into Thursday 19 December 2019 and had woken twice with disturbing dreams. She was thereafter seen by Senior Charge Nurse Cochrane, and a Risk Assessment review was undertaken. This was a lengthy and detailed assessment, lasting approximately an hour, which included the completion of a pro forma questionnaire and a written note by Nurse Cochrane. It was noted that at the time that the MiDIS system was offline and that the records were completed manually. The fact that this system was off-line would presumably also have prevented Nurse Cochrane from accessing any information which was held online about the background and previous circumstances of Ms Finnigan.

[249] Nurse Cochrane stated in evidence that Ms Finnigan was very unwell when she saw her. She was aware of one suicide attempt when Ms Finnigan had placed a shower hose around her neck. It is not clear from where Nurse Cochrane would have obtained this information. She believed that she usually read detention certificates but could not specifically recall if she had read this particular certificate. Had she done so she would have noted four attempts at suicide and not one. This certificate also did not refer to the mechanics of the attempt as mentioned.

[250] The Risk Assessment Review document asked a number of questions in relation to the appearance, behaviour and general observations of the patient. In relation to the first question, "Does the person pose an immediate risk to self, you or others?" the answer recorded was "No" which might be regarded as surprising given the recent attempted suicide attempts by Ms Finnigan and the fact that she was on constant observations. Further the answer to the question "Is the person displaying a high level of disturbed behaviour that suggests psychosis and/or plans immediate (i.e. within the next few minutes or hours) risk?" again was "No." Ms Finnigan was also recorded as not having any immediate (i.e. within the next few minutes or hours) plans to harm herself or others. The only question recorded as "Yes" was in response to the question "Are there known triggers that increase the risk to the patient or others?" which contained the additional comments: "Increased risk of psychosis if taking illicit substances. Kerry demonstrated very good insight around this and cause of admission. Denies any hallucinations or thoughts/ intent to harm self."

[251] In relation to the questions specifically addressing Suicide Risk Screens, two questions were answered "yes", The first related to whether the patient's family were worried about them, (although there was no further specification regarding this question) and in relation to the question about whether the person had any thoughts of doing something to harm herself, it was recorded that Ms Finnigan had demonstrated "self harm to wrists prior to admission – relates this to drug use." The category of suicide identified was "Medium Risk. "

[252] The position of the witness was that she believed that she was aware of the previous suicide attempts, however this appears to be entirely inconsistent with the evidence as recorded by her. It is difficult to understand why it was considered to be relevant in the context of current suicide risk to record a historic self harm to her wrists, but not to record extremely recent attempts at hanging within a hospital environment a matter of hours before on the Review form. This was continued on the handwritten notes where it was recorded that there was a discussion about "superficial self harm to her wrist" but again there was no reference to the attempted hanging incidents. The information held by Nurse Cochrane appears to have been based on the initial Inpatient Assessment and Treatment form and not on the terms of the STDC and the records from Monklands Hospital.

[253] It was further recorded that "Kerry realises that her recent drug use has caused her psychotic episode, very good insight and remorseful regarding same. Denies any plans or intent at this time. " Further the overall level of risk was "High" but only due to "illicit drug use and recent psychosis." In relation to the Safety Plan and Outcomes section, it was recorded that: "Further detained under STD on observations reduced to general – Kerry agrees due to improvement in mental state and absence of psychotic symptoms. Should Kerry go missing from ward – NHSL missing protocols to be initiated." And in relation to the revised risk, this was noted as being "Medium" rather than the available "Medium/High Risk."

[254] I have accepted that the evidence demonstrates that the evidence in relation to the previous suicide attempts in Monklands Hospital was not available to Nurse

Cochrane at the time when the decision was made to reduce the observations status to general rather than constant and to reduce the risk from high to medium. I have also accepted the evidence of Dr Palin in this regard to the effect that awareness of such a significant level of apparent suicide attempts apparently driven by psychotic illness would have altered the outcome of the risk assessment carried out on 19 December 2019 and thereafter as stated by Dr Palin, in these circumstances any decision to reduce observations levels would have been delayed to allow a more detailed assessment of Ms Finigan's mental state. It was a particular concern that the decision made was to reduce the observation level from constant to general only 48 hours after her repeated attempts to commit suicide by hanging. It was also a significant concern that the risk status was reduced from high to medium and not to the intermediate category of medium/high in light of the aforementioned attempts. Ms Finnigan should have been asked about her reasons for attempting suicide and these reasons should have been recorded. It would appear that this conversation did not take place which was a major failing in the context of a Risk Assessment, however even if that conversation had taken place, which is unlikely, then it should have been recorded in detail and the fact that it was not was again a major failing.

[255] The available records indicated that in the early hours of 20 December 2025, that Ms Finnigan had awoken to report a particularly bad dream, but had quickly settled with reassurance. Thereafter later that morning Ms Finnigan was seen by Dr Vusikala, her RMO, with a staff nurse and a student nurse. Whilst mentioned as an MDT, it would appear that this was a routine review and not a full MDT, particularly in the

absence of other medical staff such as social work or clinical psychologists.

Dr Vusikala's records of this meeting noted that Ms Finnigan was being treated under a STDC and he outlined her history prior to admission to hospital, giving a brief account of her progress following admission to Wishaw hospital. In the section headed "Mental State Examination" it was noted that she denied suicidal thoughts and that she would stay in hospital with a further comment that: "there was no evidence of any hallucinations, it appeared that she is much better compared to the time of admission and slowly gaining insight into her condition." This entry concluded with a plan with the comment "Impression – drug induced psychosis." The plan listed was:

(1) continue with STDC

(2) general observation

(3) urine and drugs screen

(4) review on Monday.

[256] As with the Review by Nurse Cochrane there was no reference to Ms Finnigan's previous history of self-harm either on admission to Monklands Hospital or subsequently while an inpatient there, although as with the Inpatient Form, and Nurse Cochrane's review there was reference to the attempted self harm to Ms Finnigan's wrist. Accordingly and notwithstanding the comments of the witnesses to the effect that they were aware of the previous suicide attempts in Monklands there is a consistency to the lack of recording of these suicide attempts. It was noticeable that in his letter to the Mental Welfare Commission on 23 December 2019, that Dr Vusikala provided details of the background history and circumstances leading to Ms Finnigan's admission, which

included details of her admission to Monklands Hospital and the investigations which took place. Whilst referring to a number of Ms Finnigan's symptoms, it is significant that there was no mention whatsoever of the attempted suicide attempts, which particularly in light of later developments was a glaring omission. Again this leads to a clear conclusion that Dr Vusikala was not aware of these suicide attempts at the time of the decision to maintain Ms Finnigan on general observations. In relation to the evidence of Nurse Cochrane and Dr Vusikala in relation to the reasons why they did not record the details of the attempted hanging incidents, I did not find these to be convincing and have concluded that they were not aware of these attempts when the decisions made to reduce the observation levels and risk were made. There was a clear consistency in relation to a lack of awareness in relation to the previous suicide attempts whilst in Monkland Hospital, and it is clear that the decisions made by Susan Cochrane and Dr Vusikala were made in the absence of the full information. Whilst it was not conceded that the decisions made by Nurse Cochrane and Dr Vusikala would have been altered had the correct information been provided to those making the decisions, the failure to ensure that this information was available amounted to amounted to a service which fell below an acceptable standard.

[257] A Significant Adverse Event Review commissioned and undertaken by NHS Lanarkshire in respect of the death of Kerry Finnigan, had noted that prior to this incident that a potential deficiency with the Goelst UK Ltd supplied G-Rail LRS, was identified in an Estates and Facilities Alert (EFA) was issued in March 2019, entitled "Anti-ligature type curtain rail systems: Risks from incorrect installation or

modification." This alert advised Health Boards to review their anti-ligature rail systems for possible unexpected failure to operate as intended. This included testing anti-ligature rail systems in line with the manufacturers guidance, which was vertically and also at an angle. This guidance was issued in recognition of the fact that there had been seven separate incidents in the preceding 12 months involving attempted suicide in a mental health ward where an anti-ligature curtain rail system had failed to operate as expected. It was also noted that the likely reason for these failures was due to weights being applied to the fittings at angles and not vertically. It is extremely unfortunate that NHS Lanarkshire appear not to have been aware of this information and that more urgent action was not taken in relation to this potential serious defect, particularly in light of the fact that the likely case of the failure of the LRS system in the present instance was due to the non-vertical application of weight to the fitting.

[258] The NHS Lanarkshire's findings identified that part of the shower rail system detached from one of the shower rail mounting brackets, and another section was then used in the completed ligature when the remaining shower rail sections failed to detach from the wall and ceiling mounted fittings, thereby facilitating the completed ligature and Ms Finnigan's tragic death. Whilst accepting that the witnesses all confirmed that in subsequent testing of the fitting under controlled conditions, that the fitting functioned properly, it appears to be clear that it did not in the present case due to the fact that the weight was applied at a non-vertical angle, and as noted this would have caused the fittings to not detach. Whilst I also accepted that there were installation issues in

relation to misaligned brackets, and non-standard screws I did not consider that were causative.

[259] Ultimately I accepted the findings of the Review to the effect that when the load was applied at an angle that the fittings did not always detach, and that it is accordingly likely that the fitting did not detach given that Ms Finnigan was able to apply a non-vertical load to the shower rail, causing it to be effective as a ligature point. It is noted that this particular system is no longer supplied to NHS Scotland. This change is to be welcomed and should be read in conjunction with the recommendations made above.

[260] Once again I wish to convey my deepest condolences to the family of Kerry Ann Finnigan who attended this Inquiry with great dignity in relation to their loss.