

Determination

of

Sheriff Neil Douglas

In the Fatal Accident Inquiry

into the death

of

Fraser John O'Donnell

Paisley: 7th March 2012

The sheriff having resumed consideration of the Fatal Accident Inquiry into the death of Fraser John O'Donnell, in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the Act") determines as follows:-

In terms of section 6(1)(a) of the Act, Fraser John O'Donnell who was born on 4th May 1984, died at 5.15 p.m. on 31st March 2008 on the railway line near Shilford, Scotland.

In terms of section 6(1)(b) of the Act the cause of death was multiple injuries due to impact with a train.

No findings are made in terms of section 6(1)(c) of the Act in that there were no reasonable precautions whereby the death might have been avoided.

No findings are made in terms of section 6(1)(d) of the Act in that there were no defects in any system of working which contributed to the death.

In terms of section 6(1)(e) there are no other facts which are relevant to the circumstances of the death;

Summary of the determination

On 20th February 2008, Fraser John O'Donnell, a twenty three year old student attempted suicide. At the time, in part, he attributed events in his life as being a cause. He sought medical assistance at the Victoria Infirmary Glasgow, accident and emergency department but left before treatment. He was found, brought to the department, treated and was referred appropriately to a community mental health facility at Florence Street, Glasgow.

After an incomplete initial mental health assessment by a relatively inexperienced occupational therapist and a very experienced community psychiatric nurse, Fraser was designated to be seen by that occupational therapist. The designation was made by that community psychiatric nurse, after consultation, on the basis that she was next on the rota. The designation was agreed to by a subsequent multi disciplinary team meeting. Fraser was seen by the occupational therapist five times prior to his death. In that time no focussed treatment plan was formulated; the assessment drifted. It is not good practice to continue an assessment over an extended period where no treatment plan is identified. Fraser reported to his family that his treatment was not working. Fraser did not tell the occupational therapist this.

From the last two meetings with Fraser, a more experienced clinician would have realised from what Fraser was saying that he was not improving and may have been worsening, but this was not realised by the occupational therapist. This was an error of judgement which may have been due, in part, to her relative inexperience.

There were two means of supervision of the occupational therapist at Florence Street; weekly multi disciplinary team meetings and supervision by a senior occupational therapist every six weeks. The dual supervision system had a weakness in that the weekly meetings were not designed to address the experience of a member of the team, and supervision by a senior when Fraser was there was only a case loading meeting. There appeared to be no linkage between the two systems. During the period of Fraser's attendance at Florence Street that combination of supervision was inadequate, but it has not been established whether that was due to the weakness in the system or a failure to operate the system sufficiently, or both. While the way in which Fraser was dealt with at Florence Street was a method of proceeding used by community mental health facilities such as Florence Street, the drift should have been identified by the multi disciplinary team. The error of judgement should also have been identified, but only by a date close to Fraser's death. It has not been established, and it would be speculative to determine, that on discovery of the error of judgement, a change of approach would have resulted prior to Fraser's death, the alternative suggested by an expert being that Fraser be seen by a more experienced clinician for a second opinion.

On the evening of 30th March 2008 and the early morning of 31st March 2008 some events caused Fraser to be very upset. Fraser had consumed alcohol. Fraser was aware that alcohol should be avoided by him as it tended to make his suicidal ideation worse. Later in the morning of 31st March 2008 Fraser made a further attempt on his life in the same manner as before. He did not succeed.

He telephoned an ambulance and he was taken to the Victoria Infirmary, Glasgow. The ambulance staff found an open bottle of wine beside him at his flat and he smelled of alcohol. He was coherent and he co-operated. Against the terms of a written hospital protocol, Fraser was not physically received by hospital staff when there was a handover by the ambulance technician. Hospital staff told the ambulance technician to bring Fraser into the department and seat him in the general waiting area. It was a very rare occurrence for attempt suicide patients to be placed in the general waiting area, as they

are generally kept in the treatment area so that they can be observed. Fraser complied with the instruction from the ambulance technician.

Fraser was told by ambulance staff that someone would attend to him, shortly or in a couple of minutes, by which the ambulance staff meant that he would be triaged (assessed for priority of treatment). The effect of the instruction from the hospital staff was that Fraser was unlikely to have been seen shortly (triaged). Had there been a triage process, it could have taken up to half an hour to do, depending on pressure of business. In a period of fifteen minutes while Fraser was sitting in the general waiting area, Fraser texted his girlfriend four times to say he was still waiting to be seen. After fifteen minutes, Fraser had not been seen by hospital staff and he left the hospital. Fraser's treatment card was noticed by the consultant on duty in a box in the treatment area for cards of those waiting to be treated. He did so about half an hour after Fraser had entered the department. He called Fraser for treatment. There was no reply. The consultant made efforts to find Fraser. Those efforts were unsuccessful.

Later that day, Fraser, with alcohol in his system and a broken bottle of alcohol nearby, killed himself by stepping in front of a moving train.

Notwithstanding the drift of the assessment, the error of judgement of the occupational therapist in not recognising the depth of Fraser's illness, the weakness in the systems at Florence Street, the inadequate supervision of the occupational therapist at Florence Street on that occasion, and the failure to observe the protocol by hospital staff, on the evidence led at the inquiry, it has not been established that, any of these circumstances caused or contributed to Fraser's death or were facts relevant to the death, and no findings are made in respect of the sections 6(1)(c-e) of the Act.

Fraser's parents considered that that they had not received satisfactory explanations from those managing Fraser's care and sought this inquiry. In particular, they had concerns about accountability, communication, and connectivity of services. These issues are commented on in the determination below.

Preamble and procedure

On the application of the procurator fiscal Paisley for a Fatal Accident Inquiry under the Act I heard evidence and submissions from and including Monday 19th to Wednesday 28th September 2011. Appearing at the inquiry were Mrs Dunipace, procurator fiscal depute representing the procurator fiscal; Mr Fordyce representing M/s Hill, Fraser's mother; Miss Ritchie representing Dr Marshall, Fraser's general medical practitioner at the time of his death, Mr Paterson representing the Scottish Ambulance Service; and Mr Khurana representing the Greater Glasgow Health Board. Only the procurator fiscal led evidence, there were submissions on behalf of each of those represented at the inquiry.

Mrs Dunipace led in evidence the following witnesses:-

Mr. David O'Donnell, father.

M/s Pamela Hill, mother.

Kashif Mustafa, a friend.

Dr. Graeme Marshall.

Mrs Patricia Scott.

Mrs Susan Cooper or Petrie

Dr. James Finlayson.

Dr. Gwen Jones Edwards

P.C. Michelle Mc Fadden or McLennan

M/s Sharon Hendry

Dr. Jonathan Gordon

M/s Maura Hausley

M/s Anne Taylor

By agreement of all parties the evidence of the following was introduced in the form of sworn statements and in terms of article 10 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Rules 1977 became their evidence.

Graham Wilson; train driver

Hugh McIntosh; ticket examiner

Michael Deehan, operations manager Network Rail
David McEwan; police inspector; British Transport police
Gary Brown; police officer; British Transport police
Iain Fulton; police officer; British Transport police
Alan Smith; police officer, British Transport police
David McVean; police officer British Transport police
Nicola Phillips; police officer British Transport police
Kenny Goodall; police officer British Transport police
Jed Carroll; police officer British Transport police
Fraser Phillips; police officer British Transport police
Stephen Todd; police officer British Transport police
Robert McNulty; police officer Strathclyde police
Hazel Smith; police officer Strathclyde police

In terms of article 10(3) of the Rules I directed (as more particularly set out in my direction of 28th September 2011) that the sworn statements were not to be read out at the inquiry.

A joint minute was also lodged agreeing the findings of Drs Julia Bell, and Robert Ainsworth following the carrying out of a post mortem examination of Fraser John O'Donnell on 9th April 2008 and the relative toxicology report by Dr. Gail Cooper.

I repelled an objection by Mr Kurana, and allowed Dr. Finlayson to sit in to hear most of the evidence of Mrs Petrie. I also ruled on various objections including that only the recommendations of the internal health service investigations could be looked at as part of the evidence at the inquiry.

Findings in fact

1. Fraser John O'Donnell ("Fraser") who resided at Flat 2/4 1 Maxwell Road, Glasgow, was born on 4th May 1984, died at about 5.15pm on a railway line near

Shilford, Ayrshire, Scotland on 31st March 2008 from multiple injuries caused by the impact with a train as a result of him deliberately stepping in front of a moving train.

2. Fraser had used his mobile phone to communicate to a friend shortly before his death that he was going to end his life.
3. Prior to stepping in front of the train, Fraser had consumed a quantity of alcohol and a broken bottle of alcohol was found nearby.
4. At the time of his death, Fraser was a student in his first year at the Central College of Commerce in Glasgow. In the past Fraser had commenced a degree course at Glasgow Caledonian University but had not found the course suitable to his requirements and had left the course and had been employed by the Student Loans Company until resuming his academic career.
5. Fraser lived independently in a flat on the south side of Glasgow which he shared with a person of his own age. Fraser had a part time job as a steward employed by a stewarding company. He worked as a part of a team at the Glasgow School of Art. He enjoyed this employment. Fraser had a girlfriend. At times he found the anti social hours of his employment combined with studying to be stressful but in February 2008 he was enjoying his academic course and found fulfilment and income in his employment.
6. Fraser had registered with a general medical practitioner practice in about 2006 on moving to his flat. He completed a patient questionnaire but did not provide details of his next of kin and he was not asked for that information.
7. In the autumn of 2007, Fraser had felt himself to be under some pressure academically and had reported that to his father. At that time, though he did not mention it to his father, he contemplated taking his own life and had an active

plan to do so but did not proceed with it. At the beginning of 2008, as far as was known to his family, Fraser had no mental health issues, was not depressed and was showing no signs of low mood. Immediately prior to 20th February 2008 Fraser spoke to his father on the telephone. He appeared to be in good spirits and reported that the academic pressure had lessened to some extent.

8. On 20th February 2008 Fraser attempted suicide by cutting his wrists with a knife in his flat. His flatmate and girlfriend had become aware of Fraser's intention but could not get into the flat. They had had to break into the flat and the noise of doing so resulted in others reporting the disturbance to the police who attended. Fraser's girlfriend and her mother took Fraser to the Victoria Infirmary, Glasgow to the accident and emergency department. Fraser expressed embarrassment at the situation he found himself in, including that he regretted that he had been unable to kill himself successfully.
9. Fraser was registered in the accident and emergency department as a patient and was spoken to by staff in the department but left before treatment was completed. On discovering that Fraser had left the department, a doctor in the department telephoned the police to report him missing. Police officers found Fraser, and having regard to Fraser's conduct, arrested and handcuffed him, and brought him back to the department for treatment.
10. On that occasion Fraser was found to have self inflicted lacerations to each wrist and other wounds to the wrists and forearms. Three sutures were required for a knife injury to one wrist and two sutures to a knife wound on the other wrist; the other wounds were cleaned and steristrips applied. While at the Victoria Infirmary Fraser was referred by the treating doctor to, and was seen by, a community psychiatric nurse who was part of the out of hours psychiatric team. Fraser co operated with that community psychiatric nurse. The consulting doctor noted that she considered Fraser to be at high risk of self harm and would need a compulsory mental health detention order.

11. The community psychiatric nurse assessed Fraser. She noted that Fraser was deeply regretful, remorseful, ashamed and embarrassed; and deeply upset that he had been handcuffed by the police. He had said that things had got on top of him. She noted that Fraser denied any ongoing suicidal ideation. She noted that he had agreed to be referred for further assessment by the community mental health team. She deleted the words “urgent” and “next day” from her pro forma assessment which indicated that she considered Fraser was not at high risk of suicide. Such an assessment was an assessment that Fraser was at relatively low risk of suicide.
12. Fraser was released thereafter by hospital staff into the custody of the police officers. Fraser was charged with a breach of the peace and remained in police custody and appeared at court the following day when he was released into the care of his brother on the basis that he would immediately attend his general medical practitioner.
13. Fraser attended his general medical practitioner on 21st February 2008. His general medical practitioner, a Doctor Marshall, contacted the community mental health team at Florence Street Resource Centre, Glasgow (“Florence Street”) and confirmed that they had accepted Fraser as a referral. Notwithstanding that Fraser’s care had been transferred to Florence Street, Dr. Marshall asked Fraser to attend his surgery weekly so that he could monitor with Fraser how he was progressing. Fraser did so.
14. The referral paperwork was sent by the out of hours mental health team at the Victoria Infirmary to Florence Street and a member of the multidisciplinary health team at Florence Street, an occupational therapist, Mrs Petrie, contacted Fraser to attend.

15. On 22nd February 2008 Fraser attended Florence Street and was assessed by Mrs Petrie assisted by a charge nurse, community psychiatric nurse, Mrs Scott. In that assessment it was noted that Fraser was confused following his suicide attempt; that he did not want to kill himself at the time of assessment; that he found it difficult to specify what had led to his suicide attempt as his life was better than it had been; that he had not had a happy childhood and felt that he had not fitted in educationally; that he found his current employment stressful; that alcohol had become a habit and that he had stopped drinking six months before but had had a bottle of vodka prior to his suicide attempt, that alcohol was a catalyst to his suicidal ideation; that alcohol had been involved in a previous suicide attempt in October 2007; that he had been of low mood in the week prior, such moods passed in a few days; that his mood had been up and down since he was 14 years old, a dip occurring every two months, but occurring more randomly more recently; that on 20th February 2008 he had had his first row with his girlfriend; that he had negative thoughts, and previous thoughts of suicide, “decided that I didn’t want to live anymore”; that he was not delusional or psychotic; that his concentration was “shocking”; that he had limited insight; that he had no problems with sleep or appetite; that he would not sleep during the day as that would be a waste of a day; that he had to be alive to look after his sister, that he was remorseful following his recent suicide attempt; that he had no current plans/thoughts of self harm; that he had harmed himself in the manner of suicide when fourteen years of age; that in the October 2007 attempt he had consumed alcohol written a suicide note ran a bath taken a knife but had passed out before harming himself; that he would co operate with Florence Street and “just get on with it”. The summary included a narrative that precipitating factors seem to have been an argument with his girlfriend, and lack of sleep which led him to feel that he did not want to be there anymore; that he found it difficult to specify why he attempted suicide as things were better; that his mood at assessment had been very low with no eye contact; that he would prefer not to be prescribed medication but was willing to consider medication should the team consider it

- necessary. Mrs Petrie noted that she would see him on 27th February 2008 for further assessment, to monitor his mood and risk of suicide.
16. Mrs Petrie and Mrs Scott agreed that Mrs Petrie would continue to see Fraser. Mrs Petrie told Fraser that she would continue to see him. Fraser believed that these meetings with Mrs Petrie were for treatment, where, in fact, the meetings were for the continued assessment of Fraser and to monitor his risk of suicide and to secure the trust of Fraser so that he would provide her with additional information for the formulation of a treatment plan. Fraser acknowledged to his assessors that consumption of alcohol by him increased his suicidal ideation. He was advised to avoid alcohol and he acknowledged this. Fraser was also given telephone numbers that he could call for support in any time of crisis including out of hours numbers.
17. Mrs Petrie and Fraser met on 27th February, and 7th, 14th and 28th March 2008, and had a dialogue on each occasion.
18. On 27th February 2008 Fraser's eye contact was limited. Fraser told Mrs Petrie inter alia that he had no active plans or intent of suicide and remained remorseful of his suicide attempt.
19. On 7th March 2008, a Friday, eye contact was again limited and Fraser reported what had been happening in his life that week. Fraser reported no current thought of suicide. He reported that he had lost his job. He had spent his first night at home alone since the attempt and had found it hard. He had been unable to sleep until the early hours of the morning.
20. On 14th March 2008 at 2.30 p.m. Fraser's mood was low and there was poor eye contact throughout. Fraser reported inter alia that he had suicidal thoughts since 11th March; fleeting thoughts following current life events. He thought it would be better not to be alive brought on by low self esteem; that on 12th March he

continued to have thoughts of suicide which grew stronger as the day progressed; that he had a happy visit to his mother but on returning to his flat he planned to kill himself in the morning after his flatmate had gone to work as he did not want to do anything while his flatmate was at home; that he was awake until 4 a.m. and planned suicide in the same manner as before; that when he awoke after his flatmate had left the feelings were less strong; that he did not contact emergency mental health numbers (given to him at an earlier meeting) he had been given because he felt in control; that he denied any current [that moment] suicidal thoughts, plans or intents. This narrative disclosed that Fraser continued to be unwell and that his condition may be worsening.

21. Mrs Petrie was on leave the following week. Fraser had indicated to Mrs Petrie that he did not wish to see Mrs Scott or any other member of the team in her place. Mrs Petrie may have discussed this and agreed it with Mrs Scott. Accordingly, there was no appointment on 21st March 2008.

22. On 28th March 2008, in the morning Mrs Petrie reviewed Fraser's case with the multidisciplinary team at the Friday weekly meeting and it was agreed that she would continue the weekly sessions as before. Later that day at his appointment at 1.15p.m., Fraser reported inter alia that he continued to have suicidal thoughts on a daily basis, but denied active plans; that he was currently setting a date in advance to carry out a suicide attempt but when the date arrived he felt that the situation had resolved to some extent; that he had not set a date at the time of the meeting; that he was frightened that he might fail at another suicide attempt; that a good day was difficult in the morning, better in the afternoon with occasional suicide thoughts; that he found that alcohol, which he accepted increased his suicide risk, was the only mechanism which would release him from stress. This narrative also disclosed that Fraser continued to be unwell and that his condition may be worsening.

23. During the period that he was meeting with Mrs Petrie, Fraser questioned out loud to his mother why he was being seen by an occupational therapist. His mother encouraged him to continue and indicated that if it was not working other arrangements might be made.
24. During the period he was seeing Mrs Petrie, Fraser told his father that he felt the treatment was not working, that he was making no progress and that it was not going anywhere. Fraser also reported that he found engaging with Mrs Petrie caused him distress. He was very subdued. Fraser continued to be of low mood and embarrassed about his attempt on his own life. He did not express a current wish to commit suicide to his father. Fraser had difficulty in articulating to his father what was going on in his head.
25. Fraser did not disclose to Mrs Petrie that he thought that the treatment was not working.
26. Fraser's father and mother organised that his mother would telephone Fraser immediately before his appointments to give him encouragement and his father would telephone him immediately following his appointments to find out how he was doing. Fraser's father spoke to Fraser every two or three days between 27th February 2008 and 31st March 2008. Fraser's presentation on the telephone and his conversation demonstrated to his father that his low mood did not lift at any point. Fraser reported to his mother that he was finding the sessions long and difficult and that he did not think they were helping. Fraser also visited her at her home. During those home visits Fraser did not appear depressed but he was quiet and unlike his normal self.
27. On 28th March 2008, the last day on which Fraser spoke to his father, Fraser was very subdued. He told his father that the meeting with Mrs Petrie on that day had been very difficult and had gone on too long and that he was struggling.

28. Fraser saw his general medical practitioner during his attendance at Florence Street, to report on how he was. He did so weekly and on 14th March 2008 his doctor, Dr. Marshall, noted that he looked brighter and noted that his mood had improved.
29. On 30th March 2008, Fraser was on a postponed works night out. He consumed alcohol. Late in the evening there was some form of row or disturbance involving Fraser which upset Fraser. He told a friend, who sought to know what was wrong, that he wanted to be left alone.
30. On 31st March 2008 Fraser's mother texted Fraser about going to college and he replied that he was doing so. At about one o'clock that day, Fraser telephoned the emergency services (999). He requested an ambulance because he had self harmed by cutting his wrists with a dirty disposable razor. In the 999 call Fraser appeared distressed. He stated that he had not been successful in his attempt in that he was still alive. He apologised to the operator for having to listen to his call. It was noted that he was otherwise calm and was not abusive. In view of his experience of arrest by police officers on the occasion of his previous attempt, he also indicated that he would co operate fully with the emergency services.
31. An ambulance team was despatched to his flat.
32. It is part of the ambulance regime that the ambulance attending will be sent by their control certain information about the call. This is sent electronically to a screen in the ambulance. On this occasion the screen display disclosed among other information that the caller advised that he had self harmed and that the caller had been noted in the past as being violent or aggressive and that they should stand by at the address until police officers (who had been alerted by control) attended. The ambulance was populated by Anne Taylor, a paramedic who, on that call was the driver, and Maura Hausley an ambulance technician. For the purposes of attending and processing the call each had the same status.

33. The ambulance team arrived at Fraser's flat at 13.13 hours. The police officers arrived about five minutes later and they all went to Fraser's flat.
34. Fraser opened the door and immediately made enquiry about the police attendance. The ambulance team successfully reassured him that it was a routine requirement.
35. Fraser invited them in. He was smelling of alcohol and had an open bottle of wine on a table. He appeared to be under the influence of alcohol but was coherent and functional. He indicated that he had cut his wrists and he wished assistance and would co operate. When it was put to him that he should go to hospital with them Fraser indicated that all he wanted from them was to clean and treat his wounds and that he wished to go into Glasgow to meet friends.
36. The team persuaded Fraser out of the flat and down to the ambulance on the pretext of being better able to deal with his wounds there. Fraser had fresh cuts to his wrists but they were shallow and were easily cleaned and dressed. For the most part the blood from the wounds had dried and the team considered that the wounds were superficial. Accordingly, Fraser was in no physical danger as a result of the wounds he had inflicted.
37. The team left Maxwell Road with Fraser at 13.50 hours for the Victoria Infirmary. The journey there takes about five to six minutes at that time of day depending on traffic and traffic lights. One of the police constables travelled in the back of the ambulance with Fraser and M/s Hausley, M/s Taylor driving and the other police constable driving the police car.
38. During the journey of the ambulance to the hospital, M/s Hausley added clinical and other information about Fraser electronically by means of a computer terminal located in the rear compartment of the ambulance. This allowed the team

member to print out information about Fraser. This print out is called a patient report form (PRF).

39. Fraser continued to maintain an ambivalent attitude to attending hospital or not attending hospital, maintaining at his flat, in the stationary ambulance at Maxwell Road, and en route to the hospital, both that he was willing to attend hospital and that he wanted to go into Glasgow.
40. At the entrance to the accident and emergency department of the Victoria Infirmary Fraser indicated that he wished to have a cigarette before entering. The team considered that allowing Fraser to have a cigarette may calm him and they agreed.
41. The team advised the police officers that there was no longer any need for their presence and that they could stand down. They did so and left the scene. M/s Taylor stayed with Fraser while he smoked his cigarette at the entrance to accident and emergency and M/s Hausley entered the accident and emergency department.
42. When Fraser arrived at the department on 31 March 2008 at about 13.56 hours the department was busy.
43. M/s Hausley entered the department on that day without taking Fraser with her. She went to the clinical area. There she found two nurses and a doctor. She advised them that the team had brought Fraser to the department as he had attempted suicide again. She advised that his wounds, which were superficial, had been dressed. She advised that Fraser was smoking a cigarette outside. She was told by a staff member in the treatment part of the department that the ambulance team should place Fraser in the general waiting area at reception and she was asked to hand in the PRF relating to Fraser at reception. M/s Hausley left the

- treatment area, handed in at reception the PRF, getting the acknowledgement of the receptionist of its existence, and headed back outside.
44. As M/s Hausley reached the front door she met M/s Taylor and Fraser entering the department and the team took Fraser to the waiting area at reception and advised him to wait there. They told him that he would be attended to by hospital staff shortly, or in a couple of minutes.
45. They left Fraser sitting at the back of the general waiting room beside reception and returned to their ambulance.
46. The team considered that it was unusual for an attempt suicide patient to be left in the general waiting area but considered that it was not their place to question the decision. It was usual that patients presenting as attempted suicides were found a place to wait within the treatment area of the department.
47. An hour later they were again passing through reception, and not seeing Fraser, asked what had happened to Fraser. They were told that he had left without being treated.
48. At some point following M/s Hausley leaving the PRF with the receptionist a card/file was generated in Fraser's name. There was on the form completed electronically by the receptionist, a place for indicating, "self referral" or "by ambulance". The receptionist erroneously entered information into her computer that Fraser had self referred when in fact he had been brought in by ambulance. The computer generated form was affixed to the outside of a card.
49. On being asked to sit in the general waiting area, Fraser sat and waited. While sitting in the waiting area Fraser sent a series of four or five texts to his girlfriend. These were sent over a period of, in total, 10 to 15 minutes. In one text he indicated that he was waiting in accident and emergency, in another that he was

waiting like a good boy, in another that he was still waiting, and in another that he was still waiting and there must be more important cards(sic) [meaning “people”] than me need to be seen. He left the department thereafter. Prior to going to hospital, in his texts, Fraser asked his girlfriend not to tell others about his suicide attempt and that he would be fine.

50. On leaving the department, Fraser made his way to Barrhead railway station. At some point in his journey he purchased and consumed some alcohol. He then walked two or three miles along the Lochlibo Road from Barrhead to Shilford. There he located a crossing place at the railway line and went to the trackside where he stepped in front of a passing train.
51. Fraser had contacted some of his friends by means of his mobile phone letting them know that he had left the hospital and that he intended to kill himself. They attempted to contact him in an attempt to prevent him killing himself. Fraser sent them misleading information as to his whereabouts, advising them that he was going to Stirling or Inverness.
52. Fraser's mother was contacted at 5.30 pm and told that Fraser was missing. She contacted Fraser's father and she set out immediately for Glasgow in search of Fraser. She went to Neilston, where the family had lived in the past, in case he might have gone there. En route to the flat of Fraser's brother she was contacted by the police and asked to return home. She did so. There, police officers advised her of the death of Fraser.
53. A community psychiatric nurse in appropriate circumstances can refer a patient to a specialist community mental health facility. Once transferred to such a specialist service as Florence Street, the primary medical care of the patient transfers from the care of the patient's general medical practitioner and there is no general requirement for the general medical practitioner to be involved in that course of treatment unless he is asked to do so by the facility for such things as to prescribe

medication. A general medical practitioner would not ordinarily be expected to specify a diagnosis when referring a patient to a specialist mental health facility. The general operational understanding between the general medical practitioner and the facility is that, it being the specialist facility, the assessment and treatment is for the specialist. However, the general medical practitioner retains a residual responsibility for a patient and, however referred, the system of referral requires that the specialist facility keep the patient's general medical practitioner informed of progress. An initial reporting letter from the facility to the general medical practitioner should be sent within twenty five working days of the referral.

54. In Fraser's case the referral was by the out of hours community psychiatric nurse. As regards Fraser, the first letter sent by Mrs Petrie to Dr. Marshall was dated 2nd April 2008 and was prepared by her knowing that Fraser had killed himself on 31st March 2008.
55. As users of the National Health Service, patients referred to a specialist mental health facility such as Florence Street will not necessarily be seen by a psychiatrist, psychologist, or doctor for assessment and/or treatment. While a psychiatrist is in a position to diagnose or label specific mental illnesses, it is often not necessary to do so for the successful treatment of patients presenting with mental health difficulties; often it is sufficient for suitably trained staff, on the information derived from the patient, to formulate a treatment plan. Accordingly, patients with referred mental health issues are routinely assessed, treated, and discharged on completion of treatment, by suitably qualified, trained and experienced community psychiatric nurses and occupational therapists.
56. The referral documentation for Fraser, comprised the out of hours community psychiatric nurse assessment of 22nd February. It was received at Florence Street at 8.15 a.m.

57. It was received by community psychiatric nurse, charge nurse Mrs Scott who happened to be first in the department that day. Florence Street maintain a rota for the allocation of new emergency referrals. Mrs Petrie was next on the list to be allocated such a referral. Mrs Petrie is an occupational therapist member of a multidisciplinary team.
58. Mrs Scott consulted Nurse team leader, Mr Kerr, about the allocation of Fraser to Mrs Petrie and each agreed that Fraser be allocated to Mrs Petrie. Neither Mrs. Scott nor Mr. Kerr had any supervisory responsibility for Mrs Petrie (other than any in communal meeting of the multi disciplinary team).
59. Mrs Petrie accepted the referral and contacted Fraser.
60. The first procedure taken with a new referral is to carry out a mental health assessment. Fraser's assessment was carried out in accordance with the system devised at Florence Street namely by having Fraser's mental health assessed. This assessment was carried out by Mrs Petrie assisted by Mrs Scott. Initial assessments are carried out by two members of the team. In accordance with the usual practice, Mrs Petrie carried out the assessment by asking questions and Mrs Scott noted the questions and answers. Mrs Scott was free to ask questions during the assessment had she wished to do so.
61. The assessment interview with Fraser lasted about an hour. Fraser agreed to meet Mrs Petrie again on 27th February 2008. In discussion, Mrs Scott indicated to Mrs Petrie that she should continue to work with Fraser, as Mrs Petrie's caseload was less than hers. Mrs Petrie agreed. It was the practice or culture in Florence Street at that time that the team member allocated to do the assessment would continue to see the patient unless that was changed by a decision taken at the Friday morning weekly meeting of the multi disciplinary team.

62. Mrs Petrie then transposed, by hand, the interview information noted by Mrs Scott and her conclusions about Fraser on to a draft Adult Mental Health Specialist Shared Assessment Form. This draft form was then converted into electronic typescript by an administrative member of staff. On completion of the form in typescript, the original notes of Mrs Scott and the draft manuscript form were destroyed in accordance with normal practice. Mrs Scott subsequently read and approved Mrs Petrie's assessment as set out in the completed form. She did not countersign the form as this was not the usual practice at Florence Street. The adult specialist shared assessment form contains a space for entering the details of next of kin. Mrs Scott did not record and Mrs. Petrie did not complete that space as it was not routine for Florence Street to record such details in circumstances such as Fraser's.
63. When she assessed Fraser, Mrs Petrie had been employed at Florence Street for about eight months as an occupational therapist.
64. In 2008, Mrs Petrie and Mrs Scott were part of a multidisciplinary mental health team who had a responsibility to those referred to Florence Street. The team worked in an open office area and there was frequent informal discussion and consultation of the work being undertaken by the team. In 2008, in that team were, in addition to Mrs Petrie and Mrs Scott, others including a psychiatrist and a social worker. As regards community psychiatric nurses and occupational therapists and doctors, all members of the team were considered by reason of their membership of the team to be equally qualified, effectively self certifyingly qualified. Each discipline had its own hierarchy and they were not connected. For example, the nursing hierarchy included Mrs Scott as a charge nurse and Mr Kerr as a nurse team leader, but they had no responsibility for the qualification, supervision and training of occupational therapists such as Mrs Petrie. Likewise, the psychiatrist member of the team had no responsibility as regards the qualification, training and supervision of the community psychiatric nurses or occupational therapists. As regards the occupational therapists, Mrs Petrie was a

senior grade one occupational therapist, and had Mr McGhee, a senior grade two occupational therapist as her senior. Mrs Scott did not know anything of the qualifications of or training of Mrs Petrie because Mrs Scott was a nurse and Mrs Petrie was an occupational therapist. In February 2008, Mrs Scott's basis of knowledge of the competence of Mrs Petrie was based solely on working with her over the eight months she was there.

65. As regards the taking and confirming of clinical decisions and supervision of the team members, decisions were made by agreement of the whole team in meeting. There was no one person in charge of the team. These clinical and supervisory decisions were taken at weekly meetings of the team. In 2008, that meeting usually took place each Friday morning commencing at 9.30 a.m. and lasted between two and two and a half hours. There were up to fifty cases discussed at the weekly meetings but new presentations were given more time than others. No person chaired the meetings of the team and no one person was accountable for the decisions of the team. No detailed record or minute was kept of the discussions had, and decisions taken, at the weekly meetings. It was not mandatory that all members of the team were present. Team members could be absent because of annual leave and other commitments. If team members were at work on the Friday they generally attended the meeting. The weekly meeting took precedence in the hierarchy of decision making, but the system was such that the competence of a member of the team to carry out duties was taken on trust, the issue of competence, supervision of skills, supervision of the competence to make clinical decisions, and of competence of decisions generally being left, in the case of Mrs Petrie to her senior supervisor, Mr. McGhee to be dealt with. There appeared to be no system of linkage between the supervisory role of the multi disciplinary team in weekly meeting and the supervision of Mrs Petrie by her senior, notwithstanding that their roles overlapped.

66. On 29th February 2008, Mrs Petrie presented Fraser as a new case to the weekly meeting. She read to the meeting the Adult Mental Health Specialist Shared

- Assessment Form and embellished the detail where necessary. She suggested that she continue to work with Fraser. She suggested that she continue to meet with him to build a rapport, gain his trust and monitor his mental health and his risk of suicide while formulating a treatment plan. Those at the meeting agreed.
67. Mrs Petrie considered this way of proceeding as a type of talking therapy. While Mrs Petrie was not trained in talking therapies as treatment, she had had experience of talking to patients in order to get them to open up to her to allow her to better formulate a treatment plan.
68. As the weekly meetings were operated in 2008, it was left to the member of the team who was designated to handle a patient to decide how often he or she would bring the patient's case to the attention of the meeting for discussion.
69. Mrs Petrie next took Fraser's case to a weekly meeting on 28th March 2008 for a routine review. Routine reviews were every four weeks. Fraser was reviewed and it was agreed that Mrs Petrie continue with the weekly sessions. Fraser's risk of suicide was discussed but no change of approach was suggested or agreed as Mrs Petrie considered that Fraser was opening up to her and was at the lower end of risk of suicide. Mrs Petrie had noted from her meetings with Fraser that on days between her meetings with Fraser, Fraser had suicidal ideation and planning but that he had not gone through with these plans on the days that he was meeting with her, and on the days of the meetings, he professed that he did not, that day, have plans for immediate suicide.
70. By that time she had met with Fraser on 22nd February for assessment, on 27th February, Friday 7th March, and on Friday 14th March at 2.30p.m.
71. At Florence Street there was what was known as a crisis team. This team comprised community psychiatric nurses and occupational therapists. The crisis team dealt with persons in crisis and members of the team had a lesser case load

to accommodate their crisis role. Mrs Petrie considered that at any particular meeting with Fraser, had he told her he was planning suicide on a particular day, she would have spoken to the crisis team.

72. Mrs Petrie has been an occupational therapist since July 2004. She had graduated with honours at Glasgow Caledonian University in occupational therapy with psychology. As part of finishing her honours degree she worked part time as an occupational therapist with elderly patients. After finishing her honours degree she went to work as an occupational therapist full time in the State Hospital Carstairs from June 2005 until May 2007, when she went to work full time at Florence Street.

73. The role of an occupational therapist is to help individuals maintain their life roles and depending what their illness or disabilities are to overcome that and remain independent in their different life roles.

74. Mrs. Petrie's experience as an occupational therapist prior to Florence Street as mentioned above was (a) part time as part of her degree work with the elderly, the focus being on, among other conditions, depression, dementia and Alzheimer's; and (b) at Carstairs the focus being on severe enduring mental health and acute cases but also involved experience with people with depression, bipolar disorder and personality disorder, schizophrenia, psychotic cases, suicidal thoughts. Florence Street involved dealing with patients with all such conditions but in a community setting. As regards Carstairs, the treatment of patients did not differ but the security did, as did the management of risk, because patients were not in the community at Carstairs but were in the community at Florence Street.

75. In Florence Street, Mrs Petrie had in addition to her occupational therapist role, a role as a key worker for patients, mental health assessments, and a duty worker role. When she arrived at Florence Street, Mrs Petrie had not done community mental health assessments. At Florence Street she attended no specific training

courses; learning was on the job training. For the first month she had an induction period where she shadowed colleagues and they watched her. She did five assessments before she was allowed to write one up and after ten assessments she took the lead. The first assessment she wrote up was checked by colleagues to see that it contained the correct information. Thereafter, the first few were discussed with colleagues. By the time she assessed Fraser she had done less than one hundred but in the high numbers short of one hundred. Most of such assessments included suicidal ideation or thoughts. The Adult Mental Health Specialist Shared Assessment form was a new form to Florence Street and, along with other staff, she had had two days training for it. She also did an in house lunchtime training session on suicide prevention, and other routine seminars for the team. She also had training for the Glasgow Risk Screen Form. The level of training that Mrs Petrie was given was inadequate in itself to fulfil the role for treating Fraser without proper supervision. The result was that, by the time Mrs Petrie came to deal with Fraser, she was relatively untrained and inexperienced in the assessment and treatment of patients with mental health conditions and needs in the community.

76. In 2008, the system of supervision of Mrs Petrie by her senior was that she was to meet him every six weeks. At such meetings it was for Mrs Petrie to report to him on the cases she was dealing with currently and to discuss her work and case load. No such meeting took place between the time when Fraser was first assessed and his death five weeks later. Mrs Petrie did have a meeting with Mr McGhee during that period to assess her case loading. At that meeting Fraser was mentioned briefly, but there was no full supervisory discussion about him. She told him that Fraser had attempted suicide and that she was working through a period of assessment with him. Mr. McGhee advised that it was appropriate that she continue on that basis. Mrs Petrie considered that had Mr. McGhee decided that what she was doing was inappropriate he would have advised her to go in a different direction.

77. Trainee psychiatrists and junior doctors in psychiatry, regularly have weekly meetings with their supervising colleagues to discuss their patients.
78. Notwithstanding that Fraser co operated with the assessment, he had difficulty in fully explaining his circumstances. Nonetheless, the questioning of Fraser as disclosed by the Adult Mental Health Specialist Shared Assessment form showed that he was an unhappy young man and it raised possible conditions such as depression, bi polar disorder, and personality disorder, but the Adult Specialist Shared Assessment was not sufficiently detailed to give some idea of the reasons for Fraser being mentally unwell. The consequence was that a clinician coming to Fraser's case notes would have been hampered in his progress of the case by the absence of information. The initial assessment of Fraser was incomplete and inadequate to that extent. Mrs Scott approved the assessment, and when it went forward to the weekly meeting, action based on the assessment was approved by the meeting without comment on the adequacy of the assessment. Notwithstanding that multi disciplinary team in weekly meeting were aware that the assessment was incomplete as at 29th February, no member of the team raised that at any subsequent meeting; it being left to Mrs Petrie to bring Fraser's case to such meetings.
79. While the way of proceeding with Fraser approved by the meeting was a form of action that is used by such teams from time to time, it was not a good or acceptable practice to continue an assessment of a person with mental health issues over an extended period without formulating a treatment plan. The period over which Fraser continued to be assessed was five weeks and was too long, and by the time of his death no treatment plan had been formulated for Fraser and such a plan was unlikely to have been considered until the end of April.
80. Fraser's presentation was complex. A more experienced clinician than Mrs Petrie would have recognised from Fraser's presentation on 14th and 28th March 2008 that he continued to be unwell and that his suicidal ideation was ongoing or

worsening. In particular, the fact that he had developed a plan for suicide but had not carried it out due to sleeping in, was evidence of suicide planning. A more experienced clinician would have recognised that it was appropriate to have someone more experienced join her to carry out a further and fuller assessment to establish what the diagnostic label for Fraser was, in order to see what interventions were appropriate and beneficial for Fraser. While Fraser's disclosures on 14th March 2008 were after the weekly meeting that day, Fraser was reviewed at the weekly meeting of 28th March 2008. Mrs Petrie did not recognise that Fraser continued to be mentally unwell with the possibility of his condition worsening. That was an error of judgement on her part. Her relative inexperience and lack of training may have played a part in her failure to recognise and act on the signs of illness and suicidal ideation that were present. Had Fraser been adequately reviewed that day, a more experienced clinician should have been recommended to see Fraser with Mrs Petrie. Fraser had been reluctant to see anyone other than Mrs Petrie, and had declined to see anyone else when she was on leave. It is uncertain whether he would have agreed to such a proposal. Had Fraser been prepared to see a more experienced clinician, he or she would have identified that Fraser remained unwell and that his suicidal thoughts were ongoing and may be worsening.

81. As regards Fraser, the system of supervision of Mrs Petrie operating at Florence Street had weaknesses. As the primary management tool, the weekly meeting did not address, and was not designed to address, the competence or experience of any member of the team. As a result, Mrs Petrie's experience was not addressed by them. The practical result of the system was that she lead the discussion. Her opinion was taken on trust. The team took no steps to raise themselves the progress of Fraser at weekly meetings, it being left to Mrs Petrie to do so. Further, the nature of the supervision by her senior during the period was inadequate in that the only supervision by her superior during that time was a case loading exercise. The result was that the handling of Fraser's case was allowed to drift which was not good practice and Mrs Petrie's inability to realise the extent of

- Fraser's illness was not picked up. While Fraser believed that he was being treated and that the treatment was not working, in reality Mrs Petrie was continuing with her assessment, trying to know Fraser better so that she could give him support, monitoring his risk of suicide and gathering information to formulate a treatment plan.
82. Mrs Scott and Mrs Petrie agree that having next of kin details can be of use in such matters as communicating in an emergency. Referrals can be reluctant to provide such information due to the perceived stigma of mental illness.
83. Fraser was mentally unwell from at least his suicide attempt on 20th February 2008 until his death, the nature of his illness was not diagnosed or identified. His illness included continuing thoughts of suicide.
84. Hospital accident and emergency departments by their nature are presented with fluctuating demands for their services. The treatment facilities in terms of consulting and treatment areas and availability of clinical staff to assess and treat patients results in different levels of demand. At times the facilities can be overwhelmed and determination of the level of priority of treatment is often required. At the Victoria Infirmary accident and emergency department there was in 2008 and is a need to assess priorities. There was therefore in place a system for assessing priorities. Persons attending the accident and emergency department may either self refer by appearing in person at reception in the accident and emergency department or they can be brought to the department by ambulance. In general terms persons brought by ambulance are considered to be likely to be in need of emergency or urgent treatment. On arrival, persons self presenting provide their details to a receptionist at a desk located in front of a general waiting area. After completion of a record card relative to the patient's attendance at the department and the card distributed, he is referred to a triage nurse for assessment. The patient is asked to sit in the general waiting area pending assessment by the triage nurse.

85. Persons arriving by ambulance are triaged or assessed by the clinical staff within the treatment area of the department.

86. When a patient is brought to the department by ambulance there requires to be a transfer of the patient from the ambulance team to the hospital staff who are to treat the patient. In 2008 there were no written protocols agreed between the Victoria Infirmary accident and emergency management and the Scottish ambulance service management for the handover of ambulance arriving patients.

87. The management of the accident and emergency department considered that the agreed procedure with the Scottish Ambulance Service for transfer of a patient was that a member of the ambulance service would physically bring the patient into the treatment area of the department, present the patient to the staff there, while explaining in the presence of the patient his or her presenting complaint or condition. This was and is to be done so that the receiving clinician can assess the priority of treatment of the patient in front of him and where the patient is to be placed during any waiting period. This procedure applied to attempt suicide cases. There exists and existed at February and March 2008 a written protocol for accident and emergency staff at the Victoria Infirmary Glasgow, in respect of (a)patients arriving by ambulance and (b) attempted suicide patients in the following terms:-

88. Victoria Infirmary Accident and Emergency Department APPENDIX 11

ATTEMPTED SUICIDE

Patients may arrive by ambulance or self present to the Emergency Department

Patients arriving by Scottish Ambulance Service:

Patients brought into the Emergency Department by Scottish Ambulance Service following threatened or attempted suicide should be brought into the department and handed over to a member of staff.

These patients should remain in the department in a cubicle until seen by a doctor.

Patients who self present:

The Medical Records staff at the front desk, once they are notified of a patient self presenting with suicide intent, should immediately buzz for the triage nurse to attend front desk and assess the patient.

PATIENTS ARRIVING BY AMBULANCE

There are three types of ambulance arrivals:

- a. Standby
- b. 999Emergency/Self Referral
- c. GP receiving cases.
- d. Standby Cases [not applicable]
- e. 999/GP referral Cases

Brought by ambulance into department

Verbal handover given to member of nursing staff

Relatives advised to wait in Waiting Room

Written documentation handed into front desk.

89. It is sometimes the practice of the ambulance team to note on their protective gloves, information about the patient so that the clinical staff can be alerted immediately to the circumstances of the presenting patient, read out to them by the presenting ambulance personnel.

90. On entering the accident and emergency department from the ambulance bay there is situated ahead and to the right a reception desk; to the left there is a long corridor of about 50 metres leading to the treatment or clinical area. At the top of this corridor and close to the reception desk there is an area or room occupied by a triage nurse. For the most part the triage nurse assesses self referral patients appearing at reception to assess the priority of their treatment. At the foot of the

corridor is situated the clinical or treatment area staffed by doctors and nurses. This area comprises consulting rooms or cubicles, an area that can be curtained off to provide cubicles and an a general open area. There is in this open area a desk where nurses and doctors can receive patients including patients brought in by ambulance.

91. As set out in Appendix 11 where patients brought into the department by an ambulance team, it would be the expectation of the hospital staff that a member of the team will bring the patient physically to the treatment area to be handed over to the accident and emergency team. That handover will include the member of the ambulance team briefing the clinical team about the patient brought in.
92. Once the patient is physically handed over to the receiving nurse or doctor the ambulance team member leaves the clinical area and returns to the ambulance for making ready to accept the next call.
93. In 2008, the Scottish Ambulance Service had no written protocol such as Appendix 11. The matter of practice and implementation of practice was left to discussion between, in the present case, the management of the accident and emergency department Victoria Infirmary and the ambulance service. These discussions took place on a regular basis.
94. In 2008, notwithstanding the protocol as set out in Appendix 11, the ambulance teams would give verbal handovers of patients to clinical staff, in the sense that the patient was not physically present in the treatment area with the ambulance team when his or her details were being presented, and the hospital staff would allow that to happen.
95. On entering the accident and emergency department with the patient, the member of the ambulance team takes with him or her a PRF which had been demand printed by him or her. The PRF is needed for providing information about the

- patient being presented and for the hospital reception staff to generate and Accident and Emergency patient file/card.
96. The accepted practice as regards the PRF is that it requires to be handed in at reception for the creation of an accident and emergency file in the name of the patient. The PRF is sometimes taken by clinical staff to reception and sometimes the departing ambulance team member hands it in to reception for the clinical staff. Sometimes also, if the team generate a duplicate PRF, the team member may hand in the duplicate en route to the clinical area to speed the generation of the patient file/card.
97. As regards processing the PRF, it is the accepted practice within the accident and emergency department that a member of the treating hospital staff or one of ambulance staff presenting the patient, either hands the PRF to the receptionist or puts the form through the window at the receptionist's desk but first getting the acknowledgement of the receptionist that she is aware that the form has been left for him or her.
98. On receiving the PRF the receptionist electronically creates a record for the patient which is printed out as a white label and which is fastened onto a larger four sided A4 yellow card. The PRF is affixed to the yellow card inside. It is obvious to someone looking at the yellow card that it is an ambulance generated admission because the PRF is obvious inside the card.
99. When the receptionist has completed the creation of the patient file/ card the receptionist leaves it on the reception desk for collection by a triage nurse or other clinical staff from the treatment area. Depending on whether the case is a self referral or an ambulance case the file will be taken by the triage nurse for the triaging of self referrals or taken or delivered by a member of a treating staff (usually the triage nurse) to the treatment area and left there. It is the hospital practice where there is room in the clinical area, to keep attempt suicide patients

within the clinical area so that staff can keep an eye on them. The area is restricted in size and at times the department cannot accommodate all the presenting ambulance cases at the same time and decisions are made about the placement of presenting ambulance related patients until they can be seen for treatment. Accordingly, at busy periods ambulance related patients may be asked to wait in the general waiting area in appropriate cases. The department is generally busiest during the week from 2 pm until 6 pm and later in the evening. It is a very rare occurrence that the department is so busy that a place in the treatment area cannot be found for an attempted suicide ambulance admission.

100. It was an unjustified decision by hospital staff to place Fraser in the general waiting area of accident and emergency on 31st March 2008.
101. The absence of a written Scottish Ambulance protocol identical to that of the Victoria Infirmary protocol may have had a part to play in Fraser not being the subject of a physical handover by ambulance staff to hospital treating staff.
102. In the treatment area there is a box sometimes called a second box into which the cards for those not in receipt of immediate treatment are placed. For a patient's card to get into the second box, a patient should have been assessed by the treating staff or the triage nurse. Clinicians, if not otherwise engaged, will take patient cards from the box, assess them, and, where appropriate, call the patient for treatment. It is the responsibility of the senior doctor on duty to check or monitor the cards in the box from time to time to ensure the proper priority/ order of treatment is being maintained.
103. At about 2.30 pm Dr. Gordon, the consultant in emergency medicine and person in charge of the department on that day, checked the box containing the patient files. In terms of precedence, Fraser was not the next person due for treatment. Nonetheless, Dr. Gordon took the card for Fraser and called him for treatment. There was no response. Fraser's card had been in the second box which

was indicative that he may have been called for treatment earlier. Dr. Gordon then personally searched for Fraser within the department and toilets and outside the department. He could not locate him.

104. At 2.40pm Dr. Gordon telephoned Dr. Marshall (who was recorded on Fraser's file as his general medical practitioner) to obtain information about Fraser. Dr. Marshall was in the middle of a busy surgery. He confirmed to Dr. Gordon that Fraser was known to him, that he was under psychiatric treatment at Florence Street, Glasgow, that he was engaging with mental health services. It was left that Dr. Marshall would notify Florence Street of Fraser's new attempted suicide and that they might wish to carry out a further assessment of him in light of the new events.

105. Dr. Marshall left himself a note to contact Florence Street on the following day. He also attempted to contact Fraser on his mobile telephone but was not able to speak to him. The response to the call was a flat ring tone indicating that the number was unobtainable. Neither Dr. Gordon nor Dr. Marshall otherwise took steps to contact any other person or service. Dr. Gordon could not recall if he asked Dr. Marshall whether he thought he should telephone the police.

106. During his period of treatment Fraser was not prescribed medication. He had indicated to his mother that he did not want to take medicines when she suggested to him that he should. He indicated to staff at the hospital and at Florence Street that he would prefer not to take medication but he was not asked by mental health services at any time to take any form of medication.

107. In 2008 and currently, it is not the practice of Dr. Marshall's general medical practitioner practice to record the next of kin details of adults of full age, where there is no particular requirement for the information. The electronic record form for a patient in his practice contains a field allowing for the insertion

of that information, but routinely it is not completed as it is considered by the practice to be unnecessary.

108. It is speculation to suggest that the errors of judgement of Mrs Petrie and the staff of accident and emergency at the Victoria Infirmary on 31st March 2008, the inadequate supervision of Mrs Petrie at Florence Street and the failure of the Victoria Infirmary accident and emergency department to put into operation their own protocol for the handing over of patients caused or contributed to Fraser's death, or were facts relevant to his death.

Note:

I heard the evidence in this case three and half years after the events. It was reasonably clear that a large part of the lapse of time was attributable to the time taken in investigating the issues raised by Fraser's parents and in communication with the various services. Delay in the leading of evidence can affect the quality of the evidence, because time and circumstances can affect recollection. There were two main areas of evidence; the events of 31st March 2008 and Fraser's attendance at Florence Street before that. It seemed reasonably clear from M/s Hausley's description that she did not speak to the consultant on duty that day Dr. Gordon. No one who was on duty that day as nurse or doctor in accident and emergency was called as a witness. From what Dr. Gordon said, when the matter was looked at by him at the time, no one recalled a verbal handover.

As regards Florence Street, as I understand it, because the system of recording Friday meetings was poor, it could not be discovered who attended the weekly meetings from 29th February 2008 to 28th March 2008. Certainly, I asked that any minute book or record be looked at to see if people at the weekly meetings could be identified, but while documentation was found and discussed by those represented at the inquiry, nothing was produced to the inquiry. Not surprisingly, neither Mrs Petrie nor Mrs Scott could be

certain whether Mrs Scott was at one or more of the meetings at which Fraser was discussed.

Mr Kurana submitted inter alia that it may not be appropriate, should the issue arise, for criticism to be made of individuals involved in complex health systems based on evidence of that age.

I do agree that the quantity of direct evidence made available to the inquiry was small and to an extent, after three and a half years, lacked some certainty. I accept that I should take into account his submission. While it may be inevitable from what I have gleaned in passing, I have a concern also about forming views on the performance of individuals where they have not been called as witnesses. As an example, there was scrutiny of the robustness of the performance of the multi disciplinary team in weekly meeting, but the only evidence of that performance is that of Mrs Petrie whose own actions was under scrutiny. Mrs Scott spoke of such meetings but there was some uncertainty which if any meetings she attended during that period. About the events at the Victoria Infirmary there was evidence from the two ambulance staff, but none of the staff from the accident and emergency department gave evidence other than Dr. Gordon.

Further, the submissions of Miss Ritchie, Mr Paterson and Mr. Kurana contained strongly asserted themes about the absence of comparative and expert evidence, which meant that there was little evidential basis for identifying defects in systems or reasonable precautions. They also submitted that the questioning of the witnesses as to fact was not sufficiently detailed to lay a foundation of fact on which any such comparative or expert evidence could have been based in any event. Broadly, I agree with such submissions. It follows from that, that while I found Mr Fordyce's submissions to be pertinent to the issues his client wished to be raised, on analysis of the evidence before the inquiry, there was not sufficient evidence to support many of his submissions.

The only independent comparative or expert evidence came from Dr. Finlayson. Leaving aside the criticisms of his evidence in submission, he said that he was aware that other

mental health facilities followed the practice adopted by Mrs Petrie and Florence Street but he thought that it was not a good or acceptable practice, in particular to allow an assessment to run over an extended period without a treatment plan.

The extent of the evidence led at the inquiry did not address a general review of the systems operated by the various elements of the state health care (including the general medical practitioner service and Scottish ambulance service) that Fraser came into contact with, for the purposes of identifying change. The extent of that evidence being to identify what was apparently accepted to be the established practice and proceed from there.

Further, I accept the submissions of all parties that no causal link was established in evidence between any actions or omissions of Florence Street, the Victoria Infirmary, Dr. Marshall, and the Ambulance service, and Fraser's death. Fraser's parents wished such matters as accountability communication and connectivity of services to be addressed. These issues do not always fit well within the statutory framework of an inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. Nonetheless, I consider that they should be addressed as far as possible. It is for those reasons that any comments I have made in connection with matters of connectivity, communication and accountability are in the form of observations which I hope those charged with the management of the services will look at in light of the circumstances of Fraser's death.

In these circumstances, I consider that it would be inappropriate on the evidence before me to make findings in terms of section 6(1)(c-e).

I now turn to deal with these matters in more detail.

Section 6(1)(a)

The affidavit evidence to support the date place and circumstances of Fraser's death was clear, unchallenged and convincing. It established fully that Fraser had deliberately killed himself by stepping in front of a train. All represented at the inquiry accepted and

adopted the submission of the Crown as set out in the determination above as to place of death. It was submitted by Mr Paterson that the evidence showed the Fraser had died at 5.15p.m. rather than at 18.50 hours when he was pronounced dead by the medical team. I did not understand that the difference was due to any technical matter but that on the basis of the evidence it was more probable that he was killed instantly and that I should so find. On the evidence I consider it more probable that Fraser died at 5.15p.m.

Section 6(1)(b)

The unchallenged and clear evidence from the affidavit evidence and the evidence of the post mortem findings showed the cause of death was as set out above, that Fraser died as a result of his injuries following his impact with the train. All represented at the inquiry accepted and adopted the submission of the Crown as set out in the determination above.

Section 6(1)(c)

The Crown submission was that there was no evidence on which the inquiry should make a finding in terms of this subsection.

Miss Ritchie, Mr Paterson and Mr Khurana each submitted that there should be no finding in terms of this subsection.

As I understood Mr. Fordyce's submissions his criticisms of those involved with Fraser related to systems rather than reasonable precautions. I leave therefore that subsection and turn to section 6(1)(d).

As regards section 6(1)(d)

The Crown submitted that there were defects in the systems of the health service working. The procurator fiscal identified the lack of supervision of Mrs Petrie during her period dealing with Fraser although she accepted that it would be speculation to say that such a lack of supervision contributed to the death of Fraser. The procurator fiscal identified the absence of clear guidelines for the handover of an ambulance patient to hospital staff as a defect in the system. She submitted that had there been clearer

guidelines to be followed by ambulance staff and hospital staff at handover Fraser may not have had the opportunity to leave the hospital, this too she accepted as speculative. Clearer guidelines could prevent such a position in future.

Miss Ritchie Mr Paterson and Mr. Kurana each submitted that there should be no finding in terms of the subsection.

Mr Fordyce's submissions identified seven defects in the system at Florence Street, he then went on to deal with the circumstances at the Victoria Infirmary and subsequent events.

The first defect in the system was the choice of Mrs Petrie as the person allocated to assess Fraser.

The second defect in the system was allowing Mrs Petrie to take the lead in the assessment of Fraser by direction of Mrs Scott on a comparison of work loads.

The third defect was that Florence Street should have communicated with and taken cognisance of Fraser's parents and his general medical practitioner and by so doing lessened the risk of suicide.

The fourth defect in the system was that there was no treatment plan.

The fifth defect in the system was the designation of Mrs Petrie to Fraser by Mrs Scott rather than by the multi disciplinary team.

The sixth defect in the system was the performance of the multi disciplinary team who allowed Mrs Petrie to lead on Fraser's case in circumstances where they should have engaged in a proper dialogue which would have identified the extent of Fraser's illness.

The seventh defect in the system was the absence of a detailed record of the weekly meetings the discussions engaged in, the decisions taken and the reasons for the decisions noted in detailed, recorded, and circulated to team members.

As regards section 6(1)(e)

The Crown had no submissions to make

Miss Ritchie had no submissions

Mr Paterson submitted that I should refrain from addressing issues under this subsection that could not be appropriately dealt with in the preceding subsections.

Mr Khurana submitted that I should make no findings under this subsection.

Mr. Fordyce made further submissions which probably fit within this subsection. These were:- the absence of a proper assessment leading to an absence of treatment. Fraser's state of mind getting worse, "leading him to complete the act of ending his own life", while Mrs Petrie may have tried her best there was no one to assess whether her best was good enough and the reason for that was lack of communication, the responsibility of Mrs Petrie's employers.

He also submitted that the level of contact organised by Fraser's general medical practitioner was cursory and affected the crucial telephone call between Dr. Marshall and Dr. Gordon. Further, the level of communication set as a norm by Florence Street and accepted by Dr. Marshall resulted in Dr. Marshall being unaware of the course of Fraser's attendance at Florence Street. Had the letter of 2nd April been available for his meeting with Fraser on 14th March he would have been able to explore the inconsistencies between what Fraser was reporting to him and what Florence Street were observing. The time scale for sending an assessment made a nonsense of its purpose as a communication tool. He was also critical of Dr. Marshall in not following up the assessment when it had not arrived within the "couple of weeks" timescale he was expecting.

Mr. Fordyce criticised the compartmentalised mentality of the health service, between branches of the service (general medical practitioner and Florence Street; ambulance service and hospital) and within the branches (key worker and multi disciplinary team; key worker and supervisor). Such compartmentalisation resulted in the parts paying lip service to accountability. Viewed from outside the service, his client had described the service to him as, “wallowing in a sea of unaccountability”.

As regards the Victoria Infirmary accident and emergency department, Mr. Fordyce was surprised at the number of permutations for admission. He criticised the card creation and delivery system. He submitted that there was a lack of communication which was factor in what happened.

He criticised both Dr. Marshall and Dr. Gordon for leaving it to the other to take responsibility for Fraser.

Mr Fordyce’s final submission was that, “ Fraser surrendered control of his life to the medical authorities. Those medical authorities failed Fraser through lack of communication. No one connected with Fraser understood what was going on in Fraser's mind. His family were denied the opportunity to do so because those treating Fraser failed to share responsibility. As a result of that, I submit that responsibility for Fraser's death should be shared with those who had the duty of caring for him and failed him.”

In light of the evidence before the inquiry, the cause or causes for Fraser taking his own life are unknown, and it would speculation to identify a cause. On the evidence, it is not established that Fraser's death was causally connected to the considerations set out in any of the paragraphs 6 (1)(c) to (e) of the Act. It has not been established that there was any identifiable precaution, reasonable or otherwise, whereby his death might have been avoided. It has not been established that there were any defects in any system of working that contributed to his death. There were weaknesses in the systems at Florence Street and the Victoria Infirmary but it has not been established that they rather than the

operation of the systems on this occasion gave rise to inadequate supervision and breach of the protocol. There are no other facts relevant to the circumstances of his death. I make no finding under the subsections of the Act. Nonetheless, I comment below on the matters raised at the inquiry.

Fraser

For the purposes of the formal part of this determination I have referred to Fraser John O'Donnell by his full name as I am required to do, but thereafter I have referred to him simply as Fraser, for that is how he was spoken of at the inquiry.

At the time of his death Fraser was a twenty three year old student. He was living independently, sharing a flat with a person of his own age. He was a student, he had a girlfriend, and a part time job. He told the ambulance staff who attended to him on 31st March 2008, "I've got a good mum and dad and girlfriend, a good flat, money and a good life."

According to his mother and father, Fraser's life was that of a twenty three year old student and in that sense unremarkable until 20th February 2008. It came as a shock to them that Fraser had that day attempted suicide. They had not seen it coming and there were no signs, even with hindsight, that gave them any warning. They had not known of his suicidal ideation of October 2007.

Fraser's parents had separated in 1995 and his mother lived in Ayrshire Scotland and his father in the Oxfordshire, England. They each had a very good and loving relationship with Fraser. They kept in touch regularly; they were concerned and caring parents. They were as active as they could be in the care and treatment of Fraser for his mental illness.

They were devastated by Fraser's death and they wanted to know how it came to be that their son, who was under medical care at the time of his death, could end up killing himself. They sought answers from those involved with the care of Fraser. They did not receive answers they considered satisfactory. They were tenacious in pursuit of answers

and when they did not get them they sought the assistance of the Crown, from which this fatal accident inquiry arises.

Apart from wanting answers generally, they had aspects which were of concern to them in relation to Fraser's care.

The first was the accountability of those involved with Fraser.

The second was communication of those involved with Fraser, with him, and between themselves.

The third was connectivity between the services.

I deal with the separate phases of the events and the three issues raised.

Adequacy of arrangements on 20th February 2008 ambulance to hospital, treatment and immediate aftercare

Fraser was a self referral on 20th February having been taken to the Victoria Infirmary by his girlfriend and her mother. It appears that he was seen by a doctor but left without treatment. The doctor on that occasion telephoned the police and Fraser was brought back treated and seen by the out of hours community psychiatric nurse team. The circumstances of what happened on 20th February were not explored in evidence in depth, they were explored only in relation to the procedure that followed and in contrast to what happened on 31st March 2008. There was no evidence about where he was placed within Victoria Infirmary accident and emergency department before he departed before treatment.

From the evidence of Dr. Gordon it can be a complex and delicate matter to secure that a patient remain at hospital. When Fraser was returned by the police he was in police custody and was removed in custody from the accident and emergency department after treatment.

As regards the issues of accountability, communication and connectivity there is an issue. I did not hear in evidence the treating doctor on 20th February or M. Thomson, the out of hours community psychiatric nurse who assessed Fraser that night. There is nothing in the community psychiatric nurse's assessment suggesting that she spoke to the treating doctor or had the file notes of Fraser when he was seen. The general evidence at the inquiry was that once transferred to mental health services, that specialist service took the matter from there. There was evidence also that the mental state of a patient can fluctuate, and the notes for Fraser show that he changed from non co operation to co operation over the course of the evening. I was surprised that there was no transfer of information (by reading the file note or speaking to the doctor concerned) to the community psychiatric nurse so that he or she was fully informed of what Fraser's condition was earlier, even to determine the extent of the volatility of his mood. That may have been done, but there is no record that it was done and there should be a record of that if it happened. The matter is not academic as the treating doctor appears to have recorded that Fraser was of high risk and would need compulsory mental health treatment, where the community psychiatric nurse considered him at the time of assessment a short time later (as interpreted to the inquiry by others) as low risk.

General medical practitioner issues

Mr Fordyce raised the issue of control of Fraser's care. There was evidence from some witnesses that once Fraser was with Florence Street that the control of Fraser's care was with them and that Fraser's general medical practitioner had no other role than writing prescriptions as required by Florence Street. There was other evidence that the general medical practitioner was the core of patient care and that the general medical practitioner always maintained a residual role and therefore a residual responsibility for his patient.

Now, in the present case, Dr. Marshall asked Fraser to see him regularly to keep him in touch about his progress at Florence Street. Fraser did so. Accordingly, there was continuing care from Dr. Marshall while Fraser was at Florence Street. Mr. Fordyce challenged the level of that care. As I understood the evidence, what Dr. Marshall did was at least in accordance with what is established practice within the medical profession

and was appropriate to meet that duty of care. To consider finding otherwise would have required a great deal more evidence than was before the inquiry.

There was evidence that Florence Street had a responsibility to write to Dr. Marshall to report on progress within 25 working days. The first and only letter was sent, on one view, late, and at a time when Fraser was already dead. On the evidence, had the letter been sent earlier but towards the end of the target date, it would be speculation to say that it would have affected the outcome, and no one suggested otherwise. Dr. Marshall was of the view that such letters were sent out within two weeks of the patient being assessed. In submission, Mr. Fordyce criticised Dr. Marshall for not chasing the letter up. As far as I can see Dr. Marshall was not asked why he did not chase up the letter. He did say that he was awaiting their letter. Of course, the evidence was that the assessment was ongoing and was not concluded and Mrs Petrie said that the letter was due within 25 working days of the referral. In submission Mr Fordyce criticised that practice. I do not recall the 25 day timescale being put to Dr. Jones Edwards or Dr. Finlayson as an issue. Mrs Scott said that it was twenty eight days. It would be of use if all practitioners were aware of the time scales. I comment elsewhere that the time scale is pretty remote but the issue of suggesting an alternative should be based on evidence, and I cannot recall an alternative being suggested in evidence of weight.

Next of kin recording

I heard evidence from Dr. Marshall about the procedure for a new patient registering with his practice. It was not the practice of his practice to record in the records of the practice, details of the next of kin of non vulnerable adults of full age. A new patient is given a form to fill out and if he fills in his next of kin then it may be transcribed onto his record but it is not a requirement that that be done. The patient questionnaire which Fraser completed at an earlier surgery contained details of next of kin. That appears to have been done about three years before he registered with Dr Marshall in 2006.

Doctor Marshall indicated in evidence that he could see that having next of kin information could be useful for contact, but as regards suicidal patients, were the issue to

arise, he would contact a psychiatrist for admission of the patient to hospital or the police. He would not contact the family. I accept that evidence.

When Fraser went missing the general medical practitioner records, the Florence Street records and the hospital records did not have a next of kin noted and therefore Dr. Gordon could not have spoken to the next of kin about Fraser.

The issue of confidentiality of the records and the circumstances in which a doctor could or should override confidentiality did not arise. As regards contacting next of kin, Dr. Gordon expressed the view that in appropriate circumstances, while he would give serious consideration to the issue, confidentiality would not necessarily hinder him from contacting a next of kin.

Dr. Gordon knew nothing of Fraser, and the path he chose was to speak to Fraser's GP. That was appropriate. Accordingly, the issue was hypothetical to an extent.

Dr. Marshall took the view from his conversation with Dr. Gordon that locating Fraser was not urgent and so the issue of confidentiality in contacting the next of kin was also hypothetical.

On the evidence of the earlier general medical practitioner questionnaire, Fraser's mother would likely have been recorded as his next of kin. By the time Dr. Gordon or Dr. Marshall would have telephoned, M/s Hill she would have been at work and there was no evidence before me that she would have been able to have been contacted earlier than she was. Such matters as what would have been recorded as her next of kin details, whether it would have included a mobile telephone number or a work number, whether her telephone was on, whether there would have been someone else at home to receive a call, and when Fraser's mother would have had the information were not explored.

While I understand the frustration of Fraser's parents on this matter, it is speculation to consider that Dr. Gordon or Dr. Marshall (or Florence Street) having the details of the

next of kin would have altered the events of the day. From such evidence as there was, it appears that it did not occur to either doctor to follow that line. Dr Marshall telephoned Fraser's number but could not gain a response.

The breadth of the evidence at the inquiry did not cover this as an issue to be explored at the inquiry. There was no evidence to address the possible requirement that all general medical practices should record next of kin details, or what details should be recorded. The taking and transcribing of such details has time and resource implications on which I heard no evidence. While it is a matter that those who review such matters may wish to look at, apart from various witnesses saying that such information could be of use from time to time, I express no view on the matter; although it does seem strange, as with other health service forms I saw, that forms are generated with spaces for the insertion of such information, where the spaces are routinely not completed.

Telephone call with Dr Gordon

I considered that Dr. Marshall and Dr. Gordon told me what they honestly remembered of their conversation, notwithstanding their different recollections of the telephone call between them. On the evidence, I can only conclude that there was an unfortunate miscommunication between Dr. Gordon and Dr. Marshall in their telephone call. How that could happen was unresolved. Dr. Gordon telephoned Dr. Marshall urgently because he knew nothing of Fraser and wanted information. Dr. Marshall thought that Dr. Gordon was reporting an important further incident in Fraser's case but which was of no particular urgency. However, to Dr. Marshall the call from an accident and emergency consultant was highly unusual and yet he thought there was no urgency in it, yet he tried to contact Fraser nonetheless. Dr. Gordon was reassured as to the risk to Fraser who had attempted suicide by being told that he was engaging in treatment where such treatment would include suicide prevention, which, on the facts, on one view, could not have been working.

Dr. Gordon could not remember whether he asked Dr. Marshall if he, Dr. Gordon, should phone the police. Dr. Marshall made the valid point that as he could not provide the

police any relevant information, (time left accident and emergency; what he was wearing, what direction he went in, what if anything he had said about his intentions). Dr. Gordon's best recollection was that the telephone conversation as it progressed was reassuring and that consequently the urgency of the matter was diminishing and it may not have come into his head to ask whether he should call the police.

Accountability

Dr. Marshall accepted that he continued to have a duty of care for Fraser when he was at Florence Street and Dr. Marshall fulfilled that duty to Fraser by seeing him weekly and reviewing his case. Operating within the established practices of the state medical care system, and the system of referral, I cannot see that he should have done more. According to his contemporaneous notes Fraser had told him on 14th March that he was progressing. While that is at odds with Mrs Petrie's notes, it does not necessarily follow that the record is wrong. Fraser may have been more optimistic with Dr. Marshall. The evidence showed that Fraser's mood was fluctuating throughout the period.

As regards Mr Fordyce's submission, I accept that Dr. Marshall listed Fraser as high priority. I accept that he was entitled to assume that Fraser would be seen by a competent specialist in mental health. Florence Street treated Fraser's referral as an emergency and sought to see him that day, which would meet the high priority classification. I accept that Dr. Marshall ceded control of Fraser's primary care to Florence Street. I accept, as he did, that he had a continuing duty of care. I consider that seeing and speaking to Fraser was more than note taking, as was submitted by Mr. Fordyce; he was, in a non specialist way, observing whether his patient was improving or not. The referral to Florence Street was by the out of hours community psychiatric nurse; Dr. Marshall simply confirmed by telephone that the referral had been made. Dr. Marshall position was that he was not asked to volunteer a diagnosis.

Did the extent of Dr. Marshall's duty of care include an obligation to specify his own diagnosis, and monitor Florence Street's performance in relation to his patient beyond the reporting arrangements already in place? Should he have phoned to ask why Fraser was

not receiving medication, and to ensure that Fraser was seen by a psychiatrist? The extent of a general medical practitioner's duty was not explored in evidence to this extent and I heard no expert or comparative evidence about it. I appreciate that a consequence of his duty of care may fall squarely within the issue of connectivity of services. In the circumstances prevailing on 21st February 2008, I can see no basis on which Dr. Marshall should have volunteered his own clinical assessment.

As regards next of kin, I accept Dr. Marshall's explanation of matters. In the event, it would be speculation to say that the absence of this information had a part to play in the events of 31st March.

On the matter of the telephone call, there was no evidence before the inquiry to support a proposition that it should be the practice of general medical practitioners to telephone the police in such circumstances.

Connectivity and communication

As spoken to by each, there was an unfortunate miscommunication between the doctors. The circumstances in which the call was made was one of urgency and emergency. Each came to the call unexpectedly. There was no analysis in evidence to show that each acted other than appropriately at the time. The fact that another doctor had taken a different approach successfully on an earlier occasion, is not sufficient to hold that the taking of a different approach on a later occasion was inappropriate.

Mental health services for Fraser: Florence Street

I found the evidence of Mrs Petrie to be preferable to that of Mrs Scott and Dr. Jones Edwards where it differed. I found Mrs Petrie to be a straightforward and frank witness. I considered that she gave a reasonably clear account of what had happened at Florence Street over the period when Fraser was attending. I found Mrs Scott to be defensive and a poor witness. As an example, she asserted that Mrs Petrie was fully competent when she knew nothing of her qualifications and little of her past experience. Dr Jones Edwards

was defensive of Florence Street to the point where she was not prepared to engage with legitimate propositions put to her for Fraser's parents, and that diminished her evidence.

There was no suggestion by any of the Florence Street witnesses, Mrs Scott and Mrs Petrie, that the systems that operated at Florence Street and still operate, should change. Notwithstanding the terms of the critical clinical investigation report findings, the import of Dr Jones Edwards' evidence to the inquiry supported the status quo in that there was no change of accountability, no change of the multi disciplinary team having an altered role and no change in the frequency of supervision.

I record the recommended action plan set out in that critical clinical investigation here:-

1. Adherence to supervision guidance to be reviewed by all team leaders and communication to be circulated to all staff to support this
2. Consideration should be given to increasing the frequency of supervision by all team leaders
3. Caseload weighting exercises or other supervisory activity should not take the place of clinical case supervision and time should be allocated to ensure case discussions can take place –team leaders to note.
4. Further training should be made available on the evaluation of the Glasgow Risk Screen and its usage in clinical practice.
5. Suicide awareness and prevention training for all staff will be provided on an ongoing basis and team leaders should ensure participation /updating for team members.
6. Team leaders should routinely raise the need to ensure full recording of discussion/ decisions by staff.

7. The NTL within Florence Street will produce an action plan for the above

8. The Head of Mental Health will write to all staff to clarify the above.

Of note was the evidence of Dr. Jones Edwards that the decision on the frequency of supervision meetings at six weekly intervals (action plan number 2 above) was discussed and a decision taken to make no change.

I am conscious that the methods whereby patients are treated by mental health services are complex and may have evolved with time and experience. Dr. Finlayson, a very experienced consultant psychiatrist, also pointed out that there were several different ways that community mental health facilities work to deal with patients. There are issues I consider worth commenting on about the operation of Florence Street. Standing also that, on the evidence before the inquiry, the further discussions following the critical incident investigation report action plan left supervision as existing, I do consider that a further look at certain matters might be considered.

Dr. Finlayson made it clear that it was not current clinical practice that every person referred to national health service mental health services would be seen by a doctor/psychiatrist. Many patients would be assessed and treated by community psychiatric nurses. Likewise, I did not understand Dr. Finlayson to dispute that appropriately trained and qualified staff regularly assess and/or treat referrals. Accordingly, it is not the label (occupational therapist, community psychiatric nurse) that is so important, it is the competence (qualifications, training, experience and reasonable care) of the person doing the job that matters.

The evidence showed that mental health issues arose in a proportion of members of the public consulting health services, and it was a necessary use of resources to match the patient with the appropriate level of expertise.

For that reason suitably qualified staff had come to be used.

On the evidence, only psychiatrists diagnose mental illness and label the conditions. Others such as community psychiatric nurses or occupational therapists record the manifestations of the unwellness of patients and seek to alleviate symptoms and control downside risks. Accordingly, it can be that a patient is treated successfully without attaching a mental health label to his or her condition. It was suggested also that premature diagnosis can be unhelpful.

One of Mr Kurana's submissions questioned whether Fraser suffered from a mental illness. As Fraser had not been seen by a psychiatrist there had been no diagnosis. I do not recall there being direct evidence to support the proposition that people who attempt to kill themselves are unwell or mentally ill. However, it was a given in evidence that such persons are accepted for care by the state health services and are frequently allocated to mental health facilities such as Florence Street. Where, as here, Florence Street accepted Fraser's referral, they accepted a duty to care for him. Overall, I accept that Fraser had a mental illness of some sort which required to be addressed.

For Fraser, the evidence showed that the reference paperwork arrived by fax. It appeared that more senior but non doctor staff received the referral. In any event there was a rota containing the names of those who were considered qualified to assess emergency referrals initially. This list included community psychiatric nurses and occupational therapists. It appeared that when a new referral arrived if a team member was named on the list as the next on the duty rota then that person had to take initial responsibility for that patient.

I accept that Mrs Petrie assumed that there was an expectation or culture at Florence Street that the next on the emergency rota would accept the referral, carry out the assessment and continue to be the referral's key worker.

Mrs Petrie was a member of a multidisciplinary health team. I did not hear evidence from management about what qualified her to be a member of the team. The inference was that she had been appointed by reason of being an occupational therapist. I heard that she had a degree, experience in other locations, had done some training courses, and had been monitored for the first month of her employment but thereafter was operating as an equal member of the team. Her selection as initial assessor of Fraser was decided by Mrs Scott in informal discussion with Mr Kerr and appeared to be on the basis that she was next on the rota. Mrs Scott said that the decision was one for the multi disciplinary team meeting but in effect it was hers and Mr. Kerr's.

Clearly Mrs Scott, Mr Kerr and Mrs Petrie considered that she was qualified to do so, even though Mrs Scott knew nothing of Mrs Petrie's training or qualifications. The inquiry did not hear what Mr. Kerr knew. Mrs Petrie's evidence suggested that once she was allocated a case she would continue to deal with it, unless there was some particular reason for handing it to someone else. That required a positive change, a decision of the team in weekly meeting to do so. The circumstance of whether, if ever, there had been such a change was not explored. Mrs Petrie did say that it was agreed at the meeting that she continue with Fraser. Overall the evidence shows that the allocation of Mrs Petrie depended principally on her place on a list and case load. On the information sent to Florence Street as set out in the information provided to them (the out of hours community psychiatric nurse report) Fraser appeared to come into a regular category of referrals, a young male attempt suicide where the word "urgent" had been deleted from his classification.

Dr. Finlayson questioned the adequacy of qualification, training and experience of Mrs Petrie, having heard her evidence. No foundation was laid in evidence with any other witness from which it could be determined the adequacy of Mrs Petrie's qualifications and it was not put to Mrs Petrie herself. As to her qualifications, by the time Mrs Petrie met Fraser, she had obtained an honours degree which included elements of psychology and she had interacted with the elderly patients, some with mental health conditions, at Carstairs full time where most if not all of the patients had mental health conditions and

at Florence Street she had had eight months of seeing and assessing, and being a key worker to upwards of one hundred patients a majority of whom had some element of suicidal ideation. Accordingly, she had been exposed to mental health conditions of various sorts for various purposes before meeting Fraser. The extent of her expertise from that exposure depended on what she had learned, and that in turn depended to some extent on her being trained, mentored and supervised during the period. No expert evidence was led as to the necessary qualifications and experience required to be an occupational therapist carrying out the duty worker role as part of the multidisciplinary team.

In principle, every clinician has to start somewhere. The level of experience of Mrs Petrie should not have been a bar to her assessing referrals, provided that there was some assessment of her suitability and with the appropriate level of supervision. On the evidence the principal factors addressed by Scott and Kerr in determining her suitability were largely irrelevant factors. That said, from the documentation provided to Florence Street, namely the out of hours community psychiatric nurse assessment, Fraser, on paper, was low risk and a type of referral that Mrs Petrie was seeing on a regular basis.

The thrust of Mrs Petrie's evidence, which I accept, was that she, an occupational therapist of her experience, was expected to and did take the lead in deciding on how Florence Street should act with Fraser as she had done with other referrals. According to the evidence such an approach was taken on trust by the multi disciplinary team.

As regards the assessment, I agree with Dr. Finlayson that it does not appear sufficiently full and clear on certain aspects. I accept that it was incomplete as a completed assessment. None of the detailed deficiencies subsequently identified by Dr. Finlayson as regards the assessment were put to Mrs Petrie or Mrs Scott when they gave evidence.

Fraser was co assessed initially by Mrs Scott, a very experienced community psychiatric nurse member of the team.

Not by reason of Fraser, but by reason of the system at Florence Street, he was seen by two members of the team. As it happened he was seen by a member of eight months' experience and a community psychiatric nurse of thirty four years' experience who had been at Florence Street for fifteen years.

Thereafter, by agreement with Mrs Scott, Mrs Petrie saw Fraser on his own on 27th February 2008.

Mr Fordyce submitted that the assessment was poor because the communication between Fraser and Mrs Petrie was poor. If the assessment was poor, Mrs. Scott was present and was a party to the assessment, and should have seen to it that, if capable of being obtained, the necessary information was obtained. If she did not achieve that and if it were achievable then, it is not the system that was not functioning, but the performance of Mrs. Scott and Mrs. Petrie on this occasion. If Mrs Petrie was not communicating properly, Mrs. Scott should have taken over. From her evidence, Mrs. Scott was entirely satisfied with the manner of the assessment and of its conclusions. So, it appears was the multi disciplinary team. Mr. Kurana submitted that there was not enough evidence to hold that the assessment was poor. He submitted that Dr. Jones Edwards found no fault with the assessment. She was equally well placed to comment.

I consider that the evidence of Dr. Finlayson about the absence in the assessment of exploration of issues is logical and well explained, and to be preferred to that of Dr. Jones Edwards. That said, it is clear from the documentation and the evidence of Mrs Petrie that Fraser had difficulty in communicating and it was not said in evidence that it was inappropriate for Mrs Petrie to try to get Fraser to trust her and open up to her about himself and the nature of his thoughts. I accept that one of the matters ceded to Mrs Petrie was the management of the risk of Fraser self harming. I accept that Fraser was initially assessed as low risk.

In passing, I should say that I found the practice at Florence Street of destroying the original assessment notes to be incomprehensible. So did Dr. Finlayson. Dr. Jones

Edwards tried to defend strenuously the practice and failed to convince me. At Florence Street a hard copy/ paper patient file is maintained, so there is a file into which original source material can be placed.

The conclusions from these two meetings (22nd and 27th February) were recorded in the Adult Mental Health Specialist Shared Assessment form which was seen and approved by Mrs Scott and was read in full and embellished by Mrs Petrie to the Friday meeting on 29th February without apparent comment or criticism by any of those present, including the psychiatrist.

Standing the deficiencies identified by Dr. Finlayson, at first glance, it is surprising that the assessment was, in effect, approved by the meeting on 29th February. However, it was clear from the evidence that Mrs Petrie reported to that meeting, as she had noted in the specialist shared assessment, that she wished to continue the assessment and they were aware of that. Standing on its own, that would appear not an unreasonable decision for the meeting to take, even where two assessment meetings had already taken place with Fraser. There was no evidence led that such a decision was in fact unreasonable.

On the evidence the problem probably arose thereafter.

According to Dr Finlayson, he was concerned that:-

1. The assessment/ manner of proceeding was allowed to go on for as long as it did.
2. Mrs Petrie had failed to identify that Fraser continued to be unwell and that his condition may have been worsening and that she had taken no steps in that connection.

From the evidence of Mrs Petrie it appears that she took the lead in coming to the decision reached at the weekly meeting on 29th February but that her way of proceeding was approved. While Dr. Jones Edwards identified the weekly meeting as the pre-eminent source of clinical supervision and decision making, it was not explained in evidence how the supervisory role of the weekly meeting was to interact with the

supervisory role of Mr. McGhee. It appeared to be accepted, as shown by the manner of questioning by all at the inquiry, that during the period of Fraser's referral, for the six weekly supervisory meeting there was substituted the case loading meeting. There was no evidence of when the previous supervisory meeting by her senior had taken place and when the next one was due. What was demonstrated in evidence was that the management structures and operation at Florence Street allowed a relatively inexperienced practitioner in matters of community mental health assessment and treatment to be without sufficient supervision over the critical period.

It appears that because the team operated on a basis of trust in the competence of each other, they were content to allow Mrs Petrie to take the initiative. It was her decision not to bring the matter back to the meeting until 28th March. Her evidence was that routine reviews were four weekly, hence 28th March and the end of April. It appears therefore that she considered Fraser to be a routine case. Standing her experience and standing also that the meeting were aware that the assessment had not been completed, it points to the need for someone at that weekly meeting to have been asking her whether the assessment was now complete, what it revealed, and how matters were progressing, and what the treatment plan was. Who at the weekly meeting should have asked the question? On the evidence, everyone including Mrs Petrie should have been asking that question. The lack of one person being accountable or in charge at the meetings arises. I heard no comparative or expert evidence, and no alternative way of proceeding was suggested. All I can say, therefore, from the evidence that the inquiry heard, is that it is likely that, in reality, no one assumed responsibility, notwithstanding the theory that they were all responsible. If all members of the team are equally respected and valued, it may be very difficult for a member of the team to suggest that another member of the team is unqualified to deal with a patient, or has not done something well due to inexperience, or that the assessment is drifting; especially so if there is shared responsibility.

The other issue, in which Mrs Petrie's experience was said to be a factor, was, according to Dr. Finlayson whose evidence I accept, that Mrs Petrie did not see danger signals in what Fraser was saying, particularly on 14th March and later on 28th March. I accept that

there were danger signals there. His view was that someone more experienced would have seen these signals and called someone else in for, in effect, a second opinion. However, while it was not fully looked at in evidence, it appears from Mrs Petrie's notes, that Mrs Petrie's appointment with Fraser on 14th March was after the weekly meeting and she was on leave for a week thereafter. The nature of the difficulty identified by Dr Finlayson was probably not starkly evident therefore until after the weekly meeting on 14th March. Accordingly, while the multi disciplinary team should have asked whether the assessment had been completed on 14th March, there would have been little if any information available to them from which to conclude that Fraser's condition was not improving and may have been worsening, until 28th March.

Apparently, it did not occur to Mrs Petrie to raise Fraser's state with anyone after her meeting with Fraser on the 14th March. While Dr. Finlayson was not asked specifically, it may be inferred that Dr. Finlayson did not see the discoveries at the meeting with Fraser on 14th March as so urgent as to merit Mrs. Petrie taking immediate steps, such as calling in the crisis team. Had Mrs Petrie realised the depth of Fraser's illness, Dr. Finlayson's recommended course of action was for her to call in a second opinion, presumably at the next meeting with Fraser. This would have happened, at the earliest, on 28th March.

It may well have been therefore that a review of notes with a supervisor could not have occurred until between 24th March and 28th March, (the length of her leave was not detailed). If there had been a review meeting with Mr. McGhee, her senior, that may have taken place at some time during that week; if by the multi disciplinary team, again it was likely to have been at the meeting on the morning of 28th March. There was in fact a review of Fraser's case on the 28th March in the morning, but the decision taken was that Mrs Petrie was to continue as she had been doing. I mention this to put the lapse of time in context, but I recognise that this aspect of matters was not explored in evidence in detail. Fraser was due to be seen at that afternoon's appointment. It was possible therefore that had a different decision been taken, had there been adequate supervision, someone from the crisis team or other more experienced clinician may have been

available to sit in on that meeting, if felt appropriate. As Fraser had declined, in the past, to see anyone other than Mrs. Petrie, it does not follow necessarily that Fraser would have agreed to see that other more experienced clinician, even with Mrs. Petrie, that day, or at any later date.

Dr. Jones Edwards said that Mrs Petrie's notation was exemplary. I accept that. As Dr. Finlayson said and I accept, the notes of 14th and 28th March give a vivid picture of someone whose mental health/unwellness appeared not to be improving and may have been worsening. In my view, the notation is not the issue. The issue is that the notes disclosed a situation which Mrs Petrie did not see.

It was maintained in submission that there was no justification in Dr. Finlayson's assertion that Mrs Petrie was inadequately qualified, trained and experienced to proceed without adequate supervision. The evidence of her qualification experience and training came from her. There was no evidence from an occupational therapist expert or other mental health professional, other than Dr. Finlayson and Dr. Jones Edwards, about whether her qualifications, training and experience of community mental health would entitle her to be described as experienced and competent to see Fraser. Dr. Jones Edwards maintained that Mrs Petrie was highly qualified and highly experienced. She was not asked to elaborate by reference to Mrs Petrie's actual qualifications, training and experience. She strongly asserted this in a defensive manner. I preferred the more measured and reasoned assessment of Dr. Finlayson. Dr. Finlayson heard most of Mrs Petrie's evidence where Dr. Jones Edwards did not. He, too, saw the notation. I am prepared to accept his assessment that she was relatively inexperienced in the assessing and treating Fraser's condition. He explained that even the most experienced of clinicians can make mistakes and wrong clinical decisions; his position was that Mrs Petrie had done so in Fraser's case, and that her relative inexperience may have had a part to play in not realising that Fraser was more unwell than she thought. I accept that assessment.

Mr. Fordyce submitted that there was a failure to communicate with Fraser's family and doctor to share the risk. There was no evidence that contacting parents or the doctor in the sense of sharing control or management of the risk of suicide was a routine part of arrangements for referrals at Florence Street or generally. Dr. Finlayson indicated that communication with the family was not done as a matter of current practice. He favoured communication with the family or other reliable source of information about a patient. That would depend on a case by case consideration. In general, it appears that communication with family may not be the current practice. Whether it should be otherwise is a topic on which I make no observation.

Florence Street: Accountability.

Who was accountable to explain that Fraser was treated competently?

Obviously, Mrs Petrie became Fraser's key worker and was accountable in the first instance for the quality of Fraser's treatment and she fully and frankly took responsibility for what she did. By reason of her relative lack of experience, she was not, perhaps, in the best position to judge.

Who then was accountable for Florence Street, its systems and the operation of its systems? Mrs Scott was the only other Florence Street employee to give evidence and she was not asked about such matters in detail. In terms of management structures, according to Mrs Scott and Dr. Jones Edwards the multi disciplinary team meeting was said to be accountable for managing Fraser's treatment, but only Mrs Scott was called to explain that function and she knew nothing of the qualifications, past experience or training of Mrs Petrie. She took that on trust.

Dr. Jones Edwards appeared not to be responsible for other than psychiatrists at Florence Street, the responsibility for Mrs Petrie being within some hierarchy of occupational therapists.

Mr. McGhee was not called as a witness. The thrust of the evidence was that the one meeting Mrs Petrie had with Mr. McGhee was a case loading exercise which may have taken the place of the proper review. There was no evidence before me that Mr. McGhee had the necessary competence to mentor and supervise Mrs Petrie in the skills necessary for the competent assessment and treatment of patients with mental health issues. He may have done, but I have no evidence of this.

I was struck by the fact that there was not one person who came to the inquiry and said, in terms of the system and practice, “I am the person who is accountable for the way Mrs Petrie carried out her duties at Florence Street and I can show to the inquiry that Fraser was dealt with appropriately, that Mrs Petrie was adequately supervised, guided and directed by someone with the competence and responsibility to do so.” While I appreciate, of course, that the procurator fiscal leads at the inquiry, those representing Florence Street had the opportunity to do so, had they wished. The evidence showed that the system at Florence Street splits responsibility between the weekly meeting and the occupational therapist supervisor with no link between the two. As an example, it was not suggested that Mr. McGhee ever sat in on any weekly meeting as part of his responsibility for Mrs Petrie.

While the critical clinical investigation action plan might suggest otherwise, I took from the evidence Dr. Jones Edwards that were someone like Fraser to appear in Florence Street again, as little has changed, the manner in which Fraser was dealt with could happen again. If that is correct, I would find that unacceptable, unless it could be shown that nothing could be done to improve the way of operating in Florence Street. That has not been shown to the inquiry.

There was no attempt to demonstrate how the systems at Florence Street might change. Mr Kurana submitted that the inquiry, having no clinical experience, should be slow to comment. I agree to an extent and therefore my comments should be general. If a supervisor is to be fully accountable for the performance of someone like Mrs Petrie, then the system has to be robust enough to work in practice and to be fair to the supervisor.

That may mean more frequent and longer meetings depending on the experience of the practitioner. It may mean that the supervisor has to attend the weekly meetings the team or meet weekly with someone in Mrs Petrie's position. Dr. Finlayson spoke of consultant psychiatrists meeting weekly with trainee and junior staff. Such a frequency might be looked at. I fully accept that such matters have resource and other ramifications.

On the other hand if, as Mrs Scott and Dr. Jones Edwards said, the primary responsibility for clinical supervision is the multi disciplinary team at weekly meeting, it seems that shared accountability may have the practical result of there being no accepted responsibility by anyone. I am conscious that I heard little evidence about what happened at the weekly meetings where Fraser was discussed. Nonetheless, it seems to me that one person fixed with the responsibility of being accountable for the decisions of the team in weekly meeting would bring a focus to the decision making of the team. He or she would also be better able, should the need arise, to address at first hand the concerns of enquirers such as Fraser's parents.

Florence Street; connectivity.

It seemed to be accepted by all professionals that while the general medical practitioner remains the core party responsible for a patient's health, that transfer to a specialist resource puts the resource to the forefront and they take the matter over totally.

Standing from outside, I find it surprising that there is no connectivity between the general medical practitioner and the facility. Dr. Finlayson mentioned what he referred to, perhaps historically, as a snobbery on the part of the specialist. While it did not feature particularly with Fraser, it could well be that a general medical practitioner has a great deal of knowledge of the patient or indeed, mental health expertise that could be of assistance. In the current case there was a very experienced community general medical practitioner with some knowledge of his young patient and who formed tentative view that Fraser was suffering from "neurotic depression reactive type" and, "good going biological depression. Recent suicide attempt. Not suicidal currently", handing over that patient to a non medically qualified, relatively inexperienced occupational therapist who

was still assessing Fraser five weeks after referral. It was said by the psychiatrists that coming to a premature diagnosis, conclusion or formulation of, or labelling, the patient's condition can be unhelpful; failing to form any view after five weeks would appear to be unhelpful also.

An aspect of connectivity is the fact that a general medical practitioner may well not see a patient and get a first letter as much as 25 working days after referral. Such connectivity is pretty remote, but it appears to be the accepted practice.

Communication

It could be maintained that the approach of the multi disciplinary team in weekly meeting was a failure to communicate. I consider that, if anything, it would be more appropriately a weakness of supervision and a weakness of the system. Mrs Petrie was not asked what, if anything Fraser was told about his condition, and what she was going to do, other than that she would continue to see him. Mrs Petrie was asked about talking therapies and whether they applied to Fraser's treatment. She replied that her main focus was to monitor his mental health, all as has been set out above. Dr. Finlayson said in evidence that he detected no treatment plan for Fraser prepared by Mrs Petrie either as spoken to by her in evidence or in her notes. I accept that there appeared to be no such plan.

All that having been said, it could well have been that there was a connection between Fraser taking alcohol on 30/31st March 2008, him having a row late that night and his suicide attempt on 31st March. The evidence did not disclose an obvious alternative treatment of Fraser which might or would have prevented him starting on his pattern of behaviour on 31st March 2008. Dr. Finlayson's evidence supported more experienced intervention at an earlier stage but it is speculation to conclude that that would have likely prevented the events of 31st March, and there was no evidence from him that it would. Dr. Marshall was surprised that Fraser was not medicated; Dr. Finlayson considered that talking was preferable to medication if possible.

For completeness, there was some evidence about the form called the Glasgow Risk Screen. This was completed by Mrs Petrie as part of the assessment. There was evidence about the tick box mentality and the potential for such screens masking the need for fully interacting with the patient. As I understood matters this document has been superseded. From the evidence of Mrs Petrie I did not understand her to apply inappropriate weight to it, or to be diverted by it. At the end of the day it had little part to play in the Fraser's meetings with her. Accordingly, I shall not express any view on the form. There was also evidence from Mrs Scott and Mrs. Petrie that next of kin details could be useful.

Attendance at the Victoria Infirmary on 31st March 2008

There was at least a potential dispute of fact about Fraser's delivery to accident and emergency. At least in the explanations given by the hospital management to Fraser's parents it was maintained that the accident and emergency staff were not aware of Fraser in the department. On the evidence of M/s Hausley I accept that the accident and emergency staff were aware of Fraser in the department.

Some aspects were not in doubt. The first was that a Victoria Infirmary accident and emergency department patient file/card was created in the name of Fraser and that it contained the PRF from the ambulance carrying Fraser to the Victoria Infirmary. The second was that subsequently that card arrived in the second box in the treatment area.

It is a reasonable inference from those two aspects (1) that the receptionist was handed the PRF by someone, for she created the card; (2) that the someone was a member of the ambulance team that created the PRF, or a hospital staff member having received it from a member of the ambulance team at around 2p.m. That supports the evidence of M/s Hausley about what she did that day.

There was evidence from the ambulance team and the accompanying police officer that Fraser was outside the entrance to accident and emergency at that time.

It is important to address the credibility and reliability of the evidence of M/s Hausley and Miss Taylor. M/s Hausley gave evidence first. I was surprised at the extent of detail that she gave in evidence after three years. Where a witness gives unusually detailed evidence, it is useful to scrutinise it with particular care, checking it against other sources of evidence.

Miss Taylor gave evidence that was less detailed and she did not speak to some matters of detail spoken to by M/s Hausley. The evidence of both differed in particular from that of the police constable who attended Fraser's flat. Accordingly the evidence required to be considered in depth.

I could reconcile the evidence of the police officer and its absence of detail because she was performing a peripheral function and was conveying a general impression. Miss Taylor explained towards the end of her evidence that she remembered Fraser because shortly after his death one of her family had commented that she had known Fraser. I accept that.

I thought Miss Taylor's account of the events was truthful and reliable. For the reasons set out below I also accept that M/s Hausley is a truthful and reliable. I did not consider that M/s Hausley and Miss Taylor had made up elements of their evidence to cover for something done or not done by them.

Now the evidence of M/s Hausley and M/s Taylor was to the effect that M/s Hausley entered accident and emergency while M/s Taylor stayed outside while Fraser smoked a cigarette, and that they met each other just inside the door of accident and emergency when M/s Hausley told Fraser and M/s Taylor that the clinical team had instructed that Fraser was to be seated in the general waiting area. What M/s Hausley did when entering accident and emergency was her evidence alone. While no evidence was led to contradict M/s Hausley and no challenge was made to her evidence it is important to look at the possible happenings that day. M/s Hausley could have handed in the PRF to reception and returned to tell Fraser that he was to sit and wait in the general waiting area. I do not

accept such a scenario. She said that that did not happen and that to do so was against the training she had received. I considered that she was credible and reliable on this point. To believe that she simply handed in the PRF to reception would be a gross neglect of duty and I do not believe that that would have happened. Further, it is at odds with the careful and professional manner in which both gave treatment to Fraser at the flat and in the ambulance.

That being the case, it is more likely than not that what she said happened did in fact happen, namely that she went to the desk in treatment area reported that Fraser was outside and asked what the Victoria Infirmary staff wanted to do with him. It was clear from the other evidence that Fraser's physical injuries had been cleaned and were unlikely to need attention. The only reason therefore for having him there was to monitor his mental state. M/s Hausley gave full information about this being a repeat attempt and that Fraser was attending at a community mental health facility.

Miss Taylor spoke separately about verbal handovers occurring on occasions. I accept that evidence as being truthful and reliable. Both M/s Hausley and Miss Taylor were of the view that verbal handovers were not against any Scottish Ambulance service instruction and not against Victoria Infirmary practice. It came to this, that it was better if you could to hand over physically if possible.

If M/s Hausley spoke to anyone in the clinical team that day, as I hold she did, then whoever that person was, allowed a verbal handover to take place. A verbal handover is not in accordance with the written protocol and the practice of the Victoria Infirmary accident and emergency department.

The organisation of the Victoria Infirmary accident and emergency relied on the protocol operating, namely physical handovers. Because Fraser was an ambulance case, it would be assumed that he had been assessed for priority. That meant that he did not require to be triaged in the manner that a self referral was. Accordingly, once Fraser's card was produced, it would have gone to the treatment area and been put in a box.

Fraser was told by M/s Hausley that he would be seen shortly, there was also reference in the evidence to in a couple of minutes. That suggests he was told that there would be a triage process. In the circumstances triage would not have happened. I accept also that it can take up to thirty minutes to call someone for triage. Fraser left before that.

From what Dr. Gordon said in evidence he had made enquiry of his staff and no one could remember Fraser being mentioned or remember giving instructions to place him in the general waiting area. I believe Dr. Gordon's evidence that the placing an attempt suicide patient in the general waiting area is a very rare occurrence, and yet no one remembered giving the instruction. The decision to place Fraser in the general waiting area, being so rare, it does call on the person making the decision to explain it and there is no explanation.

In these circumstances, I consider what happened that day should not have happened.

Of course, Fraser had left the Victoria Infirmary accident and emergency on an earlier occasion. We do not know if he departed from the treatment area on that occasion; he was a self referral patient on that day and would have attended the general waiting area initially. On 31st March, Fraser would have known that his wounds did not require much if any treatment. He would have known that the reason for being there might involve a further mental health assessment. He had already stated repeatedly that his mental health treatment was not working. Viewed from his perspective there was little to keep him there. That may have contributed to Fraser's decision to leave the Victoria Infirmary, but on the evidence it cannot be said that it is probable that it was.

Miss Taylor spoke of patients such as Fraser being in an unstable state and being taken to hospital for that reason. In the absence of a clear explanation for the decision, leaving Fraser alone in such a situation has not been justified. It demonstrated lack of appropriate care of Fraser at the time. It is speculation, however, to suggest he would not have left anyway. All that can be said is that there may have been a better chance that he would

have been seen to do so, and/or his absence noted sooner had he remained in the treatment area, otherwise why was it the practice to keep him there.

In summary, it is speculation to suggest that (a) his experience of the Victoria Infirmary on 31st March 2008 contributed to his decision to kill himself, (b) he would not have left in any event, (c) on leaving, had the doctors acted differently, it is likely that he would have been found, (d) that anything done with Fraser at the Victoria Infirmary that day had he stayed was likely to have prevented his death, for there was no evidence to explain why Fraser killed himself.

It was submitted that the written protocol of the Victoria Infirmary accident and emergency department did not necessarily exclude a verbal handover and on one view of the document that is arguable. It was not suggested by Dr. Gordon that that was the case; he was clear that his staff worked on the basis of a physical handover. He was not challenged on his view that there required to be a physical handover. For the avoidance of doubt the terms of the protocol, should be revisited to eliminate any ambiguity.

Connectivity and communication Victoria Infirmary

The strength of the protocol of a department is only as sound as those who operate them.

There would have been a better chance of their not being a verbal handover, if both the Scottish Ambulance Service and the Victoria Infirmary accident and emergency management had agreed upon identical protocols reinforced by regular training of both services about them requiring there to be a physical handover in all attempt suicide cases.

Dr. Gordon spoke of there being regular management meetings to tighten up procedures. That would appear to be inadequate, if workers operating the system do something different in practice. On the evidence, the ambulance personnel did what they were allowed to do, where the hospital personnel did not.

Accountability

Once again in this case, the person who made the decision to place Fraser in the general waiting area is not identified, did not give evidence, and therefore gave no account for his or her decision. Dr. Gordon said that he felt personally that he had let Fraser down. He told the inquiry that steps have been taken, but that what happened could happen again. That is not very reassuring. I accept that there is an interaction between the Scottish Ambulance Service and the Victoria Infirmary in the handover of patients and that therefore there has to be a negotiation and agreement as to how to proceed. I accept too that being an emergency service there can be occasions where all presenting may have life threatening conditions. I accept, too, that the physical treatment of Fraser was unlikely to be in that category. That does not prevent the Victoria Infirmary accident and emergency department from taking steps where possible to look at the matter again. I do consider that if, as the inquiry was told, placing an attempt suicide in the general waiting area is very rare occurrence, then it may not be seen as being unduly burdensome for the protocol to be amended to require a staff member taking the decision to place an attempt suicide patient in the general waiting area to require that person to sign the PDF to that effect, although no one suggested that in evidence.

The manner in which the state health care services dealt with Mr O'Donnell and M/s Hill, their enquiries and issues in the correspondence are not part of the remit of this inquiry, although the inquiry saw some of the correspondence. I detected in some of that correspondence, (but detected less in the evidence of witnesses at the inquiry), some suggestion that Fraser was negative at times. Overall, the evidence showed that, from return to hospital on 20th February, Fraser was not negative; he was co-operative, but he was a deeply troubled young man with unstable emotions and, understandably, was and was likely to be confused about what he wanted to and should do. His troubled state was why he sought the care and assistance that the medical care services were there to provide.

Mr Fordyce made a fitting closing submission, "I would like to pay tribute to Fraser's parents who have endured this inquiry with quiet dignity. Their determination and tenacity in pursuing the holding of this inquiry are a credit to their love of their son."

