

SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNDEE
UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRY
(SCOTLAND) ACT 1976

DETERMINATION

by

Sheriff Derek C W Pyle

in

Inquiry into the circumstances of the death of

MICHAEL DODDS

DUNDEE, 11 August 2009

The sheriff, having resumed consideration of all the evidence adduced, Determines:-

(a) that in terms of Sections 6(1)(a) and (b) of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976:

1. Michael Dodds, born on 31 December 1968, residing at the Intensive Psychiatric Care Unit, Carseview Unit, 4 Tom McDonald Road, Dundee, died between 15.45pm and 16.45pm on 8 September 2007 within bedroom number one there;
2. The cause of death was asphyxiation by hanging;

(b) that in terms of Section 6(1)(c) of said Act the following were reasonable precautions whereby Mr Dodds' death might have been avoided:

1. Mr Dodds should not have been given the hold all strap shortly prior to his death;
2. Mr Dodds should have been checked more regularly by nursing staff in the period after he was given the hold all strap;

(c) that in terms of Section 6(1)(d) of said Act the following defects in the systems of working contributed to the death:

1. The written recording of Mr Dodds' possessions on his admission to Carseview was not done;
2. The movement of his possessions during his period within Carseview was not recorded;
3. There was no system in place to check that all admission documents were completed properly by nursing staff;
4. The decision to give Mr Dodds the hold all strap was taken by one nurse without consultation with his colleagues, in particular with a doctor;
5. The nursing staff were lacking in refresher training on the level and manner of general observation in the Intensive Psychiatric Care Unit within Carseview;
6. The manner in which the general observation of patients was done by nursing staff was not properly supervised by the nurse in charge within the unit.

It is always useful at the beginning of a determination after a fatal accident inquiry to set out briefly – for the benefit particularly of the deceased's family – the purpose of the inquiry, as well as its limitations. Its primary purpose is to air in public the circumstances of the death in order to explain its cause or causes. But it also allows an inquiry into, first, whether any reasonable steps could or should have been taken whereby the death would or could have been avoided, and, secondly, whether there were any defects in any system of working which contributed to the death. But the limitations of the inquiry should also be noted: the purpose is to find facts, not to find fault. In many cases, the latter is achieved through later litigation where the normal rules apply of advance notice in writing of each party's case and control of the manner evidence is presented to the court. It is not uncommon for a deceased's family to be disappointed that blame has not been apportioned by the sheriff in his determination. Such disappointment is perhaps

understandable, but it is often due to a misunderstanding of the true purposes of the inquiry.

A common problem with fatal accident inquiries is that one or more of the interested parties is anxious that no stone is left unturned to ensure that every possible circumstance surrounding the death is aired in evidence. Sometimes that is warranted; sometimes it is not. I was grateful to the procurator fiscal depute, counsel and solicitors in the manner they represented their various interests. They ensured that the focus of the evidence was solely on the truly relevant issues.

At the inquiry representation was as follows:

1. The Crown by Keith Robertson, Senior Procurator Fiscal Depute, Dundee;
2. Mrs Patricia Dodds, the mother of the deceased, and her family by Mr Bell, Advocate;
3. Dr Helen Millar by Mr Spiers, Solicitor (and latterly by Mr McIlravey, Solicitor);
4. NHS Tayside, by Mr Scott, Advocate.

Evidence was led over 13 days, commencing on 12 January 2009 and ending on 26 March 2009. I heard submissions by parties on 1 June 2009.

I heard evidence from a number of witnesses. I am grateful to them all for their willingness to assist the inquiry. They were as follows:

Gwen Cord, who is a senior staff nurse within the IPCU and has 21 years' experience as a nurse in mental health;

Callum McPhee, who is a senior charge nurse within the IPCU and has 29 years' experience as a nurse in mental health;

David Saddler, who is a forensic pathologist and is a senior lecturer in forensic medicine at Dundee University;

Grant Gellatly, who is a staff nurse within the IPCU and has 16 years' experience as a nurse in mental health;

Stuart Gall, who is a mental health officer;

Stephen Duncan, who is a staff nurse within the IPCU and has 12 years' experience in mental health;

Dr Helen Millar, who has been a consultant psychiatrist at Carseview for ten years;

Pauline Anderson, who is a staff nurse within the IPCU and has ten years' experience in mental health;

Alan Marley, who is a staff nurse within the IPCU and has 16 years' experience in mental health;

Professor Patrick Carr, who is an expert witness on mental health nursing;

Dr William Dickson, who is a consultant forensic psychologist at Stratheden Hospital, Cupar;

Mrs Beth Wilson, who is the Head of Integrated Mental Health Services in Dundee for Tayside Health Board;

William Troup, who is the Head of Integrated Mental Health Services in Angus.

On the basis of the evidence led, I have been able to identify certain findings in fact. I have, however, avoided setting out in detail Mr Dodds' medical history out of respect for him and his family. This determination is, after all, a public document. There was a considerable body of evidence dealing with his medical history and condition both at the time of his last admission to Carseview and during the period up to his death. There was, however, clear evidence from Dr Millar, his consultant psychiatrist, as to the diagnosis of his condition. Moreover, that diagnosis was not disputed by another eminent consultant, Dr Dickson. Professor Carr, whose qualifications and experience are in nursing care, did consider that there was an alternative diagnosis, but he recognised that a nurse would always defer to the opinion of a consultant psychiatrist. Accordingly there was no evidence before me which caused me to doubt the opinion of Dr Millar, whom I found

anyway to be an impressive witness. I therefore see no need to dwell upon Mr Dodds' medical condition, except in so far as it is relevant to the issues which the parties identified at the end of the inquiry.

The following findings in fact concentrate on the events which led to Mr Dodds' death. Other findings in fact should emerge from the later narrative under the headings of the various issues which I discuss.

1. Michael Dodds, who was born on 31 December 1968, had a history of mental illness since 1995. He was diagnosed with a schizo-affective disorder and was also treated for post traumatic stress disorder following his discharge from the Army. He had symptoms of paranoid ideation, disordered thinking and limited insight. He was a patient at the Carseview Unit, Dundee, from time to time over a period of nine years.
2. On his discharge from Carseview on 25 July 2007, Mr Dodds travelled to Inverness. On 7 August 2007, he was detained under a short term detention certificate in New Craigs Hospital, Inverness, as a result of certain behaviour.
3. He was transferred to Carseview on 21 August 2007 and remained there until his death on 8 September 2007. The detention certificate expired on 4 September 2007. An application to the Mental Health Tribunal for Scotland for a compulsory treatment order had been lodged.
4. Carseview has four wards – two wards for acute admissions, one ward for disability admissions and one ward as the Intensive Psychiatric Care Unit (“the IPCU”). The IPCU is a locked ward. The maximum number of patients there is 12.
5. Each patient has a bedroom. The bedrooms are generally unlocked. Each bedroom has a Nesbitt Evans Kings Fund hydraulic hospital bed.
6. Mr Dodds was detained within the IPCU.
7. There was a staff of 41 nurses within the IPCU. They operated on an eight hour shift system with five staff on duty during daytime and four staff on duty during the night.

8. The medical staff comprised two consultants and usually two other doctors, one of whom was a senior house officer.
9. On 8 September 2007 a shift started at 1pm. On duty were Callum McPhee, the senior charge nurse, Gwen Cord, a senior staff nurse, Stephen Duncan and Grant Gellatly, both staff nurses, and David Barry, a nursing assistant. Mr McPhee was in overall charge of the nurses on the shift. As it was a weekend, there were no doctors on the ward, but they were available to be consulted if required.
10. In accordance with normal practice, at the beginning of the shift there was a change over meeting of nursing staff where the outgoing shift advised the new shift of the mental and physical state of the patients and any relevant events which had occurred during the previous shift.
11. There were nine patients in the unit.
12. At 3pm Mr Gellatly saw Mr Dodds in the garden patio which formed part of the unit.
13. At 3.30pm Mr Dodds asked Mr Duncan for a belt out of his locker. The belt, which was in fact a hold all strap, was given to him. Mr Duncan did not ask Mr Dodds why he wanted the strap. Mr Duncan assumed wrongly that Mr Dodds wanted it to hold up his trousers. Mr Duncan was unaware that Mr Dodds was already in possession of a trouser belt. There was no record of the whereabouts of the trouser belt in the nursing notes. Mr Duncan did not afterwards check what Mr Dodds did with the strap. Mr Duncan did not record in the nursing notes that the strap had been given to Mr Dodds.
14. At 3.45pm Mr Duncan did a check of the whereabouts of all the patients and saw Mr Dodds in his bedroom, which was bedroom number one. Mr Dodds was lying on his bed. Mr Duncan did not speak to him.
15. Bedroom number one was close to a nursing station which was unmanned.
16. At 4.45pm Mr McPhee did an ad hoc walk around the unit. He looked into Mr Dodds' bedroom. Mr Dodds was hanging from his bed, by means of a ligature around his neck. The bed had been upended against a wall. The ligature was the strap which had been given to him earlier. Mr McPhee sounded the alarms. Mr Duncan was not in the IPCU but was returning to it after a cigarette break. Ms

Cord was carrying out other duties in the nearby assessment centre. Mr Gellatly and Mr Barry were in the dining room, setting up tea which usually came at 4.55pm. With the help of Mr Gellatly, Mr McPhee cut the ligature and freed Mr Dodds from the bed. A Dr Stevenson attended within seconds. He and Gwen Cord, who had responded to the alarm, tried to resuscitate Mr Dodds. An ambulance arrived a few minutes later. Paramedics assisted in trying to resuscitate him. Dr Stevenson pronounced life to be extinct at 5.20pm.

17. The only time Mr Dodds was seen by a member of the nursing staff during the period from 3pm to 4.45pm was at 3.45pm when Mr Duncan saw Mr Dodds lying on his bed. The last time any member of the nursing staff spoke to Mr Dodds was at 3pm.

(I note that some of the names mentioned here are spelt differently in various documents. I apologise if any of the spellings I have used is incorrect.)

There are a number of issues which arise from this inquiry, all of which were touched on by one or more of the representatives of the parties who led evidence before me. I deal with each issue in turn:

1. Completion of paperwork

On admission to the IPCU an assessment of the patient is carried out. This is often done by more than one nurse and, presumably, also involves one of the doctors. There are prescribed documents which the nurses must complete. In Mr Dodds' case there was a failure to complete these documents. Moreover, a further assessment of the patient is carried out after 72 hours. Again, there are prescribed forms which the nurses must complete. None of them was completed in Mr Dodds' case.

I have decided not to identify in any detail the individual failures, of which there were many, in the completion of the paperwork. There was no dispute that there had been such failures and it was obvious to everyone that this should not have occurred. I agree with counsel for the family that this is a training issue. The new system for record keeping was touched upon – and indeed there are already differences of view about its effectiveness – but I did not hear enough evidence to reach any meaningful conclusions. It is axiomatic that if forms are produced they should be completed properly. There should also be a proper system in place to ensure that this is done – an issue of management which this case shows was not being properly addressed. I might add, however, that I am not satisfied that this failure (except in so far as the paperwork related to the recording of Mr Dodds' possessions) contributed in any way to his death. Professor Carr's evidence was that paperwork should be completed, but he went further, in that he also considered that a care plan was required for self harming and suicide because in his view an incident involving Mr Dodds in Inverness was a suicide attempt. But, as I have said, he did eventually concede – rightly in my view – that any nurse, including himself, would have to defer to the opinion of a consultant psychiatrist, such as Dr Millar.

2. Ligatures

Counsel for the family urged me to make a finding that at least until the 72 hour assessment after admission all of a patient's possessions which have the potential to be used for self harm should be removed. In discussion, however, counsel appeared to moderate that recommendation to the more limited extent that the issue should always be addressed and an informed decision made. As Mr Manley said, it is possible that the Mental Health Commission would not agree to a blanket rule against patients keeping possessions which might be used as ligatures. The failures in this case were obvious – first, the system for a written record of possessions was totally ignored; secondly, the movement of such possessions was not recorded in writing in the nursing notes, resulting in there being no record that Mr Dodds was already in possession of a trouser belt; thirdly, there was a failure by Mr Duncan to take even the most basic steps to check what Mr Dodds actually took out of his locker (Mr Duncan appeared to make no real decision at all as to whether it was appropriate to allow Mr Dodds to have the strap.); fourthly, he

did not discuss the request with other staff, which he ought to have done; fifthly, having given the strap to Mr Dodds he failed to watch closely what Mr Dodds wanted to do with it; and sixthly, he failed to record the event in the nursing notes. Indeed, there was a general failure of the nursing staff properly to record the return of Mr Dodds' belt after his observation was reduced from constant to general as described below.

I agree with counsel for the family that the decision to remove possessions from a patient should be done by a member of the medical staff in discussion with the nursing staff. It would also follow that a decision to return an item should be decided by the same process. I appreciate that this may mean that there is potential for delay, but given the drastic consequences in this case it seems to me that this recommendation properly balances the requirement for the safety of patients and staff against the therapeutic requirements of the patient.

3. Observation Levels

Much of the time of the inquiry was taken up discussing this important matter. There was in existence at the time of Mr Dodds' death a mental health patient observation policy which applied throughout Tayside. (I was also shown a revised policy document which applied from about November 2007, but I do not think that anything turns on that.) I do not set out its terms in any detail here. Suffice it to say that there were three levels of observation: general, constant and special. At the time of his admission it was decided to have Mr Dodds on general observation. This decision was subsequently supported by Dr Millar. For a short period the level was increased to constant, but was then reduced back to general, which is the level which was in force on the date of Mr Dodds' death. General observation is defined as follows: "The nurses in duty should have knowledge of the patients' general whereabouts at all times, whether in or out the ward." But it became clear that this policy, which applied across mental health wards in Tayside, was not considered by all as the standard which should apply in the IPCU. Ms Cord considered that general observation, which she said was the standard treatment, entailed checking every bedroom within the IPCU every hour, although intentionally not exactly on the hour. Each hourly check was recorded in writing by the nurse who performed it. Mr

McPhee thought that general observation was more than just monitoring every hour – in the IPCU there is a policy of general awareness of patients’ whereabouts. (That appears to be no different than the definition set out in the policy document.) Mr Gellatly and Mr Duncan appeared to agree more or less with their two colleagues, although Mr Duncan thought that the hourly checks were to ensure that the patients were “living and breathing”, as well as to ensure that the unit’s smoking policy was observed by the patients. Dr Millar took an entirely different approach in seeking to define what general observation means in the IPCU - nursing staff must certainly know at all times where each patient is, but it is much more than that because nurses need to speak to the patients regularly and interact with them. It is definitely not a head count. In her view, in an IPC unit, general observation does not mean merely hourly observation, particularly in a case like Mr Dodds’ given that he was the most ill patient in the ward. In particular she considered that merely knowing that between 3.45pm and 4.45pm he was in his bedroom was insufficient. In the IPCU there was always supposed to be five staff for up to 12 patients, which means that staff should be interfacing with patients every ten to 15 minutes. Even if a patient is in his bedroom, a nurse should be going in at these intervals to check what the patient is doing. She disagreed with the policy which meant that one or more nurses in the IPCU were off the ward to carry out work in the neighbouring assessment unit (as applied to Gwen Cord in this case). And she strongly disagreed that a nurse should be off the ward for a cigarette break or that four out of five nurses were in the nurses’ office for 45 minutes of every hour as maintained by Mr Duncan. Although in cross-examination by counsel for the Health Board she conceded that a decision about how many nurses should be on the ward at any specific time was a matter of judgment for the nursing staff, she pointed out that in an IPC unit there are very challenging patients. Thus a much higher level of diligence is required than would apply in a general psychiatric ward. Dr Dickson took more or less the same approach. In his view, general observation of Mr Dodds meant knowing what he was doing most of the time. Observation policies vary from health board to health board – some, for example, have only general and constant observation levels. But, said Dr Dickson, the whole point of IPC units is that there is a higher level of care because of the patient/nurse ratios. In his IPC unit at Stratheden Hospital, Cupar, anyone can increase the observation level. He

puts a lot of trust and confidence in the nursing staff. In Mr Dodds' case, because he was still suffering from command hallucinations, there should have been more observation of him in the period immediately before his death. At Stratheden most patients are observed most of the time – after all, “they are there to be observed”. Professor Carr considered that general observation in an IPC unit should mean speaking to the patient at least two or three times per hour, in addition to the hourly checks. He considered that the management of observation of patients within the IPCU at Carseview was very *laissez faire*. It was the responsibility of the manager to ensure that an observation policy operated which took into account the layout of the unit itself, particularly where the patients had their own bedrooms. The policy which appeared to operate might work well enough in a Florence Nightingale ward (where the patients were all in the one large space) but it would not work in Carseview. Alan Marley was Mr Dodds' key worker, that is to say the nurse who had overall responsibility for his nursing care. He defined general observation as knowing where the patients are at all times, but in the IPCU there was a lot of interaction with the patients. It would include hourly random checks. If a patient was in his bedroom, Mr Marley would not always go in to check him – each intervention is intended to be therapeutic. So the decision whether to go in or not depends upon the individual circumstances. He was unaware of any policy which dictated that patients be observed every 15/20 minutes.

In my view there was a clear failure properly to observe Michael during the period immediately before his death. I have no particular difficulty with the written policy on observation levels, but I have some sympathy with the view of counsel for the family that it would be better if that document included a section on the observation levels which are appropriate in IPC units. Having said that, as was said by a number of witnesses, it is possibly wrong to set out an observation policy which would fail to take into account the individual needs of patients. As Dr Dickson observed, the whole point of IPC units is that patients are there to be observed. Whether that should be done twice an hour or every ten minutes will vary from case to case. What is clear, however, is that general observation in an IPCU must be far more than a head count every hour which is what some of the nurses appeared to think was all that was necessary. Mr Duncan's evidence was curious not only

in the apparently lackadaisical manner he gave the strap to Mr Dodds, but also in his assertion that 45 minutes of every hour was spent by nurses in the office. None of the other nurses suggested this level of indifference to the patients' needs. Indeed, I was generally impressed by the devotion of all of the other nurses to what can only be a very difficult – and doubtless at times stressful – job. All that I can safely conclude is that there is a training issue for all the nursing staff so that they are reminded what their job is. In my opinion, as a matter of urgency all staff within the Carseview IPCU need training on the appropriate observation levels. Indeed, I am surprised that this has apparently not already been done since Mr Dodds' death. It is disappointing that Dr Millar's recommendation in similar terms has apparently not been acted upon. There is, in my view, also a management issue here which ought to be addressed – and indeed should have already been addressed. It was, as I understand it, Mr McPhee's duty to ensure that nurses on his shift discharged their responsibilities properly. He failed so to do – and indeed I find it incomprehensible that he allowed Mr Duncan to go for a cigarette break (or failed to notice that he had done so) in the knowledge that Ms Cord had been called away to attend the assessment centre. I am not suggesting that Mr Duncan's absence caused Mr Dodds' death, but it is in my view an illustration of the culture which was prevalent within the IPCU during that shift. Given that I found in general that the nurses were dedicated in their work, I regard this issue to be a management one which, indeed, ought to go higher than Mr McPhee. I heard no evidence about the checks and balances in place at a higher level to ensure the proper running of the IPCU, but whatever they are and whoever is in charge of them there should be an honest appraisal of how such management failed to identify the risk which resulted in Mr Dodds' death and what steps can be taken to ensure a similar incident does not occur.

My attention was directed to a Good Practice Statement on the observation of people with acute mental health problems, which was published in June 2002. With much of its content I agree, but in my view there is still a danger in not emphasising that general observation in an IPCU is at a much higher level than in wards where the degree of illness, even if still acute, is much less. More is required, whether in policy documents or

in training, to ensure that nurses in the IPCU are aware of that much greater level of observation.

Counsel for the family also identified a training issue for nursing staff in their ability to communicate with the medical staff. Certainly, Dr Millar identified a problem in the description given to her of an incident involving Mr Dodds which occurred within the IPCU. (She also explained convincingly that it would be utter speculation to argue that if the description had been better Mr Dodds would not have committed suicide.) It seems to me that all I can safely say on this matter is that training should include refresher courses for nursing staff on the need to communicate accurately with medical staff. Counsel for the family suggested that training should encompass a system of compulsory professional development. While that may well be a wise suggestion, I do not consider I have heard evidence of sufficient breadth and quality to be able to make an informed recommendation on the overall training regime for nurses. If Mr Duncan is to be believed, nurses already spend a considerable time on duty in the nurses' office checking on line for training opportunities. I doubt if that is really true, but if it is it would be better if someone else was in charge of the training programme and was responsible for directing nurses on when they should be trained and what the training should comprise.

4. Beds

I was treated to a lengthy explanation from Mrs Beth Wilson of all the steps taken over the last two years to deal with this issue. Without wishing to be unkind about her demeanour when giving evidence, she seemed perfectly satisfied at the rate of progress since Mr Dodds' death. The first indication that the issue of the beds used in the IPCU was being considered was during a meeting which was convened as part of the process of the whole significant adverse incident review. That meeting took place nearly three months after Mr Dodds' death. I was not told what had been happening by way of review before then. The minutes record that Mrs Wilson would conduct a re-examination of the beds then used in the IPCU. She was also to arrange a visit to another hospital to view the beds used there. The timeframe for the re-examination was recorded as being two months. I expected to be told that a further meeting took place at the end of February

2008 during which the results of the re-examination were reported. I was not told of any such meeting. When asked about this, Mrs Wilson said that the visit to the other hospital had taken place, but that the beds would not be replaced until the stage of the normal replacement programme was reached. And, in any event, she said that no risk assessment would have suggested that a patient could hang himself from the bed. To be fair to her, Mrs Wilson was rather vague about what risk assessment had been done of Mr Dodds' bed after his death – she suggested that a Mr Mitchell might be in charge of that, albeit in discussion with the clinical team. But I can only comment on the evidence before me. In particular, if there was a lot of other activity then it was not explained to me. I was told that Carseview is due for further development, commencing this month. I was told about discussions from May last year about the beds which should be used when the development is completed, including a document called a Decision Verification Process. This sets out the steps being taken to ascertain the most suitable bed for the IPCU. It included a note that all comments should be returned by 4 July last year. The last column on the form is headed “outcome”. One might think this was the most important column. It is blank.

From what I could glean from such an incomplete story, it appeared that no final decision on the beds will be made until the development of Carseview is completed by the end of 2010.

Mrs Wilson suggested at one point in her evidence that the making of the final decision was also awaiting the outcome of this inquiry. With the greatest respect to her (and I am not suggesting for a moment that she was trying to mislead the inquiry) I find that reason to be disingenuous. It seems perfectly clear to me that the true reasons for the delay are, first, financial and, secondly, an unwillingness to accept that there was a risk which could have been anticipated in the first place.

The issue of what is a suitable replacement for the Kings Fund beds is not an easy one, but I am still astonished that after so much time the Health Board seems no nearer reaching a final decision. I find it particularly startling that one of the reasons offered for

the delay was that no risk assessment would have identified the risk of hanging. That is illogical. Risk assessment by definition is a process of anticipation of possible future events. But in this case we do not need to speculate about a risk, because an actual event has already taken place. The only question that matters is really a simple one – given that Mr Dodds hung himself from his hospital bed, how do the Health Board avoid that happening to another patient? It might well be that changing the type of bed – or modifying it – is not a sensible option, in which case it was surely an urgent priority for the Health Board to take whatever other steps, particularly in the observation of patients and the availability of ligatures, which would manage that risk, remembering always, as Dr Dickson said, that one cannot ever be certain that a patient, particularly in an IPC unit, will not have suicidal intentions. It remains a concern of mine that this has not been done, recognising, as I do, that some changes have been made; not least in the manner notes are recorded. But such changes as have been made were described to me in a way which suggests a piecemeal approach and over far too long a period.

It seems to me that the Health Board had a responsibility to ensure that a comprehensive review took place of all aspects of Mr Dodds' care and detention in the IPCU. The sole purpose of that review would be to ensure, so far as humanly possible, that no other patient is ever put at the same risk. That is not just for the benefit of the patients but also the staff, whether nursing or medical, who have to deal directly with the consequences when events such as in this case occur. I am not at all satisfied that such a review has properly taken place, which I regard as singularly unfortunate.

Various suggestions were made to me about what I should recommend about the beds within the IPCU. I have decided not to make any recommendation. I am not satisfied that I have heard evidence of sufficient quality for me to do so with any confidence that I would be correct.

5. Medical Staff

I mention this matter only because it was a great concern for Dr Millar. She was very critical of a system which had been introduced which put GP trainees with no psychiatric

experience on a three month rotation in the IPCU. She considered that trainee doctors should have at least 12 to 18 months' experience in psychiatry before they be allowed to practise in IPC units. She wrote letters of complaint about this to, amongst others, the medical director. She was eventually told that the policy was under review. During the time that this policy operated she had two serious incidents, one being the instant one. In contrast, in a period of six years before then, when the experience of trainees was at the higher level, there had been no incidents at all. She understood that the policy had been changed back to the former one, but she still had a general concern that this change had happened at all – and might happen again. She had not been told, despite asking, the reason for the decision to revert to the old policy. She was therefore left to speculate that it was because of Michael's death. She was plainly unhappy that it might have taken a suicide on the ward for a bad policy to be revoked, albeit she did not suggest that Michael's death occurred because of the policy.

I do not think that I can do other than simply record Dr Millar's evidence in this regard. I heard no evidence from any Health Board official on this matter. It would therefore be unsafe for me to comment further.

I had promised parties that they would have my findings by the end of June. There had been a considerable delay in the start of the inquiry and I was particularly anxious to avoid more. I therefore very much regret that due to other factors outwith my control I have not honoured that promise.

Sheriff D C W Pyle

Sheriff of Tayside, Central and Fife