

SHERIFFDOM OF LoTHIAN AND BORDERS AT EDINBURGH

[2024] FAI 49

EDI-B207-23

DETERMINATION

BY

SHERIFF ALISON STIRLING, ADVOCATE

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

into the death of

DR SARA LILIAN MACRAE

EDINBURGH, 9 December 2024

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

1. In terms of section 26(2)(a) Dr Sara Macrae (born 7 August 1964) died on 17 March 2020 at 9.56pm in Room 12, Craiglockhart Ward, Royal Edinburgh Hospital, Edinburgh.
2. In terms of section 26(2)(b) there was no accident.
3. In terms of section 26(2)(c) the cause of death was:
 - 1a. External compression of neck
 - 1b. Hanging.

4. In terms of section 26(2)(d) no accident having taken place, no finding is made in terms of this subsection.

5. In terms of section 26(2)(e) there were precautions which could reasonably have been taken and had they been taken they might realistically have resulted in the death being avoided as follows:

- (i) An increase in Dr Macrae's observation levels to constant observation;
- (ii) A search of Dr Macrae's room for ligatures;
- (iii) The recording in Dr Macrae's medical records of Christopher MacRae's communication to Radoslaw Rzeznicki of Dr Macrae's voiced suicidal ideation and Christopher MacRae's presentation to Radoslaw Rzeznicki of the ligature made by Dr Macrae;
- (iv) The recording in Dr Macrae's weekly reviews of the suicidal risk assessment and management relating to her.

6. In terms of section 26(2)(f) there was a defect in the system of working which contributed to the death as follows:

Entries in the patient's medical notes of a previous suicide attempt by hanging in the same hospital were not easily accessible.

7. In terms of section 26(2)(g) there is another fact which is relevant to the circumstances of the death as follows:

The safety brief of 17 March 2020 was completed retrospectively, 4 weeks after the death of Dr Macrae.

8. In terms of in terms of section 26(1)(b) of the Act the following recommendations are made:

- (i) When staff in a secure mental health ward are presented with evidence that a patient has vocalised suicidal ideation and demonstrated means to complete suicide by presentation of a ligature, urgent action to search that patient's room and person for any other potential ligatures ought to be taken. In addition, consideration should be given to placing the patient on constant observations or invoking a "Clinical Pause" to evaluate the safety issues which exist and produce a plan of intervention to address the issues identified.
- (ii) The medical records of a patient should be accessible across different Health Boards regardless of the Health Board in which that patient is treated to ensure the treating Health Board has the patient's full medical history available to inform fully the most appropriate care and treatment plan for the patient.
- (iii) Meaningful implementation and ongoing audit (including external audit of the person centred audit tool) of the Serious Adverse Event Review action plan relating to Dr Macrae's death should continue.
- (iv) TRAK should be developed to introduce a function to alert clinicians to potential risk factors such as previous suicide attempts as soon as they open the patient's notes.

NOTE

Introduction

[1] The inquiry into the death of Dr Sara Macrae was held under the Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016. The inquiry was a discretionary inquiry under section 4(1)(a)(ii) and 4(1)(b) of the Act. Dr Sara Macrae's death had occurred in circumstances which gave rise to serious public concern and the Lord Advocate had decided that it was in the public interest for an inquiry to be held into the circumstances of her death. The Police Service of Scotland had reported her death to the procurator fiscal on 18 March 2020, the day after Dr Macrae died.

[2] Dr Sara Macrae spelled her name differently from the rest of the MacRae family.

[3] On 21 February 2023 the procurator fiscal submitted notice of the inquiry to Edinburgh Sheriff Court.

[4] The issues for the inquiry were:

- (i) to determine when and where the death occurred;
- (ii) to determine the cause of death;
- (iii) to determine whether any precautions could reasonably have been taken which might realistically have avoided the death, and in particular whether ward staff adequately responded to concerns raised by Christopher MacRae on the date of Dr Macrae's death and to the discovery of a noose that day; and whether observation levels on Dr Macrae were adequate to deal with the assessed levels of risk;

- (iv) to determine whether there were any defects in the system of working on the ward, and in particular whether systems for recording and responding to changes in Dr Macrae's presentation and behaviour were adequate to deal with levels of associated risk; whether systems for communication between ward staff and clinicians in respect of any changes in Dr Macrae's presentation and behaviour were adequate to respond appropriately to such changes and associated levels of risk;
- (v) to determine whether implementation of the recommendations resulting from the NHS Lothian Significant Adverse Event Review (SAER) carried out following Dr Macrae's death might realistically assist in preventing other deaths in similar circumstances; and
- (vi) to determine whether previous suicide attempts were appropriately recorded in terms of them being prominent and easily accessible to medical staff involved in the treatment of a patient.

[5] On 28 February 2023 the first order fixed a preliminary hearing for 20 April 2023. On 20 April 2023 the hearing was continued until 31 July 2023 (a) to allow the family to lodge notifications that they intended to participate in the inquiry, to allow them to have access to the productions and to consider the extent of their participation in the inquiry; (b) to allow the Health Board further time to consider the productions and whether to instruct experts; (c) to allow the Health Board to assist in tracing Radoslaw Rzeznicki; and (d) to allow all participants to consider what issues were in dispute. On 31 July 2023 the court made an order for disclosure of documents to the family. The hearing was

continued until 27 October 2023 to allow them to have access to the productions and to allow Radoslaw Rzeznicki to consult a solicitor, as well as for the reasons in the interlocutor of 20 April 2023. The hearing on 27 October 2023 required to be rescheduled for 28 November 2023. On 28 November 2023 an 8 day hearing was allowed commencing on 2 September 2024, and various case management decisions were made. The Health Board had instructed a psychiatrist and were considering whether to call him as a witness. The Health Board had obtained a precognition from Radoslaw Rzeznicki, who was not proposing to be legally represented. The Health Board advised that there was no conflict of interest at that stage. On 15 January 2024 the dates for the inquiry were fixed, along with a pre-inquiry hearing for 5 August 2024. On 5 August 2024 Radoslaw Rzeznicki indicated that he wished to participate in the proceedings, the Health Board having identified a conflict of interest, and the hearing was continued to 9 August 2024. On 6 August 2024 Radoslaw Rzeznicki lodged a notice of intention to participate in the inquiry. On 9 August 2024 Mr Pollock appeared for Radoslaw Rzeznicki and the hearing was continued to 26 August 2024. On 26 August 2024 Mr Pollock advised that he was in a position to proceed to the inquiry.

[6] I wish to record my thanks to Mr Pollock for accepting late instructions and being ready to proceed to the inquiry on the dates set.

[7] On 2, 3, 4, 5, 6, 10 and 11 September 2024 evidence was led. Orders were made for the lodging and exchanging of written submissions and a hearing on submissions was assigned for 8 November 2024.

[8] During the hearing the family had sought to obtain further information. They were anxious to know the identity of the nurses anonymised in the SAER report. They wanted to recover the notes of the SAER interviews with 11 individuals in particular, but if that was not possible they wanted the notes relating to Mhairi Tennant and the junior doctor. On 12 September 2024 the family received the note of the question and answer session with Mhairi Tennant along with an email from Mhairi Tennant clarifying certain matters and confirming that the record was accurate. On 25 September 2024 they received a ward round note from a junior doctor.

[9] On 4 October 2024, in light of that information, the family emailed the court with certain concerns. They sought to have all the evidence gathered for the SAER included in the inquiry. Their position was that Mhairi Tennant's statement showed that the most senior employee on duty that day was personally aware of Christopher MacRae handing over the noose. Their position was that staff on duty were unaware of their responsibilities, and of the appropriate action to take when provided with certain information. They were concerned that there appeared to be a contradiction between Mhairi Tennant's evidence to the SAER and her evidence in court 4 years later. They were concerned that there might be other witnesses whose recall of events and evidence to the inquiry may have been similarly affected by the passage of time. That email was not passed to me until 22 October 2024.

[10] On 23 October 2024 an order was made appointing all participants to consider the issues raised in that email and lodge written submissions addressing further procedure in the inquiry and in particular whether any witnesses required to be recalled

to give evidence, whether the statements of other witnesses who attended the SAER should be handed over to the family with the possibility that those witnesses would have to be recalled, and whether it was possible for the evidence of those witnesses to be agreed, and a hearing was assigned for 4 November 2024.

[11] On 4 November 2024 having considered the participants' written and oral submissions I explained that the purpose and nature of the inquiry was different from the SAER. At this stage in the procedure the inquiry had to be focussed. I declined to allow Mhairi Tennant to be recalled as a witness so that she could be asked about what she said to the SAER. I declined to order the Health Board to produce all the interview notes with a view to recalling or calling other witnesses. I declined to order that all the evidence collected for the SAER should be included as a production at the inquiry, or even that the notes of all the interviews for the SAER were included. I dealt with the issue by allowing Mhairi Tennant's interview and the junior doctor's TRAK note to be lodged as productions and for all participants to make written or oral submissions about them if they wished to do so at the hearing on 8 November 2024. All participants agreed that those two documents were what they bore to be.

[12] On 8 November 2024 having heard all the submissions I made avizandum.

Participants and representation

[13] The participants at the inquiry were the procurator fiscal, represented by Matthew Kerr procurator fiscal depute; Lothian Health Board represented by

Elaine Russell, advocate; Radoslaw Rzeznicki represented by Andrew Pollock, solicitor; and Christopher MacRae, Neil MacRae and Calum MacRae representing the family.

[14] The family did not instruct legal representation. They had many decades of experience both in relation to the presentation and treatment of Dr Macrae's illness and in the workings of hospitals, including mental health wards. They were not prejudiced by representing themselves. Their contribution to the inquiry was invaluable.

Witnesses and evidence

[15] The participating parties entered into two joint minutes agreeing facts which could be admitted into evidence without the need for a number of witnesses to be led.

[16] I had regard to the witness statements of Dr Frances Creasy dated 17 March 2020, Russell Cherrington (paramedic) dated 17 March 2020, Joel Symonds (paramedic) dated 17 March 2020, PC Gillian Graham dated 1 July 2022, PS Walker Cameron dated 19 July 2022 and DC Oliver Healy dated 7 July 2022. All participants had agreed the evidence of these witnesses in the first joint minute.

[17] The Crown led oral evidence from Christopher MacRae, Caron Thompson (staff nurse), Radoslaw Rzeznicki (staff nurse), Mieke Woodbridge (staff nurse), Joanne Compton (bank staff nurse), Joan Learmont (bank nursing auxiliary), Susan Paterson (bank nursing auxiliary), Dr Fiona Murray (Dr Macrae's consultant psychiatrist), Ommar Ahmed (pharmacist), Craig Stenhouse (chief nurse), Dr Khuram Khan (psychiatrist called as an expert witness), Gordon McGregor (coordinating charge nurse on the night shift), James Hewat and Mhairi Tennant (charge nurse). Lothian

Health Board led evidence from Mike Reid (clinical services manager) and Andrew Wills (clinical adviser within capital planning at Lothian Health Board). Neither of the other participants led oral evidence.

The legal framework

[18] This inquiry was held under section 1 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 and governed by the rules set out in the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (SSI 2017/103). The purpose of such an inquiry is to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. The sheriff's determination after the conclusion of the evidence and submissions requires to set out the sheriff's findings as to the circumstances mentioned in section 26(2) and any recommendations as to any of the matters mentioned in section 26(4) which might realistically prevent other deaths in similar circumstances. In the inquiry the procurator fiscal represents the public interest. An inquiry is an inquisitorial process. The purpose of the inquiry is not to establish civil or criminal liability. The sheriff's determination is not admissible in evidence and may not be founded on in any judicial proceedings of any nature.

Summary

[19] Having considered the oral evidence, the witness statements, the reports, the documents and the joint minutes, I find the following facts to have been established.

Medical history

[20] Dr Macrae was a psychiatrist. She initially became unwell in early years of hospital training.

[21] Dr Macrae had schizo-affective disorder. She had a long history of psychotic disorder which was complicated by alcohol misuse.

[22] Dr Macrae had an extensive history of acute psychiatric alcohol dependence. Between 14 November 2011 and 23 November 2011 she was admitted to the Ritson Clinic alcohol problem inpatient clinic for detoxification. Between 26 October 2012 and 30 October 2012 she was admitted to an adult psychiatric acute ward for detoxification and suicide risk.

[23] Dr Macrae had numerous admissions to hospital on a voluntary and compulsory basis. Between 22 December 2005 and 22 December 2009 compulsory treatment order powers were in place. Between 2 January 2013 and 5 February 2013 she was on a short term detention certificate. Between 5 February 2013 and 26 February 2013 she was on an interim compulsory treatment order. Between 13 July 2018 and 15 August 2018 she was on a short term detention certificate. Between 15 August 2018 and 27 August 2018 she was on an interim compulsory treatment order. Between 18 July 2019 and 15 August 2019 she was on a short term detention certificate.

[24] Dr Macrae had previous admissions to the Royal Edinburgh Hospital.

[25] On 12 July 2018 the electronic TRAK records noted that Dr Macrae had been admitted to Accident and Emergency at the Royal Infirmary of Edinburgh following an

attempt to hang herself at home using a mobile phone cord. She was temporarily transferred to Inverclyde due to a lack of beds in Edinburgh before being transferred to the Royal Edinburgh Hospital. On 26 July 2018 the TRAK records noted that Dr Macrae was complaining of pain in her left foot. She had fallen off her window ledge onto the floor of her room when trying to hang herself from a curtain rail using her handbag in the Hermitage ward. The rail was attached by a magnet and it fell off. She was transferred to Blackford ward, which is an intensive psychiatric care ward. On 28 July 2018 she deliberately set fire to a ward.

[26] On 5 February 2020 Dr Macrae was admitted to hospital on a short term detention certificate which expired at midnight on 3 March 2020. Between 4 March 2020 and 10 March 2020 she was lawfully detained in terms of the Mental Health (Care and Treatment) (Scotland) Act 2003 because she had made an application to the mental health tribunal. On 10 March 2020 the tribunal made an interim compulsory treatment order.

Records relating to Dr Macrae's admission on 5 February 2020

[27] There was no reference in the risk assessments dated 8, 15, 29 February and 6 and 12 March 2020 to suicidal ideation.

[28] The TRAK notes for 8 February 2020 record that Christopher MacRae told staff that Dr Macrae had tied a noose in her bedroom and was planning to hang herself. Staff searched her bedroom and nothing was found. The notes for 9 February 2020 record

that she asked for a razor and said it was to cut her throat with. Nurses queried whether this was possible suicide ideation and a possible risk.

[29] The TRAK notes for 11 February 2020 recorded that at 10.50pm Christopher MacRae telephoned the ward to say that Dr Macrae had just telephoned him to say that she intended to take her life that night. He was advised that staff had recently seen her and that she had seemed “ok” but that they would continue to check on her overnight.

[30] The TRAK notes for 14 February 2020 narrate that on 8 February 2020 she had told Christopher MacRae that she tied a noose in her room and was planning to hang herself. The plan in the consultant review note on 19 February 2020 did not refer to the suicidal threats reported by Christopher MacRae at that review.

[31] The TRAK notes for 5 March 2020 record that Christopher MacRae telephoned the ward to say that Dr Macrae was at home on pass and had been drinking. He expressed concern that when Dr Macrae drank she was at higher risk of suicidal ideation. He was concerned about what would happen if she refused to return to the ward.

[32] On 6 March 2020 at 1.00pm during a telephone call Christopher MacRae told Dr Murray that Dr Macrae had spoken to him about feeling suicidal but that she did not want to tell health care professionals about it because of the possible implications in terms of the Mental Health Act and her limitations on the ward. An entry was made in the TRAK notes that day. A further entry was made in the TRAK notes for the nursing review on 10 March 2020.

[33] The notes for 13 March 2020 narrate that she was distressed and agitated and asked for a gun.

[34] The notes for 15 March 2020 record that two razors were removed from Dr Macrae's room and that she constantly requested razors from staff.

[35] The notes for 16 March 2020 record that Dr Macrae's request for a razor was declined because staff felt that she would need to be supervised due to her not handing razors back and having cut her face the day before.

[36] The notes for the ward round dated 17 March 2020 (presumably relating to 16 March 2020 given the time recorded was 0345) noted that Dr Macrae was very unsettled, very paranoid, feeling suicidal, needed supervision with razors and required her depot medication earlier the previous week as her mental state had started to deteriorate.

[37] The plan in the consultant review note on 26 February 2020 recorded suicide ideation and that Dr Macrae had said she had recently made preparations to hang herself on the ward, but had not followed it through after receiving a text from Christopher MacRae. It recorded that despite a long history of suicidal thoughts Dr Murray could not see a record of Dr Macrae having acted on it in the past.

[38] Dr Murray was not aware of the two records from 2018 until after Dr Macrae's death.

[39] Dr Murray agreed that the incident in which Dr Macrae attempted to hang herself on 26 July 2018 was evidence of a previous suicide attempt. She agreed that evidence of a previous suicide attempt was significant.

Events of 17 March 2020

[40] On 17 March 2020 Christopher MacRae visited Dr Macrae twice on the Craiglockhart ward. In response to the expectation that the country would be locked down due to the Covid pandemic, visiting hours were restricted to 1 hour between 2.00pm and 3.00pm and 1 hour between 7.00pm and 8.00pm. At 2.00pm Dr Macrae seemed distressed, sad and of low mood. She expressed suicidal thoughts to Christopher MacRae. She was preoccupied with very negative thoughts about the past, and about Christopher MacRae and his health. These were normally indicators to him that she was of low mood. Dr Macrae said that she thought Christopher MacRae had cancer, and she regretted that because she has been a smoker. They discussed the concept of regret. She was very preoccupied with his safety and wellbeing. She told him she had made a noose and that it was in her bedroom. He asked if he could see it, and she brought it to him. It was a cord from her jacket or dressing gown. It had been fashioned into a noose. He handled it and when he pulled the longer extension the loop at the end tightened. She told him she intended to take her life with it.

Christopher MacRae took the noose to Radoslaw Rzeznicki who was visible on the ward. He told Radoslaw Rzeznicki that Dr Macrae had just brought him the noose from her room and that she intended to end her life with it. He asked Radoslaw Rzeznicki to clear out Dr Macrae's room of any other ligatures. Radoslaw Rzeznicki told Christopher MacRae that he would do so, and that he would retain the noose handed in.

Almost immediately thereafter Radoslaw Rzeznicki was distracted by another patient. Radoslaw Rzeznicki left the ward a few minutes later.

[41] Christopher MacRae remained with Dr Macrae for about another 30 minutes. Her presentation did not change. Christopher MacRae asked her how she had learned to tie a noose. Earlier on in this admission to hospital Dr Macrae had asked him if he knew how to tie a noose and he said he did not know. He had thought she did not know how to tie a noose. She said that someone had shown her.

[42] Dr Macrae habitually wore a scarf on the ward.

[43] Christopher MacRae returned to the ward at about 7.00pm. Dr Macrae was highly distressed and he was initially not allowed onto the ward. A nurse told him that Dr Macrae was preoccupied with death and they wanted her to take her medication to calm her down before he visited her. Christopher MacRae told staff that she trusted him more than them and that if they let him onto the ward she might take her medication. They let him on, and she took the medication.

[44] Dr Macrae and Christopher MacRae talked a lot about death and suicide. She mentioned a previous suicide and about coping with that loss. She told Christopher MacRae that she intended to end her life that night. They had a long conversation about promising not to commit suicide and about promising to see each other the next day. This was a coping mechanism that they had developed over the years. Previously when Christopher MacRae had asked her to promise that she would see him the following day she had made that promise. On this occasion she told him that she could not make that promise.

[45] Visiting time came to an end. The conversation about Dr Macrae not being able to promise she would see him the following day continued up to the ward door.

Dr Macrae asked him not to leave. She told him that she did not want to die alone. She asked him to kiss her and he did.

[46] Joanne Compton was nearby and had witnessed the conversation. She asked Christopher MacRae if he was all right. Christopher MacRae told her that he believed Dr Macrae would take her life that night. He was crying. He told the nurse Dr Macrae was much more distressed than usual, she had not made him the promise, and she had told him she intended to take her life that night. Joanne Compton reassured him, telling him that she would check on Dr Macrae and make sure she was all right.

[47] Christopher MacRae left the ward. He tried to telephone at about 8.45pm or 8.50pm. Normally his voice calmed Dr Macrae. He wanted to check with nursing staff and with Dr Macrae herself that she was all right. The call just rang out.

Dr Macrae's own mobile telephone had been confiscated.

[48] Between 10.00pm and 10.30pm a junior doctor telephoned Christopher MacRae to say that Dr Macrae had died.

[49] She had hanged herself in her bedroom with her scarf.

Some staff on the ward on 17 March 2020

[50] Mhairi Tennant was acting as the senior charge nurse on 17 March 2020 due to the senior charge nurse being off sick. She did not have any interactions with Dr Macrae that day. Radoslaw Rzeznicki handed the noose in to Mhairi Tennant. She advised staff

to have one-to-one conversations with Dr Macrae. She was not aware that Christopher MacRae had gone out with Dr Macrae that afternoon until she returned to work the next day. She did not know who had agreed it.

[51] Mieke Woodbridge was Dr Macrae's named nurse on 17 March 2020.

[52] The purpose of a safety brief is for all staff to know the risks on their shift. Safety briefs should not be done retrospectively. They serve no purpose once a patient has died. Mieke Woodbridge did not complete the safety brief for Dr Macrae relating to 17 March 2020 until 4 weeks after Dr Macrae's death.

[53] Caron Thompson was working a "long day" from 7.00am until 8.00pm. She had a long conversation and two short ones with Dr Macrae on 17 March 2020. It was not normal for Dr Macrae to speak to staff. Her presentation was slightly odd. She talked about her belief that Christopher MacRae had cancer. Caron Thompson reassured her, saying that as far as staff were aware he was well. She was not aware of him hanging in the noose.

Radoslaw Rzeznicki's knowledge and actions on 17 March 2020

[54] On 17 March 2020 Dr Macrae's presentation was very disturbed. She had dark thoughts about Christopher MacRae having been abused, about herself being assaulted by police or nurses, or being poisoned by staff. She was voicing suicide ideation. This had been a theme throughout her admission. She had had unescorted passes and access to razors on the ward. As far as Radoslaw Rzeznicki was aware she had not acted on thoughts before. There was no reference to that in her risk assessment at the start of her

admission. Radoslaw Rzeznicki relied on the handover by colleagues and not on the medical clerking records. He was not aware of her suicide attempts in 2018.

[55] When Christopher MacRae had handed the noose to Radoslaw Rzeznicki and told him that Dr Macrae had said she was going to hang herself, Radoslaw Rzeznicki attempted to speak to her. She was very vague and declined medication.

Radoslaw Rzeznicki's relationship with Dr Macrae was very poor. She did not trust him. Radoslaw Rzeznicki went into the nursing office, put the ligature on the desk and passed on the information to the nurses present, but he could not recall who was there. Radoslaw Rzeznicki knew that the ligature was a "restricted item" in terms of the hospital procedures.

[56] Radoslaw Rzeznicki did not search Dr Macrae's room. He said that Dr Macrae had called Christopher MacRae previously during that admission claiming to have a noose but she had not killed herself. Radoslaw Rzeznicki assessed that despite voicing suicidal intention she would not act on it. Radoslaw Rzeznicki accepted that perhaps that was an error of judgment. He accepted that he had perhaps failed to appreciate the importance of what Christopher MacRae had told him. He had underestimated how well Christopher MacRae understood Dr Macrae as a result of looking after her for many years. He accepted that he should have taken the presentation of the noose, the suicide ideation and the concerns of the family more seriously.

[57] Radoslaw Rzeznicki knew that there was a protocol for a search and that records required to be kept. He did not carry out a search. The ward was busy and he had competing tasks to do. He accepted that he should have carried out the search with a

colleague. He did not record the discussion with Christopher MacRae in the notes. He accepted that he should have done so. He did not think he was the named nurse that day and he did not know who was.

[58] When Christopher MacRae spoke to Radoslaw Rzeznicki and handed in the noose, Dr Macrae was on general observations. Radoslaw Rzeznicki assessed that she would not act on her suicidal thoughts and so an increase in her observation level was not justified. He did not discuss the possibility of increasing observations with other members of the team. He did not record anything in the notes.

[59] Radoslaw Rzeznicki accepted that it was his duty to make a note in the TRAK notes of Christopher MacRae's concerns given their significance, even if he was not Dr Macrae's named nurse. He accepted that he should also have noted it in the safety brief, where changes in risk were noted.

The night shift

[60] Joanne Compton, Joan Learmont and Susan Paterson were working on the night shift overnight from 17 to 18 March 2020. Mieke Woodbridge did the handover. There was reference to Dr Macrae not having had a good day, that she was "struggling", but that she had accepted medication. There was no reference to a noose. Joanne Compton was aware Dr Macrae had previously attempted suicide. She had either read it in her medical records or been told about it. She had looked after Dr Macrae before.

[61] Checks of patients were to be carried out at least hourly and were normally done on the hour. Susan Paterson participated in the 8.00pm and 9.00pm checks. The 8.00pm

check occurred at about 8.10pm because the handover had run over time. Dr Macrae had been in the dining room at the start of the shift, but when Susan Paterson arrived at her room she was sitting on her bed staring into space. Susan Paterson spoke to Joanne Compton who said she was going to have a chat with Dr Macrae.

[62] Joanne Compton had spoken to Christopher MacRae as she came on shift. She offered to carry out an additional check on Dr Macrae. She told Christopher MacRae that he could telephone her overnight if he had any thoughts and she would speak to him.

[63] At about 8.40pm Joanne Compton knocked on Dr Macrae's bedroom door, telling her it was Jo and that she was just checking to see that she was all right. Dr Macrae stretched out her arm, saying "leave me alone, I'm fine". Joanne Compton respected her wishes and said that they could talk later.

[64] At the 9.00pm check Susan Paterson and Joan Learmont found Dr Macrae with her back to her bedroom door and a ligature round her neck. They pushed open the door and commenced CPR. Alarms were pulled and numerous staff attended. Other medical interventions followed.

[65] Dr Macrae had used her scarf as a ligature.

[66] The co-ordinating charge nurse on the night shift which commenced on 17 March 2020 was Gordon McGregor. The co-ordinating charge nurse on the late shift had given him a general handover of each of the 10 wards for which he had responsibility. He was not aware that a noose had been handed in earlier that day.

[67] A ligature point inspection and risk assessment of Dr Macrae's bedroom carried out on 20 February 2019 identified *inter alia* the door as presenting a major level of harm, with a possible likelihood, and a high level of risk.

The Craiglockhart ward

[68] The Craiglockhart ward is an admissions ward for women aged from 16 up to 65 from the north of Edinburgh with mental health issues.

[69] There were 16 beds on the ward. On 17 March 2020 all the beds were filled.

[70] Each patient had both a key worker and a named nurse. The key worker was the nurse allocated as key worker at the start of the patient's admission. The key worker completed the risk assessments and the daily notes, and would have one - to - one sessions with the patient each week. The key worker had more opportunity to read the patient's notes. The named nurse was the nurse responsible for looking after the patient on any particular day. If the key worker was not available, the named nurse took over her responsibilities. Nurses tended to look only at a patient's care plan and risk assessment, unless they were the key worker. Then they might look back further in the notes. TRAK did not have a function showing important events relating to a patient as soon as the records were opened.

[71] There was general confusion as to who had been Dr Macrae's key worker and who had been her named nurse on 17 March 2020.

Staff on duty on 17 March 2020

[72] The nurses on the early shift (7.00am until 3.00pm) were Charge Nurse James Hewat, Radoslaw Rzeznicki, Deanna Murray, Kerrie Hume Anthony (working a long day), Caron Thompson and Mhairi Tennant. The nurses on the back shift (12 noon until 8.00pm) were Radoslaw Rzeznicki (working a long day, with overtime from 3.00pm – 8.00pm), Kerrie Hume Anthony, Caron Thompson (working a long day) and Mieke Woodbridge.

[73] Radoslaw Rzeznicki, Kerrie Hume Anthony and Caron Thompson were all working a “long day”, from 7.00am until 8.00pm.

[74] The people on the night shift (7.45pm until 7.15am) were Joanne Compton, Susan Paterson and Joan Learmont.

*Expert evidence of Dr Khuram Khan, Bachelor of Medicine and Bachelor of Surgery,
Member of the Royal College of Psychiatrists, Consultant Forensic Psychiatrist*

[75] Dr Khan reached the following conclusions.

- (i) The standards of care Dr Macrae received following her admission on 5 February 2020 were inadequate.

There was no mention of suicidal risk assessment or management in the weekly reviews despite ongoing suicidal intent throughout the admission.

The team seemed unaware of previous suicidal attempts using ligatures.

There was no record of Christopher MacRae handing in the ligature or

telling nursing staff that Dr Macrae intended to take her life. Her room was

not searched. Her case was not referred to a doctor for review of the increased significant risk. The existence of a noose was an indication of the risk of self-harm. It showed suicidal intent. Observation levels should have increased when the noose was found. Dr Macrae's presentation on the ward indicated a steady deterioration in her mental state, with her becoming more agitated and having thoughts of self-harm.

- (ii) Assessment and management of Dr Macrae's risk were inadequate and substandard.

Dr Macrae had been detained under the mental health act due to the severe nature of relapse of her chronic mental disorder and significant risk to herself. These issues remained throughout her admission. There was no evidence that her risk levels were reviewed despite the change in her presentation and mood. Christopher MacRae handed in a noose and alerted staff to her suicidal thoughts but no action was taken.

- (iii) Aripiprazole depot medication was the appropriate option for treating Dr Macrae.
- (iv) Dr Macrae's observation level was inadequate.

If her observation levels had been increased to constant observation and if her room had been searched for ligatures it was more likely than not that her death could have been prevented. Dr Macrae met the criteria for constant observation during her stay.

- (v) Meaningful implementation and ongoing audit of the SAER was likely to assist in preventing or minimising the risk of deaths in similar circumstances in Craiglockhart ward in the Royal Edinburgh Hospital.

Significant Adverse Event Review (“SAER”)

[76] Lothian Health Board instructed a Significant Adverse Event Review (SAER) into the circumstances surrounding Dr Macrae’s death. Having regard to the serious concerns raised both an internal and an external reviewer were appointed. They were Kathleen Stewart, Staff Bank Registered Mental Nurse Band 8A (NHS Lothian) and Dr Cliff Sharp, NHS Borders Medical Director, (NHS Borders). On 28 August 2020 the report was completed. By 5 November 2020 final approval at Board level had been given by the NHS Lothian Board Medical Director and the NHS Lothian Board Nurse Director.

[77] The SAER concluded that:

“a different plan and or delivery of care, on balance of probability, would have been expected to result in a more favourable outcome, i.e. how case was managed had a direct impact on the level of harm”.

This was a Level 4 outcome, which was the highest level of outcome.

[78] The SAER report made the following recommendations:

1. Short life working group already established to coordinate various actions following early concerns raised by Dr Macrae’s death and initial findings of review.

2. Escalation of concerns about clinical record keeping, omissions in handover and professional responsibility and accountability issues already escalated to senior managers.
3. Seek specialist advice and review the door design of all single bedrooms within Royal Edinburgh Hospital's acute wards to determine whether other models exist that are free of, or minimise, ligature points further than those in current use.
4. Carry out ligature point inspection and risk assessments of Craiglockhart and other in-patient areas involving health and safety advisers and take action to mitigate risks identified.
5. Provide training in ligature point inspections and risk assessment for senior ward nurses.
6. Develop quality assurance processes to ensure the annual ligature point inspections and risk assessments reported to Royal Edinburgh Hospital and Associated Services ("REAS") Health and Safety Committee are carried out to the expected standard and to ensure subsequent actions to manage identified risk are completed.
7. Review use of electronic patient record to ensure past episodes of self-harm and suicide attempts are flagged.
8. Ensure a comprehensive case summary, including current and historical risks, is accessible in TRAK to inform safe care and treatment, including where patients are transferred from one care setting to another.

9. Expressions of suicidal intent must be recorded with evidence of appropriate safety care planning and consideration of mitigating actions required.
10. Multi-disciplinary team review meetings must systematically consider and record risk assessment with reference to self-harm, suicide, absconding or risks to others and incorporate identified risks into care plans and reviews.
11. Develop clinical and quality assurance processes to ensure: (a) that risk assessments and risk management plans accurately reflect known current risks and knowledge of historical risk information; and (b) that care plans are comprehensive and reflect patients' needs.
12. Review the format of the current safety brief form, develop a Standard Operating Procedure for its use and provide training and awareness sessions for staff.
13. Review the process for handover of information and concerns within and between shifts and develop process to ensure staff competence and compliance with agreed Standard Operating Procedure, for example by including it in staff induction and appraisal systems.
14. Develop and deliver awareness training on standards for clinical record keeping; develop audit processes to monitor documentation standards; incorporate expected standards (including those within Nursing and Midwifery Council Code of Conduct) into induction and staff appraisal processes.

15. Review care planning and risk assessment/management training being provided and incorporate topics outlined above.
16. Finalise the Standard Operating Procedure for searching patients so staff have clear guidance on balancing patients' rights with managing patient/staff safety within the hospital setting.
17. Develop a process for service (the "Clinical Pause") to identify mental health deterioration in patients and to intervene appropriately and timeously.
18. Re-establish clinical supervision/reflection sessions in ward to help support the multi-disciplinary team in their care of women with multiple and complex needs. In all cases where there are identified challenges to treatment, the multi-disciplinary team should develop a formulation which takes account of patient and staff responses to the patient's condition.
19. Review the Standard Operating Procedures for the roles of shift coordinator and key workers explicitly outlining their individual responsibilities (for example with regard to record keeping) and obtain a record of understanding from nursing staff.
20. Consultant cover arrangements for ward rounds must be clarified, with a named consultant available for advice and supervision of trainees when the Responsible Medical Officer is on planned leave or unexpectedly absent.

21. Review how e-rostering system is used by senior charge nurses, charge nurses and coordinating charge nurses to ensure there is an equitable spread of permanent staff on all shifts.
22. Ongoing recruitment to ensure all vacancies are filled to reduce need for bank staff and to achieve agreed staffing model for acute wards.

Implementation of the SAER

[79] Lothian Health Board created an Action Plan in response to the SAER. The SAER Action Plan considered the contributory factors identified by the SAER which were as follows: patient focus; task and technology factors; individual staff factors; team factors; work environmental factors; and organisational and management factors. The SAER Action Plan considered the aspects within each factor which the SAER had addressed as being relevant to the death. The SAER Action Plan identified the actions to be taken to address the factors, by whom and by when they were to be taken, the evidence required to prove completion, and when the actions were completed.

[80] The actions to be taken, by whom and by when, the evidence proving completion and the date of completion were as follows.

[81] In relation to patient focus and Dr Macrae's own voiced intent to complete suicide during admission and on the day of her death, and to her previous history of attempted hanging in 2018 not being known to the multidisciplinary team, the SAER had made recommendations 7 to 10.

[82] The actions taken to address these factors were the person centred audit tool ("PCAT") being put in place, e-risk assessments being completed and documented. That was completed on 29 June 2021. The electronic risk assessment is accessible on TRAK by clicking on a tab. The most recent version appears first. There is a section for historical incidents where previous suicide attempts can be logged. Staff have been trained in its use. All members of the multi-disciplinary team can access documents, including risk assessments. The e-risk assessments commenced in June 2020. The resources are not available to input historical information about patients. Although the PCAT is evidence that documents have been completed and that they exist, it does not capture the quality of the documentation.

[83] In relation to task and technology factors including the absence of risk information about risk to herself in Dr Macrae's care plans, weekly review notes and at the handover to the night shift on 17 March 2020, the SAER had made recommendations 11(a) and (b), 12, 13 and 15.

[84] The actions taken to address recommendations 11(b) and 15 were care planning and risk assessment training, along with the PCAT audit. These actions were completed on 28 June 2021. Staff can attend refresher courses, and can be directed to do so by the senior charge nurse if their documentation does not meet the required standard. Quality is variable and standards of documentation in the Craiglockhart ward are at the lower end of the scale. In January 2024 funding was obtained for three individuals to make sure the risk assessments and care plans were of the expected standard. Other

individuals helped with staff training, by helping staff with what to put in the documentation.

[85] The actions taken to address recommendation 11(a) were an e-learning module relating to working with risk and mental health being made compulsory for clinical staff, risk assessments being completed on TRAK, and the PCAT. These actions were completed on 28 June 2021. The e-learning module gives an overview of what risk is, how to assess it, what form it might take and how to mitigate it. It is compulsory for all patient-facing staff: consultants, junior doctors, nurses of all bands and assistants. Compliance is monitored by the nursing line manager, who has access to all the modules the individuals have completed and it is reported in quarterly Health and Safety checks. Feedback from the Mental Welfare Commission about risk assessments has generally been positive, but not in relation to care plans.

[86] The actions taken to address recommendations 12 and 13 were to agree and implement a handover record for acute patients. These actions were completed on 12 May 2021 and set out in Standard Operating Procedure for *Shift Leadership and Handovers*. Feedback from practice development nurses sitting in on handovers is that almost all of what is in the Standard Operating Procedure is gone through and that handovers are robust and comprehensive. That Standard Operating Procedure also provides that all actions, interventions and discussions are to be recorded within the patient's clinical notes on TRAK before the end of the shift. Retrospective entries are to be avoided.

[87] In relation to individual staff factors relating to the lack of written record of Christopher MacRae handing in the ligature, inadequate recall of the communication about the removal of ligature and the concerns of Christopher MacRae, and the retrospective entries on TRAK by two staff on the late shift, the SAER had made recommendations 2 and 14. The actions taken to address recommendations 2 and 14 were updating the PCAT, induction training for new starts, and the monitoring of completion of training. These actions were completed on 11 June 2021. "Learnpro" reports monitor electronically the learner's competence and understanding. A specific level has to be attained. They are recorded in the Health and Safety quarterly reports. A Standard Operating Procedure for *Recording Clinical Documentation* was prepared, providing fairly high level guiding principles regarding record keeping and setting out unequivocally what is expected of staff. Records are to be made as soon as possible within the shift, not just at the end of it.

[88] In relation to individual staff factors relating to the failure to search Dr Macrae's bedroom and belongings as requested by Christopher MacRae to remove other potential ligatures, the SAER had made recommendation 16. An approved Standard Operating Procedure *Search Procedure as part of inpatient Clinical Care in Mental Health & Learning Disability Services* has been implemented. Staff are required to sign that they have read and understood it. Records require to be kept.

[89] In relation to the individual staff factors relating to the failure to escalate matters to the junior medical team on duty, the SAER had made recommendation 17. An approved Standard Operating Procedure *The Practice of Continuous Observations in*

Mental Health Wards in NHS Lothian has been implemented. That action was completed on 23 January 2021. It is based on *From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care* published by Healthcare Improvement Scotland in January 2019. It replaces the previous observation levels of “general observation”, “constant observation” (where the patient could be seen and heard at all times) and “special observation” (where the patient was within arms reach) with a “clinical pause” following which there might be “continuous intervention”.

[90] Continuous intervention is put in place when a patient requires the continuous presence of a member of staff to support them manage their distress and their interactions with others safely. Continuous intervention is triggered after a risk assessment that highlights a deterioration that can only be supported safely by one to one input. The period of continuous intervention is to be therapeutic. The purpose is to engage the patient with something that interests them such as reading a newspaper together or going for a walk.

[91] Prior to the multi-disciplinary team decision being made to commence continuous intervention, a period of up to 2 hours is to be used to facilitate an assessment of the need for full one to one support. That period allows the team, including the patient and their supporters and carers, to evaluate the current safety issues and produce a plan of intervention to address them. Attempts will be made to relieve the patient’s stress during the 2 hour period in a way that is appropriate for the patient, perhaps by engaging in a suitable activity or with medication. This is the

“clinical pause”. The clinical pause can be triggered by any member of the multi-disciplinary team.

[92] If after the clinical pause the multi-disciplinary team agrees that a period of continuous observation is required, a personal safety plan has to be developed. It is reviewed every day.

[93] The frequency with which clinical pauses are used can be monitored due to the functionality of the system. A clinical academic is assessing which patients the clinical pause works for and who it does not work for, as well as monitoring the quality of the documentation. The process will be refined in light of her conclusions.

[94] In relation to individual staff factors relating to the shift coordinator for the late shift not completing the safety brief for the shift until around 4 weeks after Dr Macrae’s death, the SAER had made recommendation 2. That action was completed on 11 May 2021. A *Standard Operating Procedure for Recording Clinical Documentation* is in place.

[95] In relation to individual staff factors relating to the registered nurses not demonstrating understanding about their professional responsibilities and accountability for their own actions, omissions and decisions, the SAER had made recommendations 2 and 19. That action was completed on 11 June 2021. Meetings were held with the team members to reinforce the standards and professional accountability expected by the Nursing and Midwifery Council and they were required to read the Standing Operating Procedures relating to their roles and to confirm their understanding.

[96] In relation to team factors relating to the staffing mix on the late and night shifts, the SAER had made recommendations 21 and 22. Those actions were completed on 28 June 2021. Recruitment continues to be challenging. Nationally there is a shortage of nurses, and generally there is a shortage of mental health nurses. Every vacancy was filled in 2024. The document *eRostering*, which provides guidance to ensure safe and high quality care, has been updated. The senior charge nurse is responsible for the roster. Allocation of days and hours is to be done fairly.

[97] In relation to team factors relating to staff finding Dr Macrae's presentation challenging and it being difficult to form a therapeutic relationship with her, the SAER had made recommendation 18. That action was completed on 28 June 2021. Ward reflective practice has been re-introduced, with the assistance of a psychotherapist. That allows staff to talk with others and maintain their perspective. Attendance fluctuates, with staff attending at busier times and less so when it is quiet. Initially group sessions were weekly, but then became fortnightly. There is the opportunity for individual sessions.

[98] In relation to work environment factors, the SAER had made recommendations 1, 3, 4, 5 and 6.

[99] An *Environmental Ligature Point Policy (Health & Safety)* was prepared by NHS Lothian and had effect from April 2021. The purpose is to help reduce or prevent the likelihood of high risk vulnerable patients using environmental ligatures to commit suicide. The policy is to remove or reduce exposure to such ligature points where vulnerable patients are cared for. The policy is applied in Craiglockhart ward in terms

of the *Standard Operating Procedure for Environmental Ligature Point Inspections and Risk Assessments* which had effect from March 2021. That Standard Operating Procedure sets out the responsibilities imposed on individual staff. Reports of inspections on each ward are to be prepared quarterly to the Health and Safety Committee. If an environmental ligature point is found, it is responded to quickly and often the same day. Replacement of a door will take longer, and the room would have to be taken out of service. Rooms are reassessed when a patient leaves. The Standard Operating Procedure also sets out the process for carrying out environmental ligature point inspections and provides a risk matrix.

[100] SAER recommendation 6 referred to ligature point inspections being done annually, but these are done quarterly now.

[101] A business paper was prepared regarding the replacement of doors. An option integral to the door was selected and costed. The cost of replacing all the doors where they were needed across Lothian mental health estate was around £8 – 10 million. That did not include the cost of decanting. The cost of putting the doors in one adult ward was about £500,000 - £600,000 at the time of the quotation, but prices have increased since then. Lothian Health Board does not want to put doors in only one adult admissions ward. Lothian Health Board made a business case to the Scottish Government for capital funding. In December 2023 the Scottish Government advised that they were no longer funding such projects. The existing doors continue to meet the required standards.

[102] In relation to cover arrangements for the responsible medical officer's annual leave falling through and contingency arrangements being unclear, the SAER had made recommendation 20. There is now a process in place.

Mental Welfare Commission reports

[103] The Mental Welfare Commission report on an announced visit to the Craiglockhart ward on 24 March 2022 identified that there were staff shortages and that patients were not actively involved in their care plans.

[104] The Mental Welfare Commission report on an unannounced visit to the Craiglockhart ward on 5 February 2024 found that there were 17 patients sleeping on the ward, with an 18th patient being on the ward during the day but boarding in another ward overnight. There continued to be issues with care plans, with limited progress since the visit in 2022.

Submissions

Submissions for the Crown

[105] The procurator fiscal depute adopted his written submissions.

[106] He invited me to find all witnesses credible and reliable, with allowances being made for the passage of time between Dr Macrae's death and the hearing.

[107] He invited me to make findings in relation to sections 26(2)(a), (b), (c), (d), (e), (f), (g) of the Act and to consider making recommendations in relation to

sections 26(1)(b) and (4)(a), (b) and (d) of the Act in the terms set out in his written submissions and for the reasons given there.

[108] With regard to any precautions which could reasonably have been taken, the procurator fiscal depute referred to the two stage test set out in section 26(2)(e). First the court required to be satisfied on the evidence that there was a precaution which could reasonably have been taken. Secondly the court had to be satisfied on the evidence led that if the precaution in question had been taken, then it might realistically have avoided the death. Unless both criteria were met, no finding should be made in terms of section 26(2)(e). The word “reasonably” related to the reasonableness of taking the precautions rather than the foreseeability of the death or accident. A precaution might realistically have prevented a death if there was a real or likely possibility, rather than a remote chance, that it might have done so.

Suggested precautions 1 and 2

[109] In support of the Crown’s suggested precautions that Dr Macrae’s observation levels should have been raised to constant observation and that her room should have been searched for ligatures, the procurator fiscal depute referred to the evidence.

[110] Radoslaw Rzeznicki accepted that on being handed a cord by Dr Macrae’s son and given evidence of Dr Macrae’s suicidal ideation he did not search her room.

Radoslaw Rzeznicki said that Dr Macrae had previously expressed similar intentions and claimed to have had a noose in her room but when her room was searched nothing was found. She had previously had suicide ideation on many occasions, but she had not

acted on that. Radoslaw Rzeznicki accepted perhaps he had made an error of judgment and had perhaps underestimated what Christopher MacRae told him that day. When it was put to Mr Rzeznicki by the fiscal depute that he underappreciated being told of Dr Macrae's suicidal ideation and the handing in of a noose he stated: "in retrospect should have taken this on board" and in relation to a search he stated: "in retrospect I should have conducted that search with the help of a colleague."

[111] In his parole evidence, Dr Khan said that a search of Dr Macrae's room and increased observation levels would have allowed staff to keep an eye on her and to stop her from harming herself. He said the room search would have made sure there were no further nooses or sharp objects or any other means used to self-harm. His report was in similar terms.

[112] The Crown submitted that on the basis of the presenting risk following the discovery and reporting of a self-fashioned ligature, it would have been reasonable to have increased the observation status of Dr Macrae to "constant observations" to maintain her own safety. Such a measure was reasonable in accordance with the evidence and the opinion of Dr Khan and there is a real or likely possibility that such a measure may have avoided her death by ensuring that, during what appears to have been a significant deterioration in her mental health, that she was monitored appropriately and with the benefit of instant intervention should any self-harm episodes occur.

[113] It would also have been reasonable to search Dr Macrae's room following the discovery and reporting of a self-fashioned ligature. Based on the evidence and

Dr Khan's opinion this would have been an entirely appropriate precaution to have taken, and one that appeared necessary in the circumstances. Had such a precaution been taken there was a real or likely possibility it may have avoided Dr Macrae's death because such a search was likely to have resulted in the removal of any other potential ligatures and/or any other potentially harmful objects, thereby removing the potential for Dr Macrae to self-harm or attempt suicide within her room.

Suggested precaution 3

[114] In support of the Crown's suggested precaution that Dr Macrae's voiced suicidal intention and the presentation of the ligature should have been recorded in Dr Macrae's medical notes, the procurator fiscal depute referred to the evidence of Radoslaw Rzeznicki and Craig Stenhouse.

[115] Radoslaw Rzeznicki was asked whether he documented in Dr Macrae's notes that he had placed the cord in the office. He said that he had not. He said that he was not Dr Macrae's named nurse, and it was usually the responsibility of the named nurse to document based on the feedback of other members of staff.

[116] The Crown submitted that had the handing in of the ligature and the information regarding Dr Macrae's voiced suicidal ideation been recorded in her medical records at the time the ligature was handed in, this would have alerted other staff on duty at the time to an increased level of risk relative to Dr Macrae and helped inform a care and treatment plan relative to the increased level of risk. Mhairi Tennant gave evidence that she was told by Mr Rzeznicki about the cord, she gave words of advice and then

finished her shift. The Crown's position was that the actions of Mhairi Tennant could not be criticised. Radoslaw Rzeznicki was a registered nurse of several years experience and he should have known of the importance of dealing appropriately with the information he was given regarding suicidal ideation and the means to complete suicide. Having regard to his experience he should have known that this signified a significant increase in the risk of suicide posed to Dr Macrae. He should have known that that increase in the level of risk should have been recorded in Dr Macrae's notes so that other staff on the ward involved in Dr Macrae's care and subsequent staff on the nightshift were aware of information which was indicative of an increase in the risk of suicidality relative to Dr Macrae.

[117] The Chief Nurse Craig Stenhouse was asked what he would do if given a noose taken from a patient. He said he would "take it off them, speak to the person, I would either put a nurse with them, search their room. Spend 1:1 time, a multitude of things." The Crown submitted that this was further evidence that demonstrated the variety of measures that could be invoked to help treat a patient with increased risk of suicide. However the measures identified by Craig Stenhouse could only be invoked had other staff been aware of the handing in of the cord and of the voiced suicidal intent. The clearest and easiest way to ensure a permanent record of that information which was accessible to all staff involved in Dr Macrae's care would have been to record it in the TRAK notes. Such a step was reasonable to take. Had such a step been taken then it might realistically have avoided Dr Macrae's death because there was a likely possibility that staff, on seeing the information about voiced suicidal intent and having access to

means to complete suicide in Dr Macrae's records, could have acted on this information. They could have invoked a number of measures referred to by Craig Stenhouse with the aim of keeping Dr Macrae safe and reducing the risk of suicide.

Suggested precaution 4

[118] In support of the Crown's suggested precaution that suicidal risk assessment/management should have been recorded in weekly reviews, the procurator fiscal depute referred to Dr Khan's evidence.

[119] Dr Khan noted in his report that:

“the inpatient record indicates there was not a mention of suicidal risk assessment/management in weekly reviews despite ongoing suicidal intent throughout the admission.”

In court he gave evidence that this is something he would expect to see. He said that suicidal risk assessment/ management would be documented in the ward round notes. A standard entry would be about whether the patient had expressed thoughts of suicide or plans. If there were suicidal intent, the treatment plan might continue as before or change depending on the severity of the ideation and the assessment on the risk. Keeping the patient safe could be done by increased input, including of medication. Evidence in relation to a plan was something that a responsible medical officer or staff would note.

[120] Dr Murray was referred to *From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care* dated January 2019, and to the challenges of relying on patient classification through

risk assessment and risk status discussed therein. What she took from it was that risk assessment was:

“not a tick box exercise that can define a person’s risk, has to be a narrative, how they engage, how receptive they are to interventions, how to try and work with them collaboratively, was a much more nuanced approach.”

She was actively implementing that principle.

[121] The Crown submitted that recording of suicidal risk assessment/ management in weekly reviews might have demonstrated and highlighted a more dynamic awareness of Dr Macrae’s current risks. This action could have reasonably been taken and might realistically have resulted in Dr Macrae’s death being avoided. Had there been a record of suicidal risk assessment/ management in weekly reviews there is a likely possibility that this would have resulted in earlier awareness of an increase in the level of risk that Dr Macrae posed to herself. Dr Khan had explained “the plan would change depending on the severity of the ideation - assessment on the risk, would then lead to change of plan.” Had this been done, measures such as increases in observation levels or a search of her room could have been deployed on recognition of the increase in the level of risk posed at an early stage to help manage the increase in risk. The procurator fiscal depute referred again to the evidence from Chief Nurse Craig Stenhouse about what he would do if a patient had a noose. That demonstrated the variety of measures that could be invoked to help treat a patient with increased risk of suicide and highlighted the importance of changes in presentation and suicidal risk assessment/ management being recorded in a patient’s notes.

Section 26(2)(f) – defects in any system of working which contributed to the death

[122] A patient's medical records from different Health Boards not being collated in one place leading to a lack of awareness of previous suicidal attempts using ligatures.

[123] The Crown submitted that there was a defect in a system of working which contributed to the death of Dr Macrae, namely, a patient's medical records from different Health Boards not being collated in one place leading to a lack of awareness of previous suicide attempts using ligatures.

[124] Dr Fiona Murray gave evidence that when reading Dr Macrae's medical notes she had not seen documentation of a significant suicide attempt. She was not aware of the entry on TRAK dated 18 July 2019 when a mental health act assessment was carried out at Accident and Emergency by a psychiatrist and a mental health officer. The risk assessment recorded that:

“During an inpatient admission in July 2018 Sara deliberately set fire to a ward within the REH. During the same admission she also attempted to hang herself with her handbag on a curtain rail.”

She was not aware of the entry in the records for Blackford Ward at the Royal

Edinburgh Hospital dated 19 July 2019 narrating that:

“Sara has previous admissions to REH last admitted July 2018. During an inpatient admission she attempted to hang herself whilst in the ward and also deliberately started a fire”.

She was not aware of an entry dated 12 July 2018 about Dr Macrae having been admitted to Accident and Emergency following an attempt to hang herself using a mobile phone cord, following which she was transferred to Langhill Acute Admissions Unit in Inverclyde, Greenock due to a lack of beds in Edinburgh. She was not aware of an entry

dated 26 July 2018 that Dr Macrae had said she had fallen off the window ledge onto the floor of her room when trying to hang herself that day. Dr Murray agreed that this was evidence of a previous suicide attempt. Dr Murray agreed that when she allowed Dr Macrae 15 minute unescorted passes, although she knew that Dr Macrae had a long history of intermittent suicidal thoughts, Dr Murray had not seen a record of her having acted on it in the past.

[125] Dr Murray's evidence was that medical records between Health Boards are not joined up. As a consultant trying to treat someone with a long history of mental illness it was important to have full information. There were difficulties with patients who had moved care, in particular outwith their home area.

[126] Other witnesses involved in the care of Dr Macrae, including Mieke Woodbridge and Joan Learmont, were not aware of Dr Macrae's previous suicide attempts. Dr Khan noted in his report "the team seemed to be unaware of previous suicidal attempts using ligatures". Dr Khan gave evidence that the team not being aware of the previous self-harming behaviours was significant, because previous behaviour was a very strong indicator of how to quantify or calculate the risk of harm. If there was a previous history, that was a "red flag."

[127] The fact that Dr Macrae's medical records from her stay at hospital in Inverclyde were not joined up with her medical records in NHS Lothian was a defect in a system of work which contributed to Dr Macrae's death because this meant that her treating consultant and medical team at the Craiglockhart ward in 2020 were unaware of previous suicide attempts. Dr Khan gave evidence that this was a "red flag" and very

strong indicator in how risk of harm is calculated. That would have had a direct bearing on the care and treatment Dr Macrae received. Her treatment plan was based on incomplete crucial past medical history relative to previous suicide attempts. This led to an incomplete understanding of the full medical picture and presenting risk of self-harm by Dr Macrae's treating clinicians at the Royal Edinburgh Hospital. This can properly be categorised as a system defect on the basis that the wider system itself, namely that relating to the lack of health record accessibility across different Health Boards, is what caused this issue to occur.

Section 26(2)(g) – any other facts which are relevant to the circumstances of the death

[128] The safety brief of 17 March 2020 was completed 4 weeks after the death of Dr Macrae retrospectively.

[129] Mieke Woodbridge gave evidence that she created the safety brief entry of 17 March 2020 relative to Dr Macrae 4 weeks after the incident. When asked what was the reason she created it she said that her charge nurse had asked her to write a statement of events of that night. She went to look at safety brief. It was blank. She panicked and copied what she had written down elsewhere. She explained that she had run out of time. There was so much going on, there were admissions, there was a patient in isolation regarding Covid-19 for which they had no tests, another patient was coming out of her room and shouting "RAPE" every 10 - 15 minutes. Craig Stenhouse gave evidence that it was important to ensure notes were done as soon as possible while the events were still fresh in the nurse's mind, and because it reduces the chance of

information being missed. He expected notes to be written up on that shift soon after the nurse had spoken to a patient. Retrospective entries should be avoided. They left a gap. A decision might be taken in respect of a patient based on incomplete information.

[130] The retrospective completion of the safety brief of 17 March 2020 relative to Dr Macrae was a fact which was relevant to the circumstances of the death because the safety brief was a key document which helped inform staff on the ward of any current risks posed by patients which would help inform the care and treatment provided to patients. Retrospective completion of the safety brief completely negated the purpose of the safety brief. The purpose of the safety brief was to help provide up to date information about patients which might help safeguard them by highlighting changes in behaviour/presentation and might help inform the care and treatment provided to patients.

Meaningful implementation and ongoing audit of the SAER action plan relating to Dr Macrae's death should continue

[131] Reference was made to the extensive evidence from Craig Stenhouse relation to the SAER Action Plan and how Lothian Health Board have sought to implement actions in response to recommendations made in the SAER that followed Dr Macrae's death.

[132] Craig Stenhouse gave evidence that a person centred audit tool provided evidence that certain documents had been completed and did exist, but the PCAT fell short in not capturing the quality of the documentation.

[133] The Crown submitted that evidence led at the inquiry demonstrated that when approaching risk assessments relative to mentally unwell patients a dynamic approach to care and treatment and thus risk assessment was required. The quality of the information contained in the documents was as important as the fact that a document has been completed because the information contained in the documents was precisely one of the tools staff used in helping them in that dynamic approach to risk assessment and care and treatment of mentally unwell patients. The point of the audit was made redundant if the quality of information contained in the documentation was not of sufficient quality. When asked by the procurator fiscal depute what was in place to improve the quality of the documentation, Craig Stenhouse explained that in January 2024 he had obtained funding to employ three people in practice development, one was full time, another worked 3 days a week and the third was one day a week. Their sole job was to make sure documentation such as care plans and risk assessments were at the expected standard. There were other people to assist with training. They might discuss a patient with a nurse and speak about how to put the details into the care plan. Now that there were people whose job was solely to do this work on the documentation, it was to be expected that changes would be seen.

[134] The Crown submitted that the fact that these three persons had only been in post since January 2024 illustrated that the actions identified from the SAER Action Plan relative to Dr Macrae's death were still being implemented by the Health Board some 4 years later.

[135] Craig Stenhouse gave evidence that in relation to the PCAT he had thought it would be better if people did not audit their own work and that different wards should audit each other. He had thought that it would provide us with a better quality audit, but it never worked and compliance of it fell. They have gone back to auditing their own work, with the senior charge nurse auditing the patient's notes and looking at whether or not documents like risk assessments had been completed properly. He thought it would be possible to link in with another ward in another health board to audit each other, but there might be an issue with access to their electronic systems.

[136] The Crown were acutely aware of the pressures that NHS staff operate under on a daily basis. Craig Stenhouse was clear in his evidence that his attempt to get an external audit process in place was not successful. He gave evidence that this was probably due to a number of factors. There was a national shortage of registered nurses, and there had been vacancies in Edinburgh for a long time. There were fewer beds, and more people needing treatment.

[137] However, the Crown submitted that there was significant merit in ensuring that there was an external audit process of the PCAT in place. An external audit of the PCAT in secure mental health wards would be invaluable as an additional check and balance to ensure that the PCAT is being complied with and that the PCAT fed effectively into the required dynamic risk assessment relative to mentally unwell patients in secure wards. Although Mr Stenhouse had given evidence that there was a vacancy rate of 10%, he said that staff had recently been recruited to acute mental health and all the vacancies would be filled when the new staff started.

[138] The Crown were cognisant of Dr Khan's stated professional opinion in his report that:

"the meaningful implementation and ongoing audit of the action plan is likely to assist in preventing or minimising the risk of deaths in similar circumstances in the Craighlockhart ward Royal Edinburgh Hospital."

[139] The Crown submitted that the court might see merit in making a recommendation that meaningful implementation and ongoing audit of the SAER action plan relating to Dr Macrae's death should continue.

The Crown's recommendations

[140] In support of the first recommendation the Crown relied on the following paragraph in Dr Khan's report:

"Dr Macrae's observations had not been increased to constant observation. Her room was not searched for ligatures. Had these two interventions been done, it is more likely than not, that her death could have been prevented. Dr Macrae's observation level was inadequate."

[141] The Crown also relied on the parole evidence of Dr Khan that a search of Dr Macrae's room and increased observation levels would have allowed staff to keep an eye on her and to stop her from harming herself. The room search would have made sure there were no further nooses or sharp objects or any other means used to self-harm.

[142] The Crown also relied on the following paragraph in *Standard Operating Procedure: The Practice of Continuous Interventions in Mental Health Wards in NHS Lothian* approved on 9 July 2020:

“Clinical Pause

Decisions about instigating a period of continuous intervention should be made in a reflective and thoughtful way that engages as many important people as possible.

Prior to the multi-disciplinary decision being made to commence continuous intervention, a period of up to 2 hours should be used to facilitate an assessment of the need for full 1:1 support. This period will allow the team, including the person affected and their supporters and carers, to evaluate the current safety issues and co-produce a plan of intervention to address the issues identified.”

[143] In support of the second recommendation the Crown relied on their submission under section 26(2)(f) in relation to defects in any system of working which contributed to the death.

[144] In support of the third recommendation the Crown relied on their submission under the heading “Meaningful implementation and ongoing audit of the SAER action plan relating to Dr Macrae’s death should continue”.

Response to other participants

[145] In a short reply to the submissions of the other participants, the procurator fiscal depute as an officer of the court re-iterated that the purpose of the inquiry was to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The Crown had discharged its duty in terms of section 20 of the Act to bring forward evidence relating to the circumstances of the death. That enabled the court to discharge its duty in terms of

section 26 of the Act to make a determination setting out the court's findings as to the circumstances relating to the death and setting out recommendations which might realistically prevent other deaths in similar circumstances. While all the participants had a great degree of sympathy for the family and their recommendations, the precautions and defects specified in the Act had to be related to the cause of death. Recommendations 1, 2 and 5, for example, were beyond the scope of this inquiry. The legislation did not permit the court to make such recommendations.

Submissions for Lothian Health Board

[146] Ms Russell adopted her written submissions and supplemented these with extensive oral submissions. She addressed the legal tests relating to inquiries of this nature. She addressed the evidence led.

[147] She referred to the wider context within which staff were working on 17 March 2020. The Craiglockhart ward was an acute mental health ward. It was a complex, high risk environment. It was busy and stressful, with the additional pressure of impending closure to visitors due to Covid.

[148] The Health Board's position was that the handing in of the noose and the risk it presented was adequately assessed and responded to by Radoslaw Rzeznicki allowing Dr Macrae to spend time outwith the ward with Christopher MacRae, rather than putting her on constant observations. Lothian Health Board acknowledged that there were issues relating to communication between staff following the handing in of the noose: Radoslaw Rzeznicki accepted that he should have noted what

Christopher MacRae had told him about the noose. Radoslaw Rzeznicki assumed Mieke Woodbridge would note the incident in TRAK: Mieke Woodbridge said the incident was not reported to her.

[149] In oral submissions counsel said that the Health Board recognised that Radoslaw Rzeznicki should have carried out a search of Dr Macrae's room, that he should also have communicated the handing over of the noose to staff on the ward and that it should have been recorded on TRAK. The Health Board recognised that there were issues about communication. Radoslaw Rzeznicki should have noted what Christopher MacRae had told him. He should have communicated that to other staff on his shift and to those coming onto the night shift. Counsel submitted, however, that the staff on the ward did know there were concerns about Dr Macrae's presentation despite the lack of communication from Radoslaw Rzeznicki.

[150] The Health Board's position was that there was adequate observation by ward staff. Ms Russell referred to the additional check on Dr Macrae at about 8.40pm by nurse Joanne Compton. The decisions about observation level and the risk were within the range of reasonable clinical decisions. The continuation of general observation was appropriate given the presentation of Dr Macrae during her admission to the ward. She had suicidal ideation.

[151] Reference was made to the evidence of Dr Murray. Dr Macrae's illness was extremely complicated. She has severe recurrent schizo-affective disorder. The presentation of that disorder was extremely complicated, and the risk was ever

changing. Dr Khan confirmed that. The only patient of his who had committed suicide suffered from the same disorder. It was a difficult disorder to manage and treat.

[152] The Health Board's position was that while placing Dr Macrae on constant observation and searching her bedroom might have prevented her death, the risk she presented on 17 March 2020 did not necessitate an escalation from general observation to constant observation. Although there were individual instances where communication could have been better and where record keeping could have been more thorough, these did not amount to defects in the system of working which contributed to Dr Macrae's death.

[153] Counsel for the Health Board referred to the SAER and the steps taken to implement the recommendations. Lothian Health Board recognised that 22 recommendations was a high number of recommendations for a SAER. Counsel referred to the Person Centred Audit Tool, TRAK, training, enhanced communication at handovers, the introduction of the Safe Care tool to allow every registered nurse in Scotland access to safety briefs, handover information and daily huddle, the *Standard Operating Procedure: The Practice of Continuous interventions in Mental Health Wards in NHS Lothian* which introduced inter alia the "clinical pause", the ongoing work relating to care plans, the imminent introduction of the Patient Centred Care Plan which will be bespoke for mental health cases and available on TRAK, the recent employment of staff to ensure documentation was at the expected standard, and the audit processes. The Improvement Plan which emerged following the SAER is monitored for compliance.

[154] Counsel in her written submissions responded to whether previous suicide attempts were appropriately recorded and easily accessible to medical staff involved in the treatment of a patient (issue (vi) in the issues for the inquiry). She referred to Dr Murray's evidence about the volume of documentation and the demands of clinical practice. Dr Murray had read previous discharge summaries and letters from outpatient care. It was not possible for her to review every entry from every profession. She had not seen evidence of a significant suicide attempt.

[155] Counsel submitted that no formal recommendations should be made by the inquiry. The SAER had made a large number of recommendations, there was an Improvement Plan and work was being done to implement these.

[156] Counsel responded to the written submissions of the other participants. She considered the Crown's four proposed precautions. The Health Board did not accept that Dr Macrae's observation levels should have been raised to constant observation. It was reasonable for her to remain on general observations, given her fluctuating presentation of suicide ideation. There was evidence that observation had been increased, with checks at 8.10pm and 8.40pm. Lothian Health Board accepted her room should have been searched for ligatures. Lothian Health Board accepted that the communication of voiced suicidal ideation and the presentation of the ligature should have been recorded in Dr Macrae's medical notes. It should have been communicated to other staff. The Health Board's position was the Mhairi Tennant should not be criticised: it was up to Radoslaw Rzeznicki to make the entry in the records. As regards the proposal to record suicidal risk assessment and management in weekly reviews, the

Health Board's position was that this would not have changed how Dr Macrae was treated or managed. Dr Murray and other witnesses had given evidence that they were aware of Dr Macrae's presentation, and that this included a fluctuating risk of suicide. The majority of patients in Craiglockhart ward had had previous suicide ideation or attempts. Dr Murray's evidence was that Dr Macrae was assessed every day.

[157] In response to the Crown's submission that there was a defect in the system of work arising out of Dr Macrae's medical records from different health boards not being collated in the one place and leading to a lack of awareness of previous suicide attempts using ligatures, counsel referred to Dr Murray's diligence in reviewing the records, to Dr Murray having a good understanding of Dr Macrae's condition and the fluctuation of it, and to Dr Macrae's treatment having been appropriate.

[158] In response to the Crown's submission about the completion of the safety brief of 17 March 2020 four weeks after the death of Dr Macrae, counsel advised that the Health Board's position was that the acute mental health ward was and is a challenging one for staff to work in and this was heightened at the time of Dr Murray's death due to impending Covid restrictions. The Health Board accepted that retrospective entries were not best practice, and there was evidence to reflect that. The Health Board accepted that it would have been better for the safety brief to have been completed at the time.

[159] Counsel for the Health Board then turned to the Crown's recommendations. The clinical pause had already been introduced, so that part of the first recommendation was not required. Work was being done on the accessibility of records and there was no

requirement for a formal finding as sought in the second recommendation. Evidence was led about the work done to implement and audit the SAER and about financial constraints and there was no need for a formal recommendation.

[160] Counsel had no response to make to the submissions for Radoslaw Rzeznicki.

[161] In response to the submissions by the family, counsel submitted that it was not appropriate for the inquiry to make recommendations 1 and 2. Counsel referred to her previous submission, which covered recommendation 3. With recommendation 4, the inquiry had heard evidence about the audit system and the development being undertaken specific to mental health services. With recommendation 5, police and NHS resources were stretched. It was not appropriate for this inquiry to make this recommendation which has resource implications. With recommendation 6, evidence had been led about “daily huddles”. The recommendation had resource implications, and resources available to clinical services in Scotland were stretched. With recommendation 7, there was evidence that patients and their families were now involved in care plans. Work is in place to develop care plans and service delivery. There was training and guidance to assist with the accurate recording of information. With recommendation 8, it was clear from the evidence that each patient had a key worker. There was a clear line of management. With recommendation 9, for events such as a noose being handed in now, a clinical pause would immediately be implemented. There were policies in place for this. With recommendation 10, the Crown submission referred to external auditing. It had been tried and tested and was not the best way forward. There was a robust audit system in place and it was

continuously reviews and developed. With recommendation 11, Andrew Wills had given evidence of the cost across Lothian Health Board. There was no funding for it. With recommendation 12, there was evidence of clearly defined roles and structures within NHS Scotland. Witnesses referred to professional standards. There was a continuous process of measuring and improving quality. With recommendation 13, it was not the purpose of an inquiry to deal with internal disciplinary decisions. With recommendation 14, the SAER and action plan had been lodged and spoken to. An inquiry is different from an internal review. This recommendation would change the procedure of an inquiry. With recommendation 15, it is not the purpose of the inquiry to do this.

Submissions for Radoslaw Rzeznicki

[162] The solicitor adopted his written submissions. Radoslaw Rzeznicki accepted and supported the Crown recommendations.

[163] The solicitor restricted his submissions to Radoslaw Rzeznicki's involvement and the issues touching on him. The submissions focussed on reasonable precautions and on defects in any system of working. He addressed the suggested reasonable precautions in reverse order.

Suicidal risk assessment/management should have been recorded in weekly reviews.

[164] This did not directly relate to Radoslaw Rzeznicki because he was not involved in the weekly reviews. However it raised a collateral but important matter, namely that

Radoslaw Rzeznicki was not aware of Dr Macrae's previous history of attempted suicide. Others, including Dr Murray, were similarly unaware. There was a defect in the system of working.

The communication to Radoslaw Rzeznicki of Dr Macrae's voiced suicidal ideation and presentation to Radoslaw Rzeznicki of a ligature made by Dr Macrae should have been recorded in Dr Macrae's medical records.

[165] Radoslaw Rzeznicki accepted that he should have recorded his conversation with Christopher MacRae in Dr Macrae's TRAK records and not assumed that Mhairi Tennant would do that.

A search of Dr Macrae's room for ligatures.

[166] Radoslaw Rzeznicki accepted that he should have carried out the search with the help of a colleague, and that he could and should have done it before the end of his shift.

[167] The evidence led indicated that the ward was busy and staff were under pressure. When Christopher MacRae spoke to Radoslaw Rzeznicki and handed over the ligature and asked him to clear Dr Macrae's room of other ligatures, Radoslaw Rzeznicki agreed to do so. Radoslaw Rzeznicki was immediately distracted by another patient and went to deal with her. It was accepted that a search might realistically have found Dr Macrae's scarf and that her death might realistically have been avoided.

[168] Radoslaw Rzeznicki spoke to Mhairi Tennant who agreed that it was appropriate for Christopher MacRae to take Dr Macrae off the ward for a walk by the lake, but Radoslaw Rzeznicki accepted that more should have been done.

[169] Dr Macrae had been admitted to the Craiglockhart ward due to severe recurrent schizo-affective disorder, a condition which can be difficult to manage in terms of risk. She could be a challenging patient at times. The solicitor did not mean this as a criticism, but it meant that robust systems needed to be in place.

[170] Dr Macrae had previously voiced suicidal ideations. Sometimes she had said that particular treatment would make her suicidal. On a previous occasion when she had said she was suicidal she explained that she was frustrated with the system rather than suicidal. She had previously telephone Christopher MacRae and told him she had a noose but none was found on searching her room, and she said she was not suicidal. Deciding what weight to attach to such statements involved an element of clinical judgment. In those circumstances the fact that Radoslaw Rzeznicki was unaware of previous suicidal attempts became critical.

An increase in Dr Macrae's observation levels to constant observation

[171] It was accepted that at the very least there ought to have been increased observation. The question of the extent of observation levels was nuanced, as the constant presence of someone else might not be conducive to the patient's mental health. Mhairi Tennant had felt concerned about Dr Macrae but she preferred the least restrictive option which was to allow Dr Macrae go out with Christopher MacRae and

see how she was on her return, rather than putting her on constant observation immediately.

Defects in any system of working

[172] The solicitor submitted that a recommendation and reasonable precaution may be to have a functionality in TRAK which alerted clinicians to potential risk factors such as previous suicide attempts.

[173] Radoslaw Rzeznicki gave evidence that there was no note of Dr Macrae's previous suicide attempts in 2018 within her risk assessments, which is where clinicians looked due to time constraints. There was a note from 12 July 2018 relating to her admission to Accident and Emergency but it was not easily accessible.

[174] TRAK lacked the functionality to alert clinicians to potential risk factors such as previous suicide attempts, but the system available in Greater Glasgow and Clyde had a functionality alerting clinicians to potential risk factors.

[175] In oral submissions the solicitor addressed some of the recommendations of the family in his capacity as officer of the court rather than as Radoslaw Rzeznicki's solicitor. Recommendation 1 was not within the court's power to grant. It was a matter for primary legislation. Recommendation 2 was outwith the scope of the inquiry as it related to the police. Regarding the Health Board, the court might like to comment on how thorough the SAER had been, and that if other health boards required a SAER they might like to use the SAER as a model. Recommendation 3 was outwith the scope of the inquiry as it would require evidence about logistics and costs. Recommendation 6 was a

resourcing issue. The court would have to have heard evidence as to whether it was feasible or realistic. The evidence was not available in this inquiry. Recommendation 9: there might be dangers in trying to legislate for this because of the enormous number of events possible. The recommendation appeared attractive, but quite a lot of cover was provided by bank staff.

Submissions for the MacRae family

[176] The family adopted their written submissions and each made oral submissions referring to the written submissions and to the submissions of the other participants. The family made 15 recommendations. It is important that their written submissions are recorded in this determination, standing the family's high level of knowledge of the issues relating not only to Dr Macrae but also to hospital procedures and audits. Their experience and recommendations as a family of having suffered the loss of Dr Macrae and their participation in the whole process since then is valuable. Many of their recommendations are outwith the scope of this inquiry.

Written submissions (supplemented orally by Neil MacRae)

[177] There was evidence before the inquiry of pervasive systems failures which remained unaddressed despite the conclusions of the SAER with its unprecedented total of 22 recommendations. There was also evidence presented of failure of individuals to meet expected professional standards. Commitments made to the family by representatives of NHS Lothian and the Royal Edinburgh Hospital were not

subsequently implemented and no official records were made of these meetings. That had a bearing on whether future incidents of a similar nature might be prevented.

Nursing staff failed to take any appropriate action when presented with evidence of clear suicidal ideation and intent. At least one individual introduced a retrospective entry in the electronic notes. There was also clear evidence of multiple deficiencies in ward, hospital, board and system-wide practices and protocols.

Recommendation 1: An inquiry should automatically be mandated for the fatality of any individual while detained under the Mental Health Act to bring all such deaths under the same standards at present applied to prisoners under the law.

[178] The inquiry uncovered numerous steps where there appeared to be an absence of clear accountability or procedural urgency despite the death of an individual who had been legally detained while in such detention.

Recommendation 2: Police and internal investigations of fatalities should meet uniform standards and timing irrespective of the location or apparent circumstances of the fatality.

[179] The evidence identified delays of as long as several years in the identification and interview of relevant witnesses for the police investigation. Christopher MacRae was only questioned 18 months after the death. It was not obvious that the investigation undertaken in response to an unexpected death of a person who had been legally detained met the standards expected for any other such unexpected death.

Recommendation 3: A universal electronic medical record must be available for all NHS Scotland patients across all areas including mental health.

[180] The evidence highlighted the absence of any rigorous electronic medical record system. Access to documentation of Dr Macrae's prior suicide attempts (even by the consultant staff who had cared for her on that occasion and on prior admissions) was not evident even after her death.

Recommendation 4: Explicit standards for documentation (including content and timing) within all electronic records must be clearly stated and audited by the relevant administrative entities.

[181] Medical, nursing and other staff documentation did not appear to be systematised in any way and there were no documentation standards outlined or audited by the hospital or NHS Lothian.

Recommendation 5: Police investigations should be resourced to readily enable forensic analyses of digital records where these are available.

[182] No forensic examination of the electronic documentation available in this case appears to have been undertaken.

Recommendation 6: Daily ward rounds with consultant staff should be mandatory in all inpatient settings so that mental health patients can be afforded identical levels of supervision and care to that of other inpatient categories.

[183] Typical levels of patient supervision within inpatient mental health services appear discordant with the minimal standards applied in other inpatient settings with similar morbidity or mortality risk for the patients such as internal medicine or surgery.

Recommendation 7: Ward staff should be mandated to involve patients in their care plans as well as any next of kin (with the permission of the patient).

All planned or unplanned meetings between responsible clinicians, chief nurses or named nurses and a patient or their next of kin should be accurately recorded immediately after such meetings.

[184] Both Dr Macrae and Christopher MacRae made repeated attempts to become more actively involved in her care plan, requesting several meetings with Dr Murray and chief nurses, none of which was properly documented or acted upon. Similar issues had been identified during Mental Welfare Commission for Scotland visits to Craiglockhart ward in 2022 and 2024, and recommendations were made. There have been at least two subsequent deaths in the hospital since 17 March 2020.

Recommendation 8: Explicit definition of the responsibility chain as well as training and enforcement of this chain (legal, medical, infrastructure, etc) must be available for each unit in NHS Scotland.

[185] Reference was made to evidence suggesting a lack of clear line of sight responsibility and to staff operating independently. That was a matter of concern with vulnerable patients who were mandated to receive care.

Recommendation 9: Mandatory protocols for discrete classes of event should be implemented in order to ensure that the management of critical clinical issues is not dependent on the capabilities or whims of the particular individuals available, but rather is based on objective criteria. In the absence of any rigorous professional culture within the relevant groups, formal minimal standards of care and performance should be put in place for nursing, medical or other staff within the Royal Edinburgh Hospital and NHS Lothian Mental Health Services.

[186] There appeared to be a lack of awareness among nursing and medical staff of their personal and collective responsibilities. For example there were no efforts made to document the noose, contact others for advice, increase observation levels or change management of the patient.

Recommendation 10: Explicit internal and external auditing procedures should be put in place to ensure that the Board's implementation of remediation measures has been

successful and that when deployed that each of these interventions have adequately addressed the underlying problems.

[187] Many of the deficits identified in the internal inquiry had been identified in the past and “solutions” had been deployed, yet these deficits remained and “near misses” or outright failures continued to occur prior to Dr Macrae’s death and have continued since her death and the completion of the SAER and its recommendations. Previously highlighted issues were identified again as active problems by the visits in March 2022 and February 2024 by the Mental Welfare Commission for Scotland.

Recommendation 11: Where a requirement has been identified through an environmental ligature risk assessment of doors within acute patient wards, NHS Lothian and other Health Boards in Scotland should immediately commence the prioritised replacement of doors within wards where the most vulnerable patients are being treated.

[188] All treatment delivered under the Mental Health (Care & Treatment)(Scotland) Act 2003 must follow ten principles, known as the Millan principles. Two of these principles are particularly prominent in the consideration of environmental ligature risks: Benefit and Reciprocity.

[189] Benefit - Any intervention under the Act should be likely to produce for the patient a benefit which cannot reasonably be achieved other than by the intervention. Where patient liberty is being withdrawn through compulsory detention on hospital,

there is a duty of care and a requirement by law to ensure that care and treatment is safe and effective.

[190] Reciprocity - Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate service. If a patient is expected to comply with care and treatment in hospital against their will, there is an obligation on the service to ensure that care and treatment reflects best standards in safe and effective care and treatment.

[191] Evidence was submitted to the SAER that acknowledged that environmental ligature risk assessments had not been completed, including that of the door of Dr Macrae's bedroom. The SAER noted that the "Ligature Point Inspection and Risk Assessment" last carried out by the ward senior charge nurse and charge nurse on 20 February 2019 and submitted with the Health and Safety Report in September 2019 had identified the presence of ligature points (namely the doors) within Dr Macrae's bedroom as high risk. The "existing control measures" section for that room were incomplete but had been filled in for other rooms on the form.

[192] The inquiry also heard evidence that despite staff reports to the NHS Lothian Board including that to the Finance and Resources Committee on 17 January 2022, there had been no door replacement across the NHS Lothian estate to address this requirement. The report noted the urgent requirement to develop the business case and the availability of:

“an evidence base for the effectiveness of this design and technology in assisting staff to prevent death from suicide in other NHS Boards in Scotland adopting these products”.

The report states that:

“local risk assessment has identified that replacement is the course of action indicated. This alone will not prevent attempts at self-asphyxiation or hanging taking place but will go a significant way to prevent permanent harm or death from such events.”

The cost to replace each door at the time of the report was estimated as £10,500 per door.

[193] There was evidence that the cost of the doors would exceed £8 million across the NHS estate. The NHS officers had made their own case for this, and the recommendation just reflected that.

Recommendation 12: Clear responsibility for leadership at all levels within NHS Scotland to ensure that current professionally-defined standards of care are not only met but are seen to be met, through enforcement of such standards, including disciplinary action in the event of failing to meet such standards. A continuous process of quality measurement and quality improvement should be put in place to assure the public that everything possible is being done by the taxpayer funded system to avoid unnecessary adverse outcomes.

[194] Reference was made to the evidence and inferences to be drawn from it.

Witnesses had appeared to acquiesce in the status quo while acknowledging obvious and recurring inadequacies.

Recommendation 13: Guidelines and thresholds for referral to the Nursing and Midwifery Council or any other regulatory body should be published in full. Transparency of disciplinary action (or lack thereof), along with reasoning for any such decision, should be extended to the next of kin when a fatality in hospital care meets the threshold for an inquiry under the 2016 Act.

[195] No staff members involved in Dr Macrae's care appear to have been subjected to any disciplinary action as a result of the circumstances surrounding her death, despite individual failings identified by the SAER, Lothian Health Board and in some cases the individuals themselves.

Recommendation 14: All prior internal and external inquiry evidence, deliberations and recommendations, including SAERs and related interviews, should automatically be included in the evidence at any inquiry under the 2016 Act.

[196] From the evidence submitted to the inquiry, it became clear that not only were many of the recommendations of the SAER still to be implemented, but also that some of the initial witness reports to the SAER were quite definitive with regard to the circumstances of Dr Macrae's death. This evidence was subsequently obfuscated by time or through reframing in light of subsequent events, with the net effect of obscuring key failings in the systems in place at Royal Edinburgh Hospital, NHS Lothian and beyond, as well as potentially undermining the integrity of the inquiry. Given the public's funding of all of these sources of evidence and inquiry, and the overwhelming public interest, it would seem invidious not to have all prior reports automatically

included for the inquiry and indeed as a matter of course in all such inquiries. During the inquiry, the family requested that the evidence gathered for the SAER be made available to all parties as it became evident that it was so heavily relied upon as a reliable source despite the report itself containing only redacted versions of the different members of staff referred to within it. As a result a considerable amount of court time was spent questioning witnesses in order to identify members of staff referred to within the report. Despite requesting specific elements of the SAER during the inquiry the family only received two documents produced for the SAER after the conclusion of evidence in the inquiry, namely the interview transcript of Mhairi Tennant and the TRAK note of the Junior Doctor Carla Julia Vilella. On receipt of this information, the family submitted their rationale for the wider SAER documentation to be made available to the inquiry.

[197] The whole of the documentation for the SAER was in one folder on the NHS server and could have been made available. The family were not judging whether that evidence was preferable to, or more robust than, the evidence at the inquiry, but it should be available at an inquiry. That material had been gathered 4 years before the inquiry, and before any of the key witnesses had had the opportunity to see the other evidence, of which the most important document was the official account of the incident as set out in the SAER, which was shared with them.

[198] The family also relied on their separate submissions relating to the interlocutor of 23 October 2024 about the evidence of Mhairi Tennant and the junior doctor. They highlighted their concerns about the credibility and reliability of Mhairi Tennant given

that some of the evidence she gave in court conflicted with what she had told the SAER. They referred in particular to the contradiction about whether Mhairi Tennant knew Dr Macrae had gone off the ward with Christopher MacRae on the day of her death. They referred to the Crown's reliance on her evidence in court that she had been aware and had apparently approved it. They were concerned that her evidence to the inquiry relied on information Mhairi Tennant had acquired since the SAER, including the contents of the SAER report.

[199] They were concerned about the note of the ward round discussion with the junior doctor which appeared to have been prepared by a nurse and which erroneously referred to Dr Macrae having ECT, and was referred to at page 10 of the SAER. The Health Board understood that in fact the junior doctor had not seen Dr Macrae and had only recorded the latter part of the discussion. The family were concerned to find out when Dr Macrae had last been seen by a doctor.

Recommendation 15: There should be comprehensive restructuring of the leadership and consultation with professional bodies to fully re-professionalise the culture, behaviours, performance standards and responsibilities of each of the relevant professions within the Royal Edinburgh Hospital and NHS Lothian Mental Health Services.

[200] The inquiry heard consistent evidence of both individual, professional, unit and system-wide failings in the care which Dr Macrae received both on the day of her death, and over the course of her 41-day admission. The retrospective entry in the documents

after Dr Macrae had died suggested there had been an attempt to cover up elements of what had happened. The professional culture at Royal Edinburgh Hospital and with NHS Lothian Mental Health Services appears to have deteriorated and requires comprehensive re-evaluation and redesign. Similar concerns were explicitly outlined by the original SAER. It is evident that at present, without legislation for every conceivable situation, traditional professional behaviours, performance standards and responsibilities can no longer be assumed.

Oral submissions

[201] The family adopted their written submissions, including their submissions relating to credibility and reliability lodged for the hearing on 4 November 2024. Calum MacRae, Neil MacRae and Christopher MacRae each made oral submissions.

Calum MacRae

[202] Calum MacRae accepted that while it was not possible to legislate for everything, it was important to highlight things that were sufficient to prevent a recurrence. He accepted that his recommendations would not necessarily be implemented due to resource implications.

[203] Calum MacRae submitted that the objective evidence was that the system failed. Dr Macrae died. As have others on that ward and elsewhere in Scotland. It was important to focus on patients and outcomes.

[204] Calum MacRae referred to there having been a joint minute agreeing evidence, but other evidence coming out in the inquiry subsequently that was important. He was very impressed with the SAER process. The testimony gathered for the SAER was the only testimony close in time to the death. It was important that evidence was collated at the time. That should have been available to the inquiry without being mandated. It was important to investigate events relating to people in care of the state in a uniform manner.

[205] It was clear that Radoslaw Rzeznicki did communicate with others, but nothing happened and nothing was documented. Some of the issues relating to him had been singled out by counsel for the Health Board, when it was clear that there were multiple individuals involved and yet nothing actually happened.

[206] One-to-one observation was standard. It was standard in NHS Lothian in 1988 when Calum MacRae worked there. Elderly patients had one-to-one observation: why did a patient with a noose not have that? There appeared to be a misallocation of resources. That might be relevant to the inquiry's determination.

[207] Calum MacRae did not envisage mandated protocols for every situation. He referred to his recommendations 9 and 15. Care should not depend on who was on the roster. In the past the professionalism of individuals could be relied upon, such that mandated minimum standards were not required. In cardiology there were several thousand guidelines for management of patients. But if a patient was not put on appropriate observation when a noose was handed in in one of the best psychiatric hospitals in Scotland, then mandated protocols were required.

[208] There was clear evidence that some element of the SAER had not yet been implemented, and that some were only implemented in 2024. That suggested that the internal audit was inadequate.

[209] Access to documentation was of limited value if there was no documentation of a noose and if records were written up retrospectively.

[210] Lothian Health Board is one of 19 health boards in Scotland. That was exactly why standardisation was required.

[211] The family did not want to be over prescriptive, but Lothian Health Board was focussed on process as could be seen from the SAER. That meant auditing was required to assess implementation.

[212] A patient should be seen daily by a psychiatrist. The staff "huddle" was insufficient to care for a patient. Nursing and medical staff did not speak with each other except at the morning "huddle". In future they should speak to each other.

Neil MacRae

[213] Neil MacRae made submissions on the credibility and reliability of some of the witnesses, and addressed the written submissions for each participant.

[214] The family had concerns about the credibility and reliability of some of the witnesses. It was hard to understand how Radoslaw Rzeznicki did not know who he had passed the noose to but Mhairi Tennant remembered being passed the noose and giving Radoslaw Rzeznicki advice that Dr Macrae could go out with Christopher MacRae and that staff should check in with them on their return to the

ward. There was an issue with Mhairi Tennant's credibility and reliability when her evidence in court was contrasted with the record of her interview to the SAER on 27 May 2020.

[215] The family were concerned that Mhairi Tennant's evidence was informed or advised by reading other evidence subsequent to her death, most likely the SAER report. They were concerned that multiple witnesses had had access to it prior to the inquiry.

[216] The family were surprised that they were the participants who asked for Mhairi Tennant to give evidence. She was the most senior member of staff when the noose was handed in. The junior doctor had not seen Dr Macrae that day. They had expected other participants to have been just as anxious to hear her evidence.

[217] The family were disappointed that they had not been given the transcripts of the interviews given by other specified witnesses including Radoslaw Rzeznicki at the SAER as a bare minimum.

[218] Neil MacRae challenged parts of the Health Board's written submissions. The Health Board had submitted that "It should be recognised that this acute mental health ward was a complex, high-risk environment". That was like saying a primary school playground was noisy.

[219] Neil MacRae challenged the Health Board's submissions that Radoslaw Rzeznicki had adequately responded to the risk presented by allowing Dr Macrae to spend time off the ward with Christopher MacRae. He challenged the suggestion that the decisions about observation levels and risk were reasonable clinical decisions. The evidence of Craig Stenhouse and Dr Khan was that more should have

been done. Neil MacRae challenged the Health Board's submissions in relation to Dr Murray's evidence including her evidence that general observation was appropriate. Dr Khan had said that it was the minimum acceptable level. If the Health Board's position was as stated in their submissions, ie that an escalation to constant observation was not necessitated, why then was the clinical pause introduced?

[220] The line of sight responsibility lay with Dr Murray. The family were concerned about day - to - day practice on the ward and at the time Dr Macrae died. There was apparently no communication between nurses and clinical staff outwith the huddle, and Dr Murray was on leave.

[221] The SAER made 22 recommendations. Craig Stenhouse said this was four times the usual number. That in itself was evidence of failings which were pervasive and systemic, rather than isolated and individual. Although significant changes were introduced, there was no evidence about the efficacy of the changes, and much was still to be implemented.

[222] Neil MacRae pointed out that although there was a significant amount of historical information about Dr Macrae's health and hospital admissions in the notes, the only previous suicide attempts were in 2018, which was her last or second last admission.

[223] Regarding the Crown's submissions, the family supported the Crown's proposed recommendations 1 and 2. They supported recommendation 3, but the word "meaningful" was too vague. The recommendation should be more specific by listing the specific actions the Health Board should take from the SAER.

[224] Regarding the submissions for Radoslaw Rzeznicki, the family felt that Radoslaw Rzeznicki seemed in places to be relying on Mhairi Tennant's oral statement as mitigating his actions. Mhairi Tennant's actions did not reduce or remove the obligations and professional conduct that was expected of him.

[225] Neil MacRae also addressed some of the family's recommendations noted above.

Christopher MacRae

[226] Christopher MacRae referred to the Health Board's reference to Dr Macrae previously having made a threat to end her life and no noose being found when her room was searched. The witnesses appeared to be trying to use this as a mitigating factor as to why her threat was not taken more seriously. Even though no noose was found, ligatures were likely to have been found. Dr Macrae had both a belt and a scarf and this was known to staff. She always wore her scarf but was not wearing it that day. The fact that there was no mention on TRAK of these items being removed suggested that the room may not have been searched, or not searched thoroughly.

[227] The Health Board's submission that there had been two extra checks on Dr Macrae after Christopher MacRae had concerns was incorrect. The Health Board had also submitted that this was sufficient. Joanne Compton checked Dr Macrae for the first time at about 8.45pm. Susan Paterson only participated in the 8pm and 9pm checks. Dr Macrae was discovered at 9pm. Susan Paterson said the first check she did was while Dr Macrae was still in the dining room with Christopher MacRae. That is because

he had not left until after 8.10pm after saying a prolonged goodbye to Dr Macrae. There was only one additional check.

[228] Craig Stenhouse was asked if any valuable information could be taken from a safety brief completed after a death and he said “I just think it looks really bad to have gone back ... cover something up really ... it should always be avoided”. A safety brief only serves a purpose where a patient is alive. Retrospective completion suggested it was with a view to future investigation into the death.

[229] The Health Board’s response to the family’s recommendation 7 (involvement of patient and family in care plans) was that patients and families were involved in the care plans. However the Mental Welfare Commission report of an unannounced visit to Craiglockhart ward on 5 February 2024 noted that there had been limited progress in promoting the participation of individuals in their care planning and that the majority of individuals they spoke with were unaware they had a care plan.

[230] The Health Board’s response to the family’s recommendation 8 (explicit setting out of the chain of responsibility for patient care) was that it was clear from the evidence that each patient had a key worker and there was a clear line of management. However although there was evidence about a key worker, no one other than the keyworker herself was able to say who the keyworker was. There was no clear line of management.

Discussion and conclusions

[231] My decision is in two parts. In the first part I assess the witnesses. That allows me to identify the evidence I can rely on. That evidence forms the basis for my other

decisions. In the second part I consider the submissions of the participants relating to the matters I require to address in terms of the legislation.

Assessment of witnesses

[232] There are two aspects to the evidence of any witness, credibility and reliability.

A credible witness is an honest one, doing his best to tell the truth. But a witness may be doing his best and yet be unreliable because, for example, his memory may not be accurate. Before a court can accept a piece of evidence from a witness, it must be satisfied that it is honest and that the evidence is reliable. In doing that the court can look at the content of the witness's evidence, compare what they say with other evidence in the case, and consider how they gave their evidence. Where there are conflicts between the evidence of different witnesses, the court can accept one witness's evidence and reject another's. Where there are conflicts in a single witness's own evidence, the court can accept part of it and reject part. Witnesses are all judged the same way, regardless of their professional qualifications.

[233] Neither the procurator fiscal depute nor counsel for the Health Board took issue with the credibility and reliability of witnesses. The family had concerns about Radoslaw Rzeznicki and Mhairi Tennant.

[234] I found Christopher MacRae to be an impressive witness. He was highly articulate, intelligent and knowledgeable. He passed on all the messages from Dr Macrae to staff. He had a very close relationship with Dr Macrae and understood her very well. He was knowledgeable about her psychiatric illness, having lived with her

for many years. He knew the signs to look out for. He cared for her very much. He was quite involved in Dr Macrae's care from her last admission to hospital on 5 February 2020 until her death. He visited her at least once a day in the Craiglockhart ward. He had a clear recollection of events on 17 March 2020. He was credible and reliable.

I accept his evidence in its entirety.

[235] Joanne Compton impressed me as a witness. She had a good recollection of the events of 17 March 2020. She was credible and reliable. She also struck me as a kind, caring and compassionate nurse. Joan Learmont impressed me as a witness. She too had a good recollection of the events of 17 March 2020. She was credible and reliable, and caring. Susan Paterson also impressed me as a witness, with a good recollection of the events of 17 March 2020. She was credible and reliable, and caring. They were all nurses on the night shift, looking after Dr Macrae. The SAER also noted the good clinical care and team working they showed in their attempts to resuscitate Dr Macrae and to preserve her dignity, while also providing ongoing care to the remaining patients on the ward.

[236] Caron Thompson (staff nurse) and Gordon McGregor (co-ordinating charge nurse on the night shift which commenced on 17 March 2020) were also credible and reliable witnesses.

[237] Dr Khuram Khan was called as an expert witness to comment on the treatment of Dr Macrae including her medication. He has been a Consultant Forensic Psychiatrist for 12 years. Dr Khan was an impressive witness. His evidence was thoughtful and careful. He had the benefit of listening to Dr Murray's evidence in court and was able to judge

her actions. He had a very good understanding of the issues. He explained his reasons clearly. I accept his evidence and conclusions. I also accept Ommar Ahmad's evidence as credible and reliable. He gave evidence about the drugs prescribed to Dr Macrae by Dr Murray. He was properly qualified to give evidence, and his evidence assisted the inquiry. Dr Murray was Dr Macrae's consultant psychiatrist. She has been a consultant psychiatrist for 18 years. Her decisions about treatment were supported by Dr Khan. Her decisions about medication were supported by him and by Ommar Ahmed. None of the participants challenged Dr Murray's credibility or reliability.

[238] Craig Stenhouse is the chief nurse at the Royal Edinburgh Hospital. He was an impressive witness. He had a detailed knowledge of all matters, and in particular the SAER and the steps taken to implement its recommendations. He was well-prepared and able to answer any question he was asked. He was open and honest. He did not try to hide anything. He candidly accepted that many mistakes had been made. Mike Reid and Andrew Wills were similarly very knowledgeable and well prepared witnesses. They were all credible and reliable.

[239] I have concerns about the credibility and reliability of Radoslaw Rzeznicki. He was reluctant to accept that he had told Christopher MacRae that he would take the cord away and carry out a check of Dr Macrae's room for any other ligatures, even when faced with his police statement dated 29 September 2021 the truth of which he had confirmed to the police. He could not remember who Dr Macrae's named nurse was on 17 March 2020, or if it was him. He seemed to make excuses about how busy the ward was and about the impending Covid pandemic. He did, however, accept that he had

made errors of judgment and failed to appreciate the importance of what Christopher MacRae had told him.

[240] I have concerns about the credibility and reliability of Mieke Woodbridge. She completed the safety brief 4 weeks after Dr Macrae's death. She said that her Charge Nurse James Hewat had told her to complete the safety brief. He denied that. She told the SAER that she believed it was not a "legal" document: she did not tell the SAER that her charge nurse had told her to do it. She said that if she had known at the time that a noose had been handed in, Dr Macrae was an informal patient and so her permission to search would have been required. That is incorrect. Dr Macrae was detained under a compulsory treatment order and not an informal patient.

[241] James Hewat's evidence was vague and not helpful. He was unable to answer questions that he should have been able to answer if he had prepared for court and checked the records from that day. He gave evidence that if, as the charge nurse, he became aware of a nurse making an entry in the safety brief after a death, it would be investigated as a potential disciplinary matter. He denied Mieke Woodbridge's claim that he had asked her to complete the safety brief 4 weeks after the death.

[242] I prefer James Hewat's evidence to Mieke Woodbridge's evidence on this point. She gave a different explanation to the SAER. She has more of an interest in not telling the truth about it.

[243] There were concerns about Mhairi Tennant's credibility and reliability.

[244] The family highlighted a discrepancy between her evidence to the SAER on 27 May 2020 and her evidence at the inquiry. She had told the SAER that when the

noose was handed in she advised staff to have 1:1s and that she only found out Christopher MacRae had gone out with Dr Macrae that afternoon when she returned to work the next day and she did not know who had agreed it. Her evidence to the inquiry was that Radoslaw Rzeznicki had reported to her that either Dr Macrae or Christopher MacRae had suggested going off the ward, and Radoslaw Rzeznicki wanted to know if that should be facilitated. Mhairi Tennant's evidence was that she thought that was appropriate as long as Christopher MacRae was comfortable with that. The plan was for Dr Macrae to go off the ward with Christopher MacRae and for a check in with her on her return to assess the risk and make a decision on how to manage it. Mhairi Tennant then ended her shift and left.

[245] Mhairi Tennant gave a one paragraph statement on 18 April 2020. That statement had to be put to her in court by the Crown because she could not remember what happened to the cord or if Radoslaw Rzeznicki had reported Dr Macrae saying that that she was going to use it to end her life. It had to be put to her by the family. She was vague and non-committal about it. She thought she had seen it before but could not remember the context. The statement said "It was my understanding at this point it was agreed Sara could go out with Christopher" (my emphasis): it does not say that she knew that directly from her own knowledge. It is consistent with her having been told that they did go off the ward in the days following the death.

[246] In my view this raises a reliability issue rather than a credibility issue. I do not think Mhairi Tennant was lying. The evidence she gave to the SAER was given closer in time to the events of 17 March 2020, which would tend to make it more reliable. She had

also emailed the SAER on 29 June 2020 requesting certain changes to that record. That suggests that she was taking care to be accurate. Her evidence to the SAER that she had not found out until the following day that Dr Macrae had gone out with Christopher MacRae in the afternoon has the ring of truth. She had nothing to gain by lying about that. I think she was just mistaken when she gave her evidence in court. I expect the evidence she gave in court (and which was relied on by Mr Pollock in his submissions) was informed by discussions with colleagues over the years following Dr Macrae's death. I suspect that her short statement on 18 April 2020 was also influenced by general discussion with colleagues. The SAER was a formal process. It was closer in time to Dr Macrae's death.

[247] While the discrepancy raises an issue about her potential reliability as a witness, the factual difference between her accounts is not significant to the issues for the inquiry.

[248] Mhairi Tennant's prior statements were not being used to circumvent the need for evidence at the inquiry. They were being used as a potential challenge to her credibility and reliability. That is a legitimate purpose, if such statements are available. Standing the agreement recorded in the interlocutor of 4 November 2024 it was open to me to prefer her prior statement to her evidence in court, and I have done so.

[249] Several nurses were unable to remember certain things, for example Mieke Woodbridge, Radoslaw Rzeznicki, James Hewat and Mhairi Tennant. I do not know why they did not prepare in advance of giving evidence to the inquiry. I do not know why they did not consult the nursing notes or the notes sent to them following their interviews in connection with the SAER.

[250] The facts I have found established in the Summary come from the evidence of the witnesses I have accepted.

Conclusions in relation to certain issues about which evidence was given

[251] I refer further to the evidence of some of the witnesses below. I have done that to show that evidence was led about some issues and I have reached conclusions about that evidence, but these conclusions have not resulted in a positive finding in terms of section 26 of the Act. Examples include Dr Murray's evidence about schizo-affective disorder, the evidence from Ommar Ahmed and Dr Khan about whether Dr Macrae should have been prescribed the antidepressant Venlafaxine, the evidence about the investigation of doors, and the family's question about staffing levels on the ward on 17 March 2020.

Christopher MacRae's evidence about antidepressants

[252] Christopher MacRae was concerned that Dr Macrae had not been put on an antidepressant, and in particular Venlafaxine. His view was that this had previously worked for Dr Macrae. He meticulously went through all the prescription records with the pharmacist Ommar Ahmed, illustrating that on almost all other occasions of ill health Dr Macrae had been prescribed an antidepressant as well as an anti-psychotic. He explored the issue with Dr Murray and Dr Khan. Ultimately he did not insist on his challenge to the medication prescribed. Standing the evidence of the experts, he was correct not to do so.

Dr Fiona Murray's evidence about Dr Macrae's condition and treatment

[253] Dr Murray was Dr Macrae's consultant psychiatrist. She has been a consultant psychiatrist for 18 years. Her decisions about treatment were supported by Dr Khan. Her decisions about medication were supported by him and by Ommar Ahmed. Although the family cross-examined Dr Murray about medication, those challenges were not maintained in submissions.

[254] Dr Macrae had a diagnosis of schizo-affective disorder. That has two broad components: psychotic symptoms and mood symptoms. The psychotic symptoms included positive symptoms (such as delusions and hallucinations) and negative symptoms (such as lack of energy and lack of motivation. The mood symptoms could be manic symptoms (such as being grandiose, over-talkative, over-energetic and lacking in insight) and depressive symptoms (such as pervasive low mood, poor sleep, lack of appetite and sometimes suicidal thoughts). Schizo-affective disorder is a chronic condition but there can be acute relapses.

[255] Before meeting Dr Macrae, Dr Murray went through her notes for information on her past treatment. There was a considerable volume of documentation. It was only practical for her to read letters such as clinic outpatient letters and discharge summaries from inpatient care. She had not seen documentation of a significant suicide attempt, though she was aware of ideation. She found references in the TRAK notes later.

[256] During this and previous admissions Dr Macrae had told staff about suicide ideation and then said she was not suicidal. She had contacted Christopher MacRae and

told him she had a noose, but on searching her room none was found. Sometimes she said various aspects of her treatment plan made her suicidal. At times she said that if she remained an in-patient under the Mental Health Act she would be suicidal.

Sometimes she was just frustrated with the system. All of what Dr Macrae said was taken seriously. Staff sought to understand her expressions of suicidality and not simply react by imposing more restrictions on her.

[257] Records from other health boards were not easily accessible. Dr Macrae had been sent to Inverclyde in 2018 because there were no beds in Edinburgh, which made it difficult to find out what had happened during that admission. Typically there was a transfer letter from a junior doctor, but access to fuller records would be of more assistance.

[258] Dr Murray recommended that there should be a process to highlight aspects of a patient's past care so that consultants had access to it. She also recommended the sharing of information across health boards.

Ommar Ahmed's evidence about antidepressants

[259] Ommar Ahmed has been a pharmacist since 2006, and was working in that capacity in the Royal Edinburgh Hospital in March 2020. He had been asked by Dr Macrae's medical team to prepare a medication history review of the medication prescribed to Dr Macrae. He reviewed her medication for the period from July 1997 to January 2020, and discussed the various prescriptions and effects and side effects Dr Macrae had experienced over the years. Compliance with oral medication had been

a long standing issue. He suggested a depot medication due to previous issues with compliance with medication and discussed possible drugs including Aripiprazole depot medication.

[260] The family cross-examined him about various drugs and the history of the medication Dr Macrae had been prescribed. They ascertained which drugs were anti-depressants and which were anti-psychotics. Ommar Ahmed explained that quite often an anti-psychotic could be used at a lower dose for other conditions including depression. Venlafaxine had been withheld on admission on 5 February 2020 because there was a query about whether Dr Macrae was hypomanic and there was a risk that the antidepressant would push her into mania.

Dr Khuram Khan's evidence about Dr Macrae's condition and treatment including the absence of antidepressants

[261] Dr Khan holds a Bachelor of Medicine and Bachelor of Surgery. He is a Member of the Royal College of Psychiatrists. He has been a Consultant Forensic Psychiatrist for 12 years. He works at the State Hospital, Carstairs. He adopted his report.

[262] Dr Khan was present in court during the evidence of Dr Murray, and was able to comment on the actions she took regarding the treatment of Dr Macrae. Having listened to her evidence he understood her decisions, but that did not change his conclusions. He maintained his conclusions that there were shortcomings in the antecedent phase including the failure to report the escalation of risk presented by the ligature. There was

no smooth flow of information in the acute phase. The team were not aware of previous self-harm incidents. Such incidents were a “red flag”.

[263] Dr Macrae’s disorder was complex, changing, difficult to grasp, and difficult to manage and treat. Schizo-affective disorder is difficult to manage, especially in terms of risk. That is because there is a combination of both schizophrenic symptoms and mood symptoms. The mood symptoms fluctuated between two extremes, from low to high. With low mood there were many dissociative symptoms such as feeling helpless, hopeless and suicidal. With high mood the symptoms included agitation, restlessness, irritability and increased arousal. Sometimes the change from one pole to the other happened very quickly. It was hard to keep pace with that, it led to a change in risk and it was hard to manage. Dr Macrae had a long history of the disorder. She also struggled with insight into it, with finding coping strategies, and with compliance with treatment.

[264] The only patient Dr Khan had lost to suicide had had schizo-affective disorder. It was a difficult disorder to manage and keep the patient safe, especially where there was a lack of compliance on the part of the patient, lack of insight and a lack of trust in health services.

[265] Dr Khan was quite properly cross-examined by the family. Their concerns related to the medication prescribed and whether Dr Macrae also had depression.

[266] Dr Khan’s opinion was that Dr Macrae’s symptoms were more in line with hypomania and delusional symptoms than depression. The introduction of an anti-depressant would have been counterproductive.

[267] For a diagnosis of depression three core symptoms needed to be present: subjectively mentioned low mood objectively observed; subjectively mentioned lethargy objectively observed; and anhedonia. In addition there could be many other symptoms such as hopelessness and weight problems.

[268] Dr Murray was right not to treat Dr Macrae with antidepressants.

Antidepressants would have exacerbated her irritability, and she would have had suicide ideation if that had not already been present. No psychiatrist would have started her on antidepressants. That would have exacerbated her hypomania and made her more delusional, with poor consequences. It would have been harmful to her.

Venlafaxine was not appropriate where Dr Macrae had schizo-affective disorder in the hypomanic phase. Although Dr Macrae had always been treated with both antipsychotics and antidepressants over a 25 year period, other than on one occasion in 2004, it was not appropriate to prescribe antidepressants during this admission.

Dr Murray had assessed her mental state. She presented as aroused, delusional and agitated rather than subdued, solemn and depressed. It was the aroused state which had to be controlled first. If there had been a depressive illness that would have shown more clearly once the aroused state was treated with Aripiprazole. Dr Khan could not say that there was no depressive illness, but it was not manifesting itself. There was a high likelihood that anti-depressants would have exacerbated her symptoms to her distress. Her mental state on this admission was more elevated than depressed. It was a calculated decision by Dr Murray to treat with antipsychotic medication first.

[269] Aripiprazole depot medication was the appropriate option to treat Dr Macrae. She had a history of non-compliance with medication, and psychiatrists would commonly use the injectable form to ensure compliance and consistency. Dr Macrae had a history of being prone to experiencing side effects, and this medication would reduce the risk of these.

[270] Having regard to Dr Khan's evidence the challenges on medication were rightly not insisted upon.

Craig Stenhouse's evidence about the SAER, expectations of nurses and other matters

[271] Craig Stenhouse has been the chief nurse and at the Royal Edinburgh Hospital since March 2024. Before that he was the deputy chief nurse, since November 2019. Before that he was the clinical nurse manager for the mental health rehabilitation service for 4 years. He qualified as a nurse in 2003.

[272] Craig Stenhouse's evidence began on 5 September 2024 just after 2.00pm and ended at 5.15pm on 6 September 2024. His evidence was detailed and at times technical. Both the Crown and the family examined him at length. There were also questions from the Health Board and on behalf of Radoslaw Rzeznicki. Much of his evidence is in the summary at the start of the determination. I narrate here miscellaneous important parts of his evidence which do not need to feature in the summary.

[273] Craig Stenhouse became responsible for implementing the SAER Action Plan. He had never seen a SAER with 22 recommendations. The usual number was about 6.

[274] In relation to auditing Craig Stenhouse had thought it was preferable if wards did not audit their own work because it would provide a better quality of audit and one that was more objective. They had tried auditing by other wards but it had not worked and compliance fell. There were problems because of a lack of mental health nurses and wards being busier so that the nurses focussed on providing care rather than completing audits. Staff were now auditing their own work again, but compliance had improved. It was the senior charge nurse who audited the notes for those on their ward. One advantage of auditing their own ward was that the senior charge nurse knew the patients and could say whether the risk assessment had been completed properly and if the care plan was relevant. Craig Stenhouse agreed that theoretically it would be possible to link up with another health board in Scotland so that acute mental health wards dealing with a similar type of patient could audit each other. There might be issues with linking up of the systems between hospitals. Although there was no external audit some issues were picked up at Mental Welfare Commission visits.

[275] In the Standard Operating Procedure *Search Procedure as part of inpatient Clinical Care in Mental Health & Learning Disability Services* a functioning noose made from a cord would be classed as a "dangerous item". The guidance did not need to tell staff what do with a noose because staff should know that themselves. It was an acute admissions ward. If Craig Stenhouse had found a noose, he would take it from the patient, speak to the patient and speak to the family, put the patient on constant observations on a one to one basis and search the room. The decision would be made after discussion with the patient.

[276] Dr Macrae was on a compulsory treatment order and was therefore a detained patient, not an informal patient. Her consent to the search of her room was not required. Craig Stenhouse would still have tried to get permission for a detained patient, but he would have searched her room anyway standing the information available.

[277] If Craig Stenhouse had told a family member that he would search a room, he would have done that. He would have spoken to the patient first. Having regard to Dr Macrae's expressed intention, a search of the room was an appropriate action to have taken.

[278] Previously if Craig Stenhouse had had concerns about a patient he would have put them on observations. However research indicated that watching people did not keep them safe, but engaging them did. Healthcare Improvement Scotland's *From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care* published in January 2019 suggested getting a multidisciplinary team comprising for example nursing, occupational therapy, psychology to look at the options and to consider how to engage the patient keep them safe. It referred to "continuous intervention", as opposed to giving a person a particular observation status.

[279] Previously a patient would have been put on "constant observation" (where they could be seen and heard at all times) or "special observation" (where they were within arms reach). They could not be removed from that level of observation unless medical staff agreed. It was very intrusive, particularly on a Wednesday or Thursday because if the patient improved by the weekend they could not be reviewed until Monday.

[280] The new procedure of a “clinical pause” followed by “continuous intervention” is set out in the Health Board’s *Standard Operating Procedure: The Practice of Continuous interventions in Mental Health Wards in NHS Lothian*” and was approved on 9 July 2020.

[281] Continuous observation was reviewed every day. It was a fairer system than the previous system.

[282] The family were concerned that the previous system depended on a single person identifying a deterioration and considering an intervention. The decision to place a patient on constant observations was made by one or two nurses, and a patient could remain on constant observations for some time. Craig Stenhouse said that staffing levels should never have been a factor in determining the level of observation, because additional staff would have been provided from elsewhere in the hospital or from bank or agency staff. If necessary the matter could be escalated to the chief nurse to find an additional member of staff to meet the legal obligation regarding safe staffing levels on a ward.

[283] Retrospective entries made after the death of a patient made it look as if someone was trying to cover something up. They should always be avoided.

[284] The people doing the investigation into Dr Macrae’s death were unable to identify who her last medical doctor was on the day of her death. Dr Murray had been on annual leave. Craig Stenhouse had been given two names but could not find them.

[285] The breakdown in passing on the information and the failure to search the room were probably both an issue relating to process and to the individual.

[286] There had been two suicides in the Royal Edinburgh Hospital since Dr Macrae's death. They were not on the Craiglockhart ward.

Andrew Wills's evidence about replacement doors

[287] Andrew Wills adopted his affidavit and gave oral evidence. He has been the clinical commissioner and advisor for Capital Planning at NHS Lothian since 2015. He is a registered mental health nurse.

[288] He was involved in SAER recommendation 3. It was not possible to remove the door to the bedroom. A door would continue to be a ligature point. However it was possible to buy a fairly new product which went round the rim of the door and alerted staff if there was weight put on it. There were also doors which themselves could measure weight and thus alert staff. Clinical staff were consulted for their views, because there were other issues to consider such as doors being used as a barricade. Companies were invited to demonstrate two products. The option integral to the door was selected and costed. It was expected that it would take 3 months to convert a ward. During that time patients would need to be decanted to another ward. Refurbishment would be required.

[289] The cost of replacing all the doors where they were needed across Lothian mental health estate was around £8 – 10 million. That did not include the cost of decanting. There was no proposal to re-fit some older adult wards, as it was felt that some of the measures relating to ligature prevention could be counterproductive or confusing. St John's Hospital in Livingston has dormitory style wards.

[290] The cost of putting the doors in one adult ward was probably about £500,000 - 600,000 at the time of the quotation, but prices had increased since then. Lothian Health Board did not want to put doors in only one adult admissions ward. Children's wards already have anti-ligature doors and also ligature reduction beds.

[291] Installing the doors would require wards to be closed for a few months. Some wards are operating at over 100% capacity. It would take 18 months to install new doors at the Royal Edinburgh Hospital. The Health Board made a business case to the Scottish Government for capital funding. In December 2023 the Scottish Government advised that they were no longer funding such projects. The existing doors continue to meet the required standards.

The staffing level on the ward on 17 March 2020

[292] Having considered all the evidence about staffing levels on 17 March 2020, I conclude that the ward was staffed at the minimum level. It was not overstaffed. Three versions of the rota were spoken to in evidence, only one of which was the electronic print-out. I accept the evidence of Craig Stenhouse that the electronic version was the up-to-date rota and the only one that should be relied on. There was evidence from some of the nurses that they checked the rota on their mobile phones, again supporting the conclusion that the electronic one was to be relied upon. At one point during the inquiry the family considered that the ward might have been overstaffed. There were extra names on one of the paper copies, but there was evidence that the additional names may have been attending training.

[293] In my view it is unrealistic to conclude that the ward was overstaffed.

Mhairi Tennant had to “act up” because a more senior nurse was on sick leave. There was other evidence about sick leave, with nurses being absent or newly returning to work after a period of sick leave. I do not think the ward was understaffed: the evidence from Craig Stenhouse and from the coordinating charge nurse Gordon McGregor was that a certain number of staff were required in order for the ward to operate safely, and if staff were absent other staff would be found from other wards, from bank staff or from an agency. Three of the nurses were working a “long day”, with Radoslaw Rzeznicki having been asked during his shift on 17 March 2020 to stay on beyond his expected 3pm finish and to finish at 8.00pm instead.

Consideration of the submissions of the participants

[294] Radoslaw Rzeznicki and the family agreed with the Crown’s submissions in relation to precautions which could reasonably be taken, the defect in the system of working which contributed to Dr Macrae’s death, that the retrospective completion of the safety brief 4 weeks after her death was a relevant circumstance, and with the three recommendations proposed. Radoslaw Rzeznicki also proposed a recommendation and reasonable precaution to have a functionality in TRAK which alerted clinicians to potential risk factors such as previous suicide attempts.

[295] The Health Board agreed with the Crown’s proposed precautions 2 and 3 but not 1 and 4. The Health Board did not agree that there were defects in the system of working which contributed to the death. Their position was equivocal regarding

whether the late completion of the safety brief was relevant to the circumstances of Dr Macrae's death. Their position was that no formal recommendations were required.

[296] The family proposed 15 recommendations of their own. These were generally opposed by the other participants.

[297] In my opinion the Crown submissions are generally well founded and supported by the evidence. They are supported by the solicitor for Radoslaw Rzeznicki and by the family.

[298] I have made the findings proposed by the Crown in relation to sections 26(2)(a), (b), (c), (d), (e) and (g) of the Act in the terms set out in the Crown's written submissions and for the reasons given there. I have made the recommendations proposed by the Crown in relation to sections 26(1)(b) and (4)(a), (b) and (d) of the Act for the reasons given.

[299] I do not accept the Crown's submission that there was a defect in the system of working caused by the medical records from different health boards not being collated in one place (section 26(2)(f)). The evidence does not support this. In July 2018 Dr Macrae was transferred to Inverclyde due to a lack of beds, but she was soon transferred back to Edinburgh. Her attempt to hang herself from her curtain rail took place in the Hermitage ward of the Royal Edinburgh Hospital, and her attempt to set fire to a ward took place after she had been transferred to the Blackford ward there. There was no evidence about what happened in Inverclyde. It cannot be said that the lack of access to records of another health board contributed to her death.

[300] It is the lack of easy access to the entries in the records from the Hermitage ward in particular which is the defect in the system of working which contributed to Dr Macrae's death. I heard evidence that some psychiatric patients have an extensive inpatient history, with many volumes of records amounting to thousands of pages. It was not practical for those treating the patient to read them all. They relied on key documents such as discharge summaries from previous admissions or risk assessments and safety briefs for current admissions. Dr Murray had not seen the most significant entry, which was the previous suicide attempt by hanging. This is a defect in the system of working which contributed to Dr Macrae's death. I accept the submissions of the solicitor for Radoslaw Rzeznicki about a recommendation on this matter. I recommend that a function is developed on TRAK to alert clinicians to potential risk factors such as previous suicide attempts as soon as they open the patient's notes.

[301] Although I have found that the lack of access to the Inverclyde records was not a defect in the system of working, it would be helpful for those treating a patient to have access to records from other health boards relating to that patient. I have made the recommendation proposed by the Crown.

[302] During the oral submissions the procurator fiscal depute recommended that the ongoing audit should include the external audit of the PCAT. I agree. I accept that there is some merit in wards auditing their own work because the senior charge nurse knows the patients and therefore knows whether the risk assessment has been completed properly and whether the care plan is relevant. I accept that there has been training and more staff have been recruited to fill vacancies. However I also heard evidence that it

might be possible to have auditing by wards in other hospitals where there were patients with similar conditions. Auditing of one ward in the Royal Edinburgh Hospital by another ward had not worked, but it might be that with the changes put in place following the SAER, including the training of staff and the employment of more nurses, this option might now work better. There is also the option of auditing between equivalent mental health wards in different health boards, which Craig Stenhouse accepted was a possibility. I note that the Mental Welfare Commission continues to have concerns about care plans in particular. The family's views about this are important, particularly given Calum MacRae's experience of audits in health care. He was concerned that some elements of the SAER had not yet been implemented and that other measures had only been put in place in 2024. That suggested that the internal audit was "manifestly inadequate". The family's recommendation 10 is, however, too wide.

[303] The family submitted that the word "meaningful" in recommendation 3 was too vague, and that the recommendation should list the specific actions the Health Board should take from the SAER. In my view flexibility is needed. The word "meaningful" implies that effective action must be taken, but at the same time it allows flexibility. With recommendation 3 (about the doors to the bedrooms), the recommendation of meaningful implementation should mean that the Health Board continue to bear this recommendation in mind rather simply saying they looked at the doors but do not have the finances at the moment.

Submissions for Lothian Health Board

[304] I do not accept the submissions for the Health Board.

[305] Counsel referred to Dr Macrae's disorder being a difficult disorder to manage and treat. That is not an excuse. The staff were aware of the nature of her disorder, and should have been taking extra care. Counsel referred to the ward being a complex, high risk environment, busy and stressful. That is not an excuse. The ward was an acute mental health ward. That is why there are protocols and professional standards. These require to be followed. Counsel referred to there being additional pressure due to the impending closure to visitors due to Covid. That is not an excuse. On 17 March 2020 Covid was not known to be life changing event it became, with multiple deaths and lengthy periods of lockdown.

[306] The Health Board's position in their written submissions was that the handing in of the noose and the risk it presented was adequately assessed and responded to by Radoslaw Rzeznicki allowing Dr Macrae to spend time outwith the ward with Christopher MacRae, rather than putting her on constant observations. In oral submissions the Health Board accepted that Radoslaw Rzeznicki should have carried out a search of Dr Macrae's room. I prefer the evidence of the Chief Nurse, Craig Stenhouse: Dr Macrae should have been put on constant observation too.

[307] It is no answer for the Health Board to refer to the additional check on Dr Macrae at about 8.40pm by nurse Joanne Compton. That was done on Joanne Compton's own initiative, after having spoken to Christopher MacRae as she came on shift. Ward staff

failed to recognise the significant increase in risk presented by the handing in of the noose. Dr Macrae had moved from suicidal ideation to intent. She had a plan.

[308] In the written submissions the Health Board acknowledged that there were issues relating to communication between staff following the handing in of the noose. Reference was made to Radoslaw Rzeznicki assuming Mieke Woodbridge would note the incident in TRAK, but Mieke Woodbridge said the incident was not reported to her. This is suggestive of a chaotic workplace. I have resolved the factual dispute in relation to the handing in of the noose, and I have found that it was Mhairi Tennant who was spoken to by Radoslaw Rzeznicki, not Mieke Woodbridge. I have also found that Mhairi Tennant advised that there should have been one to one conversations with Dr Macrae, and that she was not aware that Dr Macrae had gone off the ward until the following day. Although the Health Board describe Mieke Woodbridge as having been Dr Macrae's named nurse that day, at one point in his evidence Radoslaw Rzeznicki thought that he might have been the named nurse. This is a further example of my concern about witnesses not taking the time to prepare to give evidence on oath on matters as serious as those raised by an inquiry.

[309] In oral submissions counsel said that the Health Board recognised that Radoslaw Rzeznicki should have carried out a search of Dr Macrae's room, that he should also have communicated the handing over of the noose to staff on the ward and that it should have been recorded on TRAK. The Health Board recognised that there were issues about communication. Radoslaw Rzeznicki should have noted what Christopher MacRae had told him. He should have communicated that to other staff on

his shift and to those coming onto the night shift. Counsel submitted, however, that the staff on the ward did know there were concerns about Dr Macrae's presentation despite the lack of communication from Radoslaw Rzeznicki. I do not accept that submission. Staff did not know about the noose. While some of them may have been aware of suicide ideation in the past, the noose was evidence that Dr Macrae had moved beyond ideation to suicidal intent. The noose was the means by which she could carry out her intent.

[310] While the Health Board accepted that retrospective entries were not best practice and that it would have been better for the safety brief of 17 March 2020 to have been completed then rather than 4 weeks after the death of Dr Macrae, the Health Board referred to the challenges of working on an acute mental health ward and that having been exacerbated by impending Covid restrictions. I am concerned that the Health Board has not admitted this failing unconditionally. Craig Stenhouse was critical of late entries, particularly after the death of a patient. They made it look as if something was being covered up.

[311] There were serious failings in the treatment and care of Dr Macrae. These resulted in a level 4 outcome at the SAER and 22 recommendations being made. The Health Board in their submissions opposed the making of findings in relation to precautions, defects in the system of working, the late safety brief and the recommendations sought by the Crown. They submitted that improvements had been made and were continuing to be made.

[312] In my opinion there are areas where the Health Board has failed to appreciate the significance of the errors and omissions. There are areas where their position was not supported by the evidence of their own chief nurse. Much of this inquiry related to an absence of awareness of protocols and a failure to record information. It is appropriate that I make findings, suggest precautions and make recommendations. It is not sufficient simply to allow the Health Board to implement the recommendations made by the SAER in terms of their improvement plan. A recommendation is required.

[313] The Crown referred to a defect in the system of work arising out of Dr Macrae's medical records from different health boards not being collated in the one place and leading to a lack of awareness of previous suicide attempts using ligatures. It is no answer to refer to Dr Murray's diligence in reviewing the records and having a good understanding of Dr Macrae's condition. If those records had been available, the increase in risk might have been identified. But it seems to me that even if staff were not aware of previous attempts, and the handing in of the noose was the first attempt they were aware of, the noose was accepted in evidence to be an indication of an intention to commit suicide coupled with the means, and that should have prompted them to take it seriously. Although work is being done on the accessibility of records, in my opinion the formal finding sought in the second recommendation is required for the reasons set out above.

Submissions for Radoslaw Rzeznicki

[314] The solicitor for Radoslaw Rzeznicki accepted and supported the precautions, the defects in the system of working and the recommendations identified by the Crown. The solicitor also submitted that a recommendation and reasonable precaution may be to have a functionality in TRAK which alerted clinicians to potential risk factors such as previous suicide attempts. There was such a system in Greater Glasgow and Clyde. I accept that. The difficulty in accessing the records relating to a previous suicide attempt by hanging within the same hospital is a defect in the system of working which contributed to Dr Macrae's death. I have also made a recommendation to reflect that.

Submissions for the family: further proposed recommendations

[315] Recommendation 1. This is beyond the scope of the inquiry. Such a change would require primary legislation. I understand the family's concern that there was no right to an inquiry in this case. It would be for the Scottish Parliament to decide whether the distinction between persons detained for the purpose of punishment and who die in prison for any reason and persons detained for the purpose of psychiatric treatment because they are a risk to themselves and who commit suicide in a psychiatric hospital should still be maintained. Although a discretionary inquiry is allowed in many such cases, making an inquiry mandatory would offer the family some comfort at an early stage and might result in earlier hearing dates while evidence is fresher.

[316] Recommendation 2. This is beyond the scope of the inquiry. Furthermore the police did not participate in the inquiry. There may be reasons why there should not be

uniformity in investigations, for example having regard to the powers different organisations such as the police possess.

[317] The solicitor for Radoslaw Rzeznicki suggested that I might like to comment on how thorough the SAER had been and that other health boards might like to use it as a model. The only comment I can make is that this SAER appeared to be thorough and promptly done. That may be because it was in relation to a death.

[318] Recommendation 3. This would have required the participation of NHS Scotland as opposed to Lothian Health Board and evidence about logistics and costs.

[319] Recommendation 4. Some of this is covered by Crown recommendation 3.

[320] Recommendation 5. This would have required the participation of the police and evidence about the costs. If implemented it could potentially have produced a great volume of documentation (such as text messages), much of which may not have been of any value and which would have caused delay.

[321] Recommendation 6. This issue was not explored in detail at the inquiry.

Dr Khan said that the weekly contact with the consultant was the minimum, but that there could be further contact if required. There was reference to daily “huddles” between the consultant and the staff about patients. The recommendation has resource implications but no evidence was led about how many more staff would require to be employed.

[322] Recommendation 7. This is covered to some extent by SAER recommendations 2 and 14. The Patient Centred Care Plan is the Health Board’s solution to the concerns of the Mental Welfare Commission.

[323] Recommendation 8. This is covered by SAER recommendations 2 and 19.

[324] Recommendation 9. Craig Stenhouse made it clear in his evidence that a noose was a dangerous item, it was obvious what should be done with the noose and with the patient and it did not need to be set out in a document. SAER recommendation 16 about searching patients may have some relevance to this proposed recommendation. The Nursing and Midwifery Council deals with the professional conduct of nurses.

[325] Recommendation 10. Some of this is covered by Crown recommendation 3. The Crown submitted that the PCAT audit should be an external audit.

[326] Recommendation 11. There was evidence this is currently not affordable. It is covered by SAER recommendation 3. Making Crown recommendation 3 should mean that SAER recommendation 3 is not overlooked.

[327] Recommendation 12. This would have required the participation of NHS Scotland as opposed to Lothian Health Board and evidence about all levels of leadership and all disciplines. SAER recommendations 2, 13, 14, 15 and 19 are relevant to this recommendation, and so the measures introduced following the SAER recommendations would appear to be appropriate to this recommendation.

[328] Recommendation 13. It is not the purpose of the inquiry to reach decisions relating to disciplinary action. The Nursing and Midwifery Council guidelines may be available online.

[329] Recommendation 14. This recommendation would require amendment of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017. Those draft amendments would have to be laid before the Scottish Parliament. That is not within my power.

[330] Such a recommendation would be likely to produce a vast quantity of documentation, much of which might not be relevant to the inquiry. It is important that the inquiry can focus on evidence relevant to the statutory tests set out in the Act. The process of ingathering such information is likely to be lengthy and costly, thus delaying the start of the inquiry. If a vast quantity of documentation were to be recovered, then additional court days would be required and this too would add to delay.

[331] However I recognise that in this inquiry what Mhairi Tennant said to the SAER was different from what she said at the inquiry. I have explained why I preferred her earlier evidence. This determination may be of relevance to practitioners by putting them on notice that they may wish to recover such earlier prior statements where witnesses cannot remember events by the time of the inquiry.

[332] Recommendation 15. This is beyond the scope of the inquiry.

[333] Finally I wish to thank the procurator fiscal depute, counsel for the Health Board, the solicitor for Radoslaw Rzeznicki and the family for their assistance throughout the preliminary stages of the proceedings and at the inquiry. Throughout the procedure all participants worked collaboratively to secure the release of information to the inquiry and to agree a substantial amount of evidence which obviated the need for a number of other witnesses to attend court.

[334] Dr Macrae was a much loved mother and only sister to five brothers. I offer them and their whole family my sincere condolences.